WELLNESS • RECOVERY • RESILIENCE

Mental Health Services
Oversight & Accountability Commission

Commission Packet

Commission Meeting
October 27, 2016

MHSOAC
1325 J Street, Suite 1700
Sacramento, CA 95814

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

Mental Health Services
Oversight & Accountability Commission

WELLNESS • RECOVERY • RESILIENCE

Victor Carrion, M.D.
Chair

1325 J Street, Suite 1700
Sacramento, California 95814

Commission Meeting Agenda

October 27, 2016
9:00 A.M. – 4:40 P.M.
MHSOAC Offices
1325 J Street, Suite 1700
Sacramento, CA 95814

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

Public Notice

The public is requested to fill out a "Public Comment Card" to address the Commission on any agenda item before the Commission takes an action on an item. Comments from the public will be heard during discussion of specific agenda items and during the General Public Comment periods. Generally an individual speaker will be allowed three minutes, unless the Chair of the Commission decides a different time allotment is needed. Only public comments made in person at the meeting will be reflected in the meeting minutes; however, the MHSOAC will also accept public comments via email, and US Mail. The agenda is posted for public review on the MHSOAC website http://www.mhsoac.ca.gov 10 days prior to the meeting. Materials related to an agenda item will be available for review at http://www.mhsoac.ca.gov.

All meeting times are approximate and subject to change. Agenda items are subject to action by the MHSOAC and may be taken out of order to accommodate speakers and to maintain a quorum.

As a covered entity under Title II of the Americans with Disabilities Act, the Commission does not discriminate on the basis of disability and upon request will provide reasonable accommodation to ensure equal access to its meetings. Sign language interpreters, assisted listening devices, or other auxiliary aids and/or services may be provided upon request. To ensure availability of services, please make your request at least three business days (72 hours) prior to the meeting by contacting Cody Scott at (916) 445-8696 or email at mhsoac@mhsoac.ca.gov.

9:00 AM **Convene**
Vice Chair Tina Wooton will convene the Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission) Meeting. Roll call will be taken.

9:05 AM **Announcements**

9:10 AM **Action**
1A: Approve September 22nd, 2016, MHSOAC Meeting Minutes
The Commission will consider approval of the minutes from the September 22, 2016, MHSOAC meeting.

- Public Comment
- Vote

Information
1B: September 22, 2016 Motions Summary
A summary of the motions voted on by the Commission during the September 22, 2016 Commission meeting.

1C: Evaluation Dashboard
The Evaluation Dashboard provides information on both executed and forthcoming MHSOAC evaluation and data strengthening efforts, including primary objectives, timelines, and deliverables.

1D: Calendar
The Calendar provides information on Commission and related meetings.

9:15 AM **Information**
2: Innovation Plan Review Process
Presenter: Brian R. Sala, Ph.D., Deputy Director
The Commission will consider a proposal to revise the Commission process for reviewing and approving County Innovation projects.

- Public Comment

9:35 AM **Action**
3: Trinity County Innovation Plan
Presenter: Brian R. Sala, Ph.D., Deputy Director
County Presenter: Noel O'Neill, LMFT, Director, Trinity County Behavioral Health
The Commission will consider approval of an amendment to a previously approved Innovative Project Plan for Trinity County.

- Public Comment
- Vote

10:20 AM **Action**
4: Orange County Innovation Plan
Presenter: Brian R. Sala, Ph.D., Deputy Director
County Presenter: Flor Tehrani Yousefian, Interim Administrative Manager for Innovative Projects
The Commission will consider approval of three Innovative Project Plans for Orange County.

- Public Comment
- Vote

10:55 AM **Information**

5: Demonstration of Fiscal Reporting Tool

Presenter: Brian R. Sala, Ph.D., Deputy Director

Brian Sala will provide a demonstration of the MHSOAC Fiscal Reporting Data Visualization Tool and an update on related transparency projects.

- **Public Comment**

11:55 AM **General Public Comment**

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

12:10 PM **Lunch**

1:10 PM **Action**

6: Elect Chair and Vice-Chair for 2017

Presenter: Filomena Yeroshek, MHSOAC Chief Counsel

Nominations for Chair and Vice-Chair for 2017 will be entertained and the Commission will vote on the nominations and elect the Chair and Vice-Chair.

- Public Comment
- Vote

2:10 PM **Action**

7: Regulations Implementation Project Report

Presenter: Filomena Yeroshek, MHSOAC Chief Counsel

The Commission will consider adopting the recommendations submitted by the Regulations Implementation Project Subcommittee to implement the Prevention and Early Intervention and Innovation Project regulations.

- Public Comment
- Vote

3:10 PM **Information**

8: Overview of Triage Grant Program and Evaluation

Presenters: Norma Pate, Deputy Director and Fred Molitor, Director, Research and Evaluation.

Norma Pate will provide an overview of the Triage Grant Program. Fred Molitor will present an update on the Triage Grant Evaluation of Program Effectiveness.

- Public Comment

4:10 PM **Information**:

9: Executive Director Report Out

Presenter: Toby Ewing, Ph.D., will report out on projects underway and other matters relating to the ongoing work of the Commission.

4:25 PM **General Public Comment**

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

4:40 PM **Adjourn**

AGENDA ITEM 1A

Action

October 27, 2016 Commission Meeting

Approve September 22, 2016 MHSOAC Meeting Minutes

Summary: The Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission) will review the minutes from the September 22, 2016 meeting. Any edits to the minutes will be made and the minutes will be amended to reflect the changes and posted to the MHSOAC Web site after the meeting. If an amendment is not necessary, the Commission will approve the minutes as presented.

Presenter: None

Enclosures: September 22, 2016 Commission Meeting Minutes

Handouts: None

Recommended Action: Approve September 22, 2016 Meeting Minutes

Proposed Motion: The Commission approves the September 22, 2016 Meeting Minutes

State of California

MENTAL HEALTH SERVICES
OVERSIGHT AND ACCOUNTABILITY COMMISSION

Minutes of Meeting
September 22, 2016

California African American Museum
600 State Drive
Los Angeles, California 90037

866-817-6550; Code 3190377

Members Participating

Victor Carrion, M.D., Chair
Tina Wooton, Vice Chair
Reneeta Anthony
Khatera Aslami-Tamplen
John Boyd, Psy.D.
Sheriff Bill Brown
John Buck
Itai Danovitch, M.D.
Gladys Mitchell
Richard Van Horn

Staff Present

Toby Ewing, Ph.D., Executive Director;
Norma Pate, Deputy Director,
Program, Legislation, and Technology;
Brian Sala, Ph.D., Deputy Director,
Evaluation and Program Operations;
Filomena Yeroshek, Chief Counsel;
Peter Best, Staff Services Manager;
Ashley Mills, Research Program Specialist;
Cody Scott, Staff Services Analyst;
Moshe Swearingen, Office Technician;

Members Absent:

Lynne Ashbeck
Senator Jim Beall
David Gordon
Larry Poaster
Assembly Member Tony Thurmond

CONVENE

Chair Victor Carrion called the meeting of the Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission) to order at 9:17 a.m. and welcomed everyone. Filomena Yeroshek, Chief Counsel, called the roll and announced that a quorum was not yet present. A quorum was achieved after Vice Chair Wooton and Commissioner Boyd arrived.

Welcome

Chair Carrion introduced George Davis, Executive Director of the California African American Museum. Mr. Davis welcomed everyone to the California African American Museum. He provided a brief overview of the background, and current and future activities and exhibits of the museum. He stated the museum recently was named a Smithsonian affiliate.

ACTION

1A: Approve August 25, 2016, MHSOAC Meeting Minutes

Action: Commissioner Van Horn made a motion, seconded by Commissioner Brown, that:

The Commission approves the August 25, 2016, Meeting Minutes.

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

The following Commissioners voted "Yes": Chair Carrion, Vice Chair Wooton, and Commissioners Anthony, Aslami-Tamplen, Boyd, Brown, Buck, Danovitch, Mitchell, and Van Horn.

INFORMATION

1B: August 25, 2016, Motions Summary

1C: Evaluation Dashboard

1D: Calendar

INFORMATION

2: Mental Health and Criminal Justice Commission Project Panel Presentations

Project Chair: Commissioner and Sheriff Bill Brown
Facilitator: Toby Ewing, Ph.D., Executive Director

Executive Director Ewing stated one of the identified priorities of the Commission is to reduce the number of mental health consumers who become involved with the criminal justice system. He stated today's panel presentation will help the Commission understand this issue, the roles of the state and counties, and how the Commission can help move the state in the direction of achieving the goals of the Mental Health Services Act (MHSA).

Commissioner Brown stated he went on a site visit to Allegheny County, Pennsylvania, and is scheduled to go on two additional site visits next week to San Antonio, Texas, and Miami, Florida, to look at model systems that are in operation. Mental health and criminal justice is an issue with impacts nationwide. The sheriffs of the state of California are interested in ways to reduce the number of individuals in custody who are mentally ill and locate them into alternative treatment facilities, and ways to treat mentally ill individuals who will remain in custody. He thanked Assistant Sheriff Harrington and his staff for an informative tour of the Twin Towers Correctional Facility, and he thanked staff for their work on this important and ambitious project.

Panel 1: Consumers, Family Members, and Advocates

Presenters:

Catherine Clay, peer advocate
Harold Turner, Los Angeles County parent
Mark Gale, Criminal Justice Chair, NAMI Los Angeles County Council

Catherine Clay

Catherine Clay, peer advocate, stated trust is a large issue for consumers. She shared her story saying that in the past twenty-five years she went from being homeless, living with Posttraumatic Stress Disorder (PTSD), and depression to becoming a client expert in the California Association of Mental Health Peer-Run Organizations (CAMHPRO), a coach and ambassador of Women's Reintegration Educational Services, vice president of the Los Angeles Client Coalition, and president of her church prison ministry.

Ms. Clay discussed gaps in the system, such as the removal of services from clinics, the lack of follow-up and housing retention in MHSA housing, and education for skills to keep the housing. She stated she was incarcerated for missing her court date, had no one to advocate for her, and the judge did not understand or have empathy for someone with lived experience. She stated the jail system is the biggest mental health hospital.

Ms. Clay suggested looking at how women are affected, putting money into gender-specific clinics, having peer support navigators inside of the jails who would facilitate groups and teach evidence-based programs to help individuals navigate and know patients' rights before they are released. She also suggested having peer support navigators outside of the jail creating warm handoffs.

Harold Turner

Harold Turner, Director of Programs, National Alliance on Mental Illness (NAMI) Urban Los Angeles, shared his daughter's story of being diagnosed with paranoid schizophrenia in her junior year in college, being incarcerated for premeditated murder, being sentenced to Patton State Hospital, being released to an outpatient program under a conditional release program, and then being pressured to pay for the outpatient program. He stated the outpatient program was callous with very little therapy and counseling. The Department of State Hospitals does not provide oversight to these outpatient programs. A result is that these outpatient programs do not have standards of care, standards of operation, or customization of services. He stated he searched for nine years prior to her incarceration to find resources to help her, finally finding help at NAMI.

Mr. Turner stated, when he raised concerns about issues in the programs, public safety was the thing they hid behind. Public safety and good treatment were mutually exclusive. He stated the concern that county outpatient programs are being outsourced and privatized. He stated the need to have conditional outpatient treatment programs reviewed by counties. Also Full Service Partnerships (FSPs) slots need to be allocated for this population coming out of the state hospital system. The state hospital system does a great job but once individuals step out of the hospital they step into unreviewed and unevaluated outpatient programs.

Mark Gale

Mark Gale, Criminal Justice Chair, NAMI Los Angeles County Council, shared the story of his son, who has a serious mental illness and was sent to school in a locked facility out-of-state. He stated the need to keep children who need that level of care near their parents, not in another state. Those types of services are needed in California. Mr. Gale stated his son spent time in the Twin Towers Correction Facility after being homeless for several months. During that time he could not reach a doctor to inform about his son's medication. Mr. Gale co-authored a book during his son's detainment, titled "My Son's Been Arrested. What Do I Do?" and developed the Inmate Medication Information Form.

Mr. Gale summarized his comments provided in the meeting packet. He stated that competing belief systems can lead to discriminatory practices and funding priorities that create wide disparities and access to different levels of services and care. There is a need for a comprehensive system-wide approach that plans for full access to a complete continuum of care and services. Mr. Gale stated that the Sequential Intercept Model provides a road map for the criminal justice system to integrate with the mental health system which can reduce the number of people with mental illness in jails and prisons. The MHSA can contribute to a comprehensive strategy to reduce the criminalization of individuals with serious mental illness in many ways including through FSP programs, competency restoration programs, and leveraging SB 82 funds to provide linkage to treatment services.

Commissioner Questions and Discussion

Commissioner Aslami-Tamplen asked Ms. Clay for ideas on how individuals who are coming out of incarceration can be supported.

Ms. Clay stated it is important to have navigators inside the jail. Mental health clinics should begin working with individuals inside the jails to education them on topics such as housing and to pick up the individuals when they are released from jail. The clinic should have designated beds so the individual does not need to look for a shelter. After the short term stay in the clinic and shelter there should be innovative housing with four- to five-bed apartments for the twenty-two months it takes for individuals to seek Section 8 housing. This could be a sort of collective family type of care. At that time, all five individuals in the household would move on with a Section 8 voucher to function as a foster family model approach. She suggested that the peer support navigator who interacts with individuals inside the jail also help them get housing, visit them in the housing, and connect with them through their mental health services. It is a warm handoff with a familiar face, and that navigator guides them through the jail system and helps them reenter the community successfully.

Commissioner Brown recommended a documentary that was just released, called *The If Project.*

Panel 2: Los Angeles County Mental Health and Public Safety Representatives

Presenters:

The Honorable Jackie Lacey, Los Angeles County District Attorney
The Honorable James Brandlin, Supervising Judge, Criminal Division, Superior Court of Los Angeles County

The Honorable Scott Gordon, Assistant Supervising Judge, Criminal Division, Superior Court of Los Angeles County
Robin Kay, Ph.D., Acting Director of Mental Health, Los Angeles County Department of Mental Health
Mark Ghaly, M.D., Director of Community Health and Integrated Programs, Los Angeles County Department of Mental Health
Kelly Harrington, Assistant Sheriff, Los Angeles County Sheriff's Department

Jackie Lacey

The Honorable Jackie Lacey, Los Angeles County District Attorney, stated that there are way too many people housed within our county jails who have been diagnosed as suffering from mental illnesses. Very often there are strong links between the underlying mental illnesses and the acts that lead to an arrest. To find ways to safely divert non-violent mentally ill offenders from the county jail into community based treatment she launched the Criminal Justice Mental Health Advisory Board (Advisory Board). District Attorney Lacey stated that in 2015 she presented to the Board of Supervisors the Advisory Board's report and the Board of Supervisors, in response to the report, created the Office of Diversion and Reentry within the Department of Health Services and allocated $120 million. She also stated that the county has had great success in the area of considering treatment options for misdemeanor offenders who are mentally incompetent to stand trial.

District Attorney Lacey summarized her comments provided in the meeting packet. She stated that the State can assist local mental health diversion efforts by fostering awareness, communication, and leadership statewide. One of the enemies of the change that needs to take place is the lack of communication in the criminal justice and health systems. She spoke about key challenges, ethical implications, local mental health diversion efforts, and legislation related to the needs of individuals with mental health issues who are involved in the criminal justice system. She stated the need for data, accountability, and ambitious goals. Rules and regulations that are in place are the greatest barrier to getting people help and stand in the way of progress.

James Brandlin

The Honorable James Brandlin, Supervising Judge, Criminal Division, Superior Court of Los Angeles County, provided a brief overview of his background and some context including statistics on the caseload of the Los Angeles Superior Court, which is the largest trial court in the United States. He summarized the materials he distributed at the meeting. He spoke about the Mental Health Courthouse, the three courtrooms of Department 95, and the need for expansion and greater resources to devote more time to individuals at risk. He highlighted alternative sentencing courts, such as the four Community Collaborative Courts (CCC) that address particular vulnerable populations and unique issues. The CCC are designed to be a multidisciplinary and resource intensive response to cases involving some of the most vulnerable populations involved in the criminal justice system. This includes veterans, chronically homeless, the mentally ill, those suffering from substance use disorders, and victims of sex trafficking and transitional at risk youth. Judge Brandlin provided an overview of the eligibility requirements and the exception protocols for the CCC, as well as the matrix for the CCC to help institutionalize this approach.

Judge Brandlin stated that there is a need for additional funding for specialty mental health courthouses, more Department of Mental Health linkages officers in the courtrooms and jail, and more state hospital beds.

Scott Gordon

The Honorable Scott Gordon, Assistant Supervising Judge, Criminal Division, Superior Court of Los Angeles County, provided a brief overview of the Office of Diversion and Reentry (ODR) Pilot Project. This pilot project has been in place approximately one month and there are promising results already. The project deals with long-term homelessness and housing alternatives. The pilot project works with mentally ill defendants in the jail, identifies those who are candidates for FSPs or Integrated Case Management Services (ICMS), and processes the cases to get the individuals into those programs as a probationary sentence. The biggest challenge is not having enough resources and linkages to services.

Robin Kay

Robin Kay, Ph.D., Acting Director of Mental Health, Los Angeles County Department of Mental Health (LACDMH), summarized her comments provided in the meeting packet. She used the Sequential Intercept Model of mental health diversion planning to organize her presentation, and identified the points where clients may face the intersection of criminal justice and mental health. She shared how MHSA funding has been used in Los Angeles County to build a mental health and law enforcement partnership to divert individuals from jail and into treatment. Dr. Kay, stated that a challenge to more effective programs is the rules dealing with privacy and information sharing. These rules need to be looked at.

Mark Ghaly

Mark Ghaly, M.D., Director of Community Health and Integrated Programs, LACDMH, and the first Interim Director of the Office of Diversion and Reentry (ODR), provided an overview of the ODR vision and other initiatives that tie into ODR success. Dr. Ghaly stated that 40 percent of ODR's budget must go to permanent supportive housing. He also stated that data and data sharing is a challenge. Dr. Ghaly had the following recommendations: (1) the rules around Section 8 housing should be reviewed and revised; (2) there needs to be better understanding of how the Drug Medi-Cal waiver will be used as part of services; (3) providers need to be licensed quickly; (4) assessment and treatment needs to happen earlier in jail; (5) a comprehensive discharge plan should be done at the beginning similar to what hospitals do; (6) there should be a coordinated release time – there is no reason for a 2:00 am release; and (7) there is a need to work with the Federal government around loss of benefits while the person is in jail. Dr. Ghaly underscored that the issue is not just what is done on diversion, but how health care services are managed in the jail and how other departments are aligned on this issue.

Kelly Harrington

Kelly Harrington, Assistant Sheriff, Custody Division, Los Angeles County Sheriff's Department, gave a brief overview of his background and what is happening in jails today. The largest topics among correctional professionals across the country have been restrictive housing and the growing population of mentally ill in the prisons and jails. He

stated jails were not built for the mentally ill or to provide the appropriate level of care for mentally ill inmates.

Correctional professionals need to continue to work with medical and mental health providers to use the access to care model and participate in ongoing quality improvement. Continuity of care is key, particularly the continuity of medication and stabilization of inmates upon arrival to ensure a better opportunity for the inmate's success.

Assistant Sheriff Harrington stated the need for more state hospital beds, the development of more community-based programs upon parole and probation, and parole outpatient clinics. As the mentally ill population continues to grow, there will be a need to build or replace jails with more of a correctional treatment facility that is treatment-centric, like putting a jail within a hospital so inmates can receive needed care, because putting a hospital inside a jail does not work.

Commissioner Questions and Discussion

Commissioner Anthony asked how this has been affected by the changes due to Assembly Bill (AB) 109 and Proposition 47. Judge Gordon stated the effects may not be known for years. Los Angeles has a separate AB 109 court that works with the ODR and the LACDMH. The Superior Court is in a position of tremendous flux – filings are down significantly, crimes are up, and felonies are not down. Many intercept programs were premised on the idea of probation being the supervision model. The challenge is that this is not there, so many defendants take the jail time over probation.

Commissioner Aslami-Tamplen asked about training for judges from consumers and family members on how to engage with individuals in their courtrooms who may be struggling with mental health issues. Judge Brandlin stated judges are responsible for organizing an annual day's seminar for all judicial officers in the Los Angeles Superior Court Criminal Division. A subject that has the greatest interest among judges is mental health.

Commissioner Aslami-Tamplen asked how peer advocates can be available in courts so individuals understand there is someone to support them through the process. Judge Brandlin stated an issue that separates the judges from other justice partners is that judges have canons of ethics that prohibit them from engaging in ex parte communications. Dr. Kay stated, when the Collaborative Courts began, the judicial officers toured mental health programs for a full day. Consumers and family members were included in the tour. Judge Gordon stated the judicial team have attended trainings on supportive housing and substance abuse, toured housing units, and participated in the Crisis Intervention Team (CIT) program. The judicial team is also scheduled to tour the veterans' facility.

Commissioner Mitchell asked about panel members' thoughts on California Welfare and Institutions Code Section 5150. She stated the need for a change in the legal definition of an adult with a mental illness. It is huge in terms of barriers. Judge Brandlin stated judges have ethical constraints and cannot advocate publicly in arenas that affect the Legislative or Executive Branches.

Commissioner Boyd asked about the correlation between improved diversion efforts and decreased utilization on the other side. Judge Gordon stated the biggest challenge is

linking individuals to programs. There is a need for service navigators, service brokers, or clinicians to be that link.

Chair Carrion asked about the role of consumers in the development and implementation of programs and the methods to capture the input of consumers and put their suggestions to use. Dr. Ghaly stated the ODR and their subcommittees are open meetings with representation from community groups, but those meetings are not attended by as many consumers as they would like and additional opportunities for engagement in the programs are being planned. Los Angeles County has proposed to do a five-year pilot project called “Whole Person Care” with the key element of hiring peers or community health workers to work inside and outside of jails. The peer component is essential to the success of these programs. He stated he is open to hearing suggestions on how to better hear from consumers and family members.

Commissioner Danovitch stated hospitals are an important safety net for this population. One of the challenges is that non-county facilities and private community hospitals are not well linked with county resources. He asked what can be done to ensure that safety net can connect individuals to appropriate services. Dr. Ghaly stated there is increased interest in diversion programs, but they are still not enough. It is not just a private hospital problem; it needs to be addressed for all hospitals. The way to address it is by creating more community placements. The biggest contribution to date has been the urgent care centers but the need continues to be great. To address that need, there must be more innovations in creating the number and type of slots in the community.

Commissioner Aslami-Tamplen asked about innovative ideas and policies to help cities support housing rent caps. Dr. Ghaly stated Los Angeles County struggles with that issue. He stated that there is a need for Section 8 vouchers to keep up with rents. Cities need to be encouraged to create affordable housing units.

Panel 3: Statewide Challenges and Opportunities

Presenters:

Stephanie Welch, Executive Officer, Council on Mentally Ill Offenders (COMIO)
David Meyer, J.D., Clinical Professor, Institute of Psychiatry, Law and the Behavioral Sciences, U.S.C. Keck School of Medicine

Stephanie Welch

Stephanie Welch, Executive Officer, COMIO, provided an overview, accompanied by a slide presentation, of the background, goals, priorities, and achievements of COMIO. She stated that the primary goals of COMIO is to prevent criminal involvement, improve behavioral health services, and identify incentives to encourage state and local criminal justice, juvenile justice, and mental health programs to adopt approaches that work. Ms. Welch also discussed several challenges that COMIO is working on, such as stigma and the lack of access to care once a person is incarcerated. She stated that the MHSOAC and COMIO working together can build the needed bridges between criminal justice and behavioral health to prevent incarceration.

David Meyer

David Meyer, J.D., Clinical Professor, Institute of Psychiatry, Law and the Behavioral Sciences, U.S.C. Keck School of Medicine, shared statewide challenges:

- Systems coherence – meaningful bridges in the county mental health system to coordinate and prevent siloes
- Innovative practices – services that are delivered and practices that are used
- Measurement – effective outcome or performance measures to combat the challenging lack of data

Mr. Meyer encouraged Commissioners to attend the Words to Deeds Conference, which is a mechanism to get people together to share solutions to the problem of mentally ill offenders.

GENERAL PUBLIC COMMENT

Gwen Slattery thanked Ms. Welch for the information on juvenile justice and mental health issues. She stated this should be a high priority issue. She shared the story of a juvenile being held in detention for more than five years with the condition of his release being that he pass an IQ test. She asked the Commission to investigate that case. She shared the story of entrepreneurs who asked to teach entrepreneurship to incarcerated juveniles to help them when they were released. They were told the juveniles would use the instruction to sell drugs. This is stigma. She suggested reaching out to counties on their approach to stigma and being open-minded about services that can help youth.

Lisa Pion-Berlin, Ph.D., President and CEO of Parents Anonymous, gave an overview of the history and successes of Parents Anonymous. She stated peer support reduces hospitalization. There is talk about peers but not necessarily support for statewide evidence-based efforts. She offered Parents Anonymous as a resource to partner with the Commission.

Vickie Mendoza, Director, United Advocates for Children and Families (UACF) Parent Leadership Institute, echoed Ms. Slattery's comments. She shared the story of her ten children and the three that have gone through the mental health, probation, and child welfare system. She stated the need to start with the youth to get at the root of mental illness. If they are not helped in schools and when they first enter the juvenile justice system, they will end up in the adult system.

Carmen Diaz, former Commissioner, stated concern that the MHSOAC committees and community forum are being cut down. She stated the Client and Family Leadership Committee (CFLC) worked as advisors to the Commission and presented information as it was supposed to do, yet she was told the committees now do not accomplish anything. Chair Carrion stated staff will respond to her concerns offline.

Debbie Innes-Gomberg, Ph.D., MHSA Implementation and Outcomes District Chief, LACDMH, stated that today's discussion has the common theme that different parts of the community and different funding streams need to come together to support this effort. Communities coming together is one of the strategies in the LACDMH Innovation project that was approved by the Commission.

Dr. Innes-Gomberg stated the Three-Year Plan process for the MHSA is the vehicle to increase capacity in this area as well as improve service strategies. The Three-Year Plan process is an opportunity to identify and implement strategies. That process was started yesterday in Los Angeles.

Dr. Innes-Gomberg stated the Commission is in the process of re-bidding the mobile triage teams grants under Senate Bill (SB) 82. She suggested that the bidding date be pushed back so that the teams can demonstrate their effectiveness. She gave an example of the Crisis Transition Specialist Teams in Los Angeles. They are making a difference and are beginning to measure the outcomes of the teams.

Jim Gilmer stated African Americans feel enslaved in many ways by the criminal justice system and other systems. He suggested the book *The New Jim Crow – Mass Incarceration in the Age of Colorblindness* by Michelle Alexander, where Ms. Alexander speaks of other perspectives relative to criminal justice and mental health. Getting different health perspectives takes it to another level because not all public institutions that practice culturally-appropriate treatment for people of color will be heard. He suggested in-depth presentations, inviting stakeholder organizations representing people of color to come in and give their perspectives on issues such as misdiagnosis. In order to be true to the California Reducing Disparities Project (CRDP), people of color have to be involved at the professional, institutional, and organizational levels. He asked the Commission to help let his people go free.

Terri Boykins, Deputy Director, Juvenile Justice Mental Health, LACDMH, stated the concern that primary issues may be missed when individuals are released back into the community and no one talks with the inmates about their issues and how to reintegrate with their families and community. She stated an important thing she has learned being involved with women's reintegration is the role of peers and individuals with lived experience. She teaches that incarceration is not a destination but is a through-point to the destination of self-sufficiency – to take care of their children, families, and themselves. She suggested looking at expungement of records so that individuals can get real jobs.

Barbara Wilson, of Santa Clarita and San Fernando Valleys, discussed what is happening with licensed board and care homes and the discrepancy between homes that accept primarily individuals with serious mental illness verses individuals from regional centers. Licensed homes are being squeezed by unlicensed homes because they are unregulated. She asked the Commission to support using Proposition 63 funds to shore up the gap between the $35/day rate and the $85/day rate. She handed out further information on this issue to Commissioners.

Janina (phonetic) Marshall asked the Commission to come and have a conversation with the peers in her organization. She asked how many clients are on the Mental Health Advisory Board. She stated SB 82 is disappointing. It was an opportunity to hire clients as members of the teams. In Los Angeles, many of those involved are volunteers or receive a small stipend. The panel members that spoke today did not bring up the Health Neighborhood Service Areas. Service Area 6 has few services.

Ms. Marshall shared her story of being homeless, incarcerated, and undiagnosed. She had a probation officer "from hell" and was denied the help she begged for. Finally, she was referred to a mental health center, but arrived there only to find her appointment had

been canceled and would be rescheduled in 30 days. She stated no one considered the courage it took for her to walk through the doors of a mental health facility, fearful of what others would think. The individuals in her community are dying. She stated the LACDMH should be ashamed for what they are failing to do in the community. She asked the Commission to return to hear from the community.

Catherine Clay asked where the oversight is over the LACDMH and who is to follow up on the grievances filed. She stated she has filed over fifteen grievances and no one has followed up. Individuals should not have to go to another Health Neighborhood Service Area. Services should already be implemented in each area. She stated there should be a requirement that the eight service area representatives be from the community and look like the members of the community.

Ms. Clay asked where the family support is that her son is supposed to have. Her son was diagnosed at the age of seven but refuses to deal with the mental health system because every time he goes to the mental health center for care he is given an appointment for four months later. He is forced to self-medicate. She asked where his support is as the child of an advocate.

Ms. Clay asked where the after-hours services are that the community is supposed to receive because mental health triggers often do not flare up until after five o'clock. She stated she did not get any services from the LACDMH.

Ms. Clay supported SB 82, but one of the inhumane things she saw was the triage team refusing to give a trash bag to a lady on the ground because it was not considered housing services. The team members were afraid to get out of the car and approach her because they were not from the community and would not help the lady remove the trash from around her. She stated she is tired of the LACDMH telling lies. She asked the Commission to provide oversight over the county.

Sam Woolf, a peer counselor, mental health advocate, person with lived experience, and stakeholder, stated he runs a client-run center in Van Nuys with over 20 counselors with lived experience. He stated he oversees 230 clients with mental health problems. He spoke in support of the integration of peers in the criminal justice and mental health systems as has been discussed today. He knows from personal experience that it works. Individuals coming out of the criminal justice need help to get housing, employment and social services benefits. Peer counselors and individuals who work in the mental health world need to have training in these specialty areas so they can help others.

Mark Karnatz spoke about peer support, recovery outreach coaches, and networking with the LACDMH, law enforcement, and the courts. He suggested the Wellness Recovery Action Plan (WRAP) be used in the jails.

Kellen Russoniello, Staff Attorney, American Civil Liberties Union (ACLU), San Diego, stated the need to acknowledge the structural issues along with programmatic issues. One of those issues is that the criminal justice system is structured to bring individuals in that do not necessarily need to be there. There is an overuse of fines and fees, and bail is grant more easily to individuals who do not have mental illness. He asked the Commission to view those structural issues.

Mr. Russoniello spoke on pretrial and reentry. He stated it sounds like Los Angeles is doing a good job on the mental health urgent care centers. He encouraged the Commission to promote those across the state, particularly for no-refusal policies for law enforcement so they know that they can take individuals to these centers for services. He also encouraged the Commission to look at the "No Place Like Home" initiative to see how that can interact with the decriminalization of individuals with mental illness. On the reentry end, he encouraged the Commission to look at issues like the state terminating Medi-Cal eligibility for individuals who are incarcerated for over a year. There is also a need for jails to get individuals IDs when the leave prison because IDs are essential to access anything in society, including treatment. The state prisons are doing a good job of getting individuals IDs when they leave prison, but in county jails it is nonexistent except in small pilot programs.

Mr. Russoniello stated policies vary widely from county to county on what prescription medications individuals leave jail with. He suggested looking at how to evaluate criminal justice outcomes of mental health spending, particularly in the MHSA – the Commission can ask counties to include that in their plan and how that money is being used to decrease mental illness.

Panel 4: Mental Evaluation Unit (MEU)

Presenters:

Brian Bixler, Lieutenant II, Los Angeles Police Department
Detective Michael Morlan, Systemwide Mental Assessment Response Team (SMART)
Detective Charles Dempsey, Admin-Training Detail

Brian Bixler

Brian Bixler, Lieutenant II, Los Angeles Police Department (LAPD), stated he is the officer in charge of the Crisis Response Support section that houses the Mental Evaluation and Threat Management Units. He provided materials that are included in the meeting packet. He stated the LAPD could not do what they do without the help of the LACDMH. This unique collaboration has gained worldwide attention as a model to be replicated. He provided a brief overview of the tiered-response structure and operations of the LAPD. Lieutenant Bixler stated the Los Angeles Emergency Medical Commission is looking at how to remove police more and more from mental health emergencies. Mental health emergencies are medical emergencies.

Michael Morlan

Michael Morlan, SMART, stated he is the officer in charge of the SMART teams. He gave a presentation on how the teams are structured, the number of units, how they are deployed, and how they work. The SMART teams work twenty-four hours a day, seven days a week. There are day- and night-watch units with eight cars each and there is an additional car and triage staff around the clock. Mental health clinicians team up with specially-trained officers to assess the situation and get individuals the help they need. Senior lead officers do outreach and training, meet with stakeholders and hospitals to discuss what can be done better, and serve as liaisons to hospitals.

Charles Dempsey

Detective Charles Dempsey, Mental Evaluation Administrative Training Detail, stated SMART cases are referred to detectives to do workups and additional follow-up with these individuals to ensure they are getting services. Detective Dempsey helped set up the Mental Evaluation Unit (MEU) and the Case Assessment Management Program (CAMP) component and does the training. Everything is done by a team and collaboration is the key. It all starts with data capture and understanding the information in regards to interventions and crises that occur in the field. Data needs to be captured on the front end in order to provide outcome assessment on the back end. Cases are never closed because mental illness cannot be turned on or off. When individuals are in crisis, case management must be intensified and when they are not in crisis the system and health care providers can engage with the individual. But law enforcement always monitors those individuals and tracks outcomes.

Detective Dempsey stated training is important for the frontline officers to better understand the extremely complicated system. The better they do their job on the front end, the better they will provide information about what they observe in the field to the intake staff, and the better the officer and treatment team will help that individual. It is a social problem, not a criminal justice problem. Community-centric methods of care are key.

Commissioner Questions and Discussion

Chair Carrion stated the first encounter is critical because it may dictate the future of individuals' mental health care. He asked how to differentiate between a crime and a manifesting mental health issue. Lieutenant Bixler stated the LAPD has a policy that on a misdemeanor warrant, a watch commander has the ability to divert at that point. The watch commander makes that decision. If it is a felony crime, the individual is booked and the CAMP team follows up with probation and the court system to mandate mental health treatment for that person. There are no mental health clinicians in the city jails. Most often individuals are transported to the Twin Towers facility.

Chair Carrion asked about the roadblocks to transferring individuals to hospitals or programs. Lieutenant Bixler stated the main roadblocks are lack of continuity in health care and lack of facilities.

Commissioner Van Horn asked how many patrol teams each SMART team serves and what is considered an adequate ratio of SMART teams to patrol teams. Detective Morlan stated there are four bureaus with two SMART vehicles per bureau. Detective Dempsey stated the better the system is built, the better the response.

Commissioner Mitchell asked if there is a difference in diversion for a minor. Lieutenant Bixler stated most juveniles are not a custody situation and there is more leeway to divert because they will be cited out back to their parents. The clinician on the team finds the most appropriate facility.

Commissioner Mitchell asked about diversity. Detective Morlan stated there are almost one hundred officers and clinicians in his unit. The officers come from diverse backgrounds, speak ten different languages, and are assigned to be representative of the community.

Commissioner Aslami-Tamplen asked how law enforcement is working with the community and how it offers support to officers exposed to daily trauma. Detective Morlan stated there are four senior lead officers who are the liaisons and meet with stakeholders and hospitals to address issues and concerns. Lieutenant Bixler stated there are quarterly stakeholder meetings. Detective Dempsey stated that officer support is a part of his class where individuals share their own experiences. There are psychologists who are hired just for police officer support.

3: <u>Orange County Innovation Plan</u>

Presenter: Brian R. Sala, Ph.D., Deputy Director

County Presenters: Flor Tehrani Yousefian, Interim Administrative Manager for Innovative Projects; Brett O'Brien, Director, Children, Youth, and Prevention Behavioral Health Services, Orange County Health Care Agency

Deputy Director Sala provided an overview, accompanied by a slide presentation, of the three Orange County Innovation (INN) projects, including the Community Program Planning Process, learning objectives, evaluations, and budgets for the following proposed INN projects: (1) five-year $2,404,815.00 project, titled "Community Employment Services"; (2) five-year $1,645,657.00, project, titled "Employment and Mental Health Services Impact"; and (3) five-year $6,531,770.00 project, titled "Job Training and On-Site Support for Transition Age Youth". Dr. Sala stated the three proposals have met the minimum requirements. The staff background brief for each project and the county's comprehensive background brief are included in the meeting packet.

Brett O'Brien, Director, Children, Youth, and Prevention Behavioral Health Services, Orange County Health Care Agency, stated the county had a robust Community Planning Process. The three projects have to do with vocational support and employment services.

Flor Tehrani Yousefian, Interim Administrative Manager for Innovative Projects, provided an overview, accompanied by a slide presentation, of Orange County demographics, the stakeholder process, and the background, goals, impacts, evaluation, and timeline for each project.

Commission Questions and Discussion

Commissioner Danovitch asked how employment was chosen as a target, the percentage of the unemployed with a mental illness, how these individuals will be targeted, how the budget figures were determined, the number of individuals expected to be served, the expectations set for them, how the county will know if it is performing well, and how contractors will know they are meeting the expectations.

Ms. Yousefian stated the first and third programs will work in collaboration with the clinicians in the FSPs and Program for Assertive Community Treatment (PACT) programs for referral and those are the individuals who will be targeted. Clinicians will be stationed at the employment centers for the second program. Those screeners will help find the target population when individuals enroll into the center. Ms. Yousefian stated the budget is an estimate using the figures of current programs.

Commissioner Mitchell asked about the third program and whether the county has statistical evidence of a large number of unemployed TAY within Orange County. Ms. Yousefian stated the county has numbers for the unemployed in all age groups, but the age groups are not broken down.

Chair Carrion asked about the number of individuals targeted for the programs. Ms. Yousefian stated the annual participant target is 40 for the first project and 150 each for the second and third projects.

Chair Carrion asked if the couching is being tapered down in the first project. Ms. Yousefian stated enrollment will stop six months in so individuals can begin transitioning out.

Chair Carrion stated there are good anxiety and depression scales out there. He suggested including the shorter version. Also, measures of competency, empowerment, and self-efficacy would be good to know after the project is completed. He asked if the expertise of the peer specialist is in coaching. Ms. Yousefian stated they will be working in supportive counseling and coaching, including job training and employment readiness.

Commissioner Van Horn asked how a PACT differs from an FSP. Ms. Yousefian stated PACT programs are more intensive and target a population with more intensive needs. Mr. O'Brien stated PACT has low caseload ratios to counselors and therapists of 1:15 or 1:20 versus the normal caseload of 1:100 or more in county mental health.

Commissioner Van Horn asked if the project contracts will be added onto current FSP and PACT projects. Mr. O'Brien stated they would be freestanding contracts with an expected collaboration between agencies as part of the contract.

Vice Chair Wooton cautioned the county against giving menial tasks to peers. She suggested training TAY in meaningful work that will gain them employment as adults. Employment is critical but it needs to be fulfilling a meaningful role and making an impact.

Commissioner Anthony asked the county to think about cultural competency and reflecting the cultural needs and makeup of the community, as well as language skills. Ms. Yousefian stated there are translation services available through the multicultural department and cultural competency is looked for when hiring staff.

Commissioners Aslami-Tamplen and Van Horn asked about the innovative piece for the third project. Commissioner Van Horn stated he plans to vote against projects one and three because they are just employment programs. Employment programs have been run for years and are not innovative. Ms. Yousefian agreed that vocational support is not innovative. The innovative piece is the one-on-one support. Mr. O'Brien stated the projects have innovative components, such as targeting a certain population or age group and having job coaches.

Public Comment

Stacie Hiramoto, Director, Racial and Ethnic Mental Health Disparities Coalition (REMHDCO), stated Commissioner Anthony raised the questions she had. Orange County has large ethnic populations. The presenters said the program is open to everyone, but all MHSA programs are open to everyone. In order to reach underserved communities, there must be specific goals and methods for outreach or the communities will not come. She stated

the concern for reaching underserved communities and ensuring that specific approaches and methods are used and will be tracked. Hiring a person of color does not have much meaning anymore – they have to have roots in the community and understand and be proud of who they are.

Commissioner Danovitch stated the presenters' responses to questions have been thoughtful and detailed and reflect good thinking about the problems, but the challenge is that the information presented is so high-level that Commissioners cannot exercise the oversight process – there is no budgetary information and there is a lack of information about the Request for Proposal (RFP) to give the Commission a sense that the project will be successful.

Commissioner Danovitch moved to defer the proposed Orange County INN projects to the next meeting to be presented with additional details so the Commission can make a more informed decision. Commissioner Mitchell seconded.

Dr. Sala stated the county provided fairly detailed budget sheets that are posted on the Web site and are referenced in the staff briefs.

Chair Carrion reminded the Commission that staff brings proposals that they have already evaluated as fulfilling the criteria.

Commissioner Danovitch stated the Commission has been having a form of this discussion repeatedly. Commissioners are under scrutiny to exercise their oversight to the best of their abilities. He requested information around what is innovative here. His motion is to defer it as opposed to voting against it so the county and staff that have worked to put this together will not be penalized but are given an opportunity to provide the necessary details.

Dr. Sala stated staff will work with the county to provide additional detail in time for the October or November meeting.

Executive Director Ewing stated that some of the questions today are issues that staff could have been more robust in presenting, such as budget detail, but other questions cannot be answered because the county is not far enough along in the development of their proposal.

Commissioner Danovitch stated he does not need to see the RFP, but if the proposal is to develop an RFP, then the Commission needs to see the necessary ingredients to develop a good RFP as part of the proposal development process.

Chair Carrion asked Commissioner Danovitch to work with staff on the information needed that will serve as a model for future county INN plan presentations.

Commissioner Van Horn made an amendment to Commissioner Danovitch's motion to defer projects one and three and have a separate vote on project two. Commissioner Aslami-Tamplen seconded.

Action: The MHSOAC defers the vote on the following two Orange County Innovation projects to the October or November Commission meeting:

Name: Community Employment Services
Amount: $2,404,815

Project Length: Five Years

Name: Job Training and On-site Support for TAY
Amount: $6,531,770
Project Length: Five Years

Motion failed 3 yes, 3 no, and 1 abstain, per roll call vote as follows:

The following Commissioners voted “Yes”: Chair Carrion and Commissioners Aslami-Tamplen and Van Horn.

The following Commissioners voted “No”: Commissioners Anthony, Danovitch, and Mitchell.

The following Commissioner abstained: Vice Chair Wooton.

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

The MHSOAC defers the vote on the following three Orange County Innovation projects to the October or November Commission meeting:

Name: Community Employment Services
Amount: $2,404,815
Project Length: Five Years

Name: Employment and Mental Health Services Impact
Amount: $1,645,657
Project Length: Five Years

Name: Job Training and On-site Support for TAY
Amount: $6,531,770
Project Length: Five Years

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

The following Commissioners voted “Yes”: Chair Carrion, Vice Chair Wooton, and Commissioners Anthony, Aslami-Tamplen, Danovitch, Mitchell, and Van Horn.

INFORMATIONAL

4: MHSOAC Executive Director Report

Presenter: Toby Ewing, Ph.D., Executive Director

Executive Director Ewing presented his report as follows:

Staff Changes/Vacancies

Peter Best, Staff Services Manager, will retire in one week. Executive Director Ewing thanked Mr. Best for his work with the Commission. There is a new researcher starting in October.

Outreach

The Commission provided funding to support a documentary on the mental health needs of veterans. It will be aired on Sacramento PBS and distributed nationally to PBS on or

around Veteran's Day. Staff is working with the Department of Veteran Affairs and legislative offices on ways to showcase the documentary.

Projects

The Little Hoover Commission

The MHSOAC penned a letter to the Little Hoover Commission in response to its draft report. Staff will work on a more formal response to the final Little Hoover Commission Report in the coming days.

Regulation Implementation

Staff will present the report at the October meeting.

Mental Health in the Schools

Staff has been working with Commissioner Gordon to put together a proposal and met with the Superintendent of Public Instruction along with Commissioner Van Horn to discuss the project. The Commission will partner with the Department of Education to move the project forward. A panel presentation is planned for the November meeting.

Mental Health and Criminal Justice

Staff will report on the last few days' activities.

Children's Crisis Services

Staff will present the report at the November meeting.

Issue Resolution Process

Staff will present the report at the February meeting.

Fiscal Transparency

Staff will present at the October meeting the fiscal transparency tool showing three years of fiscal information taken from the Revenue and Expenditure Reports.

Triage

Staff meets periodically with county triage coordinators. The Commission will issue a new RFP for the next round of SB 82 grants. Staff will bring a proposed framework to the Commission for approval to inform the RFP that will be issued to counties.

Legislation

Legislation related to the Commission or mental health has been provided in the meeting packet.

The Commission supported two bills this year. The Governor vetoed the bill on fiscal transparency. The other bill, SB 614 on peer certification, was pulled by the author.

The Commission may need to sponsor legislation in the next legislative year beginning in January: One deals with offering a fellowship for consumers and a psychiatrist. The other is to help monitor unemployment within the mental health community. Currently monitoring this a challenge because of inadequate access to data. The Commission is

exploring the option of accessing unemployment data and linking that with mental health client-level data to monitor unemployment rates on a quarterly basis.

Another issue is addressing the issue of data sharing more broadly and sponsoring legislation to make it easier for state agencies to share data for the purposes of linking.

Commission Meeting Calendar

The next meeting is on October 27th in Sacramento. An in-person meeting will be held in Sacramento on November 17th. There will be no December meeting. The January 2017 meeting will focus on Mental Health and Criminal Justice.

GENERAL PUBLIC COMMENT

Ms. Hiramoto stated REMHDCO is happy to help with future panel members who may perhaps offer a different perspective.

Sharon Yates, a former committee member, thanked the Commission for coming to Southern California, doing site visits, and making their presence known.

ADJOURN

There being no further business, the meeting was adjourned at 5:13 p.m.

Mental Health Services
Oversight & Accountability Commission

WELLNESS • RECOVERY • RESILIENCE

Motions Summary

Commission Meeting
September 22, 2016

Motion #: 1
Date: September 22, 2016
Time: 1:12 p.m.

Text of Motion:

The Commission approves the August 25, 2016 Meeting Minutes.

Commissioner making motion: Commissioner Van Horn
Commissioner seconding motion: Commissioner Brown

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

Name	Yes	No	Abstain
1. Chair Carrion	☒	☐	☐
2. Vice-Chair Wooton	☒	☐	☐
3. Commissioner Anthony	☒	☐	☐
4. Commissioner Ashbeck	☐	☐	☐
5. Commissioner Aslami-Tamplen	☒	☐	☐
6. Commissioner Beall	☐	☐	☐
7. Commissioner Boyd	☒	☐	☐
8. Commissioner Brown	☒	☐	☐
9. Commissioner Buck	☒	☐	☐
10. Commissioner Danovitch	☒	☐	☐
11. Commissioner Gordon	☐	☐	☐
12. Commissioner Mitchell	☒	☐	☐
13. Commissioner Poaster	☐	☐	☐
14. Commissioner Thurmond	☐	☐	☐
15. Commissioner Van Horn	☒	☐	☐

Motion #: 2
Date: September 22, 2016

Time: 4:47 p.m.

Text of Motion:

The MHSOAC defers the vote on the following two Orange County Innovation projects to the October or November Commission meeting:

Name: Community Employment Services
Amount: $2,404,815
Project Length: Five Years

Name: Job Training and On-site Support for TAY
Amount: $ 6,531,770
Project Length: Five Years

Commissioner making motion: Commissioner Van Horn
Commissioner seconding motion: Commissioner Aslami-Tamplen

Motion failed 3 yes, 3 no, and 1 abstain, per roll call vote as follows:

Name	Yes	No	Abstain
1. Chair Carrion	☒	☐	☐
2. Vice-Chair Wooton	☐	☐	☒
3. Commissioner Anthony	☐	☒	☐
4. Commissioner Ashbeck	☐	☐	☐
5. Commissioner Aslami-Tamplen	☒	☐	☐
6. Commissioner Beall	☐	☐	☐
7. Commissioner Boyd	☐	☐	☐
8. Commissioner Brown	☐	☐	☐
9. Commissioner Buck	☐	☐	☐
10. Commissioner Danovitch	☐	☒	☐
11. Commissioner Gordon	☐	☐	☐
12. Commissioner Mitchell	☐	☒	☐
13. Commissioner Poaster	☐	☐	☐
14. Commissioner Thurmond	☐	☐	☐
15. Commissioner Van Horn	☒	☐	☐

Motion #: 3
Date: September 22, 2016

Time: 4:48 p.m.

Text of Motion:

The MHSOAC defers the vote on the following three Orange County Innovation projects to the October or November Commission meeting:

Name: Community Employment Services
Amount: $2,404,815
Project Length: Five Years

Name: Employment and Mental Health Services Impact
Amount: $1,645,657
Project Length: Five Years

Name: Job Training and On-site Support for TAY
Amount: $ 6,531,770
Project Length: Five Years

Commissioner making motion: Commissioner Danovitch
Commissioner seconding motion: Commissioner Mitchell

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

Name	Yes	No	Abstain
16. Chair Carrion	☒	☐	☐
17. Vice-Chair Wooton	☒	☐	☐
18. Commissioner Anthony	☒	☐	☐
19. Commissioner Ashbeck	☐	☐	☐
20. Commissioner Aslami-Tamplen	☒	☐	☐
21. Commissioner Beall	☐	☐	☐
22. Commissioner Boyd	☐	☐	☐
23. Commissioner Brown	☐	☐	☐
24. Commissioner Buck	☐	☐	☐
25. Commissioner Danovitch	☒	☐	☐
26. Commissioner Gordon	☐	☐	☐
27. Commissioner Mitchell	☒	☐	☐
28. Commissioner Poaster	☐	☐	☐
29. Commissioner Thurmond	☐	☐	☐
30. Commissioner Van Horn	☒	☐	☐

AGENDA ITEM1C

Information

October 27, 2016 Commission Meeting

MHSOAC Evaluation Dashboard

Summary: The Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission) Evaluation Dashboard assists in monitoring the major evaluation efforts currently underway. The Evaluation Dashboard provides information, objectives, and the status of all current deliverables for internal and external evaluation contracts and projects. Below is a list of all changes/updates to all evaluation projects, which are highlighted in red within the Dashboard.

Changes/Updates:

External Evaluation Contracts

- **Recovery Orientation of Programs Evaluation** *The Regents of the Univ. of California, University of California, San Diego*
  Update: Deliverable 3 is under review

- **Early Psychosis Evaluation** *The Regents of the Univ. of California, University of California, Davis*
  Update: Deliverable 4 is under review

Enclosures: MHSOAC Evaluation Dashboard

Recommended Action: None

Presenter: None

Motion: None

MHSOAC Evaluation Dashboard October 2016

(updated 10/13/16)

Mental Health Services
Oversight & Accountability Commission

Current MHSOAC Evaluation Contracts and Deliverables

Mental Health Data Alliance (MHDATA)				
Full Service Partnership (FSP) Classification Project				
MHSOAC Staff: Brian Sala **Active Dates**: November 2014 – June 30, 2017 **Objective:** The purpose of this evaluation effort is to assess Full Service Partnerships (FSPs) on a statewide level in order to classify them in a meaningful and useful fashion that should ultimately enable clients, family members, providers, counties, and the State to further understand the diversity of FSPs across California.				
	Deliverable	**Due Date***	**Deliverable Cost**	**Status**
1	Preliminary Statewide FSP Classification System Presentation Based on Focus Groups and/or Interviews	February 27, 2015	$52,650	Completed
2	Report of Proposed Statewide FSP Classification System Based on Stakeholder Input	August 31, 2015	$53,750	Completed
3	Report of Final Statewide FSP Classification System Based on Public Comment	October 30, 2015	$11,225	Completed
4	Report of Online Statewide FSP Classification System Website Version 1.0 Design Specification	February 29, 2016	$56,900	Completed
5	Online Statewide FSP Classification System Website Version 1.0	August 31, 2016	$119,900	Pending
6	Online Statewide FSP Classification System Website Administrator Training and Technical Assistance Report	October 31, 2016	$11,225	Pending
7	Online Statewide FSP Classification System Website User Training and Technical Assistance Report	October 31, 2016	$11,225	Pending
8	Online Statewide FSP Classification System Website Hosting and Cost Report	May 1, 2017	$10,438	Pending
Total Contract Amount			$327,313	

* Reflects the date that the deliverable is due to the MHSOAC for an internal review for compliance and approval.

MHSOAC Evaluation Dashboard October 2016

(updated 10/13/16)

Mental Health Services
Oversight & Accountability Commission

The Regents of the University of California, University of California, San Diego

Recovery Orientation of Programs Evaluation

MHSOAC Staff: Ashley Mills

Active Dates: January 1, 2015 – May 31, 2017

Objective: To identify, describe, and assess existing measures and methods of evaluating the recovery orientation of programs and services, conduct an evaluation of the recovery orientation of direct and indirect services and/or programs provided within the Community Services and Supports (CSS) component (focused on the adult system of care), and use results from the evaluation to provide recommendations to providers, counties, and the State for achievement/promotion of recovery orientation in programs/services, as well as recovery and wellness of the clients that are served via these programs/services.

	Deliverable	Due Date*	Deliverable Cost	Status
1	Report on Existing Measures of Recovery Orientation	June 30, 2015	$50,000	Completed
2	Report of Proposed Research Design and Analytic Plan to Evaluate the Recovery Orientation of Programs and Services	July 15, 2015	$100,000	Completed
3	Technical Report of Evaluation Results, Data, Stakeholder Materials, and Dissemination Plan	September 30, 2016	$200,000	Under Review
4	Resources for Evaluating Recovery Orientation and Dissemination Plan	January 15, 2017	$50,000	Pending
5	Resources for Promoting Practices that Encourage Recovery Orientation and Dissemination Plan	January 15, 2017	$50,000	Pending
6	Report of Policy and Practice Recommendations for Ensuring, Maintaining, and Strengthening the Recovery Orientation of Programs and Services	March 30, 2017	$50,000	Pending
Total Contract Amount			$500,000	

* Reflects the date that the deliverable is due to the MHSOAC for an internal review for compliance and approval.

MHSOAC Evaluation Dashboard October 2016

(updated 10/13/16)

Mental Health Services
Oversight & Accountability Commission

The Regents of the University of California, University of California, Davis

Early Psychosis Evaluation

MHSOAC Staff: Ashley Mills

Active Dates: June 1, 2015 – June 30, 2017

Objective: To identify and analyze program costs (i.e., costs expended to implement the program), outcomes (e.g., decreased hospital visits), and costs associated with those outcomes (e.g., costs associated with hospitalization) related to providing early psychosis programs. This evaluation will use the data from the Early Diagnosis and Preventative Treatment of Psychosis Illness (SacEDAPT) program in Sacramento County to pilot a method to calculate the program costs, outcomes, and costs associated with those outcomes when providing the SacEDAPT program, and to identify appropriate sources of comparison data (e.g., costs and outcomes during the period preceding SacEDAPT implementation). The evaluation will also develop and implement a method for identifying and describing all early psychosis programs throughout the State, to include specifically, for example, the data elements that are collected by these programs and the various ways in which they are collected (e.g., via Electronic Health Records or EHRs); data elements will be used to provide insight regarding existing capacity to assess costs and outcomes for early psychosis programs statewide, as well as help to define methods for use during the Sacramento County pilot.

	Deliverable	Due Date*	Deliverable Cost	Status
1	Summary Report of Descriptive Assessment of SacEDAPT Early Psychosis Program	July 1, 2015	$75,000	Completed
2	Proposed Methodology for Analysis of Program Costs, Outcomes, and Changes in Costs Associated with those Outcomes in the SacEDAPT/Sacramento County Pilot	November 1, 2015	$35,000	Completed
3	Report of Research Findings from Sacramento County Pilot	July 1, 2016	$45,000	Completed
4	Proposed Plan to Complete the Descriptive Assessment of Early Psychosis Programs Statewide	October 1, 2016	$20,000	Under Review
5	Summary Report of Descriptive Assessment of Early Psychosis Programs Statewide	March 1, 2017	$20,000	Pending
6	Proposed Statewide Evaluation Plan	May 1, 2017	$5,000	Pending
Total Contract Amount			$200,000	

* Reflects the date that the deliverable is due to the MHSOAC for an internal review for compliance and approval.

Mental Health Services
Oversight & Accountability Commission

The Regents of the University of California, University of California, Los Angeles

Assessment of System of Care for Older Adults

MHSOAC Staff: Brian Sala

Active Dates: June 1, 2015 – June 30, 2017

Objective: The purpose of this evaluation effort is to assess the progress made in implementing an effective system of care for older adults with serious mental illness and identify methods to further statewide progress in this area. This assessment shall involve gauging the extent to which counties have developed and implemented services tailored to meet the needs of the older adult population, including un/underserved diverse older individuals, recognizing the unique challenges and needs faced by this population. In order to bolster the State's ability to promote improvements in the quality of services for older adults, a series of indicators shall be developed focused specifically on older adults with mental health issues; these indicators shall be developed with the intention of incorporating them into future data strengthening and performance monitoring efforts. The Contractor shall also identify and document the challenges and barriers to meeting the unique needs of this population, as well as strategies to overcome these challenges. Lessons learned and resultant policy and practice recommendations for how to improve and support older adult mental health programs at the State and local levels shall be developed and presented to the Commission.

	Deliverable	Due Date*	Deliverable Cost	Status
1	Proposed Research Methods	September 7, 2015	$100,000	Completed
2	Recommended Data Elements, Indicators, and Policy Recommendations	June 30, 2016	$118,292	Completed
3	Summary and Analysis of Secondary and Key Informant Interview Data	November 10, 2016	$75,000	Pending
4	Summary of Focus Group Data and Policy Recommendations	March 17, 2017	$75,000	Pending
5	Policy Brief and Fact Sheet(s)	April 28, 2017	$31,708	Pending
Total Contract Amount			$400,000	

* Reflects the date that the deliverable is due to the MHSOAC for an internal review for compliance and approval.

MHSOAC Evaluation Dashboard October 2016

(updated 10/13/16)

Mental Health Services
Oversight & Accountability Commission

The Regents of the University of California, University of California, Los Angeles

Evaluation of Return on Investment (ROI) for Prevention and Early Intervention (PEI) Evidence-Based Practices (EBPs)

MHSOAC Staff: Fred Molitor

Active Dates: June 30, 2015 – June 30, 2017

Objective: Through a previous MHSOAC contract, Trylon Associates Inc. studied the use and impact of Mental Health Service Act (MHSA) funds for PEI programs. Via this prior study, Trylon determined the total amount of MHSA PEI funds spent on PEI efforts during a designated time period; costs were broken down by program, among other things. The prior study highlighted the potential return on investment (i.e. cost savings) for PEI programs that were evidence based practices (EBPs), based on savings identified via implementation of such EBPs in other areas. The purpose of this evaluation is to investigate potential return on investment (ROI) for EBPs being implemented in California with MHSA PEI funds, and to educate MHSOAC staff on ROI and other comparable evaluation methods.

	Deliverable	Due Date*	Deliverable Cost	Status
1	Fidelity Assessment Summary	March 31, 2016	$12,500	Under Review
2	Report of Cost Savings from WSIPP-Documented EBPs: Fiscal Year (FY) 2011/2012 though FY 2014/2015	June 30, 2016	$25,000	Under Review
3	Report of Cost Savings from WSIPP-Documented EBPs: FY 2011/2012 though FY 2015/2016	March 31, 2017	$12,500	Pending
4	Training/Technical Assistance (T/TA) Plan	August 1, 2015	$12,500	Completed
5	Training Manual and Summary of Training/Technical Assistance (T/TA)	March 31, 2017	$12,500	Pending
Total Contract Amount			$75,000	

* Reflects the date that the deliverable is due to the MHSOAC for an internal review for compliance and approval.

MHSOAC Evaluation Dashboard October 2016

(updated 10/13/16)

Ongoing MHSOAC Internal Evaluation Projects

Mental Health Services
Oversight & Accountability Commission

MHSOAC Evaluation Unit

Tracking and Monitoring of Mental Health Services Act (MHSA) Programs and Activities via Plans, Updates, and Expenditure Reports

MHSOAC Staff: TBD

Active Dates: December 2013 – TBD

Objectives: Develop and implement a system for extracting and utilizing information of interest for tracking and monitoring MHSA program activities and outcomes for fiscal year (FY) 2011/12 and FY 2012/13 from County Annual Updates, Three-Year Plans, and Annual Revenue and Expenditure Reports. Consider what additional information may be useful to capture via the reporting process.

****This internal evaluation project is in transition to an external evaluation project.***

	Work Effort or Product	Due Date	Status
1	Determine State Needs For Information That Is Currently Provided Within Reports	March 31, 2014	Completed
2	Develop System For Extracting And Cataloging State's Data Needs	April 30, 2014	Completed
3	List Of Recommended Data Elements	June 16, 2014	Completed
4	Complete Construction Of Tables	August 15, 2014	Completed
5	Test Database Functionality	August 22, 2014	Completed
6	Complete Construction Of Queries And Forms	TBD	Pending
7	Use System To Extract And Catalog Data Needed By State For FY 2012/13	TBD	Pending
8	Data Quality Check	TBD	Pending

* Reflects the date that the deliverable is due to the MHSOAC for an internal review for compliance and approval.

MHSOAC Evaluation Dashboard October 2016

(updated 10/13/16)

Mental Health Services
Oversight & Accountability Commission

MHSOAC Evaluation Unit

Mental Health Services Act (MHSA) Performance Monitoring

MHSOAC Staff: Brian Sala

Active Dates: Ongoing

Objectives: Implement a process and system for monitoring and reporting on individual- and system-level data, including the CSI and DCR, to support characterization and assessment of MHSA programs and outcomes.

This internal evaluation project is in transition to an external evaluation project.

	Work Effort or Product	Due Date	Status
1	Develop Process For Adding Additional Client, System, And Community-Level Indicators	December 31, 2014	Completed
2	Secure Health Insurance Portability And Accountability Act (HIPAA) Compliance For MHSOAC Staff And Information Systems To Allow Secure Storage And Analysis Of Client-Level Data	May 31, 2015	Completed
3	Descriptive Statistics Report of Key CSI Data Elements, by County	April 30, 2016	Pending
4	MHDA Development and Training of Enhanced Partner Level Datas Templates and Protocols for Analysis of DHCS Databases	May 15, 2016	Pending
5	Develop Strategic Plan Identifying Specific Research Questions Assessing Aspects of the Mental Health System and the Impact of the MHSA	TBD	Pending
6	Web-based Dynamic Visual Analytics of Key Data Elements	TBD	Pending
7	Develop and Implement Strategic Plan for Assessing Aspects of the Mental Health System and the Impact of the MHSA	TBD	Pending

* Reflects the date that the deliverable is due to the MHSOAC for an internal review for compliance and approval.

Mental Health Services
Oversight & Accountability Commission

1325 J ST STE 1700
SACRAMENTO CA 95814
(916) 445-8696
www.mhsoac.ca.gov

Public Meeting Schedule 2016 - 2017

Meeting Date and Location	Group / Topic
Thursday, December 08, 2016 1325 J Street, Suite 1700, Sacramento, CA 95814	**Client and Family Leadership Committee and Cultural and Linguistic Competence Committee** Joint Business Meeting
Thursday, January 26, 2017 TBD	**Commission Meeting** Mental Health/ Criminal Justice
Thursday, February 23, 2017 1325 J Street, Suite 1700, Sacramento, CA 95814	**Commission Meeting** Business Meeting
Thursday, March 23, 2017 1325 J Street, Suite 1700, Sacramento, CA 95814	**Commission Meeting** Project Meeting
Thursday, April 27, 2017 1325 J Street, Suite 1700, Sacramento, CA 95814	**Commission Meeting** Mental Health/ Criminal Justice
rev 10/20/2016	

AGENDA ITEM 2

Information

October 27, 2016 Commission Meeting

Innovation Plan Review Process

Summary: Brian R. Sala, Ph.D., Deputy Director for Evaluation and Program Operations at the Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission), will present for discussion a draft plan to revise technical assistance materials and staff guidance to Counties in preparation for their presentation of Innovative Project workplans to the Commission for approval.

In 2009, the Department of Mental Health (DMH) issued Information Notice 09-02, *Proposed Guidelines for the Mental Health Services Act Innovation Component of the Three-Year Program and Expenditure Plan*. Those guidelines were developed through a comprehensive stakeholder process and were based on principles and priorities adopted by the MHSOAC.

DMH replaced the Innovation templates in 2010 via Information Notice 10-21, *Proposed Guidelines for the Mental Health Services Act (MHSA) Fiscal Year 2011/12 Annual Update to the Three-Year Program and Expenditures Plan*, with two forms (both enclosed). One (Enclosure 17) was a budget sheet for use by counties in requesting Innovative Project funding. The second (Enclosure 22) was a "New/Revised Program Description" for Innovative Project workplans, better known as Exhibit F4. Many Counties have continued to rely on the Exhibit F4 template to provide the MHSOAC with background descriptions of their proposed Innovative Project workplans.

The Commission's adoption of Innovation regulations, effective in October 2015, supersedes these prior DMH Information Notice documents. Deputy Director Sala will present for discussion a draft plan to hold one or more public engagement meetings to discuss with Counties and other stakeholders revisions to the Exhibit F4 template in light of the Commission's Innovation regulations.

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

Enclosures (3): (1) DMH Information Notice 10-21, Enclosure 17; (2) DMH Information Notice 10-21, Enclosure 22 (Exhibit F4); (3) Staff Draft New Innovative Project Description.

Handout: A PowerPoint will be presented at the meeting

INSTRUCTIONS FOR INN FUNDING REQUEST

Counties should complete the INN Funding Request to obtain funding for the INN component under the MHSA. Below are the specific instructions for preparing the MHSA INN Funding Request worksheet.

General: Round all expenditures to the nearest whole dollar.
Heading: Enter the County name and the date.

Previously Approved and New Programs
Previously Approved (Lines 1-15) and New (Lines 1-5)

Enter the program number and name. Identify whether the program is a new program (i.e., a program that has not previously been approved by the MHSOAC or is a previously approved program with changes to the primary purpose and learning goal.) Previously Approved programs are those that have been approved as part of the most recent Plan or update. Enter the proposed MHSA funding required. Funding requested for new programs should match the amounts requested on Exhibit F4.

Subtotal Programs - Previously Approved (Line 16) and New (Line 6)

Indirect Administrative Costs - Previously Approved (Line 17) and New (Line 7)

Counties may request up to 15% of the direct program costs (line 16 for Previously Approved or line 6 for New) for indirect administrative costs separately for previously approved and new programs. Enter the total INN indirect administrative costs. Contract providers and other County governmental organizations with management and support costs should include budgeted expenditures in the relevant INN program funding request. Indirect administrative costs should not exceed 15% of the direct program costs unless accompanied by a signed statement by the County Mental Health Director

18. **Operating Reserve - Previously Approved (Line 18) and New (Line 8)**
    Counties may request up to 10% of the direct program costs (line 16 for Previously Approved or line 6 for New) and INN administration (line 17 for Previously Approved or line 7 for New) separately for previously approved and new programs for an operating reserve. The Operating Reserve should not exceed 10% of the sum of lines 16 and 17 (Previously Approved) or lines 6 and 7 (New).
19. **Subtotal of Previously Approved or New Programs/County Admin./Operating Reserve - Previously Approved (Line 19) and New (Line 9)**
    This is automatically calculated as the sum of lines 16-18 (Previously Approved) or lines 6-8 (New).
20. **Total MHSA Funds Requested for INN - (Line 10)**
    This amount is automatically calculated. This reflects the amount of funding requested for the INN component in FY 2011/12 under the MHSA. Include this amount on line B1 of Exhibit E - MHSA

INN FUNDING REQUEST

County: _____ **Date:** _____

	INN Programs		FY 11/12 Requested MHSA Funding	
	No.	**Name**		
Previously Approved Programs				
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				
14.				
15.				
16.	Subtotal: Programs		$0	Percentage
17.	Plus up to 15% Indirect Administrative Costs			#DIV/0!
18.	Plus up to 10% Operating Reserve			#DIV/0!
19.	Subtotal: Previously Approved Programs/Indirect Admin./Operating Reserve		$0	
New Programs				
1.				
2.				
3.				
4.				
5.				
6.	Subtotal: Programs		$0	Percentage
7.	Plus up to 15% Indirect Administrative Costs			#VALUE!
8.	Plus up to 10% Operating Reserve			#VALUE!
9.	Subtotal: New Programs/Indirect Admin./Operating Reserve		$0	
10.	**Total MHSA Funds Requested for INN**		$0	

Note: Previously Approved Programs that propose changes to the primary purpose and/or learning goal are considered New.

Revised 12/29/10

NEW/REVISED PROGRAM DESCRIPTION
Innovation

County:_____ ☐ **Completely New Program**

Program Number/Name:_____ ☐ **Revised Previously Approved Program**

Date:_____

Complete this form for each new INN Program. For existing INN programs with changes to the primary[1] purpose and/or learning goal, please complete the sections of this form that are applicable to the proposed changes. If there are no changes in the applicable section, please state "No Changes."

Select **one** of the following purposes that most closely corresponds to the Innovation's learning goal.

- ☐ Increase access to underserved groups
- ☐ Increase the quality of services, including better outcomes
- ☐ Promote interagency collaboration
- ☐ Increase access to services

1. Describe why your selected primary purpose for Innovation is most relevant to your learning goal and why this primary purpose is a priority for your county.
2. Describe the INN Program, the issue and learning goal it addresses, and the expected learning outcomes. State specifically how the Innovation meets the definition of Innovation to create positive change; introduces a new mental health practice; integrates practices/approaches that are developed within communities through a process that is inclusive and representative of unserved and underserved individuals; makes a specific change to an existing mental health practice; or introduces to the mental health system a community defined approach that has been successful in a non-mental health context.
2a. Include a description of how the project supports and is consistent with the applicable General Standards as set forth in CCR, Title 9, Section 3320.
2b. If applicable, describe the population to be served, number of clients to be served annually, and demographic information including age, gender, race, ethnicity, and language spoken.
3. Describe the total timeframe of the program. In your description include key actions and milestones related to assessing your Innovation and communicating results and lessons learned. Provide a brief explanation of why this timeline will allow sufficient time for the desired learning to occur and to demonstrate the feasibility of replicating the Innovation. Please note that the timeline for your Innovation Program can be longer than the period for which you are currently requesting Innovation Component funds.
4. Describe how you plan to measure the results, impacts, and lessons learned from your Innovation, with a focus on what is new or changed. Include in your description the expected outcomes of the Innovation program, how you will measure these outcomes, and how you will determine which elements of the Innovation Program contributed to successful outcomes. Include in your description how the perspectives of stakeholders will be included in assessing and communicating results.

[1] The term "essential purpose" has been replaced with the term "primary purpose" for INN.

NEW/REVISED PROGRAM DESCRIPTION
Innovation

5. If applicable, provide a list of resources to be leveraged.
6. Please provide a budget narrative for total projected costs for the entire duration of the Innovation Program, and also provide projected expenditures by each fiscal year during the program time frame, including both the current and future funding years. (For Example, Program 01- XXXX, the entire project is $1,000,000. The first year projected amount will be $250,000, the second year projected amount is $250,000, the third year is $250,000 and the fourth year is $250,000.) Please also describe briefly the logic for this budget: how your proposed expenditures will allow you to test your model and meet your learning and communication goals.
7. Provide an estimated annual program budget, utilizing the following line items.

NEW ANNUAL PROGRAM BUDGET					
A. EXPENDITURES					
	Type of Expenditure	**County Mental Health Department**	**Other Governmental Agencies**	**Community Mental Health Contract Providers/CBO's**	**Total**
1.	Personnel				
2.	Operating Expenditures				
3.	Non-recurring Expenditures				
4.	Contracts (Training Consultant Contracts)				
5.	Work Plan Management				
6.	Other Expenditures				
	Total Proposed Expenditures				
B. REVENUES					
1.	New Revenues				
	a. Medi-Cal (FFP only)				
	b. State General Funds				
	c. Other Revenues				
	Total Revenues				
C. TOTAL FUNDING REQUESTED					

D. Budget Narrative

1. Provide a detailed budget narrative explaining the proposed annual program expenditures for each line item.

INNOVATIVE PROJECT PLAN DESCRIPTION – Optional Template

County:_____ **Date Submitted**_____
Project Name:_____

PLEASE NOTE: USING THIS TEMPLATE IS **OPTIONAL**. It is being provided as a technical assistance tool to staff who wish to make use of it.

> *The MHSA Innovation Component requires counties to design, pilot, assess, refine, and evaluate a "new or changed application of a promising approach to solving persistent, seemingly intractable mental health challenges" (Welfare and Institutions Code Section 5830, subdivision (c)). The eventual goal is for counties to implement successful practices without Innovation Funds and to disseminate successful practices to other counties. In this way, the Innovation Component provides the opportunity for all counties to contribute to strengthening and transforming the local and statewide mental health system and contributes to developing new effective mental health practices. (Mental Health Services Oversight and Accountability Commission, Innovative Projects Initial Statement of Reasons)*

An "Innovative Project" means "a project that the County designs and implements for a defined time period and evaluates to develop new best practices in mental health services and supports" (*California Code of Regulations, Title 9, Sect. 3200.184*). Each Innovative Project "shall have an end date that is not more than five years from the start date of the Innovative Project" (*CCR, Title 9, Sect. 3910.010*). Counties shall expend Innovation Funds for a specific Innovative Project "only after the Mental Health Services Oversight and Accountability Commission approves the funds for that Innovative Project" (*CCR, Title 9, Sect. 3905(a)*). Further, "The County shall expend Innovation Funds only to implement one or more Innovative Projects" (*CCR, Title 9, Sect. 3905(b)).*

The goal of this template is to assist County staff in preparing materials that will adequately explain the purpose, justification, design, implementation plan, evaluation plan, and succession plan of an Innovative Project proposal to key stakeholders, including local and State decision-makers, as well as interested members of the general public. Additionally, a County that fully completes this template should be well prepared to present its project workplan to the Commission for review and approval.

General regulatory requirements for Innovative Projects can be found at CCR, Title 9, Sect. 3910. Regulatory requirements for the Innovation (INN) Component of the 3-Year Program and Expenditure Plan & Annual Update can be found at CCR, Title 9, Sect. 3930. In some cases, the items contained in this **OPTIONAL** template may be ***more specific or detailed*** than those required by the regulations; you may skip any questions or sections you wish.

The template is organized as follows. Part I, Project Overview steps through a series of questions designed to identify what the County has identified as a critical problem it wishes to address via an Innovative Project, the steps the County has taken to identify an innovative strategy or approach to address that critical problem; how it intends to implement the innovative strategy or approach; what it hopes to learn and how those learning objectives relate the innovative strategy or approach to the critical problem it has identified; how it intends to address the learning objectives; and how the County intends to address any transition for affected stakeholders at the end of the time-limited project.

Part II, Additional Information for Regulatory Requirements, poses a series of questions that relate to specific regulatory requirements, either for the proposal or for subsequent reports.

I. Project Overview

1) Primary Problem

a) What primary problem or challenge are you trying to address? Please provide a brief narrative summary of the challenge or problem that you have identified and why it is important to solve for your community.

CCR Title 9, Sect. 3930(c)(2) specifically requires the Innovation Component of the Three-Year Program and Expenditure Plan or Annual Update to describe the reasons that a County's selected primary purpose for a project is "a priority for the County for which there is a need … to design, develop, pilot, and evaluate approaches not already demonstrated as successful within the mental health system." This question asks you to go beyond the selected primary purpose (e.g., "Increase access to mental health services,") to discuss more specifically the nature of the challenge you seek to solve.

b) Describe what led to the development of the idea for your INN project and the reasons that you have prioritized this project over alternative challenges identified in your county.

2) What Has Been Done Elsewhere To Address Your Primary Problem?

"A mental health practice or approach that has already demonstrated its effectiveness is not eligible for funding as an Innovative Project unless the County provides documentation about how and why the County is adapting the practice or approach… (*CCR, Title 9, Sect. 3910(b)*).

The Commission expects a County to show evidence that they have made a good-faith effort to establish that the approach contained within their proposed project either has not been demonstrated to be effective in mental health or is meaningfully adapted from an approach that has been demonstrated to be effective. Describe the efforts have you made to investigate existing models or approaches close to what you're proposing (e.g., literature reviews, internet searches, or direct inquiries to/with other counties). Have you identified gaps in the literature or existing practice that your project would seek to address?

a) Describe the methods you have used to identify and review relevant published literature regarding existing practices or approaches. What have you found? Are there existing evidence-based models relevant to the problem you wish to address? If so, what limitations to those models apply to your circumstances?
b) Describe the methods you have used to identify and review existing, related practices in other counties, states or countries. What have you found? If there are existing practices addressing similar problems, have they been evaluated? What limitations to those examples apply to your circumstances?

3) The Proposed Project

Describe the Innovative Project you are proposing. Note that the "project" might consist of a process (e.g. figuring out how to bring stakeholders together; or adaptation of an administrative/management strategy from outside of the Mental Health field), the development of a new or adapted intervention or approach, or the implementation and/or outcomes evaluation of a new or adapted intervention. See CCR, Title 9, Sect. 3910(d).

Include sufficient details so that a reader without prior knowledge of the model or approach you are proposing can understand the relationship between the primary problem you identified and the potential solution you seek to test. You may wish to identify how you plan to implement the project, the relevant participants/roles, what participants will typically experience, and any other key activities associated with development and implementation.

a) Provide a brief narrative overview description of the proposed project.
b) Identify which of the three approaches specified in CCR, Title 9, Sect. 3910(a) the project will implement (introduces a practice or approach that is new to the overall mental health system; makes a change to an existing practice in the field of mental health; or applies to the mental health system a promising community-driven practice approach that has been successful in non-mental health contexts or settings).
c) Briefly explain how you have determined that your selected approach is appropriate. For example, if you intend to apply to mental health a practice from outside of mental health, briefly describe how the practice has been applied previously.

4) Innovative Component

Describe the key elements or approach(es) that will be new, changed, or adapted in your project (potentially including project development, implementation or evaluation). What are you doing that distinguishes your project from similar projects that other counties and/or providers have already tested or implemented?

a) If you are adapting an existing mental health model or approach, describe how your approach adds to or modifies specific aspects of that existing approach and why you believe these to be important aspects to examine.
b) If you are applying an approach or practice from outside of mental health or that is entirely new, what key aspects of that approach or practice do you regard as innovative in mental health, and why?

5) Learning Goals / Project Aims

The broad objective of the Innovative Component of the MHSA is to incentivize learning that contributes to the spread of effective practices in the mental health system. Describe your learning goals/specific aims and how you hope to contribute to the spread of effective practices.

a) What is it that you want to learn or better understand over the course of the INN Project, and why have you prioritized these goals?
b) How do your learning goals relate to the key elements/approaches that are new, changed or adapted in your project?

There is no maximum number of learning goals required, but we suggest at least two. Goals might revolve around understanding processes, testing hypotheses, or achieving specific outcomes.

I. Project Overview (continued)

6) Evaluation or Learning Plan

For each of your learning goals or specific aims, describe the approach you will take to determine whether the goal or objective was met. What observable consequences do you expect to follow from your project's implementation? How do they relate to the project's objectives? What else could cause these observables to change, and how will you distinguish between the impact of your project and these potential alternative explanations?

The greater the number of specific learning goals you seek to assess, generally, the larger the number of measurements (e.g., your "sample size") required to be able to distinguish between alternative explanations for the pattern of outcomes you obtain.

In formulating your data collection and analysis plan, we suggest that you consider the following categories, where applicable:

a) Who are the target participants and/or data sources (e.g., who you plan to survey to or interview, from whom are you collecting data); How will they be recruited or acquired?
b) What is the data to be collected? Describe specific measures, performance indicators, or type of qualitative data. This can include information or measures related to project implementation, process, outcomes, broader impact, and/or effective dissemination. Please provide examples.
c) What is the method for collecting data (e.g. interviews with clinicians, focus groups with family members, ethnographic observation by two evaluators, surveys completed by clients, analysis of encounter or assessment data)?
d) How is the method administered (e.g., during an encounter, for an intervention group and a comparison group, for the same individuals pre and post intervention)?
e) What is the *preliminary* plan for how the data will be entered and analyzed?

7) Contracting

If you expect to contract out the INN project and/or project evaluation, what project resources will be applied to managing the County's relationship to the contractor(s)? How will the County ensure quality as well as regulatory compliance in these contracted relationships?

II. Additional Information for Regulatory Requirements

1) Certifications

Innovative Project proposals submitted for approval by the MHSOAC must include documented evidence of County Board of Supervisors review and approval as well as certain certifications. Additionally, we ask that you explain how you have obtained or waived the necessity for human subjects review, such as by your County Institutional Review Board.

a) Adoption by County Board of Supervisors. Please present evidence to demonstrate that your County Board of Supervisors has approved the proposed project. Evidence may include explicit approval as a stand-alone proposal or as part of a Three-Year Plan or Annual Update; or inclusion of funding authority in your departmental budget. If your project has not been reviewed in one of these ways by your Board of Supervisors, please explain how and when you expect to obtain approval prior to your intended start date.

b) Certification by the County mental health director that the County has complied with all pertinent regulations, laws, and statutes of the Mental Health Services Act (MHSA). Welfare and Institutions Code (WIC) 5847(b)(8) specifies that each Three-Year Plan and Annual Update must include "Certification by the county behavioral health director, which ensures that the county has complied with all pertinent regulations, laws, and statutes of the Mental Health Services Act, including stakeholder participation and nonsupplantation requirements."

c) Certification by the County mental health director and by the County auditor-controller if necessary that the County has complied with any fiscal accountability requirements, and that all expenditures are consistent with the requirements of the MHSA. WIC 5847(b)(9) specifies that each Three-Year Plan and Annual Update must include "Certification by the county behavioral health director and by the county auditor-controller that the county has complied with any fiscal accountability requirements as directed by the State Department of Health Care Services, and that all expenditures are consistent with the requirements of the Mental Health Services Act."

   Of particular concern to the Commission is evidence that the County has satisfied any fiscal accountability reporting requirements to DHCS and the MHSOAC, such as submission of required Annual Revenue and Expenditure Reports or an explanation as to when any outstanding ARERs will be completed and filed.

d) Documentation that the source of INN funds is 5% of the County's PEI allocation and 5% of the CSS allocation.

2) Community Program Planning

Please describe the County's Community Program Planning process for the Innovative Project, encompassing inclusion of stakeholders, representatives of unserved or under-served populations, and individuals who reflect the cultural, ethnic and racial diversity of the County's community.

Include a brief description of the training the county provided to community planning participants regarding the specific purposes and MHSA requirements for INN Projects.

3) Primary Purpose

Select **one** of the following as the primary purpose of your project. (I.e. the overarching purpose that most closely aligns with the need or challenge described in Item 1 (The Service Need).

a) Increase access to mental health services to underserved groups
b) Increase the quality of mental health services, including measurable outcomes
c) Promote interagency collaboration related to mental health services, supports, or outcomes
d) Increase access to mental health services

II. Additional Information for Regulatory Requirements (continued)

4) MHSA Innovative Project Category

Which MHSA Innovation definition best applies to your new INN Project (select one):

a) Introduces a new mental health practice or approach

b) Makes a change to an existing mental health practice that has not yet been demonstrated to be effective, including, but not limited to, adaptation for a new setting, population or community

c) Introduces a new application to the mental health system of a promising community-driven practice or an approach that has been successful in a non-mental health context or setting.

d)

5) Population (if applicable)

a) If your project includes direct services to mental health consumers, family members, or individuals at risk of serious mental illness/serious emotional disturbance, please estimate number of individuals expected to be served annually. How are you estimating this number?

b) Describe the population to be served, including relevant demographic information such as age, gender identity, race, ethnicity, sexual orientation, and/or language used to communicate. In some circumstances, demographic information for individuals served is a reporting requirement for the Annual Innovative Project Report and Final Innovative Project Report.

c) Does the project plan to serve a focal population, e.g., providing specialized services for a target group, or having eligibility criteria that must be met? If so, please explain.

6) MHSA General Standards

Using specific examples, briefly describe how your INN Project reflects and is consistent with all potentially applicable MHSA General Standards set forth in Title 9 California Code of Regulations, Section 3320. (Please refer to the MHSOAC Innovation Review Tool for definitions of and references for each of the General Standards.) If one or more general standard could not apply to your INN Project, please explain why.

a) Community Collaboration

b) Cultural Competency

c) Client-Driven

d) Family-Driven

e) Wellness, Recovery, and Resilience-Focused

f) Integrated Service Experience for Clients and Families

II. Additional Information for Regulatory Requirements (continued)

7) Continuity of Care for Individuals with Serious Mental Illness

Will individuals with serious mental illness receive services from the proposed project?
If yes, describe how you plan to protect and provide continuity of care for these individuals when the project ends.

8) INN Project Evaluation Cultural Competence and Meaningful Stakeholder Involvement.

a) Explain how you plan to ensure that the Project evaluation is **culturally competent**.
Note: this is not a required element of the initial INN Project Plan description but is a mandatory component of the INN Final Report. We therefore advise considering a strategy for cultural competence early in the planning process. An example of cultural competence in an evaluation framework would be vetting evaluation methods and/or outcomes with any targeted ethnic/racial/linguistic minority groups.

b) Explain how you plan to ensure **meaningful stakeholder participation** in the evaluation.
Note that the mere involvement of participants and/or stakeholders as participants (e.g. participants of the interview, focus group, or survey component of an evaluation) is not sufficient. Participants and/or stakeholders must contribute in some meaningful way to project evaluation, such as evaluation planning, implementation and analysis. Examples of stakeholder involvement include hiring peer/client evaluation support staff, or convening an evaluation advisory group composed of diverse community members that weighs in at different stages of the evaluation.

II. Additional Information for Regulatory Requirements (continued)

9) Deciding Whether and How to Continue the Project Without INN Funds

Briefly describe how the County will decide whether and how to continue the INN Project, or elements of the Project, without INN Funds following project completion. For example, if the evaluation does (or does not) indicate that the service or approach is effective, what are the next steps?

10) Communication and Dissemination Plan

Describe how you plan to communicate results, newly demonstrated successful practices, and lessons learned from your INN Project.

a) How do you plan to disseminate information to stakeholders within your county and (if applicable) to other counties?
b) How will program participants or other stakeholders be involved in communication efforts?
c) KEYWORDS for search: Please list up to 5 keywords or phrases for this project that someone interested in your project might use to find it in a search.

11) Timeline

a) Specify the total timeframe (duration) of the INN Project: ____ Years ____ Months
b) Specify the expected start date and end date of your INN Project: ____ Start Date ____ End Date

Note: Please allow processing time for approval following official submission of the INN Project Description.

c) Include a timeline that specifies key activities and milestones and a brief explanation of how the project's timeframe will allow sufficient time for
   i. Development and refinement of the new or changed approach;
   ii. Evaluation of the INN Project;
   iii. Decision-making, including meaningful involvement of stakeholders, about whether and how to continue the Project;
   iv. Communication of results and lessons learned.

II. Additional Information for Regulatory Requirements (continued)

12) INN Project Budget and Source of Expenditures

The next three sections identify how the MHSA funds are being utilized:

a) BUDGET NARRATIVE (Specifics about how money is being spent for the development of this project)

b) BUDGET BY FISCAL YEAR AND SPECIFIC BUDGET CATEGORY (Identification of expenses of the project by funding category and fiscal year)

c) BUDGET CONTEXT (If MHSA funds are being leveraged with other funding sources)

A. Budget Narrative:

Provide a brief budget narrative to explain how the total budget is appropriate for the described INN project. The goal of the narrative should be to provide the interested reader with both an overview of the total project and enough detail to understand the proposed project structure. Ideally, the narrative would include an explanation of amounts budgeted to ensure/support stakeholder involvement (For example, "$5000 for annual involvement stipends for stakeholder representatives, for 3 years: Total $15,000") and identify the key personnel and contracted roles and responsibilities that will be involved in the project (For example, "Project coordinator, full-time; Statistical consultant, part-time; 2 Research assistants, part-time…"). Please include a discussion of administration expenses (direct and indirect) and evaluation expenses associated with this project.

B. New Innovative Project Budget By FISCAL YEAR (FY)*						
EXPENDITURES						
PERSONNEL COSTs (salaries, wages, benefits)	**FY xxxx**	**FY xxxx**	**FY xxxx**	**FY xxxx**	**FY xxxx**	**Total**
1. Salaries						
2. Direct Costs						
3. Indirect Costs						
4. Total Personnel Costs						
OPERATING COSTs	**FY xxxx**	**FY xxxx**	**FY xxxx**	**FY xxxx**	**FY xxxx**	**Total**
5. Direct Costs						
6. Indirect Costs						
7. Total Operating Costs						

NON RECURRING COSTS (equipment, technology)	**FY xxxx**	**FY xxxx**	**FY xxxx**	**FY xxxx**	**FY xxxx**	**Total**
8.						
9.						
10. Total Non-recurring costs						
CONSULTANT COSTS/CONTRACTS (clinical, training, facilitator, evaluation)	**FY xxxx**	**FY xxxx**	**FY xxxx**	**FY xxxx**	**FY xxxx**	**Total**
11. Direct Costs						
12. Indirect Costs						
13. Total Operating Costs						

OTHER EXPENDITURES (please explain in budget narrative)	**FY xxxx**	**FY xxxx**	**FY xxxx**	**FY xxxx**	**FY xxxx**	**Total**
14.						
15.						
16. Total Other expenditures						

BUDGET TOTALS						
Personnel						
Direct Costs (add lines 2, 5 and 11 from above)						
Indirect Costs (add lines 3, 6 and 12 from above)						
Non-recurring costs (line 10)						
Other Expenditures (line 16)						
TOTAL INNOVATION BUDGET						

*For a complete definition of direct and indirect costs, please use DHCS Information Notice 14-033. This notice aligns with the federal definition for direct/indirect costs.

C. *Expenditures By Funding Source and FISCAL YEAR (FY)*

Administration:							
A.	**Estimated total mental health expenditures <u>for ADMINISTRATION</u> for the entire duration of this INN Project by FY & the following funding sources:**	**FY xxxx**	**FY xxxx**	**FY xxxx**	**FY xxxx**	**FY xxxx**	**Total**
1.	Innovative MHSA Funds						
2.	Federal Financial Participation						
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other funding*						
6.	**Total Proposed Administration**						
Evaluation:							
B.	**Estimated total mental health expenditures <u>for EVALUATION</u> for the entire duration of this INN Project by FY & the following funding sources:**	**FY xxxx**	**FY xxxx**	**FY xxxx**	**FY xxxx**	**FY xxxx**	**Total**
1.	Innovative MHSA Funds						
2.	Federal Financial Participation						
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other funding*						
6.	**Total Proposed Evaluation**						
TOTAL:							
C.	**Estimated TOTAL mental health expenditures (this sum to total funding requested) for the entire duration of this INN Project by FY & the following funding sources:**	**FY xxxx**	**FY xxxx**	**FY xxxx**	**FY xxxx**	**FY xxxx**	**Total**
1.	Innovative MHSA Funds						
2.	Federal Financial Participation						
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other funding*						
6.	**Total Proposed Expenditures**						

*If "Other funding" is included, please explain.

AGENDA ITEM 3

Action

October 27, 2016 Commission Meeting

Trinity County Innovation Plan

Summary: The Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission) will consider approval of Trinity County's request to increase funding and extend the time for their previously approved Innovative (INN) project titled, *Milestones Outreach Support Team (M.O.S.T.).* Trinity County is requesting authorization from the MHSOAC to increase funding and extend the time line for six (6) months, due to delays in implementation of the service component of the project. The requested increase amount is $54,491.

The County is requesting a funding increase of $54,491 and an extension to June 30, 2017 due to delays in initiating project services. The Commission originally approved the *M.O.S.T.* Project on December 18, 2014 for $132,712 over two years. The County states that the project start date was December 2014. The County reports it had $27,617 (20.8 percent) remaining in its originally approved INN funding.

Under the Commission's Rules of Procedure, a County seeking authorization for additional funding on an INN Project may seek administrative approval from the Executive Director when the amount sought falls below the lesser of $500,000 or 15 percent of the original project total, but must present requests above that threshold directly to the Commission. Trinity County's requested funding increase constitutes 41 percent of the original funding amount.

Trinity County is requesting authorization from the MHSOAC to increase funding and extend the time line for six (6) months. The requested increase amount is $54,491. The County is not proposing to change other aspects of the approved project.

Presenters:

- Brian R. Sala, PhD, Deputy Director, Evaluation and Program Operations
- Noel O'Neil, LMFT, Director, Trinity County Behavioral Health

Enclosures (2): (1) Staff Innovation Extension Request Summary; (2) County Extension Request and supporting documents.

Handout: A PowerPoint will be presented at the meeting

Proposed Motion: The MHSOAC approves Trinity County's request for the Innovation plan extension and funding increase, as follows:

Name: *Milestones Outreach Support Team (M.O.S.T.)* request for Funding Increase and Time Extension
Additional Amount: $54,491
Project Extension Length: Six (6) months

STAFF INNOVATION SUMMARY— TRINITY COUNTY

Name of Innovative (INN) Project: Milestones Outreach Support Team (M.O.S.T.)

Total INN Funding Increase Requested for Project: $54,491

Duration of Time Extension for Innovative Project: Six (6) Months to June 30, 2017

Review History

The original INN plan was submitted on August 29, 2014. The Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission) approved the project in December 18, 2014. The County's start date for this project was December 2014 based on the start of services and spending.

Request for Project Funding Increase and Time Extension Introduction:

Trinity County is requesting approval for a funding increase and a time extension. The requested extension does not fall ouside of the five (5) year maximum for INN projects.

The County's objective is to determine whether providing peer support at crisis intake in a rural county setting will increase the quality of services and better outcomes. The innovation is using a lead peer staff member as the initial contact in crisis interventions. The County seeks to evaluate whether the innovation will reduce emergency room visits; lessen law enforcement agency burdens; reduce the number of out-of-county hospitalizations; develop peer staff skills; develop a strong referral process; and provide more intensive interventions.

Background

Trinity County is a small, rural county with limited resources, a slow economy, high poverty rate, and transportation difficulties. Trinity County had a successful peer counseling INN program affiliated with their "Respite Bed Project." The present innovation plan intends to build on the Respite Bed Project by having a lead peer specialist and trained peer specialists as the initial contact for individuals and families seeking crisis services (see Trinity County Mental Health Services Act (MHSA) Annual Update for fiscal year 2015/16).

As further stated in the Trinity County MHSA Annual Update for fiscal year 2015/16 plan, a portion of the INN project is to create a peer career ladder. The County, in an innovative approach, created their own career ladder program for individuals with lived experience. Peer staff have entered the workforce as volunteers and contractors, and with the appropriate training, support, guidance, and innovative design, they have moved to paid civil servant positions within positions adopted and sustained through County internal trainings and skill development. The County has partnered with the Superior Region WET Collaborative to independently support persons in California Association of Social Rehabilitation Agencies (CASRA) trainings for crisis team staff. The lead peer support staff position is fully developed under this INN project. The current project will have the lead peer support person as the lead contact for crisis intervention.

The Request

The County is requesting a time extension to 30 June 2017 and additional funding of $54,491, 41 percent of the original requested amount, for the lead peer specialist (salary with benefits; see budget attachments for additional information). Even with the six-month extension, 25 percent of the original requested time, the project will not extend beyond the 5-year program limit mandated in MHSA regulations.

The lead peer specialist staff was hired prior to January 2016 to complete internal professional development trainings prior to the start of a thirteen-month CASRA peer certification training, which was designed to promote development in psychiatric rehabilitation.. Trinity County states that peer certification training for the crisis staff was not completed until July 2016. The County states this resulted in insufficient time to evaluate employee skill development and obtain consumer feedback on the effectiveness of the lead peer evaluations and peer support functions.

The County notes that they have $27,617 (20.8 percent of the original authority) in authorized INN funding remaining. We have asked the county to clarify in their presentation how the 25 percent time extension, together with the remaining unspent authority, necessitates an additional 41 percent augmentation in authorized INN funding.

Learning Objectives and Evaluation

Trinity County states that its primary learning goal is unchanged. The County wants to discover if peer staff taking the lead in crisis intervention will be effective in minimizing the use of emergency hospitalization, burden on local law enforcement, and other additional costs and services.

References

Trinity County 3-Year Plan and Annual Update:
http://www.trinitycounty.org/index.aspx?page=60

http://www.peersnet.org/articles/2014/may/what-you-need-know-about-state-peer-specialist-certification-california

http://psycnet.apa.org/index.cfm?fa=buy.optionToBuy&id=1997-42649-006
Study by Mowbray & Tan (1993), studies of consumer-run drop-in centers show high satisfaction and increased quality of life, enhanced social support and problem-solving.

Klein, Canaan, & Whitecraft (1998) study of one-to-one peer support for mental health services over time (Chinman et al, 2001; Klein, Canaan, and Whitecraft, 1998; Simpson and House, 2002).

Bluebird, G. (2008). Paving new ground: Peers working in in-patient settings. National Technical Assistance Center, National Association of State Mental Health Program Directors (NASMHPD).

Chamberlin, J., Rogers, E.S., & Ellison, M.L. (1996). Self-help programs: A description of their characteristics and their members. Psychiatric Rehabilitation Journal, 19, 33-42.

Chinman, M.J., Weingarten, R., Stayner, D., & Davidson, L. (2001). Chronicity reconsidered: Improving person-environment fit through a consumer run service. Community Mental Health Journal, 37(3) 215-229.

Davidson, L., Chinman, M., Kloos, B., Weingarten, R., Stayner, D., & Tebes, J.K. (1999). Peer support among individuals with severe mental illness: A review of the evidence. Clinical Psychology: Science and practice, 6, 165-187.

Davidson, L., Chinman, M., Sells, D., & Rowe, M. (2006). Peer support among adults with serious mental illness: A report from the field. Schizophrenia Bulletin, 32(3), 443-450.

INNOVATIVE PROJECT CHANGE REQUEST-Optional Template

MHSOAC *Office Use Only*
*Version #:*_____
Staff:

County: Trinity County **Date Submitted: July 18, 2016**

Project Name: Milestones Outreach Support Team (M.O.S.T)

PLEASE NOTE: USING THIS TEMPLATE IS **OPTIONAL**. It is being provided as a technical assistance tool to staff who wish to make use of it. Regulatory requirements for the Innovation (INN) Component of the 3-Year Plan & Annual report can be found in section 3930 of the INN Project Regulations. In some cases, the items contained in this **OPTIONAL** template are ***more specific or detailed*** than those required by the regulations: you may skip any questions or sections you wish.

1. **Restate the INN Project's primary learning question(s) or objective(s).** *What is it that you want to learn or better understand of the course of the Innovative Project?*

2. **Changes to the Inn Project Requiring Approval**
   What change(s) would you like to make to this INN Project? (Check all that apply)
   □ Change the primary purpose
   □ Change the basic practice or approach
   □ An increase in expenditures, such that more funds are expended than previously approved
   □ Any other change for which you would like to voluntarily submit for approval

   Please Note:
   - *Proposing a change to the primary purpose, please explain how the learning question or objective is tied to the proposed new primary purpose of the project.*
   - *If proposing change to the basic practice or approach, please explain how the learning question or objective is focused on the impact of what is new or changed about the approach or intervention.*

   For each change,
   a) *State wat was approved and describe the proposed change(s).*
   b) *List the reasons for the change.*
   c) *Describe how stakeholder involvement contributed to the change request.*
   d) *Desired date that the change would take effect: mm/dd/yyyy*

INNOVATIVE PROJECT CHANGE REQUEST-Optional Template

MHSOAC *Office Use Only*
*Version #:*_____
Staff:

Trinity County Response to Item #1:

Trinity County wishes to continue the focus of its primary learning question and that is how providing peer support in a rural county setting supports the increase in quality services including better outcomes. The current plan is in its third iteration to investigate the utility and effectiveness of peer support. In the current plan, Trinity County is hoping to discover if having peer staff take the lead in crisis intervention will be effective in minimizing the use of the local acute care facility emergency department to care for psychological crises, minimizing the burden on local law enforcement agencies, reducing the occurrence of additional crisis episodes and reducing the number of out of county hospitalizations. Integral to the success of this project is developing and refining the skills of peer staff who will be assuming this role. Also key, is developing a strong referral process so that peer staff interacting with individuals who are experiencing a serious crisis can access the services of a triage crisis worker who is able to deliver a more intensive intervention, including evaluating the individual for a psychiatric hospitalization.

Trinity County Response to Item #2:

The time line described in the approved plan stated that the project would begin officially in December of 2014 and come to a close on June 30, 2016. Ostensibly, this timeframe would have allowed the county about eighteen months for planning and implementation. As the project has been underway the county has had opportunity to perform program monitoring to assure that there has been no shift from the original intent and focus. The narrative of the approved plan described the county's plan to identify appropriate trainings that would be accessed to provide peer staff with the training necessary to increase their professional development and efficacy at first-level interventionists. The county was successful in partnering with the Superior Region WET Collaborative and sent peer staff to a thirteen month peer certification training presented by CASRA. The training for the peer staff just finished in July of 2016. With that said, there has been no time to perform meaningful evaluation regarding employee skill development and to gather consumer feedback regarding their work with peers who received this training. Therefore the proposed change is extending the amount of expenditures for project that was originally approved as well as extending the time frame in order to evaluate the project.

Feedback from stakeholders about this phase of the county's Innovation Project has been very positive. During this year's round of focus groups held to gather input for the 2016/17 Annual Update stakeholders were in favor of continuing the project long enough to evaluate effectiveness. Members of the Quality Improvement Committee, two of which are consumers, are in favor of extending the program so that more thorough outcome evaluation can be completed. This echoed the sentiments of the Trinity County Behavioral Health Advisory Board. Members of this board are interested in the career growth of peer staff as well as the evolution of the Innovation Project while still maintaining the focus on quality services and better

outcomes. Community partners, law enforcement and emergency department personnel, are witnessing a serious reduction in the amount of individuals they contact who are experiencing a mental health crisis. They are in support of maintaining a resource in the community that will appropriately serve individuals in need without drawing on resources of these agencies. Given enough time for analysis and evaluation Trinity County will be able to transition funding from Innovation to Community Supports and Services in order to sustain this crisis intervention effort. The county would like the effective date of the extension to begin July 1, 2016 and wrap up officially June 30th, 2017.

Attachment A

Trinity County Behavioral Health Services

Innovation Funding Used/Budgeted						
	YEAR 1		YEAR 2		TOTAL	Extension Request
	Jan '15-jun '15	july- Dec '15	Jan '16-jun'16	July-Dec '16 (Budgeted)		
Approved Innovation Plan	$ 33,178	$ 33,178	$ 66,356	$ -	$ 132,712	
Available Carryover		$ 33,178	$ 17,859	$ 27,617		
Total Funding available	$ 33,178	$ 66,356	$ 84,215	$ 27,617		
Peer Specialist Actual Cost/Budgeted	$ -	$ 48,497	$ 56,598	$ 41,054	$ 146,149	$ 41,054
Shortfall		$ -		$ 13,437	$ 13,437	$ 13,437
innovation funding used/budgeted	$ -	$ 48,497	$ 56,598	$ 27,617	$ 132,712	$ 54,491
Balance for carryover	$ 33,178	$ 17,859	$ 27,617	$ (13,437)		

Attachment B

Trinity County Behavioral Health Services

Milestones Wellness Center Expenditures FY 2015-16								
Classification	PEI Funding	INN Funding	MHSA OES Funding	SB 82 Funding	Intergovernmental Transfer (IGT) Funding	PATH Funding	Medi-Cal FFP	Total
MHSA Coordinator III	$82,048			$0			$23,808	$105,856
Case Manager II (Peer Coordinator)*				$26,323	$35,965	$16,641	$6,056	$84,985
Peer Specialist #1*		$41,252	$22,814	$7,543				$71,608
Peer Specialist #2		$1,143	$53,179	$0				$54,322
Peer Specialist #3*		$23,961	$14,702	$7,543				$46,206
Peer Specialist #4	$11,583			$0	$6,026			$17,609
TOTAL	$93,631	$66,356	$90,695	$41,409	$41,991	$16,641	$29,864	$380,586

Triage Expenditures FY 2015-16							
Classification	MHSA OES Funding	SB 82 Funding	Intergovernmental Transfer (IGT) Funding	PATH	Medi-Cal FFP*	Total	Total Triage Cost
Mental Health Clinician I	$18,701	$33,527			$18,040	$70,268	$70,268
Case Manager II (Peer Coordinator)*		$26,323	$6,150	$16,641	$6,056	$55,170	$55,170
Case Manager II	$0	$26,323			$31,353	$57,676	$55,170
Case Manager II	$7,626	$26,323			$18,714	$52,663	$55,170
Peer Specialist #1*	$8,266	$7,543				$15,808	$15,808
Peer Specialist #3*	$8,266	$7,543				$15,808	$15,808
Evaluation	$1,882	$1,718				$3,600	$3,600
Indirect Costs	$11,517	$10,510				$22,027	$22,027
Admin Costs	$6,424	$5,863			$0	$12,287	$12,287
TOTAL	$62,681	$145,672	$6,150	$16,641	$74,163	$305,307	$305,307

Milestones Costs	$380,586
Triage Costs	$305,307
Duplicated Costs	-$86,786
Total Milestones and Triage Cost (unduplicated)	$599,107

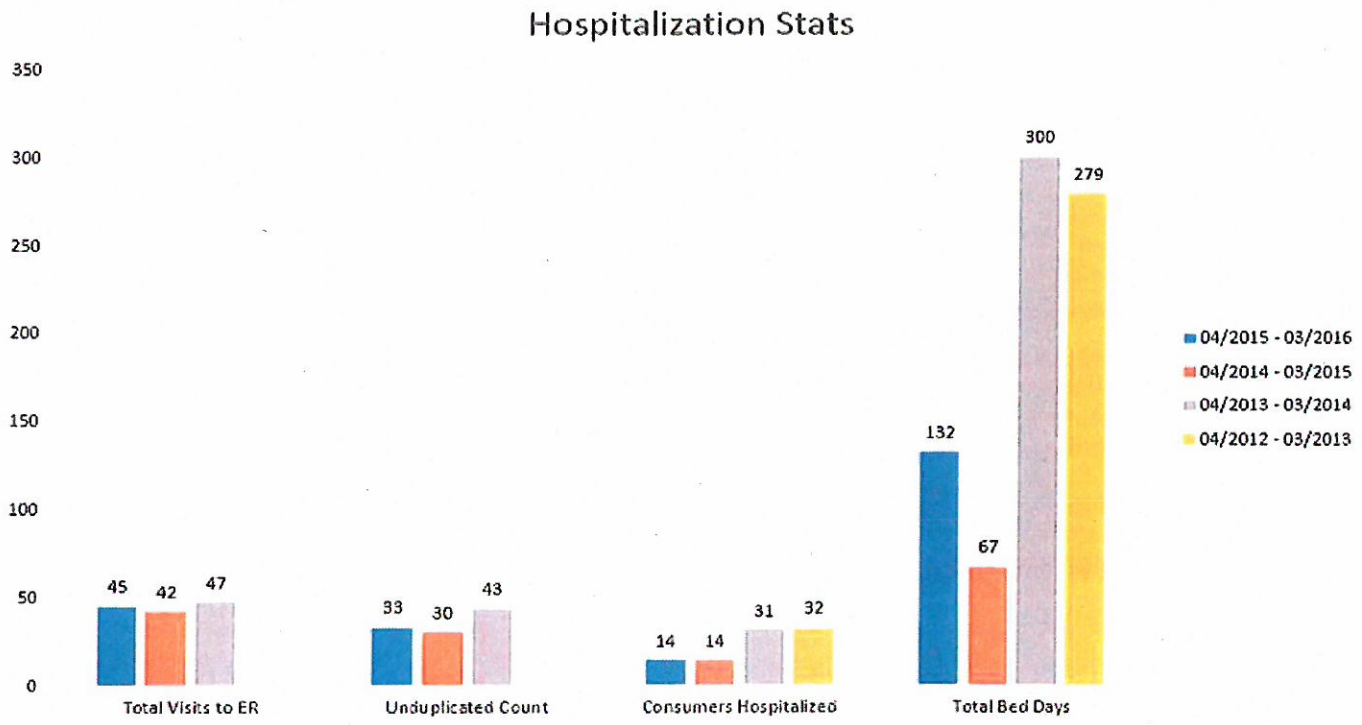
* Milestone's Staff that also works on Triage

Attachment C

Hospitalization and Peer Support Brief

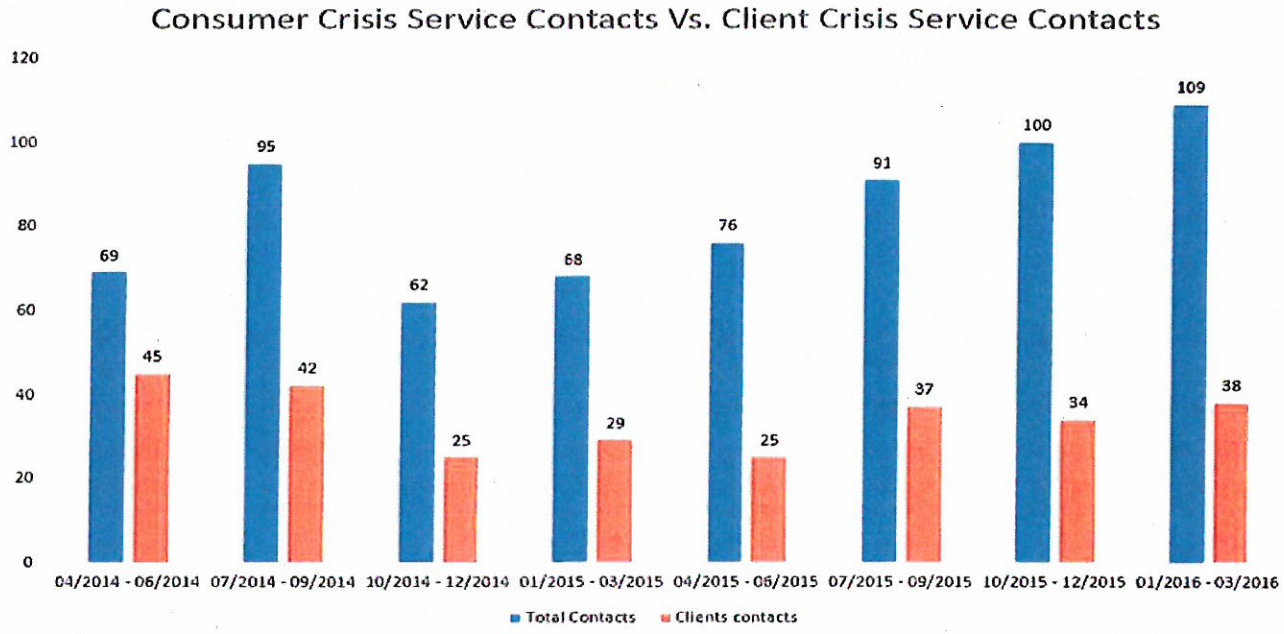
While we continually work to gain a better appeal with other agencies and within our community, we face the same challenges as many other rural agencies to accomplish this goal. The statistics from our hospitalizations have given us a more complete picture of just how effectively our Triage Program is working. During the last two years, we have seen a reduction in the number of hospital admissions and bed days, in comparison to the previous two years.

Hospital numbers are the most significant indicator of the success of the Triage Program. During the time frame of April 2012 through March 2013, there were 32 hospital admissions with 279 bed days used. During April 2013 through March 2014, there were 57 crisis call visits to the emergency room for 43 unduplicated consumers of services. Of those 43 consumers, 31 were hospitalized, with a total of 300 bed days. During this past year, in the same monthly time period, TCBHS had 42 crisis call visits from 30 unduplicated consumers. Of those 30 consumers, 14 were hospitalized for psychiatric care, with a total of 67 bed days. There were only four who were hospitalized during the last six months, which is typically the season for the highest amount of hospitalizations. TCBHS attributes several factors arising as a result of the Triage Program for this change.



Attachment C

Medication management, wrap around services, and client socialization has been an integral piece of the puzzle for improving mental health of our clients requiring higher needs and facing possible hospitalization. When they are not working in a crisis situation, the triage workers will concentrate their efforts to assist our highest need clients by assisting with medication management education, as well as any other needed case management 'type' services, in a proactive measure to decrease hospitalizations. We find this has specifically resulted in decreased hospitalizations and overall improved outcomes for the clients. The best indicator of this is the numbers depicted in the chart B, shown below. During the first three months of the Program there were 45 contacts, or 65.22%, of the requests for crisis services from clients who already received medication management and other mental health services, while in the last three month reporting period there were 38 contacts, or 34.86%, of the requests for crisis services. This is a significant difference in the amount of requests from our own clients. Since both the number of clients and the percentage declined, while our number of clients in service at the Agency has actually increased by over 40 clients in this same time period, we can deduce that the Program is having a positive outcome.



Additionally, the combination of a Peer Specialist working within the structure of the Wellness Center and the availability of the Triage Crisis Worker to conduct an intervention is a model that has been quite effective for TCBHS and Trinity County as a whole. Together with a revamp of the Wellness Center's core membership program, this Crisis Triage Program has increased the Wellness Center's monthly attendance counts by over 10 times in one year.

Attachment D

Milestones Wellness Center

Peer Crisis Support

1) On a scale from 1 to 5, with 1 being completely unsatisfied and 5 being completely satisfied; how did peer staff do when you came into the center?


1 2 3 4 5


2) On a scale from 1 to 5, with 1 being completely unsatisfied and 5 being completely satisfied; were they able to help you?


1 2 3 4 5


3) On a scale from 1 to 5, with 1 being completely unsatisfied and 5 being completely satisfied; do you feel like you were heard?


1 2 3 4 5


If you were to offer suggestions regarding ways to improve peer staff interactions with those who may be in crisis, what would these suggestions be?

_____

_____

_____

_____

_____

_____

Trinity County Wellness Centers
TCBHS 2016

Attachment E

Peer Specialist Professional Development Survey

This survey is the final in a series of three that have been administered over the last year and a half. Its primary focus is to document your current knowledge, skills and perceptions of various aspects of 'professional development', and measure outcomes after participation in a CASRA's peer specialist trainings.

Now that you are nearing the completion of the CASRA trainings offered through the Superior Region WET Collaborative, how would you define professional development? Please discuss its continued relevance as it pertains to your role of Peer Specialist.

Please rate these eight area of professional competence using the following scales.
On a scale from 1 to 10 (I being the lowest; 10 the highest) please record your current knowledge/skill level based on what you actually know and do. On a scale from 1 to 10, again with 1 being the lowest and 1 being the highest, please record how important you think this knowledge or skill set is to performing you job. (Consider how this helps you to work as part of a team and with wellness center members).

1. Development of professional writing skills

Sub Topic Item	Knowledge/Skill	Importance
1.1 Correct usage of grammar		
1.2 Concise and focused communication		
1.3 Appropriate email correspondence		

2. Computer Skills

Sub Topic Item	Knowledge/Skill	Importance
2.1 Standard word processing		
2.2 Internet navigation		
2.3 Spreadsheet development		

3. Developing healthy and appropriate boundaries /respecting the boundaries of others

Sub-Topic Item	Knowledge/Skills	Importance
3.1 Between Self and Client		
3.2 Between Self and Colleague		
3.3 Between Self and Supervisor		
3.4 Between Self in Role of Peer Specialist and Community Members/Partner Agencies		

4. Continue proficiency development in regard to psychiatric rehabilitation interventions and strategies

Sub-Topic Item	Knowledge/Skills	Importance
4.1 Understanding the purpose and following directions while using published information gathering tools		
4.2 Choosing appropriate strategies and interventions for individual needs		
4.3 Being aware of learning styles when choosing intervention strategies		

5. Ongoing development in regard to working in a collaborative manner

Sub-Topic Item	Knowledge/Skills	Importance
5.1 With clinical staff		
5.2 With staff from partner agencies		
5.3 With direct colleagues		

6. Ensuring that an ethical approach is used in all interactions/relationships

Sub-Topic Item	Knowledge/Skills	Importance
6.1 Rules of confidentiality		
6.2 Appropriate reporting to supervisors		
6.3 Sharing information with outside agencies		

7. Understanding symptoms and how they impact interaction patterns/participation

Sub-Topic Item	Knowledge/Skills	Importance
7.1 Recognizing troubling symptoms		

7.2 Adjust methods to assist those with certain symptoms for greater inclusion and participation		

8. Understanding the meaning of advocacy which includes considering:

Sub-Topic Item	Knowledge/Skills	Importance
8.1 The context of the situation		
8.2 Unintended consequences		
8.3 Assessing the individual's true need in the situation		
8.4 Not creating and "us" vs. "them" dynamic when a situation involves two clients		
8.5 How to recognize when advocacy has turned to enabling		

In the space below discuss one strength that you posses that helps you in your role of Peer Specialist. Then discuss one area of growth that has proven to be a challenge in your role of Peer Specialist.

AGENDA ITEM 4

Action

October 27, 2016 Commission Meeting

Orange County Innovation Projects

Summary: The Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission) will consider approval of Orange County's request to fund three new Innovative (INN) projects: (1) *Community Employment Services* for a total of $2,404,815 in INN component funding over five years; (2) *Employment and Mental Health Services Impact* for a total of $1,645,657 in INN component funding over five years; and (3) *Job Training and On-site Support for TAY* for a total of $6,531,770 in INN component funding over five years.

This item is a continuance of Commission consideration at from the September 22, 2016 meeting. All enclosed materials are identical to those presented for that meeting. The County will be providing a revised PowerPoint presentation as a handout.

The Mental Health Services Act (MHSA) requires that an INN project does one of the following: (a) introduces a new mental health practice or approach, including but not limited to prevention and early intervention; (b) makes a change to an existing mental health practice or approach, including, but not limited to, adaptation for a new setting or community; (c) introduces to the mental health system a promising community-driven practice/approach, that has been successful in non-mental health contexts or settings; or (d) participates in a housing program designed to stabilize a person's living situation while also providing supportive services on site. The law also requires that an INN project address one of the following as its primary purpose: (1) increase access to underserved groups, (2) increase the quality of services including measurable outcomes, (3) promote interagency and community collaboration, or (4) increase access to services.

(1) The Community Employment Services project proposes to increase the quality of services, including measurable outcomes in employment, by offering on-site, peer-supported employment coaching for up to 40 individuals per year living with persistent mental health challenges. The INN project complies with all MHSA requirements.

For this five-year project Orange County is requesting MHSA INN funds authorization from the MHSOAC in the amount of $2,404,815.

(2) Employment and Mental Health Services Impact project proposes to increase access to services by co-locating and integrating behavioral health clinicians at employment centers in Orange County. The INN project complies with all MHSA requirements.

For this five-year project the County is requesting MHSA INN funds authorization from the MHSOAC in the amount of $1,645,657.

3) Job Training and On-Site Support for TAY project proposes to increase the quality of services, including better outcomes in employment of TAY by creating a kitchen/food service business with on-site employment and behavioral health coaches. This INN project complies with all MHSA requirements.

For this five-year project the County is requesting MHSA INN funds authorization from the MHSOAC in the amount of $6,531,770.

Presenters:

- Brian Sala, Ph.D., Deputy Director, Evaluation and Program Operations
- Flor Tehrani Yousefian, Interim Administrative Manager for Innovative Projects

Enclosures (4): (1) Staff Innovation Summary, Community Employment Services; (2) Staff Innovation Summary, Employment and Mental Health Services Impact; (3) Staff Innovation Summary, Job Training and On-site Support for TAY; (4) County Innovation Brief.

Handout: A PowerPoint will be presented at the meeting.

Proposed Motion: The MHSOAC approves Orange County's Innovation plans, as follows:

Name: Community Employment Services
Amount: $2,404,815
Project Length: Five Years

Name: Employment and Mental Health Services Impact
Amount: $1,645,657
Project Length: Five Years

Name: Job Training and On-site Support for TAY
Amount: $ 6,531,770
Project Length: Five Years

STAFF INNOVATION SUMMARY— ORANGE COUNTY

Name of Innovative (INN) Project: Community Employment Services

Total INN Funding Requested for Project: $2,404,815

Duration of Innovative Project: Five (5) Years

Review History

County INN plan approved by County Board of Supervisors on June 2, 2015.

Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission) consideration of INN Project: September 22, 2016. Continuance to October 27, 2016.

Project Introduction:

Orange County proposes to increase the quality of services, including better outcomes by providing 100% on-site job coaching by peers to help participants living with a persistent mental health challenge manage symptoms that are interfering with workplace performance. The program aims to improve participant employment skills and abilities, behavioral health outcomes and their global health.

In the balance of this brief we address specific criteria that the Commission looks for when evaluating Innovation Plans, including: What is the unmet need that the county is trying to address? Does the proposed project address the need? Are there clear learning objectives that link to the need? And, will the proposed evaluation allow the county to make any conclusions regarding their learning objectives? In addition, the Commission checks to see that the Innovation meets regulatory requirements that the proposed project must align with the core Mental Health Services Act (MHSA) principles, promote learning, funds exploration of a new and/or locally adapted mental health approach/practice, and targets one of the four allowable primary purposes.

The Need

The County notes that employment is often identified by individuals with mental health challenges as a significant goal towards recovery, but that the very large majority of individuals with mental illnesses are unemployed. Indeed, the U.S. Bureau of Labor Statistics reported recently that only 17.5 percent of persons with a disability were employed in 2015. While the County has not demonstrated that employment for persons with mental illness is especially high within Orange County, it has explained that this

proposal emerged from a series of stakeholder meetings designed to develop INN project concepts. Pilot projects that cost-effectively improve the job skills and employment success of clients could have wide appeal beyond the case of Orange County.

The Response

Orange County intends to determine if a comprehensive coaching model will ease participants' transition into currently existing supported employment programs and assist in moving participants toward employment stability and independence. The County intends to contract with a provider to supply and manage trained peer specialists to work alongside participants and provide comprehensive supportive services related to employment readiness. Peer Specialists would be placed with up to five participants at the same job site and provide on-site coaching for up to 6 months per client. Participants would work up to 15 hours a week earning minimum wage. The County expects that the selected contractor would staff the project with one full-time, Masters-level clinician, four peer specialists and one clerical support person. The program is intended to serve 40 participants annually.

The County notes that this proposal makes a change to an existing approach in mental health, but is somewhat unclear as to the model or approach that the County is adapting. Hence it is challenging to clearly articulate what is novel or innovative about their proposal. The County could better articulate the degree to which the proposed INN project differs both from two existing supported employment programs in the County and from such well-established supported employment strategies as Individual Placement and Support (IPS), the best-known evidence-based practice in supported employment (Rockville Institute). The County may also find useful examples to consider from the U.S. Department of Housing and Urban Development's "Bridges to Work" demonstration projects from the 1990s (see, e.g., Watson and Palubinsky), although these projects were not designed to serve persons with mental illnesses.

Orange County recently completed a prior INN project for supported employment entitled "Volunteer to Work," focused on helping clients build job skills by connecting them with volunteer opportunities. The County transitioned that program into Community Systems and Supports (CSS) funding in fiscal year (FY) 2015-16 (Orange County, p. 3). The County is currently working on the final report which will discuss nine INN projects. They plan to submit the report in October.

The County also maintains a Supported Employment program as part of its CSS program. This program was budgeted for $1,021,417 for FY 2015-16 and included job coaching, counseling, and peer support services, among other attributes. Specifically, "each individual placed into competitive employment has the ongoing support of an Employment Specialist (ES). The ES is responsible for providing the consumer with one-on-one job support to ensure successful job retention" (Orange County MHSA Annual Update, p. 68). The County reported some successes in that program in "graduating" participants who had successfully retained paid employment for more than 90 days. The County states that the currently proposed INN project is targeted at participants who were not or likely

would not be successful in this CSS program because they required greater levels of support or persons who have not had any prior work experience.

The Community Employment Services project builds on gaps in services and areas of need identified during these two projects. The County maintains that the 100% on-site coaching and specialized trainings prior to and following the work day are what is innovative about the project.

The Community Planning Process

The County reports that it held a series of stakeholder meetings across the county to solicit and develop INN project concept proposals. This appears to have been a robust process to generate meaningful stakeholder participation in the development of the County's INN proposals. See, e.g., the "Innovation Idea Form" for this project (Orange County Community Employment Services Plan). However, the proposal presented to the Commission has evolved somewhat from the project that was approved by the County Board of Supervisors on June 2, 2015 and included in the County's 2015-16 Annual Update (Orange County MHSA Annual Update, pp. 244-5).

Learning Objectives and Evaluation

Orange County states that its primary learning goals with this program are to determine whether on-site peer support will increase the quality of their supported employment services, improve participants' employment skills and abilities, and, ultimately, improve participants' behavioral health outcomes and participants' global health.

The County proposes to measures these outcomes with intake/enrollment and project exit data, self-report outcome measures, employment retention rates following project exit and satisfaction surveys. The County could more clearly articulate how it will test the marginal impact of on-site peer support on outcomes for program participants relative to the County's standard Supported Employment approach or other models.

At the end of the fourth year, project services will be concluded. The fifth year will be used to draft the final report and document the lessons learned from the project. Given this timeline, it is not clear how long the county intends to track employment retention rates of employees if they extend beyond the project. The standard for "graduation" from supported employment programs appears to be retention of paid employment for at least 90 days, but the degree to which existing programs follow up with "graduated" participants to track job retention after exit from the supportive services is unclear.

The budget narrative states that included in the expenditures is an estimated percentage for evaluation.

The Budget

The proposed budget includes $2,404,815 in expenditures all of which are being attributed to Innovation funding. The budget includes an estimated $219,644 (9 percent) for evaluation. Clarification needs to be obtained from the County on the budget plan. In

particular, the County attributes in documents submitted to the Commission $994,035 of its estimate to “Other expenditures,” such as “the County Procurement Process, Flexible Funds, Work Plan Management, and Innovation Project Final Report.” Much of this latter line-item appears to be administrative costs associated with the project. The total amount of funding for administration is not specified explicitly.

Additional Regulatory Requirements

The proposed project appears to meet or exceed minimum standards for compliance with other requirements under the MHSA. This program aligns with the core Mental Health Service Act principles. The program makes a change to an existing employment approach by providing 100% on-site job coaching by peers. The primary purpose is to increase access to mental health services.

References

Orange County Board of Supervisors Meeting minutes June 2, 2015 https://docs.google.com/gview?url=https%3A%2F%2Focgov.granicus.com%2FDocumentViewer.php%3Ffile%3Docgov_b985024cbcfec03d66fce25a3b04c04f.pdf%26view%3D1&embedded=true. Accessed September 13, 2016.

Orange County Communtiy Employment Services Plan https://media.ocgov.com/civicax/filebank/blobdload.aspx?BlobID=41245. Accessed September 13, 2016.

Orange County Mental Health Services Act Three Year Plan FY 14/15-16/17.

Orange County Mental Health Services Act Annual Update FY 15/16.

Rockville Institute. N.d. “About IPS.” https://www.ipsworks.org/about-ips/. Accessed September 12, 2016.

U.S. Department of Labor, Bureau of Labor Statistics News Release June 21, 2016.

Watson, Bernardine H., and Beth Z. Palubinsky. 1997. “Getting From Here to There: The Bridges to Work Demonstration First Report to the Field.” Field Report Series. Public/Private Ventures (Philadelphia). https://www.huduser.gov/portal/publications/povsoc/btw/demowork.html. Accessed September 12, 2016.

STAFF INNOVATION SUMMARY— ORANGE COUNTY

Name of Innovative (INN) Project: Employment and Mental Health Services Impact

Total INN Funding Requested for Project: $1,645,657

Duration of Innovative Project: Five (5) Years

Review History

Approved by County Board of Supervisors June 2, 2015

Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission) consideration of INN Project: September 22, 2016. Continuance to October 27, 2016.

Project Introduction:

Orange County proposes to increase access to services by co-locating and integrating behavioral health clinicians at employment centers in Orange County. They anticipate that by having visitors to the employment centers complete a health and quality of life assessment in conjunction with other application materials for employment services, they will provide a stigma-free point of entry (if appropriate) to the mental health care system in the County.

The County proposes to serve 150 unduplicated individuals per year who are unemployed or at risk of unemployment and who present as having mild to moderate symptoms of mental illness or co-occurring substance use disorders.

The final year of the project will consist of project evaluation as well as a decision process as to whether to support these services through another Mental Health Services Act (MHSA) component, most likely Prevention and Early Intervention.

In the balance of this brief we address specific criteria that the MHSOAC looks for when evaluating Innovation Plans, including: What is the unmet need that the county is trying to address? Does the proposed project address the need? Are there clear learning objectives that link to the need? And, will the proposed evaluation allow the county to make any conclusions regarding their learning objectives? In addition, the MHSOAC checks to see that the Innovation meets regulatory requirements that the proposed project must align with the core MHSA principles, promote learning, funds exploration of a new and/or locally adapted mental health approach/practice, and targets one of the four allowable primary purposes.

The Need

Orange County reports there are no employment centers in the County that provide onsite emotional/behavioral health support services. The county cites research that "unemployment negatively impacts emotional and behavioral health". Perhaps because of the economic downturn in California, in 2007 Orange County employment centers saw an increase of job seekers. The County also has experienced about a 10% population increase since 2000, which may account for some of the rise in job seekers. The County reports that while the center representatives could help most of the job seekers, they "were not prepared for the collateral emotional and behavioral health support that these individuals needed to address symptoms typically associated with unemployment."

What is not particularly clear in the proposed Innovative plan is the actual need for these services. Data from the Employment Development Department indicates that the unemployment rate for Orange County is 5.8 %, which is about 3% lower than the total unemployment for the State of California at 8.5%. Given the population data in Orange County, this does not represent a large cohort of unemployed. Further, the County indicates that some of the beneficiaries of this plan will be job seekers with substance use issues. The plan lacks detail as to the numbers of job seekers in this target population.

The Response

The County posits that traditionally, regardless of how job seekers may be feeling or how aware they are of the emotional impact of their unemployment, job seekers do not necessarily seek behavioral health support as part of a job search effort. By co-locating clinicians in employment centers, the County hopes to assist employment center staff, as well as job seekers, by identifying persons who may be having emotional problems through this early intervention.

Over the course of this five-year Innovation plan, the County intends to establish a pool of clinicians to staff various employment centers. These clinicians will provide supportive counseling (16 sessions), behavioral health workshops and support groups to the centers' clientele. During the initial stages of this plan, County administrative staff will conduct site visits to coordinate agreements, data tracking and charting along with creating a policy and procedures manual. Emotional and behavioral health screening of new and existing employment center clientele will occur throughout the course of this innovation and persons flagged by clinicians as being mildly to moderate impacted, will receive emotional support services, if they are interested.

Co-location of auxiliary and related services in employment centers is not a new concept in California. Examples include the Sacramento Employment and Training Agency (SETA) program here in Sacramento where various agencies co-located to provide bundled vocational services to the unemployed; various co-locations between the Department of Rehabilitation (DOR) and Employment Development Department facilities; and Career One Stops that have co-located individual DOR vocational counselors, veterans representatives and supported employment service agencies.

Outside of California, research to date only identifies two similarly situated programs: one in Missouri (Missouri Department of Mental Health) and another in Minnesota (Resource). The information provided for these programs, however, does not indicate whether these co-located behavioral health services are adjunctive to the employment centers in the same way that Orange County proposes.

What makes Orange County's project potentially innovative is that it provides both a methodology for identifying emotional problems (assessments) and on-site support service staff to address these problems. Other programs and co-located entities mentioned appear to have been less institutionally structured to both identify and address behavioral health concerns on-site.

It appears that the County is trying to learn and possibly to establish if there is a "causal link" between emotional problems and unemployment. In part, research that the County has relied upon appears to question whether such a connection can be made directly. Goldsmith and Diette, researchers, cited by the County articulate this:

> *Social scientists from a range of disciplines have provided cross-sectional evidence of a connection between unemployment and various indicators of mental health. However, these researchers recognize the potential for reserve causality where poor mental health can lead to joblessness and thus call their results into question. Numerous researchers attempt to address this problem by examining persons who switch over time from work to unemployment. However, their findings supporting the link between unemployment and a decline in emotional well-being, although compelling, are not definitive evidence of a causal link because something unobserved by the researcher may have changed before the onset of unemployment that damaged a person's emotional wellbeing. . . .A second shortcoming identified by Kessler, Turner and House (1988) in conventional studies using both cross-sectional and panel data is the selection into unemployment on the basis of prior mental health.*

The Community Planning Process

Orange County conducted its community planning process for this Innovation in Fiscal Year 14/15. They state that they developed strategies to assist stakeholders throughout the process of community meetings, including providing clear definitions of the process and criteria to be used for vetting Innovation projects. They also provided stakeholders with a template for submitting ideas and provided them technical assistance via Q & A about projects that were being considered. These questions and responses are included on the County's website.

Five community stakeholder meetings were held regionally throughout the County.

> *Participation in these regional meetings included consumers, family members, providers, and individuals representing the larger health care community in Orange County that have an interest in behavioral health care.*

> *Invitations for participation were sent to consumers and consumer organizations as well as to individuals who represent safety (e.g., Probation and Sheriff), education, faith communities, physical healthcare providers (e.g., CalOptima, hospitals, community clinics), Social Services Agency), among others. Interpretive services were available for each of the meetings to remove barriers to participation for those whose primary language was not English. (Orange County New Innovative Project Description, page 2)*

This process generated thirty-one project suggestions submitted to the County. Behavioral Health staff reviewed the suggestions for fit with Innovative Project criteria and conducted a literature review to assess whether these ideas had been tried previously or if they had, if was there something about the Orange County suggestions that differentiated them sufficiently from the previous Innovation project.

Projects that passed both these preliminary levels were then presented to the MHSA Steering Committee. "The MHSA Steering Committee voted for the Employment and Mental Health Services Impact project proposal to move forward for consideration and formal submission to the MHSOAC for approval." (Orange County New Innovative Project Description, p.3)

Learning Objectives and Evaluation

Orange County states that the goals of this project will be to:

1. Increase participant access to community behavioral health and supportive services/programs.
2. Improve participant knowledge and/or awareness of behavioral health resources.
3. Improve participant behavioral health outcomes.
4. Improve participant global health. (Orange County New Innovative Project Description, p. 5)

The County intends to start the data gathering process in the second year of the project (first full service year) by collecting intake/exit data and documenting the types of services provided, types of trainings a participant may attend, referrals and linkages to other community services and participation in actual treatment with onsite clinicians. (Orange County New Innovative Project Description, p. 5).

The description of the learning objectives and evaluation methodology for this project closely mirror the statements provided in the County's Job Training and On-site Support for TAY project, also before the Commission. In both cases, the County's specification of its learning objectives and evaluation approach needs further clarification.

The Budget

The project is to be contracted out to a community-based organization and so the County is only estimating suggested line item costs. The County indicates that the actual budget will depend on the selected provider's proposal. Therefore, staffing and other expenses

are contingent upon the contract provider's final budget. The County's proposed budget should clarify what expected costs will be for contracted services versus direct County costs.

The projected budget is $1,645,657 over the five (5) year project. Evaluation costs estimated for this project are $197,814, or approximately 12% of the total plan costs. The breakout for the evaluation dollars is as follows:

5% from Personnel ($750,000) =	$37,500
5% from Operating Expenses ($303,000) =	$15,150
5% from Non-Recurring Expenditures ($15,000) =	$750
25% from Other Expenditures ($577,657) =	$144,414

As mentioned above, there do not appear to be any specific budget allocations or differentiation for administrative costs, although much of the Other Expenditures category appears to be for administrative expenses.

This project proposal has evolved considerably from the project described in the County's fiscal year (FY) 2015/16 Annual Update (Orange County MHSA Annual Update, pp. 246-248). The County is asking the Commissioners to approve a total Project amount of $$1,645,657 for five (5) years, considerably more than the one-year funding amount included in the Annual Update discussion. The County does not clarify in its proposal how these new project amounts were determined.

Additional Regulatory Requirements

The County could provide clarifications regarding budget items (including administration expenses and proposed purchase of software) and more clarity on the actual need for this service. The proposal as presented appears to meet or exceed other minimum regulatory requirements.

References

Goldsmith, A. H. & Diette, T. M. (2012). "Exploring the link between unemployment and mental health outcomes." The SES Indicator, 5(1). Abstract

Orange County Board of Supervisors Meeting minutes June 2, 2015 https://docs.google.com/gview?url=https%3A%2F%2Focgov.granicus.com%2FDocumentViewer.php%3Ffile%3Docgov_b985024cbcfec03d66fce25a3b04c04f.pdf%26view%3D1&embedded=true. Accessed September 13, 2016.

Orange County MHSA Annual Update, FY 15/16.

Orange County New Innovative Project Description. September 1, 2016. "INN 03-003 Employment and Mental Health Services Impact."

Missouri Department of Mental Health. “Mental Illness.” Accessed September 7, 2016. https://dmh.mo.gov/mentalillness/adacpsemploymentservices.html.

Resource. “About Resource.” http://www.resource-mn.org/about-resource/. Accessed September 7, 2016.

Wikipedia. “CA Unemployment Statistics.” Accessed September 7, 2016. https://en.wikipedia.org/wiki/California_unemployment_statistics.

STAFF INNOVATION SUMMARY— ORANGE COUNTY

Name of Innovative (INN) Project: Job Training and On-Site Support for TAY

Total INN Funding Requested for Project: $6,531,770

Duration of Innovative Project: Five (5) Years

Review History

Approved by the County Board of Supervisors June 2, 2015.

Mental Health Oversight and Accountability Commission (MHSOAC or Commission) consideration of INN Project: September 22, 2016. Continuance to October 27, 2016.

Project Introduction:

Orange County proposes to increase the quality of services for Transitional Aged Youth (TAY), including better outcomes by creating a working kitchen/food service business with on-site employment and behavioral health coaches. These coaches will provide job training and behavioral health support to participants/employees of the business. The County also indicates that it will provide a stipend to "a School of Business" (p. 4) in order to develop a business plan for the business.

In the balance of this brief we address specific criteria that the Commission looks for when evaluating Innovation Plans, including: What is the unmet need that the county is trying to address? Does the proposed project address the need? Are there clear learning objectives that link to the need? And, will the proposed evaluation allow the county to make any conclusions regarding their learning objectives? In addition, the Commission checks to see that the Innovation meets regulatory requirements that the proposed project must align with the core MHSA principles, promote learning, funds exploration of a new and/or locally adapted mental health approach/practice, and targets one of the four allowable primary purposes.

The Need

The County does not provide statistical evidence of a large number of unemployed TAY within Orange County. However according to the July 2014 National Alliance on Mental Illness (NAMI) report, *Road to Recovery: Employment and Mental Illness,* "the current service system is ill suited to meet their needs. Mental illness often emerges during the late teens and early adult years, hitting the gap between child and adult mental health

service systems" (p.12). This is also the same time frame when youth traditionally begin their exploration of the world of work and begin to develop work habits and skills. Persistent mental health issues create, in the TAY age group "the highest school dropout and failure rates of any disability group" (p. 12). Orange County proposes to mitigate this with a work experience that combines developing work skills building with an environment that provides emotional and behavioral support strategies for TAY.

The County states that neither its existing FSP programs nor its TAY Program for Assertive Community Treatment (PACT) address the need for TAY with a serious mental illness to develop job skills.

The Response

While the County acknowledges that there are similar work training/hardening types of programs throughout the County, they indicate that these are designed for foster youth, adults, criminal offenders and individuals with substance use disorders. This Innovative Project is only being developed for TAY. This Project will employ TAY and work on employment skills and emotional challenges while the youth is employed. It is anticipated that the TAY in this program will be better served by job coaches who are sensitive to their potential work place challenges and can better provide positive reinforcement and work place interventions for behaviors related to their persistent mental health issues, even as they are working.

The County maintains that this program will dedicate training only for those TAY who are diagnosed with persistent mental health challenges and will provide a "unique supported environment that will address a cognitive emotional component in conjunction with workplace inexperience. (Orange County INN Proposal, p. 1).

Following completion of a series of more academic and therapeutic courses, TAY recruited will work in the business and learn work behaviors, as well as meet work challenges related to their particular mental health circumstances. The County Proposes to serve 150 TAY per year who are not currently participating in or succeeding in existing supported employment programs and who are receiving behavioral health services in the County. The final year of the project will consist of project evaluation as well as a decision process as to whether to support these services through another Mental Health Services Act (MHSA) component.

Orange County acknowledges that this is not a new concept, per se. California county-based organizations and mental health agencies in the 1990s modelled this type of programming in mental health, largely through the California Association of Social Rehabilitation Agencies (CASRA). Businesses were developed for persons with mental illness. Recipients of mental health services were recruited through numerous entities such as the Department of Rehabilitation, socialization centers and group homes to be employees of these businesses.

Skill building at these businesses include "work hardening," socialization through work team efforts, learning how to manage time as well as employment preparation in the form

of occupational development were the hallmarks of numerous programs. Examples, include The Village in Long Beach, CA, Rubicon Bakery in Richmond, CA. a recycling center in Martinez, CA. and a janitorial/gardening/clerical service in Davis, CA.

What differentiates these programs from the food service program outlines in Orange County's Innovative Project is that Orange County intends to only service TAY. The vocational programs such as those identified above, initially served all adults in the mental health system. The County should further investigate the lessons learned from those examples.

For example, while the County describes some personnel expenses in its budget narrative, it does not address other issues related to running a commercial enterprise, such as workers compensation, health and safety codes, business licensing, payroll taxes, minimum wage, and insurance costs. Since it does not appear that the County intends to run this program as a sheltered workshop, these are very real issues related to doing business in California, regardless of whether it is under the auspices of a mental health program. Full development of a business plan would appear to be a necessary step prior to launching this project.

Our research indicates that supported employment programs for persons with emotional and/or behavioral issues most often are offered as part of an array of services such as housing. For example, Daniel's Place and Humanim are two housing programs for TAY in Los Angeles and Maryland, respectively, that incorporate a vocational component (supported employment). Many other programs nationwide, such as Cornerstone and the Young Adult Vocational Program and Peer Mentoring Project in Boston, offer stand-alone vocational services, not related to a business. Local to Sacramento, there are business such as Cool Beans and Crossroads Diversified Services which work with persons with mental health issues. These examples are not exclusively for TAY, however.

The Community Planning Process

Orange County conducted its community planning process for this Innovation in Fiscal Year 14/15. They state that they developed strategies to assist stakeholders throughout the process of community meetings, including providing clear definitions of the process and criteria to be used for vetting Innovation projects. They also provided stakeholders with a template for submitting ideas and provided them technical assistance via Q & A about projects that were being considered. These questions and responses are included on the County's website.

Five community stakeholder meetings were held regionally throughout the County.

> *Participation in these regional meetings included consumers, family members, providers, and individuals representing the larger health care community in Orange County that have an interest in behavioral health care. Invitations for participation were sent to consumers and consumer organizations as well as to individuals who represent safety (e.g., Probation and Sheriff), education, faith communities, physical healthcare providers*

> *(e.g., CalOptima, hospitals, community clinics), Social Services Agency), among others. Interpretive services were available for each of the meetings to remove barriers to participation for those whose primary language was not English. (Orange County New Innovative Project Description, page 2)*

This process generated thirty-one project suggestions submitted to the County. Behavioral Health staff reviewed the suggestions for fit with Innovative Project criteria and conducted a literature review to assess whether these ideas had been tried previously or if they had, if was there something about the Orange County suggestions that differentiated them sufficiently from the previous Innovation project.

Projects that passed both these preliminary levels were then presented to the MHSA Steering Committee. "The MHSA Steering Committee voted for the Job Training and On-site Support for TAY project proposal to move forward for consideration and formal submission to the MHSOAC for approval." (Orange County New Innovative Project Description, p.3).

Learning Objectives and Evaluation

Orange County states that the goals of this project will be to:

1. Increase participant access to community behavioral health and supportive services/programs.
2. Improve participant knowledge and/or awareness of behavioral health resources.
3. Improve participant behavioral health outcomes.
4. Improve participant global health. (Orange County New Innovative Project Description, p. 5)

The County intends to start the data gathering process in the second year of the project (first full service year) to establish a baseline for outcomes for Years 3 and 4 of the Project. The exact tools for this evaluative process have not yet been defined.

The description of the learning objectives and evaluation methodology for this project closely mirror the statements provided in the County's Employment and Mental Health Services Impact project, also before the Commission. In both cases, the County's specification of its learning objectives and evaluation approach needs further clarification.

The Budget

The Project is to be contracted out to a community based organization and so the County is only estimating suggested line items costs. The County indicates that the actual budget will depend on the selected provider's proposal. Therefore, staffing and other expenses are contingent upon the contract provider's final budget. The County's proposed budget should clarify what expected costs will be for contracted services versus direct County costs.

The projected budget is $6,531,770 over the five (5) year project. Evaluation costs estimated for this project are $700,642, or approximately 11% of the total plan costs. The breakout for the evaluation dollars is as follows:

5% from Personnel ($1,611,000)	$80,550
5% from Operating Expenses ($2,890,500)	$144,525
5% from Non-Recurring Expenditures ($160,000)	$8,000
25% from Other Expenditures ($1,870,270)	$467,567

As mentioned above, there do not appear to be any specific budget allocations or differentiation for administrative costs for County staff, or costs related to payroll, health and safety, payroll taxes, or other costs related to running a food service business, apart from leasing trucks and kitchen appliances. It may be that these particulars will be part of the scope of work provided to the School of Business selected to write the business prospectus for the County. Because these costs are not clearly delineated there are some costs, such as purchasing software, office furniture, etc. under non-recurring costs, which may not be appropriate to a time-limited Innovation project.

The project proposal has evolved considerably from the project described in the County's fiscal year (FY) 2015/16 Annual Update (Orange County MHSA Annual Update, pp. 255-256). The County is asking the Commissioners to approve a total Project amount of $6,531,770 for five (5) years, considerably more than the funding amount included in the Annual Update discussion. The County does not clarify in its proposal how these new project amounts were determined.

Additional Regulatory Requirements

The County could provide clarifications regarding budget items (including administration expenses and purchase of software and office equipment) and more clarity on the intended evaluation outcomes anticipated for this Innovation. The proposal as presented appears to meet or exceed other minimum regulatory requirements.

References

Crossroads Diversified Services. Employment Services. http://www.cdsdiv.com/employment-services/. Accessed September 13, 2016.

Eliot Community Human Services. Young Adult Vocational Program. www.yavp.org. Accessed September 13, 2016.

Humanim. Mental Health services. www.humanin.com/human-services/mental-health. Accessed September 13, 2016.

National Alliance on Mental Illness. 2014. "Road to Recovery: Employment and Mental Illness." http://www.nami.org/work. Accessed September 12, 2016.

Orange County Board of Supervisors Meeting minutes June 2, 2015 https://docs.google.com/gview?url=https%3A%2F%2Focgov.granicus.com%2FDocumentViewer.php%3Ffile%3Docgov_b985024cbcfec03d66fce25a3b04c04f.pdf%26view%3D1&embedded=true. Accessed September 13, 2016.

Orange County MHSA Annual Update, FY 15/16.

Orange County New Innovative Project Description. September 1, 2016. "INN 03-007 Job Training and On-site Support for TAY."

Step Up and Daniel's Places. Programs for Transitional Age Youth http://www.stepuponsecond.org/transitional-age-youth-tay/. Accessed September 13, 2016.

AGENDA ITEM 5

Information

October 27, 2016 Commission Meeting

Demonstration of Fiscal Reporting Tool

Summary: Brian R. Sala, Ph.D., Deputy Director for Evaluation and Program Operations at the Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission), will provide a demonstration of the MHSOAC Fiscal Reporting Data Visualization Tool and an update on related transparency projects.

In mid-2015, the MHSOAC Financial Oversight Committee requested that staff begin to explore options for providing regular, descriptive information to the public about County Mental Health Services Act (MHSA) expenditures, revenues, and unspent funds by MHSA component. The Commission subsequently in March 2016 and July 2016 authorized the Executive Director to negotiate contracts to develop a series of web applications and tools to inventory and display key information about County MHSA programs and expenditures.

The first deliverable from this effort is a Fiscal Reporting Data Visualization Tool, which is based on the MHSA Annual Revenue and Expenditure Reports (ARERs). It is submitted by the Counties to the Department of Health Care Services and to the Commission. The Tool will provide users with an opportunity to explore MHSA Component-level fiscal information by year and County. The initial release of the Tool will display information regarding MHSA expenditures and County's closing balances for recent fiscal years, as well as allow users to download the associated ARERs from the MHSOAC website.

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

Enclosures: None

Handout: A PowerPoint will be presented at the meeting

AGENDA ITEM 6

Action

October 27, 2016 Commission Meeting

Elect Chair and Vice-Chair for 2017

Summary: Elections for the Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission) Chair and Vice Chair for 2017 will be conducted at the October 27, 2016 Commission Meeting. The MHSOAC Rules of Procedure state that the Chair and the Vice-Chair shall be elected at a meeting held preferably in September but no later than during the last quarter of the calendar year by a majority of the voting members of the MHSOAC. The term is for one year and will start January 2017.

This agenda item will be facilitated by the commissioner with the most years on the Commission, Commissioner Larry Poaster.

Enclosures: Commissioner Biographies

Handout: None

Recommended Action: Elect a Chair and Vice-Chair of the MHSOAC for 2017

Presenter: Filomena Yeroshek, Chief Counsel

Facilitator: Commissioner Larry Poaster

Mental Health Services
Oversight & Accountability Commission

MHSOAC COMMISSIONERS

Reneeta Anthony, Fresno
Reneeta Anthony has been executive director at A3 Concepts LLC since 2013. She was principal staff analyst at the Fresno County Department of Social Services from 2005 to 2012, at the Fresno County Department of Behavioral Health from 2004 to 2005 and at the Fresno County Human Services System from 2001 to 2004. Anthony was principal staff analyst at the Fresno County Department of Children and Family Services from 2000 to 2001, where she was senior staff analyst from 1999 to 2000. Commissioner Anthony fills the seat of a family member of an adult child with a severe mental illness.

Lynn Ashbeck, Clovis
Lynne Ayers Ashbeck has been vice president at Community Medical Centers since 2015. She was regional vice president at the Hospital Council of Northern and Central California from 2006-2015. Ashbeck was also director of global and continuing education at California State University, Fresno from 2003-2006 and director of education at Valley Children's Hospital from 1997-2003. She is a member of the California Partnership for the San Joaquin Valley Board of Director and the Maddy Institute Board of Directors. She received her Master of Arts degree from Fresno Pacific University and a Master of Science degree from California State University, Fresno. Commissioner Ashbeck fills the seat of a representative of a health care service plan or insurer.

Khatera Aslami-Tamplen, Fairfield
Khatera Aslami-Tamplen has been consumer empowerment manager at Alameda County Behavioral Health Care Services since 2012. She was executive director at Peers Envisioning and Engaging in Recovery Services from 2007 to 2012 and served in multiple positions at the Telecare Corporation Villa Fairmont Mental Health Rehabilitation Center from 2002 to 2007, including director of rehabilitation. Aslami-Tamplen is a founding member of the California Association of Mental Health Peer Run Organizations, on the Board of Directors for Sutter Health Sutter Care at Home, and Board President of the Copeland Center for Wellness and Recovery. Commissioner Aslami-Tamplen represents clients and consumers.

Senator Jim Beall, San Jose
Jim Beall was elected to the California State Senate in 2012 and represents the 15th Senate District. He was elected to the State Assembly in November 2006, representing District 24. He is the chairman of the Senate Transportation and Housing Committee, in addition to serving on several other committees. He has spent three decades in public service as a San Jose City Councilman, a Santa Clara County Supervisor and an Assembly member. On the Commission, Senator Beall represents the member of the Senate selected by the President pro Tempore of the Senate.

John Boyd, Psy.D., Folsom
John Boyd, Psy.D., has been chief executive officer of Sutter Solano Medical Center and Sutter Center for Psychiatry since 2014. He was chief administrative officer of Sutter Health's Sacramento Sierra Region Behavioral Health Services and Continuing Care, including Sutter Medical Center, Sacramento, from 2008 to 2014. He was assistant administrator at Kaiser Permanente Sacramento Medical Center from 2007 to 2008. He held positions at Shriners Hospitals for Children from 1999 to 2006. He served as a City of Sacramento planning and design commissioner from 2004 to 2008. Boyd is a fellow at the American College of Healthcare Executives. He earned his Doctor of Psychology from the California School of Professional Psychology and a Master of Health Administration from USC. Commissioner Boyd represents an employer with more than 500 employees.

Bill Brown, Lompoc
Bill Brown was elected as sheriff and coroner for Santa Barbara County in 2006. He had previously served as chief of police for the city of Lompoc from 1995 to 2007, and chief of police for the city of Moscow, Idaho from 1992 to 1995. He was a police officer, supervisor and manager for the city of Inglewood Police Department from 1980 to 1992, and a police officer for the city of Pacifica from 1977 to 1980. Prior to his law enforcement career, Sheriff Brown served as a paramedic and emergency medical technician in the Los Angeles area from 1974 to 1977. Sheriff Brown holds a master's degree in public administration from the University of Southern California and is a graduate of the FBI National Academy and the Delinquency Control Institute. Commissioner Brown fills the county sheriff seat.

John Buck, Folsom
John Buck has served in multiple positions at Turning Point Community Programs since 1977, including Chief Executive Officer. He is a member of the Rotary Club of Sacramento and the Sacramento County Developmental Disabilities Planning and Advisory Council. Buck earned a Master of Business Administration degree from National University. Commissioner Buck fills the seat of an employer with less than 500 employees.

Victor Carrion, M.D., Palo Alto
Victor Carrion, M.D., is a Professor at the Stanford University School of Medicine, and the Director of Stanford's Early Life Stress Research Program. He is a board certified Child and Adolescent Psychiatrist, and his sub-specialties include maltreatment, neglect, and post-traumatic stress disorders. Dr. Carrion practices at the Lucile Packard Children's Hospital at Stanford. He is also an Associate Editor for the Journal of Traumatic Stress. His current research focuses on the relationship between brain development and vulnerability to stress, and developing treatments that include individual and community-based interventions for trauma-exposed children and adolescents. Dr. Carrion is also the recipient of awards from the National Institute of Mental Health, the American Foundation for Suicide Prevention, the National Association for Research in Schizophrenia and Affective Disorders, and the American Academy of Child and Adolescent Psychiatry. Dr. Carrion joins the Commission as the Attorney General's designee.

Itai Danovitch, M.D., Los Angeles
Itai Danovitch has been chair of the Psychiatry Department at Cedars-Sinai Medical Center since 2012, where he has held several positions since 2008, including director of addiction psychiatry clinical services and associate director of the Addiction Psychiatry Fellowship. He is a member of the American Society of Addiction Medicine and the American Psychiatric Association and past president of the California Society of Addiction Medicine. Danovitch earned a Doctor of Medicine degree from the University of California, Los Angeles School of Medicine and a Master of Business Administration degree from the University of California, Los Angeles School of Management. Commissioner Danovitch fills the seat of a physician specializing in alcohol and drug treatment.

David Gordon, Sacramento
David Gordon has been county superintendent at the Sacramento County Office of Education since 2004. He served at the Elk Grove Unified School District as superintendent from 1995 to 2004. He worked at the California Department of Education as deputy superintendent from 1985 to 1991. He earned a Master of Education degree from Harvard University. Commissioner Gordon holds a seat as superintendent of a school district.

Gladys Mitchell, Sacramento
Gladys Mitchell served as a staff services manager at the California Department of Health Care Services from 2013 to 2014 and at the California Department of Alcohol and Drug Programs from 2010 to 2013 and from 2007 to 2009. She was a health program specialist at California Correctional Health Care Services from 2009 to 2010

and a staff mental health specialist at the California Department of Mental Health from 2006 to 2007. She was interim executive officer at the California Board of Occupational Therapy in 2005 and an enforcement coordinator at the California Board of Registered Nursing from 1996 to 1998 and at the Board of Behavioral Science Examiners from 1989 to 1993. She is a member of the St. Hope Public School Board of Directors. Mitchell earned a Master of Social Work degree from California State University, Sacramento. Commissioner Mitchell fills the seat of a family member of a child who has or has had a severe mental illness.

Larry Poaster, Ph.D., Modesto
Larry Poaster served as a private consultant to government agencies in the field of health care delivery by public entities from 2002 until the Governor appointed him to the Commission in 2007. He previously served as the Director of Behavioral Health Services for the Stanislaus County Department of Behavioral Health Services from 1980 to 2002 and was the Director of Clinical Services for that department from 1970 to 1980. He was President of the California Conference of Mental Health Directors, twice president of the California Mental Health Directors Association, and president of the Board of Directors of the California Institute of Mental Health. Commissioner Poaster fills the seat of a mental health professional.

Assemblymember Tony Thurmond, Richmond
Tony Thurmond was elected to represent California's 15th Assembly District in November 2014. The district includes the East Bay communities that stretch along the I-80 corridor from Hercules to Oakland. First elected to the Richmond City Council in 2005, Thurmond served as Council Liaison to Richmond's Youth Commission, the Workforce Investment Board and the West Contra Costa Unified School District. On the Commission, Assemblymember Thurmond represents the member of the Assembly selected by the Speaker of the Assembly.

Richard Van Horn, Los Angeles
Richard Van Horn has been President and Chief Executive Officer (CEO) of the Mental Health American (MHA) of Los Angeles since 1980 and President Emeritus since his retirement. He is a member of the board of the Mental Health Association of California, the California Institute for Mental Health, the California Council Community Mental Health Agencies, and the National Council for Community Behavioral Health (NCCBH). He is a past member of the National Board of Directors of Mental Health America. On behalf of Mental Health America, he has testified before the Congress of the United States regarding issues affecting people with mental illnesses. He also served for six months as principal consultant for the MHSOAC in 2005. Commissioner Van Horn fills the seat of designee of the State Superintendent of Public Instruction.

Tina Wooton, Santa Barbara

Tina Wooton has worked in the mental health system for 17 years, advocating for the employment of consumers and family members at the local, state and federal levels. Since 2009 she has served as the Consumer Empowerment Manager for the Santa Barbara County Department of Alcohol, Drug, and Mental Health Services. From 2005 through 2009 she worked as the Consumer and Family member liaison for the California State Department of Mental Health and was staff to the state Mental Health Services Act Implementation Team. Between 1997 and 2005 she served as Consumer Liaison for the Mental Health Association / County Mental Health of Sacramento and as service coordinator for Human Resources Consultants from 1994 through 1997. Wooton is Vice President of AMP (Arts Mentorship Program) for Santa Barbara Dance Arts and a Santa Barbara Elks member. Commissioner Wooton represents clients and consumers.

AGENDA ITEM 7

Action

October 27, 2016 Commission Meeting

Regulations Implementation Project Report

Summary: The Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission) will consider adopting the recommendations unanimously approved by the Regulations Implementation Subcommittee (Subcommittee) to implement the Prevention and Early Intervention and Innovation Projects regulations.

The Subcommittee (consisting of Commissioner Larry Poaster as chair, and Commissioners Khatera Aslami-Tamplen and Richard Van Horn) was formed by the MHSOAC during the latter part of 2015 to work with the County Behavioral Health Directors Association (CBHDA), counties, consumers, family members, community mental health providers, and other stakeholders to address specific concerns about the implementation of the Commission's regulations that went into effect in October of 2015. Those concerns dealt with:

- New reporting requirements on the demographics of persons served, including race, ethnicity, sexual orientation, and gender identification.
- New program and measurement requirements, under the statutorily required Access and Linkage to Treatment for people with a serious mental illness.
- New requirement to measure the duration of untreated mental illness.

The Subcommittee held six public meetings throughout the State to better understand the challenges faced by counties and providers in the implementation of the regulations in the three areas listed above. More than 200 people, representing over 40 counties, attended the meetings. These public meetings included persons with a range of perspectives and expertise to ensure the Subcommittee received guidance that appropriately balanced statewide needs and responsibilities with local priorities and resources. The Subcommittee benefited from participation in the meetings by representatives from county behavioral health departments and the Department of Health Care Services, as well as subject-matter experts including a diverse set of people with lived experiences of being at risk of or diagnosed with mental illness, or their families.

Informed by the knowledge, experience, and expertise of the meeting participants, the Subcommittee identified key findings regarding the challenges to operationalizing the three regulatory requirements and recommendations to address those challenges. The Subcommittee

at its June 29, 2016 meeting obtained input to the draft findings and recommendations and at its August 3, 2016 meeting unanimously approved the revised findings and recommendations to be submitted to the full Commission for consideration.

The draft full report containing the findings and recommendations that were approved by the Subcommittee are enclosed for your review and consideration.

Presenter: Filomena Yeroshek, Chief Counsel

Enclosures: The draft report containing findings and recommendations approved by the Regulations Implementation Project Subcommittee.

Handout: A PowerPoint presentation will be made available at the meeting

Proposed Motion: The MHSOAC adopts the recommendations submitted by the Regulations Implementation Project Subcommittee

MHSOAC
Mental Health Services
Oversight & Accountability Commission

Finding Solutions

Helping Counties Comply with Regulations Governing Innovation Projects and Prevention and Early Intervention Programs under the Mental Health Services Act

CONTENTS

I. Executive Summary

In 2004 California voters passed the Mental Health Services Act, directing the state and counties to undertake a sweeping transformation of how they deliver mental health care. The Act established the Mental Health Services Oversight and Accountability Commission (Commission) to guide implementation, develop strategies to reduce the stigma associated with mental illness, and advise the governor and legislators on policy as needed. In 2013, the Legislature expanded the Commission's role and asked it to draft regulations for two components of the Act – Prevention and Early Intervention and Innovation programs. In response, the Commission worked for two years to create the regulations, convening 15 public meetings and reviewing hundreds of pages of comments. The regulations were approved by the Office of Administrative Law and took effect in October 2015.

In the months since, representatives of California's county behavioral health agencies have raised multiple concerns about their ability to comply with the new regulations. Specifically, the County Behavioral Health Directors Association asked the Commission to provide guidance regarding three principal challenges:

- **How to report the demographics of people provided mental health services, including their race, ethnicity, sexual orientation, and gender identification**. Among other problems, the counties say the existing data system for transmitting mental health information from the counties to the California Department of Health Care Services is not equipped to receive the more detailed demographic data now required.
- **How to manage the new program and measurement requirements under the Access and Linkage to Treatment for people with a serious mental illness**. New regulatory requirements for how programs are organized and funded may be inconsistent with how counties were initially directed to establish programs funded under the Mental Health Services Act.
- **How to measure the duration of untreated mental illness.** The regulations require the counties to measure and report how long a person with untreated serious mental illness waits for services after a referral to care through a Prevention or Early Intervention Program. Yet there is no set standard for measuring that timeframe.

In response to these concerns, the Commission formed a subcommittee of three Commissioners to explore possible solutions. The subcommittee was guided by a diverse range of professionals from throughout the mental health community, including representatives from county behavioral health departments and the Department of Health Care Services. The subcommittee also received valuable input from people with mental illness and their families and representatives of diverse ethnic, racial, and cultural communities.

The subcommittee held six public meetings throughout California to better understand the challenges counties and providers have encountered under the new regulations, with a specific focus on the three concerns outlined above. This report summarizes the subcommittee's findings and recommends five actions the Commission should take:

1. Initiate collaborative processes

    - with county behavioral health agencies and other subject matter experts to ensure the use of best practices in the collection and reporting of sensitive demographic information;
    - with other state entities to coordinate the adoption of consistent standards and regulations for demographic data reporting;
    - with all parties involved, including stakeholders, to consider revisions to the current regulations.

2. Recognize the unique needs of very small counties that must carry out the Prevention and Early Intervention and Innovation regulations.

3. Develop technical assistance strategies to clarify the Access and Linkage to Treatment reporting requirements, including the measurement of duration of untreated mental illness.

4. Consider amending the regulations to clarify that an Access and Linkage to Treatment program or strategy administered under the Mental Health Services Act Community Services and Supports (CSS) component may be funded through CSS as long as the other program or strategy requirements specified in the Prevention and Early Intervention regulations are met.

5. Amend the Prevention and Early Intervention regulations to align counties' annual and periodic reporting deadlines with their budget-making timetables to maximize the value of the reports to local policymakers.

This report also provides background on how and why the Commission adopted the Prevention and Early Intervention and Innovation regulations as well as details regarding development of the subcommittee's five recommendations.

II. Background

The Mental Health Services Act

When California voters passed the Mental Health Services Act (the Act) in 2004, they laid the foundation for fundamental change in the state's mental health care system. The Act prioritized a focus on wellness, recovery, community consultation in decision-making, and a high level of public accountability. To achieve transformational change, the Act relies on three principal components:

- Community Services and Supports, which encompasses most direct mental health services, including an approach known as "whatever it takes" to support recovery;
- Prevention and Early Intervention (PEI), which emphasizes an early response to emerging needs before they become severe and disabling; and
- Innovation Programs, which propose new ways of operating on the mental health care landscape.

At the state level, California's mental health system is administered and overseen by the California Department of Health Care Services (DHCS) and the Mental Health Services Oversight and Accountability Commission (Commission). Additional state functions are administered by the Office of Statewide Health Planning and Development, which provides workforce development; the California Department of Education, which supports some school-based mental health programs; the California Department of State Hospitals, which provides hospital care to the most gravely disabled, and other state agencies.

While the state has an administrative and oversight role, mental health service delivery is handled by California's counties.[1] Many counties provide direct services to their residents, while others rely on contracts to deliver care, working with private, primarily nonprofit providers.

The Act includes a range of requirements that counties and their providers must meet. In 2013, the Legislature directed the Commission to adopt regulations governing programs and expenditures for PEI and Innovation programs (Assembly Bill 82, Committee on Budget, Chapter 23, Statutes of 2013). This change in the law meant that both the Commission and the DHCS now have authority to issue regulations to implement the Act. The DHCS is charged with issuing regulations for all of the components except for PEI and Innovation, which are under the authority of the Commission. The Legislature required that regulations adopted by DHCS be consistent with the regulations adopted by the Commission (Welfare and Institutions Code section 5846(b)).

The Regulatory Process

Regulations help clarify standards or expectations in the law. While they cannot modify or change the law, regulations provide clear language for carrying out the law or responding to it. For example, the law may require counties to submit to the state specific information on people served by the mental health system in order to document the range of needs being met. Regulations, meanwhile, would specify in what form, and how often, that information should be gathered and sent to the state. In California, the Office of Administrative Law is charged with ensuring that regulations are consistent with the law, are clear and necessary, and adequately meet the law's legal requirements.

To adopt regulations for California's PEI and Innovation programs, the Commission undertook an exhaustive public process, soliciting input between August 2013 and August 2015. Through 15 public meetings and the review of hundreds of pages of public comment, the Commission heard testimony from mental health consumers and family members, counties, representatives from diverse racial and ethnic communities, and other members of the public. In response to this extensive public input, the Commission developed regulations to provide a clear framework for the counties to execute, evaluate, and report on the PEI and Innovation projects they fund and operate. These regulations were reviewed and approved by the Office of Administrative Law and took effect in October 2015. By approving the regulations, the Office of Administrative Law determined that:

- the Commission has the authority to issue the regulations;
- the regulations correctly reference the specific law that they execute, interpret or make specific;
- the regulations are consistent with the law;
- the text of the regulations is clear;
- the regulations are necessary; and
- the Commission followed specified procedural requirements.

The Subcommittee Advisory Process

In response to the three specific concerns listed earlier in this report, the Commission formed a subcommittee – comprised of Commissioner Larry Poaster as chair and Commissioners Khatera Aslami-Tamplen and Richard Van Horn – to explore the issues and propose solutions. The subcommittee held six public meetings throughout the state to better understand the challenges faced by counties and providers operating under the new regulations.

More than 200 people representing more than 40 counties, as well as providers, community-based organizations, the California Behavioral Health Directors Association, the DHCS, and other stakeholders attended the subcommittee meetings. The first gathering, was a two-day meeting held in February 2016 in Sacramento. Additional meetings were held in Alameda County, Los Angeles County, and Calaveras County. At each meeting, participants explored the rationale behind the new regulatory requirements, the challenges associated with those requirements, and strategies the state and the counties could pursue to remedy the problems.

II. Findings and Recommendations

Finding One: Not all counties are sufficiently equipped to collect sensitive demographic information.

One indisputable goal of the Mental Health Services Act is improving access to care and the quality of that care for people who have historically been underserved. The Prevention and Early Intervention (PEI) portion of the Act, in particular, is intended to reduce the long-term, adverse

impacts of untreated mental illness by reducing barriers to care prior to first onset of a mental illness or before that illness becomes severe and disabling.

The Mental Health Services Oversight and Accountability Commission (Commission) has adopted regulatory requirements for counties to report detailed demographic information on who is served by California's mental health system and whether they have difficulties getting the care they need. This information includes age, gender, race and ethnicity, sexual orientation, language used, veteran status, disabilities and other details. (See the Required Demographic Data chart at right.)

The Commission developed these demographic reporting requirements based on consultation with a range of stakeholders who presented information about groups who have historically faced barriers to care. For instance, research shows that veterans have a suicide rate higher than the rate for non-veterans.[2] And while it is commonly assumed that veterans can receive mental health care through the U.S. Department of Veterans Affairs, many veterans either lack eligibility or live far from a Veterans Affairs facility.

Similarly, the League of United Latin American Citizens has raised concerns that non-Spanish speaking Latino immigrants, who are eligible for county mental health services, are struggling to access care because few providers speak their indigenous languages.[3] Equally significant, there is growing evidence that California's lesbian, gay, bisexual, transgender, queer, and/or questioning communities (LGBTQ) have disproportionately higher rates of poverty, suicide, homelessness, isolation, substance abuse, and trauma associated with violence.[4] For certain groups, such as transgender people of color and women, health and mental health disparities are particularly severe.[5] The statistics are even more alarming for LGBTQ youth, who are particularly vulnerable to suicide. Lesbian, gay, and bisexual youth are more than twice as likely than their heterosexual peers to have attempted suicide.[6]

Required Demographic Data

(A) Age groups
1. 0-15 (children/youth)
2. 16-25 (transition age youth)
3. 26-59 (adult)
4. Ages 60+ (older adult)

(B) Race
1. American Indian or Alaska Native
2. Asian
3. Black or African American
4. Native Hawaiian or other Pacific Islander
5. White
6. Other
7. More than one race
8. Decline to answer

(C) Ethnicity
1. Hispanic or Latino:
   a. Caribbean
   b. Central American
   c. Mexican/Mexican-American/Chicano
   d. Puerto Rican
   e. South American
   f. Other
   g. Decline to answer
2. Non-Hispanic or Non-Latino:
   a. African
   b. Asian Indian/South Asian
   c. Cambodian
   d. Chinese
   e. Eastern European
   f. European
   g. Filipino
   h. Japanese
   i. Korean
   j. Middle Eastern
   k. Vietnamese
   l. Other
   m. Decline to answer
3. More than one ethnicity
4. Decline to answer

(D) Primary language used listed by threshold language for the individual county
(E) Sexual orientation
1. Gay or Lesbian
2. Heterosexual or Straight
3. Bisexual
4. Questioning or unsure of sexual orientation
5. Queer
6. Another sexual orientation
7. Decline to answer
(F) Disability
1. Yes
a. Communication domain
(i) Difficulty seeing
(ii) Difficulty hearing or having speech understood
(iii) Other (specify)
b. Mental domain not including mental illness
c. Physical/mobility domain
d. Chronic health condition
2. No
3. Decline to answer
(G) Veteran status
1. Yes
2. No
3. Decline to answer
(H) Gender
1. Assigned sex at birth
a. Male
b. Female
C. Decline to answer
2. Current gender identity
a. Male
b. Female
c. Transgender
d. Genderqueer
e. Questioning or unsure of gender identity
f. Another gender identity
g. Decline to answer

To better document and understand mental health disparities, the Commission regulations require the counties to report, by demographic category, information on who is served. To meet this new reporting requirement, both the counties and the mental health providers who deliver mental health care on their behalf must create policies and procedures to gather this detailed demographic information and transmit it to the state.

California's mental health system includes a diverse array of programs and services, ranging from mental health treatment provided in a clinical or office setting to home-based outreach and group meetings. Prevention services are particularly diverse and include school-based education and awareness services for youth as well as outreach services for older adults who are isolated due to loss, illness and/or substance abuse.

The regulations require that each county annually report specific information about its mental health services, including the number of people served in each Prevention and Early Intervention program, the number of referrals made for members of underserved communities, and the average time that passed between a referral and the recommended treatment.

Reflecting that diversity, California's network of providers use a variety of information-gathering tools to document the people they serve. Some programs use sophisticated electronic health records, which are common in traditional clinical settings, while others still gather information using pencil and paper. The latter group includes *promotoras,* community members with basic health education training who typically meet with small groups of residents in a private home, library or other community setting. Expanding data-reporting requirements that are applied equally across these diverse service settings and collection methods is a significant challenge.

To collect the required demographic information, counties and providers must overcome multiple obstacles:

1. Asking for information on sexual orientation and gender identity must be handled in a sensitive manner, and not all counties or providers have established appropriate policies and procedures. Complicating this task, it is unclear

whether there are best practices governing how to gather this information, particularly for racial, ethnic, religious, and cultural groups that may be less aware or accepting of sexual orientation and gender diversity.

2. The counties and their providers often serve young children. It is unclear what the acceptable age range is for asking children about their sexual orientation and gender identity.
3. For programs administered through or in partnership with California's elementary and secondary schools, federal and state law may limit the type of questions regarding sexual orientation and gender identify that may be asked of a child without written permission from a parent or guardian.
4. In addition to complying with the Commission regulations, California's counties must follow state and federal laws that establish similar and potentially conflicting data-gathering requirements. Creating consistent demographic reporting requirements would streamline and simplify their work.
5. The state lacks a data-reporting system that can accept the detailed demographic information required by the new regulations.

Failure to address each of these concerns could undermine regulatory compliance or the quality of the data submitted to the state. These challenges are discussed in more detail in the following pages.

Support culturally sensitive approaches to gathering information on sexual orientation and gender identity.

The Commission's regulations require providers to collect information on an individual's sexual orientation and gender identity, information deemed essential to documenting whether LGBTQ people are accessing care and the outcomes of that care. Advocates are concerned that collecting sexual orientation and gender information may cause offense in some cultures. For example, asking about anything other than the traditional male or female gender identities may clash with cultural, linguistic or religious values. Advocates report that some cultures do not have words to describe details related to lesbian, gay, bisexual, transgender or queer, as required by the regulations.[7] Failure to address that concern could lead to confusion and conflict between providers and mental health clients, ultimately producing invalid data. The Centers for Medicare & Medicaid Services Office of Minority Health is developing a web-based training to aid providers in the collection of sexual orientation and gender identity data. The federal agency also is working on a new best practices tool box for providing culturally and linguistically appropriate services with an emphasis on sexual and gender minorities and people with disabilities.[8]

In 2016 the U.S. Department of Health and Human Services Health Resources and Services Administration added sexual orientation and gender identity to its reporting requirements. Federal officials say the new data are necessary because "sexual orientation and gender identity can play a significant role in determining health outcomes. Gaining a better understanding of populations served by health centers, including sexual orientation and gender identity, promotes culturally competent care delivery and contributes to reducing health disparities overall."

U.S. Department of Health and Human Services, Health Resources and Services Administration, Program Assistance Letter. March 22, 2016. http://bphc.hrsa.gov/datareporting/pdf/pal201602.pdf

While those concerns are valid, gathering detailed information on sexual orientation and gender identity is not new and will become increasingly more common. Recent federal and state laws require the collection of this data in population health surveys.[9] This new requirement is intended to facilitate identification of health issues and the reduction of health disparities among LGBTQ communities. Gathering this data is consistent with key recommendations in Healthy People 2020, the 2011 Institute of Medicine report on LGBTQ health issues and research gaps, and the federal government's implementation of the Patient Protection and Affordable Care Act.[10]

Despite this trend, most counties have not established policies and procedures for gathering this information. Fortunately, some counties have considerable experience gathering detailed demographic information, including data on sexual orientation and gender identity. The City and County of San Francisco and San Mateo County have been collecting gender identification and sexual orientation data for years and have developed guidelines for the work.[11] In 2013, the San Francisco Department of Public Health issued guidelines for collecting and reporting sexual orientation and gender identity data (see "Sexual Orientation and Gender Identity Data Collection in San Francisco" on the next page). The Commission's regulations parallel the two-part question approach developed by San Francisco.

Despite these models, the vast majority of California counties lack the protocols and guidelines in place in San Francisco and San Mateo. To benefit from the work done in those counties and elsewhere, the state should support peer-to-peer learning. This would help each county develop protocols for the effective and culturally sensitive gathering of data.

The **New York City Commission on Human Rights has** made it illegal to discriminate on the basis of gender identity and gender expression in the workplace, in public spaces, and in housing –and **identified 31 different gender identities.**

New York City Commission on Human Rights. http://www1.nyc.gov/site/cchr/law/legal-guidances-gender-identity-expression.page

Sexual Orientation and Gender Identity Collection in San Francisco

In 2013, the San Francisco Department of Public Health issued guidelines for collecting and reporting sexual orientation and gender identity data. The stated purpose of the guidelines was to "promote accuracy, transparency and consistency" so "data collection and reporting on health by sex and gender reflect the spectrum of gender categories that are meaningful for identifying differences in health outcomes, conditions that impact health and delivery of health services."

The guidelines state that sex and gender should be self-identified and that a concise, feasible method for identifying a person's sex and gender identity involves asking these two questions:

1. What is your gender?
2. What was your sex at birth?

San Francisco Department of Public Health, *Policy and Procedure* – Principles for Collection, Coding, and Reporting Identity Data Sex and Gender Guidelines, September 1, 2014

Clarify the age threshold for gathering detailed information on sexual orientation and gender identity.

Under California law, a minor who is 12 years of age or older may consent to outpatient mental health services.
Health and Safety Code §124260

The core principle of PEI is to intervene early in the onset of mental illness to prevent it from becoming severe and disabling. (WIC §5840(a)) Half of all lifetime cases of diagnosable mental illnesses begin by age 14 and three-fourths begin by age 24.[12] Gathering demographic information from youth is key to tracking the effectiveness of programs serving young people. Such efforts are especially critical for California's LGBTQ community, for reasons described earlier. [13]

Given the evidence of the early onset of mental illness in youth, particularly youth from underserved communities, it is critical that the state identify which programs are effective for which youth. To make that determination, and to assess whether Californians continue to face barriers to care, the state needs demographic and other data. But as with state law, the PEI and Innovation regulations do not specify the age at which such information should be collected. Some providers have raised concerns about collecting sexual orientation and gender identification information from people younger than 18. But there is little research providing insights about whether some children are too young to be asked, or to answer, questions about their sexual orientation and gender identity.

In analyzing this issue, it's useful to look at what age a minor may consent to outpatient mental health services. Under California law, a minor who is 12 years of age or older may consent to mental health treatment or counseling on an outpatient basis if, in the opinion of the attending professional, the minor is mature enough to participate intelligently in the services (Health and

Safety Code section 124260). This law was enacted in 2010 to eliminate barriers faced by youths eligible for mental health services specifically under the Prevention and Early Intervention component of the Act.[14] Given that a minor as young as 12 can consent to receiving mental health services, it may be reasonable to conclude that minors of the same age are old enough to answer demographic questions, including those about sexual orientation and gender identity.

Because the regulations do not provide counties and providers an age range for the collecting of such information, the Commission should consider an amendment to the regulations that specifies an age threshold.

Ensure consistency with other laws for programs administered through or in partnership with California's elementary and secondary schools.

Mental health programs administered through or in partnership with California's elementary and secondary schools face another challenge related to sexual orientation and gender identity questions – a lack of consistency with other state and federal laws over what may be asked without a parent or guardian's written consent. Some parents have withdrawn their children from programs because of objections to the sexual orientation and gender identity question.[15] This issue raises two significant questions for programs administered through or in partnership with California's elementary and secondary schools:

1. Is parental permission required before youth may be asked their sexual orientation and gender identity?

Advocates have cited California Education Code section 51513 in support of obtaining parental consent prior to asking students about their sexual orientation and gender identity. Section 51513 prohibits a school from asking a student's personal beliefs or practices in sex, family life, morality, and religion in grades 1 to 12 unless a parent gives written permission (i.e. an "opt-in" requirement). There is a strong argument that section 51513 does not apply in this instance because questions about the student's race, ethnicity, sexual orientation and gender identity are not about the "student's beliefs or practices in sex, family life, morality, or religion." Nevertheless, some people insist that questions about sexual orientation and gender identity infringe on morality and religious beliefs.

Even if section 51513 were applicable, Education Code section 51938 provides for a specific exception to the opt-in requirement for students in grades 7 to 12 for anonymous, voluntary, and confidential research and evaluation tools to measure students' health behaviors and risks. This code section is part of the comprehensive health education programs and includes instruction on mental and emotional health and development. It provides for a passive consent (i.e. an "opt-out" process), meaning that parents or guardians must be notified that the survey is to be administered, given an opportunity to review the survey, and told that excusing their child from taking the survey requires a written request to the school district. Thus, depending on whether the PEI program fits within the boundaries of this Education Code section, parent or guardian permission may not be required.

Other than the two Education Code sections mentioned here, the Commission's research found no state or federal law that requires parental consent prior to collecting sexual orientation and gender identity information from a student. This conclusion is based upon an independent legal review as well as discussions with the California Department of Education and local and national experts on youth law.[16] According to these experts, considerable confusion persists around the laws governing parental consent in general. For example, although the law specifying that a 12-year-old minor may consent to outpatient mental health services has been in effect since 2010, many school districts are still unaware of it.[17]

There is considerable confusion in California regarding when parental consent is required for participation in mental health programs in schools.

Recognizing the need for more clarity on this topic, the National Center for Youth Law is working with law firms representing California school districts to convene a conference to provide technical assistance and training to local school district administrators on parental consent.[18]

Whether or not parental consent is legally required to obtain sexual orientation and gender identity information from students, it must be emphasized that participation in PEI programs is not contingent upon providing *any* demographic information. Put another way, while the regulations require the counties to report demographic information, they do not make its collection a condition for providing services. Even so, students and their parents or guardians deserve more information about why these questions are being asked and how the answers will be used.

2. Once sexual orientation and gender identity information is collected, can it be reported to the state without parental consent?

The answer to this question depends on whether the information is subject to the Family Educational Rights and Privacy Act (FERPA) or the Health Insurance Portability and Accountability Act (HIPAA). These two federal laws protect privacy and limit how certain personal information can be shared.

"Protected health information" is individually identifiable health information in any form, including oral communications as well as written or electronically transmitted information. (45 C.F.R. Part 162)

Generally, FERPA limits disclosure of information in education records maintained by schools while HIPAA limits disclosure of health information by health care providers. When health care providers work on school campuses, HIPAA or FERPA may apply to the provider's records depending on a number of complex variables.[19]

In addition to FERPA and HIPAA, California state law protects the confidentiality of information held by schools and mental health providers, and dictates how and when information can be shared.[20] These laws parallel HIPAA in many ways, but in some cases provide greater confidentiality protection. When that occurs, providers must follow the state law. California confidentiality law does apply to health information in an education record subject to FERPA; therefore, FERPA and California law may apply to the same information at the same time.

Identifying the applicable statute is important because the laws' requirements differ. Under FERPA, for example, a parent must sign a release authorizing the exchange of information on behalf of a minor child. Under HIPAA, a parent must sign for a minor except only the minor student must sign if the records pertain to health services (including mental health) the minor consented to, or could have consented to, under state law. This distinction is important because of the California law cited previously that authorizes 12-year-olds to consent to their own outpatient mental health services.

No matter which of the federal and state privacy protection laws apply, information omitting personal identifiers may be released without consent for purposes of research and evaluation.[21] The demographic information required by the PEI regulations is aggregated information (i.e. lacking personal identifiers) about the participants of each PEI program; this information can be released by the provider unless it is for such a small-sized group that an individual might reasonably be considered identifiable. Even so, given the complex maze of laws, the Commission should amend the regulations to provide clearer guidance on data collection for programs serving children in schools.

Create consistent demographic reporting requirements and streamline the data collection and reporting process.

While California's county mental health agencies and their private sector providers recognize the value of collecting the demographic information, they are hindered by several practical problems. These include the two following challenges:

1. The state-maintained computer system through which counties submit demographic information is not configured to accept the new data.
2. Recent legislation directed multiple state departments to gather sexual orientation and gender identity information, but there is no common protocol governing this data reporting.

The counties have noted that under previously adopted regulations, they are required to submit demographic information on people they serve through a computer system known as the Client & Service Information (CSI) system, which is maintained by the California Department of Health Care Services (DHCS). Because of its current configuration, however, the CSI is not able to accept the more detailed information on ethnicity required by the Commission's new regulations. For instance, the CSI uses only "Hispanic/Latino" and "Unknown" for ethnicity categories, but the regulations call for differentiating between six Latino identities and 12 non-Latino identities, including nine Asians identities. The more detailed information requested under the regulations mirrors the expanded set of data on ancestry or ethnic origin now required under recently approved legislation.[22] The intent of the broader reporting on ethnicity is to equip the state with more accurate data with which to meet the needs of its diverse communities.

The DHCS is working to update its data collecting capabilities, including the CSI, and ultimately it must develop an integrated system that allows counties to submit information in a timely, reliable, and efficient manner. In the interim, the new regulations call for the demographic data to be delivered directly to the Commission.

Despite concerns, the Commission concluded that gathering the more detailed information is necessary to determine whether diverse communities are accessing care and experiencing the positive mental health outcomes envisioned by the Mental Health Services Act.

On a related issue, the counties and providers have indicated that the more detailed demographic information required by the new regulations can create inconsistencies within a medical record. For instance, traditional demographic data in a file might list a patient as Asian or Latino, yet the recently adopted regulations call for differentiating between multiple categories of Asians or Latino identities, as discussed earlier. As a result, in addition to gathering greater demographic detail for new clients, providers will need to update the medical records of all clients.

While updating such medical records may create additional cost, most contracts governing electronic health records systems require the vendor to make updates at little or no cost to comply with regulations. Counties and providers should engage with their electronic health records vendors to clarify procedures for modifying and updating their data collection systems as a result of the new reporting requirements.

Following recent legislation, multiple state departments also are developing new sexual orientation and gender identity reporting requirements. Yet because there is no universal standard governing such data reporting, counties may be asked to comply with a variety of requirements. In 2015 the California Legislature enacted Assembly Bill 959 (Chiu, Chapter 565, Statutes of 2015), the Lesbian, Gay, Bisexual, and Transgender Disparities Reduction Act, to address the significant health and well-being disparities that affect LGBTQ individuals. The bill requires the collection of sexual orientation and gender identity data by departments that work in health and human services. Specifically, the DHCS, Department of Public Health, Department of Social Services, and Department of Aging must add sexual orientation and gender identity data to their current demographic data collection efforts as soon as possible, and no later than July 1, 2018.

Counties and providers are concerned that these four state departments will establish sexual orientation and gender identity reporting requirements that differ from or conflict with each other and those set by the Commission. The Mental Health Services Act requires that regulations adopted by DHCS be consistent with the regulations adopted by the Commission. Consistent with the law, the Commission should ensure that the DHCS adopts demographic reporting requirements that match its own.

The Mental Health Services Act requires that regulations adopted by the California Department of Health Services and the Mental Health Services Oversight and Accountability Commission be consistent.

Similarly, the Commission should work with the other state departments covered under Assembly Bill 959, to follow a consistent set of data collection requirements.

Despite these concerns, the Commission concludes that gathering the detailed demographic information – including sexual orientation and gender identity – is vital. Without it, California will not know whether its diverse communities are receiving mental health care and whether that care is producing the positive mental health outcomes envisioned by the Act.

Recommendation

The Commission should support collaborative processes with county behavioral health agencies and other subject matter experts to apply best practices to the collection and reporting of sensitive demographic information. It also should work with other state departments to ensure the adoption of consistent standards and regulations regarding demographic data reporting. Finally, the Commission should partner with all parties, including stakeholders, on potential revisions to current regulations.

- In keeping with the law, the Commission should ensure that DHCS demographic reporting requirements are consistent with its own.

- The Commission should support counties by facilitating learning collaboratives and peer-to-peer guidance on best practices for collecting sensitive, culturally and linguistically competent, and age appropriate data. Collaboratives would allow

    - counties with experience in collecting demographic information to share lessons learned and best practices; and
    - other subject matter experts, including those representing unserved and underserved communities, to share best practices for individual communities.

- In conjunction with the learning collaboratives, the Commission should develop training and guidance materials for counties and providers. This training should include

    - guidance on data collection in clinical and non-clinical programs; and
    - toolkits and training to explain the reasons behind data collection and how it will be used to support improved service delivery.

- For programs serving children or youth, the Commission should amend the regulations to clarify that data on youth shall be collected and reported to the extent permissible by federal and state law, including the California Education Code. The Commission should specify an age threshold for data collection.

- The Commission should work with the DHCS and the Department of Public Health, Department of Social Services, and Department of Aging which have been directed to collect sexual orientation and gender identification data (Assembly Bill 959 Chiu, Chapter 565, Statutes of 2015), and with the Health and Human Services Agency and the Legislature, to set a statewide uniform standard for collecting this data.

- As the state puts in place a statewide integrated data collection system, the Commission should amend its regulations to require individual-level and non-aggregated data, allowing it to better monitor who is served by California's mental health system and determine whether some Californians continue to face barriers to care.

In order to implement the reporting requirements, the Department of Health Care Services must develop an integrated data collection system that allows counties to submit data in a timely, reliable, and efficient manner.

Finding Two: The regulatory requirements create unique challenges for counties with a population of 100,000 or fewer.

The Mental Health Services Oversight and Accountability Commission subcommittee heard considerable testimony about the obstacles some of California's smallest counties face as they seek to comply with the regulations. Counties with a population at or below 100,000 typically lack the staff and resources to meet some of the regulatory requirements, which are designed for larger counties. In addition, programs in very small counties tend to serve few consumers, raising a high risk that individuals' identity would be disclosed through the collection of information.

Very small counties range in population from less than 2,000 to 100,000.[23] The chart on the lists the counties and the minimal funding for Prevention and Early Intervention (PEI) programs for each county. For example, in fiscal year 2014-2015 the PEI funds distributed to these counties ranged from less than $300,000 for Alpine County to approximately $900,000 for Nevada County.[24] Yet under the regulations, these counties have the same programs and reporting requirements as counties as large as San Diego and Los Angeles.

Table 1: Very Small Counties

County	Population	MHSA Distributed FY 2014-15	PEI Funds
Alpine	1,100	$ 1,577,732.00	$ 299,769.08
Amador	37,001	$ 2,839,999.00	$ 539,599.81
Calaveras	44,828	$ 3,070,840.00	$ 583,459.60
Colusa	21,482	$ 2,557,177.00	$ 485,863.63
Del Norte	27,254	$ 2,691,699.00	$ 511,422.81
Glenn	28,017	$ 2,706,216.00	$ 514,181.04
Inyo	18,260	$ 1,825,265.00	$ 346,800.35
Lake	64,591	$ 3,580,612.00	$ 680,316.28
Lassen	31,345	$ 2,695,924.00	$ 512,225.56
Mariposa	17,531	$ 1,839,276.00	$ 349,462.44
Mendocino	87,649	$ 4,356,166.00	$ 827,671.54
Modoc	8,965	$ 1,715,250.00	$ 325,897.50
Mono	13,909	$ 1,788,887.00	$ 339,888.53
Nevada	98,877	$ 4,769,934.00	$ 906,287.46
Plumas	18,409	$ 2,477,848.00	$ 470,791.12
San Benito	58,792	$ 3,458,004.00	$ 657,020.76
Sierra	2,967	$ 1,611,808.00	$ 306,243.52
Siskiyou	43,554	$ 2,995,957.00	$ 569,231.83
Sutter	96,463	$ 8,269,453.00	$ 1,571,196.07
Tehama	63,308	$ 3,470,770.00	$ 659,446.30
Trinity	13,069	$ 1,782,141.00	$ 338,606.79
Tuolumne	53,709	$ 3,316,766.00	$ 630,185.54
Yuba	74,492		

The regulatory program and reporting requirements.

Regulations, unlike statutes enacted by the Legislature, are limited to implementing, interpreting or increasing the specificity of existing law, and they cannot add or change a statute. The PEI regulations implement Welfare and Institutions Code section 5840 that established PEI to prevent mental illness from becoming severe and disabling.

Under section 5840, the PEI regulations require each county to provide five PEI-funded programs. In some cases, programs can be combined to maximize resources. For example, a single clinic might serve a preventive role by helping individuals at ultra-high risk for psychosis while also treating those with recent onset psychosis. The five required programs are:

- **Prevention:** A program that is focused on people or communities with greater than average risk factors (e.g. serious chronic medical condition, adverse childhood experience, experience of severe trauma) for developing potentially serious mental illness and is designed to reduce those risk factors.

- **Early Intervention:** A program designed to provide services to address and promote recovery for individuals with a mental illness early on to prevent that illness from becoming severe and disabling.

- **Outreach for Increasing Recognition of Early Signs of Mental Illness:** A program designed to educate and train families, employers, primary health care providers, school personnel, cultural brokers, law enforcement personnel, and others to identify and respond effectively to early signs of potentially severe and disabling mental illness.

- **Access and Linkage to Treatment:** A program that connects individuals with severe mental illness to medically necessary treatment.

- **Stigma and Discrimination Reduction:** A program to reduce the stigma associated with either being diagnosed with a mental illness and/or seeking mental health services, and to reduce discrimination against people with mental illness.

Each of the five required programs must be designed and operated in a non-stigmatizing, non-discriminatory fashion. Each program must also include **strategies** to

- help create access and linkage to treatment for people needing a higher level of services; and
- improve the timely access to mental health services for people and/or families from underserved populations.

Under the regulations each county must annually report specific information about each of the five programs. This information must include the unduplicated number of individuals served in prevention and early intervention programs, the number of people referred from underserved communities, and the average wait time between a referral and participation in the recommended treatment.[25]

Unique challenges and concerns of very small counties.

In addition to their small populations and limited funding, very small counties face two unique challenges related to the PEI regulations.

1. The program requirement. Officials in very small counties say they face an unfair burden under rules mandating that counties operate at least one of each of the five distinct programs. Given their size, these counties typically offer their residents more integrated mental health services, and the requirement for so many stand-alone programs creates a financial strain. [26] In addition, these counties struggle to cope with limited number of staff. Alpine County, with only about 1,100 residents, has a staff of 13, including 2.5 staff members working exclusively in programs created under the Act and three clinicians providing services in the county's comprehensive behavioral health care system.[27] Modoc County has 12 to 13 direct service staff for its population of about 9,100.[28]

Under the regulations, a process exists to allow small counties – those with a population under 200,000[29] – to opt out of offering a stand-alone prevention program.[30] This opt-out provision was created in response to concerns raised during the regulatory process about the limited resources of small counties, thereby providing them with greater flexibility in how they use their limited funds.

Given the continuing concern, the Commission may want to consider whether counties with a population of 100,000 or less need even more flexibility regarding the requirement for stand-alone programs. In addition, the Commission might want to explore other ways in which very small counties can achieve the transformational change envisioned by the Act.

2. The Reporting Requirement. The small size of the population also creates challenges with the Commission's reporting requirements, especially those requesting specific information about each of the five required PEI programs. Because such programs in very small counties tend to serve few consumers, summary statistics can vary wildly year to year and, thus, can be misleading. For example, Alpine County serves a total of 45 individuals per month in the county's mental health program – 45 individuals for the entire county, not for a particular program.[31] And Modoc County served just 396 clients during all of fiscal year 2014-2015.[32] Given such small countywide numbers, one person can make a huge impact on a summary report, skewing the data and creating an inaccurate picture. If the counties reported data by program instead of countywide, that effect would be magnified.

An additional concern voiced by officials from very small counties was that, due to the population size, the data reporting requirements cannot be completed without providing individually identifiable health information in violation of federal and state privacy laws, such as the Health Information Portability and Accountability Act (HIPAA), the Confidentiality of Medical Information Act (Civil Code §56 et seq.) or Welfare and Institutions Code §5328. These laws protect against the disclosure of health information that either specifically identifies an individual or, in combination with other information, can be used to make such an identification.

Currently, the regulations require counties to collect and report only aggregated program-level information, not client-level information. For example, a county is required to report the total number of people served by demographic category. But because very small counties have so few people in any single specific demographic group, even program-level reporting might inadvertently disclose individual identities. Modoc County serves as a useful case in point. Of the 396 Modoc residents served in fiscal year 2014-2015, 220 are female and 176 are male, and 101 are under the age of 18. Officials fear that these countywide numbers are already so small that any further breakdown by individual program could expose the identities of individual clients. As such, the regulations should be amended to allow very small counties to report data on a countywide basis, instead of by program.

Very small counties also face some of the same challenges besetting other counties when collecting sensitive demographic information, as discussed earlier in this report. As such, the Commission should support very small counties through learning collaboratives and peer-to-peer guidance on best practices for the collection of sensitive, culturally and linguistically competent, and age appropriate data.

Recommendation

The Commission should recognize the unique needs of very small counties working to comply with the PEI regulations.

- The Commission should amend the regulations to allow very small counties to report data on a countywide level instead of by program.

- The Commission should support very small counties by facilitating learning collaboratives and peer-to-peer guidance on best practices, including the collection of sensitive, culturally and linguistically competent, and age appropriate data. Collaboratives would provide an opportunity for

    - counties with expertise in collecting demographic information to share lessons learned and best practices; and
    - other subject matter experts, including those representing unserved and underserved communities, to share best practices for individual communities.

- Along with the learning collaboratives, the Commission should develop training and guidance materials for counties and providers. This training would include

    - guidance on data collection in clinical and non-clinical programs; and
    - toolkits and training on how to use them to explain why the data is being collected and how it will be used to support quality improvement.

- Recognizing the unique needs of very small counties, the Commission may want to consider a broader discussion, including possible amendments to the Act, to explore other ways in which such counties can work to achieve the transformational change envisioned by the Act.

Finding Three: Counties lack the tools to collect some of the required Access and Linkage to Treatment data, including information on referrals and the duration of untreated mental illness.

One driving goal of the Mental Health Services Act is a significant reduction in the number of Californians who are unable to get timely and appropriate mental health care. To ensure access to programs established under the Act, the Prevention and Early Intervention (PEI) regulations require counties to use an Access and Linkage to Treatment strategy in all PEI-funded programs. In short, that means every PEI program must connect people in need of a higher level of services with necessary treatment, typically through a referral. In addition, counties must operate at least one stand-alone Access and Linkage to Treatment program.

To document progress on Access and Linkage to Treatment efforts, counties are required to collect and report the following data:

1. The number of people with serious mental illness who were referred to treatment, and the kind of treatment recommended;
2. The number of people who followed through on the referral;
3. The average duration of untreated mental illness for people without prior treatment for serious mental illness; and
4. The average time that passed between the referral and participation in the recommended treatment program.

Counties and service providers say they face several technical challenges with collecting this information. The concerns include difficulties with defining the term, "referral" as well as challenges with measuring the average duration of untreated mental illness.

Clarify the meaning of "referral."

The regulations do not define "referral" nor differentiate the tracking requirements for non-clinical and/or outreach-oriented programs from those for clinical programs. As a result, county officials worry that data may be collected by people who lack the expertise to determine if a person has serious mental illness and needs a referral. Advocates also are unsure if referrals to programs outside of the county mental health system must be tracked.

Given these concerns, the Commission should provide clarification. First, the Commission should clarify that the term "referral" as used in the regulations should be interpreted according to the word's traditional meaning: to direct or redirect a person to services. As such, a referral does not include providing people with a list of resources for mental health services. Given that, outreach programs that supply lists of community resources would not have to document those activities because they do not constitute a "referral." Along with clarifying definitions, the Commission should specify when referrals are to be documented for non-clinical and/or outreach-oriented programs and clinical programs. In addition, counties should be informed that they need only report referrals to other county programs (either county or provider operated).

An additional problem is the absence of an information technology system to track the referrals. One county working to resolve this challenge is Lake County. Recently, the Commission approved a Lake County innovation project that will test an on-line web portal to help track referrals and improve interagency coordination.

Offer guidance and technical assistance with measuring the duration of untreated mental illness.

As outlined above, the PEI regulations require counties to report the average duration of untreated mental illness for people with serious mental illness who have not previously received treatment, and counties can choose what metrics to use for measuring this across diagnostic mental disorders. While assessment tools for measuring the duration of untreated psychosis exist in some early intervention programs, there are no such tools for other disorders (e.g. non-psychotic affective disorders, personality disorders, post-traumatic stress disorder).

Staff from the Commission's Research and Evaluation Unit, along with representatives of the counties and the County Behavioral Health Directors Association, have begun exploring a possible pilot study to determine how counties are assessing duration of untreated psychosis. A longer-term goal would be to use the study findings to develop standardized methods for measuring the duration of untreated mental illness, and then sharing those methods with all counties and providers.

The Commission has a contract with the Department of Psychiatry at the University of California, Davis, to assess outcomes and cost savings resulting from the early psychosis programs operating in California. The contract could be expanded to include recruitment of the 29 active early psychosis programs for the proposed pilot study to illuminate how counties are assessing duration of untreated psychosis. Such a project would generate useful data and recommendations to help the Commission develop validated measurement procedures for counties to use.

Recommendation

The Commission should clarify the meaning of Access and Linkage to Treatment reporting requirements, including the measurement of the duration of untreated mental illness.

- The Commission and other statewide entities should organize learning collaboratives and develop training and guidance materials, including standardized metrics for measuring the duration of untreated mental illness.

    - As part of this effort, the Commission should partner with counties to identify the effectiveness of county strategies for measuring Access and Linkage to Treatment and the duration of untreated mental illness. This could include focused studies and/or pilot projects as part of a continuous effort to improve the quality of such measurement.

- The Commission should clarify the meaning of "referral," and specify when referrals must be documented for non-clinical and/or outreach-oriented programs and clinical programs.

- The Commission should specify that a county is only responsible for reporting referrals made to other county programs, whether such programs are operated by counties or providers.

Finding Four: Some counties have trouble distinguishing referral data generated by Prevention and Early Intervention programs from data related to programs funded by Community Services and Support (CSS).

The purpose of the Access and Linkage to Treatment element of Prevention and Early Intervention (PEI) is to ensure that people with serious mental illness are matched with the most appropriate level of services, regardless of where they first sought help. This approach, anchored in the concept that there should be "no wrong door" into the mental health system, is key to reducing the number of Californians who fail to receive timely and appropriate care. As such, it is critical that every PEI program has a mechanism that ensures people are promptly connected to the services they need. Initially, the Mental Health Services Oversight and Accountability Commission's regulations required only that each program had a strategy to assure linkage occurred. But the Office of Administrative Law subsequently required that counties complement that strategy by also operating a stand-alone Access and Linkage to Treatment program.

Because the guidelines and funding for each component of the Mental Health Services Act were rolled out sequentially, some counties integrated their referral services as part of the Outreach and Engagement program funded by Community Services and Supports (CSS).[33] Outreach and Engagement, one of four service categories required by regulations issued by the California Department of Mental Health, is intended to reach, identify, and engage unserved people with serious mental illness so they receive appropriate services.[34]

Consequently, some counties provide services similar to Access and Linkage to Treatment within their CSS program. For those counties, it can be difficult to differentiate PEI-funded referrals from CSS-funded referrals.

For example, the Los Angeles County Department of Mental Health has one point of entry for services delivered under the Act, and, depending on a needs assessment, an incoming client could be directed to either a CSS-funded program or a PEI-funded program.[35] In such cases, county officials say it is difficult to separate Access and Linkage to Treatment data funded under a PEI program from that funded by CSS. In addition, counties expressed a persistent concern that requiring an Access and Linkage to Treatment stand-alone program funded by PEI is duplicative and not an efficient use of funds.

Community Services and Supports (CSS) Funding Categories

1. **Full Service Partnership:** program to provide direct mental health services for people with serious mental illness through an approach known as "whatever it takes" to support recovery.[36]
2. **General System Development:** program to improve the mental health service delivery system for all clients.[37]
3. **Outreach and Engagement:** program to reach, identify, and engage unserved people with serious mental illness so they receive appropriate services.[38]
4. **Mental Health Services Act Housing Program:** program to acquire, rehabilitate or construct permanent supportive housing for clients with serious mental illness.[39]

Under the regulations a precedent exists to deal with overlapping PEI and CSS programs. The regulations allow counties to fund the PEI Outreach for Increasing Recognition of Early Signs of Mental Illness program through another MHSA funding stream such as CSS.[40] A similar approach could be used to address this challenge.

Recommendation

The Commission should consider amending the PEI regulations to allow a county to pay for Access and Linkage to Treatment Program through another Mental Health Services Act funding stream, such as Community Services and Supports, as long as the other requirements in the PEI regulations are met.

Finding Five: The Mental Health Services Oversight and Accountability Commission's timeline for developing and implementing new data collection system is too short, depriving counties of sufficient time to comply.

Until recently, there was no data collection and reporting requirement for individual PEI programs or Innovation projects established under the Mental Health Services Act. Instead, under the state Department of Mental Health guidelines issued in 2007, counties were required to provide an outcome evaluation of only one PEI program of the county's choosing.[41] With adoption of the Commission's regulations in October 2015, counties for the first time were directed to collect demographic information for people served by each PEI program or Innovation projects and to report that information annually.

For more than nine years, counties have been voluntarily collecting their PEI program data, but these efforts lacked a uniform, data collection and reporting approach. The Commission regulations created a standardized set of reporting expectations for counties. The new regulations also require that county reports be submitted as part of the Act's required Three-Year Program and Expenditure Plan (the Three-year Plan) and the Annual Update.[42] Under the Act, every county must prepare Three-Year Plans setting forth an integrated blueprint for all

components required by law (i.e. programs for PEI, Innovation, Community Services and Supports, Workforce and Education, and Technological and Capital Facilities). The Three-Year Plans must be updated annually, and those plans as well as the Annual Updates must be presented to and approved by each county's Board of Supervisors prior to submission to the Commission.[43]

The Three-year Plans and Annual Updates are reporting documents intended to meaningfully reflect counties' budget and programming plans and rationales, as well as the outcomes such programs have produced in preceding years. During the planning process, county behavioral health officials are required to work closely with community stakeholders to identify mental health needs and strategies to meet those needs.[44] The Three-Year Plans and Annual Updates thus are to reflect meaningful stakeholder involvement in program selection, including choices about monitoring, quality improvement, performance evaluation, and budget prioritization.[45]

Three-Year Plans and Annual Updates are prepared and submitted to county supervisors as part of the annual budgeting process. The documents should provide supervisors with evidence about behavioral health program operation, support for or concerns about programs and the County Behavioral Health Department's performance by community stakeholders, and recommendations.

The Mental Health Services Act requires an extensive community planning process – complete with ample stakeholder involvement – prior to Board of Supervisor approval. County officials report that this approval process can last as long as six to nine months because of the required 30-day public comment period, the scheduling of a public hearing by the local mental health board, and the time required to get on the Board of Supervisors' agenda.[46] This timetable, and the intention that the Three-year Plan or Annual Update shape local decisions about mental health program budgets and priorities, confirm that the reports should be delivered to county supervisors in time for them to use the documents in their annual budget deliberations.

The PEI regulations require counties to submit annually either an Annual Program and Evaluation Report or a Three-Year Program and Evaluation Report. These reports are required to be a part of each county's Three-Year Plan or Annual Update.[47] That requirement was intended to support meaningful stakeholder involvement in county decision-making regarding the design, funding, and implementation of behavioral health services. One key example is the need for stakeholder involvement in the Community Planning Process, where input can shape county supervisors' decision-making about Behavioral Health Department budgets and integrated service plans.

In order for Three-Year Program and Expenditure Plans and Annual Updates to affect supervisors' annual budget deliberations, they must be delivered in time to be included in those deliberations and they must provide up-to-date, relevant information. These factors suggest that the Commission may wish to revisit and revise due dates for PEI Program and Evaluation Reports. Furthermore, because the regulations did not become effective until several months into fiscal year 2015-2016, the Commission may wish to revise the due dates and data reporting periods required to be included in the initial reports. (See Table 2, "Required County Data Reports and Recommended Changes," at the end of this section).

Clearly, establishing data collection systems to comply with these regulations in a timely manner is challenging. Although some counties may be able to meet the deadlines for the first reports, other counties may lack sufficient time to design the evaluation, create data collection protocols, and obtain and analyze the required data.

Recommendation

The Commission should amend the Prevention and Early Intervention regulations to align counties' annual and periodic reporting deadlines with their budget-making timetables to maximize the value of the reports to local policymakers.

- The Commission should provide a waiver for the initial Annual Report, which is due no later than December 30, 2017. Under the waiver, a county would report whatever data it had collected thus far, would explain the obstacles to meeting its reporting deadline, and would provide an implementation plan and timeline for complying fully with future Annual Reports.

- For subsequent Annual Reports and the initial and subsequent Three-Year Evaluation Reports, the Commission should amend the regulations to modify due dates, aligning them with the county budgeting process. These reports would be due within 30 days of board of supervisor approval but no later than June 30.

Table 2: Required County Data Reports and Recommended Changes

Report	Current	Recommended
Annual Report	**Initial Annual Report** ➢ Due 12/30/17 ➢ Data from FY 2016-2017 **Second Annual Report** ➢ Due12/30/19 ➢ Data from FY 2018-2019	**Initial Annual Report** ➢ Due 12/30/17 ➢ Data from FY 2016-2017 to extent available and implementation plan for future reports **Second Annual Report** ➢ Due 06/30/20 ➢ Data from FY 2018-2019
Report	**Current**	**Recommended**
Three-Year Report	**Initial Three-Year Report** ➢ Due 12/30/18 ➢ Data from FY 2017-2018; Prior fiscal years only if available **Second Three-Year Evaluation Report** ➢ Due December 30th every third year thereafter ➢ Data from three prior fiscal years	**Initial Three-Year Report** ➢ Due 6/30/19 ➢ June 30th every third year thereafter **Second Three-Year Evaluation Report** ➢ Due December 30th every third year thereafter ➢ Data from three prior fiscal years

Endnotes

[1] California has 59 local mental health agencies that include 56 California counties, a joint county entity (Sutter-Yuba) and two city-run agencies: City of Berkeley and TriCities, which includes the cities of Pomona, Claremont, and La Verne.

[2] Han K. Kang DrPH, Tim A. Bullman MA, Derek J. Smolenski MPH, PhD, Nancy A. Skopp PhD, Gregory A. Gahm PhD, Mark A. Reger PhD *Suicide risk among 1.3 million veterans who were on active duty during the Iraq and Afghanistan wars*, Annals of Epidemiology 25 (2015) 96-100

[3] League of United Latin American Citizens (LULAC), *An investigative report on perceived mismanagement and inequitable distribution of behavioral health services and resources to the Latino/a community*, November 21, 2014

[4] Grant, J.M., Mottet, L.A., Tanis, J., Harrison, J., Herman, J.L., Keisling, M. (2011). *Injustice at Every Turn: A Report of the National Transgender Discrimination Survey.* Washington, DC: National Center for Transgender Equality and National Gay and Lesbian Task Force.

[5] Kellan E. Baker, MA, MPH. (2014). *Identifying Transgender and Other Gender Minority Respondents on Population-Based Surveys: Why Ask?* In J.L. Herman (Ed.), *Best Practices for Asking Questions to Identify Transgender and Other Gender Minority Respondents on Population-Based Surveys*. (01- 08) Los Angeles, CA: The Williams Institute.

[6] Grossman AH, D'Augelli AR. Transgender youth and life-threatening behaviors. Suicide & life-threatening behavior 2007;37:527-537.

[7] Kiran Sahota, Behavioral Health Manager, Proposition 63, Ventura County Behavioral Health Department. April 14, 2016 testimony to the California Mental Health Services Oversight and Accountability Commission Subcommittee.

[8] The July 28, 2016 official blog for the Centers for Medicare & Medicaid Services (CMS)] can be found at https://blog.cms.gov/2016/06/28/advancing-health-equity-for-sexual-and-gender-minorities/

[9] U.S. Department of Health and Human Services, Health Resources and Services Administration, Program Assistance Letter 2016-02; Chapter 565, Statutes of 2015 (Assembly Bill 959, Chiu)

[10] Bradford, J.; Cahill, S; Grasso, C.; and Makdon, H. "Policy Focus: Why gather data on sexual orientation and gender identity in clinical settings." The Fenway Institute, 2012; and Health People 2020. "Lesbian, Gay, Bisexual and Transgender Health: Objectives." U.S. Department of Health and Human Services, 2012. http://www.healthypeople.gov/2020/topicsobjectives2020/objectiveslist.aspx?topicId=25

[11] Juan G Ibarra, DrPH, MPH, MSW, Epidemiologist, San Francisco Department of Public Health and Jei Africa, Director, Office of Diversity and Equity, County of San Mateo. March 23, 2016 testimony to the California Mental Health Services Oversight and Accountability Commission Subcommittee.

[12]National Institute of Mental Health, June 2005 press release, "Mental Illness Exacts Heavy Toll, Beginning in Youth" https://www.nimh.nih.gov/news/science-news/2005/mental-illness-exacts-heavy-toll-beginning-in-youth.shtml.

[13] Grant, J.M., Mottet, L.A., Tanis, J., Harrison, J., Herman, J.L., Keisling, M. (2011). *Injustice at Every Turn: A Report of the National Transgender Discrimination Survey.* Washington, DC: National Center for Transgender Equality and National Gay and Lesbian Task Force.

[14] Senate Bill 543 (Leno), Chapter 503, Statutes of 2010. Senate Third Reading Analysis.

[15] Mark Sorensen, Outreach Consultant, Ontario-Montclair School District. April 14, 2016 testimony to the California Mental Health Services Oversight and Accountability Commission Subcommittee.

[16] Personal communication between Commission staff and Bruce Yonehiro, Deputy General Counsel and Jim Alford, Special Education Consultant from California Department of Education; Teresa Stinson, Chief Counsel, Sacramento County Office of Education; and Rebecca Gudeman, Senior Attorney, National Center for Youth Law.

[17] Rebecca Gudeman, Senior Attorney, National Center for Youth Law, personal communication with Commission staff.

[18] *ibid*.

[19] The main variable is the relationship between the provider and the school. This variable sounds simpler than it is. That is, the records are not subject to the Family Educational Rights and Privacy Act (FERPA) if the PEI program provider is funded, administered and operated by or on behalf of a public or private health, social services, or other non-educational agency. (U.S. Dept of Education, Family Policy Compliance Office, Letter to Ms. Melanie P. Baise, University of New Mexico, November 29, 2004, available at www.ed.gov/policy/gen/guid/fpco/ferpa/libray/baiseunmisslc.html.) However, if the PEI program is administered or operated by or on behalf of a school, the provider's records may be considered education records and subject to FERPA. For example, if a school mental health provider is hired by the district with funds from an agency not subject to FERPA, such as a community-based mental health agency or department of behavioral or mental health that provider's records may be subject to FERPA depending on whether the provider is acting as a school employee. It is important to note that HIPAA explicitly states that its rules do not apply to health information in an education record subject to FERPA. (45 C.F.R. section 160.103 ("Protected Health Information… excludes individually identifiable health information in: (i)Education records covered by the Family Educational Rights and Privacy Act, as amended, 20 U.S.C. section 1232g:…") Therefore, FERPA and HIPAA can never apply to the same information at the same time.

[20] California Civil Code section 56 et seq; Welfare and Institutions Code sections 5328 and 5329; and Education Code sections 49060 et seq.

[21] 34 C.F.R. Section 99.31(b); California Education Code sections 49074 and 49076.

[22] Assembly Bill 1088, Chapter 689, Statutes of 2011; Assembly Bill 1726, Chapter 607, Statutes of 2016.

[23] Title 9, California Code of Regulations, section 3750.

[24] California State Controller's Office website at http://www.sco.ca.gov/ard_payments_mentalhealthservicefund_fy1415.html

[25] Title 9, California Code of Regulations, section 3560.010.

[26] Karen Stockton, Ph.D., MSW, BSN, Director Modoc County Behavioral Health. April 27, 2016 testimony to the California Mental Health Services Oversight and Accountability Commission Subcommittee.

[27] Alissa R. Nourse, Director, Alpine County Behavioral Health Services. February 11, 2016 written testimony to California Mental Health Services Oversight and Accountability Commission Subcommittee.

[28] Karen Stockton, Ph.D., MSW, BSN, Director Modoc County Behavioral Health. February 23, 2016 testimony to the California Mental Health Services Oversight and Accountability Commission Subcommittee.

[29] The regulations issued by the state Department of Mental Health and still in effect define "Small County". (Title 9, California Code of Regulations, section 3200.260.)

[30] Title 9, California Code of Regulations, sections 3705 and 3706. A small county that opts out of the requirement must include in its Three-Year Program and Expenditure Plan and/or Annual Update documentation describing the rationale for the county's decision and how the county ensured meaningful stakeholder involvement in the decision to opt out.

[31] Alissa R. Nourse, Director, Alpine County Behavioral Health Services. See endnote 26.

[32] Karen Stockton, Ph.D., MSW, BSN, Director Modoc County Behavioral Health. See endnote 27.

[33]Department of Mental Health Letter 05-05, August 1, 2005, Mental Health Services Act Community Services and Supports Guidelines; Department of Mental Health Information Notice 07-19, September 25, 2007, Mental Health Services Act Prevention and Early Intervention Components Guidelines.

[34] Title 9, California Code of Regulations, sections 3200.240, 3615, and 3640.

[35] Debbie Innes-Gomberg, Ph.D., Program Manager III, Los Angeles County Department of Mental Health Program Support Bureau, MHSA Implementation and Outcomes Division. February 23, 2016 testimony to California Mental Health Services Oversight and Accountability Commission Subcommittee.

[36] Title 9, California Code of Regulations, sections 3200.130, 3620, 3620.05, and 3620.10.

[37] Title 9, California Code of Regulations, sections 3200.170 and 3630.

[38] Title 9, California Code of Regulations, sections 3200.240 and 3640.

[39] Title 9, California Code of Regulations, sections 3200.225 and 3615.

[40] Title 9, California Code of Regulations, section 3715(f).

[41] Department of Mental Health Information Notice 07-19, September 25, 2007, Mental Health Services Act Prevention and Early Intervention Components Guidelines.

[42] Title 9, California Code of Regulations, sections 3560, 3560.010, and 3560.020.

[43] Welfare and Institutions Code section 5847.

[44] Welfare and Institutions Code sections 5847 and 5848.

[45] Welfare and Institutions Code section 5848(a).

[46] Debbie Innes-Gomberg, Ph.D., Program Manager III, Los Angeles County Department of Mental Health Program Support Bureau, MHSA Implementation and Outcomes Division. June 29, 2016 testimony to California Mental Health Services Oversight and Accountability Commission Subcommittee.

[47] Title 9, California Code of Regulations, sections 3560, 3560.010, and 3560.020.

AGENDA ITEM 8

Information

October 27, 2016 Commission Meeting

Overview of Triage Grant Program and Evaluation

Summary: At the Commission meeting Deputy Director Norma Pate will provide an overview of the Mental Health Wellness Act of 2013 program and future funding. Director of Research Fred Molitor will present on the evaluation of the triage programs.

Background: In 2013, then Senate President pro Tempore Darrell Steinberg introduced Senate Bill 82, which enacted the Investment in Mental Health Wellness Act of 2013 (SB 82) that established competitive grants for crisis intervention and triage personnel. The purpose of the grants was to increase California's capacity for client assistance and services in crisis intervention including availability of crisis triage personnel, crisis stabilization, crisis residential treatment, rehabilitative mental health services, and mobile crisis support teams.

Under SB 82 there were two competitive grant opportunities. One grant program was administered by the California Health Facilities Financing Authority ($142 million one-time general fund allocation) to fund mobile crisis support teams, crisis stabilization, and crisis residential programs. The other grant program, administered by the Commission, provided $32 million per year of state administrative Mental Health Services Act funds for counties to hire triage personnel statewide to provide intensive, short-term case management.

SB 82 became effective immediately, and required the Commission to promptly initiate a competitive application process. In developing the criteria for the application, the Commission obtained input from subject matter experts including homeless advocates, consumers and family members, counties, and representatives of unserved and underserved communities, veterans, hospitals, providers, criminal justice system and education. At the September 2013 meeting, the Commission approved the criteria for the competitive application .The grant was released in October 2013. In January 2014, the Commission awarded grants to 24 counties for triage personnel programs. These grants began in March of 2014 and are currently due to end in June 2017.

The Commission is responsible for the oversight of the triage personnel grant program. Staff conducts site visits, provides technical assistance, and facilitates quarterly triage coordinator meetings that provide an opportunity for peer to peer learning and to discuss challenges and lessons learned.

Part of the requirement is for counties to submit annual encounter bases data such as number of persons served, personnel hired, specific services provided, and unspent funds. Counties submitted the required evaluation of the effectiveness of their programs to the Commission on June 30, 2016. Norma Pate, Deputy Director, will present on the funding of triage programs after June 30, 2017. Dr. Fred Molitor, Director of Research, will summarize current and future efforts to evaluate triage programs.

Enclosures: None

Handout: PowerPoint will be handed out at the meeting

Recommended Action: None

Presenters:

- Norma Pate, Deputy Director
- Dr. Fred Molitor, Director of Research

AGENDA ITEM 9

Information

October 27, 2016 Commission Meeting

Executive Director Report

Summary: Executive Director Toby Ewing will report on projects underway, the Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission) calendar, and other matters relating to the ongoing work of the Commission.

Presenter: Toby Ewing, Executive Director

Enclosures: None

Handout: None

Recommended Action: Information item only