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Mental Health Services
Oversight & Accountability Commission

Commission Packet

Commission Meeting
March 23, 2017

San Diego City College
Corporate Education Center
(in the Mathematics & Social Sciences building)
Room MS140
1551 C Street
San Diego, CA 92101

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

Mental Health Services
Oversight & Accountability Commission

Tina Wooton
Chair
John Boyd, Psy.D.
Vice Chair

1325 J Street, Suite 1700
Sacramento, California 95814

Commission Meeting Agenda

March 23, 2017
9:00 A.M. – 5:15 P.M.
San Diego City College
Corporate Education Center
(in the Mathematics & Social Sciences building)
Room MS140
1551 C Street
San Diego, CA 92101

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.

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Tina Wooton
Chair

AGENDA
March 23, 2017

John Boyd, Psy.D.
Vice Chair

9:00 AM **Convene**
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 **Welcome**

9:10 AM **Announcements**

9:15 AM **Action**
1: Approve February 23, 2017, MHSOAC Meeting Minutes
The Commission will consider approval of the minutes from the February 23, 2017 MHSOAC meeting.

- Public Comment
- Vote

9:20 AM **Information**
2: Criminal Justice and Mental Health Project
Project Chair: Commissioner and Sheriff Bill Brown
Subject matter experts and stakeholders have been invited to participate in the three panels to support the Commission's understanding of opportunities to improve outcomes for adults with mental health needs and who are involved in the criminal justice system.

9:30 AM **Panel 1: Jail and Re-entry Services**
Invited panelists will discuss opportunities to improve outcomes for those in custody and those re-entering the community, including the use of those with lived experience as peers to support recovery and reduce future incarceration.

Panelists: Dr. Alfred Joshua, Chief Medical Officer, San Diego County Sheriff's Department**;** Patricia Ceballos, Re-entry Supervisor, San Diego County Sheriff's Department; Mona Minton, Ph.D., General Manager, Neighborhood House Association; Cassandra Arnold, Certified Substance Use Case Manager*, Project In-Reach*

10:20 AM **Panel 2: County Approaches to Improving Outcomes**
Invited panelists will present how their counties are initiating local systems change to address the mentally ill justice-involved population, the impetus of that change and how data is being used to support decision-making with regards to programming and funding.

Panelists: Jay Orr, Riverside County Executive Officer**;** Garry Herceg, Deputy County Executive, Santa Clara County

11:10 AM **Panel 3: Best Practices in the Community and in Custody**

Invited panelists will present examples of model programs, how they were implemented, and the current/planned training and technical assistance to support local and state implementation of best practices.

Panelists: Stephen Amos, Chief of Jail Administration, National Institute of Corrections (NIC)**;** Jennie Simpson, Ph.D., Substance Abuse and Mental Health Services Administration (SAMHSA)

Public Comment on All Panels

12:10 PM **General Public Comment**

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

12:25 PM **Lunch**

1:25 PM **Action**

3: San Diego County Innovation Plans

County Presenters: Holly Salazar, MPH, Assistant Director, Departmental Operations for Behavioral Health Services; Piedad Garcia, EdD, LCSW, Deputy Director, Adult and Older Adult Behavioral Health Services; Laura Vleugels, MD, Supervising Child and Adolescent Psychiatrist, Children, Youth and Families Behavioral Health Services; Jeffrey Rowe, MD, Supervising Psychiatrist, Juvenile Forensics Division; Michael Miller, LMFT, Behavioral Health Program Coordinator; Adrienne Collins Yancey, MPH, MHSA Coordinator

The Commission will consider approval of additional funding and time for five previously approved Innovative Project Plans for San Diego County.

- Public Comment
- Vote

3:15 PM **Action**

4: Orange County Innovation Plan

County Presenters: Flor Yousefian Tehrani, Psy.D., LMFT, Innovation Projects Interim Program Manager; Terri Styner, MSW, Innovation Projects Service Chief; Sharon Ishikawa, Ph.D., MHSA Coordinator

The Commission will consider approval of one Innovative Project Plan for Orange County.

- Public Comment
- Vote

3:45 PM **Action**

5: Ventura County Innovation Plan

County Presenters: Kiran Sahota, MA, MHSA Manager; Hilary Carson, MSW, MHSA Administrator, Innovations; Genevieve Flores-Haro, MPA, Associate Director, Mixteco/Indigena Community Organizing Project; Henry E. Villanueva, ED.D., Behavioral Health Manager, Quality Assurance; Patricia Gonzales, PhD, Research Psychologist, Quality Improvement Department

The Commission will consider approval of one Innovative Project Plan for Ventura County.

- Public Comment
- Vote

4:15 PM **Action**

6: Award of Stakeholder Contracts

Presenter: Angela Brand, MHSOAC Staff

The Commission will consider awarding stakeholder contracts in response to the Requests for Proposals released by the Commission in December 2016.

- Public Comment
- Vote

4:45 PM **Information**

7: 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.

Informational Documents Enclosed:

Enclosed are: the motions summary from the February 23, 2017 Commission meeting; Evaluation Dashboard; Calendar of Commission activities; and Innovation Review Outline.

5:00 PM **General Public Comment**

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

5:15 PM **Adjourn**

AGENDA ITEM 1A

Action

March 23, 2017 Commission Meeting

Approve February 23, 2017 MHSOAC Meeting Minutes

Summary: The Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission) will review the minutes from the February 23, 2017 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: February 23, 2017 Commission Meeting Minutes.

Handouts: None.

Recommended Action: Approve February 23, 2017 Meeting Minutes.

Proposed Motion: The Commission approves the February 23, 2017 Meeting Minutes.

State of California

MENTAL HEALTH SERVICES
OVERSIGHT AND ACCOUNTABILITY COMMISSION

Minutes of Meeting
February 23, 2017

MHSOAC
Darrell Steinberg Conference Room
1325 J Street, Suite 1700
Sacramento, CA 95814

866-817-6550; Code 3190377

Members Participating:

Tina Wooton, Chair
John Boyd, PsyD, Vice Chair
Khatera Aslami-Tamplen
Jim Beall
John Buck
Kathleen Lynch
Gladys Mitchell
Larry Poaster, PhD
Tony Thurmond
Richard Van Horn

Members Absent:

Reneeta Anthony
Lynne Ayers Ashbeck
Sheriff Bill Brown
Itai Danovitch, MD
David Gordon

Staff Present:

Toby Ewing, PhD, Executive Director
Filomena Yeroshek, Chief Counsel
Norma Pate, Deputy Director, Program, Legislation, and Technology
Brian Sala, PhD, Deputy Director, Evaluation and Program Operations
Urmi Patel, PsyD, Consulting Psychologist
Tom Orrock, Health Program Manager

CONVENE

Chair Tina Wooton called the meeting of the Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission) to order at 8:43 a.m. and welcomed everyone. Filomena Yeroshek, Chief Counsel, called the roll and confirmed the presence of a quorum.

Announcements

Chair Wooton announced the names of the Commissioners appointed to the newly-formed Innovation Subcommittee: Vice Chair Boyd (chair), Commissioners Danovitch (vice chair), Ashbeck, and Gordon, and Chair Wooton.

Chair Wooton stated the next Commission meeting will be on March 23rd in San Diego.

Brian Sala, PhD, Deputy Director, Evaluation and Program Operations, introduced new staff members: Sydney Armendariz, Health Program Specialist, Sharmil Shah, Chief of Program Operations, Hu Pang, Research Scientist, Kayla Landry, Staff Services Analyst, and Korinne Sugasawara, Associate Government Program Analyst.

Commissioner Aslami-Tamplen announced the names of the members of the Cultural and Linguistic Competence Committee (CLCC) and the Client and Family Leadership Committee (CFLC).

ACTION

1A: Approve January 26, 2017, MHSOAC Meeting Minutes

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

The Commission approves the January 26, 2017, Meeting Minutes.

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

The following Commissioners voted "Yes": Chair Wooton, and Commissioners Aslami-Tamplen, Buck, Lynch, Mitchell, Poaster, and Van Horn.

INFORMATION

1B: January 26, 2017, Motions Summary

1C: Evaluation Dashboard

1D: Calendar

ACTION

2: Santa Cruz County Innovation Plan

County Presenters: Erik Riera, MBA, MED, CAS, Director, Mental Health and Substance Abuse Services; Pam Rogers-Wynam, LMFT, Director of Adult Services; Alicia Nájera, LCSW, Director of Watsonville Services

Erik Riera

Erik Riera, MBA, MED, CAS, Director, Mental Health and Substance Abuse Services, provided an overview, accompanied by a slide presentation, of the demographics of Santa Cruz County and the intent, target population, and learning objectives of the proposed Innovation project. He stated the goal of the Innovation project is to more effectively support individuals in supportive housing through the use of telehealth monitoring devices and peer and family mentors. He handed out a graphic highlighting key components of the integrated health and housing program model. He also reviewed the proposed budget for the Innovation project.

Pam Rogers-Wynam

Pam Rogers-Wynam, LMFT, Director of Adult Services, continued the slide presentation and discussed the challenge of security housing in Santa Cruz County for individuals with severe mental health conditions. To address some of these challenge, the Innovation project will lease apartments through a master lease agreement and then use a permanent supportive housing case management psychiatrist/therapist model along with peer providers to help support social integration into the community. The use of the word, “peer” in this context means both peer partners and family members.

Alicia Nájera

Alicia Nájera, LCSW, Director of Watsonville Services, Mental Health Services Act (MHSA) Coordinator, continued the slide presentation and discussed the community engagement process and requirements for individuals to participate in the proposed innovation project.

Commissioner Questions

Commissioner Aslami-Tamplen asked about the rate of Latinos targeted in this proposal and the number of peer support staff that will be hired. Ms. Nájera stated the prevalence of different ethnic groups mirrors the general population. The county plans to hire three bilingual/bicultural full time peer support staff.

Commissioner Aslami-Tamplen asked about protecting patient information and about the county’s policy for undocumented individuals. Mr. Riera stated the telehealth equipment are encrypted HIPAA devices. The county prioritizes serving undocumented individuals.

Commissioner Buck stated that pieces of this proposal are not innovative but he liked that the tablet can help monitor individuals around the clock and was interested in the outcomes of this project, particularly for individuals with psychiatric disabilities in combination with medical issues, and how the effects of paranoia affect the ability to monitor and work with individuals. He asked for clarification on the $580,000 administrative expense figure. Urmi Patel, PsyD, Consulting Psychologist, stated the $580,000 amount is the total administrative expense budget for the five-year project.

Commissioner Lynch asked how the county plans to market this program to underrepresented populations, including LGBTQ, older adult, and veteran populations. Ms. Rogers-Wynam stated the county actively outreaches to underrepresented groups

and they have been part of the Innovative project planning process to date. The county plans to continue to hold public meetings for stakeholder input.

Commissioner Aslami-Tamplen asked what organization that is trusted by the Latino population the county is working. Mr. Riera stated the Latino population is a priority for the county. He stated Ms. Nájera is located in the southern part of the county and works with that population. A new behavioral health office building is currently being constructed that will double the capacity to serve the residents in that area.

Ms. Nájera stated the county team is based in Watsonville but many services are not office-based. The team is integrated in the community and has close working relationships with wellness centers, community based organizations, and family services.

Chair Wooton asked about the number of clients that will be housed in the apartment units and about homeless individuals with severe mental illness (SMI). Ms. Rogers-Wynam stated the apartments will be mixed single-and double-occupancy. The county has approximately 2,200 homeless individuals, 40 percent of whom have a major mental illness - those individuals will be prioritized for this project.

Chair Wooton asked the county to send to the Commission information on the peer employee starting wage.

Public Comment

Sandra Marley, private advocate, asked about the cost of the housing units, the budget line item those funds are under, what training for peer and family mentors will be conducted, and how the county will monitor whether patients consume the dispensed medications. She stated family members are not the best choice for blood pressure and medication enforcement. Ms. Marley stated nutrition is a big part of recovery and that takes training. She spoke against prioritizing providing services to undocumented individuals for this project.

Michaele Beebe, Public Policy Director, United Advocates for Children and Families (UACF), asked if transition-aged youth (TAY) are included in the project. She asked if the county has a Family Find program and how training will be integrated for the peer support workers.

Heidi Strunk, Advocacy Coordinator, California Association of Mental Health Peer-Run Organizations (CAMHPRO), stated the term “locked boxes” raises red flags. She stated the hope that patients will not be penalized from participating in this program for not taking their medications and hopes patients will be allowed to use other natural and/or holistic treatment methods to address their mental and physical health. She cautioned against peers taking a back seat to family members while providing services.

Poshi Walker, LGBTQ Program Director, Mental Health America of Northern California (NorCal MHA), stated obesity and diabetes are listed as a risk factor for SMI, but patients may gain weight as a side effect of their prescribed medications. She suggested collaborating with the Santa Cruz Diversity Center, an LGBTQ organization doing good work in Santa Cruz County. She agreed with Ms. Strunk on the importance

of peer workers with appropriate training. She stated, although family member support is also important, oftentimes patients' family members are part of the problem.

Commissioner Discussion

Commissioner Poaster stated that innovation is an evolving concept and suggested that the future presentations focus on how the innovations come about in counties.

Chair Wooton suggested that the Innovations Subcommittee take on that project.

Commissioner Mitchell asked to see one of the housing units. Mr. Riera stated he will send product brochures to staff showing their functionality.

Action: Commissioner Poaster made a motion, seconded by Commissioner Buck, that:

The MHSOAC approves Santa Cruz County's Innovation Project, as follows:

Name: Integrated Health and Housing Supports
Amount: $4,451,280
Program Length: Five (5) Years

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

The following Commissioners voted "Yes": Chair Wooton and Commissioners Aslami-Tamplen, Buck, Lynch, Mitchell, Poaster, and Van Horn.

ACTION

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

County Presenter: Sharon Jones, MHSA Coordinator; Yvonnia Brown, Director, Behavioral Health and Recovery Services

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

<u>Yvonnia Brown</u>

Yvonnia Brown, Director, Behavioral Health and Recovery Services of Merced County, provided an overview of the Innovation project accompanied by a slide presentation. She noted that the consistent themes among stakeholders is the gap between services and the community and who is reaching individuals on a more holistic, wraparound approach. The proposed Innovation project will create a seamless delivery system to meet clients where they are and to provide whole person care.

<u>Sharon Jones</u>

Sharon Jones, the MHSA Coordinator for Merced County, continued with the slide presentation. She began her presentation with the statement, "hope changes everything" and then discussed the proposed two-fold project: developing an ABC (Appreciative Inquiry, Building Community, and Care Coordination) framework model and implementing it through an Innovative Strategist Network (ISN). She discussed the goals, objectives, and strategies of the proposed Innovation project. Ms. Jones handed out a revised proposed budget for the Innovation project.

Commissioner Questions

Commissioner Aslami-Tamplen asked what part of using county employees as strategists is innovative. Ms. Jones stated that mental health system workers have a similar worldview. The proposed project is more about cultural responsiveness and includes strategists that come from different walks of life and have differing worldviews.

Commissioner Poaster asked if the county has quantified the amount of evaluation funding for the project. Ms. Jones stated the goal is to build evaluation from within and without, as such, the eighth member of the ISN will be an internal evaluator and the county also plans to contract with an external evaluator.

Commissioner Poaster asked if services are billed per strategist. Ms. Jones stated it is still in the testing phase and may be a possibility for sustainability. It is about opening up pathways because some patients do not fit into the classic boxes.

Commissioner Mitchell asked if individuals who do not fit the profile can be passed off to other members of the ISN team who may offer a different approach to help them. She stated from that standpoint the proposed project does not seem innovative, but she stated she loved the one-stop shop, giving a client to a team that can come up with something very different. Ms. Jones stated the ISN team will not judge patients, is culturally responsive, and has a variety of team members to whom patients may relate better.

Commissioner Mitchell asked about the technology that will be part of the project. Ms. Brown stated the county is considering using Tableau, tele-psych, and a telehealth mobile component.

Public Comment

Ms. Marley asked if the strategist are county employees or contractors and whether they are social workers. She also asked for whether there is a job description for the strategists. She suggested putting together a team workbook and offered her assistance to the county.

Ms. Walker stated the concern that the extra help consumer assistance worker is not full-time and is paid at a much lower pay scale then the family community development partner. Being a part of the ISN team is high-level and should be a full-time position equivalent to at least Step 3, the same as the family community development worker. She stated the need for the strategists to represent intersectionality and prioritize them as part of different communities and for training and effective evaluation for LGBTQ competency.

Stacie Hiramoto, Director, Racial and Ethnic Mental Health Disparities Coalition (REMHDCO), spoke in support of the proposed Innovation project but stated the concern that the strategists will be county employees. She suggested contracting out for workers in the community.

Ms. Strunk spoke in support of the proposed Innovation project but stated the concern about the disparity between the part-time peers on the strategist team. She pointed out that county workers can be peers.

Commissioner Discussion

Chair Wooton asked how the proposed Innovation project differs from a Full Service Partnership (FSP). Ms. Jones stated FSPs are transactional at a system level while the Innovative project is about transformational change, culture change, stigma reduction, adaptability, flexibility, and going beyond traditional services.

Commissioner Aslami-Tamplen stated she is struggling with the innovation and peer wage pieces.

Commissioner Poaster stated he did not understand portions of the project but liked that it will try to change systems. He stated this project will be scrutinized because it is either truly innovative or not innovative at all. He stated the need for the project to capture important outcome and process data.

Chair Wooton stated she, as a consumer who works in a county and has received services, feels the innovative part is in the stigma reduction, cultural change, choice in strategists, and recognizing strengths in the clients. She agreed that the innovation, outcomes, and evaluation components should be scrutinized.

Commissioner Van Horn stated the original version of the FSP was flexible but became rigid over time. That flexibility needs to be recovered and having a variety of pathways available to individuals is important; however, he stated he has many questions and agreed that the project should be scrutinized.

Action: Commissioner Poaster made a motion, seconded by Chair Wooton, that:

The MHSOAC approves Merced County's Innovation Project, as follows:

Name: Innovative Strategist Network (ISN)
Amount: $6,862,288
Program Length: Five (5) Years

Motion carried 5 yes, 1 no, and 0 abstain per roll call vote as follows:

The following Commissioners voted "Yes": Chair Wooton and Commissioners Lynch, Mitchell, Poaster, and Van Horn.

The following Commissioners voted "No": Commissioner Aslami-Tamplen.

ACTION

4: <u>Riverside County Innovation Plan</u>

County Presenters: Bill Brenneman, Deputy Director, Adult Services (Acting MHSA Administrator); Paul Thompson, Deputy Director, Children Services; Paul Gonzales, Administrative Services Officer, Fiscal; Suzanna Juarez-Williamson, Supervising Research Specialist; Diane Mitzenmacher, Supervisor, Children Treatment Services

<u>Paul Thompson</u>

Paul Thompson, Deputy Director, Children Services, provided an overview, accompanied by a slide presentation, of the demographic information, community

planning process, and expected outcomes of the proposed Innovation project. He stated commercially sexually exploited children (CSEC) are often hardest to engage into treatment and care and traditional outpatient care and approaches were ineffective.

Diane Mitzenmacher

Diane Mitzenmacher, Supervisor, Children Treatment Services, continued the slide presentation and discussed the definition of CSEC, the unique challenges for therapy of victims of CSEC, and the lack of effective mental health intervention models. She stated the proposed Innovation project adapts the trauma-focused cognitive behavioral therapy (TF-CBT) model in combination with a field-based coordinated Specialty Care Team approach to meet those challenges.

Suzanna Juarez-Williamson

Suzanna Juarez-Williamson, Supervising Research Specialist, continued the slide presentation and discussed the primary purpose and learning goals of the proposed Innovation project.

Bill Brenneman

Bill Brenneman, Deputy Director, Adult Services (Acting MHSA Administrator), stated that in Riverside County plans must be approved by the Commission prior to presenting them to the county Board of Supervisors, so Riverside County is requesting a conditional approval of their Innovative project today.

Commissioner Questions and Discussion

Commissioner Aslami-Tamplen asked how many children fall victim to exploitation because they are homeless and if this Innovation project will also address the housing issue. Ms. Mitzenmacher stated the project will include a housing element but the number of victims is unknown.

Commissioner Poaster asked about the budget. Paul Gonzales, Administrative Services Officer, Fiscal, Riverside County, explained how the Innovation project budget fits into the total $17 million program.

Commissioner Mitchell asked if workers will identify children and youth while out in the field. Ms. Mitzenmacher stated workers will collaborate with organizations that identify CSEC and will provide treatment out in the field for the identified children and youth.

Commissioner Aslami-Tamplen asked about salary for peer health specialists. Mr. Gonzales stated the starting salary for the peer and parent partners is $16.92 per hour and tops out at $27.00 per hour with full benefits.

Public Comment

Ms. Marley asked about the flex funding and the $17 million program.

Ms. Walker suggested working with the Family Acceptance Project. One of the things that puts LGBTQ youth at risk for bad outcomes is rejection from their families, including youth in the foster care system. It is not always denial of trauma, but it is the trauma itself that keeps individuals from wanting to touch the trauma. She stated the need for

affirmation of identity, because if the person who affirmed who they were and touched them in a way they wanted to be touched was actually a traumatic event, that can, of itself, be traumatizing and feed into that internalized stigma that they already carry that got them to the place where they were to begin with. She asked if there is any data on using the TF-CBT on LGBTQ youth and if the county is open to other treatments midstream if it does not work for these kids.

Ms. Beebe spoke in support of the proposed Innovation project and stated she looked forward to the outcomes.

Ms. Hiramoto asked if this program is supported by the Latino community, what Latino organizations the county will work with going forward, and if there are bilingual/bicultural services and personnel.

Dawniell Zavala, Associate Director and General Counsel, NorCal MHA, stated the importance for the peer support specialists to receive training on trauma, cultural competency, LGBTQ youth issues, and peer support concepts in general. She stated it is difficult to recruit and retain Transitional Age Youth (TAY) peer support specialists. She asked about the plan when TAY peer support specialists age out of the TAY slot. She encouraged adding a drop-in component to the proposed Innovation project.

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

Pending Riverside County Board of Supervisors approval, the *MHSOAC approves Riverside County's Innovation Project, as follows:*

Name: Commercially Sexually Exploited Children Mobile Response
Amount: $6,252,476
Program Length: Five (5) Years

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

The following Commissioners voted "Yes": Chair Wooton and Commissioners Aslami-Tamplen, Buck, Lynch, Mitchell, Poaster, and Van Horn.

ACTION

5: <u>Contract Authorization</u>

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

Executive Director Ewing stated the Commission created the Innovation Subcommittee to provide more clarity and surety in what to look for in county Innovation project plans and has been talking with counties about ways they can be more successful in their Innovation proposals. He stated that last year's budget signed by the Governor added staff to the OAC to better guide and support the innovation agenda in the MHSA. The additional staff was as a result of Budget Change Proposal (BCP) requested by staff. He discussed the four key challenges identified in the BCP:

- The need for a collective strategy around innovation
- Technical assistance and how to draw in resources from other sectors to support counties' ability to succeed
- Research and evaluation to learn from these investments
- Dissemination of the lessons learned from the research and evaluation

Executive Director Ewing stated another way to inform counties and other partners about innovation is to host innovation events. The contract authority request is to support those events and activities relating to the Innovation component of the MHSA.

Public Comment

Ms. Hiramoto stated concern over what the $350,000 contract will be spent on without input and collaboration from stakeholders. She stated collaboration is working together from the beginning of the process.

Marcel Harris, National Alliance on Mental Illness (NAMI) California, asked if there will be a Request for Proposal (RFP) process, how the funds will be administered, and if more than one event will be convened.

Commissioner Discussion

Commissioner Mitchell stated that state agencies often enter into contracts without public input.

Commissioner Poaster stated he fully supports the request. The contracts will help the Commission move towards transformation in innovation. He pointed out that the Executive Director will work jointly with the Chair, Vice Chair, and three Commissioners on the Innovation Subcommittee throughout the process.

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

The Commission authorizes the Executive Director to enter into one or more contracts, not to exceed $350,000, to support events or activities relating to the MHSA Innovation Component.

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

The following Commissioners voted "Yes": Chair Wooton and Commissioners Aslami-Tamplen, Buck, Lynch, Mitchell, Poaster, and Van Horn.

GENERAL PUBLIC COMMENT

Ms. Marley stated her background was in parliament in British Columbia where the government is only as good as the opposition. The MHSA discriminates in that only certain individuals qualify for MHSA funding. There is nowhere for middle-income individuals who are going through depression and anxiety to turn unless they have private insurance.

CLOSED SESSION

The Commission went into closed session to discuss personnel matters pursuant to Government Code 11126(a).

INFORMATION

6: The Role of Innovation in the Healthcare and Mental Health Industry

Presenters: Tom Insel, MD, Director, Clinical Neuroscientist, Verily Life Sciences/Google; Danielle Schlosser, PhD, Lead, Clinical Research Scientist, Verily Life Sciences

Tom Insel

Tom Insel, MD, Director, Clinical Neuroscientist, Verily Life Sciences/Google, provided an overview, accompanied by a slide presentation, of the issues, barriers, and challenges of the mental health system and ways that software and technology can transform mental health care. He shared examples of the kinds of free online mental health services that are available, such as 7 Cups, an online behavioral health service that includes peer support, coaching, and online therapy with over one million users. He stated there is currently a greater opportunity to link up with innovations happening in the private and academic sectors. The full value of this technology has not yet been proven, but the feasibility is there. It is new and it must be demonstrated that it works.

Danielle Schlosser

Danielle Schlosser, PhD, Lead, Clinical Research Scientist, Verily Life Sciences, continued the slide presentation and showed a mobile platform, which she designed in cooperation with stakeholders while she was on the faculty at UCSF, that is now global. The mobile platform was designed to improve the motivation to engage more fully in one's life by connecting young people to a coach trained in evidence-based practices and to each other so they can inspire one another to work on goals. She stated individuals seek out the mobile platform as an alternative to traditional mental health treatment.

Commissioner Questions

Vice Chair Boyd stated the Commission can be a bridge between the public and private sectors in harnessing the combined power, influence, and expertise as it works on raising the standard on innovation.

Commissioner Aslami-Tamplen stated the importance of creating trust by ensuring the protection of the privacy of users so individuals are not abused and communities are not targeted. Dr. Insel stated there is a focus on protecting information but it is an ongoing challenge.

Executive Director Ewing stated he was struck during the presentation by how much progress has been made in physical health but how little progress has been made in mental health. He asked why this is so difficult.

Dr. Insel stated current best-practice treatments, when given early, are good, but the issue is most individuals do not come into treatment due to stigma in the workforce. The workforce needs to be changed in fundamental ways to learn what works and how to deliver it, because it is not clear that what the workforce is doing is what patients need. That is a place where technology can be helpful. Technology will not solve complicated mental health issues and will not replace the human touch, but it can improve the quality of and access to treatment.

Dr. Schlosser agreed. She stated she was at an event in San Francisco that had a panel of prestigious, powerful people in Silicon Valley and she was surprised that all of them came out as having depression. She asked why it is so emotionally laden to admit to having depression when nearly one in four individuals struggle with depression. She stated the need for a paradigm shift, but that shift will not occur by continuing to do what is already being done. She stated there is a whole population of individuals who are opting to get help in a radically different way than they ever have before. Learning to understand this and taking risks will lead to finding solutions.

Dr. Insel stated he asked 7 Cups how many of the individuals represented in their data are already in treatment. 7 Cups immediately responded that they did not know but that they would ask. Within 24 hours, 12,000 individuals responded to their query and 7 cups sent Dr. Insel a table of their responses. He stated, of the 12,000 individuals, 82 percent were not in treatment anywhere else.

Public Comment

Rusty Selix, Executive Director, California Council of Community Behavioral Health Agencies (CCCBHA), stated Dr. Insel's presentation about bending the curve is at the heart of why innovations and prevention and early intervention are in the MHSA. He stated little progress has been made in the 13 years since the MHSA was implemented. It is refreshing to hear from individuals who are part of the technology world who can help to create innovative solutions. He stated the CCCBHA sent a letter to staff about not limiting the innovations funding to what comes through the local stakeholder process, but to drive things from the top and change the whole system so all counties can benefit from projects happening anywhere in the state. He suggested combining the innovation dollars from multiple counties to make big differences and doing the kind of innovations that will achieve the goals set out in the MHSA.

Anna Hasselblad, Steinberg Institute, thanked the Commission for its continued focus on innovation programs and stated she is excited about what is possible when public and private sectors collaborate. There is a perfect storm brewing - the enthusiasm and commitment of counties to provide innovative care, the private industry engaging like never before, and the majority of state decision makers acknowledging that care needs to be provided earlier. It is time to work together to define what truly innovative programming is using the most up-to-date research, and to provide counties with models, technical assistance, and financial support to implement or expand innovation programs. The Steinberg Institute stands as a ready partner and applauds the Commission's commitment to scaling up California's network of care so that more

individuals are entering treatment early, accessing care in innovative ways, and learning together at a statewide level.

Commissioner Discussion

Executive Director Ewing stated the $100 million innovation fund is meant to drive transformational change. Current innovations fill gaps, but one of the things to think about is scalability and investing innovation funds in areas that will be most productive. He asked for ideas to help the Commission frame out the relative value of different kinds of innovation investments.

Dr. Insel stated, although scale is important, he comes at it from a different lens - this is an extraordinary opportunity to transform the delivery of care. The state of California put this money aside for innovation and prevention and early intervention, which also happens to be in the state that has more innovation on the technology side than anywhere else in the world. This presents an opportunity to do something remarkable - something that is good not only for California but for the globe. There is an opportunity to take trials out of academic labs that test 20 individuals and put them into counties where 20,000 individuals can be tested in a week or two where learning and improving can happen quickly.

INFORMATION

7: Executive Director Report

Presenter: Toby Ewing, PhD, Executive Director

Staff Changes/Vacancies

There are three staff vacancies left - one in the Evaluation Unit and two in the Innovation Unit.

Communication

Jennifer Whitney, Director of Communications, is working on a biennial report on how Commission resources are being used.

May is Mental Health Month.

May 24th is the Mental Health Matters event at the capital. The Commission provides financial support for the lead speaker for that event.

Projects

Work continues on the Reversion Report and the Issue Resolution Report.

Yesterday, Executive Director Ewing and Vice Chair Boyd gave a presentation to the California Alliance for Children and Family Services on the crisis services work and received input and feedback on programs around the country that can be used as models where other states have found ways to ensure that individuals have access to care in a crisis and that the bureaucratic issue of eligibility does not delay that.

Briefing Papers

Staff is interviewing subject matter experts to help put together the briefing papers requested by the Commission.

Committees

Staff is working with the chairs of the Committees on putting together a work plan to keep the Committees focused and effective. Tom Orrock, Manager of Health Services, has taken the lead on Committees.

Triage

Three meetings have been convened to learn from counties, law enforcement, and other stakeholders about the first round of triage grants. A Request for Application (RFA) will be discussed in a future Commission meeting for the next round of triage grants. The next coordinator meeting is in April, where the Office of State Health Planning and Development (OHSPD) will present the work they are doing on the Workforce Education Programs to help the Commission learn how to better connect with the work that OSHPD and the California Health Facilities Financing Authority (CHFFA) are doing with their portions of the Senate Bill SB 82 funds.

Stakeholder Contracts

The Request for Proposals (RFP) for stakeholder advocacy work is on schedule to be presented at the March Commission meeting.

Legislation

The introduction deadline recently passed. Staff is watching several bills, including AB 850 (Chou), AB 488 (Kiley) that may affect the Commission and bills introduced by Senator Beall and Assemblymember Thurmond on school mental health. It is very early in the session and he will report on these bills later in the legislative process. Consistent with the Commission's vote in November 2016, the Commission is sponsoring three bills: Assembly Bill (AB) 462 by Assemblymember Thurmond that would allow the OAC to receive employment data from Employment Development Department; AB 862 by Assemblymember Ken Cooley relating to the Bagley-Keen Act and the Commission's site visits to non-public locations; and AB 1134 by Assemblymember Gloria that would create a fellowship program for mental health practitioner and a consumer.

Commission Meeting Calendar

The March 23rd meeting will be in San Diego on the Criminal Justice project. Site visits in San Diego will be scheduled the day before the meeting.

The March meeting agenda is full. Counties have asked the Commission to present seven county Innovation plans at the March meeting, along the six RFP stakeholder results, and requests to review and take a position on legislation. Staff will work with the Chair on how to fit the agenda items into one meeting.

Commissioner Questions and Discussion

Chair Wooton asked for an update on the No Place Like Home program. Executive Director Ewing stated the Department is validating the measure and holding meetings

around the state on how the program will be rolled out. An advisory body is scheduled to convene later this year.

GENERAL PUBLIC COMMENT

Patricia Cossio, Peer Specialist, Office of Consumer Empowerment, told her story of being a person with lived experience and an undocumented immigrant living in a state of fear and suffering in silence. She stated she is sad to have been exposed to cruelty where she felt powerless to do anything about it. She stated concern about members of her old community who have no means of filing for legal residency, who work hard for their children to have a future. She asked the Commission to prioritize mental health in immigrant communities because individuals need to know that they will not be reported to law enforcement if they seek help.

Ms. Walker asked that the Executive Director Report be moved up in the agenda. She also requested that Innovation plans be made available to the public prior to Commission meetings so stakeholders can provide input while there is still an opportunity to make changes.

ADJOURN

There being no further business, the meeting was adjourned at 3:09 p.m.

AGENDA ITEM 2

Information

March 23, 2017, Commission Meeting

Criminal Justice and Mental Health Project

Summary: The Criminal Justice and Mental Health Project began in spring 2016 with the goals of reducing the number of adults with mental health needs who become justice-involved and improving outcomes for those in custody and upon release into the community. In order to achieve these goals, the Commission has engaged with local, state and national experts to better understand barriers and best practices, created opportunities to hear from diverse communities, and reviewed current research, policy and practice.

For the March 23, 2017, public hearing, subject matter experts and stakeholders have been invited to share their knowledge and experiences to assist the Commission in developing its action agenda.

Presenters:

Panel 1: Jail and Re-entry Services

- Dr. Alfred Joshua, *Chief Medical Officer, San Diego County Sheriff's Department*
- Patricia Ceballos, *Re-entry Supervisor, San Diego County Sheriff's Department*
- Mona Minton, Ph.D., *General Manager, Neighborhood House Association*
- Cassandra Arnold, *Certified Substance Use Case Manager, Project In-Reach*

Panel 2: County Approaches to Improving Outcomes

- Jay Orr, *Riverside County Executive Officer*
- Garry Herceg, *Deputy County Executive, Santa Clara County*

Panel 3: Best Practices in the Community and in Custody

- Stephen Amos, *Chief of Jail Administration, National Institute of Corrections (NIC)*
- Jennie M. Simpson, Ph.D., *Office of Policy, Planning, and Innovation, Substance Abuse and Mental Health Services Administration (SAMHSA)*

Enclosures: *March Site Visits and Panel Presentations Brief* and panelist invitation letters, written presentations, and biographies.

Handouts: None.

Criminal Justice and Mental Health Project

March Site Visits and Panel Presentations Brief

PURPOSE

This purpose of this document is to provide background and rationale for the design of the March 22nd site visits and March 23rd public hearing panels to support the development of the Commission's action agenda to reduce the number of adults with mental health needs who become justice-involved, and improve outcomes for those in custody and those reentering the community.

INTRODUCTION

The Mental Health Services Oversight and Accountability Commission is charged with overseeing the implementation of California's Mental Health Services Act (also known as Prop 63) and the transformation of California's mental health system. In collaboration with stakeholders, the Commission provides vision and leadership to expand awareness and understanding of issues facing community mental health. The Commission conducts projects to examine critical issues and make informed decisions on how to improve services and provide better care to consumers.

The Criminal Justice and Mental Health Project began in spring 2016 with the goals of reducing the number of adults with mental health needs who become justice-involved and improving outcomes for those in custody and upon release into the community. In order to achieve these goals, the Commission has engaged with local, state and national experts to better understand barriers and best practices, created opportunities to hear from diverse communities, and reviewed current research, policy and practice.

First, this brief will provide a brief background to demonstrate the importance of examining the criminal justice system as it influences the lives of those with mental health needs, and a short summary of what the Commission has heard and seen via prior site visits and public testimony/presentations. Next, this brief will outline the organization of upcoming site visits and panels, and pose questions for the Commissioners to consider to support the development of the Commission's agenda.

BACKGROUND

The criminal justice system is not designed to serve people with mental health needs, yet research suggests that a disproportionate share of mental health consumers become involved with the criminal justice system at some point in their lives because of unmet mental health needs. The U.S. Bureau of Justice Statistics, the national clearinghouse on criminal justice data, identifies three points of concern:

- 25 to 40 percent of those living with serious mental illness will have been incarcerated at some point in their lives.
- 63 percent of jail inmates in the U.S. have a mental health need. Of those, 76 percent report substance abuse or dependence.
- 1 in 6 jail inmates with a mental health need, or only 17 percent, received treatment during their period of incarceration.

California has made tremendous progress in the past decade through a range of diversion strategies, including establishing mental health courts, training for law enforcement officers, and establishing more comprehensive services to prevent incarceration and hospitalization. But many local jurisdiction lack the staffing, training dollars, facilities or other strategies necessary to respond to the scale of need.

DISCUSSION SUMMARY

Through public engagement activities, the Commission has heard from experts and stakeholders that the number of those in need of services is too great for the system's current capacity, resulting in unnecessary incarceration or law enforcement involvement. Counties are well positioned to safely reduce the number of those with mental health needs in jail but the State must be aligned with this goal as well, and ensure that counties have the resources needed to succeed.

While most will agree that jails are inappropriate places for those with mental illness, there will be those who commit serious offenses who must remain in custody. Counties should have the tools and resources to treat and manage their mentally ill inmate populations, and programming should address more broadly individual and environmental risk factors, such as substance use, housing and employment. Once released from custody, whether under supervision of the criminal justice system or not, those with mental health needs must be connected to appropriate resources.

In September, Commissioners had the opportunity to tour the Los Angeles Twin Towers Correctional Facility, also known as the Twin Towers Jail. The facility was selected for a site visit to allow the Commissioners the opportunity to view and explore in custody treatment and housing options for those with mental illness. Commissioners and staff were escorted to and observed inmates in the moderate observation, high observation, and inpatient hospitalization areas of the jail.

During the September Commission Meeting in Los Angeles, Commissioners heard presentations from stakeholders and subject matter experts on gaps in the system that may prevent those from receiving treatment and the needs of those with mental health needs who become justice involved, like supportive education, employment and housing. Testimony was provided that it was not uncommon for individuals to receive mental health care for the first time while in custody but that jails were not built for the mentally ill or to provide treatment; space to hold individual or group mental health services are almost non-existent. Testimony was provided that there is a lack of acute and sub-acute psychiatric beds that limit treatment options for those needing a higher level of care while incarcerated.

Finding appropriate housing for those with mental health needs who become involved with the justice system was identified as a problem. It was stated that these individuals are often chronically in crisis. A large percent of mentally ill people who enter the criminal justice system have a history of homelessness. Methods identified by presenters and panelists at the public hearing to improve outcomes for those returning back to the community from custody include "peer navigators" inside the jail to link individuals with community-based treatment and a "warm hand-off" to treatment and housing when individuals are released.

The Commission heard testimony that a comprehensive system based on best practices is needed. At the local level, this was said to mean that county leadership must collaborate across agencies and with stakeholders to identify ways in which programs can be developed, funding can be blended and data can be shared. Testimony was heard that the state should support counties by promoting best practices, identifying incentives, and reexamining the laws governing the treatment of those with mental illness during a crisis which often results in law enforcement intervention. Meeting participants also stated that performance measurements should be instituted, because outcomes cannot be changed without data that shows what is and is not working.

MARCH SITE VISITS

On March 22, 2017, Commissioners will have the opportunity to explore programs and facilities in San Diego that are designed to divert those with mental health needs from the criminal justice system prior to incarceration, and explore the full array of services provided to those who are reentering the community from custody. Please note, the Community Transitions Center (CTC) is for those leaving *prison* and reentering the community. While the Commission's focus is on those leaving county *jail*, the Commission will still benefit from exploring the diversity of reentry services provided by this facility.

- Community Transition Center (CTC)

Under the leadership of the San Diego County Probation Department, the CTC is the site of a multi-disciplinary team (MDT) comprised of OPTUM licensed mental health clinicians, a United HealthCare nurse case manager, two Medi-Cal application assistors, and Probation Officers. The Probation Officer develops the COMPAS (Correctional Offender Management Profiling for Alternative Sanctions) case plan, with input from the MDT and in conjunction with the offender, based on assessment results and provide direct linkage to service needs. The center offers a continuum of services. Offenders are transported to the CTC from all CDC-R facilities in the state, tested for current substance usage, and assessed for criminogenic, substance abuse/mental health, and other needs. Offenders requiring detoxification services or short-term transitional housing will be afforded those services immediately. For offenders in need of brief housing assistance, up to sixty (60) beds for male and female offenders are available at the CTC. The CTC provider has staff on duty 24/7 to provide security as well as structure to the programs and daily schedule. Probation staff and the Behavioral Health Service Team (BHST) are on site seven days a week during regular business hours to conduct assessments, pre-release screenings, develop case plans, and link to appropriate services.

- Psychiatric Emergency Response Teams (PERT)

The Psychiatric Emergency Response Teams (PERT) consist of specially trained officers and deputies who are paired with licensed mental health professionals. Together, they respond on-scene to situations involving people who are experiencing a mental health-related crisis and have come to the attention of law enforcement. The goal is to provide the most appropriate resolution to the crisis by linking people to the least restrictive level of care and to help prevent the unnecessary incarceration or hospitalization of those seen.

- Vista Balboa Crisis Center, a Short Term Acute Residential Treatment (START) facility

The START programs (Short Term Acute Residential Treatment, also referred to as crisis residential programs) are located throughout San Diego County and offer an alternative to hospitalization for adults who are suffering an acute psychiatric crisis that is not manageable on an outpatient basis. CRF's START programs are the only integrated system of crisis residential programs in the United States that have been recognized by SAMHSA as evidence-based and listed in the National Registry of Evidence-based Programs and Practices (http://nrepp.samhsa.gov/ProgramProfile.aspx?id=145). In a community-based, homelike environment, the multidisciplinary team of Master's prepared clinicians, nurses, psychiatrists and peers specialize in the psychosocial rehabilitation of each individual who comes through the door.

MARCH PUBLIC HEARING

For the public hearing schedule on March 23, 2017 in San Diego, three panels of stakeholders and subject matter experts have been organized to add to the information already presented and documented from previous efforts[1] or activities hosted by the Commission to continue developing the Commission's action agenda.

Panel One. The first panel will highlight in custody and reentry services delivered by the San Diego County Sheriff's Department and *Project In-Reach*, a program funded by MHSA dollars that works with the department to connect inmates with mental health services once inmates are released. Panelists will describe in custody treatment and best practices with regard to reentry/reintegration, including programming to address risks for offending, and warm handoffs to community-based care.

- *Project In-Reach is designed to help incarcerated individuals with substance abuse and/or mental health disorders as they prepare for re-entry into the community, and assists in the successful linkage to community resources and services pre- and post-release, guiding in the transition process.*

Panel Two. The second panel will focus on local systems change to address the mentally ill justice-involved population, the impetus of that change and how data is being used to support decision-making. The panelists will discuss some of the cost drivers associated with reducing the incarceration of those with mental illness and the opportunities to control those costs over time with effective community-based services and other alternatives. Panelists will be asked how the State could support local systems change efforts. Testimony during this panel will support the Commissioners' understanding of how counties are collaborating across agencies and funding streams, and focusing on collective outcomes instead of siloed programs.

Jay Orr, Riverside County Executive Officer, will discuss how costly lawsuits led to change in his county, and how they are now using data to safely reduce their jail population and make investments in community-based alternatives. Riverside County is hoping to reduce the number of those with mental illness who do not need to be in custody so they can free up resources for those that must remain in custody. Garry Herceg, Deputy Santa Clara County Executive, will describe how his county developed a collaborative plan to address the justice-involved mentally ill population. Mr. Herceg will outline the county's plan and give an update on implementation, including a status on their involvement with the *Data Driven Justice Initiative*, a federal initiative focusing on local data exchanges, diversion, and data-driven risk assessment tools.

Panel Three. The third panel will focus on presentations from national experts on best practices in custody and in the community, examples of model programs and how they were implemented, and current/planned training and technical assistance to support local and state implementation of best practices.

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[1] Previous efforts include those presented during the Project Subcommittee on September 21, 2016, such as Words to Deeds (http://www.fmhac.net/trainingw2d.html), Judicial Council's Task Force for Criminal Justice Collaboration on Mental Health Issues (http://www.courts.ca.gov/documents/MHIITF-Final-Report.pdf) and http://www.courts.ca.gov/documents/Mental_Health_Task_Force_Report_042011.pdf), and the Council of State Governments via the Criminal Justice / Mental Health Consensus Project (https://csgjusticecenter.org/wp-content/uploads/2013/03/consensus-project-full-report.pdf) and The Stepping Up Initiative (https://stepuptogether.org/).

CONSIDERATIONS

Below are some considerations for Commissioners as they visit sites and hear presentations:

The Commission directly administers a $100 million grant program to support crisis triage personnel, approves a $100 million annual investment in innovations, and regulates a $350 annual state investment in prevention and early intervention, that includes the goal of reducing the incarceration of those with mental health needs, among others. The Commission receives and reviews plans and updates from counties detailing their plans for expending these funds, in order to, but not limited to, ensuring MHSA funds are expended in the most cost effective manner.

- Given these tools, how can the Commission support local improvements to the community-based service delivery system to prevent incarceration, including crisis services as alternatives to jails?
- How can the Commission incentivize investments in safely reducing those with mental health needs who become involved in the justice system?
- Should the Commission encourage local planning efforts to look collectively at all programs and services impacting those with mental health needs, regardless of funding source? How could the Commission encourage this integrated approach in a way that will not be overly burdensome to counties?

The Commission has heard the challenges associated with delivering mental health care in jails, which were never meant to provide long-term care to those with severe mental health conditions. The Commission has also heard some counties have seen an increase in the number of those found mentally incompetent to stand trial. In some cases, these individuals unnecessarily stay in jail waiting to be transferred to a hospital for competency restoration due to a shortage of hospital staff and/or psychiatric beds[2].

- How should the Commission work with other State entities to promote nationally recognized best practices for treating and housing those with mental illness, and alternative custody options for jail administrators?
- How can the Commission ensure that individuals with mental health needs in custody are being transitioned into comprehensive community care, including the full array of services known to reduce recidivism that are or should be available?
- How should the Commission work with other State entities to address the needs of those found incompetent to stand trial and encourage jail- or community-based restoration when appropriate?

[2] California Legislative Analyst's Office. (2012, January 3). An alternative approach: Treating the incompetent to stand trial. Legislative Analyst. Retrieved from http://www.lao.ca.gov/reports/2012/hlth/ist/incompetentstand-trial-010312.pdf.

Criminal Justice and Mental Health Project
Panelist Biographies
March 23, 2017

ALFRED A. JOSHUA, MD, MBA, FAAEM Chief Medical Officer, San Diego County Sheriff's Department

Dr. Joshua was selected in 2013 to lead the San Diego County Sheriff's Medical Services Division as CMO to design and manage a medical system that provides comprehensive medical care for the 91,000+ inmate/patients who are annually booked with a daily census of 5,800+ inmate/patients who are housed at one of seven county jails across San Diego County. Prior to the Sheriff's Department, Dr. Joshua, who is a board-certified Emergency Medicine physician, served as the Senior Medical Officer in Healthcare Reform at Tri-City Medical Center and as Medical Director for Volunteers of America, a non-profit organization that assists the homeless. Dr. Joshua has been designing an innovative managed care model for the county jails in order to meet the medical and financial challenges of AB 109 or Public Safety Realignment. He was instrumental in creating a Managed Care Department for central utilization review within the Sheriff's Department and established new value based hospital contracting to save department $27.5 Million in inpatient and outpatient medical care over past two years. He has revised or created 30+ Departmental Medical policies to standardize medical care across seven facilities as well as revising Sheriff's department medical and psychiatric formulary to be efficacious, cost effective, and least side effect profile for patients. He has redesigned Mental Health care with a new Inmate Safety Program that is designed to reduce suicide deaths, attempts and safety cell placements. He has created a Telehealth program which provides expedites timely access to outpatient specialty care for inmates. Dr. Joshua earned his medical degree from the State University of New York, Syracuse where he was inducted into the Alpha Omega Alpha Medical Honor Society and holds a Master's degree in Business Administration from UC Irvine where he was awarded the Top GPA Award for HCEMBA Class of 2013. He completed a two-year hospital administrative fellowship at UCSD. He has worked clinically in the Emergency department at UC San Diego and at Tri-City Medical Center and currently practices clinically at the Veterans Affairs Emergency Department. He currently sits on the Board of Directors for San Diego Health Connect and Council of Mentally ill Offenders.

PATRICIA CEBALLOS, Re-entry Supervisor, San Diego County Sheriff's Department

Patricia Ceballos is the Reentry Supervisor at East Mesa Reentry Facility, South Bay Detention Facility and the County Parole and Alternative Custody Unit. She oversees Correctional Counselors, Educational and Vocational staff, as well as serves as a liaison between contracted staff for alternative custody programs. She currently serves as the Sheriff's Department Community Engagement Representative and participates in the San Diego Reentry Roundtable.

Prior to the Sheriff's Department, Patricia was a Program Specialist with the San Diego County Probation Department. She was a collaborative partner in the development and implementation of reentry services for Mandatory Supervision Offenders in custody as well as in the community.

As a result of California's SB 81, Juvenile Realignment, Patricia was selected to be part of the development and implementation of evidence based programing and case management for youth in San Diego County. During her experience in the juvenile justice system, Patricia served as the Program Coordinator for the San Diego County Youthful Offender Unit.

Patricia has provided training and conducted workshops throughout San Diego County on evidence based practices, reentry and realignment. Patricia holds a Masters in Arts of Human Behavior from National University.

MONA S. MINTON, PH.D., General Manager, Programs/Clinics/Community Affairs at The Neighborhood House Association

Dr. Mona Minton, General Manager, Programs/Clinics/Community Affairs at The Neighborhood House Association located in San Diego CA, has an extensive background working with children, adolescence, adults and older adults struggling with chemical dependency, homelessness, life skills and mental health disorders.

Dr. Minton has a Ph.D. in Clinical Psychology and a Masters in Marriage and Family Therapy.

She speaks and understands multiple languages (English, Spanish, Hindi and Gujarati) and currently serves on 6 committees throughout the East/Central San Diego and North County Region lending her expertise to address a variety of socio-economic, gender and cultural issues. While working for other organizations such as Circle of Friends, Department of Family Services, North County Serenity House, Mental Health Systems, Donavan State Prison, and San Diego County Jails, Dr. Minton has made significant contributions in women and men's prevention, intervention, treatment and recovery programs.

Born and raised in India until age 8. She is passionate about improving the quality of life for women, children and families. Her multi-cultural background enables her to view treatment options from varying perspectives that address socio-economic, gender inequality and stereotypes common to women of color.

With over 16 years' experience in clinical research and development, Dr. Minton is accustomed to working with diverse groups, homeless population and changing demographics that provide counseling and supportive services for drug and alcohol dependency, domestic violence, sex offenders, adolescence support, trauma and mental health.

Dr. Minton has experience working with the judicial system as an advocate for children, battered men, women and senior citizens. She worked with the Child Protective Custody Department of Family Services of Las Vegas for five years and has four years' experience working at the High Desert State Prison in Las Vegas. She has also worked with San Diego County jails for four years, all of which, she feels has broadened her understanding of individual's issues as it relates to incarceration, reentry, recidivism and post re-entry linkages.

After being inspired by her own personal experiences of drug use, being in and out of court systems, family relationships, trauma and being a cancer survivor, Dr. Minton remains dedicated to men and women's wellness, family advocacy and sharing her expertise with those in need.

CASSANDRA E. ARNOLD, Certified Substance Use Case Manager, Project In-Reach Program

Cassandra Arnold CATCI, Certified Substance Use Case Manager at the Neighborhood House Association Project In-Reach Program located in San Diego has worked in the recovery field for over 7 years.

Ms. Arnold is certified in Alcohol and Other Drug Studies and has a Mental Health Worker Certificate from City College. Besides her role at Project In-Reach, Ms. Arnold has been volunteering at Las Colinas Detention and Reentry Facility with Welcome Home Ministries teaching Relapse Prevention for the past 3 years. Additionally, Ms. Arnold oversees 5 sober living homes for A STEP ABOVE sober living organization. She also continues to be invited by the Probation Department to co-facilitate classes about substance use.

Born and raised in San Diego, Ms. Arnold grew up in a home with a heroin addicted father and a mother who worked hard to maintain the family home while her husband was in and out of prison. Ms. Arnold was addicted to crack cocaine for 14 years and served 5 prison terms due to her lifestyle while on drugs. She was a resident of almost every residential treatment program in San Diego before she was able to address the trauma of her father being murdered and of the lifestyle she chose to support her addiction. Today, with over 10 years of sobriety, it is Ms. Arnold's passion to give back what was so freely given to her; that is hope.

Ms. Arnold has worked with men and women who are supervised by the judicial system and shares her lived experience in the hopes of allowing those on the path of recovery to realize they are not alone and they, too, can overcome their addictions and other life issues. She has gone into Juvenile Hall to share her story in the hopes of convincing those who are willing to listen that it is never too late to want and achieve a better quality of life.

Although her brother died from a heroin overdose in Donovan State Prison and her niece went to federal prison for drug charges, Ms. Arnold remains highly committed to educating herself and others about the disease of addiction and the importance of mental health. Despite being confronted with painful memories, she continues to assist other family members in addressing their own mental health challenges.

JAY ORR, County Executive Officer, Riverside County

Jay E. Orr was appointed CEO of the County of Riverside on April 1, 2012 by the Riverside County Board of Supervisors. Orr began his service with the county in 1987, practicing law with the Office of the Riverside County Public Defender.

In 1989, he joined the Office of the Riverside County District Attorney as a deputy district attorney. In just 10 years, he rose to second-in-command as assistant district attorney. Leading California's most successful prosecution teams and recording record conviction rates were among his numerous accomplishments. He also earned a reputation as an attorney whose personal integrity and ethics were above reproach.

After two decades with the Office of the District Attorney, the county named Orr director of the Code Enforcement Department in 2006. In that capacity he rebuilt the department, professionalized it, and prioritized education, training and customer service. Along the way, the Board of Supervisors and the community commended Orr on his team-building approach and a cleaner and safer Riverside County.

Just two years later, Orr was appointed assistant county CEO and developed budget programs and strategies to maintain critical county services during the "Great Recession." Additionally, Orr

established the Health Care Governance Committee, which developed and implemented new models for health-care delivery in the county. He served as acting CEO when needed.

As the county CEO, Orr now leads a team of 22,000 dedicated public servants and oversees an annual operating budget of $ 5.4 billion. He implements of policies set forth by the five members of the Riverside County Board of Supervisors.

A graduate of University of California at Santa Barbara, he holds a B.A., Political Science and a J.D. from Ventura College of Law. Jay resides in Corona, California, with Dorinda, his wife of 35 years. Dorinda is a local elementary school teacher. The couple has three adult children.

GARRY HERCEG, Deputy County Executive, Santa Clara County

Garry Herceg has been a Deputy County Executive with Santa Clara County since June of 2016. His current portfolio includes the Public Defender's Office, Office of Pretrial Services, Office of Reentry Services, Office of Emergency Services, County Fire and County Communications. Prior to this appointment he was the Director of the Office of Pretrial Services for Santa Clara County from December 2010 to June 2016. Prior to 2010, Mr. Herceg spent over 16 years in adult and juvenile probation services with Santa Cruz and Monterey Counties. He served as Assistant Division Director of Santa Cruz County Juvenile Hall from 2007 to 2010. During this time he was responsible for implementing evidence based programs that improved the conditions of confinement for juvenile detainees. In addition he oversaw the daily operations of the home supervision and electronic monitoring programs. Mr. Herceg also currently works as a consultant for Justice System Partners. During 2015 and 2016 he worked with Denver Colorado on the Bureau of Justice Assistance Smart Pretrial Initiative.

In addition to his bachelor's degree from San Jose State University in Administration of Justice, Mr. Herceg's professional training includes Stanford University's Leadership and Transformation Program, National Institute of Corrections Pretrial Executive Program, California Institute of Mental Health Aggression Replacement Instructor Training, Burns Institute Racial and Ethnic Disparity Training and the Annie E. Casey Foundation's Juvenile Detention Alternatives Initiative. He is a member of the California Association of Pretrial Services as well as the National Association of Pretrial Services Agencies. He was honored in 2006 as Santa Cruz County's Probation Officer of the Year.

JENNIE SIMPSON, PH.D., Substance Abuse and Mental Health Services Administration (SAMHSA)

Dr. Jennie Simpson is the Staff Lead for the Substance Abuse and Mental Health Services Administration (SAMHSA) Trauma and Justice Strategic Initiative and the Lead for Criminal Justice Policy in the Office of Policy, Planning, and Innovation. In these roles, she guides the vision for SAMHSA's criminal justice portfolio and coordinate's the agency's criminal justice policies, programs and activities. Over her career, Dr. Simpson has focused on the intersections of behavioral health and criminal justice systems, with an emphasis on law enforcement diversion programs for individuals with mental and substance use disorders. Prior to joining SAMHSA, Dr. Simpson worked at the Council of State Governments (CSG) Justice Center and Pathways to Housing DC, a nationally recognized community mental health organization. At the CSG Justice Center, she served as a technical assistance provider to law

enforcement agencies through the Bureau of Justice Assistance (DOJ/BJA) Justice and Mental Health Collaboration Program. During her tenure at Pathways to Housing DC, Dr. Simpson managed a multi-disciplinary team of behavioral health practitioners and expanded the organization's partnerships across the criminal justice system, including law enforcement departments, pre-trial services, specialized treatment courts, and community supervision agencies. Dr. Simpson has also conducted research on law enforcement diversion programs and behavioral health and law enforcement collaborations. She has published and presented on her research in both national and international forums. Dr. Simpson received a Ph.D. in medical anthropology and a M.A. in public anthropology from American University and a B.A. in anthropology from the University of Texas at Austin.

STEPHEN AMOS, Chief of the Jails Division, National Institute of Corrections (NIC)

Stephen Amos was appointed Chief of the Jails Division, National Institute of Corrections (NIC) on November 15, 2015.

Stephen is a veteran of the United States Army and has 36 years of International, Federal, State, local and tribal law enforcement and correctional experience. He received his Master's degree in Law Enforcement and Corrections Administration from the California State University, Stanislaus in 1987 and has served as adjunct faculty or guest lecturer at numerous universities.

His career as a practitioner includes service as a police officer, probation officer, youth counselor and field agent for which he has been awarded citations for heroism and outstanding service. Stephen's executive experience includes service in the roles of Director of Research for the Oregon Department of Corrections; Deputy Director for the Corrections Program Office, U.S. Department of Justice; Executive Director for the State of Maryland, Governor's Office of Crime Control and Prevention; Chief of Staff for the District of Columbia, Department of Transportation; Chief Deputy Director, California Department of General Services; and Senior Advisor to the Secretary of Corrections, for the State of California's Department of Corrections and Rehabilitation where he retired in 2013. He has since served as Operations Manager for the Pew Charitable Trust, Public Safety Performance Project, and just before his appointment at NIC; served 15 months with the U.S. State Department's, Bureau of International Narcotics and Law Enforcement in Afghanistan, where he served as a Special Advisor-Manager.

Stephen has served on or chaired a variety of advisory boards to include the State of California's, Board of Public Works, Prison Industries Authority, and State Fair Leasing Authority. In the State of Maryland, he chaired the Commission on Public Safety Technology and Critical Infrastructure, Juvenile Justice, Cabinet Council for Criminal and Juvenile Justice, and the Board of Victims of Crime. At the national level, he has chaired or served as a board member of the American Corrections Association, Substance Abuse Committee; Executive Office of the President's, Demand Reduction Interagency Working Groups; President's Law Enforcement Initiative in Indian Country; and the National Task Force on Federal Youth in Custody. He has received numerous awards and recognitions for his leadership from the Executive Office of the President; U.S Department of Justice; Governors of the State of Maryland and California, and the Islamic Republic of Afghanistan, Ministry of Interior.

STATE OF CALIFORNIA
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Mental Health Services
Oversight & Accountability Commission

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February 21, 2017

Alfred Joshua MD, MBA, FAAEM
Chief Medical Officer
County of San Diego Sheriff's Department
5530 Overland Avenue, Ste. 370
San Diego, CA 92123

Dear Dr. Joshua:

The Mental Health Services Oversight and Accountability Commission invites you to participate in the Commission's public hearing on Thursday, March 23, 2017, in San Diego, California. Your participation will assist the Commission in developing an action agenda to reduce the number of adults with mental health needs who become justice-involved, and improve outcomes for those in custody and upon release into the community.

Your panel presentation is scheduled for approximately 9:30 am. Please plan on speaking for approximately 10 minutes, specifically in the areas of:

- The behavioral health services delivery system provided by the Medical Services Division of the Sheriff's Department, including screening and assessment, housing options, stabilization, and strategies to managing the high risk mental health population via the Multi-disciplinary Behavioral Group.
- How the Medical Services Division promotes continuity of care for inmates who received community-based treatment prior to incarceration and for those who are being released into the community, including coordination and data-sharing with other partners.
- Trends in the number of those found incompetent to stand trial and upcoming efforts to develop a jail-based competency restoration program.

We ask that you please send a brief biography and written responses to the items above by Monday, March 13, 2017, to Ashley Mills (ashley.mills@mhsoac.ca.gov). Your written responses will allow those Commissioners attending the meeting the opportunity to prepare questions for you after your presentation, and will be available for those Commissioners unable to attend the meeting. Please note that your written responses and biography will be shared as public documents.

Should you have any questions, I can be reached at toby.ewing@mhsoac.ca.gov or 916.445-8696. Thank you again for your willingness to participate in this important meeting.

Respectfully,

Toby Ewing

Toby Ewing, Ph.D.
Executive Director

STATE OF CALIFORNIA
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March 2, 2017

Patricia Ceballos
East Mesa Reentry Facility
446 Alta Road
San Diego, CA 92158

Dear Ms. Ceballos:

The Mental Health Services Oversight and Accountability Commission invites you to participate in the Commission's public hearing on Thursday, March 23, 2017, in San Diego, California. Your participation will assist the Commission in developing an action agenda to reduce the number of adults with mental health needs who become justice-involved, and improve outcomes for those in custody and upon release into the community.

Your panel presentation is scheduled for approximately 9:30 am. Please plan on speaking for approximately10 minutes, specifically in the areas of:

- The reentry services provided by the Reentry Services Division of the Sheriff's Department, including programs aimed at changing criminal thinking, substance abuse treatment, vocational training and education.
- Efforts to collaborate with other partners to transition those with mental health needs from a custody setting to the community, including discharge planning or case management.
- Challenges and opportunities to reducing the likelihood that an individual with mental health needs will return to custody.

We ask that you please send a brief biography and written responses to the items above by Monday, March 13, 2017, to Ashley Mills (ashley.mills@mhsoac.ca.gov). Your written responses will allow those Commissioners attending the meeting the opportunity to prepare questions for you after your presentation, and will be available for those Commissioners unable to attend the meeting. Please note that your written responses and biography will be shared as public documents.

Should you have any questions, I can be reached at brian.sala@mhsoac.ca.gov or 916.445-8696. Thank you again for your willingness to participate in this important meeting.

Respectfully,

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

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March 8, 2017

Dr. Mona Minton
General Manager
The Neighborhood House Association
5660 Copley Drive
San Diego, CA 92111

Dear Dr. Minton:

The Mental Health Services Oversight and Accountability Commission invites you to participate in the Commission's public hearing on Thursday, March 23, 2017, in San Diego, California. Your participation will assist the Commission in developing an action agenda to reduce the number of adults with mental health needs who become justice-involved, and improve outcomes for those in custody and upon release into the community.

Your panel presentation is scheduled for approximately 9:30 am. Please plan on speaking for approximately 5-10 minutes, specifically in the areas of:

- How *Project In-Reach* helps those with behavioral health needs who are incarcerated re-enter the community, and any outcomes that have been documented.
- Challenges and opportunities for identifying those with behavioral health needs prior to release, and connecting those individuals with appropriate and available services in the community.

We ask that you please send a brief biography and written responses to the items above by Monday, March 13, 2017, to Ashley Mills (ashley.mills@mhsoac.ca.gov). Your written responses will allow those Commissioners attending the meeting the opportunity to prepare questions for you after your presentation, and will be available for those Commissioners unable to attend the meeting. Please note that your written responses and biography will be shared as public documents.

Should you have any questions, I can be reached at toby.ewing@mhsoac.ca.gov or 916.445-8696. Thank you again for your willingness to participate in this important meeting.

Respectfully,

Toby Ewing

Toby Ewing, Ph.D.
Executive Director

Mental Health Services Oversight and Accountability Commission
3/23/17 at 9:30 am

THE
NEIGHBORHOOD HOUSE ASSOCIATION
PROJECT IN REACH PROGRAM
By: Dr. Minton

1. How Project In Reach helps those with behavioral health needs who are incarcerated re-enter the community, and any outcomes that have been documented.

The Project In-Reach (PIR) program is a "Prevention Early Intervention" outreach and engagement program for incarcerated individuals ages 18+ who have or are at risk of substance use and/or psychological disorders as the clients prepare to exit the detention facility. Services include providing case management, care coordination, peer support, outreaching and organizing the necessary community resources in order to support clients' transition out of the correctional facility. Further, PIR offers pre and post release group, individual counseling, mental health recovery, and crisis intervention services.

Program goals are to improve clients' quality of life, decrease relapse, reduce recidivism and diminish impact of untreated mental health and/or substance use issues. Further, PIR helps inmates with substance use and co-occurring disorders to become educated about addiction, learn and implement new coping mechanisms and wean off cravings through appropriate use of medication and treatment services.

PIR has been successfully addressing barriers to successful reentry since 2012, when the program was first implemented through funding by the County of San Diego's Behavioral Health System. In 2016, the program was enhanced to be able to serve severely mentally ill clients with Classification Levels 4, 5 and 6 at Central and Las Colinas Detention Facilities.

A typical PIR client has a history of repeated incarceration; mental health and substance use challenges along with diminished physical health; homelessness upon release; indigent; no health insurance or identification documents; and unemployed.

A reason for the PIR's success is attributed to the fact case management/care coordination starts pre-release with a projected release dates of 60-180 days. During this time, clients have an opportunity to build rapport with his or her case manager and or peer specialist. This gives the staff the opportunity to learn more about the client's risks and needs before their release from jail. Post-release, clients may stay with PIR for up to 90 days. As stated above, PIR provides pre- and post-release case management/care coordination services using the evidence-base and cognitive behavioral treatment.

A. Program Goals and Performance Outcomes

5660 Copley Drive, San Diego, California 92111 Telephone: 858.715.2642 Facsimile: 858.715.2670 info@neighborhoodhouse.org

www.neighborhoodhouse.org

2014-2015 Fiscal Year – County Contract

	County Targets	Program Actual	% Of Objective Complete
Engaged	300	352	117%
Admitted cases	300	270	90%
Percentage of clients linked to services	60%	58%	97%
Recidivism	40%	13%	145%

2015-2016 Fiscal Year - County Contract

	County Targets	Program Actual	% Of Objective Complete
Engaged	300	317	106%
Admitted cases	300	206	69%
Percentage of clients linked to services	65%	72%	111%
Recidivism	35%	13%	133%

2015-2016 – Sheriff's Department Contract

	County Targets	Program Actual	% Of Objective Complete
Engaged	100	86	86%
Admitted cases	100	66	66%
Percentage of clients linked to services	65%	72%	111%
Recidivism	35%	13%	133%

In 2013, California Department of Corrections and Rehabilitation, Correctional Clinical Case Management System reported 51% recidivism within one year from release and 48% recidivism within 6 months of release. PIR cumulative recidivism from 2012 to current is at 25%. These performance outcomes are remarkable given the majority of PIR clients are homeless, indigent and no probation and/or on papers upon release. Clients are released with the same clothes he or she was wearing when arrested. The majority of clients typically do not have access to identification documents, birth certificates, food, hygiene items, medical or other types of benefits, employment, etc. Unless his or her basic needs are met, such as housing, food, hygiene, employment, legal forms of identification, clients are not prepared to enter treatment, seek and/or

enter employment, find stable housing, maintain ties with healthy social networks and reunite with their families and loved ones. In April 2015, PIR's contribution to lowering the recidivism rate in San Diego County was acknowledged by journalist Steve Hargreaves of CCN Money who praised PIR's approach to supporting people not just with medical and mental health treatment, but also housing and job training. As pointed out in the article, according to Dr. Alfred Joshua, Chief Medical Officer at the San Diego County Sheriff's Department, only 23% of PIR clients are re-arrested after six months whereas 48% of prisoners released by the State are charged with another crime.

2. Challenges and opportunities for identifying those with behavioral health needs prior to release, and connecting those individuals with appropriate and available services in the community.

The program is thriving due to committed staff and dedicated leadership. However, many clients could be led to a successful path if the program was able to meet some of his or her basic needs in a more sufficient and sustainable manner. The main areas of deficiency are access to short term housing, funds for food, transportation such as monthly bus passes, hygiene, clothing and various types of documents (e.g., birth certificates or California IDs). When one is released with the background that he or she has mental health issues (such as depression, anxiety or high risk mental health diagnosis such as bipolar, schizophrenia, depression with manic episodes, etc.) and he or she does not have a placement, he or she can relapse and or return back to jail. Housing upon release is the number one challenge NHA PIR identifies. If we had the opportunity to link all clients to short term housing and or transitional housing upon release, the individual can learn basis life skills before stressing about getting a job, a home, meeting their basic needs such as food, shower, etc. Once the individual is in a safe placement, we can provide WRAP around services so they can cope with stress, by focusing on therapy, treatment, medication, and not so much on finding a job, where do I go to get what--- WRAP services can help them have a Case Manager for long term who can lead and coach them to the right path.

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March 8, 2017

Cassandra Arnold
286 Euclid Avenue, Suite 207
San Diego, CA 92114

Dear Ms. Arnold:

The Mental Health Services Oversight and Accountability Commission invites you to participate in the Commission's public hearing on Thursday, March 23, 2017, in San Diego, California. Your participation will assist the Commission in developing an action agenda to reduce the number of adults with mental health needs who become justice-involved, and improve outcomes for those in custody and upon release into the community.

Your panel presentation is scheduled for approximately 9:30 am. Please plan on speaking for approximately 5-10 minutes, specifically in the areas of:

- Your experience with the criminal justice and mental health systems.
- The benefits of using those with lived experience as peers to promote behavioral health recovery and reduce future incarceration, for both peers and those they help.

We ask that you please send a brief biography and written responses to the items above by Monday, March 13, 2017, to Ashley Mills (ashley.mills@mhsoac.ca.gov). Your written responses will allow those Commissioners attending the meeting the opportunity to prepare questions for you after your presentation, and will be available for those Commissioners unable to attend the meeting. Please note that your written responses and biography will be shared as public documents.

Should you have any questions, I can be reached at toby.ewing@mhsoac.ca.gov or 916.445-8696. Thank you again for your willingness to participate in this important meeting.

Respectfully,

Toby Ewing

Toby Ewing, Ph.D.
Executive Director

Chairperson
Judith A. Wenker

President and CEO
Rudolph A. Johnson, III

Mental Health Services Oversight and Accountability Commission
3/23/17 at 9:30 am

THE
NEIGHBORHOOD HOUSE ASSOCIATION
PROJECT IN REACH PROGRAM
By: Cassandra Arnold

1. **Your experience with the criminal justice system and mental health systems**.
   Having served 5 prison terms from 1992 to 2006 and working with clients and professionals in the system today, I can say that the climate of the criminal justice system has changed. I used to be addressed as a number (W54687) by one parole officer. I realized that "I invited the judicial system into my life and I had to invite them out." However, working with probation officers who supervise the AB 109 population I have seen the shift to client-centered supervision rather than a culture that embraces the attitude, "once a criminal, always a criminal, that's all you know because of where you come from." I have learned to manage my anxiety without medication (I did not like the side effects); I find solace and guidance through my spirituality.

2. **The benefits of using those with lived experience as peers to promote behavioral health recovery and reduce future incarceration, for both peers and those they help.**
   I find that sharing about the obstacles I have faced such as finding a job as a convicted felon or being denied a volunteer position at Las Colinas helps our clients realize that others before them have been able to overcome obstacles which they may have been encountering as well. Sharing about my persistence in overcoming those obstacles helps them understand that things may not fall into place the first time they try to right the wrongs. I can also address criminal thinking and behaviors as something we learned and adopted to cope and survive while in our addiction. I can teach our clients about which of those learned can now translate into something positive in our recovery process. I share about the generational aspect of addiction and incarceration in families and the stereotypes that no longer hold true for me. My goal is to share that I'm lucky to have lived 2 lives. I will not sugarcoat that my recovery process has been difficult. However, it is a far cry better from some of the places my addiction took me to. In addition, I will continue to work in the community and with my clients to reduce the stigma of mental illness, which is rampant in society to this day despite all the improvements we have seen in the treatment of mental health challenges. Many of my clients still use words like "crazy" or "psycho" when

talking about their mental health. Helping them understand that those kinds of challenges have nothing to do with being “crazy” or a “psycho” is one of the first steps towards motivating clients to accept mental health treatment. Having gone through my own struggles, I can relate to my clients on an emotional level, not just based on what I have learned in my training. I find this to be extremely important since clients may accept insight from “one of their own” more than from someone who has not gone through some of the same life experiences.

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February 21, 2017

Jay Orr, County Executive Officer
County Administrative Center
4080 Lemon Street – 4th Floor
Riverside, CA 92501

Dear Mr. Orr:

The Mental Health Services Oversight and Accountability Commission invites you to participate in the Commission's public hearing on Thursday, March 23, 2017, in San Diego, California. Your participation will assist the Commission in developing an action agenda to reduce the number of adults with mental health needs who become justice-involved, and improve outcomes for those in custody and upon release into the community.

Your panel presentation is scheduled for approximately 10:30 am. Please plan on speaking for approximately 10 minutes, specifically in the areas of:

- Circumstances that led to a focus on working across local agencies to create systems change to reduce the number of those with mental health needs in jail and improve outcomes for those in custody, including how data is driving decision-making.
- Cost drivers associated with reducing the incarceration of those with mental illness and the opportunities to control those costs over time with effective community-based services and other alternatives.
- Investments in sustaining systems change efforts overtime, and how the State could support such investments.

We ask that you please send a brief biography and written responses to the items above by Monday, March 13, 2017, to Ashley Mills (ashley.mills@mhsoac.ca.gov). Your written responses will allow those Commissioners attending the meeting the opportunity to prepare questions for you after your presentation, and will be available for those Commissioners unable to attend the meeting. Please note that your written responses and biography will be shared as public documents.

Should you have any questions, I can be reached at toby.ewing@mhsoac.ca.gov or 916.445-8696. Thank you again for your willingness to participate in this important meeting.

Respectfully,

Toby Ewing

Toby Ewing, Ph.D.
Executive Director

Circumstances that led to a focus on working across local agencies to create systems change to reduce the number of those with mental health needs in jail and improve outcomes for those in custody, including how data is driving decision-making.

- Common understanding that across the nation jails had become the largest provider of behavioral health services in the nation
- Mental Illness more prevalent in the jail population (25-30%) than in the general population (10%)
- In the past 25 years population in Riverside has almost doubled taxing both the criminal justice and behavioral services available as funding growth did not keep up with population growth
- Lack of hospital or crisis beds for those with mental illness meant people diverted to jails if they had a mental illness and were convicted of a crime
- And, of course, the PLO lawsuit
- The lawsuit dictates what data is required and county will be accountable to achieve certain outcomes, to show the efficacy of treatment and interventions used.
- AB109 realigned certain criminal justice populations to local counties and a portion of the realigned population have mental illness which is now the responsibility of our county rather than the State. This has exacerbated our local capacity challenges in both Behavioral Health and Criminal Justice systems
- Through our jail study conducted by CA FWD we learned that people with mental illness were more likely to be incarcerated for longer periods of time and more likely to return to county jail than those without mental illness. KPMG is conducting a deeper dive into our local jail populations to identify the true impacts of the mentally ill population on our jail system. It is hoped this will better equip the county to have conversations surrounding priorities and alternatives to incarceration

Cost drivers associated with reducing the incarceration of those with mental illness and the opportunities to control those costs over time with effective community-based services and other alternatives.

- People convicted of a crime with mental illness stay in jails longer, less likely to seek healthcare in the community when released, more likely to use crisis and emergency services
- Services to address this:
    - Whole Person Care (links new probationers with significant health issue and a mental illness to the health services they need – including care coordination)
    - Drug Medi-Cal Waiver – opens a full range of possible levels of care for Substance abuse for all, including those involved in the criminal justice system
    - Affordable Care Act – opened the door to healthcare to many people exiting the jail system.
    - Prop 47 – pending competitive process offers funding for services in the community rather than in detention settings
    - Stepping up Initiative, provides technical assistance, training and resources to counties to build systems that treat BH issues in the community rather than jail
- Collaborative efforts already in place include our countywide Mental Health Courts and the Day Reporting Centers located in Indio, Temecula and Riverside.

Investments in sustaining systems change efforts overtime, and how the State could support such investments.

- Investments in the future:
    - Expansion of childrens' services across the BH system of care
    - Create resilient communities
        - Identify and treat trauma early
        - Juvenile hall services, including wraparound for the family
        - Seamless interagency experience for kids and families
- What the state can do:
    - Fix the funding inequities which have continues to set counties like Riverside back in terms of service levels with all populations
    - Ease MHSA Innovations money restrictions – after 10+ years counties are having increasing difficulties identifying new projects that fit the requirements; meanwhile the legislature is passing bills that hijack MHSA funding before it even gets to counties (i.e., No Place Like Home)
    - Open Medi-Cal billing to detention settings for behavioral healthcare services
- Investments in adequate housing options for the mentally ill that are designed to stabilize and/or maintain individuals and prevent the need for incarceration.
- Allow the use of MHSA innovations money in juvenile detention settings.
- Ensure future allocations to the juvenile and adult Mentally Ill Offender Crime Reduction grants.

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Oversight & Accountability Commission

WELLNESS · RECOVERY · RESILIENCE

February 21, 2017

Garry Herceg, Deputy County Executive
County Government Center – East Wing
70 W. Hedding Street, 11th Floor
San Jose, CA 95110

Dear Mr. Herceg:

The Mental Health Services Oversight and Accountability Commission invites you to participate in the Commission's public hearing on Thursday, March 23, 2017, in San Diego, California. Your participation will assist the Commission in developing an action agenda to reduce the number of adults with mental health needs who become justice-involved, and improve outcomes for those in custody and upon release into the community.

Your panel presentation is scheduled for approximately 10:30 am. Please plan on speaking for approximately 10 minutes, specifically in the areas of:

- Adopted recommendations from the Jail Diversion and Behavioral Health Subcommittee (JDBHS) and how Santa Clara County will be or is already implementing those recommendations.
- Involvement in the Data Driven Justice Initiative.
- Cost drivers associated with reducing the incarceration of those with mental illness and the opportunities to control those costs over time with effective community-based services and other alternatives.
- Investments in sustaining systems change efforts overtime, and how the State could support such investments.

We ask that you please send a brief biography and written responses to the items above by Monday, March 13, 2017, to Ashley Mills (ashley.mills@mhsoac.ca.gov). Your written responses will allow those Commissioners attending the meeting the opportunity to prepare questions for you after your presentation, and will be available for those Commissioners unable to attend the meeting. Please note that your written responses and biography will be shared as public documents.

Should you have any questions, I can be reached at toby.ewing@mhsoac.ca.gov or 916.445-8696. Thank you again for your willingness to participate in this important meeting.

Respectfully,

Toby Ewing

Toby Ewing, Ph.D.
Executive Director

County of Santa Clara

Office of the County Executive

County Government Center, East Wing
70 West Hedding Street
San Jose, California 95110
(408) 299-5105

Date: March 10, 2017

To: Ashley Mills, Project Director, Criminal Justice/Mental Health

From: Garry Herceg, Deputy County Executive

Subject: MHSOAC Public Hearing

In response to a critical incident with Santa Clara County Jail, the Santa Clara County Board of Supervisors adopted the Blue Ribbon Commission in October 2015. The purpose of the Blue Ribbon Commission was to assess custody operations and to recommend improvements. What resulted from the work of the Commission is over 600 recommendations for improvements that continue to be implemented to this day. One of those recommendations included the development of the Jail Diversion and Behavioral Health Subcommittee which began meeting in the spring of 2016.

The focus of the Jail Diversion and Behavioral Health Subcommittee of the Re-Entry Network was:

1. Identify strategies for preventing individuals with mental health needs from becoming offenders
2. Identify gaps and strategies for community based treatment solutions for individuals with mental health and substance use problems who have a history of or are at a risk of offending
3. Assess training needs of relevant personnel (for example, law enforcement, first responders)
4. Ensure cultural competency is included in community based solutions and discharge planning
5. Be prepared to address any other relevant issues as they arise from the Subcommittee's work

The Subcommittee is co-chaired by a County Board of Supervisors member and a Superior Court Judge. The Subcommittee consists of stakeholders from county departments, contracted service providers, and members of the community. Throughout 2016 the Subcommittee held many public meetings which included bringing in experts to provide testimony, researching on best practices and traveling for site visits to several jurisdictions. Out of these efforts, the Subcommittee developed key goals and recommendations. They included:

1. Reduce the number of clients/inmates on the Jail Assessment Coordination (JAC) list, which ranges from 80-100 individuals daily, with a goal of eliminating incarceration of individuals who are held only because adequate residential and outpatient services are not available.

2. Expand the community-based continuum of care for clients/inmates to move clients/inmates out of the jail and into community programs.

3. Partner with Custody Health staff to ensure planned care transitions – "warm handoffs" – and effective connections to community-based services, supports and/or treatment for individuals leaving custody.

4. Reduce the number of people with mental illness and/or co-occurring (mental health and substance use) disorders that are booked into jail. Goal: 250 fewer people over two years.

5. Reduce the length of time people with mental illness and/or co-occurring disorders remain in jail. Current length of stay: 159 days for males and 58 days for females. Goal: 80 days for males and 30 days for females.

6. Implement the initial phase of SCVHHS Health Link Electronic Medical Record System in Custody Health and Behavioral Health Services to capture individual client and aggregated service data to assess service utilization patterns, service needs and gaps, and recidivism rates for custody and deep end behavioral health services, such as hospital stays.

7. Develop metrics to identify and track service utilization and outcomes of individuals diverted from jail.

On August 16, 2016 the Board of Supervisors adopted the recommendations authorizing 8.2 million dollars to be used for implementation. See pages 4-5 for specifics on recommendations and allocation funding sources.

Another effort the County has been involved with is the Data Driven Justice Initiative. This began in spring of 2016 and at the time was sponsored by the White House. The County of Santa Clara initially got involved as a tie into the County's efforts regarding Pay for Success in addressing the chronically homeless population which impacts jail and hospital visits. Since becoming involved in this effort, and learning from other jurisdictions across the country, the County has developed a multi-disciplinary community supervision program for those awaiting treatment beds. Instead of waiting for treatment beds in custody, defendants will now be supervised in the community in a collaborative effort by Probation, Sheriff, Pretrial Services, Behavioral Health Services and Reentry Services. An additional effort just underway in the County is the implementation of a case management data base for mentally ill and homeless individuals. The Data Driven Justice Initiative has provided linkage for the County to Loom, Inc. Loom is a high tech

startup who will be developing a data base system for the County. Loom has developed systems that link data from health care, criminal justice and social services under one umbrella.

The main cost drivers the County is focusing on through these efforts is reducing the number of hospital visits and jail bed days associated with mentally ill, homeless, and substance abuse defendants. This includes reducing the risk of litigation. In addition to this, the County is also closely looking at program outcomes of services being provided by County programs and contracted treatment providers through the County's Results First Initiative. Currently a comprehensive study is being done of all county programs that serve justice involved individuals. The study will also include cost benefit analysis of these programs which will be extremely beneficially in deciding where to invest county resources going forward.

One of the biggest investments in sustaining change over time is really being able to measure results. Data tracking and regular reports on the data in order to adjust and modify policy and practices over time is needed both at a county and state level. Thorough independent ongoing research on what works and what doesn't needs to be a priority. Then incentives to counties from state could be offered to motivate jurisdictions to move to more effective and efficient practices in servicing this population. Finally, there really needs to be campaign at the state level to move jurisdictions towards a therapeutic justice model in dealing with these difficult populations.

	ADMINISTRATION'S RECOMMENDATION	COST	REVENUE	GF FY17 COST
1.	Screening and Assessment: BHSD to develop and implement a standardized, validated screening tool and assessment process with public safety partnersto divert individuals from being booked into jail and instead send them to community services.(Subcommittee's Recommendation #2)Estimated Implementation Timeline:BHSD will convene a work group to select a tool in September and conduct the training of selected local law enforcement agencies, County staff, and Court staff that will take approximately six months after selection, no sooner than March 2017.	TBD	Existing MHSA & AB109 Training Funds	$0
2.	Behavioral Health Treatment: a. Expand post-custody mental health and/orco-occurring outpatient services by 40 slots to address a service gap for clients that need this level of care or are ready to step down from a Full Service Partnership (FSP) program into outpatient services. BHSD currently offers 180 outpatient slots for post-custody clients, however, there is an ongoing wait list for these services limiting step-down capacity from FSP to this lower level of care. (Static Capacity: 40; Dynamic Capacity: 40; Average LOS Days: 365) (Subcommittee's Recommendation #1a) Estimated Implementation Timeline: Service start date of July 2017 as an RFP will be required for this new service modality.	$294,038	$132,317 (Medi-Cal)	$161,721
	b. Increase the Criminal Justice (CJ) FSPby 20 slots. The JAC list demand is largely for FSP slots, which are currently full due to the limited number of outpatient slotsand some of these individuals cannot be released from jail until stable housing is available, based on their charges. (Static Capacity: 20; Dynamic Capacity: 20; Average LOS Days: 365) (Subcommittee's Recommendation #1b) Estimated Implementation Timeline: Service start date of July 2017 since this require amending existingrecently awarded BHSD agreementsor conduct RFPin January 2017.	$425,019	$191,259 (Medi-Cal)	$233,760
	c. Expand the 90-day Intensive Outpatient Service Team by50 additional post-custody clients. This service will support clients as they leave custody, linking them to housing, BHSD services, primary care services and benefit assistance, as well as addressing any other needs. In addition, the team will employ Peer Mentor staff who will connect clients to the appropriate BHSD services upon discharge. (Static Capacity: 50; Dynamic Capacity: 152; Average LOS Days: 120) (Subcommittee's Recommendation #1c) Estimated Implementation Timeline: Service start date of July 2017 as an RFP will be required as this is a new service modality.	$1,329,982	$598,492 (Medi-Cal) $423,675 (MHSA)	$307,815 $1,272,021
	d. Develop one Behavioral Health Urgent Care Center in East San Jose as a drop-in center for law enforcement, and incorporate functions that currently exist at the "Restoration Center," similar to Bexar County's center in Texas. Urgent Care Centers would offer voluntary services 24 hours a day/7 days a week and provide a community drop-off site for law enforcement that would divert individuals to treatment, rather than jail or Emergency Psychiatric Services (EPS). Individuals served in an Urgent Care Center would be assessed for treatment needs and referred to the appropriate level of care in the community. If an individual requires a 5150 involuntary hold, they would be transported to EPS. Estimated Implementation Timeline: Minimum of 18-24 months (Staff is looking at the feasibility of using an existing site and staff plans to tour the Bexar County Restoration Center in Sept/Oct. 2016)	$4,269,720 (24/7 Care)	$1,921,374 (Medi-Cal) $1,000,000 (AB109) $76,325 (MHSA)	$1,272,021

	ADMINISTRATION'S RECOMMENDATION	COST	REVENUE	GF FY17 COST
3.	Housing Services: a. Add flex funds for CJ FSP to provide housing for 50 clients referred into treatment services under 2a-2c. Flex Fundexpenditures will be utilized for individuals, after it is established that there are insufficient funds available for the clients' housing subsidies; and it will assist clientsin successfully meeting theirgoals on their Personal Service Plan. Estimated Implementation Timeline: Implementation would require amending existingrecently awarded BHSD agreementsor conduct RFPin January 2017 with services starting on July 2017.	$500,000	$500,000 (AB109)	$0
	b. Establish a Permanent Supportive Housing (PSH) program for up to 90 chronically homeless clients with SMI. This PSH program would consist of two integrated components. (1) Multi-disciplinary team that is capable of providing mental health services, substance abuse services, housing services and vocational/education support. The team would be able to leverage specialty mental health and, working with the SUTS team, may also be able to leverage drug Medi-Cal. (2) Consist of deep permanent housing subsidies or deeply subsidized housing units. Initially, this programwould serve 90 persons, but could expand asparticipants stabilize and requireless services. This programwould be a part of the countywide coordinated entry system and would build operational relationships to coordinate services and receive referrals from ORS, Custody Health Services, the specialty courts and other system partners. Estimated Timeline Implementation: Service start date of July 2017 since this would require amending one or more of the six recently awarded BHSD agreements in January 2017 with PSH providers that provide intensive outpatient services and permanent supportive housing.	$1,300,000	$500,000 (Medi-Cal) $800,000 (AB109)	$0
4.	Supervision: Enhance an existing Pretrial Mental Health Supervision Program with Superior Court and integrate the program with future Behavioral Health Services Court and Transitions Team by adding a Pretrial Service Officer. (Subcommittee's Recommendation #5a) Estimated Timeline Implementation: After Board approves second reading of salary ordinance – three months for posting and recruitment – January/February 2017 position hired.	$72,027 (7 months cost)	$0	$72,027
5.	Administrative Support and Data/Evaluation Resources: Add a Health Care Program Manager at Behavioral Health Services Department to assignJail Diversion referrals to Clinical Social Worker/Marriage and Family Therapists for screening, referral, and treatment placements of clients. (Leverage staff at Office of Reentry Services to coordinate program operations and data/evaluation support & staff the Jail Diversion Subcommittee). Estimated Timeline Implementation: After Board approves second reading of salary ordinance – three months for posting and recruitment – January/February 2017 position hired.	$87,010 (7 months cost)	$0	$87,010
	TOTAL ONGOING	**$8,277,796**	**$6,143,442**	**$2,134,354**

STATE OF CALIFORNIA
EDMUND G. BROWN JR., Governor

MHSOAC
Mental Health Services
Oversight & Accountability Commission

WELLNESS · RECOVERY · RESILIENCE

February 9, 2017

Stephen Amos, Chief of Jails Division
National Institute of Corrections
320 First Street – 5002
Washington, D.C. 20534

Dear Mr. Amos:

The Mental Health Services Oversight and Accountability Commission invites you to participate in the Commission's public hearing on Thursday, March 23, 2017, in San Diego, California. Your participation will assist the Commission in developing an action agenda to reduce the number of adults with mental health needs who become justice-involved, and improve outcomes for those in custody and upon release into the community.

Your panel presentation is scheduled for approximately 11:00 am. Please plan on speaking for approximately 10 minutes, specifically in the areas of:

- The work of the National Institute of Corrections (NIC) and its initiatives to support public safety officials in safely reducing the number of adults with behavioral health needs in jails and improving outcomes for those who must remain in custody.
- Best practices with regard to in custody care, release and reentry into the community, with examples of each and how those best practices were implemented.
- Current or planned training and technical assistance support for counties and states interested in implementing best practices.

We ask that you please send a brief biography and written responses to the items above by Monday, March 13, 2017, to Ashley Mills (ashley.mills@mhsoac.ca.gov). Your written responses will allow those Commissioners attending the meeting the opportunity to prepare questions for you after your presentation, and will be available for those Commissioners unable to attend the meeting. Please note that your written responses and biography will be shared as public documents.

Should you have any questions, I can be reached at toby.ewing@mhsoac.ca.gov or 916.445-8696. Thank you again for your willingness to participate in this important meeting.

Respectfully,

Toby Ewing

Toby Ewing, Ph.D.
Executive Director

Stephen Amos, NIC: Panel Presentation Written Remarks

Prepared for the California Mental Health Services Oversight and Accountability Commission

"The evidence of a mental health crisis in America is overwhelming. The need for an informed evidence based approach for correctional technical assistance and training is also very apparent. The National Institute of Corrections stands ready to do its part in addressing this crisis by equipping correctional professionals with the best possible tools to address the challenge."
Chief Amos of the Jails Division-National Institute of Corrections

I would like to thank the California Mental Health Services Oversight and Accountability Commission *(MHSOAC)* for inviting me here today to address the Justice Involved Mental Illness and Co-Occurring Disorder epidemic that we are facing in this country today. This commission has appropriately recognized that this issue transcends locality, income level, gender, and race. More specifically, I want to thank this commission for their leadership as demonstrated today by bringing your federal partners here to engage and provide you with our collective input and perspective to more clearly define the important roles that we, as Federal, state, local and supporting partners, have in addressing this growing public health and safety epidemic.

The National Institute of Corrections (NIC) was established under Public Law 93-415 in 1974 by the United States Congress following the riot at New York's Attica Prison in 1971. The legislation gave NIC authorization to engage in numerous activities aimed at improving the field of corrections. Among these the authority to:

- Serve as a clearinghouse and information center;
- Assist and serve in a consulting capacity to Federal, state, and local criminal justice agencies;
- Encourage Federal, state, and local governments to develop and implement improved corrections programs;
- Devise and conduct seminars, workshops, and training programs;
- Conduct, encourage, and coordinate research relating to corrections; and
- Formulate and disseminate correctional policy, goals, standards, and recommendations.

The charges embodied in these authorizations shaped NIC's mission to serve as a center of learning, innovation, and leadership that shapes and advances effective correctional practice and public policy. NIC has become known for its unique role as a provider of services to corrections agencies and practitioners and respected for the level of excellence reflected in the content and delivery of these services. One of the hallmarks of this excellence is NIC's ability to respond to requests for assistance quickly with content that can address needs at the agency level, as well as serve the broader field of criminal justice and corrections in particular.

FY17 Behavioral Health Initiative-Jails

Last March, I hosted the NIC Bi-Annual Meeting of the Large Jail Network at the National Corrections Academy in Aurora. The executive level membership of this network consists of approximately 77 sheriffs, undersheriffs and jail administrators representing the nation's largest jails with bed capacities exceeding 1,000. After asking each of the representative members of these agencies to introduce themselves, I asked them to identify in ranked order what were the pressing challenges that they

face at this time in administering their jails. As each one of the members stood and presented, it became painfully clear that mental illness was the universally ranked as the number one category of challenge and followed by opioid and alcohol abuse as a co-occurring disorder. As my staff captured these individual reportings, it became apparent that we, as the National Institute of Corrections, must commit ourselves to expanding our knowledge and collaborations and further engage our federal, state, local and supporting partners to be more responsive to this growing population of mentally ill offenders with co-occurring disorders in our offerings to the field.

In May 2016, we began this effort by engaging in a conferral process by hosting on very short notice, the first of its kind inaugural Corrections Executives Coordination Meeting (CEMC). This meeting included two separate sessions, and some of this meeting's attendees are present today, but collectively they included:

Six (6) Federal Agencies:

- White House Office of National Drug Control Policy
- Bureau of Prisons
- National Institute of Justice
- Bureau of Justice Assistance
- Office of Justice Programs
- Health and Human Services

One (1) State Agency:

- California Mental Health Services Oversight and Accountability Commission (Toby, Ashley, and Sheriff Brown.

Three (3) Local Agencies:

- Department of Corrections, District of Columbia
- Department of Corrections, Montgomery County, Maryland
- Santa Barbara County Sheriff's Office, California

The Executive Leadership of Nine (9) Professional Associations:

- National Sheriffs Association
- National Association of Pretrial Services Agency
- Association of State Correctional Administrators
- American Corrections Association
- California Sheriffs Association
- National Commission on Correctional Health Care
- National Association of Drug Court Professionals
- American Jail Association
- National Association of Counties

While these meetings are not limited to any singular correctional topic, I felt it imperative that the inaugural meeting's agenda would be dedicated to the most pressing topic to the field of corrections and of greatest promise…**Promising Behavioral Health Initiatives.** I attribute the significant number of executive level invitees that attended this last minute meeting to be the topic of discussion.

The first session was dedicated to **Medication Assisted Treatment or (MAT).** MAT is a public health and safety tool that, when utilized by the criminal justice system in conjunction with good substance abuse programming, can significantly break the cycle of relapse and re-incarceration. Furthermore, MAT affords the justice system an opportunity to play an incredibly important role in reversing the ongoing opioid epidemic, as well as the ongoing challenges associated with serious mental illness.

The second session of our Corrections Executives Coordination Meeting (CEMC) was dedicated to the **Stepping Up Initiative** and was presented by the leadership of the Bureau of Justice Assistance, Council of State Governments, and the National Association of Counties. The recognition that there is an estimated two (2) million people in our nation's jails each year that are diagnosed as seriously mentally ill [i1]and that there are as many as ten (10) times as many mentally ill inmates in our jails and prisons than state mental health facilities is astonishing. "In 2012, there were an estimated 356,268 inmates with severe mental illnesses in U.S. prisons and jails during the same period there were only 35,000 mentally ill individuals in state psychiatric hospitals."(ii)

However astonishing these statistics are, they are not inconsistent with the larger challenge communicated by the executive leadership of the Large Jail Network…***That our jails have become de facto mental health facilities*** as a result of our failure to recognize that we have a growing public health policy crisis in this country that needs to be addressed. And, it did not necessarily involve the arresting and incarceration of individuals with mental health disorders.

These figures did not include the significant number who suffer from other potentially disabling disorders such as serious anxiety disorders, including PTSD; non-psychotic mood disorders; impulse control disorders; cognitive impairment disorders; and the large number having substance use disorder as the only diagnosis.

Mental illness is exacerbated by incarceration, and deterioration of the mentally ill's condition is further hastened by segregation, to which they are disproportionately sent. The mentally ill are often incarcerated as a direct result of the symptomatic behaviors associated with a lack of proper medication and/or behavioral interventions. Mentally ill inmates are frequently unable to comprehend or properly follow staff directions. Historically, correctional staff in jails, by and large, are not normally trained to intervene effectively with the mentally ill. If a mentally ill inmate acts out in a manner that is unsafe or threatening to themselves or others, jail staff may employ force unnecessarily as a means of compliance, rather than a trained, informed approach that would diminish the perceived need for the use of force. Many agencies rely solely on medical or mental health providers to properly identify behavior with an associated mental health disorder. They also have to provide the best course of treatment to de-escalate the inmate immediately and then follow up with a clinically determined longer termed path towards acceptable behavior.

Continuity of care upon confinement from and release to the community is a critical component to addressing the needs of the justice involved mentally ill. Lapses in treatment or medication, availability of treatment programs, relationships with community providers, and physical plant and fiscal limitations, are all challenges agencies face en masse in affecting a wide spectrum approach to the justice involved mentally ill.

NIC Mental Health Jail Assessment Findings:

In response to the dramatic increase of requests for technical assistance and training to address the challenges of an expanding population of justice involved mentally ill inmates in jails, the NIC has conducted numerous behavioral and operational assessments in institutions across the nation. The sheer number of request for and interest in technical assistance and training related to the mentally ill, indicate the stark realization by justice system agencies across the country that local criminal justice systems and staff require an updated approach to managing their justice involved mentally ill populations with thoughtfulness and fidelity in the face of evidenced based practices, scientific fact, and public opinion.

- ✓ The mentally ill inmates are overrepresented in segregated housing.
- ✓ The correctional staff is not normally trained to intervene effectively with the mentally ill, so they isolate them.
- ✓ Incarceration exacerbates the symptoms of mental illness – segregation hastens deterioration.
- ✓ Mentally ill offenders are better housed in units with access to open space (e.g. dayrooms and outside recreation), and with staff who are informed about their conditions and needs.
- ✓ Upon booking and intake, the mentally ill are often unable to comprehend or follow the correctional staff directions.
- ✓ A use of force is traditionally used to get mentally ill inmates to comply with movement or general directions (changes in housing, orders to shower or clean their cells).
- ✓ Some jails do not refer to prior classification records to put the inmate's "story" together.
- ✓ Staff repeatedly asks the same questions each time the inmate is processed as a new intake.
- ✓ Mentally ill inmates are often not able to recall their history (medication names or dosage, address, next of kin)
- ✓ The mentally ill are booked in after periods of not taking their medication.
- ✓ The lack of medication may have led to the behavior(s) which led to the arrest.
- ✓ Staff must determine if there was a lack of medication or noncompliance.
- ✓ Many of the mentally ill have a dual diagnosis (co-occurring mental illness and substance abuse).
- ✓ The mentally ill are not suited for jail unless their criminogenic behaviors demand incarceration.
- ✓ They are better suited in the community with proper housing, case management, and medication.
- ✓ Diversion to community-based care is a better option.
- ✓ The mentally ill are often returned to the community with no treatment plans or housing.

NIC is uniquely positioned to be a driving force in the development of new innovative approaches geared toward reducing offender recidivism and criminal victimization. NIC provides training and technical assistance to states and local jurisdiction which often serve as the "testing ground" for innovative correctional reforms. Currently, NIC is directly engaged in a host of efforts designed to build a knowledge base on "what works" in corrections across multiple states and local sites.

FY17-18 Expanded Services to the Field:

- **Evidence-Based Decision Making Model (EBDM).** NIC began the Evidence-Based Decision Making in Local Criminal Justice Systems Initiative in 2008. The overarching goal was to create a framework for justice systems that will result in improved system outcomes through true collaborative partnerships, systematic use of research, and shared vision of desired outcomes. EDBM principles include:
  - The professional judgement of criminal justice system decision makers is enhanced when informed by evidence-based knowledge.
  - Every interaction within the criminal justice system offers an opportunity to contribute to harm reduction.
  - Systems achieve better outcome when they operate collaboratively.
  - The criminal justice system will continually learn and improve when professionals make decisions based on the collection, analysis, and use of data and information.

  Currently, NIC supports 21 EBDM sites in Wisconsin, Indiana and Virginia. Many of which have notable accomplishments with regards to addressing issues of mental illness through utilization of the EBDM Model with NIC's direct technical assistance. Currently, NIC has suspended funding for new sites pending budget authorization.

- **Medication Assisted Treatment.** NIC recently partnered with the Office of National Drug Control Policy and the Bureau of Justice Assistance and has developed the Promising *Practice Guidelines for Medication Assisted Treatment* publication to be released this spring. This document is in the final review stages and I want to publically thank Commission Member Sheriff Brown for his attendance and significant contributions at the vetting roundtable meeting in Washington D.C. last month. NIC has recently begun providing technical assistance, training and peer-to-peer learning vehicles to assist counties in response to the national opioid epidemic. NIC believes that it is crucial that correctional care providers become trained in Medication-Assisted Treatment (MAT), an approach that uses FDA-approved pharmacological treatments, often in combination with psychosocial treatments, for patients with opioid use disorders. Nationally, there is currently 47 BJA grant funded, Residential Substance Abuse Treatment Program, jails and a dozen aftercare programs that have pioneered the development of medication assisted treatment (MAT) reentry initiatives.

- **Centers of Innovation (COI) Network.** To meet this expanded need for technical assistance and training for jails and local justice systems, NIC has established the COI Network consisting of an initial consortium of regional pilot sites. COIs are typically affiliated with a locally accredited university, work closely with the corrections community to develop customer-driven, innovative tools and technologies to address the needs of the justice involved mentally ill offender, and have a close working relationship with the local justice systems and mental health services. The following outlines pilot sites with existing medical-assisted treatment (MAT) programs, or sites that demonstrated the capacity to implement a MAT program, were given particular consideration for selection as COI Jail MAT Programs:

  - Barnstable, MA House of Correction: Pioneering and now mature reentry MAT program with two major aftercare providers integrated into a model evidence-based treatment program; has served as a host site training program.

- Montgomery County, Maryland Correctional Center: Pioneering and now mature reentry MAT program, with evidence-based in house substance abuse treatment programming
- Sacramento County, California Jail MAT Program: One-year-old MAT reentry program, one of four in California with impressive initial performance data. Recently, served as a host site training program.
- Middlesex, MA House of Correction MAT program: Overcoming initial false start, is building MAT reentry program for mostly self-referred inmates, collaborates with local drug court to serve its clients pre and post adjudication; has served as host site program.

An agency using an evidenced-based intervention such as MAT, in conjunction with a symbiotic relationship with community pharmacotherapy providers, has the potential to impact significantly the rate of rearrests and re-incarceration as well as criminal justice system and societal costs.

- **Stepping Up Initiative-NIC Technical Assistance:** The Stepping Up Initiative is a national initiative to help advance counties' efforts to reduce the number of adults with mental and co-occurring substance use disorders in jails. Nearly 340 counties have pledged themselves to the six goals of the Stepping Up Initiative and NIC is commited to supporting these counties. The National Institute of Corrections (NIC), Bureau of Justice Assistance (BJA), Council of State Governments (CSG), National Association of Counties (NACo), and the American Psychiatric Association Foundation (APAF) are working in collaboration to leverage NIC's technical assistance, training, and peer-to-peer learning vehicles to support counties in their efforts to reduce the prevalence of people with mental illnesses.

- **Crisis Intervention Teams (CIT) Training.** CIT is offered as a regional 40-hour training, which provides the host agency with 30 certified CIT staff. The focus of CIT is to teach correctional officers about the signs and symptoms of mental illness, how to de-escalate mentally ill inmates in crisis, how to get the inmate to the proper mental health or medical services, and how to utilize community-based mental health services.
    a) The NIC Jails Division will provide 12 regional offerings of this course a year.
    b) Mental health advocacy is a major component of the CIT training.
    c) NIC parallels this training with the agency's administrative staff, to prepare them to replicate the CIT training on their own.
    d) NIC has partnered with the Texas Sheriff's Association and Sam Houston to implement a certified training for trainers program for 48 trainers from 11 jurisdictions that will deliver the training throughout the 254 counties in Texas.

- **Veterans Trauma Informed Care.** NIC has partnered with the U.S. Department of Veterans Affairs, to develop a Justice-Involved Veterans Network as an effective means for professionals to share information, germinate ideas, provide a repository for information and educate stakeholders (throughout the continuum of criminal justice. NIC conducted an initial focus group session in June with a broad array of representatives from law enforcement, courts, jails and prisons to identify key strategies which include: 1) Enabling and supporting data-informed approaches; (2) Identification and promotion of crucial operating features of excellence; 3) and Encouragement of enhanced communication, coordination and commitment. NIC has been providing the Veterans Treatment Courts with direct technical assistance and is committed to the development of a Veterans Trauma Informed Care training curriculum to address the responsivity issues for veterans entering the court system.

a) NIC is prepared to provide agencies with direct technical assistance in support of planning, implementing and program assessments for jail based veteran pods.

- **Planning and Implementing Mental Health Services in Jails.** A eleven (11) module course designed to help jail administrators, mental health directors and treatment providers design and implement comprehensive mental health services.
    a) The course was vetted in July 2016 by 20 mental health, medical, security and administrative jail practitioners from across the country.
    b) NIC has partnered with the Florida Sheriffs Association to offer numerous sessions as needed throughout FY17-18.

- **Mental Health Assessment Services-Technical Assistance.** The Jails Division responds to technical assistance requests for both system and facility mental health assessments.
    a) Several of the technical assistance requests have led to CIT and suicide prevention training.
    b) Texas Mental Health Initiative for Jails is a collaboration in which NIC and SAMHSA worked closely with the Texas Sheriffs' Association, Texas Commission on Law Enforcement and the Texas Jail Standards Commission and enhanced the mental health training standards for certification from 8 hours to 24 hours.
    c) It is important to note that mental health assessments often require a concurrent assessment of mental health and medical operations.

- **Detention Services for Women**. A planning meeting was held by the NIC in September 2016 with three national experts to begin the development of a training program which utilizes a Trauma Informed Care approach for women housed in jails and detention centers.
    a) A major component of this training will be on the mental health needs of women.
    b) A forum was held in September 2016 with jail practitioners from across the country to examine this issue further and to identify the specific training needs for staff that work with this population.

I want to thank you for the opportunity to be here to today, to share with you NIC's assessments and what we have found to be most effective in addressing mental health and co-occurring disorders in jails. It is our commitment to support your efforts and develop a collaborative, timely and responsive service to you utilizing these promising practices.

REFERENCES

[i] Steadman, Henry, et al., "Prevalence of Serious Mental Illness among Jail Inmates." Psychiatric Services 6o, no. 6 (2009): 761-765.

[ii] Lamb, Eslinhger, et. al., "The Treatment of Persons With Mental Illness in Prisons and Jails: A State Survey." Joint Report, (2014) National Sheriffs Association and the Treatment Advocacy Center, TACReports.org/treatment-behind-bars

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February 9, 2017

Jennie M. Simpson, Ph.D.
Office of Policy, Planning, and Innovation
Substance Abuse and Mental Health Services Administration (SAMHSA)
5600 Fishers Lane, Rm 18E85D
Rockville, MD 20852

Dear Dr. Simpson:

The Mental Health Services Oversight and Accountability Commission invites you to participate in the Commission's public hearing on Thursday, March 23, 2017, in San Diego, California. Your participation will assist the Commission in developing an action agenda to reduce the number of adults with mental health needs who become justice-involved, and improve outcomes for those in custody and upon release into the community.

Your panel presentation is scheduled for approximately 11:00 am. Please plan on speaking for approximately 10 minutes, specifically in the areas of:

- The work of the Substance Abuse and Mental Health Services Administration (SAMHSA) on the behavioral health and criminal justice intersection, and the latest in terms of what is known to work for justice-involved adults with mental health needs, particularly with regards to community-based crisis services delivery.
- The characteristics of state and local systems that support diversion at multiple "touch points", and examples of effective models or approaches.
- Current or planned training and technical assistance support for counties and states interested in implementing best practices.

We ask that you please send a brief biography and written responses to the items above by Monday, March 13, 2017, to Ashley Mills (ashley.mills@mhsoac.ca.gov). Your written responses will allow those Commissioners attending the meeting the opportunity to prepare questions for you after your presentation, and will be available for those Commissioners unable to attend the meeting. Please note that your written responses and biography will be shared as public documents.

Should you have any questions, I can be reached at toby.ewing@mhsoac.ca.gov or 916.445-8696. Thank you again for your willingness to participate in this important meeting.

Respectfully,

Toby Ewing

Toby Ewing, Ph.D.
Executive Director

Jennie Simpson, SAMHSA : Panel Presentation Written Remarks

Prepared for the Mental Health Services Oversight and Accountability Commission

I. The work of SAMHSA on the behalf of the behavioral health and criminal justice intersection, and the latest in terms of what is known to work for justice-involved adults with mental health needs, particularly with regards to community-based crisis service delivery.

a. Agency Characteristics

SAMHSA is the agency within the Department of Health and Human Services that leads public health efforts to advance the behavioral health (mental illness and substance use) of the nation. Congress established SAMHSA in 1992. Since that time, SAMHSA has been:

- Helping Americans find and access quality treatment for people with mental and substance use disorders;
- Developing and managing programs and policy initiatives designed to reduce the impact of behavioral problems on individuals, families and communities;
- Developing and launching campaigns to increase awareness of prevention, treatment and recovery in mental health and addictions;
- Funding block grants to states to support services for people with serious mental illness and youth with serious emotional disorders, and individuals with substance use disorders;
- Collecting, analyzing and disseminating behavioral health data to inform public policy; and
- Supporting the implementation of evidence-based practices to translate research to practice and policy.

SAMHSA's mission is to reduce the impact of substance use and mental illness on America's communities. The agency's efforts aim to increase effective prevention, treatment and recovery support services for the millions of people within the U.S. with a mental and/or substance use disorder.

SAMHSA leads efforts at the national level through six main roles:

- Serve as a national voice to create a behavioral health system that better meets the needs of individuals, communities, and providers;
- Inform policy and program decision-making with critical data from evaluation and surveillance;
- Ensure the delivery of state-of-the-art services by supporting innovation and practice improvement;
- Promote the importance of behavioral health and wellness with traditional and digital awareness campaigns and public education;
- Protect public health, privacy, and patients' rights by supporting regulation and standard setting; and
- Help behavioral health systems to produce measurable results through strategic grant making.

SAMHSA operationalizes these roles through six Strategic Initiatives:

- Prevention of Substance Abuse and Mental Illness
- Health Care and Health Systems Integration
- Trauma and Justice

- Recovery Support
- Health Information Technology
- Workforce Development

b. SAMHSA's Criminal Justice Portfolio

SAMHSA's criminal justice grants, programs, and policy initiatives are planned and coordinated under the leadership of the Trauma and Justice Strategic Initiative. This initiative addresses the behavioral health needs of people involved in - or at risk of involvement in - the criminal justice system. Additionally, it provides a comprehensive public health approach to addressing trauma and establishing a trauma-informed approach in health, behavioral health, human services, and related systems, including criminal justice. The intent is to reduce both the observable and less visible harmful effects of trauma and violence on children and youth, adults, families, and communities.

SAMHSA has a significant investment at the intersection of criminal justice and behavioral health, supporting justice-involved individuals with mental and substance use disorders, criminal justice practitioners and behavioral health providers. The framework for SAMHSA's criminal justice work is the **Sequential Intercept Model**. This model identifies five key points for "intercepting" individuals with behavioral health issues, linking them to services and preventing further penetration into the criminal justice system. This model:

- Builds on collaboration between the criminal justice and behavioral health systems;
- Highlights points to intercept individuals as they move through the criminal justice system;
- Identifies critical decision-makers who can authorize diversion from the justice system and into treatment; and
- Delineates essential partnerships among mental health, substance abuse, law enforcement, pre-trial services, courts, judges, jails, community corrections, social services, and others.

At the first intercept, SAMHSA's efforts are focused on early diversion and prevention. SAMHSA funded multiple cohorts of Jail Diversion programs to nearly every state and awarded Law Enforcement and Behavioral Health Partnerships for Early Diversion grants whose aim was to divert people with mental health, substance use, or co-occurring disorders from the criminal justice system at the earliest opportunity into community-based service alternatives without the leverage of the court.

At the third intercept, SAMHSA has funded multiple cohorts of treatment courts across the country. This includes Behavioral Health Treatment Court Collaboratives, Adult and Youth Drug Treatment Courts, Family Treatment Courts, and Tribal Healing to Wellness Courts. Using the levereage of the court, these grantees have diverted thousands of individuals from detention, jails and prisons into mental and substance use treatment.

SAMHSA continues to use innovative and emerging state of the art practices in its portfolio of treatment court grantees. Grantees are trained in trauma informed approaches and are encouraged to use up to 20% of their grant funding for medication assisted treatment.

At the fourth intercept, the Offender Reentry Program expands and enhances substance use treatment services for individuals reintegrating into communities after being released from correctional facilities. These grantees can use funding for trauma-informed approaches and medication assisted treatment and also incorporates the evidence-based Risk-Needs-Responsivity approach to rehabilitation. The RNR Simulation Tool, a web-based tool designed to assist agencies in determining the most effective strategies in reducing recidivism, improving outcomes within their population, identifying service gaps, and guiding resource allocation.

c. Best Practices in Crisis Services and Behavioral Health Interventions for Justice-Involved Individuals with Mental and Substance Use Disorders

Current thinking about the intersections of behavioral health and criminal justice has led to the conceptualization of "Intercept 0," as community-based services that prevent and intervene prior to justice-involvement. Robust crisis services can prevent entry into the criminal justice system for individuals with mental and substance use disorders. The primary goals of crisis services are to stabilize and engage individuals in the most appropriate treatment services. The following crisis services have been developed and adopted in local jurisdictions across the United States, with some empirical evidence on their effectiveness. For research related to crisis services, see "Crisis Services: Effectiveness, Cost-Effectiveness, and Funding Strategies," SAMHSA, 2014.

- Crisis stabilization, detoxification or psychiatric emergency programs provide short-term (24-72 hours) stabilization for individuals in crisis and may include detoxification. The primary objectives include psychiatric assessments, stabilization and determination of an appropriate level of care.
- Community respite programs and crisis residential services offer 1-2 week psychiatric stabilization as an alternative to hospitalization. Programs offer psychiatric, peer, and recovery support services in a community residential setting.
- 24/7 Crisis hotlines are direct services delivered via telephone to a person in crisis. The goal of a crisis hotline is to reduce immediate distress and support callers in developing a plan for coping with their situation or identifying other resources to provide assistance.
- Mobile crisis services provide acute mental health crisis stabilization and psychiatric assessment to individuals in the community. Mobile crisis teams are staffed by behavioral health professionals, including peer specialists.
- Peer crisis services are delivered by people with lived experiences of mental illness or substance use disorders. Services are provided in calming environments and connect individuals with community-based services and supports.
- Warm lines are telephone hotlines staffed by peer specialists. Unlike a crisis hotline, warm lines are for individuals not in acute distress, but rather provide supports prior to a potential crisis situation.

Community-based behavioral health services and interventions specific to the justice-involved population include Forensic Assertive Community Treatment (FACT), Forensic Intensive Case Management (FICM), and Medication Assisted Treatment. It should be noted that more research is needed on the identification and effectiveness of treatment modalities specific to justice-involved populations.

FACT is modeled on Assertive Community Treatment (ACT),[i] an evidence-based treatment modality that provides intensive behavioral health services to individuals with serious mental illness through multidisciplinary teams comprised of psychiatrists, psychologists, social workers, nurses, substance abuse counselors, vocational rehabilitation specialists, service coordinators, and peer support specialists. Services are delivered in situ, available 24 hours, and participation is time unlimited for individuals assigned to ACT/FACT. Research on ACT has been demonstrated to be effective in randomized controlled trials,[ii] but research on FACT has found mixed results.[iii] Some studies have found that participation in FACT is associated with positive short- and long-term criminal justice outcomes, including reduced re-arrests, convictions, and jail days and improved clinical outcomes, including reductions in substance use and hospitalizations.[iv]

FICM provides less involvement by providers than FACT programs, but similarly, collaborative teams of treatment professionals offer behavioral health services in the community. Participation in FICM has demonstrated outcomes in reducing violent offending, re-arrest, and jail days and longer community

tenure.[v] As with FACT, the research shows mixed results at this time, with some studies finding neutral or negative outcomes.[vi]

Medication-assisted treatment (MAT), including opioid treatment programs (OTPs), combines behavioral therapy and medications to treat substance use disorders and is effective in the treatment of substance use disorders, and can help some people to sustain recovery.[vii] Benefits of MAT for justice-involved populations may include reductions in all-cause mortality, reduction in HIV risk, improved adherence to medical treatment, improved social function, and decreases in criminal activity and drug use. Additionally, continuing MAT during a brief incarceration increases the likelihood that upon release, people will return to their community-based treatment program. Starting MAT during incarceration can reduce opioid use post-release and increase rates of entering treatment after release.[viii]

For justice-involved individuals with mental and substance use disorders, housing instability may impact the delivery of treatment services in the community. Supportive housing combines subsidized housing and support services and can be used in conjunction with community-based treatment modalities such as FACT and FICM.

II. The characteristics of state and local systems that support diversion at multiple "touch points" and examples of effective models or approaches.

Approximately 2 million individuals with mental disorders enter jails annually. In the most comprehensive survey to date, the Bureau of Justice Statistics found that 74% of state prisoners, 63% of federal prisoners and 76% of jail inmates met the criteria for a mental health disorder. An estimated 42% of state prisoners and 49% of jail inmates met the criteria for both a mental health and substance use disorder. From this same data set, among prison and jail inmates, almost half had ever received mental health treatment and only a third of individuals received any treatment after prison or jail admission. Data from SAMHSA's National Survey on Drug Use and Health shows that among adults with and without serious mental illness, a significantly higher proportion of people with a serious mental illness reported recent criminal justice involvement or being arrested at some point in their lives.

At each intercept of the Sequential Intercept Model, there are programs and practices that have been demonstrated to increase diversion opportunities and provide best available care to justice-involved individuals. It should be noted that the research base is still growing on diversion programs and practices, so at this time there are few "evidence-based practices."

Successful diversion of individuals with mental and substance use disorders from the criminal justice system has been demonstrated by local jurisdictions that have adopted a comprehensive array of crisis and diversion services across the Sequential Intercept model.

Intercept 1: Law Enforcement

At Intercept 1, specialized police-based response models, including Crisis Intervention Teams (CIT), co-responder models, and police-led substance use diversion, have been adopted by jurisdictions across the country. With these models, diversion occurs at the initial contact between law enforcement and an individual in the community. The goal is to divert an individual from entrance to the criminal justice system, if appropriate, provide connection to treatment services in lieu of arrest for minor offenses, and reduce the likelihood of injury to the officer and individual. Collaboration between law enforcement and community-based behavioral health service providers is a critical element for successful diversion to treatment services.

CIT programs have been adopted by approximately 3,000 law enforcement agencies. Also known as the "Memphis Model," the CIT model includes 40-hours of training for law enforcement officers,

partnerships with behavioral health providers, and collaboration with people with lived experience, families, and advocates. A robust community-based behavioral health system, including crisis response services increases the likelihood of successful diversion outcomes for CIT.

Co-responder models pair law enforcement officers and behavioral health professionals to respond to calls for service involving individuals with mental and substance use disorders. Portland (ME) Police Department utilizes a co-responder model and is nationally recognized as Law Enforcement Learning Site by the Bureau of Justice Assistance.

Police-led substance use diversion models are increasing in adoption across the United States as communities respond to the current increase in opioid use disorders and overdose-related deaths. The common characteristic of models across the country is referral to treatment in lieu of arrest. Law Enforcement Assisted Diversion (LEAD) and the Gloucester (MA) Angel program are among the most well-known models.

Intercept 2: Initial Detention/Initial Court Hearings

Studies have found that individuals with mental and substance use disorders may be excluded from or given less access to pretrial release and deferred prosecution when compared to other defendants.[ix] After arrest, initial detention and initial court hearings provide the opportunity for formal assessment and diversion from standard prosecution, if appropriate, for individuals with mental and substance use disorders or co-occurring mental and substance use disorders. Diversion at Intercept 2 includes coordination between criminal justice personnel involved with the initial detention, including local law enforcement (including the Sheriff's Office), local jail staff, and court personnel involved with initial hearings, including the prosecutor's office, public defender's office, probation department, pre-trial services, and district judges. Opportunities for pretrial release and assistance in treatment compliance should be maximized.

Screening and assessment for mental illness, substance use disorders, co-occurring disorders, trauma and criminal risk at the earliest opportunity increases the likelihood of diversion opportunities and connection to treatment services. The use of a validated tool ensures reliability and accuracy in the screening and assessment of an individual. Miami-Dade County, Florida has post-booking jail diversion programs for misdemeanors and felonies. Program participants meet with court case management specialists that link them to community-based treatment, social supports, and housing services. Legal charges may be dismissed or modified based on treatment engagement.

The empirical base on the effectiveness of post-booking and pre-trial diversion is limited and needs further development.[x] For more information on diversion at the pretrial stage, see "Improving Responses to People with Mental Illness at the Pretrial Stage," Council of State Government Justice Center.[xi]

Intercept 3: Jails/Courts

Specialty or problem solving courts are the most common diversion strategy at the third intercept. These courts have a separate docket and a dedicated judge, prosecution, and defense counsel. Participation is voluntary and defendants agree to a course of treatment. If an individual successfully complies with treatment, charges may be dismissed or reduced.

Drug courts are the most common specialty courts, and this model has been adapted by other problem solving courts, including mental health courts, tribal wellness courts, veterans' courts, and domestic violence courts. The focus of these courts is to address the underlying mental health and substance use issues and related needs of individuals by using the judicial leverage of the court to connect them with treatment and other alternatives to incarceration. Research has demonstrated that drug courts result in reductions in recidivism and increased connection to services and support.[xii] Drug courts can help reduce

substance use through early, continuous, and intense judicially supervised treatment, mandatory periodic drug testing, and the use of appropriate judicial sanctions and linkage with other services and supports.

Research on the effectiveness of mental health courts is still in a nascent period, but recent studies have shown positive reductions in recidivism and increased participation in community-based treatment.[xiii] [xiv]

Hundreds of drug courts and other problem-solving courts exist across the United States. The National Association of Drug Court Professionals has identified best practice standards for drug courts.[xv] Similarly, the Council of State Governments Justice Center has developed the essential components of a mental health court.[xvi]

In FY15, among participants in drug courts funded by SAMHSA's Grants to Expand Substance Abuse Treatment Capacity in Adult Drug Courts, the percentage of individuals who reported that they did not use alcohol or illegal drugs within the past 30 days increased by 28% from intake to 6-month follow-up.

For more information, see SAMHSA's publication, "Municipal Courts: An Effective Tool for Diverting People with Mental and Substance Use Disorders from the Criminal Justice System." [xvii]

Intercept 4: Reentry

In one study of re-incarceration among individuals with mental and substance use disorders, researchers found a 54% re-incarceration rate for people with severe mental illness, 66% for individuals with substance use problems, and 68% for those with a co-occurring mental and substance use disorder.[xviii] The complexity of treatment needs and social supports for individuals with mental and substance use disorders returning to their communities from jails or prisons requires coordinated planning between correctional staff and community-based providers. Reentry is a general term that includes all pre-release institutional coordination and community-based programming following release from jails or prisons.

The National Reentry Resource Center,[xix] funded by the Bureau of Justice Assistance (U.S. Department of Justice) hosts the What Works Clearinghouse. This clearinghouse offers access to research on the effectiveness of reentry programs and practices and assists practitioners and policymakers in understanding and implementing evidence-based practices in reentry.

SAMHSA's Offender Reentry Program has funded grants in communities that have demonstrated successful outcomes. For example, the percentage of clients who reported no arrests within the past 30 days increased by 19% from intake to 6-month follow-up. Additionally, the percentage of clients who reported no arrests within the past 30 days increased by 19% from intake to 6-month follow-up.

Intercept 5: Community Corrections

Studies have found that individuals with mental illness and co-occurring mental and substance use disorders under community supervision have a higher likelihood of having their community sentences revoked.[xx] One strategy to improve community tenure under probation and parole for individuals with mental and substance use disorders is specialized community corrections programming. These programs have a reduced caseload and include relevant training for officers. In a review of the literature, Manchak et al found that specialty programming is associated with improved clinical and criminogenic outcomes for individuals with mental illness.[xxi] The National Institute of Corrections has a number of resources available on its website at http://nicic.gov/mentalillness.

National Initiatives to Reduce Incarceration of Individuals with Mental and Substance Use Disorders in the Criminal Justice System and Improve Outcomes

Two national initiatives – the Data Driven Justice Initiative and the Stepping Up Initiative – provide technical assistance and support to local jurisdictions to reduce the number of individuals with behavioral health issues in jails. Both initiatives offer promising and evidence-informed strategies that cities and counties can adopt. SAMHSA supports the goals and strategies of both initiatives, including:

- The use of data integration and analysis to: 1) identify high utilizers of multiple service systems, including behavioral health and criminal justice, and 2) support local jurisdictions in developing coordinated and comprehensive care to reduce repeated cycling between systems.
- Use of Stepping Up's blueprint document, "Reducing the Number of People with Mental Illnesses in Jail: Six Questions County Leaders Need to Ask."

III. Current or planned training and technical assistance support for counties and states interested in implementing best practices.

SAMHSA recognizes the importance of reducing the number of individuals with mental and substance use disorders in the criminal justice system, as well as improving outcomes for individuals with serious mental illness, many of whom experience increased rates of hospitalization, homelessness, and arrest.

SAMHSA funds the GAINS Center for Behavioral Health Transformation and Justice which focuses on expanding access to services for people with mental and substance use disorders who come into contact with the justice system.[xxii] The GAINS Center provides publications, resources, and technical assistance opportunities for behavioral health providers and criminal justice practitioners. Some opportunities include Trauma Training for Criminal Justice Practitioners and Sequential Intercept Mapping Workshops.

As part of SAMHSA's support of the Data-Driven Justice Initiative, the Stepping Up Initiative, and the International Association of Chiefs of Police's One Mind Campaign, SAMHSA is convening a series of policy academies and strategic planning meetings to assist county teams in creating a diversion implementation plan for their jurisdiction. These efforts will also identify high utilizers in both systems and identify best strategies to reduce repeated use of jails and emergency rooms and engage these individuals in appropriate treatment.

The recently passed 21st Century Cures Act further advance the work of SAMHSA, including provisions relevant to SAMHSA's criminal justice programs.

As part of the Cures Act, new and existing grant programs are authorized or reauthorized including:

- Jail Diversion program with an emphasis on veterans
- Cooperative Agreements for the Benefit of Homeless Individuals
- Assertive Community Treatment grants
- Assisted Outpatient Treatment program
- Crisis Response Systems grant program to help communities develop or strengthen community-based crisis services

As funds are appropriated, SAMHSA will begin implementing these programs and developing relevant technical assistance opportunities.

[i] See http://store.samhsa.gov/product/Assertive-Community-Treatment-ACT-Evidence-Based-Practices-EBP-KIT/SMA08-4345

[ii] Heilbrun, Kirk, et al. "Community-based alternatives for justice-involved individuals with severe mental illness: Review of the relevant research." Criminal Justice and Behavior 39.4 (2012): 351-419.
[iii] Marquant, Thomas, et al. "Forensic assertive community treatment: a review of the literature." Community mental health journal 52.8 (2016): 873-881.
[iv] Ibid
[v] DeMatteo, David, et al. "Community-based alternatives for justice-involved individuals with severe mental illness: Diversion, problem-solving courts, and reentry." Journal of Criminal Justice 41.2 (2013): 64-71.
[vi] Ibid
[vii] See https://www.samhsa.gov/medication-assisted-treatment
[viii] http://www.rsat-tta.com/Files/Proceedings-for-MAT-for-Justice-Involved-Populatio
[ix] John Clark, "Non-Specialty First Appearance Court Models for Diverting Persons with Mental Illness: Alternatives to Mental Health Courts," February 2004, Retrieved from http://www.pacenterofexcellence.pitt.edu/documents/NonSpecialty%20First%20Appearance%20Court%20Models.pdf.
[x] Heilbrun, Kirk, et al. "Community-based alternatives for justice-involved individuals with severe mental illness: Review of the relevant research." Criminal Justice and Behavior 39.4 (2012): 351-419.
[xi] https://csgjusticecenter.org/wp-content/uploads/2015/09/Improving_Responses_to_People_with_Mental_Illnesses_at_the_Pretrial_Stage_Essential_Elements.pdf
[xii] Latessa, Edward J., and Angela K. Reitler. "What works in reducing recidivism and how does it relate to drug courts." Ohio NUL Rev. 41 (2014): 757.
[xiii] Honegger, Laura N. "Does the evidence support the case for mental health courts? A review of the literature." Law and human behavior 39.5 (2015): 478.
[xiv] Goodale, Gregg, Lisa Callahan, and Henry J. Steadman. "Law & psychiatry: What can we say about mental health courts today?." Psychiatric Services 64.4 (2013): 298-300.
[xv] See http://ndcrc.org/content/ten-key-components
[xvi] See https://www.bja.gov/publications/mhc_essential_elements.pdf
[xvii] http://store.samhsa.gov/product/Municipal-Courts-An-Effective-Tool-for-Diverting-People-with-Mental-and-Substance-Use-Disorders-from-the-Criminal-Justice-System/All-New-Products/SMA15-4929
[xviii] Amy Blank Wilson, Jeffrey Draineb, Trevor Hadley, Steve Metraux, Arthur Evans (2011). Examining the impact of mental illness and substance use on recidivism in a county jail. International Journal of Law and Psychiatry, v34, n4, July-August, p264-268
[xix] See https://csgjusticecenter.org/nrrc
[xx] Messina et al., One year return to custody rates among co-disordered offenders, Behavioral Sciences & the Law 22(4):503-18.2004
[xxi] Manchak, Sarah M., et al. "High-fidelity specialty mental health probation improves officer practices, treatment access, and rule compliance." Law and human behavior 38.5 (2014): 450-461.
[xxii] See https://www.samhsa.gov/gains-center

AGENDA ITEM 3

Action

March 23, 2017 Commission Meeting

San Diego County Innovation Plan Extensions (5)

Summary: The Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission) will consider approval of San Diego County's request to extend the following previously approved Innovative Projects for an additional eighteen months (18 months) each, totaling four and half years each, and an additional funding (see below for project breakdown), totaling $11,292,708:

1) ***Innovation 11 Caregiver Connection****- $1,485,250 (new project total $2,170,750)*
2) ***Innovation 12 Family Therapy Participation****- $4,309,646 (new project total $7,889,000)*
3) ***Innovation 15 Peer Assisted Transitions****- $3,152,591 (new project total $6,486,939)*
4) ***Innovation 16 Urban Beats****- $973,059 (new project total $2,183,672)*
5) ***Innovation 17 CREST Mobile Hoarding Units****- $1,372,162 (new project total $2,704,081)*

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.

San Diego County Innovation Mental Health Project extensions, propose:

1) Innovation 11 Caregiver Connection- proposes to extend the program for an additional eighteen months to allow time for increasing its sample size and developing a new comparative review for caregivers of youth ages 0-5 by expanding the program to caregivers of older youth ages 6-12 and 13-18.

2) Innovation 12 Family Therapy Participation- proposes to extend the program for an additional eighteen months and to increase the

sample size by adding a provider in six geographical regions to increase parent and caregiver engagement in their child's treatment through family therapy sessions in underserved communities.

3) Innovation 15 Peer Assisted Transitions- proposes to extend the program for an additional eighteen months, increasing its sample size, and to expand the program to a new location, a third crisis residential facility in Central San Diego, Jary Barreto.

4) Innovation 16 Urban Beats- proposes to extend the program for an additional eighteen months and increase its sample size in additional regions of the County in order to continue using multiple models of artistic expression provided by peers and Transition Aged Youth (TAY) to improve outcomes of severely mentally ill (SMI) TAY individuals.

5) Innovation 17 CREST Mobile Hoarding Units- proposes to extend their Mobile Hoarding Units program for an additional eighteen months to add the program in one new region of the County to continue using a well-supported best practice, peer support, and after care to reduce hoarding behaviors and improve mental health outcomes in older adults.

San Diego County requests authorization from the MHSOAC to fund these independent extensions, totaling the amount of $11,292,708.

Presenters:

Holly Salazar, MPH, Assistant Director, Departmental Operations for Behavioral Health Services.

Piedad Garcia EdD, LCSW, Deputy Director for the County of San Diego, Adult and Older Adult Behavioral Health Services (BHS).

Laura Vleugels, MD, Supervising Child and Adolescent Psychiatrist for the County of San Diego, Children, Youth and Families Behavioral Health Services .

Jeffrey Rowe, MD, Supervising Psychiatrist for the Juvenile Forensics Division of the County of San Diego Behavioral Health Services.

Michael Miller, LMFT, Behavioral Health Program Coordinator for the County of San Diego

Adrienne Collins Yancey, MPH, Mental Health Services Act Coordinator for the County of San Diego

Enclosures (10): (1) Staff Summary, Innovation 11 Caregiver Connection; (2) County Brief Innovation 11 Caregiver Connection; (3) Innovation 12 Family Therapy Participation; (4) County Brief Innovation 12 Family Therapy Participation; (5) Innovation 15 Peer Assisted Transitions; (6) County Brief Innovation 15 Peer Assisted Transitions; (7) Innovation 16 Urban Beats; (8) County Brief Innovation 16 Urban Beats; (9) Innovation 17 CREST Mobile Hoarding Units; (10) County Brief Innovation 17 CREST Mobile Hoarding Units

Handout(s): A PowerPoint(s) will be presented at the meeting.
Additional Resources: Innovation 11 Caregiver Connection -

http://mhsoac.ca.gov/document/2017-03/san-diego-county-inn-plan-description-caregiver-connections-additional-material

Innovation 12 Family Therapy Participation- http://mhsoac.ca.gov/document/2017-03/san-diego-county-inn-plan-description-family-therapy-participation-additional

Innovation 15 Peer Assisted Transitions- http://mhsoac.ca.gov/document/2017-03/san-diego-county-inn-plan-description-peer-assisted-transition-additional-material

Innovation 16 Urban Beats- http://mhsoac.ca.gov/document/2017-03/san-diego-county-inn-plan-description-urban-beats-additional-material

Innovation 17 CREST Mobile Hoarding Units- http://mhsoac.ca.gov/document/2017-03/san-diego-county-inn-plan-description-crest-mobile-hoarding-units-additional

Proposed Motion: The MHSOAC approves the requested extension of time and additional funding for San Diego County's Innovation Projects.

Name: Innovation 11 Caregiver Connection
Additional Amount: $1,485,250 (new project total $2,170,750)
Additional Project Length: 18 Months (new project length 4.5 years)

Name: Innovation 12 Family Therapy Participation
Additional Amount: $4,309,646 (new project total $7,889,000)
Additional Project Length: 18 Months (new project length 4.5 years)

Name: Innovation 15 Peer Assisted Transitions
Additional Amount: $3,152,591 (new project total $6,486,939)
Additional Project Length: 18 Months (new project length 4.5 years)

Name: Innovation 16 Urban Beats
Additional Amount: $973,059 (new project total $2,183,672)
Additional Project Length: 18 Months (new project length 4.5 years)

Name: Innovation 17 CREST Mobile Hoarding Units
Additional Amount: $1,372,162 (new project total $2,704,081)
Additional Project Length: 18 Months (new project length 4.5 years)

Mental Health Services
Oversight & Accountability Commission

Bios for San Diego County Innovation Presenters

Holly Salazar, MPH, is the Assistant Director, Departmental Operations for Behavioral Health Services. She previously held a strategic operations position within Scripps Health medical management leading the development of an Acute Electronic Medical Record and Hospital Meaningful Use. Prior to this, she was the Director of Strategic Outcomes for Community Health Improvement Partners in San Diego overseeing behavioral health, access to care and community needs assessments.

Piedad Garcia EdD, LCSW, is the Deputy Director for the County of San Diego, Adult and Older Adult Behavioral Health Services (BHS). Dr. Garcia oversees the mental health and substance use disorders system of care for adult and older adults across the County and serves as the Ethnic Services Manager. Dr. Garcia oversees the development and implementation for BHS and Primary Health Integration, the Faith-Based Initiative, the Supportive Housing and Employment Initiative, Transition Youth and Older Adult initiatives, for persons with serious mental illness and substance use disorders, BHS and justice system integration, and the integration of cultural competence standards in the mental health system.

Laura Vleugels, MD, serves as the Supervising Child and Adolescent Psychiatrist for the County of San Diego, Children, Youth and Families Behavioral Health Services. Having worked in public mental health for a decade, Dr. Vleugels promotes collaboration amongst organizations to best meet the needs of youth. In her role she regularly advocates for youth with behavioral health challenges who are involved in Probation, Child Welfare, Regional Center and Special Education.

Jeffrey Rowe, MD, is the Supervising Psychiatrist for the Juvenile Forensics Division of the County of San Diego Behavioral Health Services. He has served the County in various capacities over the past 20 years including as a clinical supervisor, special evaluator for the Juvenile Court, administrator, and clinical consultant. In addition, Dr. Rowe is a Clinical Associate Professor in Psychiatry for the UCSD School of Medicine.

Michael Miller, LMFT, has worked as a Behavioral Health Program Coordinator for the County of San Diego since August 2015. He oversees and monitors County contracted Children, Youth and Family programs in the North Coastal, North Inland and East regions. Prior to this he had worked for a large non-profit agency with County contracted programs since 2003, providing school and community based specialty mental health services as a therapist and then as a program director.

Adrienne Collins Yancey, **MPH**, has served as the Mental Health Services Act Coordinator for the County of San Diego since November 2013. In her role she is responsible for community engagement activities around the development of the County's plan for spending of MHSA funding for treatment services for persons with serious mental illness and mental health prevention programs. She has over 26 years working in the fields of public health, mental health, and social services.

STAFF INNOVATION SUMMARY— SAN DEIGO

Name of Innovative (INN) Project: INN – 11 Care Giver Connection to Treatment

Total INN Funding Extension Amount Requested: $1,485,250

Duration of Extension: Eighteen Months (18) Months

Review History

MHSOAC Original Approval Date: 2/16/2015

Original Program Dates: 7/1/2015 - 6/30/2018 Three (3) years

Original Budget: $685,500

Percentage of change: 216.67%

Project Introduction:

San Diego County proposes to extend their Care Giver Connection to Treatment program for an additional eighteen months and to increase its funding by $1,485,250 to allow time for increasing its sample size and developing a comparative review for youth ages 0-5 by expanding the program to older youth ages 6-18. The County identified the need to support caregivers of children/youth receiving mental health services from providers onsite through their local planning process and a review of literature.

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 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 original primary purpose was to increase access to services for underserved groups. The group identified were parents and other caregivers of children ages 0-5 with complex emotional, behavioral and developmental issues receiving services within the local mental health system.

The primary purpose of the extension is to expand the current project model to parents and other caregivers of children to two additional sub-populations of caregivers for older youth: latency age youth, 6-12 years old, and adolescent age youth, 13-18 years old, with complex emotional, behavioral and developmental issues receiving services within the local mental health system.

The County stated that the expansion of support to the two subdivisions will allow for a better opportunity to examine how the support of caregivers impact the outcomes of treatment for youth of varying ages and improve their confidence in sustaining the program through an alternative funding source. The County states the request does not include any changes to the approved purpose, expected outcomes, or operation of the program. The County states they will not make any no substantive changes to the screening, education and treatment model for the project. The County may wish to expand given research demonstrated parenting styles vary for children ranging from age 0-5, up to the age of 18. Furthermore, the emotional, behavioral, or developmental needs of children and youth also vary which may affect the mental health needs of their parents/caregivers. These variations could lead to a change in purpose, expected outcomes or the general operation of the program, which the County will need to clarify.

Given San Diego is currently 18 months into the original timeframe for their program, the County may wish to share results that have led to this extension and how the increase in time and funding to bring in additional sub-populations will not change their learning objectives.

The Response

The original program was approved for Innovation funds to place Parent Care Coordinators in clinical settings to provide motivational interviewing, education, and linkage to parents/caregivers of children ages 0-5, receiving services, to support parents/caregivers to obtain their own treatment. The County seeks to expand this successful program to parents/caregivers of older children/youth up to the age of 18. Over the years, other counties have utilized Medi-Cal expansion, Prevention and Early Intervention, and other funding sources to provide similar services within their children and youth system of care. Given the success of this program, the County may wish to discuss how moving this program to Prevention and Early Intervention (PEI) for continued funding, as oppose to extending the Innovation program, can lead to increased data they are seeking.

The County states that the initial findings of the program have been successful. The current program projected a goal of screening 200 caregivers and connecting 100 caregivers annually. In 18 months, the County has achieved the goal of screening 200 caregivers and have linked 24 caregivers to services. They still have eighteen more months on the original Innovation plan to continue the successful program. They have served a diverse population which helped facilitate the County to identify various cultural impacts and continue to obtain positive feedback, including an award. The County states the sample size is limited in duration and scope and wants to expand their timeframe to collect data for an additional 18 months and increase their sample size to 600 caregivers screened and 300 caregivers connected annually through additional staffing. The County may wish to explain what aspect of their evaluation still needs support given their current

time frame and sample size has demonstrated positive results and have addressed their learning objectives. The County may wish to discuss the value added with expanding the sample size.

The Community Planning Process

The MHSA regulations indicate the stakeholder participation should be present at every step of the way for Innovation Projects, including the Community Planning Process (CPP). Counties should provide training where needed to ensure meaningful participation by consumers with serious mental illness and/or serious emotional disturbance and their family members in the CPP. This subsection should clarify what evidence the County presents for meeting this requirement.

San Diego County stated they held a focus driven CPP meeting to discuss four major topics: Children's Behavioral Health; Unserved/Underserved; Care Coordination; and the proposed concepts for Innovation projects. The County engaged 551 community members and providers at twelve regional forums, and more than 100 representatives from targeted populations (i.e. Native American, Southeastern San Diego Community, Justice Partners, Male and Female incarcerated individuals and Peer Workers, who attended six focus groups. These meetings consisted of more than 650 participants and were held from August 2016 to October 2016. The outcome was to extend several of San Diego County Innovation programs.

The County may wish to provide more information on how it developed the idea to request an extension of this program throughout its Community Planning Process.

Learning Objectives and Evaluation

This section addresses the degree to which the County has a plan to evaluate the Innovative Project, including: (a) expected outcomes of Innovation, (b) how and at what frequency outcomes will be measured, (c) how outcomes relate to the Innovation's primary purpose, (d) how the County will assess which elements of the Innovation contributed to positive outcomes, and (e) how, if the County chooses to continue it, the project work plan shall transition to another category of funding, as appropriate.

San Diego states their original project anticipated learning new approaches to supporting parents/cargivers of children with serious mental illness/ serious emotional disability (SMI/SED), the improved outcomes of children when their caregiver is linked to services, the cultural preference, and the effect of providing support to caregivers varies with age ranges.

The extended version includes the same goal and adds a provision of services for additional age ranges that will allow the County to ascertain which subgroup of caregivers is best able to utilize the resources provided through the Caregiver Connections project. In the original project, it appears the County sought to determine how providing services to a caregiver will affect the outcome of the child age 0-5 living with SMI/SED and in services. This new project appears to be expanding to now learn how providing services to a caregiver will affect the outcome of the child/youth age 0-18 living with SMI/SED and in services. The County may wish to further discuss how expanding the age range of the

child/youth helps answer the original project's learning objectives given the variables have changed now. The County may wish to discussion how making the suggestion of doing a cross comparison of the caregivers from the three different age groups will address their original learning objectives.

The County stated the initial feedback reflects improved caregiver capacity. Respondents almost universally agreed or strongly agreed with being able to "better handle things", "more comfortable seeking help" and "know where to get help" due to their participation in the program. Based on the initial positive reviews, the County may wish to address how additional funding and time to extend the project will lead to additional learning. The County may wish to discuss how searching for other funding sources such as PEI or CSS to continue the program further is not sufficient given the success of the current program.

The Budget

This section addresses the County's case for the scope of their project, the length and monetary amount of the project. Has the County provided both (a) a budget narrative and (b) detail about projected expenditures by Fiscal Year (FY) and funding source in the required and expected categories listed in the regulations?

The County's original budget total that the Commission approved in February 2015 was $685,500. The proposed addition totals $1,485,250, for a new proposed total of $2,170,750. The County states they will be hiring a new 0.5 Full Time Equivilent (FTE) licensed/licensed eligible clinician for the youth program (age 6-18) and two 1.0 FTE Parent Care Coordinator. The proposed addition includes an increased amount requested for evaluation, which totals $108,583 (5% of Innovation funds).

The County may wish to provide more detailed information about how it will use the additional funds on specific aspects of the program, including hiring more personnel or acquiring more resources. The County will need to provide more details and breakdown of the budget request, including operating expenses, personnel salary and benefits, administration expenses, and any other expenses requested in the extension.

Additional Regulatory Requirements

The proposed project appears to meet or exceed minimum standards for compliance for requirements of the MHSA.

References

"County of San Diego Transforming Behavioral Health MHSA Three-Year Program and Expenditure Plan: Fiscal Year 2014-15 through Fiscal Year 2016-17." Last modified July 26, 2013. Accessed March 9, 2017. http://sandiego.camhsa.org/files/MHSA-3-Year-Plan-FYs-2014-15-thru-2016-17-11-21-14-Final.pdf.

San Diego County Innovation Change Request

Project Name: Caregiver Connection **MHSOAC Approval Date:** 2/26/2015

Through caregiver screenings, assessments, group counseling services and direct connection to individual treatment the **Caregiver Connection** is project provides for licensed/license eligible clinicians to screen and assess caregivers for behavioral health concerns and subsequently provide specialty groups to educate families about behavioral health issues, stigma and the impact of caregiver illness and stress on child development. Specially trained parent care coordinators ensure that caregivers in need of individual behavioral health services are connected to the appropriate resources and function as a liaison between the child's treatment team and the caregiver's provider.

1. The Need

The County of San Diego Behavioral Health Services (BHS) identified, though input from local stakeholders and a review of literature, the need to support caregivers of youth receiving services for complex emotional, behavioral and developmental needs. It is well-documented that caregivers experience a unique burden that may result in physical, psychological, emotional, social and financial consequences and that caregiver stress can be a barrier to a child's treatment. Historically, funding regulations have limited BHS-Children, Youth and Families (CYF) from providing services specific to the caregiver and, prior to the ACA, many caregivers were unable to access services. Additional barriers to caregiver treatment have included continued stigma and caregivers already overwhelmed with caring for children with complex needs.

2. The Response and Proposed Change

The MHSOAC-approved primary purpose of Caregiver Connection is to increase access to underserved groups. The current request is for an increase in expenditures so that a greater number of caregivers are served and so that caregivers of youth of varying ages can be served. Currently 200 caregivers of youth age 0-5 are screened and 100 of these caregivers are connected annually. The proposal would increase the numbers served to 600 caregivers screened and 300 caregivers connected annually. The target group would be expanded: in addition to caregivers of youth age 0-5 years receiving services for serious emotional disturbance (Existing Target), caregivers of latency-aged youth (6-12 years of age) receiving services for serious emotional disturbance and caregivers of adolescents (13-17 years of age) receiving services for serious emotional disturbance would additionally be screened, treated and connected to services (Proposed Additional Targets). There is no change in the purpose of the program.

An updated literature review reflects there is still no data on outcomes for children when their caregivers are connected to services for their own behavioral health needs, a learning objective of the original project. By expanding support to caregivers of older children, there will be an opportunity to examine how support of the caregiver impacts the outcomes of treatment for youth of varying ages. Approved by the MHSOAC in 2015, the project screens caregivers in programs where their children are receiving services, provides education, treatment groups, and connects them to services when appropriate.

In the Caregiver Connection Program, BHS-CYF places specially-trained Parent Care Coordinators in clinical settings. Through strategies including motivational interviewing, practitioners: 1) support connections to behavioral health services (through health plans and the Adult/Older Adult System of Care); 2) support

connections to Cal-Works and other support programs; and 3) work to serve as a liaison between the child's treatment team and the caregiver's provider. When indicated, a program clinician is available to provide clinical intervention. Disparities in services accessed by racial/ethnic, cultural and linguistic populations and communities, including the LGBTQI parenting population will be examined, with the goal of tailoring services to best meet the needs of these sub-populations.

This proposal requests an 18 month extension (through 12/31/2019) to allow for collection of a more robust sample and development of a meaningful comparative review. While initial findings report satisfaction with services and success with identifying and linking caregivers to services, the time extension would increase the ability to firmly establish if parents/caregivers successfully engaged in their own care is associated with improved outcomes for children. With a greater sample size, more meaningful data would be available about racial/ethnic, cultural, and linguistic populations and communities as it relates to caregiver support. Greater confidence in the reliability of our outcome data would enhance our ability to sustain the program if found to be effective.
BHS-CYF requests additional funding to expand the existing model to two additional sub-populations of caregivers—caregivers of latency age youth and caregivers of adolescent youth. By expanding support to caregivers of older children, there will be an opportunity to examine how support of the caregiver impacts the outcomes of treatment for youth of varying ages. No substantive changes will be made to the screening, education and treatment model.

3. The Community Planning Process

During August through October 2016, more than 650 individuals participated in BHS's 2016 Community Engagement process: 551 community members and providers at twelve (12) regional forums and more than 100 representatives from targeted populations (Native American, Southeastern San Diego Community, Justice Partners, Male and Female incarcerated individuals and Peer Workers) who attended six special focus groups. Behavioral Health Services (BHS) engaged consultant Hoffman & Clark to facilitate the forums and focus group and analyze feedback. Participants provided commentary through a group process that asks questions aimed at strengthening system capacity by focusing on productive potential.

The focus of the discussions centered around four topics: Children's Behavioral Health; Unserved/Underserved; Care Coordination; and the proposed concepts for Innovation projects, which had emerged from previous years of the Community Planning Process. Statistical analysis of the forum discussions showed 15 "Essential Themes". The themes of Access & Services, Continuum of Care, and Education & Awareness stood out across the three topics and were considered when making decisions for the expansion and extension of existing Innovation programs.

Throughout the year, BHS' stakeholder-led monthly councils provide a forum for council representatives and the public to stay informed of MHSA programs and offer input. BHS' MHSA Coordination team presented the proposed expansion and extension of existing Innovation programs to the Adult System of Care (ASOC) Council, the Older Adult Council, the Children, Youth and Family System of Care (CYFSOC) Council, and the Housing Council for their input. Stakeholders were asked to complete a community feedback questionnaire individually or as a council. The CYFSOC assigned a sub-committee to consider and provide comment, and the ASOC reviewed the Innovations programs as part of their meeting and provided written feedback. Additionally, BHS utilized an expansive, stakeholder email listserv to distribute the Innovation proposals and provide recipients a Survey Monkey link for their electronic feedback. Furthermore, the proposed Innovation programs were posted on BHS' MHSA website along with the Survey Monkey link for feedback.

4. Learning Objectives and Evaluation

As caregiver stress can be cumulative over time and because youth with complex medical, developmental and behavioral challenges have chronic, relapsing/remitting behavioral health challenges, BHS-CYF would like to move forward to explore the impact of support for caregivers of both latency age youth (6-12 years old) and adolescent youth (13-17 years old). Provision of services for additional age ranges will allow BHS-CYF to ascertain which subgroup of caregivers is best able to utilize the resources provided through the Caregiver Connections project.

The main learning goals are: 1) to learn if these new approaches lead to improved access to mental health services for unserved and underserved caregivers; 2) to learn if caregiver connection to education, resources and treatment leads to improved outcomes for the children who depend on them; 3) to identify cultural preference of treatment mode, either on-site or through referrals; and 4) to determine if providing support for caregivers of youth at different age ranges (early childhood, latency and adolescence) leads to improved outcomes.

While the initial findings are promising, the sample size is limited both in duration and in scope. When initially proposed, this request was limited due to expected budget constraints at the time of the initial proposal. Extension of the current program by another 18 months would allow for a more robust sample size to show more powerful results. This longer time frame would provide for more solid data to support continuation of services through other funding streams. Stakeholder feedback included the need for expanding support to caregivers of older youth. This would include support for caregivers of latency age youth (6-12 years of age) and caregivers of adolescents (13-17 years of age).

Data collection monitors: 1) number of caregivers screened; 2) number of caregivers assessed; 3) number of caregivers engaged in on-site group sessions; and 4) number of caregivers who received care coordination linkage to their individual behavioral health provider.

The program met the established goal of screening 100% of caregivers. The program received positive reviews from caregivers who were screened and from the stakeholder process. Demographic data shows the program has served caregivers from a varying racial/ethnic, cultural, and linguistic populations; this afforded BHS-CYF to work toward identifying cultural impact of services provided. Of the 24 caregivers who received services, 58% self-identified as Hispanic, 17% as African-American, 8% Asian and 4% multiracial. Spanish was the primary language for 67% of identified caregivers. BHS-CYF hypothesizes that expansion of the program to serve families with older children engaged in treatment would allow for a wider range of outcomes critical for strategically supporting additional programs in the future.

A total of 5% of project funds is set aside for evaluation analysis and outcome reporting through an existing contract with the University of California, San Diego. Details about San Diego County's contracting process were provided to MHSA staff.

5. Additional Regulatory Requirements

The purpose of this Innovation project 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. The proposed expansion and extension does not change the purpose and

continues in alignment with all MHSA General Standards, including continuity of care; cultural competences; stakeholder involvement; continuity planning; and dissemination planning. Details have been provided to MHSA staff.

6. Budgeting and Time Period

Programs for older youth will receive an additional 0.5 FTE for a licensed/license eligible mental health clinician to screen caregivers and provide treatment services. Two FTE Parent Care Coordinators will be added to the programs to engage, educate and connect caregivers to a variety of resources. As with the current INN-11 program, efforts will be made to establish nuances to services and service connection for differing racial/ethnic, cultural and linguistic populations and communities, including the LGBTQI parenting population.

Original Duration	7/1/2015 – 6/30/2018
Original Total	$685,500
Requested Extension and Expansion	7/1/2017- 12/31/19 (2 years, 6 months)
Requested Addition	$1,485,250
New Total	$2,170,750
New Evaluation Total	$108,538 (5% of Total)

Reference

1. Thakar, D., Coffino, B., & Lieberman, A. F. (2013). Maternal symptomatology and parent–child relationship functioning in a diverse sample of young children exposed to trauma. Journal of Traumatic Stress, 26(2), 217-224.

STAFF INNOVATION SUMMARY— SAN DEIGO

Name of Innovative (INN) Project: INN – 12 Family Therapy Participation

Total INN Funding Extension Amount Requested: $4,309,649

Duration of Extension: 18 Months

Review History

MHSOAC Original Approval Date: 2/16/2015

Original Program Dates: 7/1/2015 - 6/30/2018 Three (3) years

Original Budget: $3,381,000

Percentage of Change: 127.47%

Project Introduction:

San Diego County proposes to extend the Family Therapy Participation Engagement program for an additional eighteen months and to increase it's funding by $4,309,649 in order to increase the sample size by adding a provider in six geographical regions to increase parent and caregiver engagement in their child's treatment through family therapy sessions in underserved communities.

In the balance of this brief we address specific criteria that the OAC 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 OAC 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

Similar to the original Innovation plan proposal, San Diego County states that expansion efforts would enhance the program's sustainability plan by integrating Parent Partners in supporting clinicians with the engagement process so more families can receive services. The County states primary purpose of the program is to increase access to services for underserved populations. The County indicates it is well documented that parents who are actively engaged in the treatment of their child (ren), living with serious emotional

disturbances, make crucial contributions to positive outcomes and lasting change. The County states that it has noted difficulties in engaging families, despite efforts to provide wide clinical availability in terms of location, appointment times, etc., to facilitate ease of participation. The County explains that expanding the program will increase the sample size and lead to the development of a more meaningful comparative review of the difference between families who receive services from this program versus those who do not. The County states acquiring better outcome data would increase the reliability of the data and enhance their ability to sustain the program through ongoing funding sources.

The Response

San Diego County's Innovation commits specially trained Parent Partners (individuals with lived experience) to increase parent and caregiver engagement in their child's treatment through participation in family therapy sessions. The goals of the program include: 1) engaging underserved communities, with particular attention to culturally competent services in African American and Latino populations; 2) providing education regarding the importance of authentic family participation; 3) exploring reasons for reluctance to family therapy participation; and 4) mobilizing strategies to reduce stigma.

The County states their current Innovative program has proven to be successful. They stated 2,595 Parent Partner visits in the first year to various caregivers of 592 children. The County may wish to explain how this data translate to their sample size. The County states since the program's implementation, regular participation in family therapy increased 57%. Caregivers reported very high overall levels of satisfaction with Parent Partner services and over 90% indicated the Parent Partners "understood [their] experiences", "helped [them] understand the importance of Family Therapy", and made them "feel [they] could help [their] child".

San Diego County proposes to increase the target population sample size from 480 caregivers to 960 caregivers annually and double the number of clinics with available services from 6 to 12. With this increase, the County seeks to achieve its goal that 80 percent or more of children in treatment receive at minimum one family therapy contact per month with the client's biological, surrogate, or extended family member.

The County states this extension request does not include any changes in the approved purpose, scope, program operation, or expected outcomes. OAC staff concurs with this assertion. However, the County states that this program has proven to be successful.

Since this program's success has been proven, the County may wish to elaborate on the need for additional time and funding of the Innovation project. The County may wish to explain:

- What new or additional data it plans to gain by expanding the sample size and expanding the services to more providers?
- What nuances is the county seeing in its current Innovation plan that led it to consider expanding the project's sample size?
- What is the county hoping to compare to the larger sample size which they did not compare in its previous evaluation process?

The goal of Innovation projects is to learn something to contribute to the mental health field. The County's program seems to accomplish its learning objective of assessing if Parent Partners support increased engagement of parents/caregivers in their children's therapy and discovering which strategies Parent Partners can utilize to engage families.

The Community Planning Process

The MHSA regulations indicate the stakeholder participation should be present at every step of the way for INN projects, including the Community Planning Process (CPP). Counties should provide training where needed to ensure meaningful participation by consumers with serious mental illness and/or serious emotional disturbance and their family members in the CPP. This subsection should clarify what evidence the county presents meeting this requirement.

The County prioritized this Innovation program based on feedback and input from multiple entities and stakeholders in San Diego County. The County engaged 551 community members and providers at twelve regional forums, and more than 100 representatives from targeted populations (i.e. Native American, Southeastern San Diego Community, Justice Partners, Male and Female incarcerated individuals and Peer Workers, who attended six focus groups. The County may wish to provide more information on how it developed the idea to request an extension of this program throughout its Community Planning Process.

Learning Objectives and Evaluation

This section addresses the degree to which the County has a plan to evaluate the Innovative Project, including: (a) expected outcomes of Innovation, (b) how and at what frequency outcomes will be measured, (c) how outcomes relate to the Innovation's primary purpose, (d) how County will assess which elements of the Innovation contributed to positive outcomes, and (e) how, if the County chooses to continue it, the project work plan shall transition to another category of funding, as appropriate.

As described in the original work plan, the primary learning goal of the Family Therapy Participation Engagement is to determine if the utilization of Parent Partners to provide outreach to families through motivational interviewing engages the family unit in family therapy services. The County also hopes to learn what are the specific strategies and best practices that family partners can utilize to successfully assist caregiver see the value of consistently participating in family therapy.

As described in the original work plan, the County states the project will focus on the following learning objectives:

- Will Parent Partners support increase engagement of parents/caregivers in their children's therapy (as compared to the traditional model of clinician outreach to families)?
- What specific strategies and best practices can Parent Partners utilize to successfully assist the caregiver in seeing the value of consistently participating in family therapy?
- Which intervention strategies successfully increased engagement in treatment?

The data source for evaluation and analysis will include the following: routine youth outcomes measures for families who receive services through Family Therapy Participation Engagement, racial/ethnic and cultural details, rates/frequency of family therapy sessions, caregiver attitudes about family therapy, and caregiver satisfaction.

The County may wish to explain how it will change the learning objectives and evaluation plan to reflect a new purpose to do a comparative review focusing on racial/ethnic linguistic and cultural variables. The County is approximately halfway into its approved Innovation project, and it states that 18 months has not been sufficient to collect ample data for their learning objectives. The County may wish to explain what has not been learned in the past 18 months, what will not be learned in the next 18 months, that requires an additional 18 months thereafter.

The Budget

This section addresses the County's case for the scope of their project, the length and monetary amount of the project. Has the County provided both (a) a budget narrative and (b) detail about projected expenditures by Fiscal Year (FY) and funding source in the required and expected categories listed in the regulations?

The original Innovations budget total that the Commission approved in February 2015 was $3,381,000. The proposed addition totals $4,508,000, for a new proposed total of $7,889,000. The proposed addition includes an increased amount requested for evaluation, which totals $394,450 (5% of Innovation funds). The County may wish to provide more detailed information about how it will use the additional funds on specific aspects of the program, including hiring more personnel or acquiring more resources. The County will need to provide more details and breakdown of the budget request, including operating expenses, personnel salary and benefits, administration expenses, and any other expenses requested in the extension.

The original project dates were July 1, 2015 through June 30, 2018. The County also requests to extend the timeline of the project to July 1, 2018 through December 31, 2019, which is eighteen months past the original dates.

Additional Regulatory Requirements

The proposed project will benefit from additional clarification, as stated throughout this summary. The County may wish to elaborate on the need for the extension request, as the project's results have proven its success.

References

"County of San Diego Transforming Behavioral Health MHSA Three-Year Program and Expenditure Plan: Fiscal Year 2014-15 through Fiscal Year 2016-17." Last modified July 26, 2013. Accessed March 9, 2017. http://sandiego.camhsa.org/files/MHSA-3-Year-Plan-FYs-2014-15-thru-2016-17-11-21-14-Final.pdf.

San Diego County Innovation Change Request

Project Name: Family Therapy Participation **MHSOAC Approval Date:** 2/26/2015

The **Family Therapy Participation Engagement (FTPE**) program commits specially trained Parent Partners (individuals with lived experience) to increase parent and caregiver engagement in their child's treatment through participation in family therapy sessions. Emphasis is on teaching the caregiver the benefit of active engagement in the treatment process and addressing barriers on an individual basis. The Parent Partner works with the parent to overcome identified barriers and to assist the multidisciplinary team to better accommodate the family needs in order to foster participation.

1. The Need

Literature shows that family-based therapy can lead to improvement in multiple domains of psychosocial functioning and improvement in behavioral health outcomes. Though there are County-set goals for family therapy participation, literature review and anecdotal reports suggest that maximizing involvement leads to better outcomes for youth and their families. With Innovation funding, the specially trained Parent Partners have focused on providing short-term support utilizing strategies including motivational interviewing. Goals include: 1) engaging underserved communities, with particular attention to culturally competent services in African American and Latino populations; 2) providing education regarding the importance of authentic family participation; 3) exploring reasons for reluctance to family therapy participation; and 4) mobilizing strategies to reduce stigma.

2. The Response and Proposed Change

The MHSOAC-approved primary purpose of "Family Therapy Participation Engagement" is to increase access to underserved groups. The current request is for an increase in expenditures so that a greater number of caregivers can be served. Currently 480 caregivers are served annually; the proposal would increase the number served to 960 caregivers annually and would double the number of clinics where service is available from 6 clinics to 12 clinics. The target groups remain caregivers of youth (0-17 years of age) receiving services at agencies throughout the County for serious emotional disturbance.

Existing practice involves therapists and professional case managers encouraging family participation in treatment. The County of San Diego Behavioral Health Services (BHS) has noted continued difficulties in engaging families despite efforts to provide wide clinical availability in terms of location, appointment times, etc. to facilitate ease of participation. Efforts have additionally included psychoeducation services aimed at reducing perceived barriers, including stigma. This adapted Innovation project utilizes specially trained Parent Partners in first establishing a relationship with the families of clients, and then using strategies including motivational interviewing techniques to overcome barriers to involvement in treatment and activating change. There is no established literature that details the success of Parent Partners trained in motivational interviewing in mobilizing families to participate in family therapy services.

The FTPE program was implemented in 2015 and well received by programs, families and the community. The current request seeks additional funds for an extension of 18 months for the existing program's term and to expand the program to an additional provider in each of the county's six geographical regions. There are no changes to the program's primary purpose. Expansion efforts would enhance the overall program's sustainability plan by further integrating Parent Partners in the treatment team's efforts with

the engagement process so that more families can receive services. Program expansion would lead to a significantly larger sample size and the development of a more meaningful comparative review, which is particularly critical for nuanced data around racial/ethnic, linguistic and cultural variables. Greater confidence in the reliability of the outcome data would enhance the ability to sustain the program through ongoing funding sources.

3. Community Planning

During August through October 2016, more than 650 individuals participated in BHS's 2016 Community Engagement process: 551 community members and providers at twelve (12) regional forums and more than 100 representatives from targeted populations (Native American, Southeastern San Diego Community, Justice Partners, Male and Female incarcerated individuals and Peer Workers) who attended six special focus groups. Behavioral Health Services (BHS) engaged consultant Hoffman & Clark to facilitate the forums and focus group and analyze feedback. Participants provided commentary through a group process that asks questions aimed at strengthening system capacity by focusing on productive potential.

The focus of the discussions centered around four topics: Children's Behavioral Health; Unserved/Underserved; Care Coordination; and the proposed concepts for Innovation projects, which had emerged from previous years of the Community Planning Process. Statistical analysis of the forum discussions showed 15 "Essential Themes". The themes of Access & Services, Continuum of Care, and Education & Awareness stood out across the three topics and were considered when making decisions for the expansion and extension of existing Innovation programs.

Throughout the year, BHS' stakeholder-led monthly councils provide a forum for council representatives and the public to stay informed of MHSA programs and offer input. BHS' MHSA Coordination team presented the proposed expansion and extension of existing Innovation programs to the Adult System of Care (ASOC) Council, the Older Adult Council, the Children, Youth and Families System of Care (CYFSOC) Council, and the Housing Council for their input. Stakeholders were asked to complete a community feedback questionnaire individually or as a council. The CYFSOC assigned a sub-committee to consider and provide comment, and the ASOC reviewed the Innovations programs as part of their meeting and provided written feedback. Additionally, BHS utilized an expansive, stakeholder email listserv to distribute the Innovation proposals and provide recipients a Survey Monkey link for their electronic feedback. Furthermore, the proposed Innovation programs were posted on BHS' MHSA website along with the Survey Monkey link for feedback.

4. Learning Objectives and Evaluation

The County of San Diego BHS-Children, Youth and Families (CYF) hypothesized that implementation of Parent Partner support, as described above, would address the following learning objectives: 1) will Parent Partners support increase engagement of parents/caregivers in their children's therapy (as compared to the traditional model of clinician outreach to families)?; 2) what specific strategies and best practices can Parent Partners utilize to successfully assist the caregiver in seeing the value of consistently participating in family therapy?; 3) which intervention strategies successfully increased engagement in treatment?

The Family Therapy Participation Engagement program has shown promise, producing positive outcomes where it has been applied. The initial approved plan, although comprehensive in scope, was limited to

just one program in each of the geographically large and widespread regions of San Diego County. Access to additional data will be critical to extracting meaningful outcomes for the learning objectives stated. Greater numbers will be particularly important to understand the racial/ethnic, cultural and linguistic variables to family participation.

Programs involved, families, youth and stakeholders in the System of Care have all communicated support for this Innovation program. Stakeholders advocate for opportunities for those with lived experience. This program provides training and employment opportunities. Involved programs report that transition of responsibility for engaging families from clinician to Parent Partner has afforded clinicians the opportunity to focus their efforts on providing service as opposed to engagement efforts.

Data collection includes: 1) routine youth outcome measures for families who receive services through FTPE, as opposed to services as usual; 2) racial/ethnic, linguistic and cultural details; 3) rates/frequency of family therapy sessions; 4) caregiver attitudes about family therapy; and 5) caregiver satisfaction.

Operations commenced through amendments to six existing regional mental health contracts (one contract in each of the six regions). During the first year, 2015-16, a total of 2,595 Parent Partner visits were provided to caregivers of 592 children receiving behavioral health treatment services at six agencies throughout San Diego County. Average length of service in the augmented programs was 146 days. Many of the youth whose families received the additional support through the duration of their treatment have only recently started to complete their treatment episode. At the time of this request, the program is approximately half way through its scheduled Innovation lifespan.

Caregiver demographics indicate the caregiver participants were typically female, and the majority spoke Spanish as their primary language. Over half the caregivers had a high school or lower level of education. After implementation of FTPE, regular participation in family therapy, defined as at least one family therapy session per month, increased 57%. The Parent Partners focused on caregivers least likely to participate in family therapy sessions. Despite this, caregivers who received FTPE services had a 48% higher rate of family therapy participation as compared to those caregivers who did not receive FTPE services. Caregivers reported very high overall levels of satisfaction with Parent Partner services and over 90% indicated the Parent Partners “understood [their] experiences”, “helped [them] understand the importance of Family Therapy”, and made them “feel [they] could help [their] child”.

A total of 5% of project funds is set aside for evaluation analysis and outcome reporting through an existing contract with the University of California, San Diego.

5. Additional Regulatory Requirements

The purpose of this Innovation project 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. The proposed expansion and extension does not change the purpose and continues in alignment with all MHSA General Standards, including continuity of care; cultural competences; stakeholder involvement; continuity planning; and dissemination planning. Details have been provided to MHSA staff.

6. Budgeting and Time Period

The expansion would double the number of clinics where service is available from 6 to 12, thereby increasing support staff and training expenses for the Parent Partners.

Original Duration	7/1/2015 – 6/30/2018
Original Total	$3,381,000
Requested Extension and Expansion	7/1/2017- 12/31/19 (2 years, 6 months)
Requested Addition	$4,508,000
New Total	$7,889,000
New Evaluation Total	$394,450 (5% of Total)

STAFF INNOVATION SUMMARY— SAN DEIGO

Name of Innovative (INN) Project: INN – 15 Peer Assisted Transitions

Total INN Funding Extension Amount Requested: $3,152,591

Duration of Extension: 18 Months

Review History

MHSOAC Original Approval Date: 2/16/2015

Original Program Dates: 7/1/2015 - 6/30/2018 Three (3) years

Original Budget: $3,334,347

Percentage of Change: 94.55%

Project Introduction:

San Diego County proposes to extend the Peer Assisted Transitions program for an additional eighteen months and $3,152,591 in funding to allow time for increasing its sample size and to expand the program to Jary Barreto, the third crisis residential facility in Central San Diego. This program places Peer Support Coaches (PSC) to facilitate discharge planning and shared decision-making for individuals age 18 and older living with serious mental illness.

In the balance of this brief we address specific criteria that the OAC 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 OAC 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

Similar to the original Innovation plan proposal, San Diego County states that it has identified the need to better engage individuals diagnosed with serious mental illness to connect them with a variety of available community services and supports. The Commission approved the original plan, Peer Assisted Transitions, in February of 2015,

with the learning objective to increase the depth and breadth of services to adults diagnosed with serious mental illness.

The County originally planned on conducting a randomized control trial (RCT). Their extension indicates they were unable to meet the requirements of an RCT due to a small sample size and inability to get an Internal Review Board approval. The County states that it also faces barriers regarding not providing services for those in need when services are available and the inability to engage people who elect not to participate as the "control group" to account for selection effect. The County states they will now do a comparative review of the outcomes for the individuals who receive this support from peers during a discharge process in comparison to those who do not.

San Diego County states that the omission of the third crisis residential facility inhibits the ability to compare the effectiveness of the project on a regional basis. A regional comparison is essential due to the demographics of the clients, access to services, and capacity of programs. Adding a third site to the project will enable the County to test if peer support staff affects the outcomes of those clients linking to services.

The Response

San Diego County's Innovation proposes to use PSCs to engage with clients through peer support, "Welcome Home Baskets", social/recreational activities, mentoring, and shared decision-making, which are designed to identify and promote connections with relevant community services and supports. The PSC will work closely with the client and the assigned discharge planner to ensure that the client is actively involved in his/her discharge planning. Priority for services will be for persons who have been previously hospitalized or in a crisis residential facility for a psychiatric emergency, are homeless, and/or who live alone or in a Board and Care facility. Program goals include to increase client engagement, improve well-being and level of functioning, enhance recovery, and promote continuation of social activities and connections after clients' involvement with this program ends. This project is an adaptation to the peer support program San Diego County operated through an earlier Innovative Program. The County may wish to discuss how this program will not be better served by Senate Bill 82/Triage grants, which is used in other counties with similar needs.

San Diego County proposes to increase the target population from 240 adults to 300 adults annually. The County may wish to further discuss how increasing the sample size by 60 will lead to a more robust outcome and evaluation. The County states the average length of service is expected to be three months. The County is halfway through their original plan and has stated this time has not been sufficient in obtaining ample data. The County may wish to discuss what has not been learned in the past 18 months which will not be learned in the remaining 18 months of the original project, and an additional 18 months is needed. The County also included 2 out of the 3 crisis residential facilities in their original Innovation plan request due to budgetary constraints. They may wish to elaborate on these budgetary constraints and how they have removed them to now add the third crisis residential facility with the extension.

The County states that this extension request does not include any changes in the approved purpose or expected outcomes. The County explains that adding the third crisis residential facility will allow for better data analysis of the program relative to the other regions in San Diego County that have crisis residential facilities that are not part of this project. OAC staff concurs with the County's assertion that this extension request does not change the purpose or expected outcomes. As stated in the original work plan, the County proposed to compare outcomes with persons at the other three crisis centers that do not have Innovation services available.

The Community Planning Process

The MHSA regulations indicate the stakeholder participation should be present at every step of the way for INN projects, including the Community Planning Process (CPP). Counties should provide training where needed to ensure meaningful participation by consumers with serious mental illness and/or serious emotional disturbance and their family members in the CPP. This subsection should clarify what evidence the county presents meeting this requirement.

The County prioritized this Innovation program based on feedback and input from multiple entities and stakeholders in San Diego County. The County engaged 551 community members and providers at twelve regional forums, and more than 100 representatives from targeted populations (i.e. Native American, Southeastern San Diego Community, Justice Partners, Male and Female incarcerated individuals and Peer Workers, who attended six focus groups. The County may wish to provide more information on how it developed the idea to request an extension of this program throughout its Community Planning Process.

Learning Objectives and Evaluation

This section addresses the degree to which the County has a plan to evaluate the Innovative Project, including: (a) expected outcomes of Innovation, (b) how and at what frequency outcomes will be measured, (c) how outcomes relate to the Innovation's primary purpose, (d) how County will assess which elements of the Innovation contributed to positive outcomes, and (e) how, if the County chooses to continue it, the project work plan shall transition to another category of funding, as appropriate.

The primary learning goal of PAT is to evaluate a peer-based program for persons diagnosed with SMI who present at a crisis house or hospital for a psychiatric emergency and who are socially isolated.

As described in the original work plan, the County states the project will focus on the effectiveness of peer support in the discharge planning process at crisis residential facilities, including peer coach/mentor support, welcome home backpack, and experiences in social/recreational outings.

The data source for evaluation and analysis will include, but is not limited to, the following: the number of hospitalizations and hospitalization days, number of crisis house admissions and days, linkage with formal support services, and the level of recovery as

measured by participant report and scale (e.g. Recovery Markers Questionnaire) collected annually.

The Budget

This section addresses the County's case for the scope of their project, the length and monetary amount of the project. Has the County provided both (a) a budget narrative and (b) detail about projected expenditures by Fiscal Year (FY) and funding source in the required and expected categories listed in the regulations?

The original Innovations budget total that the Commission approved in February 2015 was $3,334,347 for two sites. The proposed addition totals $3,152,592 to add one additional site, for a new proposed total of $6,486,939. The proposed addition includes an increased amount requested for evaluation, which totals $324,347 (5% of Innovation funds). The County may wish to discuss how the expansion budget will extend services to one additional crisis residential facility for the same cost as the original budget which provided services to two crisis residential facilities.

The original project dates were July 1, 2015 through June 30, 2018. The County also requests to extend the timeline of the project to July 1, 2018 through December 31, 2019, which is eighteen months past the original dates.

The County may wish to provide more detailed information about how it will use the additional funds on specific aspects of the program, including hiring more personnel or acquiring more resources. The County will need to provide more details and breakdown of the budget request, including operating expenses, personnel salary and benefits, administration expenses, and any other expenses requested in the extension.

Additional Regulatory Requirements

The proposed project appears to meet minimum standards for compliance for requirements of the MHSA

References

"County of San Diego Transforming Behavioral Health MHSA Three-Year Program and Expenditure Plan: Fiscal Year 2014-15 through Fiscal Year 2016-17." Last modified July 26, 2013. Accessed March 9, 2017. http://sandiego.camhsa.org/files/MHSA-3-Year-Plan-FYs-2014-15-thru-2016-17-11-21-14-Final.pdf.

San Diego County Innovation Change Request

Project Name: Peer Assisted Transitions **MHSOAC Approval Date:** 2/26/2015

Peer Assisted Transitions employs Peer Specialist Coaches (PSCs) to serve adults (age 18+) diagnosed with serious mental illness, promoting engagement through peer support, use of 'Welcome Home Backpacks,' social/recreational activities, and to help them connect with relevant services. Peer Specialist Coaches engage the client in designated inpatient settings, such as acute care psychiatric hospitals and crisis houses, and, as part of the discharge team, assist with planned discharge and transition back to the community.

1. The Need

Many individuals who use the most acute services do not become effectively connected with relevant follow-up services and have limited social supports. The San Diego Behavioral Health Services (BHS) system has identified the need for better engagement of persons diagnosed with serious mental illness to connect with the variety of services and supports available in the community.

Peer support staffing and programs have become firmly established in our system of care since establishment of MHSA and are congruent with the practices and principles of recovery. However, the literature solidly correlating peer support staffing to better outcomes or cost-effectiveness does not exist. For example, the State of Georgia has a well-established peer support system which has billed for peer support since 2001; however, an examination of the impact of Medicaid peer support utilization on cost, a study done by Landers and Zhou (2014), found that peer support was associated with a significantly higher total Medicaid cost. The basis of the study was to recognize that peer support programs have continued to grow, building on recovery oriented programming, yet relationships between peer support services and the costs to public programs had not been well described in literature. The study aimed to fill that gap and identified that the implementation of Medicaid financed peer support programs did not necessarily result in savings from reductions in costly crisis stabilizations and psychiatric hospitalizations, it did support the principles of self-direction and recovery from severe mental illness.

2. The Response and Proposed Change

The MHSOAC-approved primary purpose of "Peer Assisted Transitions" is to increase the quality of mental health services, including measurable outcomes. The current request is for an increase in expenditures, such that more funds are expended than previously approved. Currently, the project targets 240 adults, and the proposal increases the target to 300 adults. The target groups remain adults (18+) diagnosed with serious mental illness (SMI) who use acute, crisis-oriented mental health services but are not effectively connected with community resources through the provision of peer specialist coaching incorporating shared decision-making and active social supports.

Behavioral Health Services created an Innovations project called Peer Assisted Transitions, beginning in July 2016, with the goal of increasing the depth and breadth of services to adults (18+) diagnosed with serious mental illness (SMI) who use acute, crisis-oriented mental health services but are not effectively connected with community resources through the provision of peer specialist coaching incorporating shared decision-making and active social supports. The target population is adults who present at Scripps Mercy and University of California at San Diego (UCSD) Behavioral Health Units, and in their Emergency Departments (ED), as well as at the Community Research Foundation's (CRF) Vista Balboa and New Vistas crisis residential facilities contracted by BHS.

The Peer Assisted Transitions program employs Peer Support Coaches (PSC), who work closely with the client, crisis house, and hospital-assigned discharge planner to participate in the discharge planning team by promoting use of shared decision-making and ensuring the client is actively involved in his/her discharge planning process. After discharge, the PSC engages in the active provision of and coaching about shared decision-making, linkage to relevant community services, and social/recreational outings. Caseloads are low to ensure service providers have sufficient time to provide highly individualized support to each person, as well as coordinating and participating in social outings with individuals and groups of persons served.

The initial Innovation project was designed to only include two of the three crisis residential facilities in the Central San Diego region due to budgetary constraints. The omission of this third crisis residential facility inhibits the ability to compare the efficacy of the project on a regional basis. The ability to compare between regions is important due to a number of region-specific factors including, but not limited to demographics of clients, access to services, and capacity of programs. While randomized controlled trials is not a viable learning tool at this time, adding a third site will allow us to test if the usage of peer support staff, as opposed to those who have comparable training but without lived experience, impacts the outcomes of those clients linking to services. This comparison would provide evidence if the specific usage of PSC is effective or if it is another factor.

San Diego County requests that the Peer Assisted Transistions program be extended an additional year to allow for more time for sufficient data collection. More importantly, it is also requested that the program be expanded to Jary Bareto, the third crisis residential facility in Central San Diego. This expansion would allow for better data analysis of the program relative to the other regions in San Diego County that have crisis residential facilities, but are not part of this innovative projected. The addition of this third crisis residential facility allows the ability to test if the usage of peer support services really do impact outcomes when compared with those staff hired who may have equal training, but without lived experience. Peers trained in a number of recovery principles are currently used in the teams at both Vista Balboa and New Vistas crisis residential facilities. The control group at the third crisis residential facility, Jary Bareto, would be staffed with individuals who are trained in recovery principles, but do not posses lived experience to qualify as a peer.

Prior to the inception of Peer Assisted Transitions, stakeholders such as the Adult Council and NAMI San Diego were supportive of the peer support model. An example of the program utilizing stakeholder input is the change from the usage of a “welcome-home basket” filled with bedding, towels, linens, sundries, etc. to a “welcome-home backpack” filled with reflective clothing, shampoo, soap, toothbrush, toothpaste, brush/comb, refillable water bottle, snack, blanket, calendar/planner (to keep track of appointments), flash light, and sunscreen to more appropriately address individuals who are homeless and the younger population. Additionally, the idea to expand to a third crisis residential facility to test the effectiveness of PSC was developed with stakeholder partnership.

3. Community Planning

During August through October, 2016, more than 650 individuals participated in BHS’ 2016 Community Engagement process: 551 community members and providers at twelve (12) regional forums and more than 100 representatives from targeted populations (Native American, Southeastern San Diego Community, Justice Partners, Male and Female incarcerated individuals and Peer Workers) who attended six special focus groups. Behavioral Health Services (BHS) engaged consultant Hoffman & Clark to facilitate

the forums and focus group and analyze feedback. Participants provided commentary through a group process that asks questions aimed at strengthening system capacity by focusing on productive potential.

The focus of the discussions centered around four topics: Children's Behavioral Health; Unserved/Underserved; Care Coordination; and the proposed concepts for Innovation projects, which had emerged from previous years of the Community Planning Process. Statistical analysis of the forum discussions showed 15 "Essential Themes". The themes of Access & Services, Continuum of Care, and Education & Awareness stood out across the three topics and were considered when making decisions for the expansion and extension of existing Innovation programs.

Throughout the year, BHS' stakeholder-led monthly councils provide a forum for council representatives and the public to stay informed of MHSA programs and offer input. BHS' MHSA Coordination team presented the proposed expansion and extension of existing Innovation programs to the Adult System of Care (ASOC) Council, the Older Adult Council, the Children, Youth and Family System of Care (CYFSOC) Council, and the Housing Council for their input. Stakeholders were asked to complete a community feedback questionnaire individually or as a council. The CYFSOC assigned a sub-committee to consider and provide comment, and the ASOC reviewed the Innovations programs as part of their meeting and provided written feedback. Additionally, BHS utilized an expansive, stakeholder email listserv to distribute the Innovation proposals and provide recipients a Survey Monkey link for their electronic feedback. Furthermore, the proposed Innovation programs were posted on BHS' MHSA website along with the Survey Monkey link for feedback.

4. Learning Objectives and Evaluation

This project seeks to answer the following: 1) does incorporating a major shared decision-making element into this program, by utilizing resources such as SAMHSA's Shared Decision-Making tools and/or other shared decision-making tools (e.g., elements of the web-based application CommonGround), result in improved outcomes in clients participating in this project versus clients in another acute setting; 2) can PSC at a privately operated psychiatric hospital, with the addition of the shared decision-making and social/recreational components, be effectively used at privately operated, non-County-operated psychiatric hospital (i.e. Scripps Mercy and UCSD hospitals)?; 3) does the project's focus on providing a peer coach/mentor support, welcome home backpack, and experiences in social/recreational outings increase client engagement, improve well-being, level of functioning and promote the continuation of social activities after their involvement with this program ends?; and 4) does the specific usage of individuals with lived experience (PSC) increase outcomes or can individuals without lived experience yield the same results?

The project is assessed on an annual basis and the resultant report will be made available to the County of San Diego's Adult System of Care Council, Older Adult Council, and Transition Age Youth Workgroup. The County's internal Performance Outcomes Team will also review the reports.

Data to be gathered and evaluated includes: 1) number of hospitalizations and hospitalization days; 2) number of crisis house admissions and days; 3) linkage with formal support services; 4) number of people in a person's active social support network; 5) level of recovery as measured by participant report and scale (e.g., Recovery Markers Questionnaire); 6) level of recovery as measured by provider report and scale (e.g., PHQ-9, IMR); 7) client input, including focus groups, about shared decision-making element of the project; 8) client input, including focus groups, about the 'welcome home basket' element of the project; 9) client input, including focus groups, about social/recreational activities element of the project; 10) other outcomes as indicated by stakeholders.

A total of 5% of project funds is set aside for evaluation analysis and outcome reporting through an existing contract with the University of California, San Diego.

5. Additional Regulatory Requirements

The purpose of this Innovation project 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. The proposed expansion and extension does not change the purpose and continues in alignment with all MHSA General Standards, including continuity of care; cultural competences; stakeholder involvement; continuity planning; and dissemination planning. Details have been provided to MHSA staff.

6. Budgeting and Time Period

Original Duration	7/1/2015 – 6/30/2018
Original Total	$3,334,347
Requested Extension and Expansion	7/1/2017- 12/31/19 (2 years, 6 months)
Requested Addition	$3,152,592
New Total	$6,486,939
New Evaluation Total	$324,347 (5% of Total)

STAFF INNOVATION SUMMARY— SAN DEIGO

Name of Innovative (INN) Project: INN – 16 Urban Beats

Total INN Funding Extension Amount Requested: $972,059

Duration of Extension: Eighteen (18) Months

Review History

MHSOAC Original Approval Date: 2/16/2015

Original Program Dates: 7/1/2015 - 6/30/2018 Three (3) years

Original Budget: $1,211,613

Percentage of change: 80.23%

Project Introduction:

San Diego County proposes to extend the Urban Beats program for an additional eighteen months and $972,059 in funding and increase its sample size in order to reach the original goal. The original program sets up behavioral health programs using multiple models of artistic expression provided by peers and Transition-Aged Youth (TAY) to improve outcomes of severely mentally ill (SMI) TAY individuals.

In the balance of this brief we address specific criteria that the OAC 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 OAC 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 stated in its original Innovation plan proposal, the TAY population with mental health issues has historically been difficult to engage and has resisted traditional treatment modalities. The Urban Beats program will focus on engagement strategies for African-American and Latino TAY in the Central Region of San Diego, using multiple

models of artistic expression including: visual arts, spoken word, music, videos, dance, and performances, including social media, created and developed by TAY.

The County requests an extension of the program because of constraints of a small number of participants and limited time to gather meaningful data. It is requested that Urban Beats outreach and performances be expanded into the North Central region of San Diego, which will allow additional access to TAY. Additionally, since the original inception of Urban Beats, stakeholders, particularly the East African community, have advocated for culturally sensitive services geared towards their youth. San Diego County stated it is the intent of this extension to add a third academy track through a subcontract, specifically for the purpose of attaining culturally competent services as well as engagement with the East African TAY community.

The Response

The County states the Urban Beats program is designed to increase the engagement and retention rates in mental health treatment of SED/SMI and at risk TAY by incorporating a TAY focused recovery message into artistic expression and social marketing/media. The intent is to provide TAY with increased access to and knowledge of wellness services while also reducing the stigma surrounding mental illness in them and the community.

According to the County this extension does not include any changes in approved purpose or expected outcomes. The County also stated the program currently targets 600 individuals and the extension will increase this number to 800 individuals to be served through the extended program. The County may wish to clarify its reasoning for expanding the program to a target population of 800 individuals. Staff suggests this proposal could benefit from more information about the strategies it will use to reach its increased target population, since it has only gathered data from 94 participants in the past eighteen months when their target was 600 and the County is asking for more time and funds to increase their sample size. The County may wish to discuss how reallocating their current resources to reach other areas in the County which appears may not have considered in the original plan.

The County also reported approximately 80% of the 94 enrolled TAY in 2015/2016 described being satisfied with the program despite the short timeframe since implementation. The majority indicated that as a result of participating in the program they knew where to get help, were more comfortable seeking help, could more effectively deal with problems, and were less bothered by symptoms. The County may wish to discuss what additional information they need to obtain to validate the success of the original Innovation project which has not been obtained in the past eighteen months and will not be obtained in the remaining time of the original project, leading to a request for an extension.

The County originally proposed their project was innovative because the Urban Beats program was provided by non-clinical staff (specifically peers and TAY) while other programs using artistic expression staffed licensed clinical staff. The County is now requesting using Innovation funds to add a therapist to address clinical issues. This

appears to be changing the original purpose of the project which the County may need to discuss.

The Community Planning Process`

The MHSA regulations indicate the stakeholder participation should be present at every step of the way for INN projects, including the Community Planning Process (CPP). Counties should provide training where needed to ensure meaningful participation by consumers with serious mental illness and/or serious emotional disturbance and their family members in the CPP. This subsection should clarify what evidence the county presents meeting this requirement.

The County prioritized this Innovation program based on feedback and input from multiple entities and stakeholders in San Diego County. The County engaged 551 community members and providers at twelve regional forums, and more than 100 representatives from targeted populations (i.e. Native American, Southeastern San Diego Community, Justice Partners, Male and Female incarcerated individuals and Peer Workers, who attended six focus groups.

The County may wish to provide more information on how it developed the idea to request an extension of this program throughout its Community Planning Process and feedback from current participants in the program.

Learning Objectives and Evaluation

This section addresses the degree to which the County has a plan to evaluate the Innovative Project, including: (a) expected outcomes of Innovation, (b) how and at what frequency outcomes will be measured, (c) how outcomes relate to the Innovation's primary purpose, (d) how County will assess which elements of the Innovation contributed to positive outcomes, and (e) how, if the County chooses to continue it, the project work plan shall transition to another category of funding, as appropriate.

The primary learning goal of the Urban Beats program is to use artistic expression encourages at-risk/at-promise youth to share their stories and experiences through a process of creating the narrative via music, spoken word, and creative expression, promoting positive mental health, well-being and connection among TAY.

As described in the original work plan, the County states the project will focus on if using artistic expression improves wellness and mental health of TAY, reduces stigma in seeking services and isolation of TAY, and increases access to services for TAY.

According to the County evaluations will be conducted annually to determine learnings and identify any modifications that need to be made to the model. At monthly intervals, the contractor will report results that capture participation rates, self-rating scores, observer ratings, and other measurable outcomes. There will be monthly review of SOW contract deliverables to determine contractor's performance in meeting contract objectives, review contractor exclusion/debarment/Medi-Cal Sanctions lists employee review process as well as a minimum of one in-depth invoice review annually. A total of

5% of project funds is set aside for evaluation analysis and outcome reporting through an existing contract with the University of California, San Diego.

The County may wish to discuss the constraints it has experienced having provided the program for 18 months which they do not see being resolved by completing the program with the additional 18 months left in the original proposal.

The Budget

This section addresses the County's case for the scope of their project, the length and monetary amount of the project. Has the County provided both (a) a budget narrative and (b) detail about projected expenditures by Fiscal Year (FY) and funding source in the required and expected categories listed in the regulations?

The original Innovations budget total that the Commission approved in February 2015 was $1,211,613. The proposed addition totals $972,059, for a new proposed total of $2,183,672. The proposed addition includes an increased amount requested for evaluation, which totals $109,184 (5% of Innovation funds). The County may wish to provide more detailed information about how it will use the additional funds on specific aspects of the program, including hiring more personnel or acquiring more resources. The County will need to provide more details and breakdown of the budget request, including operating expenses, personnel salary and benefits, administration expenses, and any other expenses requested in the extension.

The County may wish to provide more information to the Commission on the purchase of a van, which could be considered durable goods. The County may also like to share more detail on how adding the third academy track to target East African TAY will be supported in the budget and expansion of culturally competent services.

Additional Regulatory Requirements

The proposed project appears to meet or exceed minimum standards for compliance for requirements of the MHSA.

References

"County of San Diego Transforming Behavioral Health MHSA Three-Year Program and Expenditure Plan: Fiscal Year 2014-15 through Fiscal Year 2016-17." Last modified July 26, 2013. Accessed March 9, 2017. http://sandiego.camhsa.org/files/MHSA-3-Year-Plan-FYs-2014-15-thru-2016-17-11-21-14-Final.pdf.

San Diego County Innovation Change Request

Project Name: Urban Beats **MHSOAC Approval Date:** 2/26/2015

Urban Beats delivers a customized service to youth created by TAY with a serious mental illness (SMI) and at-risk TAY who incorporate their message into TAY-friendly social media that creatively combines therapeutic, stigma reducing, cultural expression and social justice messaging. The program is intended to engage TAY in wellness activities by providing a youth-focused message created and developed by youth. These may include the visual arts, spoken word, videos, and performances.

1. The Need

Transition Age Youth (TAY) are difficult to engage and retain in traditional models of behavioral health services and often report feeling a disconnect from traditional services and the people providing them. Additionally, TAY often encounter stigma within their community regarding both accessing and maintaining behavioral health services. The field recognizes that "the most effective program models are those that address the personal, familial, and societal variables that are essential to healthy transitional age development and are community based. These programs help the transitional age youth in developing increased personal competence and connectedness to pro-social elements of a larger community (California Institute for Mental Health (CIMH); 2005). Specialist indicate that engaging TAY with Serious Mental Illness (SMI) with unique strategies, including social media and expressive arts, is essential to addressing barriers to engagement and retention in services. (Engaging (while not engaging) Youth and young adults' webinar- November 15, 2016, Wayne Munchel, LCSW).

In non-clinical fields, there has been research around music education and mentoring at-risk (not mental health related) urban youth (e.g Shields, 2001) as well as using hip-hop to promote academic literacy among urban youth (Morrell & Duncan-Andrade, 2002). Similarly, there has been research in the clinical mental health field regarding the utilization of music therapy. However, while there are Evidence Based Practices regarding music therapy, these practices are used as tools to assist in the administration of mental health treatment by a licensed professional (American Music Therapy Association). There is little to no research on engaging and retaining TAY with SMI or at-risk TAY who show existing or emerging diagnostic characteristics consistent with early onset of Severe Emotional Disturbance (SED)/SMI via multiple models of artistic expression through the utilization of peers in a therapeutic, but non-clinical manner as an auxillary service to improve treatment outcomes.

2. The Response and Proposed Change

The MHSOAC-approved primary purpose of "Urban Beats" is to increase access to mental health services to underserved groups. The current request is for an increase in expenditures, such that more funds are expended than previously approved. The current annual target is 600 individuals served; the proposed change will increase the annual target to 800 individuals. The target group includes persons ages 16-25 (TAY) with SMI or at-risk TAY who show existing or emerging diagnostic characteristics consistent with early onset of SMI

With the limited number of participants enrolled in Urban Beats in FY 15/16 (n=94) and the short time frame of one year; the outcomes, however promising, cannot be cited as definitive evidence that the program model works. Addtionally, other barriers have been idenified. The first barrier is the lack of clinical staff to address therapeutic assessment, consultation, short term treatment and referral to

resources in the community to address longer term behavioral health needs, especially to those participants who have SMI and are not connected. The second barrier is the lack of transporation. TAY, being the target population, lack readily available transportation, thereby limiting access to the program, performances and available venues.

San Diego Behavioral Health Services (BHS) launched Urban Beats, beginning in July 2015, with the goal of increasing the quality of services, including better outcomes by reducing behavioral health services access barriers. The program integrates multiple models of artistic expression including visual arts, spoken word, music, videos and performances. This program does not provide any clinical treatment.

Urban Beats delivers a customized service to TAY with SMI and at-risk TAY to incorporate their artistic expression that creatively combines therapeutic, stigma reducing, cultural expression and social justice messaging to the TAY community. Participants who enrolled in the Urban Beats program had concerns about their ability to handle stress, earn enough income to meet their needs, and the quality of their social relationships and health. Urban Beats TAY are enrolled in 20-week "academies" focusing on engagement, artisitic exploration, expression and delivery of anti-stigma messaging via performances, and social media in various exisiting TAY friendly community locations with the goals of enhancing empowerment, increasing participation and/or accessing quality treatment/services, increasing level of funcitioning, and reducing. The program participants reflected substantial racial/ethnic diversity and diversity of sexual orientation. 43% identified as Hispanic, 36% African-American, and 27% were multi-racial/ethnic. 16% of participants identified as bisexual, pansexual, or sexually fluid.

Due to the constraints of a small number of participants and limited time to gather meaningful data, San Diego County requests that Urban Beats be extended for an additional year, making its end date June 2019 instead of June 2018. Additionally, it is requested that Urban Beats outreach and performances be expanded into the North Central region of San Diego, which will allow additional access to TAY. To address the barriers identified (lack of clinical personnel and transportation), it is requested to add a therapist to address the clinical issues that are currently lacking as detailed above; as well as the inclusion of funding for the addition of a van lease to reduce the barrier of transportation and allow the TAY participants to gain access to the program and be transported to venues across the Central and North Central regions of San Diego, thereby expanding the programs outreach, engagement and performances.

Stakeholders, particularly the East African community, have advocated for culturally sensitive services geared towards their youth. Behavioral Health Services and the United Women of East African and Nile Sisters Development Initiative partnered to target escalated gang activity and increased mental health needs. The expansion adds a third academy, aimed at culturally competent services as well as engagement with the East African TAY community. This request does not include any changes in approved purpose or expected outcomes.

3. Community Planning

During August through October, 2016, more than 650 individuals participated in BHS' 2016 Community Engagement process: 551 community members and providers at twelve (12) regional forums and more than 100 representatives from targeted populations (Native American, Southeastern San Diego Community, Justice Partners, Male and Female incarcerated individuals and Peer Workers) who attended six special focus groups. Behavioral Health Services (BHS) engaged consultant Hoffman & Clark to facilitate the forums and focus group and analyze feedback. Participants provided commentary through a group process that asks questions aimed at strengthening system capacity by focusing on productive potential.

The focus of the discussions centered around four topics: Children's Behavioral Health; Unserved/Underserved; Care Coordination; and the proposed concepts for Innovation projects, which had emerged from previous years of the Community Planning Process. Statistical analysis of the forum discussions showed 15 "Essential Themes". The themes of Access & Services, Continuum of Care, and Education & Awareness stood out across the three topics and were considered when making decisions for the expansion and extension of existing Innovation programs.

Throughout the year, BHS' stakeholder-led monthly councils provide a forum for council representatives and the public to stay informed of MHSA programs and offer input. BHS' MHSA Coordination team presented the proposed expansion and extension of existing Innovation programs to the Adult System of Care (ASOC) Council, the Older Adult Council, the Children, Youth and Family System of Care (CYFSOC) Council, and the Housing Council for their input. Stakeholders were asked to complete a community feedback questionnaire individually or as a council. The CYFSOC assigned a sub-committee to consider and provide comment, and the ASOC reviewed the Innovations programs as part of their meeting and provided written feedback. Additionally, BHS utilized an expansive, stakeholder email listserv to distribute the Innovation proposals and provide recipients a Survey Monkey link for their electronic feedback. Furthermore, the proposed Innovation programs were posted on BHS' MHSA website along with the Survey Monkey link for feedback.

4. Learning Objectives and Evaluation

The main learning goals are: 1) to learn if the purposeful integration of various artistic expressions facilitate wellness and mental health as well as reduce stigma and the effects of untreated health and behavioral health conditions in at risk TAY; 2) to learn if this program will decrease stigma and resistance to needed services; 3) to increase TAY engagement in artistic expressions of wellness and health while reducing isolation to improve engagement with peers and the community; 4) to improve access to needed services to advance the well-being and treatment outcomes for TAY enrolled in BHS; and 5) to learn if artistic expressions help TAY better engage in needed services.

During FY 15/16, approximately 80% of the 94 enrolled TAY reported being satisfied with the program despite the short timeframe since implementation. The majority indicated that as a result of participating in the program they knew where to get help, were more comfortable seeking help, could more effectively deal with problems, and were less bothered by symptoms. Evaluations will continue to be conducted annually. At monthly intervals, the contractor will report results that capture participation rates, self-rating scores, observer ratings, and other measurable outcomes. Evaluations will also allow the program to gather extensive baseline and follow-up information on each participant.

Data collection includes: 1) number of SMI and at-risk TAY who have an increased knowledge of how to access care; 2) number of SMI or at-risk TAY whose access to services has improved/increased; 3) number of SMI TAY engaged in treatment services who's level of clinical impairment improved (e.g. MORS); 4) number of TAY who demonstrate reduced stigma via pre and post-test; 5) number of TAY who have an increased knowledge of whole health, including sexual health; 6) number of TAY who report a positive impact from the artistic expression model; 7) TAY, community and staff satisfaction surveys; 8) number of TAY who show improved social functioning/connectedness; and 9) other outcomes as identified by stakeholders prior to the final review process.

A total of 5% of project funds is set aside for evaluation analysis and outcome reporting through an existing contract with the University of California, San Diego.

5. Additional Regulatory Requirements

The purpose of this Innovation project 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. The proposed expansion and extension does not change the purpose and continues in alignment with all MHSA General Standards, including continuity of care; cultural competences; stakeholder involvement; continuity planning; and dissemination planning. Details have been provided to MHSA staff.

6. Budgeting and Time Frame

Adds a therapist as well as the inclusion of funding for the addition of a van lease to reduce the barrier of transportation and allow TAY participants to gain access to the program and be transported to venues across additional regions of San Diego, including the North Central Region and targeting the East African community, thereby expanding the programs outreach, engagement and performances.

Original Duration	7/1/2015 – 6/30/2018
Original Total	$1,211,613
Requested Extension and Expansion	7/1/2017- 12/31/19 (2 years, 6 months)
Requested Addition	$972,059
New Total	$2,183,672
New Evaluation Total	$109,184 (5% of Total)

STAFF INNOVATION SUMMARY— SAN DEIGO

Name of Innovative (INN) Project: INN – 17 CREST Mobile Hoarding Units

Total INN Funding Extension Amount Requested: $1,372,162

Duration of Extension: Eighteen Months

Review History

MHSOAC Original Approval Date: 2/16/2015

Original Program Dates: 7/1/2015 - 6/30/2018 Three (3) years

Original Budget: $1,331,919

Percentage of change: 103.02%

Project Introduction:

San Diego County proposes to extend their Cognitive Rehabilitation and Exposure/Sorting Therapy (CREST) Mobile Hoarding Units program for an additional eighteen months and to increase its funding by $1,372,162. The program provides outreach, education, screening, and therapy services to older adults living with serious mental illness (SMI) and hoarding behaviors.

The primary purpose of this program is to increase the quality of services, including better outcomes, by testing whether combining therapy with hands-on training and collaboration with community organizations and family members will increase access to services, reduce hoarding behaviors, and improve mental health outcomes in older adults.

In the balance of this brief we address specific criteria that the OAC 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 OAC 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 CREST program provides outreach and engagement, screening and education, after-care, and an established best practice for hoarding behaviors (Cognitive Behavioral Therapy) to older adults living with SMI who are at risk of eviction due to hoarding behaviors. The program initiated in March 2016 and has successfully served 25 unduplicated clients in the identified zip codes within two regions of the County, Central, and North Central. Over time, other regions have surfaced demonstrating the same need so the County states additional time and funding is needed to serve the other regions in need of a similar program. One region includes a higher Hispanic/Latino population and it is not clear if this region was considered in the first Innovation project planning process.

The Response

The original Innovation proposal sought to serve 30 unduplicated clients annually. This decision was made due to budget constraints at the time. The County may wish to explain what these constraints were and how they have been addressed. The County seeks to increase their sample size to 50 unduplicated clients annually. The County may wish to discuss how this increase will change their learning objectives.

The County also implemented the program in a limited number of zip codes within two regions- Central and North Central San Diego. Since inception, 25 unduplicated clients were served over ten months, with 70% avoiding eviction. It appears the program has been a success with identifying and serving the target population in certain regions of their County and are requesting an extension to expand the service to other regions which were not accounted for during the original Innovation project. The County specifically discusses expanding to the South County region where 61% of the population is Hispanic/Latino, 19% are monolingual Spanish speakers, and 36.5% are bilingual. The County requests expanded CREST here and hiring bilingual Spanish/English staff to implement and test CREST bilingually. The County may wish to discuss how this request to add a different variable still addresses the same learning objectives and does not change the previously approved purpose or expected outcomes of the CREST program. The County may wish to discuss how continuing their successful Innovation program through other MHSA components will not achieve the same goal as oppose to extending the program for the purpose of increasing data.

The Community Planning Process

The MHSA regulations indicate the stakeholder participation should be present at every step of the way for Innovation Projects, including the Community Planning Process (CPP). Counties should provide training where needed to ensure meaningful participation by consumers with serious mental illness and/or serious emotional disturbance and their family members in the CPP. This subsection should clarify what evidence the County presents for meeting this requirement.

San Diego County stated that it held a focus driven CPP meeting to discuss four major topics: Children's Behavioral Health; Unserved/Underserved; Care Coordination; and the proposed concepts for Innovation projects. The County engaged 551 community members and providers at twelve regional forums, and more than 100 representatives

from targeted populations (i.e. Native American, Southeastern San Diego Community, Justice Partners, Male and Female incarcerated individuals and Peer Workers, who attended six focus groups. These meetings consisted of more than 650 participants and were held from August 2016 to October 2016. The outcome was to extend several of San Diego County Innovation programs.

The County may wish to provide more information on how it developed the idea to request an extension of this program throughout its Community Planning Process.

Learning Objectives and Evaluation

This section addresses the degree to which the County has a plan to evaluate the Innovative Project, including: (a) expected outcomes of Innovation, (b) how and at what frequency outcomes will be measured, (c) how outcomes relate to the Innovation's primary purpose, (d) how the County will assess which elements of the Innovation contributed to positive outcomes, and (e) how, if the County chooses to continue it, the project work plan shall transition to another category of funding, as appropriate.

The County originally sought to learn what is the effective model to treat hoarding behaviors in older adults living with SMI and how to engage this target population into services. The County also sought to determine if peer support by other older adults affected the hoarding behaviors. The program has demonstrated positive results for the 25 unduplicated clients so the County may wish to discuss more on the role of the peers in the CREST program. The County may wish to discuss how expanding the current Innovative project for an additional 18 months and funding will change the outcomes currently obtained and how adding a different variable by providing these services to a new population in the South region with bilingual services will still address the same learning objectives.

The Budget

This section addresses the County's case for the scope of their project, the length and monetary amount of the project. Has the County provided both (a) a budget narrative and (b) detail about projected expenditures by Fiscal Year (FY) and funding source in the required and expected categories listed in the regulations?

The County's original budget total that the Commission approved in February 2015 was $1,331,919 for two regions. The proposed addition totals $1,372,162, to expand to one additional region, for a new proposed total of $2,704,081. The County may wish to discuss how the expansion budget will extend services to one additional region for the same cost as the original budget which provided services to two regions.

The proposed addition includes an increased amount requested for evaluation, which totals $135,204 (5% of Innovation funds).

The County may wish to provide more detailed information about how it will use the additional funds on specific aspects of the program, including hiring more personnel or acquiring more resources. The County will need to provide more details and breakdown

of the budget request, including operating expenses, personnel salary and benefits, administration expenses, and any other expenses requested in the extension.

Additional Regulatory Requirements

The proposed project appears to meet or exceed minimum standards for compliance for requirements of the MHSA.

References

"County of San Diego Transforming Behavioral Health MHSA Three-Year Program and Expenditure Plan: Fiscal Year 2014-15 through Fiscal Year 2016-17." Last modified July 26, 2013. Accessed March 9, 2017. http://sandiego.camhsa.org/files/MHSA-3-Year-Plan-FYs-2014-15-thru-2016-17-11-21-14-Final.pdf.

San Diego County Innovation Change Request

Project Name: CREST Mobile Hoarding Units **MHSOAC Approval Date:** 2/26/2015

Cognitive Rehabilitation and Exposure/Sorting Therapy (CREST) Mobile Hoarding Units diminishes hoarding behaviors in Older Adults long-term by combining an adapted cognitive- behavior-rehabilitation therapy with hands-on training and support. The team consists of specially-trained professionals and peers who will also collaborate with the participants other health providers. An aftercare support group helps participants maintain the skills learned.

1. The Need

Hoarding is particularly dangerous for older adults, who may have physical and cognitive limitations. Basic functioning in the home may be impaired as the acquisition of items piled up in various rooms prevents the use of the rooms intended function. One study found that 45% could not use their refrigerators; 42% could not use their kitchen sink; 20% could not use their bathroom sink; and 10% could not use their toilet. Hoarding can present a physical threat due to fires, falling, unsanitary conditions, and inability to prepare food. Many suffer from great social impairment due to the unwelcoming state of the home. Most older adults live on a fixed income and suffer from financial problems due to paying for extra storage space, purchasing unneeded items, and/or cost of house fires. Older adults are at risk for eviction or premature relocation to less desirable housing (International Obsessive Compulsive Disorders Foundation).

2. The Response and Proposed Change

The MHSOAC-approved primary purpose of "CREST" is to Increase the quality of mental health services, including measurable outcomes. The current request is for an increase in expenditures, such that more funds are expended than previously approved. The current annual target is 30 clients served; the proposed change will increase the annual target to 50 clients. The target group is older adults identified as exhibiting serious hoarding behaviors.

While completed treatment outcomes are not yet available due to the short amount of time that CREST has been operational, several challenges have arose. The first challenge is the small number of clients involved in the program. The small number is due to program design of serving 30 unduplicated clients annually, not due to the need; with 18 unduplicated clients already enrolled in FY 16/17 (data from July 2016-December 2016), CREST is expected to exceed the target of 30 unduplicated clients served annually. Furthermore, of the 64 older adults that contacted the CREST Community Program between March 2016 and December 2016, aside from the 25 clients that were enrolled, an additional 14 older adults met diagnostic criteria but were not enrolled due to living outside of the eligible zip codes of the Central and North Central regions in San Diego.

San Diego Behavioral Health Services (BHS) originally launched Innovative Mobile Hoarding Intervention Program (IMHIP) with the primary purpose to reduce hoarding behaviors, improve health and safety, quality of life and housing stability through the provision of evidence-based services to older adults suffering from serious mental illness (SMI) and hoarding behaviors who are at risk for homelessness. The mobile nature of the project allows for accessibility to services for a population of older adults who tend to be isolated and may have lost their social contacts and family connections due to the hoarding behaviors. The eligible population is uninsured, Medi-Cal and or Medi-Cal/Medicare beneficiaries who are 60 and older who meet medical necessity criteria for SMI. The program name was changed from IMHIP to Cognitive Rehabilitation and Exposure/Sorting Therapy (CREST) by the contractor (University of

California at San Diego) to reflect the treatment paradigm. The program began in February 2016 due to a delay in the contracting process and began seeing clients in March 2016.

Components of the CREST Community Program include: 1) Outreach and education about the program, review of referrals and collaboration with mental health providers, primary care, Aging and Independent Services, Psychiatric Emergency Response Team (PERT), Fire Dept., Vector Control, Code Enforcement, Animal Services, private fiduciaries, professional organizers, etc. Referrals are also accepted from family members; 2) screening and hoarding to establish baseline using the Clutter scales and/or other hoarding measures; 3) using the Screening, Brief Intervention and Referral to Treatment (SBIRT) for Older Adult Prescription/Alcohol misuse; 4) home-based exposure/sorting therapy along with adapted Cognitive Behavior Therapy; 5) after-care support group to maintain acquired skills; and 6) psychoeducation components developed from following possible models such as: a. 24-26 weeks of Cognitive Rehabilitation and skill building; b. "Buried Treasure" curriculum (Help for Compulsive Acquiring, Saving & Hoarding); and c. a fifteen-week support group, graduates become "action group" which follows with intense 8 weeks of active de-cluttering with a clutter buddy

The concept for this program was developed with participation from the Older Adult Council and San Diego Hoarding Collaborative. This program includes the ongoing involvement of clients and family members in roles such as, but not limited to, outreach, implementation, evaluation, and future dissemination. Peer staff is also part of the outreach and treatment team.

Between March 2016 and December 2016, 25 unduplicated clients from the Central and North Central regions of San Diego have been enrolled. One outcome thus far is that of the 25 clients enrolled, there are no evictions. Upon entry into the program, 70% of the clients had multiple eviction risk factors and five were in the process of eviction. The CREST team was able to work closely with landlords and halt the eviction process in these cases.

When the program was initially approved, the design included 30 unduplicated clients in the Central and North Central regions of San Diego due to budgetary constraints at that time. It is now requested that CREST be extended for an additional two years to add more time for data to be included. It is also requested that CREST be expanded to another region of San Diego to increase its ability to provide services to more clients. The Hispanic/Latino population is the largest minority group in San Diego County (33%). In the South County region, 61% of the population is Hispanic/Latino, 19% are monolingual Spanish speakers, and 36.5% are bilingual. It is requested that CREST be expanded into the South County region and bilingual Spanish/English staff be hired to enable the program to implement and test CREST bilingually. This request does not include any changes in approved purpose or expected outcomes.

3. Community Planning

During August through October, 2016, more than 650 individuals participated in BHS' 2016 Community Engagement process: 551 community members and providers at twelve (12) regional forums and more than 100 representatives from targeted populations (Native American, Southeastern San Diego Community, Justice Partners, Male and Female incarcerated individuals and Peer Workers) who attended six special focus groups. Behavioral Health Services (BHS) engaged consultant Hoffman & Clark to facilitate the forums and focus group and analyze feedback. Participants provided commentary through a group process that asks questions aimed at strengthening system capacity by focusing on productive potential.

The focus of the discussions centered around four topics: Children's Behavioral Health; Unserved/Underserved; Care Coordination; and the proposed concepts for Innovation projects, which had emerged from previous years of the Community Planning Process. Statistical analysis of the forum

discussions showed 15 “Essential Themes”. The themes of Access & Services, Continuum of Care, and Education & Awareness stood out across the three topics and were considered when making decisions for the expansion and extension of existing Innovation programs.

Throughout the year, BHS’ stakeholder-led monthly councils provide a forum for council representatives and the public to stay informed of MHSA programs and offer input. BHS’ MHSA Coordination team presented the proposed expansion and extension of existing Innovation programs to the Adult System of Care (ASOC) Council, the Older Adult Council, the Children, Youth and Family System of Care (CYFSOC) Council, and the Housing Council for their input. Stakeholders were asked to complete a community feedback questionnaire individually or as a council. The CYFSOC assigned a sub-committee to consider and provide comment, and the ASOC reviewed the Innovations programs as part of their meeting and provided written feedback. Additionally, BHS utilized an expansive, stakeholder email listserv to distribute the Innovation proposals and provide recipients a Survey Monkey link for their electronic feedback. Furthermore, the proposed Innovation programs were posted on BHS’ MHSA website along with the Survey Monkey link for feedback.

4. Learning Objectives and Evaluations

Learning objectives include: 1) what is an effective model to treat hoarding behaviors in Older Adults with serious mental illness?; 2) what are the most effective ways to engage an older adult to participate in interventions geared for hoarding behaviors?; 3) are peer supports effective with older adults who have hoarding behaviors either individually and/or as part of an aftercare support group?

This project is expected to add new learning to the mental health field on effective practices to abate hoarding behaviors in older adults. Research on treatment models for hoarding behaviors is relatively new and there’s limited knowledge (usually single case studies) on how to effectively treat the condition in older adults particularly those with serious mental illness. Studies by Dr. Catherine Ayers show that effective hoarding interventions for older adults require specialized training such as adapted Cognitive Behavior Therapy/Cognitive Restructuring along with home-based coaching. CREST is currently testing this in the field.

The project will be assessed on a semi-annual basis and the resultant report will be made available to the County of San Diego’s Older Adult Council, composed of older adult stakeholders, for review and questions. The County’s internal Performance Outcomes team will also review the reports.

Outcomes to be tracked: 1) number of community participants outreached; 2) number of community participants enrolled in program; 3) number of reduced hoarding related evictions; 4) reduce mental health symptoms, compulsive behaviors, and substance use; 5) improve safety of older adult participant by reducing clutter that poses trip danger, fire and pest infestation potential, unhealthy sanitation and other hazardous conditions; 6) improve quality of life as measured by participant report and scale; 7) reduced clutter as evidenced by improved scores on clutter scales (example: recovered a room for intended use) at conclusion of treatment as well as 30, 90, 180 days f/u; 8) improved quality of life as evidenced by client self-reporting (QOL measure; 1 page); and 9) improved mental health by Milestones Of Recovery Scale (MORS) or other measure- Recovery Markers Questionnaire (RMQ)

A total of 5% of project funds is set aside for evaluation analysis and outcome reporting through an existing contract with the University of California, San Diego.

5. Additional Regulatory Requirements

The purpose of this Innovation project 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. The proposed expansion and extension does not change the purpose and continues in alignment with all MHSA General Standards, including continuity of care; cultural competences; stakeholder involvement; continuity planning; and dissemination planning. Details have been provided to MHSA staff.

6. Budgeting and Time Period

The proposed budget adds staffing to cover a third region of San Diego County.

Original Duration	7/1/2015 – 6/30/2018 (Start delayed until February 1, 2016
Original Total	$1,331,919
Requested Extension and Expansion	7/1/2017- 6/30/20 (3 years)
Requested Addition	$1,372,162
New Total	$2,704,081
New Evaluation Total	$135,204 (5% of Total)

AGENDA ITEM 4

Action

March 23, 2017 Commission Meeting

Orange County Innovation Project

Summary: The Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission) will consider approval of Orange County's request to fund a new Innovative project: Continuum of Care for Veterans and Military Families for a total of $3,083,777 in Innovation component funding over five (5) years. Orange County proposes to increase access to mental health services by increasing outreach and engagement to veterans and their families through placing staff at Family Resource Centers (FRCs) to provide trainings and basic case management services.

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.

The Continuum of Care for Veterans and Military Families project will be implemented by a community-based organization selected though a Request for Proposal (RFP) Process. Staffing for the project includes Program Manager (1.0 FTE), a Research Analyst (1.0 FTE), a Data Quality Analyst (1.0 FTE), Master's Level clinicians (1.5 FTE) and Military Peer Navigator (5.0 FTE). The INN project appears to meet the minimum Innovation regulations.

Presenters:

- Flor Yousefian Tehrani, Psy. D., LMFT, Innovation Projects Interim Program Manager
- Terri Styner, MSW, Innovation Project Service Chief
- Sharon Ishikawa, Ph.D., MHSA Coordinator

Enclosures (2): (1) Staff Innovation Summary, Continuum of Care for Veterans and Military Families; (2) County Innovation Brief; (3) County Budget Narrative.

Handout (1): PowerPoint Presentation (available at meeting)

Additional Materials (1): A link to the County's complete Innovation Plan is available on the MHSOAC website at the following URL: http://mhsoac.ca.gov/document/2017-03/orange-county-inn-plan-description-continuum-care-veterans-and-military-families

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

Name: Continuum of Care for Veterans and Military Families
Amount: $3,083,777
Project Length: Five (5) Years

Orange County Innovation Projects
Presenter Bios

Flor Yousefian Tehrani, Psy.D., LMFT
Orange County Innovation Projects Interim Program Manager
Flor Yousefian Tehrani has been involved in the development, implementation, and evaluation of Orange County Innovation projects since 2011. She is a licensed marriage and family therapist and earned a Doctor in Couple and Family Therapy degree from Alliant International University, Irvine.

Terri Styner, MSW
Innovation Projects Service Chief
Terri Styner has a Master's Degree from the University of Southern California. She has worked for the Health Care Agency since 2005. During this time, she has collaborated with numerous county contracted agencies to ensure quality services are provided to diverse populations including court mandated drug offenders, participants requiring integrated health care services, homeless court participants, and veteran families.

Sharon Ishikawa, Ph.D.
Orange County MHSA Coordinator
Sharon Ishikawa is the MHSA Coordinator for Orange County. She was previously a researcher for Orange County's Community Services and Supports (CSS) programs, and earned a Doctor in Clinical Psychology from the University of California, Los Angeles.

Mental Health Services
Oversight & Accountability Commission

STAFF INNOVATION SUMMARY—ORANGE COUNTY

Name of Innovative (INN) Project: Continuum of Care for Veterans and Military Families

Total INN Funding Requested for Project: $3,083,777

Duration of Innovative Project: Five (5) Years

Review History

Approved by the County Board of Supervisors: May 24, 2016

County Submitted Innovation (INN) Project: February 3, 2017

MHSOAC Consideration of INN Project: March 23, 2017

Project Introduction:

Orange County proposes to increase outreach and engagement to veterans and their families by placing staff at Family Resource Centers (FRCs). It will hire ten staff, including five peer navigators, to provide training on outreach strategies directly to FRC staff. The Peers will also provide veteran-specific case management services.

In the balance of this brief we address specific criteria that the OAC 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 OAC 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 states 123,000 veterans reside in the county, based on 2015 U.S. Census Bureau data. The County states that an estimated 12,600 veteran households in the county have children, and 6,500 families settle into the county each year. The County explains common barriers to military families seeking treatment as: travel to a central location for services, the stigma associated with behavioral health clinics, difficulty navigating the health system, and the belief that outside help is unnecessary. The County

states that its challenges in treating military family are due to its limited knowledge of military culture, limitations in assessment strategies, and the stigma associated with mental illness.

The MHSOAC staff were able to identify information from the 2015 "The State of the American Veteran: Orange County Veterans Study", which reported in their study of 1,227 vets residing in Orange County, 58% of Post 9/11 veterans and 49.3 % of Pre 9/11 screened positive for mental health problems but did not seek help.

Orange County's Innovation project proposes to integrate peer navigators into fifteen FRCs in the County to provide services to veterans and military-connected families. The peer navigators will have experience and knowledge of military culture and will train FRC staff to identify factors that may affect the individuals and family members. The County proposes to use this strategy to link military-connected families to resources through a less stigmatizing point of entry and to expand the community's knowledge of military cultures by training non-veteran organizations. The County proposes using nonclinical settings will promote cultural competence to non-veteran organizations and expand their resource network through the FRCs' partnerships.

The Response

FRCs exist throughout California and provide a variety of services to families. The County states FRCs are family friendly community-based collaborative partners that provide on-site access to prevention and treatment services. In FY15-16, their MHSA Prevention and Early Intervention (PEI) program completed a needs assessment and determined FRCs were requesting more behavioral health services and training at their sites. MHSOAC staff identified other FRCs playing a similar role of providing valuable services in a family friendly community-based setting to underserved populations throughout California. While Orange County has 15 FRCs, it is unclear how many military families use FRCs for services, especially given FRCs just started collecting Veterans status about two years ago. The County may wish to explain how this was identified as a need and how they are able to determine the impact this project will have given very little baseline data has been collected. The County may wish to discuss the penetration rate they anticipate making on military families by having this Innovative project placed at FRCs and how this may not be better appropriated under PEI funds given other counties have used these funds to provide training and education to other providers of services in the community.

Military families face similar barriers to seeking mental health treatment services as do other underserved populations, including access, lack of knowledge, stigma, and resistance to seeking outside help. As a result, just like other underserved populations, they may seeking social services in alternate locations such as FRCs. Siskiyou County has an outreach and engagement program that they operate out of 9 FRCs. While they are not specifically focusing on Veterans, Orange County may want to confer with them regarding lessons learned. Many counties and states have used non-traditional settings to reach out to military families to address the barriers. The Green Mountain Vietnam Era Veterans Assistance Corporation in Vermont utilized volunteers and peers to open a Veterans Outreach & Family Resource Center in 2009 that offers support groups and

various activities in a wellness center setting. SAMHSA's National Registry of Evidence–Based Programs and Practices, open to all providers including FRCs, includes Kognito Family of Heroes, a 1-hour online role-playing training simulation for military families of service members, recently returned from deployment as an evidence based practice that targets primarily family members.

The County states they have prioritized increasing services to military families over the last five years in many settings. The County has a college Veterans Program called the Drop Zone where they collaborate with local community colleges to provide services to veteran students on campus at the Veterans Resource Center. In 2013 the County initiated an Innovative project called Vets Connect which was later changed to OC4vets. This program co-located County staff at the County's Veteran's Services Office. It is a collaboration of different partners offering leadership and clinical expertise, expertise on veteran benefits and compensation claims, and job skill enhancement, job search and housing. This program also utilizes peer specialists to provide navigation. This program was deemed successful and ongoing funding for the project was assumed by PEI funds. The County also has a Veterans Services for Military/Veterans Families and Caregivers that provide trained behavioral health clinicians and peers to provide services for families of vets currently being seen in a behavioral health program. The peers offer individual and group support. It would be helpful if Orange County would elaborate on how the current programs, which utilizes similar training and providing similar services, differs from this new Innovation Project, aside from being placed at a new location. The County may wish to share how the expansion of services has improved outcomes for military families seeking services. The County may wish to also discuss their strategies to utilize FRC's to reach veterans and their family members that are not currently pursuing services through any of the counties established programs. The County may also wish to explain how they reviewed the purpose and value of their current Veterans program to determine the need to develop this new Innovation project.

The Community Planning Process

The MHSA regulations indicate the stakeholder participation should be present at every step of the way for INN projects, including the Community Planning Process (CPP). Counties should provide training where needed to ensure meaningful participation by consumers with serious mental illness and/or serious emotional disturbance and their family members in the CPP. This subsection should clarify what evidence the county presents meeting this requirement.

The County states they prioritized this Innovation program based on input and feedback from multiple entities and stakeholders. The County's stakeholders include: Health Care Agency's Behavioral Health Services staff, community-based service providers, consumers, family members, providers, and individuals representing the health care community interested in behavioral health care. The County may wish to provide more information on how it developed the idea to serve veterans and their families and if their process included reviewing their programs currently providing a variety of services to military families in various settings.

Learning Objectives and Evaluation

This section addresses the degree to which the County has a plan to evaluate the Innovative Project, including: (a) expected outcomes of Innovation, (b) how and at what frequency outcomes will be measured, (c) how outcomes relate to the Innovation's primary purpose, (d) how County will assess which elements of the Innovation contributed to positive outcomes, and (e) how, if the County chooses to continue it, the project work plan shall transition to another category of funding, as appropriate

The County states their learning objectives focus on the utilization of services by military families at FRCs, if using peers will build strength and resilience in military families, and if providing training on military culture at FRCs improves FRCs staff's knowledge and increases the number of military families seeking services at FRCs. There already exists significant research indicating the positive effect of using peer support with military families and the positive effect of training service providers on military culture. The County may wish to explain further additional learning contributions their Innovative project will make to the mental health field. The County states that it will serve an estimated 250 unduplicated participants annually, including veterans, reservists, active service members, and military-connected children, spouses, partners, and loved ones. The County states it determined the target number by examining demographic reports from Orange County FRCs, however they also indicated this data is not comprehensive given FRC's just started collecting Veterans status about two years ago.

The County states their data source for evaluation and analysis will include participant-level data on veterans, reservists, active service members, and their families from each location, including the demographics, number served, services provided, and referrals/linkages. The County will also collect self-reported measures of overall well-being using PROMIS Global Health at enrollment and project exit. Other data sources include structured interviews of FRC staff and partners on the value of the staff training and a satisfaction survey completed by participants.

The County states that it will evaluate participant outcomes throughout the course of the project to determine if it will continue the services through another MHSA component. If the project is not recommended to continue, the final year of contracted services will focus on referral, linkage, and the transition of active participants to comparable services. The County may wish to discuss what value this Innovation Plan will add to the mental health field different from their current Veterans programs. The County may wish to explain how learning and evaluation from their current PEI and INN projects supporting Veterans and their families was considered when developing this Innovation project.

The Budget

This section addresses the County's case for the scope of their project, the length and monetary amount of the project. Has the County provided both (a) a budget narrative and (b) detail about projected expenditures by Fiscal Year (FY) and funding source in the required and expected categories listed in the regulations?

The estimated Innovations budget total for this project is $3,083,777 over the five (5) year proposed duration. The County's budget shows limited services in Year One, the majority of services at the FRCs in Years Two to Four and only evaluation in Year Five.

Approximately 63% of Innovation funds (a total of $1,939,800) will be utilized to hire the following staff:

Program Director	1.0 FTE ($91,500 per year 2, 3, & 4- including S&B)
Research Analyst	1.0 FTE ($103,700 per year 2, 3, & 4- including S&B)
Clinician (Master's Level)	1.5 FTE ($85,400 per year 2, 3, & 4- including S&B)
Peer Navigator	5.0 FTE ($54,900 per year 2, 3, & 4- including S&B)
Data Quality Analyst	1.0 FTE ($48,800 per year 2, 3, & 4- including S&B)

*S&B stands for salary and benefits

The budget allocates $339,570 (11% of the total budget) to the contracted provider for indirect costs (under personnel and operated costs) and $10,000 for start-up costs, but it is not clear what indirect cost the contracted provider will incur and what is needed to start this project given the County indicates that actual costs will be negotiated through a Request for Proposal process. The County indicates they will be spending about 11% of the total budget for operating expenses, including direct costs such as office space/lease and office/technology supplies. It is unclear if this will be contracted out and what the County's plan is to sustain this expense given Innovation projects are time-limited project.

The budget also allocates $470,407 15% of the total Innovation funds, for County administrative costs, including procuring a contractor for the provision of services for the first year, contract monitoring by program staff for the second through fourth years, and evaluation during the fifth year. What is unclear and may need further clarification is the evaluation budget. It appears the community organization will be collecting the data and the County administration will be completing the data analysis. The budget though has allocated 1.0 FTE for the community organization and the County may wish to expand on the differences in evaluation duties between the County administrative team and the Research Analyst/Data Quality Analyst position.

Additional Regulatory Requirements

The proposed project appear to meet the minimum regulations of Innovation.

References

Referenced on March 7, 2017 **www.gmvevac.com**

Carl Andrew Castro, Sara Kintzle and Anthony Hassan, The State of American Veteran: The Orange County Veterans Study, 2015

https://www.samhsa.gov/ebp-web-guide/mental-health-treatment

Orange County Innovation Project
Continuum of Care for Veterans and Military Families

Orange County is the third most populous county and second most densely populated county in California, with a little over 3 million people currently residing in this region. Approximately 123,000 veterans reside in Orange County (U.S. Census Bureau, 2015), with an additional 6,500 settling into the County each year (Castro, Kintzle, & Hassan, 2015). Based on available data, it can be estimated that approximately 12,600 veteran households in Orange County have children, with a total of 18,900 children in these families. Military-connected children are at an increased risk for behavioral health disorders, including depression, anxiety, and traumatic grief. They also tend to exhibit more aggression and have lower academic performance than their peers (Morris & Age, 2009). Furthermore, military spouses can often feel isolated, overwhelmed, anxious or depressed. As military-connected families reintegrate into civilian life, they often become hidden and isolated within their communities. Over 70% of military families live in civilian communities (National Military Family Association, 2011), but are often not known to be military-connected. In a recent survey of over 1,200 Orange County veterans, over 70% of veterans reported their child's school was not aware that their child is military connected (Castro, Kintzle, & Hassan, 2015). Military-connected families with behavioral health concerns often go unnoticed due to the community's limited knowledge of military culture; limitations in assessment strategies; lack of coordinated community based services; and stigma associated with mental illness. Common barriers to families seeking treatment include: travel to a single central location for services; stigma associated with behavioral health clinics; difficulty navigating the behavioral health system; and the belief that outside help is not needed.

Primary Problem

Despite the large population of veterans residing in Orange County, there is no local Veterans Administration (VA). The VA is located in Los Angeles County, which poses a barrier to accessing services due to distance. In addition, although the VA provides services to veterans it typically does not serve veterans with other than honorable discharge, requires additional eligibility criteria for reservists, and rarely serves spouses and children. Further complicating the situation, many veterans who are entitled to VA services do not access them due to distrust of government agencies. Within Orange County, there are two Vet Centers, which also require the veteran to be eligible for VA benefits. Furthermore, spouses seeking support must have the veteran accompany them in order to receive services. Within the last five years, Orange County Mental Health Services Act (MHSA) programs have begun providing services that specifically target the veterans' spouses, partners, children, and loved ones. However, these services are centralized, provided within a potentially stigmatizing clinical setting, and require military-connected families to proactively seek out these services. Furthermore, outside of these specialized programs, nonveteran community organizations rarely take the initiative to identify military-connected families who seek out their resources, nor do they have the military cultural competency to engage this target population. Currently there are no programs that utilize a regionalized, family-friendly, community-based platform to increase services for military-connected families. As a result, the integration of veteran-specific services into family resource centers has not been evaluated. It is imperative that this project is implemented through the

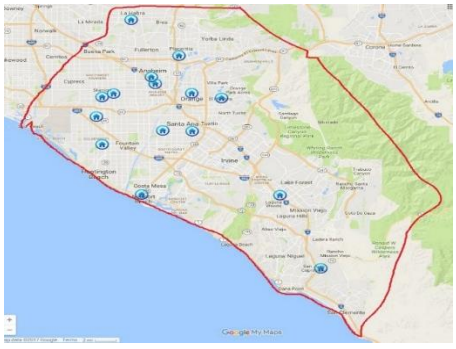
MHSA Innovation component in order to study the effectiveness of the services offered in this project and identify how this approach can lead to the successful integration of culturally competent veteran-specific services into nonveteran organizations. Based on the outcomes of this evaluation, it may then be determined whether this approach can be implemented through the MHSA Prevention and Early Intervention or Community Services and Supports components.

Community Planning Process

During FY 2014-15, the Orange County MHSA Office facilitated a series of stakeholder meetings to solicit community input for potential Innovation projects. Two stakeholder meetings were held specifically targeting organizations and individuals providing direct services within the community: one meeting for Health Care Agency's Behavioral Health Services staff, and the second meeting for community-based service providers. In addition, a series of five community stakeholder meetings were held across the County. Invitations for participation were sent to consumers, family members, and consumer organizations, as well as to individuals who represent: public safety, education, faith communities, physical healthcare providers, and welfare, among others. Interpretive services were available for each of the meetings to remove barriers to participation for those whose primary language was not English. A thorough review of Innovation project guidelines was provided, along with instructions on drafting and submitting a project proposal. Technical assistance (TA) sessions were also offered by County staff from the MHSA Office, Innovation Projects, Research, and Budget to reinforce Innovation regulations and provide guidance to stakeholders submitting proposals. After a thorough review of submissions, projects that met innovation criteria were presented to the MHSA Steering Committee to vote on and rank proposals to submit to the Mental Health Services Oversight and Accountability Commission for approval. The MHSA Steering Committee ranked the Continuum of Care for Veterans and Military Families project as the top priority.

Project Description

This project will be a collaboration between a community-based organization with experience serving military-connected families and Orange County Family Resource Centers (FRCs). FRCs are community-based, family-friendly sites run by a collaborative partnership that includes nonprofit, government, faith-based, and other service partners (Families and Communities Together Orange County, 2017). There are 15 FRCs located throughout Orange County's highest-risk communities, all of which provide family support services, education, and resources. Overall FRC demographics based on a fiscal year (FY) 2015-16 annual report indicate 15,355 individuals were served; 83.4% identified as Hispanic/Latino; and 74% of families that reported their income were below the poverty threshold. Several key factors contributed to the identification of FRCs as the appropriate community-based organization chosen for this project. FRCs are run by collaborative partnerships with a shared vision and coordinated approach to problem-solving, which is essential to establishing a consistent method of identifying military connected-families. In addition, FRCs have the potential to deliver the message of military awareness to a much larger audience, while at the same time establishing a



strong resource network to meet the complex needs of military-connected families. Lastly, FRCs are considered to be an easily accessible and trusted environment, which makes it ideal for engaging military-connected families who may not otherwise seek out resources.

Currently, FRCs do not consistently gather demographic information on military connection and lack the training and cultural knowledge to screen and engage this population. Military peer navigators will be regionalized at FRCs throughout the County. To increase military cultural awareness, peer navigators will educate FRC staff on the type of questions they can ask patrons to identify, screen, and engage military-connected families. The ability to effectively identify and screen military families can result in increased engagement, retention, and more appropriate service delivery. In addition, peer navigators will also participate in FRC partner meetings, where agencies meet to share information and resources. During these meetings, peer navigators will network with partner agencies to expand the knowledge base of resources for military-connected families, as well as offer trainings on military cultural awareness. FRC staff will screen their patrons and make appropriate referrals to peer navigators. Peer navigators will contact potential participants and utilize their lived experience and behavioral health training to engage the veteran and/or their family members into project services. Peer navigators will also provide outreach activities directly in the community to engage military families. As the family is enrolled into services, the peer navigator will provide case management to connect the family to services that will best meet their behavioral health needs. The program will also be staffed with clinicians who, with the on-going support of peer navigators, will provide trauma-informed care and utilize evidence-based practices to serve veterans and their families. This project will serve an estimated 250 unduplicated participants annually. This includes veterans (regardless of their discharge status), reservists, active service members, and their children, spouses, partners, and loved ones. The estimated annual number to be served was determined by examining demographic reports obtained from the FRCs. According to these reports, FRCs counted 122 active and inactive military families in FY 2014-15, and 175 active and inactive military families in FY 2015-16. These numbers are under reported, as FRCs do not consistently ask patrons about their veteran status.

Personnel

This project will be contracted out to a community-based organization that will be responsible for recruiting all project staff. Full-time equivalent (FTE) positions and salaries are as follows:

Program Manager (1.0 FTE) responsible for project oversight and administrative duties including: development of project materials; staff recruitment, support, and supervision of 8.5 staff rotating within 15 FRC sites; management of daily operations; coordination with FRCs and County; liaison between County, FRC and community based organization; regular attendance at monthly contract meetings with County INN staff; preparation for yearly program reviews; and completion of program reports. This position is essential to the development and oversight of project services. The annual salary for this position, including 22% benefits, is $91,500.

Research Analyst (1.0 FTE) responsible for ongoing project data evaluation and analysis. This position is essential to addressing the evaluation and learning component of this project. The annual salary for this position, including 22% benefits, is $103,700.

Data Quality Analyst (1.0 FTE) responsible for collecting, tracking, and entering all program data into the monthly Excel worksheets; reviewing program data; correcting data entry

errors; and providing project data reports to County INN staff upon request. The Data Quality Analyst will also function as office support to assist with maintaining participant documentation and managing daily office operations. This position is essential to the daily operations, as well as accurate data collection and tracking component of the project. The annual salary for this position, including 22% benefits, is $48,800.

Master's level Clinicians (1.5 FTE) who will provide trauma-informed treatment services to project participants and facilitate military cultural awareness trainings to behavioral health providers. The clinicians will also provide crisis intervention to participants, as well as clinical guidance and supervision to military peer navigators. This position is required for the implementation of project services. The total annual salary for one full-time clinician is $85,400. The total annual salary for one half-time clinician is $42,700. The combined total including 22% benefits is $128,100.

Military Peer Navigators (5 FTE) who will provide outreach and engagement; supportive services; case management; and military cultural awareness trainings. This position is required for the implementation of project services. The total annual salary, including 22% benefits, is $54,900 for each position, for a total of $274,500 for all 5 peer navigator positions.

Budget

The total funding requested for this 5-year project is $3,083,777.

Innovative Component

The innovative component of this project is the integration of veteran-specific services into FRCs that are traditionally not focused on serving military families. This integration will be achieved through two separate, yet related efforts: (1) training FRC staff on military culture so that staff are able to identify and engage this population; and (2) having clinicians and peers available at FRCs to provide veteran-specific services throughout the County, rather than a centralized location. The integration makes a change to an existing mental health practice and increases access to this underserved population. This project will bring veteran services directly into the community, begin the process of asking individuals about any military connection, and provide nonveteran organizations with skills that will help identify and serve this hidden population. As a result, military-connected families seeking resources in the FRCs will have the opportunity to access behavioral health services through a new, less stigmatizing point of entry.

Learning Goals

- *Overall Mental Health System of Care*: How does engagement and retention of military-connected families improve as a result of military peer navigators training FRC staff compare to the best practice of integrating peers at the FRC?
- *Orange County System of Care:* Do military-connected families seeking services within FRCs have different needs across the varying regions?
    - How can behavioral health services and community support organizations utilize this information to better serve military-connected families?

Continuum of Care for Veterans and Military Families

					FY 2018-19	FY 2019-20	FY 2020-21	FY 2021-22	FY 2022-23
Personnel Costs									
Positions	FTE	Salary/FTE	Benefits	Rate					
Program Manager	1.0	$75,000	22%	$36		$91,500	$91,500	$91,500	
Research Analyst	1.0	$85,000	22%	$41		$103,700	$103,700	$103,700	
Data Quality Analyst	1.0	$40,000	22%	$19		$48,800	$48,800	$48,800	
Master's Level Clinician	1.5	$70,000	22%	$34		$128,100	$128,100	$128,100	
Military Peer Navigator	5.0	$45,000	22%	$22		$274,500	$274,500	$274,500	
						$646,600	$646,600	$646,600	
15% Provider Personnel Indirect Cost						$96,990	$96,990	$96,990	
Operating Costs									
Operating Direct Costs						$108,000	$108,000	$108,000	
15% Provider Operating Indirect Cost						$16,200	$16,200	$16,200	
Non-recurring									
Start-up						$10,000			
Other Expenditures									
18% County Operating Costs					$94,081	$94,081	$94,081	$94,081	$94,081
			Annual Budget		**$94,081**	**$971,871**	**$961,871**	**$961,871**	**$94,081**
								Total Budget:	**$3,083,777**

AGENDA ITEM 5

Action

March 23, 2017 Commission Meeting

Ventura County Innovation Project

Summary: The Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission) will consider approval of Ventura County's request to fund a new Innovative project: Mixteco Project: Healing the Soul for a total of $838,985 in Innovation component funding over four (4) years. Ventura County proposes to increase the quality of mental health services for the indigenous Mexican population (Mixteco) working as farmworkers in the region through a research project that would evaluate blending indigenous healing practice(s) with more traditional mental health services to reduce symptoms of stress, anxiety, and depression.

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.

The Mixteco Project: Healing the Soul project proposes to hire Consulting Support (1 hour per week); Indigenous Traditional Therapist (6 hours per week in Year 2, 3, & 4), Executive Director (4 hours per week), Associate Director (4 hours per week), 4 Promotores (20 hours per week, number of weeks per year varies) and a Financial Manager (3 hours per week). The INN project appears to meet the minimum regulations for Innovations.

Presenters:

- Kiran Sahota, MA Mental Health Services Act Manager
- Hilary Carson, MSW, MHSA Administrator, Innovations
- Genevieve Flores-Haro, MPA, Associate Director Mixteco/Indigena Community Organizing Project
- Henry E. Villanueva, ED.D Behavioral Health Manager, Quality Assurance

Enclosures (2): (1) Staff Innovation Summary, Mixteco: Healing the Soul; (2) County Innovation Brief; (3) County Budget Narrative; (4) County Flow Chart.

Handout (1): PowerPoint Presentation (available at meeting)

Additional Materials (1): A link to the County's complete Innovation Plan is available on the MHSOAC website at the following URL: http://mhsoac.ca.gov/document/2017-03/ventura-county-inn-description-mixteco-project-healing-soul-additional-material

Proposed Motion: The MHSOAC approves Ventura County's Innovation Project, as follows:

Name: The Mixteco Project: Healing the Soul

Amount: $ 838,985

Project Length: Four (4) Years

Presenting on the Mixteco Innovations Project will be:

Kiran Sahota, MA
Mental Health Services Act Manager
Ventura County Behavioral Health
Kiran has managed all MHSA activities in Ventura County since 2015. She has worked in Ventura County Social Services for over 20 years. She has experience in the child welfare system, law enforcement, and community collaboration. Her advanced education is in Clinical and Community Psychology.

Hilary Carson, MSW
MHSA Administrator, Innovations
Ventura County Behavioral Health
Hilary received her MSW from NYU in Policy and Programs; she has a background in working with Community-Based Organizations specializing in parents and families involved in the criminal justice system. She joined Ventura County Behavioral Health in June 2016.

Genevieve Flores-Haro, MPA
Associate Director
Mixteco/Indigena Community Organizing Project
Genevieve Flores-Haro serves as the Associate Director of the Mixteco/Indigena Community Organizing Project(MICOP), where she oversees grant writing, development, and programs specific to health advocacy and mental health. Genevieve earned her BA in Psychology and her Master's Degree in Public Administration from the University of Southern California.

Others in attendance:

Henry E. Villanueva, ED.D.
Behavioral Health Manager, Quality Assurance
Ventura County Behavioral Health
Henry has nearly ten years of experience working as the Quality Assurance Manager providing reporting and evaluation for Ventura County Behavioral Health department. He has over 35 years of experience working the with low-income Latino community, farm workers, and indigenous populations.

Patricia Gonzales, PhD
Research Psychologist, QI Department
Ventura County Behavioral Health
Patricia Gonzalez, PhD., is a bilingual and bicultural Research Psychologist. She earned her Ph.D. in Social Psychology (Health Emphasis) from Colorado State University and completed postdoctoral training at the City of Hope National Medical Center and San Diego State University. She brings over 20 years of community-based experience working with organizations that serve diverse, underserved communities

STAFF INNOVATION SUMMARY—VENTURA COUNTY

Name of Innovative (INN) Project: Healing the Soul

Total INN Funding Requested for Project: $838,985

Duration of Innovative Project: Four (4) Years

Review History

Approved by the County Board of Supervisors: December 6, 2016

County Submitted Innovation (INN) Project: February 8, 2017

MHSOAC Consideration of INN Project: March 23, 2017

Ventura County proposes to increase the quality of mental health services for the indigenous Mexican population (Mixteco) working as farmworkers in the region through a research project that would evaluate blending indigenous healing practice(s) with more traditional mental health services to reduce symptoms of stress, anxiety, and depression.

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, fund exploration of a new and/or locally adapted mental health approach/practice, and target one of the four allowable primary purposes.

The Need

The County shared the 2009 Farmworkers Indigenous Study reported 17,500 indigenous Mexican farmworkers in Ventura County. More recent estimates put that number at over 20,000 persons. The County reports they have recognized the importance of meeting the needs of the indigenous farmworkers in their County, including using traditional healers, providing services in native languages, and have already enlisted support from other community programs.

The County states the idea of expanding services to the Mixteco speaking population in the region is something in discussion since 2012, with previous PEI and Innovation project

ideas having been developed along the way. The County may wish to discuss what occurred which led to previous ideas not coming to fruition and how this project will be more successful than previous ideas/attempts at projects to address the mental health needs of this population.

The Response

The County states they will be entering into a sole source contract with the *Mixteco/-Indigena Community Organizing Project (MICOP)* for the completion of much of this INN project. Majority of the MICOP staff represent an indigenous group from Mexico and have a mission "to aid, organize and empower the indigenous community in Ventura County". It appears MICOP has already been a collaborative partner for other valuable programs, some funded by MHSA Prevention and Early Intervention (PEI), to increase the services to the Mixteco speaking farmworkers in the County. The County states other services have focused on providing translation services. The County may wish to explain how this innovation project differs from the work already completed by MICOP or how the current work of MICOP is supporting this innovative project.

The County states their project will have a few key components. First, the County states MICOP will establish an advisory board, made up of ten individuals from local indigenous populations local to the area and advocates and community health professionals familiar with the Mexican community in the County. The County states the board will recruit 150 local indigenous Mexican persons to participate in a focus group or a structured survey to explore traditional practices that are currently being used to treat adverse mental health symptoms; participant's level of acculturation, values and beliefs about mental health services; the likelihood they will use available western mental health services; and prevalence rates of mental illness. OAC staff were able to identify a report by the UC Davis Center for Reducing Disparities, called "Building Partnerships: Conversations with Latina/o Migrant Workers about Mental Health Needs and Community Strengths", which states the most common mental health concerns described by migrant workers overall were depression, stress, drugs, alcohol, and domestic violence. Many indigenous farmworkers are even more isolated and unable to access services as they speak languages that are exclusive to each region. The County may wish to discuss what areas the current MICOP programs or other organizations have not identified or addressed especially given this component of their Innovative project appears to be information gathering. The County may also wish to explain why Innovation is the appropriate funding source to expand services to the indigenous population rather than expanding current PEI funded programs by MICOP.

The County states MICOP will then incorporate the feedback from the focus groups and structured survey to develop strategies to provide to indigenous community members in a group setting led by local healer/Promotoras(es). The County may wish to explain further what current strategies have been developed by MICOP or others in the County and why these current strategies have not been successful. The County may wish to explore how this program differs from community based groups led by Promotores used by other counties, through PEI or other funding sources, including on a volunteer basis.

The County states MICOP will recruit groups of 20 individuals until they reach 300 individuals total participating in these community based groups. The County may wish to explain how this program will account for current political climate and its direct effect on undocumented immigrants and the current challenge in identifying individuals willing to come forward and have any interaction with government agencies.

The County states they will continue to move forward with the final component of their project should the traditional strategies used in the groups led by Promotores demonstrate successful outcomes. The County states MICOP will develop a half-page questionnaire tool which MICOP will train licensed therapists providing Cognitive Behavioral Therapy (CBT) to use in sessions to establish rapport, provide psychological education to the client, and help the therapist learn more about the Mixteco traditions. CBT tools have been successfully adapted in many languages, including Spanish, and used in sessions by trained clinicians working with underserved populations. Given the County already uses MICOP to provide services for this population, the County may wish to discuss how MICOP has supported their licensed therapists with serving the population and how this innovative project differs from what MICOP currently provides to their mental health workforce or how their current contract cannot be expanded to offer this half-page tool and training. The County also states they will be using Indigenous Traditional Therapists to help facilitate the groups with Promotores. The County may wish to discuss the difference in their duties in comparison to the licensed therapists and how the Indigenous Traditional Therapists are not able to provide mental health services to the Mixteco population.

The County states they may conclude the project after the groups led by Promotores if the board and the County do not agree or think an adaptation of the strategies is possible. The County may wish to discuss what they will do with the remaining Innovation funds then should they decide to discontinue the program before training their licensed therapists. The County may wish to explain how they developed this project with an unknown deliverable as oppose to developing a project with two deliverables to learn from first before setting a follow-up project based on their learnings.

The Community Planning Process

The MHSA regulations indicate stakeholder participation should be present at every step of the way for INN projects, including the Community Planning Process (CPP). Counties should provide training, where needed, to ensure meaningful participation by consumers with serious mental illness and/or serious emotional disturbance and their family members in the CPP. This subsection should clarify what evidence the County presents meeting this requirement.

The community planning process for this program was a little unusual in that the County had a previous locally approved program to do engagement with the Mixteco community. Therefore, as a starting place, the Innovations work group reviewed the proposal, and then MICOP built upon that plan to design the current plan. This plan was put before the Leadership Committee. The Leadership Committee includes representation from the Board of Supervisors, Directors of the Health Care Agency, Human Service Agency,

Public Health and Probation, representatives from the Behavioral Health Advisory Board, various MHSA components, education, underserved communities, and faith based community. At least half of its members must be consumers and family members. The plan was posted for 30-day review and then discussed at a public hearing on September 19, 2016.

The CPP does not appear to be as robust and inclusive of consumers and family members given the target population the County hopes to provide the program to. The County may wish to discuss how the process has been shaped since its inception in 2012 and their decision to involve the stakeholders they did in the CPP process.

Learning Objectives and Evaluation

This section addresses the degree to which the County has a plan to evaluate the Innovative Project, including: (a) expected outcomes of Innovation, (b) how and at what frequency outcomes will be measured, (c) how outcomes relate to the Innovation's primary purpose, (d) how the County will assess which elements of the Innovation contributed to positive outcomes, and (e) how, if the County chooses to continue it, the project work plan shall transition to another category of funding, as appropriate.

The County's learning objectives are to determine the mental health status of the Mixteco community, what their traditional healing beliefs are, if using these traditional healing beliefs will help reduce mental health issues and if educating licensed therapists on the traditions and beliefs of this population will make them more culturally competent to treat the Mixteco community. Given these learning objectives are similar to other Spanish speaking communities (and have been well researched by other Spanish-speaking communities), the County may wish to discuss how this learning will contribute to the mental health field and how this cannot be served under PEI funds.

It appears the County are conducting a research study but have not been clear if approval from an Internal Review Board is necessary. The County may wish to explain further their research study and what steps they have taken to ensure meeting requirements of conducting such a project.

The Budget

This section addresses the County's case for the scope of their project, the length, and monetary amount of the project. Has the County provided both (a) a budget narrative and (b) detail about projected expenditures by Fiscal Year (FY) and funding source in the required and expected categories listed in the regulations?

The total Innovation funding request is for $838,985. The County allocates $578,028 to personnel costs to fund the following staff:

1. 4-hours per week for an Executive Director ($6,422 per year, $25,688 total)
2. 4-hours per week for an Associate Director ($5,174 per year, $20,696 total)
3. 1.0 FTE Project Director/Researcher ($75,920 per year, $303,680 total)

4. 3-hours per week for a Finance Manager ($4,966 per year, $19,864 total)
5. 4 0.5 FTE Promotores(as) ($202,800 total):
    a. Year 1 & 4: working 26 weeks total
    b. Year 2 & 3: working 52 weeks total

The County may wish to specify the hourly rate for the Promotores. Also, the total budget allocates $104,917 (approximately 12.5%) for indirect costs such as taxes and benefits. There is an additional $24,648 allocated for Indigenous Traditional Therapists. It appears these therapists will be supporting the Promotores-led groups in the community. The County may wish to share what is the difference in the job duties of the Promotores and Indigenous Traditional Therapists. There is an additional $10,400 to cover 1 hour per week of a consultant who will support and mentor the full-time researcher and Promotores. The County may wish to discuss the difference in job duties between the Executive Director, Associate Director, Project Director, and Consultant given their similarities listed in the Innovation plan budget description. The County may also discuss what the administrative budget will entail, or if the entire project including evaluation, will be contracted out.

10% of the total Innovation budget is for operating costs, of which almost 77% of the operating costs budget are attributable to the indirect costs, including 300 $50 gift cards as an incentive for participating, food for the participants, transportation and supplies for the community programs, and mileage for staff. There is also $27,292 dedicated to office rent. The County may wish to discuss how they will support ongoing expenses like a lease should this need arise and given Innovations is a time-limited funding source.

Evaluation functions appear to be primarily housed within the role of the Project Director/Researcher under personnel. It is 36% of the entire Innovation project budget. Other counties tend to stay around the 15% range. The County may wish to further explain their evaluation allocations within the entire Innovation project budget or if the salary of the Project Director/Researcher is their evaluation budget.

Additional Regulatory Requirements

The proposal meets the minimum Innovation regulations requirements.

References

Richard Mines, Sandra Nichols and David Runsten, Final report of the Indigenous Farmworker Study to the California Endowment January 2010 Web Version 1.

UCDAVIS Center For Reducing Health Disparities; Building Partnerships: Conversations with Latina/o Migrant Workers about Mental Health Needs and Community Strengths.

Mixtecs in Ventura County (http://mixteco .org) MICOP 2015

Ventura County Behavioral Health, Mental Health Services Act Innovations Mixteco Project: Healing the Soul December 6, 2016 (revised February 8, 2017)

VENTURA COUNTY BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

Innovation Project Brief

Ventura County The Mixteco Project: Healing the Soul

Primary Problem

Ventura County has the second largest concentration of indigenous Mexican people living in the state[1]. The majority of which work in labor intensive agricultural work. Despite their growing numbers, indigenous Mexican individuals are not utilizing County mental health services at a comparable rate. During the most recent three-month period, Ventura County Behavioral Health (VCBH) translation services bill reflected just for six exchanges needing language support for the indigenous Mexican population. Of these six contacts only one was for clinical treatment services. These low numbers are significant given the documented need for services. A study by the National Institute of Mental Health found that anxiety disorders affect 18% of the farmworker population[2]. Disparities in mental health treatment of minority cultures exist because of service inadequacies rather than any differences in need for services or access-related factors[3]. When the VCBH director asked agency workers serving the population how they would provide therapeutic services differently, the response was, “everything”.

Indigenous Mexican cultures have a very different perspective on how to treat and even describe mental health issues. To cope with symptoms such as stress, many indigenous families have relied on their traditional indigenous practices. Some of these traditions include creating art using natural sources, such as clay or palm leaves, burning copal (tree resin) to help individuals find equilibrium or rituals that involve the tossing of white flowers in the river while singing. These practices provide perceived mental health benefits including relief from feelings of anxiety and sadness. The striking underrepresentation of indigenous Mexicans in treatment services has demonstrated the need for change.

Indigenous Mexicans have a unique set of circumstances to be considered by mental health providers including cultural and linguistic issues, legal status, social isolation, work conditions, family, and substance abuse[4]. Instead of Spanish, the indigenous Mexican population speaks Mixteco or other indigenous languages that are exclusive to each region of origin. As a result of these language differences this community is especially isolated. A system such as VCBH that does not have native speakers of the language could cause an already closed community to withdraw further or distrust mental health services as an extension of government.

The County would like to develop a more culturally competent perspective that could help encourage treatment. To do this mental health providers will need more information about the

[1] Guzik, Hannah “Mixtecs face severe hardships as they toil in shadows: Health care, housing access for farmworkers hindered by language, cultural differences” Ventura County Star, Ventura, September 07, 2013: Special to the issue
[2] National Institute of Mental Health, National Institutes of Health, U.S. Department of Health and Human Services. The Numbers that Count: Mental Disorders in America. 2013
[3] Smedley BD, Smith AY, Nelson AR, editors. Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care.Washington, DC: Natl. Acad. Press; 2003. p. 764
[4] Grzywacz JG, Quandt SA, Early J, Tapia J, Graham CN, Arcury TA. Leaving family for work: ambivalence and mental health among Mexican migrant farmworker men. J Immigr Minor Health. 2006;8(1):85–97.

local indigenous community before they can consider how to change the way they are providing services. One way to start is by learning how the local indigenous Mexican communities currently understand and treat mental health imbalances. Cognitive Behavioral Therapy (CBT), the treatment modality that VCBH providers use, is a flexible treatment that has already been proven compatible many times for specific cultural adaptations[5]. Clinician's with higher levels of cultural competence experience more favorable outcomes with their clients, utilizing multicultural competency to tailor CBT effectively seems to serve the mental health needs of marginalized populations better[6]. If traditional practices and perspectives can be incorporated into a CBT approach mental health providers would have a clear understanding of how to change service plans to be culturally congruent for indigenous Mexicans.

In light of these considerations, the County is proposing a research project in collaboration with Mixteco/Indígena Community Organizing Project (MICOP). The project would evaluate the effectiveness of indigenous cultural practices and perspectives on mental well-being then assess the feasibility of those results to be integrated with the Cognitive Behavioral Therapy approach for the alleviation of symptoms of stress, anxiety, and depression.

Program Summary

The project will begin with the establishment of an advisory board made up of Mixteco, Zapoteco, and other indigenous populations local to the area; as well as advocates and community health professionals who are familiar with the indigenous Mexican community in the County. The advisory board's purpose will be to provide stakeholder input for a stronger community driven program from start to finish. The board will be actively involved to help recruit 150 local indigenous Mexican community members to participate in either a focus group or a structured survey. The focus group will be an in-depth discussion on the topics and questions that will eventually be included in the structured surveys. Topics for the focus groups will include traditional healing practices for treating adverse mental health symptoms, values and beliefs about mental health, acculturation, likelihood of using available Western mental health services, and prevalence rates of mental illness. The later created structured survey will be quantitative-style questions designed to incorporate a multitude of perspectives on the topics above. Results from the surveys will be compiled for two purposes. First, to assess whether or not any of the practices can be adapted into a structured, time-limited strategy that could be used by a provider using CBT. Second, is to inform a cultural learning card that will be developed at a later stage of the project. If the practices identified from the surveys cannot be adapted into a CBT congruent strategy, the project will be concluded.

The strategy(ies) will be tested by 300 community members that will voluntarily participate in the intervention. Interested participants who are over 18 and identify as belonging to the indigenous Mexican culture or whose parents or grandparents speak indigenous languages will

[5] Bernal, G. and Jime´nez-Chafey, M. Cultural Adaptation of Treatments: A Resource for Considering Culture in Evidence-Based Practice Article in Professional Psychology Research and Practice · July 2009

[6] Graham, J. Sorenson, S. Hayes-Skelton, S. Enhancing the Cultural Sensitivity of Cognitive Behavioral Interventions for Anxiety in Divers Populations *Behavioral Therapy* June 2013 101-108.

take part in one of the intervention strategies facilitated by a local healer/Promatoras(es). The intervention strategies will take place over six weeks. Participants will be assigned to a strategy based on availability until one or both strategies has 150 participants. Participants will take a pre and posttest to assess whether or not the intervention had an effect in alleviating levels of stress, anxiety, or depression symptoms. Results will be analyzed and if successful, VCBH clinical staff will advise how the strategies can be utilized by clinicians administering CBT with indigenous Mexican clients. If the board and VCBH do not agree or think an adaption of the strategies is possible, the project will conclude.

The secondary purpose for the structured surveys is to develop a cultural learning card. The card imagined as a half page sheet will be for mental health providers to use and for new indigenous Mexican clients to bring with them when they are beginning treatment. The card is meant to facilitate conversation between the client and mental health provider about how their indigenous background will be included and acknowledged in their treatment. The learning card, intended to be completed in collaboration with the client and their provider, will be used for the following purposes: establish client rapport, provide opportunity for psychological education, and to inform both parties of the client's personal acculturation process. The card will also provide brief background information to the mental health provider assuming they are unfamiliar with the indigenous Mexican culture.

The final component of the project will include a training workshop provided by VCBH staff in partnership with MICOP for mental health providers in the County. The workshop will review the synthesized data from the structured survey's covering community values and beliefs on mental health, as well as the unmodified traditional healing practices. The purpose of reviewing this data will be to share language and perspectives that mental health providers can use to inform clinical treatment of indigenous Mexican clients. The workshop will train the providers on how to utilize the culturally tailored interventions in conjunction with CBT and how to use the cultural learning cards with their clients.

Innovative Component

The local community has been working on a version of this project since 2012. After years of meetings and strategy discussions all parties are satisfied with the valuable knowledge to be gained by enacting the Mixteco project; *Healing the Soul*. The study will honor the culture's values, investigate the effectiveness of traditional practices on mental wellbeing, as well as inform a culturally tailored CBT approach for the population which will improve outcomes. The project, if successful, will allow the VCBH community to learn more about how the perspective and practices of the indigenous Mexican culture can be incorporated into treatment to improve the quality of services with a new integrated approach.

Evaluation Plan

The proposed innovative program will work with a researcher from MICOP (to be named), as well as the county's third-party investigator (Evalcorp), to examine the implementation and impact of the Healing the Soul study.

Learning Goals

- What is the mental health status of the indigenous Mexican community in the County?
- What are the traditional healing beliefs and strategies of indigenous Mexican community members?
- Does the chosen intervention strategies based on the traditional healing practices have an effect on symptoms of stress, anxiety, and depression?
- Does providing educational training to VCBH mental health providers, improve knowledge and acceptability regarding the integration of indigenous healing into the mental health services delivery for indigenous Mexicans?

The study employs a sound scientific methodology to develop and evaluate the feasibility and effectiveness of Healing the Soul in a culturally and linguistically appropriate manner. This mixed methods research design involves qualitative (focus groups), and quantitative (interview administered surveys) approaches conducted in three parts. Part one consists of conducting focus groups with approximately 20 community stakeholders and interviewer-administered surveys with 150 indigenous Mexican participants to 1) examine the mental health status and 2) healing beliefs and strategies used to manage mental health distress among indigenous Mexicans. Part two will test the acceptability, feasibility, and utility of the traditional indigenous healing intervention. The testing will follow a pre-post-test research design to compare baseline to post-intervention changes in mental health outcomes. Part three will test an educational training to County mental health providers, on improving knowledge of traditional healing beliefs and strategies and acceptability of integrating indigenous Mexican cultural factors into mental health service delivery.

Project Budget

The project will be contracted with MICOP, a current contractor with a proven record of success in outreach to the indigenous Mexican population and program implementation. They currently provide outreach to the indigenous Mexican community to provide access and linkages to county services. They have a good standing relationship with the County and are held in high regard by the local community for their cultural competency. The County will provide project management, data analysis, technical support, regulation compliance, and evaluation throughout each of the three phases of the project.

BUDGET TOTALS	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**Total**
Personnel	$122,306	$159,068	$163,590	$133,064	$578,028
Direct Costs	$28,004	$49,092	$48,348	$34,021	$159,465
Indirect Costs	$18,202	$27,363	$28,964	$24,462	$98,992
Non-recurring costs	**$2,500**				**$2,500**
TOTAL INNOVATION BUDGET	**$171,012**	**$235,523**	**$240,902**	**$191,547**	**838,985**
Additional MHSA Expenditures	**$26,278**	**$41,919**	**$44,015**	**$46,215**	**$158,427**

A. Budget

A. Budget Narrative total of 4 years however year 4 is at the discretion of the County

PERSONEL COSTS

Salaries

Executive Director, 4 hours per week.
Executive Director will be in charge will general oversight of the project
Time to project 16hrs for 48 months FTE; TOTAL Project Salary: $25,688

Associate Director, 4 hours per week.
Associate Director will supervise the Project Director/Researcher throughout the project
Time to project 16hrs for 48 months FTE; TOTAL Project Salary: $20,696

Project Director/Researcher, FTE 40 hour per week.
Project Director/Researcher will be responsible for the supervision, oversight & implementation of the proposed project. Experienced in evaluation research.
Time to project 40hrs for 48 months FTE; TOTAL Project Salary: $303,680 $20,696

4 Promotores(as), Year 1 & 4: 20hrs/wk. x 4 healers x 26 weeks; Year 2 & 3: 20hrs/week x 4 healers x 52 weeks.
Promotores(as) will provide indigenous insight, in conjunction with the advisory board, for the formation of the cultural learning card and training workshop review. The Promotores(as) will primarily assist with focus groups, structured oral interviews, pre and posttest administration, and translation of the aforementioned. Promotores(as) will also assist as needed with implementing any aspect of the indigenous healing approaches in Years 2 & 3.
Time to project 80hrs for 33 months FTE; TOTAL Project Salary: $202,800

Finance Manager, 3 hours per week.
MICOP finance manager will be in charge of budget oversee and management as needed
Time to project 10hrs for 48 months FTE; TOTAL Project Salary: $19,864

Taxes & Benefits. Year 1: 17.5%; Year 2: 18%; Year 3: 18.5% and Year 4: 18.5%.
TOTAL: $104,917

OPERATING COSTS

Direct Costs

Advisory Board Stipend and Supplies TOTAL: $10,500
10 Advisory board members will be given small stipend for meeting participation
Year 1: Advisory board will be meeting approximately once every other week for six months. Board and Promotoras will be facilitating 150 interviews and two focus groups.
Year 2 & 3: Recruitment meetings pre and posttest administration will be meeting at least once a month
Year 4: meetings and workshop training will take place at least six meetings.

Any needed generic office supplies for the advisory board to accomplish their goals.

Advisory Board Supports
Miscellaneous Support Funds for Advisory Board Meetings. TOTAL: $5,300
MICOP will be working with indigenous families who may or may not be employed and would like to be able to provide supports such as gas cards, bus passes, food, and incentives for attending the board meetings so committee members can participate in the regular project responsibilities for the project's duration.

Client Supports
Food for Focus Groups, Structured Interviews, and Practices TOTAL: $4,500
Year 1: Advisory board will be meeting approximately once every other week for six months. Board and Promotoras will be facilitating 150 interviews and two focus groups.
Year 2 & 3: Recruitment meetings pre and posttest administration will be meeting at least once a month
Year 4: meetings and workshop training will take place at least six meetings.

Indirect Costs

Incentive-Participants. TOTAL: $20,500
300 participants will be awarded $50 incentive gift card for their full participation 400 participants will be recruited.

Mileage. TOTAL $5,000
Mileage costs for Project Director/Researcher

Office Supplies. TOTAL $6,000
This budget item includes the office supplies directly used by the project staff for program activities. It includes paper, printing, pens, binders, file folders, tape, staples, and other office supplies as needed. Indirect costs include office rent.

Program Supplies. $9,500
Program supplies include supplies for curriculum and traditional healing approaches.

Building Occupation $27,292
Building rent, maintenance costs, etc.

NON RECURRING COSTS

Equipment (Onetime expense). $2,500
Equipment, purchased on a one time bases includes: computer, printer, desk, chair, and phone stipend for Project Director/Researcher

CONSULTANT

Consulting Support, 1 hour per week. TOTAL: $10,400
Consultant will support & mentor Research Project Director/Researcher and four indigenous healers throughout the project

Indigenous Traditional Therapy. TOTAL $24,648
Indigenous Traditional Therapists will be needed to lead the indigenous healing practices to be authentic to the approaches chosen by the Steering Committee. They will guide the 300 participants. This will be implemented in the year 2, 3 & 4 at 6 hours per week.

B. PERSONNEL COSTS (salaries, wages, benefits)		FY 2017	FY 2018	FY 2019	FY 2020	Total
1.	Salaries	$122,306	$159,068	$163,590	$133,064	$578,028
2.	Direct Costs	$21,404	$28,632	$30,264	$24,617	$104,917
3.	Indirect Costs	$	$	$	$	$
4.	Total Personnel Costs	**$143,710**	**$187,700**	**$193,854**	**$157,681**	**$682,945**
OPERATING COSTs		**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**Total**
5.	Direct Costs	$4,000	$9,500	$4,500	$2,000	$19,500
6.	Indirect Costs	$11,502	$17,163	$18,764	$16,362	$63,792
7.	Total Operating Costs	**$15,502**	**$25,663**	**$24,264**	**$18,862**	**$83,292**

NONRECURRING COSTS (equipment, technology)		FY 2017	FY 2018	FY 2019	FY 2020	Total
8.	Equipment	$2,500				$2,500
9.						
10.	Total Non-recurring costs	**$2,500**				**$2,500**
CONSULTANT COSTS/CONTRACTS (clinical, training, facilitator, evaluation)		**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**Total**
11.	Direct Costs	$2,600	$11,960	$12,584	$7,904	$35,048
12.	Indirect Costs	$6,700	$10,200	$10,200	$8,100	$35,200
13.	Total Operating Costs	**$9,300**	**$22,160**	**$22,784**	**$16,004**	**$70,248**

OTHER EXPENDITURES (please explain in budget narrative)	FY 2017	FY 2018	FY 2019	FY 2020	Total
14.					
15.					
16. Total Other expenditures					

BUDGET TOTALS	FY 2017	FY 2018	FY 2019	FY 2020	Total
Personnel	$122,306	$159,068	$163,590	$133,064	$578,028
Direct Costs (add lines 2, 5 and 11 from above)	$28,004	$49,092	$48,348	$34,021	$159,465
Indirect Costs (add lines 3, 6 and 12 from above)	$18,202	$27,363	$28,964	$24,462	$98,992

Non-recurring costs (line 10)	**$2,500**				**$2,500**
Other Expenditures (line 16)					
TOTAL INNOVATION BUDGET	**$171,012**	**$235,523**	**$240,902**	**$191,547**	**838,985**

*For a complete definition of direct and indirect costs, please use DHCS Information Notice 14-033. This notice aligns with the federal definition of 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 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**Total**
1.	Innovative MHSA Funds	$19,219	$30,658	$32,191	$33,801	$115,869
2.	Federal Financial Participation					
3.	1991 Realignment					
4.	Behavioral Health Subaccount					
5.	Other funding*					
6.	**Total Proposed Administration**	**$19,219**	**$30,658**	**$32,191**	**$33,801**	**$115,869**
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 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**Total**
1.	Innovative MHSA Funds	$7,059	$11,261	$11,824	$12,414	$42,558
2.	Federal Financial Participation					
3.	1991 Realignment					
4.	Behavioral Health Subaccount					
5.	Other funding*					
6.	**Total Proposed Evaluation**	**$7,059**	**$11,261**	**$11,824**	**$12,414**	**$42,558**
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 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**Total**
1.	Innovative MHSA Funds	$26,278	$41,919	$44,015	$46,215	$158,427

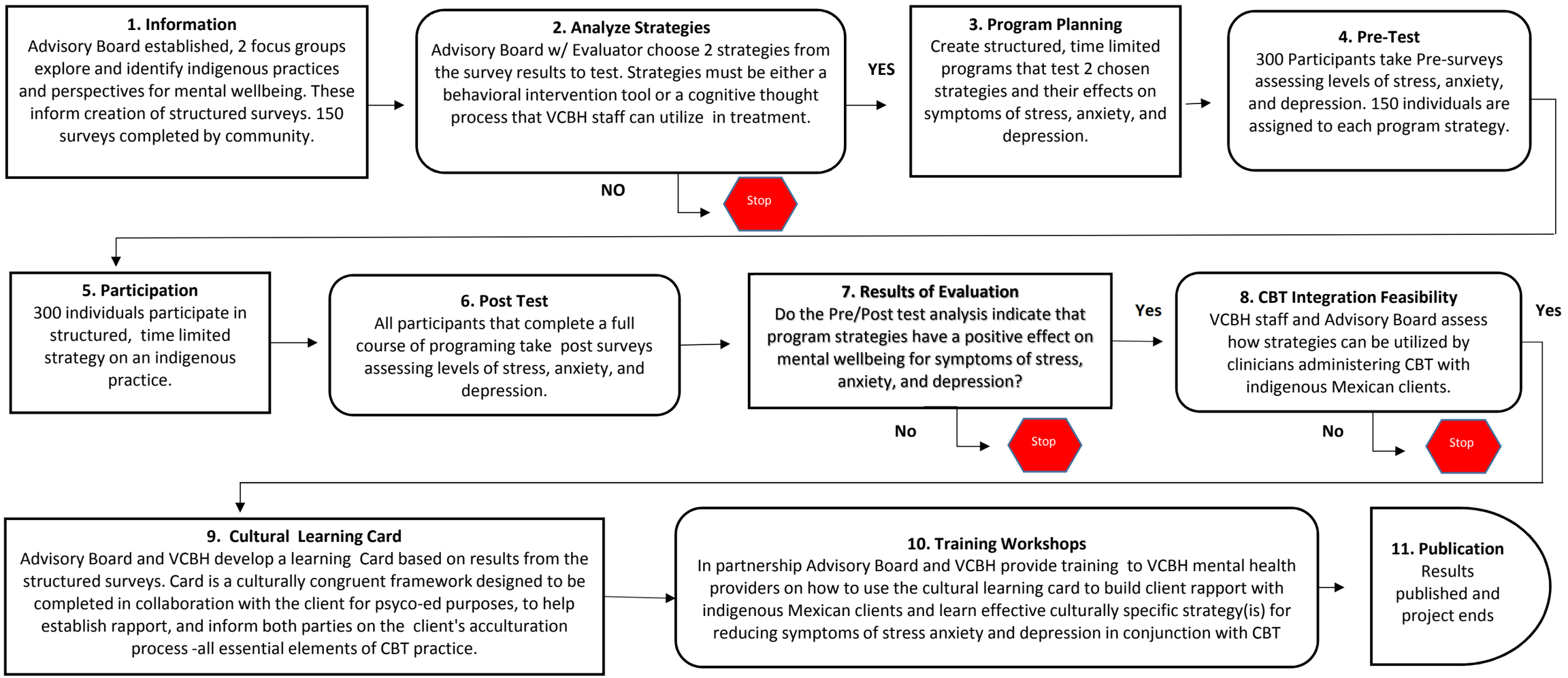
2.	Federal Financial Participation					
3.	1991 Realignment					
4.	Behavioral Health Subaccount					
5.	Other funding*					
6.	**Total Proposed Expenditures**	**$26,278**	**$41,919**	**$44,015**	**$46,215**	**$158,427**
*If “Other funding” is included, please explain.						

MIXTECO PROJECT: HEALING THE SOUL

INN General Requirement: Makes a change to existing mental health services

INN Requirement Primary Purpose: To improve the quality of mental health services including measurable outcomes

Innovations Programatic Goal: To improve the quality of mental health services provided to the indigenous Mexican population of Ventura County by introducing changes to existing treatment services through evaluating the effectiveness of indigenous cultural practices and perspectives on mental wellbeing and then assessing the feasibility of those results to be integrated with the Cognitive Behavioral Therapy approach for symptoms of stress, anxiety, and depression.



MIXTECO PROJECT: HEALING THE SOUL

AGENDA ITEM 6

Action
March 23, 2017, Commission Meeting
Award Stakeholder Contracts

Summary: The Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission) will consider awarding stakeholder contracts in response to the Requests for Proposals (RFP) released by the Commission in December 2016.

At its August 25, 2016 meeting, the Commission authorized the Executive Director to initiate a competitive bid process for six (6) stakeholder contracts for the following populations:

- Clients/Consumers;
- Diverse Racial and Ethnic Communities;
- Families of Clients/Consumers;
- LGBTQ;
- Parent/Caregivers of Children and Youth (under 18 years);
- Veterans.

The RFPs were released on December 2, 2016. They were posted to Cal e-Procure, the MHSOAC website, and advertised through an email notification to the MHSOAC listserv.

Scope of Work

Proposers were asked to develop deliverables in response to the scope of work as outlined in the RFPs in the following three priority areas:

- Advocacy;
- Training and Education;
- Outreach, Engagement, and Communication.

RFP Timeline

- December 2, 2016: RFPs released to the public.
- February 10, 2017: Deadline to submit proposals.
- March 23, 2017: Results presented to the Commission.

RFP Evaluation Process

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

- **Stage 1: Administrative Submission Review**
  Each proposal was reviewed by MHSOAC staff for the presence of all required documents including certification that the proposer met all minimum requirements as listed in the RFP. This first Stage was scored on a pass/fail basis. Proposals that passed the requirements of Stage 1 moved to Stage 2. *Proposals that did not meet the requirements of Stage 1 were deemed non-compliant and are not eligible to receive an award.*

- **Stage 2: Technical Review**
  Proposals were scored by review panels comprised of subject matter experts from multiple state agencies during the Stage 2 evaluation. The panels reviewed and scored proposals on the following requirements:
    - Desired Qualifications;
    - Response to the Scope of Work;
    - Workplan;
    - Letters of Support.

  The maximum points possible for this stage was 320 points. All proposals were required to meet a minimum point score of 220 points to move to Stage 3.

- **Stage 3: Reference Checks**
  For all proposals that reached the minimum point value of 220, MHSOAC staff contacted the references provided.

- **Stage 4: Evaluation of Cost Proposal**
  The proposal offering the lowest total cost earns the maximum available points for this section.

- **Stage 5: Combining Proposer's Scores**
  MHSOAC staff combines the points from stages 2 through 4 to determine the total scores for each qualifying proposer.

- **Stage 6: Adjustments to Score for Bidding Preferences**
  MHSOAC staff determines and confirms which entities, if any, are eligible to receive a bidding preference for the Disabled Veterans and Small Business preference.

  Final selection is determined on the basis of the highest overall point score and not the lowest bid. The recommended award is to be made to the proposer receiving the highest overall point score.

RFP Award and Protest Process

Within five working days of the Commission's vote to award, unsuccessful proposers, wishing to protest the decision, must submit to the MHSOAC a letter of intent to protest. If a protest is filed within this timeframe, the RFP requires the letter of protest to describe the factors that support the protesting proposer's claim. For a protest to be successful the protesting proposer must prove one of the following:

1. The protesting proposer would have been awarded the contract had the MHSOAC correctly applied the prescribed evaluation rating standards in the RFP; or
2. The protesting proposer would have been awarded the contract had the MHSOAC followed the evaluation and scoring methods in the RFP.

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

Enclosures: None

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

Presenters: Angela Brand, Project Lead

Recommended Action: Authorize the Executive Director to execute six (6) contracts for stakeholder advocacy.

AGENDA ITEM 7

Information

March 23, 2017 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: Motions summary from the February 23, 2017 Commission meeting; Evaluation Dashboard; Calendar of Commission activities; and Innovation Review Outline.

Handout: None

Recommended Action: Information item only

Mental Health Services
Oversight & Accountability Commission

WELLNESS • RECOVERY • RESILIENCE

Motions Summary

Commission Meeting
February 23, 2017

Motion #: 1
Date: February 23, 2017
Time: 8:52am

Text of Motion:

The Commission approves the January 26, 2017 Meeting Minutes.

Commissioner making motion: Commissioner Poaster
Commissioner seconding motion: Commissioner Van Horn

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

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

Motion #: 2
Date: February 23, 2017

Time: 9:55am

Text of Motion:

The MHSOAC approves Santa Cruz County's Innovation Project as follows:

Name: Integrated Health and Housing Supports
Amount: $4,451,280
Project Length: Five (5) Years

Commissioner making motion: Commissioner Poaster
Commissioner seconding motion: Commissioner Buck

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

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

Motion #: 3
Date: February 23, 2017

Time: 11:11am

Text of Motion:

The MHSOAC approves Merced County's Innovation Project as follows:

Name: Innovative Strategist Network (ISN)
Amount: $6,862,288
Project Length: Five (5) Years

Commissioner making motion: Commissioner Poaster
Commissioner seconding motion: Commissioner Wooton

Commissioner Buck recused himself. Motion carried 5 yes, 1 no, and 0 abstain per roll call vote as follows:

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

Motion #: 4
Date: February 23, 2017

Time: 11:59am

Text of Motion:

Pending Riverside County Board of Supervisors approval, the MHSOAC approves Riverside County's Innovation Project as follows:

Name: Commercially Sexually Exploited Children Mobile Response
Amount: $6,252,476
Project Length: Five (5) Years

Commissioner making motion: Commissioner Poaster
Commissioner seconding motion: Commissioner Van Horn

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

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

Motion #: 5
Date: February 23, 2017
Time: 12:10pm

Text of Motion:

The Commission authorizes the Executive Director to enter into one or more contracts, not to exceed $350,000, to support events or activities relating to the MHSA Innovation Component.

Commissioner making motion: Commissioner Van Horn
Commissioner seconding motion: Commissioner Poaster

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

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

AGENDA ITEM 7A

Information

March 23, 2017 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

- **Early Psychosis Evaluation** *The Regents of the Univ. of California, University of California, Davis*
  Update: Deliverable 5 is under review.

- **Assessment of System of Care for Older Adults** *The Regents of the Univ. of California, University of California, Los Angeles*
  Update: MHSOAC staff Fred Molitor now oversees the project.

- **Mental Health Services Act (MHSA) Performance Monitoring** *MHSOAC Evaluation Unit*
  Update: MHSOAC staff Fred Molitor now oversees the project.

Enclosures: MHSOAC Evaluation Dashboard

Recommended Action: None

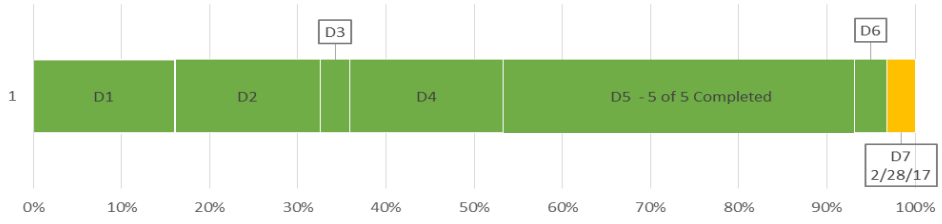
Presenter: None

Motion: None

Snapshot of Contract Deliverables

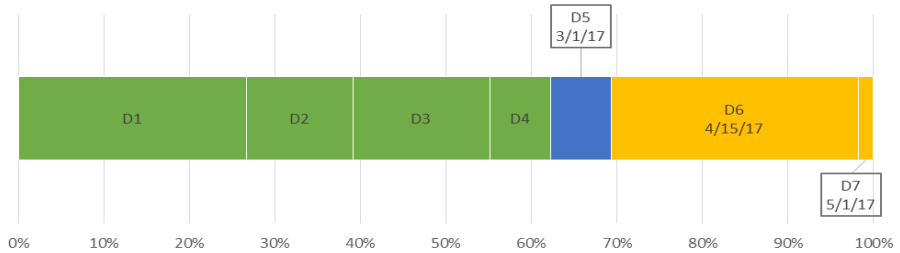
FSP Classification Project
November 2014 - June 30, 2017

Assess Full Service Partnerships on a statewide level to enable clients, family members, providers, counties, and the State to further understand the diversity of FSPs across California. *(Contract Amount: $327,313)*



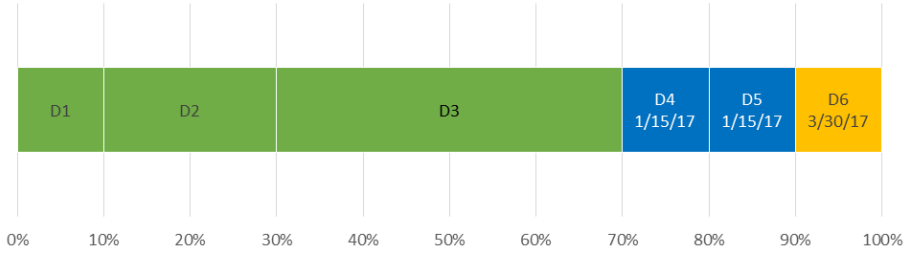
Early Psychosis Evaluation
June 1, 2015 - June 30, 2017

Identify and analyze program costs, outcomes, and costs associated with those outcomes related to providing early psychosis programs. *(Contract Amount: $281,151)*



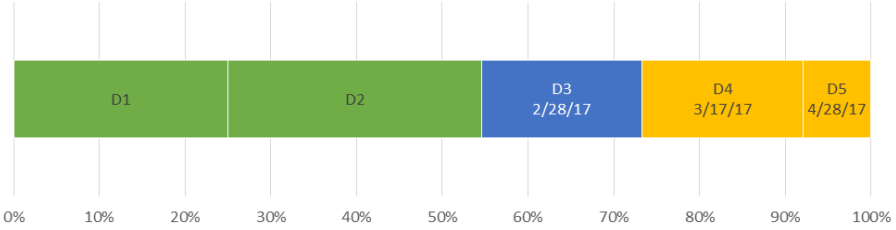
Recovery Orientation of Programs Evaluation
January 1, 2015 - May 31, 2017

Identify, describe, and assess existing measures and methods of evaluating the recovery orientation of programs and services. *(Contract Amount: $500,000)*



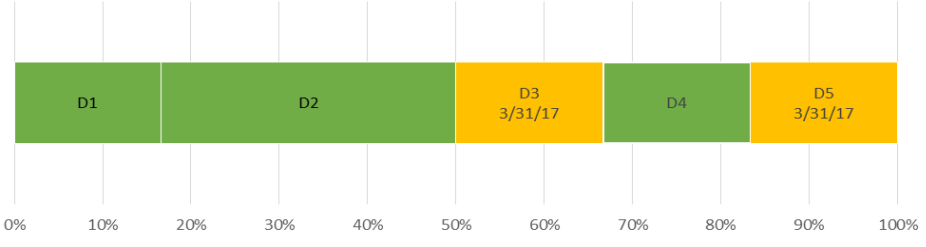
Assessment of the System of Care for Older Adults
June 1, 2015 - June 30, 2017

Assess the progress made in implementing an effective system of care for older adults with serious mental illness and identify methods further statewide progress in this area. *(Contract Amount: $400,000)*



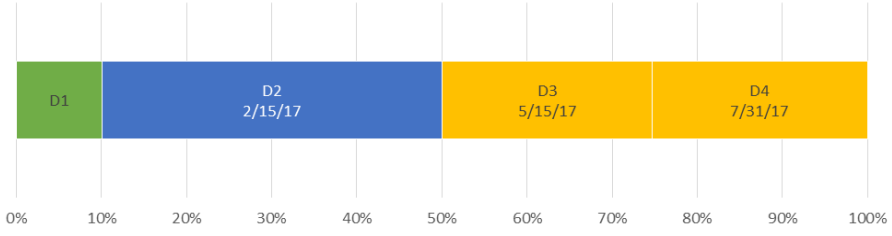
Evaluation of Return on Investment (ROI) for Prevention and Early Intervention (PEI) Evidence-Based Practices (EBPs)
June 30, 2015 - June 30, 2017

Investigate potential return on investment (ROI) for EBPs being implemented in CA with MHSA PEI funds, and to educate MHSOAC staff on ROI and other comparable evaluation methods. *(Contract Amount: $75,000)*



Community Services and Supports (CSS) Tracking, Monitoring, and Evaluation System Toolkit
August 15, 2016 - August 14, 2017

Assess the feasibility of adopting and implementing CSS Tracking, Monitoring, and Evaluation System to help providers, counties, and the State understand the clinical and functional status of clients within individual CSS programs/services, and determine whether clients are in appropriate services. (*Contract Amount: $99,000)*



Legend: Deliverable Complete; Deliverable Pending; Deliverable Under Review

Lengths of deliverable segments are proportional to each deliverable's share of the overall contract budget.

MHSOAC Evaluation Dashboard March 2017

(updated 3/16/17)

Mental Health Services
Oversight & Accountability Commission

Current MHSOAC Evaluation Contracts and Deliverables

Mental Health Data Alliance (MHDATA)				
Full Service Partnership (FSP) Classification Project (14MHSOAC008)				
MHSOAC Staff: Brian Sala **Active Dates**: November 2014 – June 30, 2017 **Objective:** The original purpose of this evaluation effort was to classify Full Service Partnerships (FSPs) in a meaningful and useful fashion on a statewide level to support statewide assessment and evaluation. In mid-2016, a portion of this contract was amended to provide support for implementation of a broader MHSOAC data transparency tool.				
	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	MHSOAC Website Application Configuration Support and Documentation Monthly Progress Reports (5)	From Sept. 30, 2016 to January 31, 2017	$130,350	Completed 5 of 5
6	Fiscal Transparency Component Acceptance Support	October 31, 2016	$12,000	Completed
7	Final Report—MHSOAC Website Application Activities and Recommendations	February 28, 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 March 2017

(updated 3/16/17)

Mental Health Services
Oversight & Accountability Commission

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

Recovery Orientation of Programs Evaluation (14MHSOAC003)

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	Completed
4	Resources for Evaluating Recovery Orientation and Dissemination Plan	January 15, 2017	$50,000	Under Review
5	Resources for Promoting Practices that Encourage Recovery Orientation and Dissemination Plan	January 15, 2017	$50,000	Under Review
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	

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MHSOAC Evaluation Dashboard March 2017

(updated 3/16/17)

Mental Health Services
Oversight & Accountability Commission

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

Early Psychosis Evaluation (14MHSOAC010)

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 data from the Early Diagnosis and Preventative Treatment of Psychosis Illness (SacEDAPT) program in Sacramento County to pilot a method to calculate program costs, outcomes, and costs associated with those outcomes in 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, including, for example, data elements collected by these programs and the various ways in which they are collected (e.g., via Electronic Health Records). These data elements will be used to review existing capacity to assess costs and outcomes for programs statewide, as well as help to define methods for the Sacramento County pilot. The Contractor further shall develop (with the involvement of stakeholders) a pilot study to examine and document how county early psychosis programs define, collect, and measure the duration of untreated psychosis (DUP).

	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	Completed
5	Summary Report of Descriptive Assessment of Early Psychosis Programs Statewide	March 1, 2017	$20,000	Under Review
6	Report on the Pilot Study Findings and Recommendations for Measuring DUP and DUMI	April 15, 2017	$81,151.00	Pending
7	Proposed Statewide Evaluation Plan	May 1, 2017	$5,000	Pending
Total Contract Amount			$281,151	

* 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 (14MHSOAC016)

MHSOAC Staff: Fred Molitor

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

Objective: The purpose of this evaluation effort is to assess 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	February 28, 2017	$75,000	Under Review
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 March 2017

(updated 3/16/17)

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) (14MHSOAC018)

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	Completed
2	Report of Cost Savings from WSIPP-Documented EBPs: Fiscal Year (FY) 2011/2012 though FY 2014/2015	June 30, 2016	$25,000	Completed
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.

Mental Health Services
Oversight & Accountability Commission

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

Community Services and Supports (CSS) Tracking, Monitoring, and Evaluation System Toolkit (16MHSOAC016)

MHSOAC Staff: Fred Molitor

Active Dates: August 15, 2016 – August 14, 2017

Objective: Assist county behavioral health departments in assessing the feasibility of adopting and implementing a Community Services and Supports (CSS) Tracking, Monitoring, and Evaluation System designed to enable providers, counties, and the State to understand the clinical and functional status of clients within individual CSS programs/services, and determine whether clients are in appropriate services. The evaluation effort seeks to improve the MHSOAC's capacity to provide ongoing technical assistance to county behavioral health departments to track, evaluate, and compare CSS program outcomes.

	Deliverable	Due Date*	Deliverable Cost	Status
1	**Work Plan**	**October 15, 2016**	**$10,000**	**Completed**
2	**Draft County Toolkit**	**February 15, 2017**	**$39,500**	**Under Review**
3	**Regional Meetings Report**	**May 15, 2017**	**$24,500**	**Pending**
4	**Final County Toolkit and Report on Recommendations for Implementation of Toolkit**	**July 31, 2017**	**$25,000**	**Pending**
Total Contract Amount			**$99,000**	

* 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

Ongoing MHSOAC Internal Evaluation Projects

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 March 2017

(updated 3/16/17)

Mental Health Services
Oversight & Accountability Commission

MHSOAC Evaluation Unit

Mental Health Services Act (MHSA) Performance Monitoring

MHSOAC Staff: Fred Molitor

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 EPLD 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

Commission Meeting Schedule 2017

Meeting Date and Location	Group / Topic
Thursday, March 23, 2017 San Diego	**Commission Meeting** Mental Health/ Criminal Justice
Thursday, April 27, 2017 Sacramento	**Commission Meeting** Business Meeting
Thursday, May 25, 2017 Sacramento	**Commission Meeting** Mental Health /Schools
Thursday, June 23, 2017 No Meeting	**Commission Meeting** No Meeting
Thursday, July 27, 2017 Sacramento	**Commission Meeting** Business Meeting
Thursday, August 24, 2017 TBD	**Commission Meeting** Project Meeting
Thursday, September 28, 2017 Sacramento	**Commission Meeting** Business Meeting
Thursday, October 26, 2017 TBD	**Commission Meeting** Project Meeting
Thursday, November 16, 2017 Sacramento	**Commission Meeting** Business Meeting
Thursday, December 28, 2017 No Meeting	**Commission Meeting** No Meeting

Mental Health Services
Oversight & Accountability Commission

Innovation Review Outline

Regulatory Criteria

- **Funds exploration of new and/or locally adapted mental health approach/practices**
  - Adaptation of an existing mental health program
  - Promising approach from another system adapted to mental health
- **One of four allowable primary purposes:**
  - Increase access to services to underserved groups
  - Increase the quality of services, including measurable outcomes
  - Promote interagency and community collaboration
  - Increase access to services, including permanent supportive housing.
- **Addresses a barrier other than not enough money**
- **Cannot merely replicate programs in other similar jurisdictions**
- **Must align with core MHSA principles (e.g. client-driven, culturally competent, recovery-oriented)**
- **Promotes *learning***
  - Learning ≠ program success
  - Emphasis on extracting information that can contribute to systems change

Staff Summary Analysis Includes:

- **Specific requirements regarding:**
  - Community planning process
  - Stakeholder involvement
  - Clear connection to mental health system or mental illness
  - Learning goals and evaluation plan
- **What is the unmet need the county is trying to address?**
  - Cannot be purely lack of funding!
- **Does the proposed project address the need(s)?**
- **Clear learning objectives that link to the need(s)?**
- **Evaluation plan that allows the county to meet its learning objective(s)?**
  - May include process as well as outcomes components