Mental Health Services
Oversight & Accountability Commission

Client and Family Leadership Committee
Meeting Agenda

Wednesday, May 10, 2017 **9:30 AM – 12:00 PM**

MHSOAC, 1325 J Street, Suite 1700, Sacramento, CA 95814
Call-In Number 1-866-817-6533; Participation Code 1189021

Other Public Locations

Encina Hall
616 Serra Street
Stanford, CA 94305

Starview Children and Family Services
649 E. Albertoni Street, Suite 100
Carson, CA 90746

TIME	TOPIC
9:30 AM	**Welcome, Introductions, and Opening Remarks** *Chair, Khatera Aslami-Tamplen* Welcome and Introduction of Members, Review Agenda
9:35 AM	**Approval of Minutes** *Chair, Khatera Aslami-Tamplen* The minutes from the March 8th, 2017 CFLC meeting will be reviewed and considered for approval. • **Public comment** • **Vote**

Public Notice

All meeting times are approximate and subject to change. Pursuant to the Americans with Disabilities Act, individuals who, because of a disability, need special assistance to attend or participate in any Mental Health Services Oversight and Accountability Commission Meeting may request assistance at the Commission offices, 1325 J Street, Suite 1700, Sacramento, CA 95814, by calling 916-445-8696, or by emailing the MHSOAC at mhsoac@mhsoac.ca.gov. Requests should be made one week in advance whenever possible. To accommodate people with chemical sensitivity, please do not wear heavily scented products to MHSOAC meetings.

9:40 AM	**Adoption of the CFLC Charter** *Chair, Khatera Aslami-Tamplen* The committee will consider adopting the CFLC Charter which outline the purpose, goals, and activities of the committee. • **Public comment** • **Vote**
10:10 AM	**Phase II MHSOAC Transparency Tool** *Brian Sala, MHSOAC Deputy Director* Deputy Director Sala will provide an update on Phase II of the Transparency Tool and hear feedback from the committee about the type of descriptors to include in the tool that would help clients and families find the services they need. • **Public comment**
10:50 AM	**Presentation by NAMI California** *Beth Wolf, Director of Programs; Melen Vue, Director of Community Engagement* The MHSOAC recently awarded a stakeholder contract to NAMI California to provide advocacy and training for Families of Clients/Consumers. NAMI California will share its goals, objectives, and advocacy on behalf of clients and families. • **Public comment**
11:20 AM	**Schools and Mental Health Project Update** *Commissioner Gladys Mitchell* Commissioner Mitchell will give an update of the Schools and Mental Health Project and seek input on the project. • **Public comment**
11:40 AM	**Discussion of Future Agenda Items for July 12th Meeting** *Chair, Khatera Aslami-Tamplen* Agenda items for the July 12th meeting will be proposed.
12:00 AM	**Adjourn**

___ **INFORMATION** **TAB SECTION:** 1

X **ACTION REQUIRED** **DATE OF MEETING:** 5/10/2017

AGENDA ITEM: **Vote: Adoption of March 08, 2017 Meeting Minutes**

ENCLOSURES: Draft Minutes from March 08, 2017 Meeting

OTHER MATERIAL RELATED TO ITEM: None

ISSUE:

Minutes from March 08, 2017 need to be reviewed and approved.

Proposed Motion

The CFLC Committee adopts the minutes from the March 08, 2017 meeting.

Mental Health Services
Oversight & Accountability Commission

CLIENT AND FAMILY LEADERSHIP COMMITTEE
MEETING MINUTES • March 8, 2017

TIME and LOCATION: CFLC assembled at 9:30 am, in the MHSOAC Steinberg Conference Room.

MEMBERS PRESENT:

Khatera Aslami-Tamplen (Chair)

Gladys Mitchell- Guest Commissioner

CFLC members: Michaele Beebe, Jeffrey Decker (by phone), Richard Krzyzanowski, Peter LaFollette, Yvette McShan, Laysha Ostrow (by phone), Darlene Prettyman (by phone), Min Suh, Julia Sweeney (by phone), Jairo Wilches, Sam Woolf, Emily Truong, Sandra Villano, Sharon Yates.

MEMBERS ABSENT:

Andrea Crook

MHSOAC Staff: Filomena Yeroshek, Brian Sala, Tom Orrock, Keely Connelly

WELCOME AND OPENING REMARKS:

Chair Aslami-Tamplen welcomed all in attendance and opened the meeting at 9:32 am. Roll call was taken. Minimum quorum was met with nine members present at the start of the meeting. Three members called in but were not able to participate as committee members due to the Bagley-Keene Open Meeting Act restrictions regarding the posting of addresses for members who are in other locations. Brian Sala, MHSOAC Deputy Director, stressed the importance of members communicating their intention to join the meeting by phone and providing a public address. Commissioner Gladys Mitchell was introduced and welcomed the members. All members of the CFLC introduced themselves and gave a short statement about their background and experience with the public mental health system. Members shared about their interest in the MHSOAC Client and Family Leadership Committee.

PURPOSE AND VISION OF THE MHSOAC

Brian Sala, MHSOAC Deputy Director, gave an overview of the MHSOAC. He reviewed the MHSOAC mission statement, projects underway, and helped to frame the opportunities for this committee. The Commission created the committee for the specific purpose of sharing information with clients and families as well as providing help to the Commission in order for it to achieve its objectives. Deputy Director Sala read the MHSOAC mission statement to the committee. He pointed out that in the mission statement there exists a lot of opportunity for the committee to participate. Key components of the Commission activities were shared including the research and evaluation projects. The research and evaluation budget is limited which means that the Commission needs to be specific about how it uses the resource. We need to leverage those funds in key ways to allow the funding to go further toward the goals of the MHSOAC. In April a Fiscal Transparency tool may be available to allow counties to raise awareness about the expenditures made by counties as well as unspent funds in county accounts. The hope is that the tool will bring about a greater level of engagement from the community at the county level. Holding County MH departments accountable for how money is spent is an important part of transparency. At the next meeting we can look at Phase II of the transparency tool and address the question: *What are the right kind of descriptions we should include on the site which will help consumers and families find the services they need?* The transparency tool will allow information about best practice to be spread around to other counties. We are trying to create an ethic of continued quality improvement. The MHSOACs role is really to connect the dots between counties.

Deputy Director Sala also highlighted the SB 82 grant program. A program that provides 32 million dollars a year for Crisis services. These funds provide personnel for these programs in 24 counties. The new RFA will be released in the spring of 2017. Also, Stakeholder contracts will be provided to seven organizations. Awards will be made on March 23rd. Deputy Director Sala explained that the MHSOAC has a plan review unit as counties are to submit their three year plans to the MHSOAC not for approval but review. If the MHSOAC recognizes issues with the plans, those concerns are communicated to Department of Health Care Services for enforcement. The Commission also approves Innovations plans for the counties. A subcommittee has been designed to review the process for approving INN proposals. In 2011 the Legislature removed the role of the MHSOAC in INN and in 2012 in restored the role.

Public Comment:

No public comment

COMMITTEE GOALS, EXPECTATIONS, AND REVIEW OF THE 2016/17 CHARTER

Chair Aslami-Tamplen led a discussion about the committee charter. The past charter was reviewed. The purpose and goals were reviewed. The Chair felt that we could rethink the need to include an evaluation of the committees own performance since that did not take place last year. This may not be necessary in the future. The Chair stated that we would like to adopt a charter in the next meeting. It was stressed that the goals should be easily achievable and relate directly to the work of the Commission so that the committee brings value to the work of the Commission.

Commissioner Mitchell stated that she'd rather see us have less on the charter but achieve the goals as stated. We should be strategic in our meeting.

Sam Woolf thought we should talk about what to keep first and then move from there.

Emily Truong has had a focus on the unserved communities of color. She stated that it was Asian Pacific MH Awareness Day on our next meeting.

Michaele Beebe asked for clarification regarding the committees role in the MHSOAC projects i.e. schools, Issue Resolution Process (IRP), etc.

Deputy Director Sala stated that the OAC needs the committees support and guidance on projects such as the Schools and Mental Health Project. The committee should be designed to make connections for the Commission and to make sure that we have the rights voices at public events, community forums, meetings, etc. When the Commission is trying to get information gathered it needs help to do the appropriate outreach to talk to the appropriate people in order to inform the Commission. The committee answers the questions: *Who are the people we should have in the room when we discuss particular topics?*

Julia Sweeney pointed out the committee strengthens the connection between local communities and our Commission. Whatever the MHSOAC goals are will influence how the committees connect communities to the Commission. She stated that we need to answer the HOW question.

Richard Krzyzanowski asked about attending a meeting if he is out of the state. The same guidelines discussed earlier would exist for this scenario. He stated that he is interested in building on the foundation we started last committee especially in Issue Resolution Process. Expanding public participation is very important. Public participation translates in to community involvement which translates into community

empowerment.

Deputy Director Sala stated that the draft of the IRP report will be presented to the Chair within a week and then shared with the subcommittee. Three core issues were addressed. General lack of knowledge about the IRP at the local level. A lack of utilization of the data collected on actual cases so that continuous quality improvement can be accomplished. And, a lack of participation in the IRP at the local level.

Sandra Villano asked how people on the committees are notified of the MHSOAC projects. She stated that with the schools project this did not happen with some of those she knows who were not notified. For the next meeting Chair stated that we will have a list of projects to share with the committee.

Sam Woolf stated that we should utilize the talent of people in this room in order to reduce stigma by sharing their stories. This could be done through panel participation. He shared that a more clear vision and goal for the committee could be, "Through unity and experience, the Client and Family Leadership Committee will support the Mental Health Services Oversight and Accountability Commission projects by empowering individuals in their communities to provide feedback emphasizing involvement, participation, and partnership from clients, families, and all other stakeholders affording them a voice and forum for praise and criticism of the mental health services they receive under the auspices of the Mental Health Services Oversight and Accountability Commission.

Sharon Yates stated that committee members need to keep their ear to the ground to better track what is going on at the local level so that we can follow up as a committee.

Jairo Wilches works with the grievance process in his county and is willing to assist with this project. He stated that it would be helpful to address stigma that exists within our county systems, especially within substance use treatment. The current framework is like a law enforcement/inmate relationship which furthers trauma.

Yvette McShan commented about the public involvement which is needed at the local level. She stated that we often get the professional voice and not the local consumer voice. Some people who try to advocate for themselves are mistreated in meetings and this leads to a low self-esteem and limited input.

Emily Truong highlighted the stigma reduction efforts that are needed in order to reach out to unserved and underserved communities. We want to help underserved communities access MH services but stigma interrupts this. She wondered if the committee is interested in reviewing how private insurance companies are providing access to MH services.

The Chair shared the idea of highlighting committee members who wanted to share their story of recovery and their hopes for the Mental Health Services Act (MHSA) through a video. It could be shared in communities to encourage others to tell their stories and to get involved locally. People want to know the committee members and who they represent. The video would accomplish this. The Chair stated that she would love to see a policy paper regarding how to engage local consumers and family members to become involved in the planning process.

Public Comment:

Wendy asked how the public can support the committee and also hold the committee accountable.

REVIEW OF BAGLEY-KEENE OPEN MEETING ACT

Filomena Yeroshek, MHSOAC Chief Counsel, presented to the committee on the Bagley Keene Open Meeting Act and how it relates to the committee functions. Items discussed centered on the three main duties under the act. Transparency is one of the main focuses of the act. The goal is to have the state conduct their meetings in open and transparent ways. The act applies to the MHSOAC and the committees that are organized or created by the commission. It also applies to any group of three or more individuals who are a part of the committee. If three is a meeting with a specific purpose of the majority of members to hear, discuss and deliberate, it's a meeting. It is not only when you are making a decision or taking a vote. Gathering does not require a physical meeting. Emails can be considered a meeting if there are several members using Reply All to each other. We ask that members Reply but not Reply All. Violations of the Act are typically not intentional. One of the main issues that occurs with teleconference meetings is when members want to participate by phone but have not provided a public address from which they will be calling in. This address needs to be public and the address has to be listed on the agenda. Calling from home is not an option and so the staff will help members find a public location. This needs to be done well prior to the meeting because agendas have to be posted 10 days in advance. The agenda has to have a brief description of the items with enough information to allow the public to make a decision about whether they want to come to hear about the item or make public comment on the item. You may not discuss items or take action on items that are not on the agenda. All documents that are given to the majority of the members must be provided to the public as well.

Julia Sweeney asked if a survey could be sent to all the committee members without public notice. Chief Counsel Yeroshek stated that it would constitute a meeting and

therefore it would have to be posted

TRAVEL PROCEDURES

Keely Connelly, MHSOAC staff, shared information about travel procedures. Packets were distributed with all necessary forms. Standard form, 204 was explained and discussed. Ms. Connelly asked that it be filled out and turned in so that travel expenses can be reimbursed. The Travel Expense worksheet was explained and discussed. This form is filled out for every meeting with the date, meeting, and receipts attached. It is important for everyone to have an email listed on this form so that communication can take place via email. Everything must be signed in blue ink pen. Ms. Connelly invited members to email her with any questions or help that they may need to make travel and reimbursement for expenses more efficient.

PROPOSED CALENDAR FOR 2017 AND NEXT MEETING TOPICS

A proposed calendar for 2017 was shared with the committee members. Dates of future meetings are May 10th, July 12th, September 13th, and November 8th. Some of the possible future agenda items include the following: Phase II of Transparency Project, Adoption of the Charter for CFLC, Draft IRP report, Presentation of the current projects underway by the MHSOAC.

A question was posed about whether the committee would be doing any community forums. It was expressed by the Chair and by MHSOAC staff Tom Orrock that the committee's role would be to support the Commissions community projects by helping them to get the right people in the room and by identifying experts who could assist with projects.

Julia Sweeney suggested that the health insurance topic be put on the agenda to discuss the intersection of public and private insurance as well as how people are able to access services.

Sam Woolf suggested that speakers come to present to the commission about topics related to the projects.

Commissioner Mitchell stated that where we get the most out of our efforts is to continue to educate the public about mental health so that stigma is reduced. Wherever this education could fit in to this committee discussion would be very important.

The meeting adjourned at 11:58AM.

___ **INFORMATION** **TAB SECTION:** 2

X **ACTION REQUIRED** **DATE OF MEETING:** 05/10/17

AGENDA ITEM: **Vote: Adoption of CFLC Charter**

ENCLOSURES: CFLC Draft Charter

OTHER MATERIAL RELATED TO ITEM: None

ISSUE:

The CFLC will review the draft charter and consider for approval.

Proposed Motion

The CFLC adopts the 2017-2018 CFLC Charter.

Mental Health Services Oversight and Accountability Commission
Client and Family Leadership Committee (CFLC)
2017-2018 Charter

CFLC CHAIR FOR 2017-2018

• Chair, Commissioner Khatera Aslami-Tamplen

PURPOSE AND GOALS

Through unity and collective experience, the CFLC will support the projects of the Mental Health Services Oversight and Accountability Commission (MHSOAC) by inviting individuals to provide feedback, from the client and family perspective, in the creation of mental health policy recommendations and Mental Health Services Act (MHSA) program implementation. Our common goal is to bring support and guidance to the MHSOAC on projects selected by the Commission and to ensure that the client and family voice is "in the room" to be heard and considered when policies and practices are discussed at the local and state levels.

CORE VALUES

- Carry out the mission, values, and goals of the MHSOAC.
- Promote Commission and Committee participation of diverse community members with lived experience and severe mental health issues.
- Encourage methodologies to reduce stigma and discrimination for all individuals.
- Keep the MHSOAC apprised of client, parent, caregiver, and family issues as they relate to the projects of the Commission.
- Ensure projects, contracts, tools, and advocacy efforts incorporate the Recovery and Resilience vision.

GROUND RULES AND GUIDELINES

Members are expected to attend all meetings (by phone or in person) and be on time.

Members are expected to be prepared and fully participate in all meetings and assignments.

Members will respect all cultures, backgrounds, and ideas.

Members will abide by a code of integrity, excellence, and efficiency in carrying out the mission of the MHSOAC.

Members of the Committee will actively participate in the projects.

If members are unable to attend a meeting they will notify the Chair and MHSOAC staff member prior to the meeting.

MEETINGS AND COMMUNICATIONS

Primary communication is during the scheduled Committee meetings and in strict adherence to the Bagley-Keene Open Meeting Act. The use of email, cell phones, website, or postings may be used for quicker communication as long as no business is conducted and follows the mandates of the Bagley-Keene Open Meet Act. Meetings will be conducted in open session.

Adequate notice of meetings will be posted. Members of the public must be provided an opportunity to comment on each agenda item.

RULES OF PROCEDURE

Committee members are reimbursed in accordance with the State of California per diem laws. Decision making is by voting and follows Robert's Rules of Order:

- A Committee member clearly states a motion.
- Another member seconds the motion.
- Discussion by Committee members.
- Public comment is heard.
- Committee members vote on the motion.

CHARTER ACTIVITIES for 2017-2018

1. CFLC members will participate with and actively support selected Commission projects. The Committee will be informed by MHSOAC Commissioners as well as MHSOAC staff members of the projects and priorities of the MHSOAC so that the Committee may lend its knowledge and expertise to the process.
    a. Provide active involvement with the Issues Resolution Process (IRP) project.
    b. Provide active involvement with the Schools and Mental Health project.
    c. Provide feedback on the Fiscal Transparency Tool to ensure usability by families and clients.
    d. Provide assistance to the MHSOAC on other projects as they arise.

2. The CFLC will produce a policy document which outlines best practices for client and family member engagement in local mental health programs.

3. Create a “Tell Your Story” video project highlighting committee members who will share the importance of hearing from consumers and family members on how to improve the mental health services delivery system and/or their stories about the impact of the MHSA on them and their family members.

CHARTER APPROVED AND ADOPTED: _____

X **INFORMATION** **TAB SECTION:** 3

__ **ACTION REQUIRED** **DATE OF MEETING:** 05/10/17

AGENDA ITEM: **Phase II MHSOAC Transparency Tool**

ENCLOSURES: Slide presentation

OTHER MATERIAL RELATED TO ITEM: None

ISSUE:

An update of the Phase II Transparency Tool will be presented to the committee for their review and comment. The Transparency Tool is being designed to provide information about how counties have spent MHSA revenue, the amount of unspent funds, and information about the programs available in each county.

Proposed Motion

Not Applicable

X **INFORMATION** **TAB SECTION:** 4

__ **ACTION REQUIRED** **DATE OF MEETING:** 05/10/17

AGENDA ITEM: **Presentation by NAMI California**

ENCLOSURES: None

OTHER MATERIAL RELATED TO ITEM: None

ISSUE:

NAMI California will present to the committee on their program goals and objectives. The presenters will outline NAMI's priorities for the coming year and will discuss the most current issues related to advocacy efforts for the families of individuals with mental health disorders.

Proposed Motion

Not Applicable

X **INFORMATION** **TAB SECTION:** 5

__ **ACTION REQUIRED** **DATE OF MEETING:** 05/10/17

AGENDA ITEM: **Schools and Mental Health Project Update**

ENCLOSURES: Schools and Mental Health Project Outline

OTHER MATERIAL RELATED TO ITEM: None

ISSUE:

An update on the Schools and Mental Health project will be provided including a debriefing of the recent site visit to Grant Elementary School in Richmond, CA. This project is focusing on access and effectiveness of the mental health services which are offered in the schools.

Proposed Motion

Not Applicable

School-Based Mental Health Services for Children in Early Education

Project Framework

Background and Rationale for Project

More than 300,000 children ages 4 to 11 years in California are estimated to have a mental health need, of which only one-fourth receive treatment regardless of health care coverage.[1] Children at increased risk for developing a mental health condition early in life are boys, those from disadvantaged backgrounds and/or living in single parent households, those who have suffered early trauma, those living with a parent who has poor physical or mental health, and those with chronic health problems such as asthma.[2]

Untreated mental health needs can derail a child's development and lead to many poor school outcomes, including low achievement, suspension, and expulsion. Thus, the early identification of mental health needs is critical and a first step to ensure that children and their families receive evidence-based interventions to support the child's success.

School teachers and other school personnel are often in the best position within a community to identify and engage children exhibiting markers of risk for developing a psychological disorder.[3] However, teachers and administrators may not have the skills to properly assess students as in need of mental health treatment. When need is established, appropriate services may not be available at the school, and referrals for students exhibiting more severe emotional and behavioral problems may not lead to community-based treatment for reasons such as parent distrust of government agencies outside of the school or lack of transportation. Too often symptoms progress to the point that a special education assessment process is initiated, resulting in the decision that the general education program cannot meet a student's needs, not because of learning difficulties but rather due to increasingly disruptive behaviors.

Addressing children's mental health needs through special education is very costly and generally does not yield positive long-term outcomes. In California, 9.9 percent of Kindergarten through 12th grade public school children receive special education services.[4] The average costs of educating children in special education is more than double that for students in general education, $22,300 versus $9,600 in 2013.[5] In 2010-11, special education expenditures in California totaled $8.6 billion, with less than one-fifth (18.6 percent) of these costs covered by federal Individuals with Disabilities Education Act (IDEA) funds.[6]

A total of 25,984 children, or 0.4 percent of the total Kindergarten through 12th grade school population, were assessed as having "emotional disturbance" in 2011-2012, which is one of 13 disability categories for special education. Students diagnosed as emotionally disturbed have the poorest outcomes of all students in special education, both academically and socially.[7] One study found that 44 percent of students who had been diagnosed with emotional disturbance eventually dropped out of high school, which is much higher than the dropout rate of 28 percent for all students who had received special education.[8] More than half (58 percent) of 15 through 19 year olds with a history of special education placement due to emotional disturbance reported in a survey that they had been arrested at least once.[9]

In September 2014, leaders in the fields of education and mental health along with representatives from the California Endowment, Sierra Health Foundation, and the Blue Shield Foundation met at the MHSOAC to

participate in discussions related to the challenges and missed opportunities to effectively identify and help children in need of mental health services. Consensus was reached at this meeting that current practices do not adequately support children demonstrating emotional and behavioral needs toward reaching their full academic potential and avoiding unnecessary placements in special education. Meeting attendees were supportive of alternative approaches, but indicated that a new model(s) must be based on empirical findings demonstrating effectiveness from a well-designed pilot study.

Project Goal

Develop a series of recommendations that are supported by key partners and stakeholders for the Commission to review and act upon (also known as an "action agenda"). This would include implementing a continuum of early interventions and supports to improve mental health access and outcomes and increase academic success among children in preschool and elementary school who are exhibiting emotional and behavioral problems.

Project Objectives

With the support of county mental health administrators, school superintendents, teachers, school personnel, parents/caregivers, and other stakeholders, this project will address the following eight objectives:

1. Document the current practices in California public schools to identify and treat young children (preschool – 3rd grade) with emotional and behavioral needs.
2. Within the context of current practices, identify any existing barriers, challenges, and gaps in services for addressing children's mental health needs.
3. Examine the impact of current practices on children from diverse communities.
    a. Assess the distribution of rates of referrals to special education programs due to a diagnosis of emotional disturbance across racial/ethnic groups toward investigating disparities in identifying and treating children with emotional and behavioral needs.
4. Identify alternative promising practices and evidence-based models implemented within and outside California schools for the provision of mental health services to young children.
    a. Identify limitations and core components of such approaches towards developing a project-based study to provide data or test intervention(s) (e.g., pilot study) that would be generalizable and feasible to implement on a large-scale level across California.
5. Design an alternative model(s) for the prevention, early intervention, and provision of mental health treatment services for children in early education programs toward improving mental health outcomes and increasing academic success.
    a. Implement and evaluate the identified alternative model(s) per specified outcomes in relation to implemented fidelity as well as the cost-benefit of the intervention.
    b. Based on the results of the proposed evaluation, and input from partners and stakeholders, develop recommendations for the implementation of the proposed changes in practices for mental health services in early education programs in California.

These objectives will be addressed via four project components: project structure, public engagement, pilot study implementation and evaluation, and communications.

Project Structure

The full MHSOAC Commission will be kept apprised of project activities and milestones at Commission meetings. The outcome of project Subcommittee meetings, chaired by Commissioner David Gordon, Superintendent of the Sacramento County Office of Education, will be to develop action-oriented recommendations for consideration by the Commission to improve mental health assessment, services and outcomes for early education students in California. These recommendations will incorporate the input provided at public hearings before the full Commission and public engagement meetings before the Subcommittee, and from focus groups of parents/caregivers, educations, and county administrators and providers. The recommendations may also be informed by the findings from a MHSOAC-initiated pilot study, with the intervention model and evaluation design developed with input from the Subcommittee and facilitated by staff overseen by the MHSOAC Director of Research and Education.

Public Engagement

Public Hearings. Communication of the structure, limitations, and advantages of current practices to assess and treat children in need of mental health services will be offered by persons with lived experience, subject matter experts, leaders in education and county mental health services, front-line early education teachers and administrators, and members of the public at hearings at MHSOAC Commission meetings. The format for the hearings will include presentations to the Commission and follow-up public discussions between presenters and Commissioners. These public hearings will provide forums for both identifying alternative practices overall and the project pilot study, and for formulating recommendations based on the findings from the pilot study and other information obtained over the course of the project.

The public hearings will be designed to identify answers to the following questions:

1. What are the standard and alternative practices in California for identifying and treating preschool and K-3rd grade students in need of mental health services?
2. What are the school-, family- and community-based factors that impede the appropriate assessment and treatment of children in need?
3. What is the information, training, and/or support that teachers and school personnel need to identify children at risk of developing a psychological disorder?
4. What are innovative, best practice models for the early identification and treatment of children's mental health needs?
5. How can school districts and counties improve their collaboration and coordination efforts to effectively integrate services and serve children and their families with mental health needs?
6. How can schools enhance parent engagement and ensure that families are receiving needed supports and services?

Workgroup Meetings. MHSOAC Subcommittee meetings will be designed to engage stakeholders and provide opportunities for more in-depth discussions on current and alternative school-based mental health practices for children in early education. These meetings should include a broad array of stakeholders including persons with lived experience; parents and caregivers; representatives from state government agencies; elementary school teachers, personnel, and administrators; community-based mental health administrators and providers; professional organizations; and advocacy groups.

Community Forum. A community forum may be organized to engage a larger group of stakeholders and members of the public who cannot participate in the public hearings and public meetings.

Focus Groups. Focus groups will be held with parents and caregivers of children with mental health needs. Efforts will be made to recruit parents/caregivers from diverse communities, particularly those for which

mental health needs are highly prevalent and largely unmet. Focus groups will be designed to understand from parent/caregiver's perspective how schools and communities have responded to their child's mental health needs, challenges they have encountered in accessing services, and their recommendations for improving treatment and services. In addition, focus groups will be conducted with teachers and other school personnel, as well as county behavioral health administrators and providers.

Pilot Study Development and Implementation

Literature Review. The findings and recommendations available in articles and reports from the research, policy, and other literature will be reviewed and summarized to assist in defining the scope of the problem, identify practices and models that have demonstrated positive student- and school-based outcomes, and provide the foundation for a pilot study to evaluate the impacts associated with an alternative approach(es) to the assessment and treatment of children with emotional and behavioral disorders.

There are a number of existing evidence-based school programs to enhance children's social and emotional functioning and school achievement. Programs targeting preschool and elementary school students are generally classroom-based with teachers providing regular lessons to students to help them understand and express emotions, manage anger, problem solve, practice conversation skills, build friendships, and behave appropriately in the classroom. One such program is The Incredible Years® programs for children ages 2 to 10, which includes a classroom management component and curriculum (Dina Dinosaur Classroom Curriculum).[10] There is also a parent program that strengthens parental competencies and a child treatment program that utilizes a small group setting to treat children with ADHD, conduct problems, and internalizing disorders.

The Promoting Alternative Thinking Strategies (PATHS®) is another evidence-based prevention program to promote social and emotional competencies and reduce the risk of children developing emotional and behavioral problems.[11] It is designed for children in pre-K to fifth grade and is delivered through classroom instruction on a regular basis (3 times per week for a minimum of 20-30 minutes per day). In controlled trials, PATHS has been shown to be effective in reducing social, emotional, and behavioral problems in children in regular and special education.[12,13]

Programs like The Incredible Years® and PATHS® are effective classroom-based prevention programs that can minimize the risk of children developing social and behavioral problems. However, alone these programs are unable to adequately detect emerging mental health needs as well as address the needs of children with more severe problems in which a team-based, integrative approach, coupled with infrastructure for targeted and intensive mental health interventions, would be best suited.

Positive Behavioral Interventions and Supports (PBIS) is an evidence-based school-wide system of interventions to create a positive school climate that supports and reinforces positive social behaviors among children, campus-wide within and outside of the classroom. It is based on a multi-tiered model for promoting student wellness based on students' level of need: Tier 1 supports all children (prevention, universal interventions), Tier 2 targeted provides targeted services to those at-risk (secondary interventions), and Tier 3 provides more intensive services to those with emotional and/or behavioral disturbance (tertiary interventions). Intervention efforts are collaborative, team-based, and overseen by an intervention team that works closely with teachers and school personnel to set and reinforce school-wide expectations for appropriate behavior, provide ongoing staff training and support, implement targeted and intensive interventions, and monitor school data and school performance. A 5-year randomized controlled effectiveness trial demonstrated significant reductions in problem behavior, office discipline referrals, and suspensions for children in PBIS, relative to children in comparison schools.[14] Furthermore, children in PBIS schools showed

better concentration and emotion regulation, and greater prosocial behavioral than their counterparts in the comparison schools.[15]

The programs and curriculum described above have been implemented across California, the extent to which is currently unknown. Anecdotal evidence suggests that the implementation of PBIS in California has not been uniform and there is considerable variation in how schools and districts are using the PBIS framework. Furthermore, the system structure and capacity to support Tiers 2 and 3 interventions for children may not be well established. This point was made by parent advocates and stakeholders at the December 6, 2016 Subcommittee Workgroup meeting and the January 26, 2017 Commissioner meeting. Identified barriers to support children in these tiers included a diffusion of responsibility between schools and counties for providing services, an inadequate referral process, long wait times and treatment delays, and a lack of care coordination of services across various systems.

Pilot Study. One primary objective of this project is to conceptualize and implement a pilot study to evaluate an alternative approach(es) over current practices to identify children in early education at risk of a disability of emotional disturbance and provide timely and effective services to improve mental health outcomes and enhance academic success. One challenge in selecting a model for study will be to achieve a balance between identifying an intervention with sufficient intensity to demonstrate measureable outcomes, and one not so vast and resource intense that it would be challenging for the Legislator and others to support an MHSOAC recommendation to implement the model across the state.

Based on feedback from stakeholders at the December 6, 2017 Subcommittee Workgroup Meeting and the January 26, 2017 Public Hearing, components of a potential model would include the following:

- A multi-tiered intervention.
- A full-time, onsite mental health clinician such as a school social worker.
- Improved screening and early detection of children's mental health needs.
- Enhanced communication and coordination of services between school districts and county mental health departments.
- Enhanced parent engagement and support.
- A preschool component.

Once a suitable model is identified for study, the MHSOAC Director of Research and Evaluation will work with the Subcommittee to incorporate the feedback from public hearings and workgroup meetings, and research and policy literature, to:

1. Explicate the core attributes of a model for study to ensure uniformity in implementation, including intervention staff educational requirements and service-delivery components, procedures, and standards.
2. Develop a budget for the study and explore options for funding through MHSOAC or other mechanisms.
3. Identify individual-level (mental health functioning, attendance, academic achievement, positive classroom participation) and system-level (referrals and placement to special education) measures that will serve as the primary outcomes to determine effectiveness.
4. Identify methods to document cost and benefits (direct and indirect) data to calculate the cost-benefit of the intervention.
5. Identify procedures for collecting data on these outcomes and transmitting these data on an ongoing basis for quality checks and preliminary analyses.

6. Recruit California counties and school districts to implement the model (intervention sites) and, ideally, a sample of counties and school district to provide outcome data in non-intervention (comparison) sites.
7. Implement the model in selected counties and school districts and document related challenges, successes, and lessons learned.
8. Provide an introductory and ongoing opportunities for the knowledge transfer across implementation sites as well as the presentation and discussion of preliminary findings.
9. Interpret the study findings in terms of the effectiveness and cost-benefit of the intervention and, as warranted, recommendations for the expansion of the model to other schools.

An additional item for the Subcommittee's consideration will be to determine the duration of the pilot study, which could potentially be a 2 to 5 year endeavor depending on the model. The probability of detecting significant differences in outcomes between the intervention and comparison schools will increase with each year of study implementation, but will delay the release of recommendations accordingly. The duration of the study can be shortened to the extent that the number of participating schools is increased, particularly if the participating schools have large numbers of children at risk for special education placement due to emotional disturbance.

Communications

A number of products will be produced from this project. A final report will include recommendations from the findings from all public engagement activities and pilot study. The report will be available on the Commission's website, with summaries of the activities and information gathering and as ongoing resource for implementation efforts. The final report, adopted by the Commission, will include the following four elements:

1. What is the problem?
2. What can be done (policies, best practices, delivery systems)?
3. How to get there (lowering barriers, building capacity, developing incentives).
4. The mechanisms for adoption and implementation (county plan proposals, legislation, learning collaboratives).

The methodology and findings from the pilot study will also be summarized in abstracts submitted for presentation at professional conferences and a manuscript for consideration as a publication in a peer-reviewed journal so that practitioners and researchers within and outside of California can also benefit from this research endeavor.

Project Schedule

Subcommittee Workgroup Meeting #1 to address Project Objectives 1 through 3.	December 6, 2016 Greater Sacramento Urban League 12:30 to 4:30 p.m.
1st Public Hearing before full Commission	January 26, 2017 at the MHSOAC
Subcommittee Workgroup Meeting #2	June 2017 TBD

2nd Public Hearing before full Commission	July 2017 TBD
Community Forum	September/October TBD
3rd Public Hearing before full Commission	January 2018 TBD

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X **INFORMATION** **TAB SECTION:** 6

__ **ACTION REQUIRED** **DATE OF MEETING:** 05/10/17

AGENDA ITEM: Discussion of Future Agenda Items

ENCLOSURES: None

OTHER MATERIAL RELATED TO ITEM: None

ISSUE:

The committee will have a discussion of agenda items to be considered for the July 12, 2017 meeting.

Proposed Motion

Not Applicable