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Mental Health Services
Oversight & Accountability Commission

Commission Packet

Commission Meeting
October 26, 2017

Los Angeles Law Library
Main Reading Room
301 W 1st St
Los Angeles, CA 90012

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

Mental Health Services
Oversight & Accountability Commission

WELLNESS • RECOVERY • RESILIENCE

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

1325 J Street, Suite 1700
Sacramento, CA 95814

Commission Meeting Agenda

October 26, 2017
9:30 A.M. – 4:20 P.M.

Los Angeles Law Library
301 W 1st St
Los Angeles, CA 90012

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

Public Notice

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

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

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

Tina Wooton
Chair

AGENDA
October 26, 2017

John Boyd, Psy.D.
Vice Chair

Approximate Times

9:30 AM **Convene**
Chair Tina Wooton will convene the Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission) Meeting. Roll call will be taken.

9:35 AM **Welcome and Announcements**

9:40 AM **Action**
1: Approve September 28, 2017, MHSOAC Meeting Minutes
The Commission will consider approval of the minutes from the September 28, 2017, MHSOAC meeting.

- Public Comment
- Vote

9:45 AM **Action**
2: Los Angeles and Kern Counties Innovation Plans
Presenters: Jonathan E. Sherin, M.D., Director, Los Angeles County Department of Mental Health; Debbie Innes-Gomberg, Ph.D, Deputy Director, Los Angeles County Department of Mental Health; Bill Walker, LMFT, Director, Kern County Behavioral Health and Recovery Services; Bradley Cloud, Psy.D., Deputy Director of Special Clinical Services

The Commission will consider approval of Innovation Project plans for Los Angeles and Kern Counties.

- Public Comment
- Vote

10:45 AM **Action**

3: Mendocino County Innovation Plan

Presenters: Jenine Miller, Psy.D., Director, Mendocino County Behavioral Health and Recovery Services; Karen Lovato, Acting Deputy Director, Mendocino County Behavioral Health and Recovery Services; Otis Brotherton, Director, Round Valley Indian Health Center; Frank Tuttle, Clinical Psychology Intern, Round Valley Indian Health Center

The Commission will consider approval of one Innovation Project plan for Mendocino County.

- Public Comment
- Vote

11:05 AM **Action**

4: Proposed Amendments to Prevention and Early Intervention (PEI) Regulations and Innovative Regulations: Commission Responses to Public Comments

Presenter: Filomena Yeroshek, Chief Counsel

The Commission will be presented with the comments received during the 45-day public comment period, August 11, 2017, through September 28, 2017, on the proposed amendments to the PEI and Innovative regulations that the Commission adopted at the July 27, 2017 Commission meeting. Staff will also present recommended responses to these public comments. The Commission will decide whether to make any changes to the proposed amendments to the PEI and Innovative regulation sections.

- Public Comment
- Vote

11:35 AM **Information**

5: Innovation Sub-Committee Report Out

Presenter: Sharmil Shah, Psy.D., Chief of Program Operations

The Commission will hear an update on the work of the Innovation Sub-committee.

- Public Comment

11:55 AM **General Public Comment**
Members of the public may briefly address the Commission on matters not on the agenda.

12:10 PM **Lunch Break**

1:35 PM **Action**
6: San Diego County Innovation Plans (Two Extensions, One New Plan)
Presenters: Alfredo Aguirre, LCSW, Director, San Diego County Behavioral Health Services; Piedad Garcia Ed.D., LCSW, Deputy Director, San Diego County Adult and Older Adult Behavioral Health Services (AOABHS); Yael Koenig, LCSW, Deputy Director, San Diego County Health and Human Services Agency, Behavioral Health Services, Children Youth and Families (CYF) System of Care; Eileen Quinn-O'Malley, LMFT, Behavioral Health Program Coordinator, San Diego County Health and Human Services Agency, Behavioral Health Services, Children Youth and Families (CYF) System of Care; Cecily Thornton-Stearns, MFT, Behavioral Health Program Coordinator, San Diego County Adult and Older Adult System of Care; and Connie German-Marquez, LMFT, Behavioral Health Program Coordinator, San Diego County Adult and Older Adult Behavioral Health Services (AOABHS)

The Commission will consider approval of two Innovation Project extensions and one new plan for San Diego County.

- Public Comment
- Vote

2:35 PM **Action**
7: Criminal Justice and Mental Health Report
Presenter: Ashley Mills, Senior Researcher and Project Staff Lead

The Commission will consider adoption of the Criminal Justice and Mental Health Report.

- Public Comment
- Vote

3:35 PM **Information**

8: Executive Director Report Out

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

Executive Director Ewing will report out on projects underway and other matters relating to the ongoing work of the Commission.

Informational Documents Enclosed:

Enclosed are: (1) The Motions Summary from the August 24, 2017, Commission Meeting; (2) Evaluation Dashboard; (3) Calendar of Commission activities; and (4) Innovation Review Outline.

4:05 PM **General Public Comment**

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

4:20 PM **Adjourn**

AGENDA ITEM 1

Action

October 26, 2017 Commission Meeting

Approve September 28, 2017 MHSOAC Meeting Minutes

Summary: The Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission) will review the minutes from the September 28, 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: September 28, 2017 Commission Meeting Minutes.

Handouts: None.

Recommended Action: Approve September 28, 2017 Meeting Minutes.

Proposed Motion: The Commission approves the September 28, 2017 Meeting Minutes.

State of California

MENTAL HEALTH SERVICES
OVERSIGHT AND ACCOUNTABILITY COMMISSION

Minutes of Meeting
September 28, 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, Psy.D., Vice Chair
Lynne Ayers Ashbeck
Khatera Aslami-Tamplen
Sheriff Bill Brown
Keyondria Bunch, Ph.D.
Itai Danovitch, M.D.
David Gordon
Kathleen Lynch
Gladys Mitchell
Larry Poaster, Ph.D.
Assemblymember Sebastian Ridley-Thomas
Deanna Strachan-Wilson

Members Absent:

Reneeta Anthony
Senator Jim Beall
Mara Madrigal-Weiss

Staff Present:

Toby Ewing, Ph.D., Executive Director
Filomena Yeroshek, Chief Counsel
Norma Pate, Deputy Director, Program, Legislation, and Technology
Brian Sala, Ph.D., Deputy Director, Evaluation and Program Operations
Sharmil Shah, Psy.D., Chief of Program Operations

CONVENE

Chair Tina Wooton called the meeting of the Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission) to order at 9:12 a.m. and welcomed everyone. Filomena Yeroshek, Chief Counsel, called the roll and confirmed the presence of a quorum.

Announcement

Chair Wooton reviewed the meeting protocols. She stated the next Community Forum is scheduled for October 28th at Los Angeles City College.

Chair Wooton welcomed Mara Madrigal-Weiss and Keyondria Bunch, Ph.D., to the Commission.

Sharmil Shah, Psy.D., MHSOAC staff, introduced new staff member Marcus Galeste.

Chair Wooton stated, in recognition of Mental Illness Awareness Week, Sacramento County's "Mental Illness: It's not always what you think" project and the Elk Grove Fine Arts Center are hosting a collaborative art exhibit titled *Journey of Hope*, which pairs local artists and writers to share stories about mental health, hope, and recovery. Each piece begins with a story written by a Sacramento County resident living with mental illness, which is then given to a local artist to be used as inspiration for an original art piece. A public reception will be held on Saturday, October 7, from 3-7 p.m. and the exhibit will be on display at the Elk Grove Fine Arts Center, free and open to the public, October 7-21.

ACTION

1: Approve August 24, 2017, MHSOAC Meeting Minutes

Action: Commissioner Ashbeck made a motion, seconded by Commissioner Aslami-Tamplen, that:

The Commission approves the August 24, 2017, Meeting Minutes.

Motion carried 7 yes, 0 no, and 5 abstain, per roll call vote as follows:

The following Commissioners voted "Yes": Chair Wooton, Vice Chair Boyd, and Commissioners Ashbeck, Aslami-Tamplen, Lynch, Mitchell, and Poaster.

The following Commissioners abstained: Commissioners Brown, Bunch, Danovitch, Gordon, and Strachan-Wilson.

INFORMATION

2: Proposed Amendments to Prevention and Early Intervention (PEI) and Innovation (INN) Regulations

Facilitator: Filomena Yeroshek, Chief Counsel

Chair Wooton read an official statement with detailed information about today's quasi-legislative hearing. She deferred to Filomena Yeroshek, Chief Counsel, to facilitate the official public hearing on the proposed amendments to the PEI and INN Regulations.

Ms. Yeroshek provided an overview of the background, process to date, and next steps of the amendments to the PEI and INN Regulations that the Commission heard and adopted at the July meeting. She stated the public comment period ends at 5:00 p.m.

today. The Commission will be presented with all of the written comments and will have an opportunity to respond to the written and oral public comments at the October or November Commission meetings.

Commissioner Questions and Discussion

Commissioner Ashbeck asked Ms. Yeroshek if the proposed amendments will be reviewed today. Ms. Yeroshek stated that they would not. Today is a quasi-legislative hearing and not the normal type of Commission meeting. The next Commission meeting will include a review of the proposed amendments, the public comments, and recommended responses to those comments.

Public Comment

Chair Wooton called the names of the members of the public wishing to provide oral public comment on the proposed PEI and INN Regulations in the order they were entered on the attendance sheet, as follows:

Poshi Walker, LGBTQ Program Director, NorCal Mental Health America (NorCal MHA), spoke in support of other members of the public who will advocate for the collection of race, ethnicity, and primary language for minors younger than 12. She stated her concern about letter D on page 5, which states that a county is not required to collect the required demographic information from a minor younger than 12 years of age. She stated NorCal MHA suggests following the Williams Institute best practices of collecting sex assigned at birth for youth under 12 as the first step of the standard two-step gender identity measure. She stated her written comments will be given to staff. She stated NorCal MHA offers to support counties requiring technical assistance in the gathering of sexual orientation and gender identity (SO/GI) data.

Stacie Hiramoto, Director, Racial and Ethnic Mental Health Disparities Coalition (REMHDCO), also referred to letter D on page 5 of the PEI and INN Regulations and stated she spoke in support of the collection of SO/GI data. She suggested that aggregated data on race, ethnicity, and other demographic information be collected. She stated she sent her written comments to staff.

Michelle Violett, Nevada County, stated that part of the regulations presents an implementation challenge for small counties in that programs, such as the Second Step program, do not include parental interaction for three- and four-year-olds. She asked for flexibility.

Elizabeth Oseguera, Senior Policy Analyst, California Primary Care Association, echoed the previous speakers about the demographic information collection including children under the age of 12.

Mandy Taylor, Health Access, California LGBT Health and Human Services Network, spoke in support of Ms. Walker's and Ms. Hiramoto's comments. She encouraged collecting appropriate data that is developmentally accurate, such as race, ethnicity, and primary language, and excluding gender identity and sexual orientation for children under the age of 12.

Kiran Savage, California Pan-Ethnic Health Network (CPEHN), stated the importance of continuing to collect race, ethnicity, and primary language data. She stated the

regulations require data in threshold languages by county, usually only English and Spanish, but that is not enough. These regulations provide an opportunity to gather data, which can then be compared to data in other systems to see how programs are impacting the state.

Chair Wooton closed the oral hearing and reminded everyone that staff will continue to receive written comments until 5:00 p.m. today.

ACTION

3: No Place Like Home Service Contract

Presenters: Filomena Yeroshek, MHSOAC Chief Counsel; Ronald Washington, Acting Executive Director, California Health Facilities Financing Authority (CHFFA); Zachary Olmstead, Deputy Director of Housing Policy Development, Department of Housing and Community Development (HCD); Angela Kim, Attorney (HCD); Monique Pierre, Section Chief, Division of Financial Assistance, Program Design and Development Branch (HCD); Matthew Wise, Deputy Attorney General, Attorney General's Office; Jenna Magan, Bond Counsel, Orrick

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

Ms. Yeroshek provided an overview of the institutional context and background of the No Place Like Home (NPLH) program, which is permanent supportive housing for Californians living with serious mental illness. She stated a copy of the NPLH law, the Service Contract, and an excerpt from the NPLH Program Guidelines were included in the meeting packet. The law requires CHFFA to submit to the Commission the service contracts between CHFFA and HCD to implement the NPLH program. She stated staff has reviewed the law and the contract and has found no egregious concerns. She stated the Commission has the option to vote to approve or disapprove the contract, or, if the Commission does not act, the contract is deemed approved.

Zachary Olmstead, Deputy Director of Housing Policy Development, HCD, thanked Executive Director Ewing for representing the Commission on the Advisory Committee for the NPLH program.

Monique Pierre, Section Chief, Division of Financial Assistance, Program Design and Development Branch, HCD, provided an overview, accompanied by a slide presentation, of the background, features, goals, funding, and timeline of the NPLH program.

Commissioner Questions

Vice Chair Boyd asked about incentives for multiple counties, especially small counties, to apply together for the $6.2 million in technical assistance (TA) grants or if each county must apply for its own portion. Ms. Pierre stated counties must apply individually but can combine their funding to work together.

Commissioner Ashbeck asked if the TA grant funding is currently available. Ms. Pierre stated the TA grant funding is a direct allocation and is expected to become available to communities by the end of this month.

Vice Chair Boyd asked about the total funding for this project and other funding sources that might be available. Mr. Olmstead stated the program is made up of new stock and HCD offers some of the capital assistance to build the housing. Low-income housing tax credits from the state and other local development funding are also leveraged. The program brings in local, state, and federal funding.

Commissioner Poaster asked about the differences between HCD-funded developmental services and county-funded developmental services and if they are parallel tracks. Jenna Magan, Bond Counsel, Orrick, stated there are two ways to get funding for the program: one is directed and administered by HCD and the other is where counties create the rules and do the funding with oversight from HCD.

Commissioner Poaster asked if there is interaction between the two funding streams where someone could get funds independent of the county. Mr. Olmstead stated the counties must be the applicant, although they could co-apply with a developer as the expert.

Commissioner Gordon asked if the state has an overall schema for evaluating this effort, beginning with the rollout of the housing program and how it connects to the services programs, so that data can be collected to ensure the program is going in the right direction from the start. Mr. Olmstead stated the legislation has many sections about evaluation and what data to collect.

Commissioner Gordon asked about the connection between the housing and services elements of the program and how they will collaborate on evaluation. Mr. Olmstead stated HCD has a good infrastructure of nonprofit developers who work in collaboration with service providers. One of the goals of the program is to ensure that coverage throughout the state.

Chair Wooton asked if voluntary services are referred from the counties for individuals to enter the housing programs. Mr. Olmstead stated counties agree to provide or coordinate the services on the substance use and mental health side.

Commissioner Poaster asked about the definition of the target population for the NPLH program. Mr. Olmstead stated the federal definitions of chronic illness and homelessness are used.

Commissioner Poaster stated the importance that participants in the program have a serious mental illness or emotional disorder. Mr. Olmstead stated the “and” in the criteria is important - they must be homeless and have a serious mental illness.

Commissioner Aslami-Tamplen asked where stakeholder involvement in the development, administration, and operation of the NPLH program is emphasized. Mr. Olmstead reviewed the robust stakeholder process during the creation of the NPLH program. He stated the contract is a legal document about the fiscal relationship between state entities.

Commissioner Bunch asked why services are not a required part of this program. Mr. Olmstead stated the NPLH program is consistent with Senate Bill (SB) 1380 and Housing First. He stated permanent supportive housing is an effective, evidence-based program that uses a county-coordinated entry system, which is an assessment of

vulnerability of the homeless population to match each individual to the right level of intervention.

Ronald Washington, Acting Executive Director, CHFFA, discussed the connection between CHFFA and HCD under the service contract and summarized CHFFA's responsibilities under the program. CHFFA will enter into this service contract with HCD. After the bonds are issued, CHFFA will pay HCD to perform under the service contract, then the bond proceeds of approximately $2 billion will be used to support and run the program.

Public Comment

Jessica Bradley, Steinberg Institute, stated the Steinberg Institute sponsored the NPLH program and supports the service contract. She thanked HCD and CHFFA for their leadership.

Ms. Hiramoto thanked Commissioners for their questions and reiterated the hope that counties will be required to collect data on enrollees so the state can create an aggregate picture of statewide trends.

Ms. Walker stated, in her partner's experience working with homeless veterans, chronically homeless veterans are most successful if they first go into transitional housing before moving into a more independent living situation. She asked if transitional housing is part of the services offered. Since transgender individuals, especially transgender women of color, have a high rate and risk of homelessness, she asked if there will be transgender services with specific support for gender dysphoria and training for providers. The surrounding community and business owners in particular need support and training for working and engaging with the residents of the NPLH program.

Ms. Taylor echoed the previous speakers' comments. She stated the hope that the TA offered to programs includes best practices for collecting SO/GI data. She urged the use of strong wording in the application process stating that programs will only be funded if they house transgender individuals according to their gender identity.

Richard Van Horn, past Commissioner, stated $400,000 was set aside in 2005 for a first try at the Housing First program. The NPLH is intended to correct mistakes from that first attempt, now including the requirement to link services to housing. However, he pointed out that the initial $400 million became about $2.5 billion of housing through tax credit investments.

Mr. Olmstead agreed that significant multiplier effects from two to six times the investments have been seen. He stated two changes made to the NPLH program from the lessons learned from the first program are the county commitment to provide services for 20 years, and the Capitalized Operating Subsidy Reserve, which meets the gap in what individuals are able to pay in rent.

Commissioner Discussion

Vice Chair Boyd asked Mr. Olmstead and his team to provide updates to the Commission on the services component of the NPLH.

Commissioner Aslami-Tamplen followed up on Ms. Walker's questions about clarifying if the option of using the resources for transitional housing is available. Mr. Olmstead stated

the NPLH program is explicitly for permanent housing and is unable to fund transitional housing.

Commissioner Brown stated the vision for the NPLH program is good but the process on how it came about was, at best, questionable. The Legislature in passing this law in some ways hijacked Mental Health Services Act (MHSA) funds, which were promised to counties to deliver mental health services, and diverted them to repay bond debt for permanent housing that will only meet a small portion of the need statewide. Mental health needs in counties always outstrip the resources, so this program will highly impact counties. This may be appropriate from a strategic standpoint, but the way this was done bypassed the MHSOAC, the counties, and other stakeholders. He stated the hope that a more inclusive and transparent process of translating vision into action will occur in the future.

Commissioner Danovitch suggested and Commissioners agreed that the Commission take no action on this item today. The Service Contract was thereby deemed approved.

ACTION

4: <u>Elect Chair and Vice Chair for 2018</u>

Presenter: Filomena Yeroshek, MHSOAC Chief Counsel

Ms. Yeroshek briefly outlined the election process and asked for nominations for chair of the MHSOAC for 2018.

Action: Commissioner Danovitch made a motion, seconded by Commissioner Aslami-Tamplen, that:

The Commission elects Vice Chair John Boyd as chair of the Mental Health Services Oversight and Accountability Commission for 2018.

Motion carried 11 yes, 0 no, and 0 abstain, per roll call vote as follows:

The following Commissioners voted “Yes”: Chair Wooton, Vice Chair Boyd, and Commissioners Ashbeck, Aslami-Tamplen, Brown, Bunch, Danovitch, Gordon, Lynch, Poaster, and Strachan-Wilson.

Ms. Yeroshek asked for nominations for vice chair of the MHSOAC for 2018.

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

The Commission elects Commissioner Khatera Aslami-Tamplen as vice chair of the Mental Health Services Oversight and Accountability Commission for 2018.

Motion carried 11 yes, 0 no, and 0 abstain, per roll call vote as follows:

The following Commissioners voted “Yes”: Chair Wooton, Vice Chair Boyd, and Commissioners Ashbeck, Aslami-Tamplen, Brown, Bunch, Danovitch, Gordon, Lynch, Poaster, and Strachan-Wilson.

ACTION

5: <u>Mono County Innovation Plan</u>

Presenters: Amanda Fenn Greenberg, MPH, MHSA Coordinator; Salvador Montanez, Mono County Behavioral Health Services Coordinator

Amanda Fenn Greenberg, MPH, MHSA Coordinator, Mono County Behavioral Health, read a statement from Robin Roberts, Director, Mono County Behavioral Health, who was unable to be in attendance. She stated Ms. Roberts asked to dedicate the presentation to Barbara Miranda, an individual who is struggling in the current mental health system and could benefit from Mono County's proposed INN plan.

Ms. Greenberg provided an overview, accompanied by a slide presentation, of the purpose, goal and objectives, funding, and evaluation of the proposed Innovation project, the Eastern Sierra Strengths-Based Learning Collaborative.

Commissioner Questions and Discussion

Commissioner Strachan-Wilson, asked how this model will address staff burnout leading to vacancies and disengagement. Ms. Greenberg stated there are mental health professional shortages across the country. The proposed model will help to reduce staff burnout. It reinvigorates, reinvests, and changes perspectives by focusing on strengths, which crosses over to the work done with one another.

Commissioner Danovitch asked for additional details on the template that will be constructed during this program. Ms. Greenberg stated the template is a combination of a checklist and an infographic that leads individuals through steps. It will be posted on the California Institute for Behavioral Health Solutions (CIBHS) and the county's websites where conference information can be shared.

Commissioner Danovitch asked how to know that the template is usable or generalizable to others. Ms. Greenberg stated the county plans to create the template to be useful across the board and to be a foundation for future collaborations. She stated the county is open to stakeholder input for ongoing improvement.

Commissioner Danovitch asked what the personnel costs were for. Ms. Greenberg stated those costs are for staff to learn how to use the strengths assessment, personal recovery plan, evaluation reporting, and to attend the trainings.

Commissioner Danovitch stated the program may be difficult to replicate if individuals must be paid for the time to learn the model.

Commissioner Ashbeck asked if the county has considered integrating other community leaders that intersect with mental health in this collaborative, such as school superintendents and hospital social workers, as a way to connect and spread the work. Ms. Greenberg stated it is part of the plan and the county is already working with community partners.

Commissioner Aslami-Tamplen asked how the voice of consumers, family members, and underserved communities will be involved. Ms. Greenberg stated there has been great stakeholder involvement throughout the planning process and there are consumers and family members working in the department. Those staff members will go through the strength-based training.

Salvador Montanez, Mono County Behavioral Health Services Coordinator, provided an overview of how strength-based programming already affects consumers in Mono County and how integrating more strengths-based services will impact the consumer population.

Public Comment

Ms. Bradley spoke in support of Mono County's INN plan and the cross-county collaboration with Alpine and Inyo Counties. She stated the Steinberg Institute is currently touring small counties across the state and recognizes the unique strengths of small counties, and continues to do what it can to support them.

Andrea Crook, Access California, spoke in support of Mono County's INN plan. She stated she participated in Mono County's strengths-based training and suggested that it be implemented statewide. She stated it is a shame it is considered innovative because it is the way business should be done.

Mr. Van Horn responded to Commissioner Danovitch's question about scale. He stated trying to move a project like this to scale is difficult. He stated it would be a real innovation if Mono County could show the rest of California how to adjust programs to the number of individuals involved. He stated Inyo and Alpine are having difficulty spending their Workforce, Education, and Training (WET) funds. He suggested they spend some of these funds engaging CIBHS to build a workbook about learning collaboratives for rural areas so it can not only be scalable but also be easily duplicated.

Ms. Walker stated working with rural counties is important but challenging. She encouraged Mono County to consider other stakeholder contracts besides CIBHS. She stated NorCal MHA would love to work as a resource with the county.

Action: Commissioner Ashbeck made a motion, seconded by Commissioner Brown, that:

The MHSOAC approves Mono County's Innovation plan as follows:

> *Name: Eastern Sierra Strengths-Based Learning Collaborative*
> *Amount: $259,046*
> *Program Length: Two (2) Years*

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

The following Commissioners voted "Yes": Chair Wooton, Vice Chair Boyd, and Commissioners Ashbeck, Aslami-Tamplen, Brown, Bunch, Danovitch, Lynch, Poaster, and Strachan-Wilson.

GENERAL PUBLIC COMMENT

Eva Nunez read a statement from Sally Zinman, Executive Director, California Association of Mental Health Peer-Run Organizations (CAMHPRO), about self-help, empowerment, and transformation. Ms. Nunez advocated for care homes in Sacramento where she attends steering committees, transitional living centers, and self-help centers for wellness and recovery.

Ms. Walker suggested doing a cost-benefit analysis of providing members of the public who attend Commission meetings with reader tablets rather than paper meeting packets.

Nancy Callahan, Ph.D., Owner, I.D.E.A. Consulting, discussed the proposed amendments to the PEI and INN Regulations. She encouraged the collection of data but stated the requirements are extensive for small counties and small providers, some of the data will be difficult for small providers to collect, and some of the regulations are complex. She stated her concern that the data gathered will not reflect the great work that is being

done. She stated she is also concerned that access and linkage programs typically do not work for the seriously mentally ill. She offered her assistance in helping to address these and other concerns.

ACTION

6: <u>Nevada County Innovation Plan</u>

Presenters: Michael Heggarty, LMFT, Director, Health and Human Services; Rebecca Slade, LMFT, Nevada County Behavioral Health Director; Theresa Hodges, A.A., CADC, Program Director, Turning Point Community Programs/Insight Respite Center; Nancy Callahan, Ph.D., Owner, I.D.E.A. Consulting; Janella Kirkman, Director, SPIRIT Peer Empowerment Center

Rebecca Slade, LMFT, Nevada County Behavioral Health Director, stated the proposed INN plan is about strengthening the crisis continuum of care. She provided an overview, accompanied by a slide presentation, of the crisis services Nevada County has built and showed photographs of the facilities.

Janella Kirkman, Director, SPIRIT Peer Empowerment Center, discussed the function and current activities at the SPIRIT Peer Empowerment Center and stakeholder involvement in Nevada County.

Theresa Hodges, A.A., CADC, Program Director, Turning Point Community Programs/Insight Respite Center, discussed the function and current activities at the Insight Respite Peer-Run Center.

Michael Heggarty, LMFT, Director, Health and Human Services, stated the crisis services built over the last three years have provided robust, high-quality programs but the challenge is how to improve the consumer and family experience across the continuum of care. He continued the slide presentation and discussed the goals and objectives of the proposed INN program.

Nancy Callahan, Ph.D., Owner, I.D.E.A. Consulting, continued the slide presentation and discussed other state-funded collaborative and evaluation activities.

Commissioner Questions

Commissioner Ridley-Thomas asked which counties are partnering with Nevada County, how many crisis stabilization beds are in that area, and how many individuals move through crisis stabilization centers there annually. Ms. Slade stated Sierra and Placer Counties are partnering with Nevada County. Placer County has its own twelve-bed unit, but Nevada County has the only crisis stabilization unit. There were about 270 individuals last year.

Commissioner Ridley-Thomas asked how they are looking at health integration. Mr. Heggarty stated they first look at whether individuals have primary health care providers. They also consider metabolic disorders.

Commissioner Ridley-Thomas asked about what will happen if other funding sources do not materialize. Mr. Heggarty stated any opportunities to petition for additional funding will of course be welcome, but in the absence of that, the behavioral health department has

sufficient fund balance to sustain the programs. However, the county has an excellent track record of securing grant funding.

Commissioner Ridley-Thomas asked if the population served in crisis stabilization is heavily MediCal-eligible. Ms. Slade stated about eighty percent of that population have had MediCal.

Commissioner Gordon asked about the level of collaboration so far between Nevada, Sierra, and Placer Counties. Mr. Heggarty clarified that the contracts with Sierra and Placer Counties were only recently executed and are still being developed. The provider contracts with the SPIRIT Peer Empowerment Center, Sierra Mental Wellness Group, and Turning Point Providence Center were executed in 2014. The collaboration with the counties is just beginning.

Commissioner Danovitch asked what level of collaboration the county is aiming for. Dr. Callahan stated the goals are to build a team that works as one, with the same policies, procedures, and admission criteria, that can also have scheduled time to discuss goals. The project will pay for staff members to come to the table, do evaluation, and research collaborative tools.

Commissioner Danovitch asked how those insights will be scaled. Mr. Heggarty stated, during the past three years, the key players in the crisis continuum of care have never overlapped. A simple, concrete goal is to create ongoing, regular planning meetings to prioritize collaboration and make it a billable service.

Dr. Callahan stated studying how funding collaboration improves outcomes will be part of the evaluation.

Commissioner Danovitch asked what innovations will come out of this project and how they will be disseminated to other counties. Mr. Heggarty stated measurable outcomes include: increased utilization of the crisis stabilization unit and the Insight Respite Peer-un Center; a shared centralized assessment; a shared service plan with measurable goals and objectives identified by consumers and family members that will move with them through the system; and a universal release of information form to promote a free flow of information.

Dr. Callahan added that this will create a model for building collaboration across Nevada, Placer, and Sierra Counties. It will produce data, forms, and decision support tools that can be disseminated.

Vice Chair Boyd asked if Sierra and Placer Counties were involved in writing the proposed project. Ms. Slade stated they were aware of its creation but not involved in writing it.

Commissioner Brown asked who will coordinate and facilitate meetings between agencies and counties. Ms. Slade stated the county manager, who works for Nevada County Behavioral Health, will facilitate those interactions.

Commissioner Strachan-Wilson asked how the project will ensure that people will continue to meet and collaborate after funding ceases. Ms. Slade stated her belief that people will continue because they will find the collaboration valuable. Mr. Heggarty added that this project is a priority with or without the Commission’s approval of the Innovation

funding. It is the right thing to do and will improve the system, create better client satisfaction, and improve the patient experience.

Commissioner Gordon asked why the contracts with Placer and Sierra Counties did not include a provision for collaboration. Ms. Slade stated the contracts may have had too limited a vision of how to work together.

Commissioner Lynch asked for clarification as to why this project is innovative. Ms. Slade stated people do not always have time to collaborate. Dr. Callahan added that the funding will create an opportunity to build collaboration to better serve the system.

Chair Wooton asked why collaboration has not already taken place when there has been collaboration in the children's system of care since 2002. She asked what the county will do when the funding runs out. She stated it is wonderful that the county wants to collaborate to deliver services efficiently, but questioned how the proposed program is innovative. In addition, the end component must have learning to share statewide.

Dr. Callahan stated it is about collaboration across organizations to meet needs. She stated the hope to teach the state that collaboration between peer-run centers, hospitals, clinics, and mental health services is valuable. She stated this level of collaboration at this part of the system cannot be compared because there is no model.

Commissioner Aslami-Tamplen stated medical and peer approaches to assessments are very different. She stated she hoped an outcome of this project will be an assessment model that uses recovery language, such as questions about what happened to an individual, not what is wrong with them. Those types of things are critical to system transformation.

Dr. Callahan stated integrating a peer-run respite center into county crisis services is a huge innovation. Commissioner Aslami-Tamplen stated what is seen in the peer movement in that approach is that peer services get more medicalized and clinical.

Public Comment

Heidi Hall, Supervisor, Nevada County Board of Supervisors, spoke in support of the proposed INN plan. She emphasized that collaboration is difficult in rural counties. She stated her desire to become a model for other rural counties.

Ms. Bradley spoke in support of the proposed INN plan.

Caroline Hart, Supervisor, Crisis Stabilization Unit and Crisis Response Team, Nevada County Behavioral Health, stated learning how to work together is imperative to better serve the mental health community. She spoke in support of the proposed INN plan.

Shera Banbury spoke in support of the proposed INN plan. She stated what is important about this INN plan is that, although collaboration is ongoing, there is limited available staff.

Amanda Wilcox, Nevada County resident, stated the importance of outreach and linkage to service. She stated she is amazed at what her small county has done. She stated she would like to think Nevada County can be a model for other counties. She spoke in support of the proposed INN plan.

Ms. Crook stated she is unclear if this INN plan is coming from underutilization of existing programs. She asked if the proposal is a way to partner and educate that these underutilized resources are available. She asked why programs are being underutilized when the county also speaks of capacity issues. She asked about stakeholder input. What she often sees is that plans are created and presented, and then stakeholders are asked for input to the already-created plan. She asked if the client community would have created this plan if they were part of the discussion.

Sandra Marley, client advocate, asked about the budget item in excess of $133 million for consultant costs and contracts when the county presented their goal to increase collaboration across counties and providers. She asked the Commission to inquire what the $133 million is being used for other than collaborating with other counties.

Commissioner Discussion

Chair Wooton stated it is wonderful to improve collaboration and services for clients. She suggested that the county check into the excess funds in the Nevada County SB 82 Triage Grant. She stated, under the Triage Grant, Nevada County reports having excellent collaboration with the emergency room (ER) staff, peer program, and other programs discussed during the county presentation and received a foundation grant for that collaboration. She again asked how this INN plan is innovative and how it differs from the Triage Grant, which is currently in place.

Ms. Slade stated the Triage Grant is to increase crisis workers, to pay for staff at the respite center, and to pay for peers to be in the ER. She stated the Triage Grant report talked about collaboration but it may have been overblown. Everyone knows and enjoys working with each other but they do not really collaborate.

Dr. Callahan stated, when the Triage Grant was written and talked about collaboration, it was about the collaboration around writing the grant. There are three components to the Triage Grant: putting crisis workers in the ERs, funding crisis peer counselor staff to have expanded hours, and the respite center. She stated the excess funding was the expanded funding for an extra year and will be expended by the end of the year. She stated the collaboration in the Triage and CHFFA grants was about the collaboration to think of community needs. She stated those silos are now built in the county and this INN plan is meant to create collaboration between the silos about client care.

Chair Wooton recommended, when submitting something, being cautious about the elaboration of it, and stated it is true that consumers are handed something from the county to approve or buy-in on. Consumers are not a voice communicating what the consumer community wants.

Commissioner Brown stated this proposal is disjointed and lacks clear vision. He stated there were six occasions in the staff report where there were suggestions that the county clarify certain areas and how this proposal meets the needs of the INN grant. He stated there have been a number of times where the Commission has asked counties to consider retooling their proposal before bringing it back to the Commission for a vote. Although everyone agrees that Nevada County is doing some great things, the Commission has concerns about this proposal:

- The agencies on the presentation slide have never met and discussed this proposal as a group.
- There is no support expressed, either in the document or during the presentation, from the other counties that Nevada County wants to collaborate with.
- Nevada County said they will do this anyway whether funding is approved or not.

Commissioner Brown suggested that the county withdraw their proposal, rework it, reach out to the other players and get commitments from other department heads and leaders to move forward on this, get letters of intent or memorandums of understanding that show that everyone wants to engage in this and has a commitment on paper ahead of time, and come back with a stronger plan that will help the county when it is implemented.

Ms. Yeroshek asked if the county representatives would like to withdraw their proposal and come back or to have a vote. Mr. Heggarty requested a vote.

Commissioner Ridley-Thomas made a motion that the MHSOAC approves the Nevada County's INN plan, Developing Collaboration to Strengthen the Crisis Continuum of Care for $1 million for five years.

Chair Wooton asked for a second. Ms. Yeroshek stated the motion failed for lack of a second.

ACTION

7: <u>Napa County Innovation Plans</u>

Presenters: Bill Carter, LCSW, Napa County Mental Health Director; Felix Bedolla, Project Manager, Napa County Mental Health Division, Napa County Health and Human Services Agency; Rocío Canchola, MPA, Staff Services Analyst II; Amber Twitchell, Associate Director at On the Move; Roxana Plancarte, School Social Worker for Napa Valley Unified School District; Charlie Toledo, Executive Director, Suscol Intertribal Council; Sal Garcia- Pinola, Coast Pomo/ PEI outreach coordinator, Cultural Advisory Committee, Suscol Intertribal Council; Rowena Korobkin, Member, Napa County Mental Health Board

Bill Carter, LCSW, Napa County Mental Health Director, reviewed the stakeholder process for this proposal. Four plans were chosen to move forward.

Mr. Carter and Felix Bedolla, Project Manager, Napa County Mental Health Division, Napa County Health and Human Services Agency, provided an overview, accompanied by a slide presentation, of the background, objectives, learning goals, and budget for each of the four proposed INN plans.

Commissioner Questions

Commissioner Strachan-Wilson asked if the county has contacted potential employers for the Work for Wellness plan and who they might be. Amber Twitchell, Associate Director at On the Move, stated one of the core beliefs is the importance of relationships. She stated a number of businesses and organizations have already expressed interest. The county surveyed employers and found that the majority of employers would be interested in participating in the program.

Commissioner Ridley-Thomas asked how many individuals the programs expect to serve. Mr. Carter provided estimates for each program except the Work for Wellness program, which will depend on the response.

Commissioner Ridley-Thomas asked what the ideal size of the program would be. Mr. Carter stated this project is unique from the others in that the county has become aware of the need but does not know much about it yet.

Public Comment

Ms. Marley asked if the Native American and Filipino populations are included in the Work for Wellness program.

Ms. Bradley spoke in support of the four INN plans.

Ms. Hiramoto thanked Napa County for their efforts to do something different to reach the Native American and Filipino communities and for including historical trauma in their programs.

Ms. Walker seconded Ms. Hiramoto's enthusiasm and commended the desire to increase cultural competence of Native American communities. She stated her concern that few Native Americans seek treatment. She asked how the training increases utilization by Native Americans, and if the plan includes county personnel participating in native healing practices or just understanding that the healing practices are vitally important and the participants will seek them out in their communities. She asked if outreach will be built into the end of this project.

Action: Commissioner Aslami-Tamplen made a motion, seconded by Chair Wooton, that:

The MHSOAC approves Napa County's Four (4) Innovation projects as follows:

1. *Name: Napa Adverse Childhood Experiences (ACEs)*
   Amount: $438,869
   Program Length: 18 Months
2. *Name: Native American Historical Trauma and Traditional Healing Innovation Project*
   Amount: $479,518
   Project Length: 18 Months
3. *Name: Understanding the Mental Health Needs of the American Canyon Filipino Community*
   Amount: $461,016
   Project Length: 18 Months
4. *Name: Work for Wellness*
   Amount: $309,250
   Project Length: 18 Months

Motion carried 8 yes, 0 no, and 0 abstain, per roll call vote as follows:
The following Commissioners voted "Yes": Chair Wooton, Vice Chair Boyd, and Commissioners Aslami-Tamplen, Brown, Gordon, Lynch, Ridley-Thomas, and Strachan-Wilson.

ACTION

8: Contract Authorization for Strategic Statewide Suicide Prevention Plan

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

Brian Sala, Ph.D., Deputy Director, stated Assembly Bill (AB) 114, a copy of which was included in the meeting packet, directs the Commission to develop a statewide strategic plan for suicide prevention and appropriates $100,000 for that purpose.

Commissioner Questions

Commissioner Ashbeck asked if the statewide plan will integrate existing work. Deputy Director Sala stated there is no legislative history on this part of the bill, but part of this effort will be to coordinate with other statewide activities. He stated Commission direction would be helpful for the overall management of this project.

Executive Director Ewing suggested treating this like a traditional project where the chair will appoint a subcommittee of Commissioners to craft out a public process of hearings, site visits, working with subject matter experts, and looking at the opportunities to leverage against the other work being done including the schools and the CalMHSA suicide project.

Public Comment

Ms. Walker stated her concern that the Commission had no choice of whether or not it will do this, and that staff is already stretched thin. She stated her concern that these are MHSA funds being expended without discussion.

Executive Director Ewing stated the subcommittee will engage in a stakeholder process and the funds from the Legislature enable the Commission to bring on external staff to support the work, including subject matter experts.

Ms. Walker encouraged the Commission to utilize their stakeholder contractors in this process.

Action: Commissioner Ashbeck made a motion, seconded by Commissioner Aslami-Tamplen, that:

Motion carried 9 yes, 0 no, and 0 abstain, per roll call vote as follows:

The following Commissioners voted “Yes”: Chair Wooton, and Commissioners Ashbeck, Aslami-Tamplen, Brown, Bunch, Danovitch, Lynch, Poaster, and Strachan-Wilson.

INFORMATION

9: Executive Director Report Out

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

Executive Director Ewing presented his report as follows:

Personnel

One of the new hires who will begin next month is a staff member with a background in cultural competency issues.

Recruitment continues for a research director and a consulting psychologist.

Biennial Report

The first Biennial Report will be presented at the January meeting.

Committees

It is time to revisit the Committees and Committee structure and revitalize those.

Legislation

Two bills the Commission is watching are on the Governor's desk: one is for fellowships for a consumer and a professional to do policy work at the MHSOAC, and the other allows the access to employment data.

Triage Grant Request for Applications (RFA) Updates

Staff continues to work on focus groups and meeting children's advocates and parents to discuss how to implement the Commission's direction on the second round of the RFA that 50 percent of the funds should go to children's services. Staff is working on pooling the three sources of funding for children's crisis services.

Criminal Justice and Mental Health

A draft report has been released and posted on the website.

Fiscal Reversion Report

The bulk of the recommendations given to the Legislature were incorporated into AB 114.

Schools and Mental Health

A proposal for a research component may be brought before the Commission in the future.

Staff will begin identifying strategies to recommend to the Legislature to address challenges. A public hearing may be held on that topic.

Innovation Summit

Staff continues to work with Vice Chair Boyd on sponsoring an Innovation Summit in February of 2018.

Stakeholder Contracts

All seven stakeholder contracts have been executed to ensure consumers and family members have a voice in the decisions and the funds are flowing.

Triage Grants

The next triage visit is scheduled for October in Lake County.

Commission Meeting Calendar

The October meeting will be in Los Angeles and paired with a Community Forum.

The November meeting conflicts with a County Behavioral Health Directors Association (CBHDA) policy meeting. Three counties are tentatively scheduled to present their INN

plans that day. Depending on what is determined, the Commission may have a teleconference meeting or may not meet in November.

Commissioner Questions and Discussion

Commissioner Ridley-Thomas asked where the CBHDA meeting will be held. Executive Director Ewing stated he was not sure but it may be in Sacramento.

Vice Chair Boyd asked about having a Commissioner retreat day or a strategic-planning day. Executive Director Ewing stated staff has interviewed two consultants to do the strategic planning and is planning to do more. The chair will appoint one or two Commissioners to take the lead in selecting a consultant and designing the consultation process.

Commissioner Ridley-Thomas suggested beginning to prepare the legislative packages with recommended proposals. He stated, given this is the second year of a two-year session, many of those proposals will be finalized by mid to late January or early February at the latest. He stated, if there are leftover items or priorities with broad support, he would be open to speaking with his Senate colleague and others about beginning their own staff research and legwork toward advancing the Commission's greatest and highest hopes.

Executive Director Ewing stated the Commission provides TA and guidance for legislative offices and supports legislation. He stated the Commission looks forward to working with Commissioner Ridley-Thomas and his staff on these opportunities.

GENERAL PUBLIC COMMENT

Ms. Hiramoto stated she understands that some of the demographic data is difficult to collect, but counties do not have to collect the data for the PEI Regulations if they are doing general outreach at fairs and other events and handing out pamphlets. She asked that the public be given more time than one week prior to meetings to review large documents such as the Criminal Justice and Mental Health Report. She stated additional time would allow for more dialogue.

Ms. Marley stated Napa County made statements that were often made in Parliament and are good government relations. She stated the county discussed including consumers who eventually benefit and focusing on staff only instead of including peers and other community members, and how they believe their project will contribute to statewide learning.

She suggested that the county explain the percentage of time each staff member is being compensated for and how county staff carves out time to focus on this project. She suggested more collaboration between the three counties.

ADJOURN

There being no further business, the meeting was adjourned at 4:22 p.m.

AGENDA ITEM 02

Action

October 26, 2017 Commission Meeting

Los Angeles and Kern Counties Innovation Project

Summary: The Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission) will consider approval of Los Angeles and Kern Counties request to fund a new Innovative project: MHSA Innovative Collaboration Project-Increasing Access to Mental Health Services and Supports Utilizing a Suite of Technology-Based Mental Health Solutions. (The Technology Collaborative). Los Angeles County is requesting a total of $33,000,000 over three (3) years. Kern County is requesting a total of $2,000,000 over three (3) years. Los Angeles and Kern Counties propose to increase access to mental health services to underserved groups by working with the Joint Powers Authority, CalMHSA, on a multi-county demonstration project to implement a group of technology-based mental health solutions that utilize chat rooms and passive data collection to identify the early signal biomarkers for mental health symptoms and offer prompt intervention.

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.

Presenters:

LA County

- Jonathan E. Sherin, M.D., Director, Los Angeles County Department of Mental Health.

- Debbie Innes-Gomberg, Ph.D, Deputy Director, Los Angeles County Department of Mental Health.

Kern County

- Bill Walker, LFMT, Director Kern Behavioral Health and Recovery Services
- Bradley Cloud, Psy.D. Deputy Director of Special Clinical Services, Kern Behavioral Health and Recovery Services

Enclosures (3): (1) Biographies for LA and Kern County Innovation Presenters (2) Staff Innovation Summary, and (3) County Project Brief Los Angeles and (4) County Project Brief Kern

Handout (1): PowerPoint Presentation

Additional Materials (2): Links to the Counties complete Innovation Plan are available on the MHSOAC website at the following URL:

Los Angeles County plan

http://mhsoac.ca.gov/document/2017-10/los-angeles-county-inn-plan-description-technology-based-mental-health-solutions

Kern County Plan

http://mhsoac.ca.gov/document/2017-10/kern-county-inn-plan-description-technology-based-mental-health-solutions

Proposed Motion: The MHSOAC approves Los Angeles County's Innovation plan as follows:

> **Name:** Increasing Access to Mental Health Services and Supports Utilizing a Suite of Technology-Based Mental Health Solutions
> **Amount:** $33,000,000
> **Project Length:** Three (3) Years

Proposed Motion: The MHSOAC approves Kern County's Innovation plan as follows:

> **Name:** Increasing Access to Mental Health Services and Supports Utilizing a Suite of Technology-Based Mental Health Solutions
> **Amount:** $2,000,000
> **Project Length:** Three (3) Years

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Biographies for Los Angeles County Presenters

Debbie Innes-Gomberg, Ph.D.

Dr. Innes-Gomberg received her PhD from CSPP-LA in 1992 and began work for the Los Angeles County Department of Mental Health the same year as a clinical psychologist. Over the 24 years she has worked for the Department she has assumed leadership roles in Jail Mental Health Services, Adult System of Care (ASOC), served as a District Chief for the Long Beach/South Bay areas of Los Angeles County, the Adult System of Care Lead for the Mental Health Services Act (MHSA), and from 2009 until October, 2016, as the Program Manager III of the MHSA Implementation and Outcomes Division, overseeing community planning, implementation, reporting and evaluation of MHSA programs. In October, 2016 Dr. Innes-Gomberg was promoted to Deputy Director in Los Angeles County, inclusive of countywide oversight of MHSA, Program Development and outcomes.

Dr. Innes-Gomberg is the Co-Chair of the County Behavioral Health Directors' Association's (CBHDA) MHSA Committee, including a member of its Governing Board. She is a leader in LA County and across the State on the MHSA and on outcome and evaluation of mental health programs.

Jonathan Sherin, M.D., Ph.D.

Jonathan Sherin, M.D., Ph.D., is a longtime wellbeing advocate and – as of this past November – the new Director of the Los Angeles County Department of Mental Health (LACDMH). In this role, he oversees the largest public mental health system in the United States with a budget approaching $2.5 billion and serving over 250,000 residents.

Prior to joining LACDMH, Dr. Sherin was chief medical officer and executive vice president of military communities for Volunteers of America, one of our nation's largest direct service non-profits. Over the years, he has also served in a variety of clinical, academic, teaching, and administrative leadership positions. In his last such post, Dr. Sherin directed mental health for the Miami VA Healthcare System and functioned as vice-chairman of the Department of Psychiatry at the University of Miami.

As an expert on veteran issues, Dr. Sherin has testified to Congress on challenges faced by members of the military community, specifically as they relate to trauma, recovery, reintegration, and the risk of homelessness and suicide. As a researcher, Dr. Sherin has published in the fields of neurobiology and psychiatry – including a seminal article in "Science" magazine that features his work identifying a core sleep circuit in mammals (the "sleep switch"). He also received the prestigious Kempf Award from the American Psychiatric Association for his conceptual model of the psychotic process.

Dr. Sherin is currently a volunteer clinical professor of psychiatry and behavioral sciences at both UCLA and the University of Miami.

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Biographies for Kern County Presenters

Bill Walker, LMFT

Mr. Walker is the Director of Kern Behavioral Health and Recovery Services. He began his career in Mental Health as a volunteer in the crisis hotline setting. He has practiced for over 30 years in a variety of treatment aspects including substance use counseling, inpatient and outpatient care for youth. Additionally, he served as an instructor in chemical dependency counseling certification for California State University, Bakersfield for over 20 years. Prior to his appointment Director of Kern Behavioral Health and Recovery Services in 2014, Mr. Walker served for 16 years as the Kern Behavioral Health and Recovery Services Crisis Services Administrator.

Bradley Cloud, Psy.D.

Dr. Cloud has served as Deputy Director of Kern Behavioral Health and Recovery Services since 2014. His career in mental health has spanned 30 years, including roles as therapist, clinical psychologist and supervisor of the Kern BHRS Forensic Services Team before being appointed Administrator of Adult Services in 2000 and ultimately his present position. Dr. Cloud also holds academic appointments as Assistant Professor of Psychiatry and Biobehavioral Sciences at the David Geffen School of Medicine at UCLA and, Clinical Training Director of the Kern Behavioral Health and Recovery Services Pre-Doctoral Psychology Internship Program.

Mental Health Services
Oversight & Accountability Commission

STAFF INNOVATION ANALYSIS
LOS ANGELES COUNTY and KERN COUNTY

Name of Innovative (INN) Project: Increasing Access to Mental Health Services and Supports Utilizing a Suite of Technology-Based Mental Health Solutions

Total INN Funding Requested for Project:

Los Angeles $33,000,000;

Kern $2,000,000

Duration of Innovative Project: Number (3) Years

Review History

Los Angeles:

Approved by the County Board of Supervisors: Pending MHSOAC approval

County Submitted Innovation (INN) Project: September, 13, 2017

MHSOAC Consideration of INN Project: October 26, 2017

Kern:

Approved by the County Board of Supervisors: Anticipated October 24, 2017

County Submitted Innovation INN Project: September 22, 2017

MHSOAC Consideration of INN Project: October 26, 2017

Project Introduction:

Los Angeles (LA) County and Kern County are part of a multi-county collaborative and will utilize the Joint Powers Authority, California Mental Health Services Authority, and (CalMHSA), to act as the fiscal agent for all participating counties. The INN proposal describes a multi-county demonstration project to implement a group of technology-based mental health solutions that utilize a web-based network of trained, on-call, peers to chat 24/7 with individuals experiencing symptoms of mental illness; digital detection of emotional, thought and behavioral disturbances through passively collected data; and virtual, evidence-based on-line treatment protocols that use avatars to deliver clinical care.

CalMHSA, acting as the Joint Powers Authority, will contract out with one or more technology vendors to implement the suite. It is proposed that LA County will lead the project and additional counties will choose which parts of the technology suite to adopt and how much of their INN funding to allocate before submitting their plan to the MHSOAC for consideration. It is anticipated that several other counties will be joining the collaborative.

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? Will the proposed evaluation allow the county to make any conclusions regarding their learning objectives? In addition, the MHSOAC checks to see that the Innovation meets regulatory requirements that the proposed project must align with the core MHSA principles, promote learning, funds exploration of a new and/or locally adapted mental health approach/practice, and targets one of the four allowable primary purposes.

The Need

According to "Disparities in Unmet Need for Mental Health Services in the United States, 1997–2010"John M. Roll, Ph.D., Jae Kennedy, Ph.D., Melanie Tran, M.S.H.P.A., and Donelle Howell, Ph.D., published online: January 01, 2013 "Unmet need for mental health services increased from 4.3 million in 1997 to 7.2 million in 2011, with the bulk of unmet need concentrated in the working-age population (18–64 years). Rates of unmet need for mental health care were approximately five times higher for uninsured respondents than for privately insured respondents.

Per the 2016 Census data LA County has a population of 10,137,915 persons. Kern County has a population of 884,788. With an estimated 1 in 5 persons across the population experiencing mental health challenges it is assumed that a significant portion of the population is not currently seeking mental health treatment. The Counties hope that this group will benefit from the addition of technology based mental health services including those individuals with sub-clinical mental health symptoms, persons at risk for developing mental health symptoms or having a mental health relapse, socially isolated individuals, high users of inpatient psychiatric facilities, existing mental health clients seeking additional support and family members of persons suffering from mental illness.

The Response

LA County proposes to partner with Kern County, and several other counties to address a shared need of increasing access to mental health services for unserved and underserved groups; to reduce stigma and increase early intervention. In order to address these shared needs, the collaboration proposes to partner with one or more technology-based mental health services with the goal to: (1) detect mental illness earlier; (2) intervene earlier to prevent mental illness and relapse and improve client outcomes;

(3) provide alternate modes of engagement, support and intervention; and (4) test out the collection of passive data as a method to identify early signs of mental health symptoms.

LA County defines passive data as "collected patterns of use without required participation from the user (devoid of content)" and plan to incorporate it into an interactive approach to digital phenotyping. The County defines digital phenotyping as, "using device usage patterns to identify behavior patterns that may be associated with mental health conditions, where the technology analyzes factors associated with cell phone usage (passive data) and interacts with the user via a pop-up or chat…" Additional research corroborates with the County's definition. In the article, *Digital Phenotyping, Technology for a New Science of Behavior*, Dr. Insel describes digital phenotyping as "…new approach to measuring behavior from smartphone sensors, keyboard interaction, and various features of voice and speech." The County hopes that the use of the digital platform, including digital phenotyping, will support the user to increase understanding of how they are feeling and lead to earlier detection of mental health needs/problems and treatment options. Dr. Insel cautions that better data does not result in better care without an effective bridge. He states that smartphones can provide the tools for assessments and interventions in order to create a "learning mental health system" but that a set of standards and a consumer's guide for digital mental health in the public sector needs to be created. Additional researchers have encouraged the development of procedures that, "… offer individuals better control of their diverse digital footprints with opportunities to control the information they wish to share" (Bidargaddi et al). This approach may build trust with individuals and avoid ethical challenges. There is an opportunity for the Counties participating in this demonstration project to develop a set of standards and a consumer's guide to digital mental health as a dynamic contribution to statewide learning.

In order to digitally expand access to mental health care, the Counties propose to develop and implement an application that individuals can voluntarily download and access through smartphones, home computers and computer stations at various locations (schools, libraries, NAMI, client run organizations, senior centers, etc.)

In addition, Kern County states that they will encourage consumers, who may not have access to a smartphone, to utilize kiosks to access the technology platform. The 40 online registration kiosks were funded through their previously approved INN plan to facilitate the use of the Smart 911 registry system and are located throughout Kern County, including rural areas.

The Counties may wish to further explain how they will collect data and measure outcomes from beneficiaries accessing the suite of technology through a computer station in a public place, as digital phenotyping may not be possible in those situations.

In addition, the collaboration of counties may wish to discuss their plans to include those individuals who do not have access to smartphones by communicating with other counties who may have addressed this issue successfully.

The Counties have received feedback about privacy concerns arising from the use of passive data and have proposed a cross-county steering committee and an LA based steering committee to guide the project, review data and analytics and ensure appropriate use of privacy and security.

Both Counties believe that the proposed project can provide a method of access and linkage to care never previously achieved in the public mental health system. They wish to test out if these technology tools can identify and engage individuals who may need mental health care but have not been successfully reached through existing pathways. Further, the Counties believe that this service delivery through virtual peer chatting will expand the use of peer support, creating new roles for trained peers in engagement and service delivery. As the Counties move forward, they may wish to look into the UK based digital platform called, “Big White Wall™” to see if there are lessons to be built upon from the collaborative between the Ministry of Defense and charities who are providing the digital platform to all UK service personnel, veterans and family members.

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.

The LA community planning process relies heavily on their System Leadership Team, (SLT). This team is composed of 58 individuals who represent service providers, county agencies and consumers and family members. The Innovation plan was provided to the SLT team with a request for feedback on June 21, 2017. Generally the stakeholder process includes consumers and family members in the development of innovation projects. **LA County may wish to discuss how consumers and family members were included in the development of this innovation plan.**

Kern County reports that in their fall 2016 community planning process, respondents identified the need for increased services in outlying areas. They also reported that 52% of stakeholder feedback collected from PEI stakeholder process identified access and linkage to care as a need. Feedback specific on the use of supports utilizing a suite of technology based mental health solutions was sought from stakeholders in the 3 year plan CPP process, in September of this year and received positive support.

Each County states that their stakeholder process identified both the need for greater access to mental health services in rural areas and to find solutions to the barriers of stigma and self-stigma.

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 how, if the County chooses to continue it, the project work plan shall transition to another category of funding, as appropriate.

LA County identifies multiple learning questions to guide their demonstration project:

- Will individuals either at risk of or who are experiencing symptoms of mental illness use virtual peer chatting accessed through a website or through a phone application?
- Will individuals who have accessed virtual peer chatting services be compelled to engage in manualized virtual therapeutic interventions?
- Will the use of virtual peer chatting and peer-based interventions result in users reporting greater social connectedness, reduced symptoms and increases in well-being?
- What virtual strategies contribute most significantly to increasing an individual's capability and willingness to seek support?
- Can passive data from mobile devices accurately detect changes in mental status and effectively prompt behavioral change in users?
- How can digital data inform the need for mental health intervention and coordination of care?
- What are effective strategies to reduce time from detection of a mental health problem to linkage to treatment?
- Can we learn the most effective engagement and treatment strategies for patients from passive mobile device data to improve outcomes and reduce readmissions?
- Can mental health clinics effectively use early indicators of mental illness risk or of relapse to enhance clinical assessment and treatment?
- Is early intervention effective in reducing relapse, reducing resource utilization and improving outcomes and does it vary by demographic, ethnographic, condition, intervention strategy and delays in receiving intervention?
- Can online social engagement effectively mitigate the severity of mental health symptoms?
- What are the most effective strategies or approaches in promoting the use of virtual care and support applications and for which populations?

LA County states that they will establish an evaluation steering committee and will form the basis of evaluation directly from the learning questions outlined above. Specifically, they will evaluate the project by tracking and analyzing passive data, level of user engagement, changes in access to care and clinical outcomes.

The Counties identified specific intended outcomes including:

- Increased purpose, belonging and social connectedness for users.
- Increased ability for users to identify cognitive, emotional and behavioral changes and act to address them.
- Increases in quality of life, as measured objectively and subjectively (by user and by indicators such as activity level, employment, school involvement, etc.).
- For high utilizers of inpatient or emergency services, decreases in utilization for those services.
- Reduced stigma of mental illness as reported by user.
- Comparative analyses of population level utilization data in Los Angeles County over the life of the project to determine impact on various types of service utilization.
- For clients with particular sorts of biomarkers (characteristics identified either through history or digital phenotyping analysis), how many clients respond well to treatment options identified through this project?
- What is the role of this technology as a source of information that can help guide the interventions provided by mental health clinicians?
- Examine penetration or other unmet need metrics to understand how the technology suite has impacted the ability to serve those in need.

Counties involved in the collaborative may wish to identify specific methods and assessments that will be utilized to measure changes in mental health symptoms, and outline how baseline data will be gathered.

Both LA and Kern Counties describe a commitment to completing a comprehensive evaluation through a contracted entity. LA County states that they have detailed the evaluation components in a Scope of Work. They state that the success of the project will be determined by the analytics associated with the technology services, assessed effectiveness of the tools, and user satisfaction and outcomes. **The Counties may wish to share an outline of the Scope of Work that ties together the tools used to measure the stated learning objectives.**

LA County will share learning as it is occurring internally and externally throughout California. The County will provide regular reports to the eight (8) Service Area Advisory Committees within LA County (Each SAAC functions as a local forum of consumers, families, service providers and community representatives), the System Leadership Team and have committed to participating in cross-county learning opportunities supported by the MHSOAC.

LA will determine the sustainability of the project based on the results of the comprehensive evaluation.

Kern County identifies the possibility of sustaining the project with Prevention and Early intervention funds if the results of the three year demonstration project are favorable.

The Counties involved in this collaborative may wish to address the continuity of care for consumers who may come to rely on the technology platform and ensure that a smooth transition of care is prioritized if the project is not continued.

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 proposed budget county budget and duration of INN project

INN funds will be the sole funding source for both LA County and Kern County and will be included as part of the Joint Powers Agreement with CalMHSA, who will act as the fiscal agent for counties involved in the collaborative program.

Los Angeles County

The total budget for LA County's Innovative project is $33,000,000 over three (3) years and includes the following estimated budget breakouts: $13,650,000 for personnel (administrative, leadership and direct service); $7,750,000 for technology development; $6,300,000 for community engagement and outreach; $3,400,000 for operational and fixed costs; and $1,900,000 for evaluation.

Personnel costs include: a Regional Director who will manage the project in LA County; Direct service staff including: Family Support Specialists and School Support Specialists; and Public Relations and Marketing Staff. Technology development costs include: hiring developers to build, modify and refine the technology platform/application and ensure all web interfaces are culturally relevant and integrate accessibility features; Database Administrators; Data Scientists and Engineers who will run reports as well as provide necessary data analysis for passive data collection to enhance early detection of mental health issues.

Kern County

The total budget for Kern County's Innovative Project is $2,000,000 split evenly over three (3) years and includes: $766,666 for personnel (administrative, leadership and direct service); $266,667 for technology development; $466,667 for community

engagement and outreach; $366,667 for operational and fixed costs; and evaluation costs of $133,333.

LA County may wish to consider if the platform development is a capital investment and if it will have value at the end of this project. Is there an opportunity to share the initial costs with other funding sources, including Prevention and Early Intervention?

Additional Regulatory Requirements

The proposed project appears to meet the minimum requirements listed under MHSA Innovation regulations.

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MHSA Innovation 3 Project: Technology Suite
Improving Access to Mental Health Care

Overview

Technology is being used regularly as a tool to assist people with parking their cars, paying their bills, monitoring physical activity, measuring sleep-quality and countless other examples. Recent research demonstrates that technology can also be used to directly impact the provision of health and mental health services, The Los Angeles County Department of Mental Health (LACDMH) is seeking approval from the Mental Health Services Oversight and Accountability Commission (MHSOAC) to use Innovation Funds to implement a technology-based project. This project, led by LACDMH with a number of other California counties already on board, will bring interactive technology tools into the public mental health system through a highly innovative set or "suite" of applications designed to educate users on the signs and symptoms of mental illness, improve early identification of emotional/behavioral destabilization, connect individuals seeking help in real time, and increase user access to mental health services when needed.

Components of the Technology Suite

Accessible from a computer, cell phone or tablet utilizing customized applications for:

1. Digital detection of emotional, thought and behavioral disturbances through passively collected data and sophisticated analyses that sense changes in the user interface known to correlate with social isolation, depression, mania, the early psychotic (prodromal) syndrome, and other indicators of either the onset of new mental illness or the recurrence of a chronic condition. As concerning signals are detected, communication to the user is generated through texts, emails, peers or clinician outreach to prompt care.
2. A web-based network of trained and certified peers available to chat 24/7 with individuals (or their family members/caregivers) experiencing symptoms of mental illness. A link to the chatroom will be available through the LACDMH web and social media will be used to promote the service across Los Angeles County. Branding will stress the resource is as both a support and triage tool for anyone experiencing problems at any time, especially those unfamiliar with self-management techniques, confused or unclear about the available resources, or reluctant to visit a mental health clinic.
3. Virtual, evidence-based on-line treatment protocols using avatars to deliver clinical care. By their nature as virtual tools, this client-provider interface is available 24/7 and can be accessed in the home, clinical settings, and mobile devices.

Implementation Plan

Departments of Mental Health in Los Angeles and other counties will engage with one or more proven companies to engineer these technologies for use in the public mental health system.

Overall Goals

1. Detect mental illness earlier, including depression, psychosis, and bipolar disorder.
2. Intervene earlier to prevent mental illness and improve client outcomes.
3. Provide alternate modes of engagement, support and intervention.

Primary Purpose and Qualification as an Innovation Project

The primary purpose of this Innovation Project is to increase access to mental health care and support and to promote early detection of mental health symptoms or predict the onset of mental illness. This project proposes a new approach to overall public mental health service delivery.

Target Population

The target population or intended beneficiaries/users of these proposed technology-based mental health solutions are:

- Individuals with sub-clinical mental health symptom presentations, including those early in the course of a mental health condition who may not recognize that they are experiencing symptoms, including college students.
- Individuals identified as at risk for developing mental health symptoms or who are at risk for relapsing.
- Socially isolated individuals, including older adults at risk of depression.
- High utilizers of inpatient psychiatric facilities.
- Existing mental health clients seeking additional sources of support.
- Family members with either children or adults suffering from mental illness who are seeking support.
- Individuals at increased risk or in the early stages of a psychotic disorder.

Overarching Learning Questions

1. Will individuals either at risk of or experiencing symptoms of mental illness use virtual peer chatting accessed through a website or through a mobile application?
2. Will individuals who have accessed virtual peer chatting services be compelled to engage in manualized virtual therapeutic interventions?
3. Will the use of virtual peer chatting and peer-based interventions result in users reporting greater social connectedness, reduced symptoms and increased wellbeing?
4. What virtual strategies contribute most significantly to increasing an individual's capability and willingness to seek support?
5. Can passive data from mobile devices accurately detect changes in mental status and effectively prompt behavioral change in users?
6. How can digital data inform the need for mental health intervention and coordination of care?
7. What are effective strategies to reduce time from detection of a mental health problem to linkage to treatment?
8. Can we learn effective engagement and treatment strategies for patients from passive mobile device data to improve outcomes and reduce re-admissions?
9. Can mental health clinics effectively use early indicators of mental illness risk or relapse to enhance clinical assessment and treatment?
10. Is early intervention effective in reducing relapse, reducing resource utilization and improving outcomes and does it vary by demographic, ethnographic, condition, intervention strategy and delays in receiving intervention?
11. Can online social engagement effectively mitigate the severity of mental health symptoms?
12. What are the most effective strategies or approaches in promoting the use of virtual care and support applications and for which populations?
13. Will issues pertaining to privacy and/or data security present a barrier to the use of these applications?
14. Will the use of these applications decrease metrics such as hospital and emergency department utilization?

Proposed Implementation and Dissemination Strategies

The technology vendor(s) will identify a project manager for the multi-county collaborative as well as one specifically for Los Angeles County. The LAC Project Manager will work with lead LACDMH staff to identify and sequence the dissemination/roll-out of the applications, including:

- Create a chat room for peers to engage with clients and family members on the LACDMH website.
- Utilizing a variety of social and traditional media to promote the website/applications.
- Building on existing DMH partnership with the LA County Library System, outreach to librarians to promote the applications.
- Create new and reinforce existing partnerships with universities and colleges to promote use among a key demographic for the project.
- Engage Transition Age Youth Drop-In Centers to utilize the website and applications.
- Engage hospital discharge and case management staff on the use of the applications.
- Promote use of applications at the LACDMH Peer Resource Center and in Wellness and Client Run Centers throughout LAC.
- Utilize peer specialist staff deployed to waiting rooms to teach clients how to use the application(s).
- Engage NAMI, MHA, senior centers and older adult service centers on the use of the peer and family chatting application as an added source of support.
- Introduce the applications to mental health clinicians as an additional tool to guide interventions.

Evaluation

This project will be evaluated by tracking and analyzing passive data, reach of users, level of user engagement, changes in access to care and clinical outcomes. Furthermore, data from mobile devices would be analyzed to detect changes in mental status and responses to online peer support, digital therapeutics and virtual care. Continuous assessment and feedback would drive the interventions. Specific outcomes include:

1. Increased purpose, belonging and social connectedness for users.
2. Increased ability for users to identify cognitive, emotional and behavioral changes and act to address them.
3. Increases in quality of life, as measured objectively and subjectively (by user and by indicators such as activity level, employment, school involvement, etc.).
4. Decreases in utilization among high utilizers of inpatient or emergency services.
5. Reduced stigma of mental illness as reported by user.
6. Comparative analyses of population level utilization data in Los Angeles County over the life of the project to determine impact on various types of service utilization.
7. For clients with particular sorts of biomarkers (characteristics identified either through history or digital phenotyping analysis), the number of clients that respond well to treatment options identified through this project.
8. Examine penetration or other unmet need metrics to understand how the technology has impacted LACDMH's ability to serve those in need.

User outcomes will be measured by analyzing retrospective and prospective utilization of hospital resources from claims data and medical records data. The analysis will incorporate disease risk stratification, digital phenotype and digital biomarker measurement, type of intervention and delay

in receiving care. Quality of life impact will include school grades, graduation rates, job retention and absenteeism, among other indicators.

Budget

$33 million over three fiscal years, starting mid-year in FY 2017-18.

Estimated Budget by Fiscal Year						
Staffing						
Administrative		**FY 17-18 (partial year)**	**FY 18-19**	**FY 19-20**	**FY 20-21 (partial year)**	**Total**
	Public Relations and Marketing, Office Assistant, Procurement (CalMHSA)	$900,000	$1,500,000	$1,500,000	$450,000	$4,350,000
Leadership		**FY 17-18**	**FY 18-19**	**FY 19-20**	**FY 20-21**	**Total**
	Regional Director (LA), Management functions	$450,000	$900,000	$900,000	$450,000	$2,700,000
Direct Service (peer/family chatting)		**FY 17-18**	**FY 18-19**	**FY 19-20**	**FY 20-21**	**Total**
	Hospital Liaisons, Peer Specialists, Family Support Specialists, Trainers, Behavioral Health Coordinators, College Liaisons	$1,100,000	$2,200,000	$2,200,000	$1,100,000	$6,600,000

Technology Development						
Technology and Digital Phenotyping		**FY 17-18**	**FY 18-19**	**FY 19-20**	**FY 20-21**	**Total**
	Developers, Data Scientists, Machine Learning, User Experience, Quality Assurance, Clinical Operations, Product Management, Healthcare Solution Architect	$1,291,666	$2,583,000	$2,583,000	$1,292,334	$7,750,000

Community Engagement and Outreach						
Community Engagement and Development		**FY 17-18**	**FY 18-19**	**FY 19-20**	**FY 20-21**	**Total**
	Family Support, School Support, Community Coordinators, Outreach Coordinators, Advertising	$1,100,000	$2,200,000	$2,200,000	$800,000	$6,300,000

Evaluation		**FY 17-18**	**FY 18-19**	**FY 19-20**	**FY 20-21**	**Total**
	Researchers and Healthcare Economists, Data Scientists and Statisticians, Health Policy Experts	$300,000	$600,000	$600,000	$400,000	$1,900,000

Operational and Fixed Costs		**FY 17-18**	**FY 18-19**	**FY 19-20**	**FY 20-21**	**Total**
	Supplies for Users, Office Space and Furnishings, Machine and Technology Infrastructure, computer kiosks	$600,000	$1,100,000	$1,100,000	$600,000	$3,400,000
BUDGET TOTAL						**$33,000,000**

Increasing Access to Mental Health Services and Supports Utilizing a Suite of Technology-Based Mental Health Solutions

In August 2017, KernBHRS joined in a collaborative effort with multiple counties to begin an innovative project utilizing contracted technology-based mental health service and support providers. Counties involved include Los Angeles, Mono, Monterey, Fresno, Santa Clara, Yolo, Sacramento, and Sonoma.

The project goal is to utilize technology-based programs accessed through devices including computers and smart phones to engage individuals in need of mental health care or additional mental health care supportive services. The program will also identify, through a series of passive data collection points and early signal biomarkers for mental health symptoms, those who may require specialty care. Through supportive services and engagement, including early intervention, it is anticipated that the project will provide better support to those experiencing symptoms of mental illness and family members of those with mental illness.

Primary Problem to be Addressed:
During the Community Planning Process 2016 and a series of stakeholder meetings held in the Spring of 2017, stakeholders voiced that there is a need for greater access to services, especially in the rural areas outside of Metropolitan Bakersfield, where transportation is largely a concern. Throughout Kern County, and especially in smaller outlying areas, there exists stigma and self-stigma regarding receiving traditional mental health care. As many towns are small and populations are well acquainted, some choose to come to Bakersfield to avoid neighbors and friends knowing about their mental health care needs. Additionally, there are many who do not feel comfortable receiving services and supports in a traditional clinical setting, which can sometimes lead to avoidance of care and increase in symptoms.

One strategy implemented by KernBHRS to address access and linkage needs is the Risk Reduction Education and Engagement Accelerated Alternative Community Behavioral Health (REACH) program. This program utilizes a hotline approach to receive referrals from family members and supports, law enforcement, behavioral health care providers, medical providers, etc. While this program provides outreach to those in the outlying areas as well as Metropolitan Bakersfield, many experience self-stigma and are apprehensive to engage in traditional behavioral health care. This approach can be effective for those with family, supports or agencies willing to provide a referral, but leave a great deal of the population seeking help for themselves yet unserved or underserved.

Utilizing existing technology-based avenues with a wide breadth of access for all populations to can mitigate stigma, especially self-stigma associated with mental illness and encourage those in need of services to engage in necessary care.

Proposed Project:
The proposed project will utilize technology-based mental health solutions designed to engage, educate, assess and intervene with individuals experiencing symptoms of mental illness, including:

- Virtual peer chatting with trained and certified peers with lived experience
- Virtual support specific to populations including family members of children and adults with mental illness and those experiencing mental health-related symptoms

- Virtual chat options for parents of children or adults with mental illness
- Virtual manualized interventions, including mindfulness exercises, cognitive behavioral or dialectical behavior skills which are delivered in an intuitive fashion.
- An active referral process for those in need of additional treatment through the System of Care

Passive sensory data will be utilized to engage, educate and suggest behavioral activation strategies to users, including:

- Incorporation of passive data from mobile devices such as smart phones into an interactive approach which uses digital phenotyping to analyze factors associated with mobile phone usage. This technology interacts with the individual through pop-up or chat functionality that allows better understanding of thought and feeling states.
- Recommended interventions and communications would be determined by utilization of web-based analytics.
- Use emerging mental health research associated with early detection of symptoms to identify those at risk and/or experiencing symptoms as well as use of passive data collection to determine risk of relapse.

Strategic engagement approaches will be used to introduce technology-based mental health solutions to individuals, including:

- School systems including colleges and universities
- Individuals using social media and through promotion on KernBHRS public website and/or other media
- Through local collaborative efforts with mental health organizations including the National alliance for Mental Illness (NAMI) to promote use
- Senior Centers and other locations frequented by older adults
- Public locations including clinics, community centers, libraries or parks

Develop and implement a method to conduct outcome evaluation of project elements to determine effectiveness concerning:

- Wellbeing of users
- Duration of untreated or under-treated mental illness
- Ability for users to identify cognitive, emotional, and behavioral changes and actively address them
- Quality of life, measured objectively and subjectively by the user and indicators of activity level, employment, school involvement, etc.

Innovative Component:

This project introduces a new set of approaches to the public mental health system in a multi-county collaborative project.

Learning Goals/Project Aims:

- Determine whether individuals at risk of or experiencing mental health symptoms will access virtual peer chatting through a website or phone-based application
- Determine whether those accessing virtual peer chatting will engage in manualized virtual therapeutic interventions
- Determine whether utilization of virtual peer chat and peer-based interventions results in users reporting better wellbeing including reduced symptoms and greater social connectedness
- Determine which virtually-based strategies work best in engaging an individual and result increased willingness to seek support

- Determine whether passive data collected from mobile devices accurately detects changes in mental health status, effectively prompting behavioral change in the user
- Determine how digital data informs the need for mental health intervention and care coordination
- Determine effective strategies to reduce the time between detection of potential mental illness and linkage to care
- Determine whether online social engagement effectively mitigates the severity of mental health symptoms
- Determine the most effective strategies/approaches to promote the use of virtual care and support applications including information by population reached

Budget Summary:
Kern will allocate $2 million in innovative component funding over three years, beginning mid-year 2017/2018. Direct costs related to the project include staff time of contracted or in-house and project-related management and evaluation and administration. It is anticipated that funding in each of the elements may shift due to the actual costs of contracts related to services and evaluation. Budgeted amounts within the elements should be considered approximations.

Additionally, the multiple counties participating in the project will utilize the Joint Powers Agreement (JPA) with the California Mental Health Services Authority (CalMHSA) to provide administrative functions including PR/Marketing and Procurement of contracts with technology-based entities and evaluators. Anticipated costs for these services include JPA increase for CalMHSA ($100,000/ 3 years), and allocation for Technology Development and Phenotyping ($266,667/ 3 years) and evaluation ($133,333/ 3 years). Combined anticipated cost is $500,000 over three years.

Kern will appoint a county regional project coordinator and support community engagement and outreach using peers, family members, educators and community outreach coordination team. KernBHRS will also implement a countywide project marketing campaign. Staff including peer specialists, family support specialists, trainers, Recovery Specialists and inpatient and outpatient care liaisons will play a role in providing information on technology-based supports to existing clients who would benefit from online or mobile application virtual chat or support groups. Anticipated combined costs over three years is $1,500,000, including Operational and Fixed Costs.

Budget Template					
Categories	Description	FY 2017-2018	FY 2018/2019	FY 2019/2020	3-Year Total
Staffing:					
Administrative	• Public Relations • Marketing • Office Assistant	$33,333	$33,333	$33,333	$100,000
Leadership	• Regional Director	$66,666	$66,667	$66,667	$200,000
Direct Service	• Peer Specialists • Family Support Specialists • Trainers • Behavioral Health Coordinators	$155,555	$155,555	$155,556	$466,666
Technology Development:					

Technology and Digital Phenotyping	• Developers • Growth Engineers • Machine Learning • User Experience • Quality Assurance • Product Management	$88,889	$88,889	$88,889	$266,667
Community Engagement and Outreach:					
Community Engagement and Development	• Family Support • School Support • Community Coordinators • Outreach Coordinators • Advertising	$155,555	$155,555	$155,556	$466,667
Evaluation:					
Evaluation	• Researchers • Data Scientists • External Consultants	$44,444	$44,444	$44,444	$133,333
Operational and Fixed Costs:					
Operational and Fixed Costs	• Supplies for Users • Office Space and Furnishings • Machines and Technology Infrastructure • Travel and conferences • Benefits and Insurance	$122,222	$122,222,	$122,222	$366,667

AGENDA ITEM 03

Action

October 26, 2017 Commission Meeting

Mendocino County Innovation Project

Summary: The Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission) will consider approval of Mendocino County's request to fund a new Innovative project: Round Valley-Crisis Response Services (RVCRS) for a total of $1,124,293 over three (3) Years. Mendocino County proposes to increase access to underserved groups, by creating a model for integrated one-stop crisis response services, adapted for Round Valley's unique needs where 30-40% of the community residents are American Indian/ Alaskan Native. This project will provide a blend of Native American healing practices with County Specialty Mental Health and co-occurring substance abuse services to both Native and Non-Native members of the community.

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.

Presenters:

- Jenine Miller, Psy.D., Behavioral Health Director, Mendocino County Behavioral Health and Recovery Services
- Karen Lovato, Acting Deputy Director Behavioral Health and Recovery Services
- Otis Brotherton, Director, Round Valley Indian Health Center
- Frank Tuttle, Clinical Psychology Intern, Round Valley Indian Health Center

Enclosures (3): (1) Biographies for Mendocino County Innovation Presenters (2) Staff Innovation Summary, Round Valley Crisis Response Services and (3) County Project Brief; (RVCRS).

Handout (1): PowerPoint Presentation

Additional Materials (1): Links to the County's complete Innovation Plan is available on the MHSOAC website at the following URL:

http://mhsoac.ca.gov/document/2017-10/mendocino-county-innovation-plan-descriptions

Proposed Motion: The MHSOAC approves Mendocino County's Innovation plan as follows:

Name: Round Valley Crisis Response Services
Amount: $1,124,293
Project Length: Three (3) Years

Biographies for Mendocino County Presenters

Jenine Miller, Psy.D.

Jenine Miller, Psy.D., Behavioral Health Director, Mendocino County Behavioral Health and Recovery Services. Served Mendocino County since 2008 in various Mental Health positions. Involved in the innovation project pre-planning phases and the management and oversight of development of the innovation plan.

Karen Lovato

Karen Lovato, Acting Deputy Director Behavioral Health and Recovery Services. Served Mendocino County since 2001 in various Mental Health positions. Involved in Innovation project pre-planning and development of the Innovation Project, and supervising the MHSA team responsible for developing the Innovation Plan and collaborating with our community partners.

Otis Brotherton

Otis Brotherton is an enrolled member of the Round Valley Indian Tribes of Nomlaki descent. He has worked for Round Valley Indian Health Center, Inc. for the past 7½ years and continues to work for them as the Director of Human Services in the Yuki Trails Human Services Program. He is also a CADC-ll (Certified Alcohol and Drug Counselor-ll) and ICADC (International Certified Alcohol and Drug Counselor). Otis received his Registered Addiction Specialist Credentials at Breining Institute in 2011 and currently holds certification as a CADC-ll, ICADC with CCAPP (California Consortium of Addiction Programs and Professionals). He also is trained in many evidenced based curriculum as a facilitator; ASIST (Applied Suicide Intervention Skills Training), FIS/MIS (Fatherhood is Sacred/Motherhood is Sacred) traditional parenting class, White Bison Wellbriety: Medicine Wheel and 12-steps for Adolescent Boys and Girls, Mending Broken Hearts and Mending Broken Hearts for Youth Red Road Wellbriety Movement.

Frank Tuttle, M.A.,Doctoral Candidate Clinical Psychology, Ph. D.

Frank Tuttle (Concow Maidu, Yuki) works for the Yuki Trails, Human Services Department Round Valley Indian Health Center. Previous work includes: Lake County Mental Health Department working with severely mental ill adults and children; Consolidated Tribal Health Project: twenty years in the administration of a rural non-profit outpatient health clinic serving eight federally recognized tribes; Mendocino College part-time instructor of painting, drawing, design, art history and introduction psychology classes; previously served as Development Coordinator for Northern Circle Indian Housing Authority, Ukiah, CA. Lastly, Mr. Tuttle was a founding staff member of a multi-county housing development non-profit for thirteen federally recognized tribal communities.

STAFF INNOVATION SUMMARY - MENDOCINO COUNTY

Name of Innovative (INN) Project: ROUND VALLEY CRISIS RESPONSE SERVICES

Total INN Funding Requested for Project: $1,124,293

Duration of Innovative Project: Number (3) Years

Review History

Approved by the County Board of Supervisors: September 19, 2017

County Submitted Innovation (INN) Project: August 25, 2017

MHSOAC Consideration of INN Project: October 26, 2017

Project Introduction:

The Round Valley Crisis Response Services is a plan that seeks to learn how institutional and governmental agencies can work effectively with the local and tribal community to meet the needs of these communities. Mendocino County hopes to identify an effective and culturally responsive crisis response system for this remote community. Working with stakeholders, they will develop a model for integrated one-stop crisis response services, adapted for Round Valley's unique needs where 30-40% of the community residents are American Indian/ Alaskan Native. This project will provide a blend of Native American healing practices with County Specialty Mental Health and co-occurring substance abuse services to both Native and Non-Native members of the community.

In the balance of this brief we address specific criteria that the Mental Health Services Oversight & Accountability Commission (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?
- Will the proposed evaluation allow the county to make any conclusions regarding their learning objectives?

Additionally, the MHSOAC checks to see that the Innovation meets regulatory requirements that the proposed project must align with the core MHSA principles,

promotes 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 population of Round Valley is between 30-40% American Indian/Alaskan Native. According to the National Congress for American Indians, Native people die at 510% higher rates from alcoholism and 62% higher rates from suicide than other Americans. Indian youth have the highest rate of suicide among all ethnic groups in the United States and is the second-leading cause of death for Native youth aged 15-24.

According to the 2014 US census:

- The median household income of single-race American Indian and Alaskan Native households in 2014 was $37,227 compared to $53,567 for the nation as a whole.

- The percentage of single-race American Indians and Alaskan Natives who were in poverty in 2014 was 28.3%, which was the highest rate among any racial group, compared to 15.5% of the nation as a whole which lives in poverty.

- The percentage of single-race American Indians and Alaskan Natives who lacked health insurance coverage in 2014 was 23.1%, compared to 11.7% of the nation as a whole that lacked health insurance.

According to the Office of Statewide Health Planning and Development Department, Mendocino County has only three hospitals with Emergency Rooms (ER) and no psychiatric hospitals. The nearest ER's are in Willits, located 43 miles from Round Valley; Fort Bragg, located 83 miles from Round Valley; and Ukiah, located 76 miles from Round Valley. There is no public transportation to and from the reservation.

The Round Valley Crisis Response Services project strives to address the lack of a community crisis response center, substance abuse services and the historical trauma and institutional distrust between this community and county Mental Health staff, with the goal of building a sustainable collaborative project for both Native and Non-Native community members.

The Response

As part of the Innovation project, Mendocino County plans to do in-depth outreach into the Round Valley/Covelo community and work in conjunction with the Round Valley Tribal Health Services in an effort to learn how to promote interagency communication, collaboration, and strategize for solutions to address crisis response/respite needs. During this process, it is the hope of the County to learn how to interact with the community in a way that will lessen the current levels of distrust and increase the ability to communicate effectively, while developing a one-stop crisis response center. As part of the project, County staff will work with Round Valley/Covelo community stakeholders to solicit feedback, best practices, and identify the types of Natural Helpers expertise that are available within this extremely rural area. Natural Helpers are Native-trained peer

support and community responders. County staff and community stakeholders will then work collaboratively with the goal of incorporating and putting into operation a crisis response program. The County indicates that community members also want to learn whether support for the native population from Natural Helpers would result in decreased need for law enforcement, hospitalizations, and incarcerations. If the community collaboration proves to be successful and is supported by community members, the County hopes it will result in new education and training opportunities for providers working in the Round Valley Community. Additionally, the County believes this may also contribute to increased outreach, community development, and the incorporation of non-traditional practitioners into the system of care by working with Natural Helpers to engage in learning what strategies are needed in order to address crisis needs.

Mendocino County states that this project is intended to increase access to mental health services to underserved groups by making 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 County hopes to achieve this by promoting interagency communication and collaboration for a predominantly Native American community who has experienced a history of trauma along with institutional trust that has been eroded for many years.

The County states that this program would be considered successful if there is an increase in trust, increased use of crisis response services which will be provided by trained Round Valley Community members, Natural Helpers and specialty mental health providers, if needed.

Colusa, El Dorado and San Diego counties have PEI programs that focus on Native American cultures, history, and trauma with an emphasis on traditional wellness and healing practices. Napa County is currently working on an innovation plan that combines education and training on Native American healing practices and culture. Mendocino's Innovation plan is different from these programs in that the County is trying to collaborate with Round Valley/Covelo community members in creating a crisis response program with the incorporation of Natural Healers and Round Valley/Covelo community members in an effort to overcome historical trauma and distrust.

The specific programmatic interventions to be included in the crisis response program will be based on the information that comes from the collaboration between the County and the Round Valley/Covelo community. These interventions might include healing circles, Wellbriety, Journey to Forgiveness interventions, and possibly others.

The Community Planning Process

The MHSA regulations indicate 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.

This Innovation project has been developed over many years. The County has sought out technical assistance from the MHSOAC on numerous occasions and MHSOAC staff attended a community planning meeting in Mendocino County in 2015 to assist the county in explaining to its stakeholders how Innovation funds differ from other component funding. Between July 2013 and January 2014, the County held targeted project planning meetings to select a general need and focus for the Innovation project. The need to improve upon the almost non-existent crisis response capability to the outlying areas in Mendocino County was selected from January 2014 through July 2015. The County held Innovation Task Force committee meetings to refine the topic and the Round Valley/Covelo area was selected for the project location. Since July 2015, the County has been holding the Innovation Task Force meetings in the Round Valley/Covelo area to include more local stakeholders and to refine the learning objectives. The plan has been posted for public comment twice, due to changes being made to the budget, with the most recent being from July 14, 2017 to August 13, 2017.

In developing this project plan, Mendocino County has incorporated technical assistance and feedback from the MHSOAC.

Learning Objectives and Evaluation

The County intends to allot 36 months to implement this plan and collect data and six months for assessment, evaluation and reporting back to stakeholders and to solicit feedback.

The primary learning goal is to determine how Mendocino County Mental Health staff can best establish community trust and work collaboratively with Round Valley Tribal Health Services. How can these entities cooperate to develop and implement a crisis response program that meets the needs of the community? They hope to learn how to utilize the strengths and resources of the community and what other external resources are needed for a successful project.

Learning indicators they plan to evaluate are:

- Measure levels of trust and confidence in the collaboration
- Test different methods of communication
- Explore which stakeholders are most effective in furthering communication and help overcoming historical distrust
- Which communication and service strategies meet the specialty mental health and crisis needs in a manner that meets the community's needs.
- Identify providers available in Round Valley/Covelo area
- Ascertain additional training that may be needed
- Identify the best methods for introducing a crisis response program that can be accepted and trusted by the community
- Additional data will also be collected to determine the effectiveness of the programmatic interventions that will be selected as a result of the collaborative process.

More specifically, the county has identified that determining the "best available resources to improve trust, knowledge and access to crisis response and referral support," is important. All methods in which the county has proposed (survey, feedback meetings, and forums) are appropriate in obtaining this information. In addition, the County has identified the community's desire to understand whether or not offering Social Model rehabilitation support to persons in crisis (particularly the Native American population) would result in a decrease of the need for law enforcement, hospitalizations, and incarcerations. The County also identifies the use of traditional healing and "natural helpers" as additional modalities that will be used in the rehabilitation process. **The County may wish to share how they plan to measure these goals and how it will contribute to statewide learning.**

The Budget

Mendocino County's project budget is a total of $1,124,293 and the plan is projected to be a total of three (3) years in duration. A total of $821,441 (73%) is going towards personnel costs; $242,450 (22%) is for direct/indirect operating costs; and $52,802 (5%) is being allocated for consultants for evaluation purposes.

In FY 17/18 $359,648 will be allocated in the first year to fund positions to include one project manager and additional staff to support the interactions with the community. Subsequent fiscal years allow additional funding to continue the costs as specified in the first project year and may add staff and training as needed. The third fiscal year will also incorporate the cost of evaluation and the determination of sustainability.

As Mendocino County learns what type of crisis response centers would best fit their community, they will then determine if other MHSA funding sources can sustain this project. The Round Valley Indian Health Center has available building space that will be used during this innovation project.

Additional Regulatory Requirements

The proposed project appears to meet the minimum requirements listed under MHSA Innovation regulations.

References

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U.S. Census Bureau (www.census.gov)

National Congress of American Indians (www.ncai.org)

Mendocino County Health and Human Services Agency
"Healthy People, Healthy Communities"
Tammy Moss Chandler ❖ Director
Anne Molgaard ❖ Chief Operations Officer

Jenine Miller, Psy.D., Director
Behavioral Health and Recovery Services

Innovation Project – Round Valley Crisis Response Services

Response to Staff Innovation Summary

The Round Valley Innovation Project is the result of several years of community planning. Mendocino County is a small rural county that is geographically large. We experience a multitude of service access challenges related to our large geographic size, mountainous terrain, and small sized population communities. Our stakeholders have emphasized the importance of developing an innovation projects that have the possibility to become direct services. Our stakeholders have also prioritized developing innovation projects that address the access needs of our most underserved populations. Mendocino County Mental Health Services Act team and Innovation Task Force members have greatly appreciated the support of the Mental Health Services Oversight and Accountability Commission staff in refining our project to meet Innovation needs and stakeholder priorities.

The Round Valley Crisis Response Services Innovation Project intends to take existing strategies for service delivery and adapt them with the underserved community members themselves guiding the process of how to improve communication and collaboration. The primary learning objective is to learn how best to promote governmental collaboration with the community of Round Valley in a manner that works toward overcoming institutional distrust and historical trauma. Historical trauma and institutional distrust impede access to crisis services. Our stakeholder committees, in particular in the Covelo community, have emphasized that prior and existing strategies to provide crisis services in the area have been insufficient to meet the needs of the community. Experience and research show that cultural sensitivity or the absence thereof, contributes to the lack of trust between providers and recipients of services.

Experiences in the Round Valley community show that it is challenging to maintain adequately qualified and trained staff to meet the community needs. When clinical mental health staff have been assigned to work in the Round Valley community, it has not been sustainable due to the remote nature of the community, or local individuals in need don't trust an outside provider, among other factors. The number of local providers that are trained and qualified to provide specialty mental health services are insufficient to meet the community need. Additionally, providing funding to local services and service providers has been insufficient. By developing strategies that effectively support the communication and collaboration between helping professionals and community and tribal members we hope to build from improved trust and collaboration to the development of a broader spectrum of crisis response services.

Our project will increase access to mental health services to the underserved populations of rural Round Valley and underserved Native American communities. The proposed project addresses the urgent need for first responder and crisis response to all community members living in the northern portion of Mendocino County. The distance between Mendocino County communities where mental health services, hospitals, and law enforcement agencies are centralized impacts the immediacy of all of these types of emergency services.

We intend to take the communication strategies, along with identification of local resources that can be developed and expanded, to test strategies of providing crisis response services

through collaboration between “institutional” services and “natural” community helpers. Through the stakeholder planning process we have found some strategies to be more successful than others regarding communication styles, meeting expectations, and trust that has developed from working together to see the project through such a long planning process.

Our Mendocino County Innovation team and stakeholders are aware that individually the components of our project have been utilized in other counties. By combining existing strategies and adapting them to the unique geographical and cultural needs of our community, we hope to find strategies that both work for Round Valley, and may be able to be adapted to other remote and unique communities in Mendocino County and other counties. Through the ongoing testing and measurement of trust, engagement, and participation in proposed crisis response activities, we hope to learn which communication strategies, staff qualifications, staffing patterns, crisis response strategies and combinations of strategies best increase access to crisis services.

If we are successful, we hope to show an increased number of Round Valley residents accessing crisis response services. We hope to show increased measures of trust and confidence in communication and services from formal service providers and county staff. We hope to have an identified list of strategies that were successful, as well as strategies that were unsuccessful, with analysis of why we feel we reached each level of success. We hope to have identified the right levels of staff that Round Valley is able to sustain to respond to crisis needs locally in the community as well as to have identified how staff provide the services most effectively. If successful, we hope that over time the rates of suicide attempts and death by suicide in Round Valley will decrease.

Mendocino County Mental Health Services Act team, stakeholders, and task force members would like to thank the Mental Health Services Accountability Commission and staff for the opportunity to present our project. We appreciate the support we have been given by staff to refine our project. At the request of our MHSA stakeholders, our Round Valley community partners, our Innovation Task force members, and our Mental Health team, we earnestly request that you consider and approve our proposal.

AGENDA ITEM 4

Action Item

October 26, 2017 Commission Meeting

Proposed Amendments to the Prevention and Early Intervention (PEI) and Innovation Regulations: Commission Responses to Public Comments

Summary
The Commission will consider staff's recommended responses to the comments received during the 45-day public comment period on the proposed amendments to the PEI and Innovation regulations that the Commission adopted in July 2017. The Commission will also decide whether to make any changes to the amendments adopted in July.

A copy of the July 2017 proposed amendments is included in the meeting packet. Those proposed amendments underwent a 45-day public comment period that ended on September 28, 2017. Staff received written comments from twelve different individuals/organizations suggesting changes to the proposed amendments. A copy of the comments are included in the meeting packet.

The process to amend the regulations is governed by the Administrative Procedures Act (APA) and is enforced by the Office of Administrative Law (OAL). Under the APA, the Commission has to respond to all relevant comments by either accepting or rejecting the recommendations made by commenter and the rationale for the Commission's response.

The enclosed document, "Staff Recommended Responses to the Substantive Comments" provides a brief background on the rationale for the July 2017 proposed amendment and summarizes the public comments received. The document also contains staff's recommended responses to the public comments, including some proposed changes to the July 2017 language.

Next Steps:
The next steps are dependent on whether the Commission decides to make any additional changes to the July 2017 proposed amendments. If the Commission votes to modify the language an additional public comment period is triggered. Depending on the nature of the changes the comment period is either a 15-day or 45-day period. If the Commission votes to make changes to the originally proposed language those changes will go out for a 15-day public comment period. At the end of that period the Commission will have to respond to the comments in the same way it is responding to the comments received during the initial 45-day period.

If no additional changes are made, the rulemaking record is closed and is submitted in December 2017 or January 2018 to the OAL for review and approval. The OAL has 30 business days to make a determination. Depending upon the timing of OAL's approval the amendments will go into effect April 1 or July 1, 2018.

The OAL reviews the rulemaking file to determine whether the amendments to the regulations are in compliance with the following APA requirements:

- Authority: Does the MHSOAC have the authority to issue the regulations;
- Reference: Do the regulations correctly reference the specific statute that the regulations implement, interpret or make specific;
- Consistency: Are the regulations consistent with the law,
- Clarity: Is the text of the regulations clear;
- Non-duplication: Are the regulations duplicative of the statute they implement, interpret or make specific;
- Necessity: Are the regulations necessary; and
- Procedural requirements: Did the MHSOAC follow the procedural requirements.

Presenter: Filomena Yeroshek, Chief Counsel

Enclosures: (1) Staff recommended responses to the relevant comments with the following attachments: (2) Attachment 1: Proposed amendments to the PEI regulations adopted in July 2017; (3) Attachment 2: Proposed amendments to the Innovative Project regulations adopted in July 2017; (4) Attachment 3: Draft proposed changes to the July 2017 version of the PEI proposed amendments; (5) Attachment 4: Draft proposed changes to the July 2017 version of the Innovative Project proposed amendments; (6) and Attachment 5: Copy of the written public comments and transcript from the September 28, 2017 public hearing.

Handouts: PowerPoint presentation will be available at the meeting.

Proposed Motion

The Commission accepts staff's recommendations to the public comments received during the 45-day public comment period.

Staff Recommended Responses to the Substantive Comments on the Proposed Amendments to the Prevention and Early Intervention (PEI) and Innovation Regulations Received During the 45-Day Public Comment Period

I. Background

In 2013 the Legislature expanded the role of the Mental Health Services Oversight and Accountability Commission (Commission) and asked it to draft regulations for two components of the Mental Health Services Act – Prevention and Early Intervention (PEI) and Innovation programs. In response, the Commission worked for two years to create the regulations which were approved by the Office of Administrative Law (OAL) and took effect in October 2015.

Representatives of California's county behavioral health agencies raised several concerns about their ability to comply with the new regulations. The Commission formed a Subcommittee consisting of Commissioner Poaster as chair, Commissioner Aslami-Tamplen, and former Commissioner Van Horn to work with the County Behavioral Health Directors Association (CBHDA), counties, consumers, family members, community mental health providers, and other stakeholders to address concerns regarding the implementation of the recently issued PEI and Innovation regulations.

The Subcommittee held six public meetings throughout the State to better understand the challenges faced by counties and providers in implementing the regulations. The Commission, at its October 2016 meeting, adopted the proposed report submitted by the Subcommittee, *Finding Solutions, Helping Counties Comply with Regulations Governing Innovation Projects and Prevention and Early Intervention Programs under the Mental Health Services Act* ("*Finding Solutions"* report). In its report, the Commission made five key recommendations, including amending the regulations. In January 2017 the Commission endorsed high-level strategies to operationalize these recommendations.

The Subcommittee met three times during the first half of 2017 to discuss and obtain input on specific proposed amendments to the PEI and Innovation regulations in accordance with the recommendations in the *Finding Solutions* report. The Commission, at its July 2017 meeting, adopted proposed amendments to:

(1) Specify for both PEI programs and Innovation projects that serve children and youth under 18 years of age that demographic information is to be collected and reported only to the extent permitted by federal and state privacy and education laws.

(2) Specify for both PEI programs and Innovation projects that counties are not required to collect demographic information from a minor younger than 12 years of age.
(3) Clarify that each county's referral reporting responsibility extends only to referrals made to other county programs, whether such programs are operated by counties or providers.
(4) Provide a definition of "referral" for purpose of data collection and reporting.
(5) Authorize the counties to provide the required Access and Linkage to Treatment Program through another Mental Health Services Act funding stream, such as Community Services and Supports.
(6) Provide data collection and program flexibility to very small counties due to their unique challenges.
(7) Change the due dates of the reports to better align with other county fiscal and programmatic reports that a county is already required to submit.

The proposed amendments adopted by the Commission in July went through a 45-day public comment period that ended on September 28, 2017. For your convenience a copy of the July version of the proposed amendments is included in the meeting packet.

Of the above listed seven categories of amendments, staff received written comments ~~only as to~~pertaining to three of those: the demographic information from a minor younger than 12 years of age, the reporting requirements related to referrals, and the amendments providing flexibility to very small counties. In addition to the written comments seven individuals provided oral testimony at the September 28, 2017 hearing. Five of those individuals also provided written comments. A copy of the hearing transcript is attached for your convenience. Below is a summary of those comments and staff's recommendations.

II. Demographic Reporting Requirements Regarding Children Younger Than 12 Years of Age: Section 3560.010(d):

The regulations issued by the Commission in October 2015 requires counties to report detailed demographic information on who is served by PEI and Innovation programs and whether they have difficulties getting the care they need. This information includes age, gender, race and ethnicity, sexual orientation, language used, veteran status, disabilities and other details. The Commission developed these demographic reporting requirements based on consultation with a range of stakeholders who presented information about groups who have historically faced barriers to care. To better document and understand mental health disparities, the Commission regulations require counties to report, by demographic category, information on who is served.

During the year-long regulations implementation process, the Subcommittee heard concerns from counties and their providers serving young children that the regulations did not specify the acceptable age range for asking children about their sexual orientation and gender identity. In response to these concerns, the Subcommittee recommended and the Commission adopted, the recommendation to amend the regulations to provide an age threshold for the demographic information. The July 2017 proposed amendments adopted by the Commission added a new subdivision (d) to section 3560.010 providing that counties are not required to report any demographic information from children under 12. (See page 5 of the July proposed amendments.) The rationale for having 12 years of age and older be the threshold was based on the idea that since a minor as young as 12 can consent to receive outpatient

mental health services that minors of the same age are old enough to answer demographic questions, including those about sexual orientation and gender identity[i].

Staff received ten (10) comments relevant to the July 2017 proposed amendments eliminating reporting requirements of demographic information from minors under 12 years old. Those comments fall into one of three categories:

(1) Delete the entire proposed amendment and require counties to report **all** (8) categories currently required demographic information, including sexual orientation and gender identity from all individuals including children under 12 years old.
(2) Modify the proposed amendment to require counties to report **all** required information **about** children under 12. That is, the information would be collected from the parents or other legal caretakers to the extent permissible under state/federal privacy laws.
(3) Modify the proposed amendment to require counties to report only certain demographic information from children under 12. Eight organizations support collecting all the demographic information **except** (a) sexual orientation, and (b) current gender identity. Two of these organizations also recommend the regulations explicitly state that counties are not required to report on the veteran status of children under 12.

Staff recommends modifying subdivision (d) of section 3560.010 consistent with the comments listed above in item (3). Chart 1 shows what demographic information is currently required under the regulations issued in 2015, and the information that would be required under the proposed July 2017 version as well as under the recommended modification to the July version.

Chart 1: Demographic Information

Demographic Information	Original 10/2015 Version (All ages)	7/2017 Version (Children under 12)	Recommended Modification to 7/17 Version
Age	Yes	No	Yes
Race	Yes	No	Yes
Ethnicity	Yes	No	Yes
Primary language	Yes	No	Yes
Sexual orientation	Yes	No	No
Disability not result of SMI	Yes	No	Yes
Veteran status	Yes	No	No
Gender (2 part question)			
• Assigned at birth	Yes	No	Yes
• Current identity	Yes	No	No

The new subdivision (d) of section 3560.010 would read as follows:

(d) Except for sexual orientation, current gender identity, and veteran status, a county shall collect the demographic information required under subdivision (b)(5) of this section from a minor younger than 12 years of age. Information that cannot be obtained directly from the minor may be obtained from the minor's parent, legal guardian, or other authorized source.

III. Referral Tracking Requirements: Section 3560.010(b)(3)(B)

A driving goal of the Mental Health Services Act is a significant reduction in the number of Californians who are unable to get timely and appropriate mental health care. To ensure access to programs established under the Act, the PEI regulations adopted in 2015 require counties to use an Access and Linkage to Treatment strategy in all PEI-funded programs. In short, that means every PEI program must connect people in need of a higher level of services with necessary treatment, typically through a referral. In addition, counties must operate at least one stand-alone Access and Linkage to Treatment program.

To document progress on Access and Linkage to Treatment efforts, the regulations require counties to collect and report specified data regarding number of referrals and follow through on the referrals as well as average time between the referral and participation in the recommended treatment program.

Counties and service providers voiced concerns about collecting this information. The concerns included difficulties with defining the term, "referral" and the inability to track whether an individual followed through on referrals to service providers outside the county system. In response to these concerns the proposed July 2017 amendments added a definition of "referral" to mean a specific written recommendation to one or more specific service providers. (See pages 2 and 3 of the July proposed amendments.) The amendments also clarify that counties are required to report specified referral data **only** with respect to programs provided, funded, administered or overseen by the county mental health department (e.g. programs within the county system). This clarification is found in amendment to subdivision (b)(3)(B) of section 3560.010. (See page 2 of the July proposed amendments.)

Staff received one comment relevant to the July 2017 proposed amendment to limit referral tracking to county programs only. The comment stated that a county should be expected to track the referrals to any services or supports even if the referral is outside the county system. The comment acknowledged that it is likely a county would have difficulty tracking the number of individuals who followed through on the referral for those programs that not within the county system.

Staff recommends amending the proposed regulations consistent with the above comment. Information to whom the county is referring the individual is information generated by the county program making the referral. The tracking of whether an individual followed through with the referral should remain limited to those referrals to providers within the county system. The chart below provides a summary of the July 2017 version and the recommended modification to that version.

Chart 2: Referral Tracking Information

July 2017 Version 3560.010(b)(3)	Recommended Modification to 7/17 Version - 3560.010(b)(3)
For each Access and Linkage to Treatment Strategy or Program report data on each referral to one or more specific providers who are **funded**, **administered or overseen by the county** mental health department ("county program" for the purposes of this discussion).	For each Access and Linkage to Treatment Strategy or Program report data on each referral to one or more specific providers as specified below.

(b)(3)(B): Number of referrals **to county programs** and the kind of treatment to which the individual was referred.	(b)(3)(B): Change – Number of referrals and kind of treatment to which the individual was referred **regardless of whether the destination target of the referral is a county program.**
(b)(3)(C): Number of individuals who followed through (participated at least once) on the referrals **to county programs**.	(b)(3)(C): No change
(b)(3)(D): Average duration of untreated mental illness using data of referrals **to county programs**.	(b)(3)(D): No change
(b)(3)(E): Average interval between the referral to a **county program** and participation in the treatment to which the person was referred.	(b)(3)(E): No change

The new subdivision (b)(3) of section 3560.010 would read as follows:

(1) For each Access and Linkage to Treatment Strategy or Program the County shall report:
  (A) The Program name
  (B) Number of individuals with serious mental illness referred to ~~treatment and the kind of treatment to which the individual was referred:~~
    1. Treatment that is provided, funded, administered, or overseen by county mental health programs and the kind of treatment.
    2. Treatment that is not provided, funded, administered, or overseen by county mental health programs and the kind of treatment.
  (C) For referrals to treatment that is provided, funded, administered, or overseen by county mental health, the number of individuals who followed through on the referral and engaged in treatment, defined as the number of individuals who participated at least once in the Program to which they were referred.
  (D) For referrals to treatment that is provided, funded, administered, or overseen by county mental health, the average duration of untreated mental illness as defined in Section 3750, subdivision (f)(3)(A) and standard deviation.
  (E) For referrals to treatment that is provided, funded, administered, or overseen by county mental health, the average interval between the referral and participation in treatment, defined as participating at least once in the treatment to which referred, and standard deviation.
  (F) "Referral" as used in this subdivision means the process by which an individual is given a recommendation in writing to one or more specific service providers for a higher level of care and treatment. Distributing a list of community resources to an individual does not constitute a referral under this subdivision.

Sections 3726(b) and 3735(a)(1)(A) would require some changes in order to be consistent with the above changes to section 3560.010.

Section 3726(b) would be amended to read:

(b) "Access and Linkage to Treatment Program" means a set of related activities to connect children with severe mental illness, as defined in Welfare and Institutions Code Section 5600.3, and adults and seniors with severe mental illness, as defined in Welfare and Institutions Code Section 5600.3, as early in the onset of these conditions as practicable, to medically necessary care and treatment~~,~~ including, but not limited to, care provided~~, funded, administered, or overseen~~ by county mental health programs.

Section 3735(a)(1)(A) would be amended to read:

(a) The County shall include all of the following Strategies as part of each Program listed in Sections 3710 through 3730 of Article 7:
  (1) Be designed and implemented to help create Access and Linkage to Treatment.
    (A) "Access and Linkage to Treatment" means connecting children with severe mental illness, as defined in Welfare and Institutions Code Section 5600.3, and adults and seniors with severe mental illness, as defined in Welfare and Institutions Code Section 5600.3, as early in the onset of these conditions as practicable, to medically necessary care and treatment~~,~~ including, but not limited to, care provided~~, funded, administered, or overseen~~ by county mental health programs.

IV. Demographic Reporting Requirements for Counties With Population Under 100,000: Section 3560.010(e)

The Regulations Implementation Subcommittee heard considerable testimony about the obstacles some of California's smallest counties face as they seek to comply with the regulations issued in 2015[ii]. Counties with a population below 100,000 typically lack the staff and resources to meet some of the regulatory requirements. In addition to their small populations and limited funding, very small counties face unique challenges related to the PEI regulations. One of those challenges deals with the reporting requirements for each of the required five PEI-funded programs[iii]. Because such programs in very small counties tend to serve few consumers, summary statistics can vary wildly year to year and, thus, can be misleading. For example, Alpine County serves a total of 45 individuals per month in the county's mental health program – 45 individuals for the entire county, not for a particular program[iv]. Given such small county wide numbers, one person can make a huge impact on a summary report, skewing the data and creating an inaccurate picture. In addition, due to the population size, the data reporting requirements by program create a higher than average risk of inadvertent disclosure of individuals' identities.

In response to these concerns, the July 2017 proposed amendments allow counties with populations under 100,000 to report demographic information for the county's entire PEI Component instead of for each PEI Program or Strategy. This provision is the new subdivision (e) of section 3560.010. (See page 5 of the July proposed amendments.)

Staff received one comment relevant to this proposed amendment. That comment recommends deleting the proposed amendment and returning to the 2015 version of the regulations on this issue. The comment states that the July 2017 proposed amendment would make it challenging for the public to compare data on counties or regions to each other and to measure the effectiveness of each individual PEI program for the 23 counties that qualify under this provision.

Staff recommends the Commission not change the July 2017 proposed amendments for the same reasons the Commission initially adopted those proposed amendments.

V. Opt-out of Access and Linkage to Treatment Program Requirement for Counties With Population Under 100,000: Section 3705(a)(A) and (a)(B)

As mentioned above, the July 2017 proposed amendments aimed to address some of the unique challenges that the 2015 regulatory requirements created for California's smallest counties. In addition to the program-level data reporting requirements discussed above, officials in very small counties stated that they face an unfair burden under the rule mandating that counties operate at least one of the five distinct PEI-funded programs[v]. Given their size, these counties typically offer their residents more integrated mental health services, and the requirement for so many stand-alone programs creates a financial strain. In addition, these counties struggle to cope with limited number of staff. Modoc County has 12 to 13 direct service staff for its population of about 9,100[vi]. Under the 2015 regulations, a process exists to allow small counties to opt out of offering a stand-alone prevention program[vii]. This opt-out provision was created in response to concerns raised during the regulatory process about the limited resources of small counties, thereby providing them with greater flexibility in how they use their limited funds.

The July 2017 proposed amendments created this same opt-out provision for the Access and Linkage to Treatment program in subdivision (a)(4)(A) and (B) of Section 3705. (See page 8 of the July proposed amendment.) The rationale for this proposed amendment is, that due to their small population, requiring an Access and Linkage to Treatment Program in addition to the required Access and Linkage to Treatment Strategy within each PEI-funded program dilutes the very small counties' efforts with the limited funds available.

Staff received one comment relevant to this proposed amendment. That comment recommends deleting the proposed amendment and returning to the 2015 version of the regulations on this issue. The comment states that counties should not be exempt from any of the five required programs.

Staff recommends the Commission not change the July 2017 proposed amendments for the same reasons the Commission initially adopted those proposed amendments.

VI. Comments On Topics Other Than The Proposed Amendments

In addition to the above discussed comments, staff received comments related to sections of the regulations that are not part of the proposed amendments or deal with general issues of implementation of the Mental Health Service Act. Those comments, from Mary Ann Bernard, Esq, California Alliance, and Pete LaFollette are included with as part of Attachment 3.

Because those comments are not directly relevant to the proposed amendments they are not discussed here. Staff recommends revisiting some of those comments during future discussion of reporting requirements. For example, California Alliance's suggestion to change the reporting groupings of ages for children and youth to match the age groupings in other state reports such as DHCS Performance Outcome System for EPSDT could be part of a broader discussion at a later date regarding obtaining individual-level data. The Commission has indicated that as the state puts in place a statewide

integrated data collection system, it will engage in a broader discussion regarding amending the data reporting requirements to obtain individual-level and non-aggregated data.

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[i] MHSOAC, *Finding Solutions Helping Counties Comply with Regulations Governing Innovation Projects and Prevention and Early Intervention Programs under the Mental Health Services Act* November 2016; Page 10

[ii] Id. Page 17

[iii] Under Welfare and Institutions Code section 5840, the PEI regulations require the following programs: Prevention, Early Intervention, Outreach for Increasing Recognition of Early Signs of Mental Illness, Access and Linkage to Treatment, and Stigma and Discrimination Reduction

[iv] MHSOAC, *Finding Solutions Helping Counties Comply with Regulations Governing Innovation Projects and Prevention and Early Intervention Programs under the Mental Health Services Act* November 2016; Page 20

[v] Under Welfare and Institutions Code section 5840 the PEI regulations require each county to provide at least one of the five PEI-funded programs: Prevention, Early Intervention, Outreach for Increasing Recognition of Early Signs of Mental Illness, Access and Linkage to Treatment, and Stigma and Discrimination Reduction.

[vi] MHSOAC, *Finding Solutions Helping Counties Comply with Regulations Governing Innovation Projects and Prevention and Early Intervention Programs under the Mental Health Services Act* November 2016; Page 10

[vii] Title 9, California Code of Regulations, sections 3705 and 3706

Attachment 1

Article 5. Reporting Requirements

Amend Section 3560 as follows:

Section 3560. Prevention and Early Intervention ~~Reports~~ Reporting Requirements.

(a) The County shall submit to the Mental Health Services Oversight and Accountability Commission the following ~~Prevention and Early Intervention reports~~:
  (1) The Annual Prevention and Early Intervention ~~Program and Evaluation~~ report as specified in Section 3560.010.
  (2) The Three-Year Prevention and Early Intervention ~~Program and~~ Evaluation Report as specified in Section 3560.020.

Amend Section 3560.010 as follows:

Section 3560.010. Annual Prevention and Early Intervention ~~Program and Evaluation~~ Report.

(a) The requirements set forth in this section shall apply to the Annual Prevention and Early Intervention ~~Program and Evaluation~~ Report.
  (1) The first Annual Prevention and Early Intervention ~~Program and Evaluation~~ Report is due to the Mental Health Services Oversight and Accountability Commission on or before December 30, 2017 as part of ~~the~~ an Annual Update or Three-Year Program and Expenditure Plan ~~and no later than December 30th every year thereafter except for years in which the Three-Year Program and Evaluation Report is due~~. Each Annual Prevention and Early Intervention Report thereafter is due as part of an Annual Update or Three-Year Program and Expenditure Plan within 30 calendar days of Board of Supervisors approval but no later than June 30 of the same fiscal year whichever occurs first. The Annual Prevention and Early Intervention Report is not due in years in which a Three-Year Prevention and Early Intervention Evaluation Report is due.
  (2) The Annual Prevention and Early Intervention ~~Program and Evaluation~~ Report shall report on the required data for the fiscal year prior to the due date. For example, the Report that is due no later than June 30, 2020 is to report the required data from fiscal year 2018-19 (i.e. July 1, 2018 through June 30, 2019).
  (3) The County shall exclude from the Annual Prevention and Early Intervention ~~Program and Evaluation~~ Report personally identifiable information as defined by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Health Information Technology for Economic and Clinical Health Act (HITECH) and their implementing privacy and security regulations, the California Information Practices Act, and any other applicable state or federal privacy laws.
    (A) When the County has excluded information pursuant subdivision (3) above, the County shall submit to the Mental Health Services Oversight and Accountability Commission one of the following:

1. A supplemental Annual Prevention and Early Intervention ~~Program and Evaluation~~ Report that contains all of the information including the information that was excluded pursuant to subdivision (3). This supplemental report shall be marked "confidential."
2. A supplement to the Annual Prevention and Early Intervention ~~Program and Evaluation~~ Report that contains the information that was excluded pursuant to subdivision (3). This supplement to the report shall be marked "confidential."

(b) The County shall report the following information annually as part of the Annual Update or Three-Year Program and Expenditure Plan. The report shall include the following information for the reporting period:

(1) For each Prevention Program and each Early Intervention Program list:

(A) The Program name.

(B) Unduplicated numbers of individuals served in the preceding fiscal year

1. If a Program served both individuals at risk of a mental illness (Prevention) and individuals with early onset of a mental illness (Early Intervention), the County shall report numbers served separately for each category.
2. If a Program served families the County shall report the number of individual family members served.

(2) For each Outreach for Increasing Recognition of Early Signs of Mental Illness Program or Strategy within a Program, the County shall report:

(A) The Program name

(B) The number of potential responders

(C) The setting(s) in which the potential responders were engaged

1. Settings providing opportunities to identify early signs of mental illness include, but are not limited to, family resource centers, senior centers, schools, cultural organizations, churches, faith-based organizations, primary health care, recreation centers, libraries, public transit facilities, support groups, law enforcement departments, residences, shelters, and clinics.

(D) The type(s) of potential responders engaged in each setting (e.g. nurses, ~~principles~~ principals, parents)

(3) For each Access and Linkage to Treatment Strategy or Program the County shall report:

(A) The Program name

(B) Number of individuals with serious mental illness referred to treatment that is provided, funded, administered, or overseen by county mental health, and the kind of treatment to which the individual was referred.

(C) Number of individuals who followed through on the referral and engaged in treatment, defined as the number of individuals who participated at least once in the Program to which they were referred.

(D) Average duration of untreated mental illness as defined in Section 3750, subdivision (f)(3)(A) and standard deviation.

(E) Average interval between the referral and participation in treatment, defined as participating at least once in the treatment to which referred, and standard deviation.

(F) "Referral" as used in this subdivision means the process by which an individual is given a recommendation in writing to one or more specific service providers for a higher level of care and treatment. Distributing a list of community resources to an individual does not constitute a referral under this subdivision.

(4) For each Improve Timely Access to Services for Underserved Populations Strategy or Program the County shall report:

(A) The program name

(B) Identify the specific underserved populations for whom the County intended to increase timely access to services.

(C) Number of referrals of members of underserved populations to a Prevention Program, an Early Intervention Program and/or to treatment beyond early onset.

(D) Number of individuals who followed through on the referral, defined as the number of individuals who participated at least once in the Program to which they were referred.

(E) Average interval between referral and participation in services to which referred, defined as participating at least once in the service to which referred, and standard deviation.

(F) Description of ways the County encouraged access to services and follow-through on referrals.

(G) "Referral" as used in this subdivision means the process by which a member of an underserved population is given a recommendation in writing to one or more specific service providers for a Prevention Program, an Early Intervention Program and/or a program providing treatment beyond early onset. Distributing a list of community resources to an individual does not constitute a referral under this subdivision.

(5) For the information reported under subdivisions (1) through (4) of this section, disaggregate numbers served, number of potential responders engaged, and number of referrals for treatment and other services by:

(A) The following age groups:

1. 0-15 (children/youth)
2. 16-25 (transition age youth)
3. 26-59 (adult)
4. ages 60+ (older adults)
5. Number of respondents who declined to answer the question

(B) Race by the following categories:

1. American Indian or Alaska Native
2. Asian
3. Black or African American
4. Native Hawaiian or other Pacific Islander
5. White
6. Other
7. More than one race

8. Number of respondents who declined to answer the question

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

(D) Primary language used listed by threshold languages for the individual county

(E) Sexual orientation,
1. Gay or Lesbian
2. Heterosexual or Straight
3. Bisexual
4. Questioning or unsure of sexual orientation
5. Queer
6. Another sexual orientation
7. Number of respondents who declined to answer the question

(F) Disability, defined as a physical or mental impairment or medical condition lasting at least six months that substantially limits a major life activity, which is not the result of a severe mental illness
1. Yes, report the number that apply in each domain of disability(ies)
   a. Communication domain separately by each of the following
      (i) Difficulty seeing,
      (ii) Difficulty hearing, or having speech understood
      (iii) Other (specify)

b. Mental domain not including a mental illness (including but not limited to a learning disability, developmental disability, dementia)
c. Physical/mobility domain
d. Chronic health condition (including, but not limited to, chronic pain)
e. Other (specify)

2. No
3. Number of respondents who declined to answer the question

(G) Veteran status,
1. Yes
2. No
3. Number of respondents who declined to answer the question

(H) Gender
1. Assigned sex at birth:
a. Male
b. Female
c. Number of respondents who declined to answer the question
2. Current gender identity:
a. Male
b. Female
c. Transgender
d. Genderqueer
e. Questioning or unsure of gender identity
f. Another gender identity
g. Number of respondents who declined to answer the question

(6) Any other data the County considers relevant, for example, data for additional demographic groups that are particularly prevalent in the County, at elevated risk of or with high rates of mental illness, unserved or underserved, and/or the focus of one or more Prevention and Early Intervention funded services.

(7) For Stigma and Discrimination Reduction Programs and Suicide Prevention Programs, the County may report available numbers of individuals reached, including demographic breakdowns. An example would be the number of individuals who received training and education or who clicked on a web site.

(8) For all programs and Strategies, the County may report implementation challenges, successes, lessons learned, and relevant examples.

(c) <u>For a program serving children or youth younger than 18 years of age, the demographic information required under subdivision (b)(5) of this section relating to children or youth younger than 18 years of age shall be collected and reported only to the extent permissible by California Education Code, Family Educational Rights and Privacy Act (FERPA), Health Insurance Portability and Accountability Act of 1996 (HIPAA), California Information Practices Act, and other applicable state and federal privacy laws.</u>

(d) A county is not required to collect the demographic information required under subdivision (b)(5) of this section from a minor younger than 12 years of age.

(e) A County with a population under 100,000, according to the most recent projection by the California State Department of Finance, may report the demographic information required under subdivision (b)(5) of this section for the County's entire Prevention and Early Intervention Component instead of by each Program or Strategy.

NOTE: Authority cited: Section 5846, Welfare and Institutions Code. Reference: Sections 5840, 5845(d)(6), and 5847, Welfare and Institutions Code; Uncodified Sections 2 and 3 of Proposition 63, the Mental Health Services Act.

Amend Section 3560.020 as follows:

Section 3560.020. Three-Year Prevention and Early Intervention ~~Program and~~ Evaluation Report.

(a) The County shall submit the Three-Year Prevention and Early Intervention ~~Program and~~ Evaluation Report to the Mental Health Services Oversight and Accountability Commission every three years as part of ~~the~~ a Three-Year Program and Expenditure Plan or Annual Update. The Three-Year Prevention and Early Intervention ~~Program and~~ Evaluation Report answers questions about the impacts of Prevention and Early Intervention Component Programs on individuals with risk or early onset of serious mental illness and on the mental health and related systems.

(1) The first Three-Year Prevention and Early Intervention ~~Program and~~ Evaluation Report is due to the Mental Health Services Oversight and Accountability Commission ~~on or before December 30, 2018~~ as part of ~~the~~ a Three-Year Program and Expenditure Plan or Annual Update within 30 calendar days of Board of Supervisors approval but no later than June 30, 2019 whichever occurs first. ~~for fiscal years 2017/18 through 2019/20~~. The first Three-Year Prevention and Early Intervention Evaluation Report shall report the required evaluations from fiscal year 2017-2018 and from fiscal year 2016-2017 if available. Each subsequent ~~The~~ Three-Year Prevention and Early Intervention ~~Program and~~ Evaluation Report shall be due within 30 calendar days of Board of Supervisors approval but no later than ~~December 30th~~ June 30th every ~~three years~~ third year thereafter whichever occurs first, as part of a Three-Year Program and Expenditure Plan or Annual Update and shall report on the evaluation(s) for the three prior fiscal years ~~prior to the due date~~.

(2) The County shall exclude from the Three-Year Prevention and Early Intervention ~~Program and~~ Evaluation Report personally identifiable information as defined by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Health Information Technology for Economic and Clinical Health Act (HITECH) and their implementing privacy and security regulations, the California Information Practices Act, and any other applicable state or federal privacy laws.

(A) When the County has excluded information pursuant subdivision (2) above, the County shall submit to the Mental Health Services Oversight and Accountability Commission one of the following:

1. A supplemental Three-Year Prevention and Early Intervention ~~Program and~~ Evaluation Report that contains all of the information including the information that was excluded pursuant to subdivision (2). This supplemental report shall be marked "confidential."
2. A supplement to the Three-Year Prevention and Early Intervention ~~Program and~~ Evaluation Report that contains the information that was excluded pursuant to subdivision (2). This supplement to the report shall be marked "confidential."

(b) The Three-Year Prevention and Early Intervention ~~Program and~~ Evaluation Report shall describe the evaluation of each Prevention and Early Intervention Component Program and two Strategies: Access and Linkage to Treatment and Improving Timely Access to Services for Underserved Populations. The Report shall include the following:

(1) The name of each Program for which the county is reporting

(2) The outcomes and indicators selected for each Prevention, Early Intervention, Stigma and Discrimination Reduction, or Suicide Prevention Program
(3) The approaches used to select the outcomes and indicators, collect data, and determine results for the evaluation of each Program and the Access and Linkage to Treatment and Improving Timely Access to Services for Underserved Populations Strategies
(4) How often the data were collected for the evaluation of each Program and for the Access and Linkage to Treatment and Improving Timely Access to Services for Underserved Populations Strategies

(c) The Three-Year Prevention and Early Intervention ~~Program and~~ Evaluation Report shall provide results and analysis of results for all required evaluations set forth in Section 3750 for the three fiscal years prior to the due date.
(d) The County may also include in the Three-Year Prevention and Early Intervention ~~Program and~~ Evaluation Report any additional evaluation data on selected outcomes and indicators, including evaluation results related to the impact of Prevention and Early Intervention Component Programs on mental health and related systems.
(e) The County shall include the same information for the previous fiscal year that otherwise would be reported in the Annual Prevention and Early Intervention ~~Program and Evaluation~~ Report in response to requirements specified in 3560.010(b).
(f) The County may report any other available evaluation results in the County's Annual Updates.

NOTE: Authority cited: Section 5846, Welfare and Institutions Code. Reference: Sections 5840, 5845(d)(6), and 5847, Welfare and Institutions Code; Uncodified Sections 2 and 3 of Proposition 63, the Mental Health Services Act.

Article 7. Prevention and Early Intervention

Amend Section 3705 as follows:

Section 3705. Prevention and Early Intervention Component General Requirements.

(a) The County shall include in its Prevention and Early Intervention Component:
(1) At least one Early Intervention Program as defined in Section 3710.
(2) At least one Outreach for Increasing Recognition of Early Signs of Mental Illness Program as defined in Section 3715.
(3) At least one Prevention Program as defined in Section 3720
(A) Small counties may opt out of the requirement to have at least one Prevention Program if:
1. The Small County obtains a ~~declaration~~ resolution from the Board of Supervisors that the County cannot meet this requirement.
(B) A Small County that opts out of the requirement in (a)(3) above shall include in its Three-year Program and Expenditure Plan and/or Annual Update documentation describing the rationale for the County's decision and how the County ensured meaningful stakeholder involvement in the decision to opt out.
(4) At least one Access and Linkage to Treatment Program as defined in Section 3726

(A) A County with a population under 100,000, according to the most recent projection by the California State Department of Finance, may opt out of the requirement to have at least one Access and Linkage to Treatment Program if:

1. The County obtains a resolution from the Board of Supervisors that the County cannot meet this requirement.

(B) A County that opts out of the requirement in (a)(4) above shall include in its Three-year Program and Expenditure Plan and/or Annual Update documentation describing the rationale for the County's decision and how the County ensured meaningful stakeholder involvement in the decision to opt out.

(5) At least one Stigma and Discrimination Reduction Program as defined in Section 3725

(6) The Strategies defined in Section 3735.

(b) The County may include in its Prevention and Early Intervention Component:

(1) One or more Suicide Prevention Programs as defined in Section 3730.

(c) A County with a population under 100,000, according to the most recent projection by the California State Department of Finance, may satisfy the requirements in subdivisions (a)(1) through (a)(5) of this Section by combining and/or integrating the Early Intervention Program, the Outreach for Increasing Recognition of Early Signs of Mental Illness Program, the Prevention Program, the Access and Linkage to Treatment Program, and the Stigma and Discrimination Reduction Program.

(1) A county that utilizes this provision shall not also opt-out of the requirement to have at least one Prevention Program under subdivision (a)(3) or of the requirement to have at least one Access and Linkage to Treatment Program under subdivision (a)(4).

NOTE: Authority cited: Section 5846, Welfare and Institutions Code. Reference: Section 5840, Welfare and Institutions Code.

Amend Section 3726 as follows:

Section 3726. Access and Linkage to Treatment Program.

(a) The County shall offer at least one Access and Linkage to Treatment Program as defined in this section.

(b) "Access and Linkage to Treatment Program" means a set of related activities to connect children with severe mental illness, as defined in Welfare and Institutions Code Section 5600.3, and adults and seniors with severe mental illness, as defined in Welfare and Institutions Code Section 5600.3, as early in the onset of these conditions as practicable, to medically necessary care and treatment~~, including, but not limited to, care~~ provided, funded, administered, or overseen by county mental health programs.

(1) Examples of Access and Linkage to Treatment Programs, include but are not limited to, Programs with a primary focus on screening, assessment, referral, telephone help lines, and mobile response.

(c) In addition to offering the required Access and Linkage to Treatment Program, the County is also required to offer Access and Linkage to Treatment as a Strategy within all Prevention and Early Intervention Programs.

(d) The County shall include all of the Strategies in each Access and Linkage to Treatment Program as referenced in Section 3735.

(e) An Access and Linkage to Treatment Program may be provided through other Mental Health Services Act components as long as it meets all of the requirements in this section.

NOTE: Authority cited: Section 5846, Welfare and Institutions Code. Reference: Sections 5600.3 and 5840, Welfare and Institutions Code.

Amend Section 3735 as follows:
Section 3735. Prevention and Early Intervention Strategies.

(a) The County shall include all of the following Strategies as part of each Program listed in Sections 3710 through 3730 of Article 7:
  (1) Be designed and implemented to help create Access and Linkage to Treatment.
    (A) "Access and Linkage to Treatment" means connecting children with severe mental illness, as defined in Welfare and Institutions Code Section 5600.3, and adults and seniors with severe mental illness, as defined in Welfare and Institutions Code Section 5600.3, as early in the onset of these conditions as practicable, to medically necessary care and treatment~~, including, but not limited to, care~~ provided, funded, administered, or overseen by county mental health programs.
  (2) Be designed, implemented, and promoted in ways that Improve Timely Access to Mental Health Services for Individuals and/or Families from Underserved Populations.
    (A) "Improving Timely Access to Services for Underserved Populations" means to increase the extent to which an individual or family from an underserved population as defined in Title 9 California Code of Regulations Section 3200.300 who needs mental health services because of risk or presence of a mental illness receives appropriate services as early in the onset as practicable, through program features such as accessibility, cultural and language appropriateness, transportation, family focus, hours available, and cost of services.
    (B) Services shall be provide in convenient, accessible, acceptable, culturally appropriate settings such as primary healthcare, schools, family resource centers, community-based organizations, places of worship, shelters, and public settings unless a mental health setting enhances access to quality services and outcomes for underserved populations.
    (C) In addition to offering the required Improve Timely Access to Services for Underserved Populations Strategy, the County may also offer Improve Timely Access to Services for Underserved Populations as a Program.
  (3) Be designed, implemented, and promoted using Strategies that are Non-Stigmatizing and Non-Discriminatory
    (A) "Strategies that are Non-Stigmatizing and Non-Discriminatory" means promoting, designing, and implementing Programs in ways that reduce and circumvent stigma, including self-stigma, and discrimination related to being diagnosed with a mental illness, having a mental illness or seeking mental health services, and making services accessible, welcoming, and positive.
    (B) Non-Stigmatizing and Non-Discriminatory approaches include, but are not limited to, using positive, factual messages and approaches with a focus on recovery, wellness, and resilience; use of culturally appropriate language, practices, and concepts; efforts to

acknowledge and combat multiple social stigmas that affect attitudes about mental illness and/or about seeking mental health services, including but not limited to race and sexual orientation; co-locating mental health services with other life resources; promoting positive attitudes and understanding of recovery among mental health providers; inclusion and welcoming of family members; and employment of peers in a range of roles.

NOTE: Authority cited: Section 5846, Welfare and Institutions Code. Reference: Section 5840, Welfare and Institutions Code.

Amend Section 3750 as follows:

Section 3750. Prevention and Early Intervention Component Evaluation.

(a) For each Early Intervention Program the County shall evaluate the reduction of prolonged suffering as referenced in Welfare and Institutions Code Section 5840, subdivision (d) that may result from untreated mental illness by measuring reduced symptoms and/or improved recovery, including mental, emotional, and relational functioning. The County shall select, define, and measure appropriate indicators that are applicable to the Program.

(b) For each Prevention Program the County shall measure the reduction of prolonged suffering as referenced in Welfare and Institutions Code Section 5840, subdivision (d) that may result from untreated mental illness by measuring a reduction in risk factors, indicators, and/or increased protective factors that may lead to improved mental, emotional, and relational functioning. The County shall select, define, and measure appropriate indicators that are applicable to the Program.

(c) For each Early Intervention and each Prevention Program that the County designates as intended to reduce any of the other Mental Health Services Act negative outcomes referenced in Welfare and Institutions Code Section 5840, subdivision (d) that may result from untreated mental illness, the County shall select, define, and measure appropriate indicators that the County selects that are applicable to the Program.

(d) For each Stigma and Discrimination Reduction Program referenced in Section 3725, the County shall select and use a validated method to measure one or more of the following:
  (1) Changes in attitudes, knowledge, and/or behavior related to mental illness that are applicable to the specific Program.
  (2) Changes in attitudes, knowledge, and/or behavior related to seeking mental health services that are applicable to the specific Program.

(e) If the County chooses to offer a Suicide Prevention Program referenced in Section 3730, the County shall select and use a validated method to measure changes in attitudes, knowledge, and/or behavior regarding suicide related to mental illness that are applicable to the specific Program.

(f) For each Strategy or Program to provide Access and Linkage to Treatment the County shall track:
  (1) Number of referrals <u>as defined in subdivision (b)(3)(F) of section 3560.010</u> to treatment, and kind of treatment to which person was referred.
  (2) Number of persons who followed through on the referral <u>as defined in subdivision (b)(3)(F) of section 3560.010</u> and engaged in treatment, defined as the number of individuals who participated at least once in the Program to which the person was referred.

(A) The County may use a methodologically sound random sampling method to satisfy this requirement. The sample must be statistically generalizable to the larger population and representative of all relevant demographic groups included in the larger population.

(3) Duration of untreated mental illness.

(A) Duration of untreated mental illness shall be measured for persons who are referred as defined in subdivision (b)(3)(F) of section 3560.010 to treatment and who have not previously received treatment as follows:

1. The time between the self-reported and/or parent-or-family-reported onset of symptoms of mental illness and entry into treatment, defined as participating at least once in treatment to which the person was referred.

(B) The County may use a methodologically sound random sampling method to satisfy this requirement. The sample must be statistically generalizable to the larger population and representative of all relevant demographic groups included in the larger population.

(4) The interval between the referral as defined in subdivision (b)(3)(F) of section 3560.010 and engagement in treatment, defined as participating at least once in the treatment to which referred.

(A) The County may use a methodologically sound random sampling method to satisfy this requirement. The sample must be statistically generalizable to the larger population and representative of all relevant demographic groups included in the larger population.

(g) For each Strategy or Program to Improve Timely Access to Services for Underserved Populations the County shall measure:

(1) Number of referrals as defined in subdivision (b)(4)(G) of section 3560.010 of members of underserved populations to a Prevention Program, an Early Intervention Program, and/or treatment beyond early onset.

(2) Number of persons who followed through on the referral as defined in subdivision (b)(4)(G) of section 3560.010 and engaged in services, defined as the number of individuals who participated at least once in the Program to which the person was referred.

(A) The County may use a methodologically sound random sampling method to satisfy this requirement. The sample must be statistically generalizable to the larger population and representative of all relevant demographic groups included in the larger population.

(3) Timeliness of care.

(A) Timeliness of care for individuals from underserved populations with a mental illness is measured by the interval between referral as defined in subdivision (b)(4)(G) of section 3560.010 and engagement in services, defined as participating at least once in the service to which referred.

(h) The County shall design the evaluations to be culturally competent and shall include the perspective of diverse people with lived experience of mental illness, including their family members, as applicable.

(i) In addition, to the required evaluations listed in this section, the County may also, as relevant and applicable, define and measure the impact of Programs funded by Prevention and Early Intervention funds on the mental health and related systems, including, but not limited to education, physical healthcare, law enforcement and justice, social services, homeless shelters and other services, and

community supports specific to age, racial, ethnic, and cultural groups. Examples of system outcomes include, but are not limited to, increased provision of services by ethnic and cultural community organizations, hours of operation, integration of services including co-location, involvement of clients and families in key decisions, identification and response to co-occurring substance-use disorders, staff knowledge and application of recovery principles, collaboration with diverse community partners, or funds leveraged.

(j) A County with a population under 100,000, according to the most recent projection by the California State Department of Finance, is exempt from the evaluation requirements in this section for one year from the effective date of this section.

(k) A County with a population under 100,000, according to the most recent projection by the California State Department of Finance, electing to follow subdivision (c) of section 3705 may satisfy the requirements of subdivisions (a) through (g) of this section by selecting, defining, and measuring appropriate indicators that the County selects to evaluate the negative outcomes referenced in Welfare and Institutions Code section 5840, subdivision (d), identified in the County's Three-year Program and Expenditure Plan and/or Annual Update pursuant to subdivision (o)(2) of section 3755.

NOTE: Authority cited: Section 5846, Welfare and Institutions Code. Reference: Sections 5840 and 5847, Welfare and Institutions Code; Uncodified Sections 2 and 3 of Proposition 63, the Mental Health Services Act.

Amend Section 3755 as follows:

Section 3755. Prevention and Early Intervention Component of the Three-Year Program and Expenditure Plan and Annual Update.

(a) The requirements set forth in this section shall apply to the Annual Update due for the fiscal year 2016-17 and each Annual Update and/or Three-Year Program and Expenditure Plan thereafter.

(b) The Prevention and Early Intervention Component of the Three-Year Program and Expenditure Plan or Annual Update shall include the following general information:

(1) A description of how the County ensured that staff and stakeholders involved in the Community Program Planning process required by Title 9 California Code of Regulations, Section 3300, were informed about and understood the purpose and requirements of the Prevention and Early Intervention Component.

(2) A description of the County's plan to involve community stakeholders meaningfully in all phases of the Prevention and Early Intervention Component of the Mental Health Services Act, including program planning and implementation, monitoring, quality improvement, evaluation, and budget allocations.

(3) A brief description, with specific examples of how each Program and/or Strategy funded by Prevention and Early Intervention funds will reflect and be consistent with all applicable Mental Health Services Act General Standards set forth in Title 9 California Code of Regulations, Section 3320.

(c) Except as provided in subdivision (o), the Prevention and Early Intervention Component of the Three-Year Program and Expenditure Plan and Annual Update shall include a description of each Early Intervention Program as defined in Section 3710 including, but not limited to:
  (1) The Program name
  (2) Identification of the target population for the specific Program including:
    (A) Demographics relevant to the intended target population for the specific Program, including, but not limited to, age, race/ethnicity, gender or gender identity, primary language used, military status, and sexual orientation.
    (B) The mental illness or illnesses for which there is early onset.
    (C) Brief description of how each participant's early onset of a potentially serious mental illness will be determined.
  (3) Identification of the type(s) of problem(s) and need(s) for which the Program will be directed and the activities to be included in the Program that are intended to bring about mental health and related functional outcomes including reduction of the negative outcomes referenced in Welfare and Institutions Code Section 5840, subdivision (d) for individuals with early onset of potentially serious mental illness.
  (4) The Mental Health Services Act negative outcomes as a consequence of untreated mental illness referenced in Welfare and Institutions Code Section 5840, subdivision (d) that the Program is expected to affect, including the reduction of prolonged suffering as a consequence of untreated mental illness, as defined in Section 3750, subdivision (a).
    (A) List the mental health indicators that the County will use to measure reduction of prolonged suffering as referenced in Section 3750, subdivision (a).
    (B) For any other specified Mental Health Services Act negative outcome as a consequence of untreated mental illness, as referenced in Section 3750, subdivision (c), list the indicators that the County will use to measure the intended reductions.
    (C) Explain the evaluation methodology, including, how and when outcomes will be measured, how data will be collected and analyzed, and how the evaluation will reflect cultural competence.
  (5) Specify how the Early Intervention Program is likely to reduce the relevant Mental Health Services Act negative outcomes as referenced in Welfare and Institutions Code Section 5840, subdivision (d) by providing the following information:
    (A) If the County used the evidence-based standard or promising practice standard to determine the Program's effectiveness as referenced in Section 3740, subdivisions (a)(1) and (a)(2), provide a brief description of or reference to the relevant evidence applicable to the specific intended outcome, explain how the practice's effectiveness has been demonstrated for the intended population, and explain how the County will ensure fidelity to the practice according to the practice model and program design in implementing the Program.
    (B) If the County used the community and/or practice-based standard to determine the Program's effectiveness as referenced in Section 3740, subdivision (a)(3), describe the evidence that the approach is likely to bring about applicable Mental Health Services Act

outcomes for the intended population(s) and explain how the County will ensure fidelity to the practice according to the practice model and program design in implementing the Program.

(d) Except as provided in subdivision (o), the Prevention and Early Intervention Component of the Three-Year Program and Expenditure Plan and Annual Update shall include a description of the Prevention Program including but not limited to the following information:

(1) The Program name

(2) Identification of the target population for the specific Program, including:

(A) Participants' risk of a potentially serious mental illness, either based on individual risk or membership in a group or population with greater than average risk of a serious mental illness, i.e. the condition, experience, or behavior associated with greater than average risk.

(B) How the risk of a potentially serious mental illness will be defined and determined, i.e. what criteria and process the County will use to establish that the intended beneficiaries of the Program have a greater than average risk of developing a potentially severe mental illness.

(C) Demographics relevant to the intended target population for the specific Program including but not limited to age, race/ethnicity, gender or gender identity, sexual orientation, primary language used, and military status.

(3) Specify the type of problem(s) and need(s) for which the Prevention Program will be directed and the activities to be included in the Program that are intended to bring about mental health and related functional outcomes including reduction of the negative outcomes referenced in Welfare and Institutions Code Section 5840, subdivision (d) for individuals with greater than average risk of potentially serious mental illness.

(4) Specify any Mental Health Services Act negative outcomes as a consequence of untreated mental illness as referenced in Welfare and Institutions Code Section 5840, subdivision (d) that the Program is expected to affect, including reduction of prolonged suffering, as defined in Section 3750, subdivision (b).

(A) List the mental health indicators that the County will use to measure reduction of prolonged suffering as referenced in Section 3750, subdivision (b).

(B) If the County intends the Program to reduce any other specified Mental Health Services Act negative outcome as a consequence of untreated mental illness as referenced in Section 3750, subdivision (c), list the indicators that the County will use to measure the intended reductions.

(C) Explain the evaluation methodology, including, how and when outcomes will be measured, how data will be collected and analyzed, and how the evaluation will reflect cultural competence.

(5) Specify how the Prevention Program is likely to bring about reduction of relevant Mental Health Services Act negative outcomes referenced in Welfare and Institutions Code Section 5840, subdivision (d) for the intended population by providing the following information:

(A) If the County used the evidence-based standard or promising practice standard to determine the Program's effectiveness as referenced in Section 3740, subdivisions (a)(1) and

(a)(2), provide a brief description of or reference to the relevant evidence applicable to the specific intended outcome, explain how the practice's effectiveness has been demonstrated for the intended population, and explain how the County will ensure fidelity to the practice according to the practice model and program design in implementing the Program.

(B) If the County used the community and/or practice-based standard to determine the Program's effectiveness as referenced in Section 3740, subdivision (a)(3), describe the evidence that the approach is likely to bring about applicable Mental Health Services Act outcomes for the intended population(s) and explain how the County will ensure fidelity to the practice according to the practice model and program design in implementing the Program.

(e) Except as provided in subdivision (o), the Prevention and Early Intervention Component of the Three-Year Program and Expenditure Plan and Annual Update shall include a description of each Outreach for Increasing Recognition of Early Signs of Mental Illness Program and for any Strategy within a Program, including, but not limited to:

(1) The Program name

(2) Identify the types and settings of potential responders the Program intends to reach.

(A) Describe briefly the potential responders' setting(s), as referenced in Section 3750, subdivisions (d)(3)(A), and the opportunity the potential responders will have to identify diverse individuals with signs and symptoms of potentially serious mental illness.

(3) Specify the methods to be used to reach out and engage potential responders and the methods to be used for potential responders and public mental health service providers to learn together about how to identify and respond supportively to signs and symptoms of potentially serious mental illness.

(f) Except as provided in subdivision (o), the Prevention and Early Intervention Component of the Three-Year Program and Expenditure Plan and Annual Update shall include a description of each Stigma and Discrimination Reduction Program, including, but not limited to:

(1) The Program name

(2) Identify whom the Program intends to influence.

(3) Specify the methods and activities to be used to change attitudes, knowledge, and/or behavior regarding being diagnosed with mental illness, having mental illness and/or seeking mental health services, consistent with requirements in Section 3750, subdivision (e), including timeframes for measurement.

(4) Specify how the proposed method is likely to bring about the selected outcomes by providing the following information:

(A) If the County used the evidence-based standard or promising practice standard, to determine the Program's effectiveness as referenced in Section 3740, subdivisions (a)(1) and (a)(2), provide a brief description of or reference to the relevant evidence applicable to the specific intended outcome, explain how the practice's effectiveness has been demonstrated for the intended population and explain how the County will ensure fidelity to the practice according to the practice model and Program design in implementing the Program.

(B) If the County used the community and/or practice-based standard to determine the Program's effectiveness as referenced in Section 3740, subdivision (a)(3), describe the evidence that the approach is likely to bring about applicable Mental Health Services Act outcomes for the intended population and explain how the County will ensure fidelity to the practice according to the practice model and Program design in implementing the Program.

(g) Except as provided in subdivision (o), the Prevention and Early Intervention Component of the Three-Year Program and Expenditure Plan and Annual Update shall include a description of each Suicide Prevention Program including, but not limited to:

(1) The Program name

(2) Specify the methods and activities to be used to change attitudes and behavior to prevent mental illness-related suicide.

(3) Indicate how the County will measure changes in attitude, knowledge, and /or behavior related to reducing mental illness-related suicide consistent with requirements in Section 3750, subdivision (f) including timeframes for measurement.

(4) Specify how the proposed method is likely to bring about suicide prevention outcomes selected by the County by providing the following information:

(A) If the County used the evidence-based standard or promising practice standard to determine the Program's effectiveness as referenced in Section 3740, subdivisions (a)(1) and (a)(2), explain how the practice's effectiveness has been demonstrated and explain how the County will ensure fidelity to the practice according to the practice model and Program design in implementing the Program.

(B) If the County used the community and/or practice-based standard to determine the Program's effectiveness as referenced in Section 3740, subdivision (a)(3), describe the evidence that the approach is likely to bring about applicable Mental Health Services Act outcomes and explain how the County will ensure fidelity to the practice according to the practice model and Program design in implementing the Program.

(h) Except as provided in subdivision (o), the Prevention and Early Intervention Component of the Three-Year Program and Expenditure Plan and Annual Update shall include a description of the Access and Linkage to Treatment Program and Strategy within each Program including, but not limited to:

(1) Program name

(2) An explanation of how the Program and Strategy within each Program will create Access and Linkage to Treatment for individuals with serious mental illness as referenced in Section 3735, subdivision (a)(1)

(3) Explain how individuals will be identified as needing assessment or treatment for a serious mental illness or serious emotional disturbance that is beyond the scope of an Early Intervention Program.

(4) Explain how individuals, and, as applicable, their parents, caregivers, or other family members, will be linked to county mental health services, a primary care provider, or other mental health treatment.

(5) Explain how the Program will follow up with the referral to support engagement in treatment.
(6) Indicate if the County intends to measure outcomes in addition to those required in Section 3750, subdivision (f) and if so, specify what outcome(s) and how will it be measured, including timeframes for measurement.

(i) Except as provided in subdivision (o), the Prevention and Early Intervention Component of the Three-Year Program and Expenditure Plan and Annual Update shall include for all Programs:
(1) Program name
(2) An explanation of how the Program will be implemented to help Improve Access to Services for Underserved Populations, as required in Section 3735, subdivision (a)(2)
(3) For each Program, the County shall indicate the intended setting(s) and why the setting enhances access for specific, designated underserved populations. If the County intends to locate the Program in a mental health setting, explain why this choice enhances access to quality services and outcomes for the specific underserved population.
(4) Indicate if the County intends to measure outcomes in addition to those required in Section 3750, subdivision (g) and, if so, what outcome(s) and how will it be measured, including timeframes for measurement.

(j) Except as provided in subdivision (o), the Prevention and Early Intervention Component of the Three-Year Program and Expenditure Plan and Annual Update shall include for all Programs:
(1) The Program name
(2) An explanation of how the Program will use Strategies that are Non-Stigmatizing and Non-Discriminatory, including a description of the specific Strategies to be employed and the reasons the County believes they will be successful and meet intended outcomes.

(k) Except as provided in subdivision (o), the Prevention and Early Intervention Component of the Three-Year Program and Expenditure Plan and Annual Update shall include for all Programs the following information for the fiscal year after the plan is submitted.
(1) Estimated number of children, adults, and seniors to be served in each Prevention Program and each Early Intervention Program.
(2) The County may also include estimates of the number of individuals who will be reached by Outreach for Increasing Recognition of Early Signs of Mental Illness Program, Access and Linkage to Treatment Program, Suicide Prevention Programs, and Stigma and Discrimination Reduction Programs.

(l) Except as provided in subdivision (o), the Prevention and Early Intervention Component of the Three-Year Program and Expenditure Plan and Annual Update shall include projected expenditures for each Program funded with Prevention and Early Intervention funds by fiscal year
(1) Projected expenditures by the following sources of funding:
(A) Estimated total mental health expenditures
(B) Prevention and Early Intervention funds
(C) Medi-Cal Federal Financial Participation
(D) 1991 Realignment
(E) Behavioral Subaccount

(F) Any other funding

(2) The County shall identify each Program funded with Prevention and Early Intervention funds as a Prevention Program, an Early Intervention Program, Outreach for Increasing Recognition of Early Signs of Mental Illness Program, Stigma and Discrimination Reduction Program, Suicide Prevention Program, Access and Linkage to Treatment Program, or Program to Improve Timely Access to Services for Underserved Populations and shall estimate expected expenditures for each Program. If the Programs are combined, the County shall estimate the percentage of funds dedicated to each Program.

(A) The County shall estimate the amount of Prevention and Early Intervention funds for Administration of the Prevention and Early Intervention Component.

(m) The Prevention and Early Intervention Component of the Three-Year Program and Expenditure Plan and Annual Update shall include the previous fiscal years' unexpended Prevention and Early Intervention funds and the amount of those funds that will be used to pay for the Programs listed in the Annual Update and/or Three-year Program and Expenditure Plan.

(n) The Prevention and Early Intervention Component of the Three-Year Program and Expenditure Plan and Annual Update shall include an estimate of the amount of Prevention and Early Intervention funds voluntarily assigned by the County to California Mental Health Services Authority or any other organization in which counties are acting jointly.

(o) A County with a population under 100,000, according to the most recent projection by the California State Department of Finance, electing to follow subdivision (c) of section 3705 shall include in the Prevention and Early Intervention Component of the Three-Year Program and Expenditure Plan and Annual Update a description of the combine and/or integrated program including but not limited:

(1) Name of the combined and/or integrated program.

(2) Description of how the five required programs were combined and/or integrated.

(3) Identification of the negative outcomes referenced in Welfare and Institutions Code Section 5840, subdivision (d) the combined and/or integrated program is intended to reduce.

(4) Description of how the combined and/or integrated program is likely to reduce the outcomes identified in part (3) above.

(5) Identification of the indicators that the County will use to measure the intended outcomes identified in part (3) above.

(6) Explanation of how the combined and/or integrated program will be implemented to help Improve Access to Services for Underserved Population, as required in Section 3735, subdivision (a)(2).

(7) Explanation of how the combined and/or integrated program will use Strategies that are Non-Stigmatizing and Non-Discriminatory, as required in Section 3735, subdivision (a)(3).

(8) Estimated numbers of children, adults, and seniors, respectively, to be served in the combined and/or integrated program.

(9) List of the projected expenditures for the combined and/or integrated program funded with Prevention and Early Intervention funds by fiscal year and by the following sources of funding:

(A) Estimated total mental health expenditures

(B) Prevention and Early Intervention funds

(C) Medi-Cal Federal Financial Participation
(D) 1991 Realignment
(E) Behavioral Subaccount
(F) Any other funding

(10) Estimated amount of Prevention and Early Intervention funds budgeted for Administration of the Prevention and Early Intervention Component.

NOTE: Authority cited: Section 5846, Welfare and Institutions Code. Reference: Sections 5840, 5847, and 5848 Welfare and Institutions Code.

Attachment 2

Article 5. Reporting Requirements

Amend Section 3580 as follows:

Section 3580. Innovative Project Reports.

(a) For each approved Innovative Project, the County shall submit to the Mental Health Services Oversight and Accountability Commission the following reports, as applicable.

(1) For a continuing Innovative Project, an Annual Innovative Project Report as specified in Section 3580.010.

(A) The first Annual Innovative Project Report is due no later than December 31, 2017 ~~following the end of the fiscal year for which the County is reporting.~~ The County may submit the Annual Innovative Project Report as part of ~~the~~ a Three-Year Program and Expenditure Plan or Annual Update. ~~as long as the documents are submitted no later than December 31 pursuant to this subdivision.~~ Each Annual Innovative Project Report thereafter is due to the Mental Health Services Oversight and Accountability Commission as part of an Annual Update or Three-Year Program and Expenditure Plan within 30 calendar days of Board of Supervisors approval but no later than June 30 of the same fiscal year whichever occurs first.

(B) The County shall exclude from the Annual Innovative Project Report personally identifiable information as defined by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Health Information Technology for Economic and Clinical Health Act (HITECH) and their implementing privacy and security regulations, the California Information Practices Act, and any other applicable state or federal privacy laws.

1. When the County has excluded information pursuant to subdivision (B) above, the County shall submit to the Mental Health Services Oversight and Accountability Commission one of the following:

   a. A supplemental Annual Innovative Project Report that contains all of the information including the information that was excluded pursuant to subdivision (B). This supplemental report shall be marked “confidential”.
   b. A supplement to the Annual Innovative Project Report that contains the information that was excluded pursuant to subdivision (B). This supplement to the report shall be marked “confidential”.

(2) Upon completion of an Innovative Project, a Final Innovative Project Report as specified in Section 3580.020.

(A) The County may submit the Final Innovative Project Report as part of the Three-Year Program and Expenditure Plan, Annual Update, or within six months from completion of the Innovative Project whichever is closest in time to the completion of the Innovative Project.

(B) The County shall exclude from the Final Innovative Project Report personally identifiable information as defined by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Health Information Technology for Economic and Clinical Health Act (HITECH)

and their implementing privacy and security regulations, the California Information Practices Act, and any other applicable state or federal privacy laws.

1. When the County has excluded information pursuant to subdivision (B) above, the County shall submit to the Mental Health Services Oversight and Accountability Commission one of the following:
   a. A supplemental Final Innovative Project Report that contains all of the information including the information that was excluded pursuant to subdivision (B). This supplemental report shall be marked "confidential".
   b. A supplement to the Final Innovative Project Report that contains the information that was excluded pursuant to subdivision (B). This supplement to the report shall be marked "confidential".

NOTE: Authority cited: Section 5846, Welfare and Institutions Code. Reference: Sections 5830 and 5847, Welfare and Institutions Code.

Adopt Section 3580.010 as follows:

Section 3580.010. Annual Innovative Project Report.

(a) The Annual Innovative Project Report shall include:
   (1) Name of the Innovative Project
   (2) Whether and what changes were made to the Innovative Project during the reporting period and the reasons for the changes.
   (3) Available evaluation data, including outcomes of the Innovative Project and information about which elements of the Project are contributing to outcomes.
   (4) Program information collected during the reporting period, including for applicable Innovative Projects that serve individuals, number of participants served by:
      (A) Age by the following categories:
         1. 0-15 (children/youth)
         2. 16-25 (transition age youth)
         3. 26-59 (adult)
         4. ages 60+ (older adults)
         5. Number of respondents who declined to answer the question
      (B) Race by the following categories:
         1. American Indian or Alaska Native
         2. Asian
         3. Black or African American
         4. Native Hawaiian or other Pacific Islander
         5. White
         6. Other
         7. More than one race
         8. Number of respondents who declined to answer the question
      (C) Ethnicity by the following categories:
         1. Hispanic or Latino as follows
            a. Caribbean

b. Central American
c. Mexican/Mexican-American/Chicano
d. Puerto Rican
e. South American
f. Other
g. Number of respondents who declined to answer the question

2. Non-Hispanic or Non-Latino as follows
   a. African
   b. Asian Indian/South Asian
   c. Cambodian
   d. Chinese
   e. Eastern European
   f. European
   g. Filipino
   h. Japanese
   i. Korean
   j. Middle Eastern
   k. Vietnamese
   l. Other
   m. Number of respondents who declined to answer the question
3. More than one ethnicity
4. Number of respondents who declined to answer the question

(D) Primary language used by threshold languages for the individual county

(E) Sexual orientation,
   1. Gay or Lesbian
   2. Heterosexual or Straight
   3. Bisexual
   4. Questioning or unsure of sexual orientation
   5. Queer
   6. Another sexual orientation
   7. Number of respondents who declined to answer the question

(F) A Disability, defined as a physical or mental impairment or medical condition lasting at least six months that substantially limits a major life activity, which is not the result of a severe mental illness.
   1. Yes, report the number that apply in each domain of disability(ies)
      a. Communication domain separately by each of the following
         (i) Difficulty seeing
         (ii) Difficulty hearing, or having speech understood
         (iii) Other (specify)
      b. Mental domain not including a mental illness (including but not limited to a learning disability, developmental disability, dementia)
      c. Physical/mobility domain
      d. Chronic health condition (including but not limited to chronic pain)
      e. Other (specify)

2. No
3. Number of respondents who declined to answer the question

(G) Veteran status,
1. Yes
2. No
3. Number of respondents who declined to answer the question

(H) Gender
1. Assigned sex at birth
a. Male
b. Female
c. Number of respondents who declined to answer the question
2. Current gender identity
a. Male
b. Female
c. Transgender
d. Genderqueer
e. Questioning or unsure of gender identity
f. Another gender identity
g. Number of respondents who declined to answer the question

(5) Any other data the County considers relevant.

(b) For an Innovative Project serving children or youth younger than 18 years of age, the demographic information required under subdivision (a)(4) of this section relating to children or youth younger than 18 years of age shall be collected and reported only to the extent permissible by California Education Code, Family Educational Rights and Privacy Act (FERPA), Health Insurance Portability and Accountability Act of 1996 (HIPAA), California Information Practices Act, and other applicable state and federal privacy laws.

(c) A county is not required to collect the demographic information required under subdivision (a)(4) of this section from a minor younger than 12 years of age.

NOTE: Authority cited: Section 5846, Welfare and Institutions Code. Reference: Sections 5830, 5845(d)(6), and 5847, Welfare and Institutions Code.

Attachment 3

Below are staff's recommended changes to the proposed amendments to the Prevention and Early Intervention (PEI) regulations Sections 3560.010, 3726, and 3735 in response to public comments received during the 45-day public comment period. Only the recommended changes are noted. The added language is in underline text and deleted language is in strikethrough text. These proposed changes will be discussed at the October 28, 2017 Mental Health Services Oversight and Accountability Commission.

Article 5. Reporting Requirements

Amend Section 3560.010 as follows:

Section 3560.010. Annual Prevention and Early Intervention Report.

(a) The requirements set forth in this section shall apply to the Annual Prevention and Early Intervention Report.

(1) The first Annual Prevention and Early Intervention Report is due to the Mental Health Services Oversight and Accountability Commission on or before December 30, 2017 as part of an Annual Update or Three-Year Program and Expenditure Plan. Each Annual Prevention and Early Intervention Report thereafter is due as part of an Annual Update or Three-Year Program and Expenditure Plan within 30 calendar days of Board of Supervisors approval but no later than June 30 of the same fiscal year whichever occurs first. The Annual Prevention and Early Intervention Report is not due in years in which a Three-Year Prevention and Early Intervention Evaluation Report is due.

(2) The Annual Prevention and Early Intervention Report shall report on the required data for the fiscal year prior to the due date. For example, the Report that is due no later than June 30, 2020 is to report the required data from fiscal year 2018-19 (i.e. July 1, 2018 through June 30, 2019).

(3) The County shall exclude from the Annual Prevention and Early Intervention Report personally identifiable information as defined by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Health Information Technology for Economic and Clinical Health Act (HITECH) and their implementing privacy and security regulations, the California Information Practices Act, and any other applicable state or federal privacy laws.

(A) When the County has excluded information pursuant subdivision (3) above, the County shall submit to the Mental Health Services Oversight and Accountability Commission one of the following:

1. A supplemental Annual Prevention and Early Intervention Report that contains all of the information including the information that was excluded pursuant to subdivision (3). This supplemental report shall be marked "confidential."
2. A supplement to the Annual Prevention and Early Intervention Report that contains the information that was excluded pursuant to subdivision (3). This supplement to the report shall be marked "confidential."

(b) The County shall report the following information annually as part of the Annual Update or Three-Year Program and Expenditure Plan. The report shall include the following information for the reporting period:

(1) For each Prevention Program and each Early Intervention Program list:

(A) The Program name.

(B) Unduplicated numbers of individuals served in the preceding fiscal year

1. If a Program served both individuals at risk of a mental illness (Prevention) and individuals with early onset of a mental illness (Early Intervention), the County shall report numbers served separately for each category.
2. If a Program served families the County shall report the number of individual family members served.

(2) For each Outreach for Increasing Recognition of Early Signs of Mental Illness Program or Strategy within a Program, the County shall report:

(A) The Program name

(B) The number of potential responders

(C) The setting(s) in which the potential responders were engaged

1. Settings providing opportunities to identify early signs of mental illness include, but are not limited to, family resource centers, senior centers, schools, cultural organizations, churches, faith-based organizations, primary health care, recreation centers, libraries, public transit facilities, support groups, law enforcement departments, residences, shelters, and clinics.

(D) The type(s) of potential responders engaged in each setting (e.g. nurses, principals, parents)

(3) For each Access and Linkage to Treatment Strategy or Program the County shall report:

(A) The Program name

(B) Number of individuals with serious mental illness referred to ~~treatment and the kind of treatment to which the individual was referred:~~

1. Treatment that is provided, funded, administered, or overseen by county mental health programs.
2. Treatment that is not provided, funded, administered, or overseen by county mental health programs.

(C) For referrals to treatment that is provided, funded, administered, or overseen by county mental health, the number of individuals who followed through on the referral and engaged in treatment, defined as the number of individuals who participated at least once in the Program to which they were referred.

(D) For referrals to treatment that is provided, funded, administered, or overseen by county mental health, the average duration of untreated mental illness as defined in Section 3750, subdivision (f)(3)(A) and standard deviation.

(E) For referrals to treatment that is provided, funded, administered, or overseen by county mental health, the average interval between the referral and participation in treatment, defined as participating at least once in the treatment to which referred, and standard deviation.

(F) "Referral" as used in this subdivision means the process by which an individual is given a recommendation in writing to one or more specific service providers for a higher level of care and treatment. Distributing a list of community resources to an individual does not constitute a referral under this subdivision.

(4) For each Improve Timely Access to Services for Underserved Populations Strategy or Program the County shall report:

(A) The program name

(B) Identify the specific underserved populations for whom the County intended to increase timely access to services.

(C) Number of referrals of members of underserved populations to a Prevention Program, an Early Intervention Program and/or to treatment beyond early onset.

(D) Number of individuals who followed through on the referral, defined as the number of individuals who participated at least once in the Program to which they were referred.

(E) Average interval between referral and participation in services to which referred, defined as participating at least once in the service to which referred, and standard deviation.

(F) Description of ways the County encouraged access to services and follow-through on referrals.

(G) "Referral" as used in this subdivision means the process by which a member of an underserved population is given a recommendation in writing to one or more specific service providers for a Prevention Program, an Early Intervention Program and/or a program providing treatment beyond early onset. Distributing a list of community resources to an individual does not constitute a referral under this subdivision.

(5) For the information reported under subdivisions (1) through (4) of this section, disaggregate numbers served, number of potential responders engaged, and number of referrals for treatment and other services by:

(A) The following age groups:

1. 0-15 (children/youth)
2. 16-25 (transition age youth)
3. 26-59 (adult)
4. ages 60+ (older adults)
5. Number of respondents who declined to answer the question

(B) Race by the following categories:

1. American Indian or Alaska Native
2. Asian
3. Black or African American
4. Native Hawaiian or other Pacific Islander
5. White
6. Other
7. More than one race
8. Number of respondents who declined to answer the question

(C) Ethnicity by the following categories:

1. Hispanic or Latino as follows
   a. Caribbean

b. Central American
c. Mexican/Mexican-American/Chicano
d. Puerto Rican
e. South American
f. Other
g. Number of respondents who declined to answer the question

2. Non-Hispanic or Non-Latino as follows
   a. African
   b. Asian Indian/South Asian
   c. Cambodian
   d. Chinese
   e. Eastern European
   f. European
   g. Filipino
   h. Japanese
   i. Korean
   j. Middle Eastern
   k. Vietnamese
   l. Other
   m. Number of respondents who declined to answer the question
3. More than one ethnicity
4. Number of respondents who declined to answer the question

(D) Primary language used listed by threshold languages for the individual county

(E) Sexual orientation,
1. Gay or Lesbian
2. Heterosexual or Straight
3. Bisexual
4. Questioning or unsure of sexual orientation
5. Queer
6. Another sexual orientation
7. Number of respondents who declined to answer the question

(F) Disability, defined as a physical or mental impairment or medical condition lasting at least six months that substantially limits a major life activity, which is not the result of a severe mental illness
1. Yes, report the number that apply in each domain of disability(ies)
   a. Communication domain separately by each of the following
      (i) Difficulty seeing,
      (ii) Difficulty hearing, or having speech understood
      (iii) Other (specify)
   b. Mental domain not including a mental illness (including but not limited to a learning disability, developmental disability, dementia)
   c. Physical/mobility domain
   d. Chronic health condition (including, but not limited to, chronic pain)
   e. Other (specify)

2. No
3. Number of respondents who declined to answer the question

(G) Veteran status,
1. Yes
2. No
3. Number of respondents who declined to answer the question

(H) Gender
1. Assigned sex at birth:
a. Male
b. Female
c. Number of respondents who declined to answer the question
2. Current gender identity:
a. Male
b. Female
c. Transgender
d. Genderqueer
e. Questioning or unsure of gender identity
f. Another gender identity
g. Number of respondents who declined to answer the question

(6) Any other data the County considers relevant, for example, data for additional demographic groups that are particularly prevalent in the County, at elevated risk of or with high rates of mental illness, unserved or underserved, and/or the focus of one or more Prevention and Early Intervention funded services.

(7) For Stigma and Discrimination Reduction Programs and Suicide Prevention Programs, the County may report available numbers of individuals reached, including demographic breakdowns. An example would be the number of individuals who received training and education or who clicked on a web site.

(8) For all programs and Strategies, the County may report implementation challenges, successes, lessons learned, and relevant examples.

(c) For a program serving children or youth younger than 18 years of age, the demographic information required under subdivision (b)(5) of this section relating to children or youth younger than 18 years of age shall be collected and reported only to the extent permissible by California Education Code, Family Educational Rights and Privacy Act (FERPA), Health Insurance Portability and Accountability Act of 1996 (HIPAA), California Information Practices Act, and other applicable state and federal privacy laws.

(d) <u>Except for sexual orientation, current gender identity, and veteran status, a county shall collect the demographic information required under subdivision (b)(5) of this section from a minor younger than 12 years of age. Information that cannot be obtained directly from the minor may be obtained from the minor's parent, legal guardian, or other authorized source.</u>

(e) A County with a population under 100,000, according to the most recent projection by the California State Department of Finance, may report the demographic information required under subdivision

(b)(5) of this section for the County's entire Prevention and Early Intervention Component instead of by each Program or Strategy.

NOTE: Authority cited: Section 5846, Welfare and Institutions Code. Reference: Sections 5840, 5845(d)(6), and 5847, Welfare and Institutions Code; Uncodified Sections 2 and 3 of Proposition 63, the Mental Health Services Act.

Article 7. Prevention and Early Intervention

Amend Section 3726 as follows:

Section 3726. Access and Linkage to Treatment Program.

(a) The County shall offer at least one Access and Linkage to Treatment Program as defined in this section.
(b) "Access and Linkage to Treatment Program" means a set of related activities to connect children with severe mental illness, as defined in Welfare and Institutions Code Section 5600.3, and adults and seniors with severe mental illness, as defined in Welfare and Institutions Code Section 5600.3, as early in the onset of these conditions as practicable, to medically necessary care and treatment~~,~~ including, but not limited to, care provided~~, funded, administered, or overseen~~ by county mental health programs.
    (1) Examples of Access and Linkage to Treatment Programs, include but are not limited to, Programs with a primary focus on screening, assessment, referral, telephone help lines, and mobile response.
(c) In addition to offering the required Access and Linkage to Treatment Program, the County is also required to offer Access and Linkage to Treatment as a Strategy within all Prevention and Early Intervention Programs.
(d) The County shall include all of the Strategies in each Access and Linkage to Treatment Program as referenced in Section 3735.
(e) An Access and Linkage to Treatment Program may be provided through other Mental Health Services Act components as long as it meets all of the requirements in this section.

NOTE: Authority cited: Section 5846, Welfare and Institutions Code. Reference: Sections 5600.3 and 5840, Welfare and Institutions Code.

Amend Section 3735 as follows:
Section 3735. Prevention and Early Intervention Strategies.

(a) The County shall include all of the following Strategies as part of each Program listed in Sections 3710 through 3730 of Article 7:
    (1) Be designed and implemented to help create Access and Linkage to Treatment.
        (A) "Access and Linkage to Treatment" means connecting children with severe mental illness, as defined in Welfare and Institutions Code Section 5600.3, and adults and seniors with severe mental illness, as defined in Welfare and Institutions Code Section 5600.3, as early in the onset of these conditions as practicable, to medically necessary care and treatment~~,~~ ~~including, but not limited to, care~~ provided~~, funded, administered, or overseen~~ by county mental health programs.
    (2) Be designed, implemented, and promoted in ways that Improve Timely Access to Mental Health Services for Individuals and/or Families from Underserved Populations.

(A) "Improving Timely Access to Services for Underserved Populations" means to increase the extent to which an individual or family from an underserved population as defined in Title 9 California Code of Regulations Section 3200.300 who needs mental health services because of risk or presence of a mental illness receives appropriate services as early in the onset as practicable, through program features such as accessibility, cultural and language appropriateness, transportation, family focus, hours available, and cost of services.

(B) Services shall be provide in convenient, accessible, acceptable, culturally appropriate settings such as primary healthcare, schools, family resource centers, community-based organizations, places of worship, shelters, and public settings unless a mental health setting enhances access to quality services and outcomes for underserved populations.

(C) In addition to offering the required Improve Timely Access to Services for Underserved Populations Strategy, the County may also offer Improve Timely Access to Services for Underserved Populations as a Program.

(3) Be designed, implemented, and promoted using Strategies that are Non-Stigmatizing and Non-Discriminatory

(A) "Strategies that are Non-Stigmatizing and Non-Discriminatory" means promoting, designing, and implementing Programs in ways that reduce and circumvent stigma, including self-stigma, and discrimination related to being diagnosed with a mental illness, having a mental illness or seeking mental health services, and making services accessible, welcoming, and positive.

(B) Non-Stigmatizing and Non-Discriminatory approaches include, but are not limited to, using positive, factual messages and approaches with a focus on recovery, wellness, and resilience; use of culturally appropriate language, practices, and concepts; efforts to acknowledge and combat multiple social stigmas that affect attitudes about mental illness and/or about seeking mental health services, including but not limited to race and sexual orientation; co-locating mental health services with other life resources; promoting positive attitudes and understanding of recovery among mental health providers; inclusion and welcoming of family members; and employment of peers in a range of roles.

NOTE: Authority cited: Section 5846, Welfare and Institutions Code. Reference: Section 5840, Welfare and Institutions Code.

Attachment 4

Below are staff's recommended changes to the proposed amendments to the Innovative Project regulations Section 3580.010 in response to public comments received during the 45-day public comment period. Only the recommended changes are noted. The added language is in underline text and deleted language is in strikethrough text. These proposed changes will be discussed at the October 28, 2017 Mental Health Services Oversight and Accountability Commission.

Article 5. Reporting Requirements

Adopt Section 3580.010 as follows:

Section 3580.010. Annual Innovative Project Report.

(a) The Annual Innovative Project Report shall include:
  (1) Name of the Innovative Project
  (2) Whether and what changes were made to the Innovative Project during the reporting period and the reasons for the changes.
  (3) Available evaluation data, including outcomes of the Innovative Project and information about which elements of the Project are contributing to outcomes.
  (4) Program information collected during the reporting period, including for applicable Innovative Projects that serve individuals, number of participants served by:
    (A) Age by the following categories:
      1. 0-15 (children/youth)
      2. 16-25 (transition age youth)
      3. 26-59 (adult)
      4. ages 60+ (older adults)
      5. Number of respondents who declined to answer the question
    (B) Race by the following categories:
      1. American Indian or Alaska Native
      2. Asian
      3. Black or African American
      4. Native Hawaiian or other Pacific Islander
      5. White
      6. Other
      7. More than one race
      8. Number of respondents who declined to answer the question
    (C) Ethnicity by the following categories:
      1. Hispanic or Latino as follows
        a. Caribbean
        b. Central American
        c. Mexican/Mexican-American/Chicano
        d. Puerto Rican
        e. South American
        f. Other

g. Number of respondents who declined to answer the question

2. Non-Hispanic or Non-Latino as follows
   a. African
   b. Asian Indian/South Asian
   c. Cambodian
   d. Chinese
   e. Eastern European
   f. European
   g. Filipino
   h. Japanese
   i. Korean
   j. Middle Eastern
   k. Vietnamese
   l. Other
   m. Number of respondents who declined to answer the question
3. More than one ethnicity
4. Number of respondents who declined to answer the question

(D) Primary language used by threshold languages for the individual county

(E) Sexual orientation,
   1. Gay or Lesbian
   2. Heterosexual or Straight
   3. Bisexual
   4. Questioning or unsure of sexual orientation
   5. Queer
   6. Another sexual orientation
   7. Number of respondents who declined to answer the question

(F) A Disability, defined as a physical or mental impairment or medical condition lasting at least six months that substantially limits a major life activity, which is not the result of a severe mental illness.
   1. Yes, report the number that apply in each domain of disability(ies)
      a. Communication domain separately by each of the following
         (i) Difficulty seeing
         (ii) Difficulty hearing, or having speech understood
         (iii) Other (specify)
      b. Mental domain not including a mental illness (including but not limited to a learning disability, developmental disability, dementia)
      c. Physical/mobility domain
      d. Chronic health condition (including but not limited to chronic pain)
      e. Other (specify)
   2. No
   3. Number of respondents who declined to answer the question

(G) Veteran status,
   1. Yes
   2. No

3. Number of respondents who declined to answer the question

(H) Gender

1. Assigned sex at birth
   a. Male
   b. Female
   c. Number of respondents who declined to answer the question
2. Current gender identity
   a. Male
   b. Female
   c. Transgender
   d. Genderqueer
   e. Questioning or unsure of gender identity
   f. Another gender identity
   g. Number of respondents who declined to answer the question

(5) Any other data the County considers relevant.

(b) For an Innovative Project serving children or youth younger than 18 years of age, the demographic information required under subdivision (a)(4) of this section relating to children or youth younger than 18 years of age shall be collected and reported only to the extent permissible by California Education Code, Family Educational Rights and Privacy Act (FERPA), Health Insurance Portability and Accountability Act of 1996 (HIPAA), California Information Practices Act, and other applicable state and federal privacy laws.

(c) <u>Except for sexual orientation, current gender identity, and veteran status, a county shall collect the demographic information required under subdivision (b)(5) of this section from a minor younger than 12 years of age. Information that cannot be obtained directly from the minor may be obtained from the minor's parent, legal guardian, or other authorized source.</u>

NOTE: Authority cited: Section 5846, Welfare and Institutions Code. Reference: Sections 5830, 5845(d)(6), and 5847, Welfare and Institutions Code.

List of Public Comments Received Within 45-Day Period Included

- Organizations
  - California Health Advocates
  - California Pan-Ethnic Health Network (2)
  - California LGBT Health & Human Services Network, NorCal Mental Health America
  - Muslim American Society
  - Racial Ethnic Mental Health Disparities Coalition (REMHDCO)
  - Young Minds Advocacy
- Individuals
  - Laurel Benhamida
  - Mary Ann Bernard
  - Rebecca Gonzales
  - Pete Lafollette
  - Jorge Wong
- Transcript of September 28th, 2017 Public Hearing

californiahealth+ advocates
ADVANCING THE MISSION OF COMMUNITY HEALTH CENTERS

(916) 503-9130
healthplusadvocates.org
1231 I Street, Suite 400, Sacramento, CA 95814

September 28, 2017

Mental Health Services Oversight and Accountability Commission
Attn: Kayla Landry and Toby Ewing
1325 J Street, Suite 1700
Sacramento, CA 95814

Re: Proposed Amendments to the Prevention and Early Intervention (PEI) and Innovation Regulations

Dear Mrs. Kayla Landry and Mr. Toby Ewing,

On behalf of California's more than 1,200 California community clinics and health centers (CCHCs) and the 6 million patients they serve, CaliforniaHealth+ Advocates (Advocates) thanks you for the opportunity to submit written comment on the draft regulations for Prevention and Early Intervention (PEI) and Innovation programs.

Health centers have a long history of providing prevention and early intervention services to underserved and low-income populations through integrated behavioral health and physical health care. In fact, over 85% of our member health centers have successfully integrated primary and mental health care services in order to treat co-occurring physical and mental health conditions. Health centers treat the 'whole person' while keeping the community-based wellness model front and center, providing culturally relevant services in the languages spoken by patients. 36 percent of health center patients speak a language other than English, and 70% are persons of color with a diverse array of racial and ethnic backgrounds.

For years health centers, some of which have partnered with counties through MHSA, have universally screened primary care patients with behavioral assessments to ensure mental health conditions are captured and addressed early, prior to becoming severe. A report done by UCLA Center for Health Policy in 2015 notes that more than 70% of behavioral health conditions are diagnosed and treated within the primary care setting, underscoring just how critical the role of primary care is in linking patients to care for their behavioral health conditions.[i] CCHCs are the best first responders to divert complications of serious mental illness, and are key partners in meeting the needs of communities of color who are otherwise untouched and underserved by the county system.

CaliforniaHealth+ Advocates is extremely concerned that the amended regulations propose to no longer require counties to collect demographic information on children 12 and under who utilize PEI and Innovation funded programs. This means that counties would no longer have the responsibility to collect and report on the race, ethnicity, age, and the primary household language for children receiving PEI and Innovation-funded services. Given that 51% of PEI funds must be used to provide services for patients 0-25, this proposed amendment would prevent the state from ensuring that counties are serving the intended recipients, particularly the most vulnerable, children.

To achieve high-quality, equitable care delivery within MHSA-funded programs, it is critical to identify health disparities among the population served and work to eliminate such disparities. CCHCs work closely with other health care providers, behavioral health providers, health plans, advocacy groups, and local government, among others, to ensure that health care services are available and accessible for *all* Californians, regardless of race, ethnicity, and primary language. For the OAC to be moving in the opposite direction – to move *away* from a requirement that counties collect this important demographic information – goes against the work that we are doing in the rest of the health care delivery system.

In creating this exemption, the OAC would sacrifice its ability, and the ability of the public, to track and ensure that services are reaching the full spectrum of communities throughout California. Even more alarming is the consideration that counties will no longer need to internally collect this demographic information, creating a potential gap in care for diverse communities – a gap we would not even know about. Ensuring that *all* Californians, regardless of race, ethnicity, or language, are able to equally access services should be a priority for the OAC, the counties, and the MHSA program. **California Health+ Advocates strongly recommends that the OAC continue to require counties to collect important demographic information for *all* recipients of MHSA funded services.**

While Advocates believes the collecting and reporting of demographic data is important for children until 12, there is one data element we do not recommend collecting. Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual communities and allies have expressed concerns in asking children 12 and under to provide their sexual orientation because this information is made available to parents and potentially violates patient rights and protections. **We ask that the OAC exempt all counties from collecting information concerning sexual orientation or gender identity for children 12 and under.**

Finally, we wish to express our sincere interest in being at the table for this and other future conversations regarding the MHSA. If you have any questions please feel free to contact Elizabeth Oseguera at 916-503-9130 or at liz@healthplusadvocates.org.

Respectfully,

Carmela Castellano-Garcia
President and CEO
California Primary Care Association

[i] UCLA Center for Health Policy Research, One-Stop Shopping: Efforts to Integrate Physical and Behavioral Health Care in Five California Community Health Centers, January 2015
http://healthpolicy.ucla.edu/publications/Documents/PDF/2015/integrationbrief-jan2015.pdf

CPEHN
California Pan-Ethnic Health Network

September 28, 2017

Mental Health Services Oversight and Accountability Commission
1325 J Street, Suite 1700
Sacramento, CA 95814

CPEHN Comments RE: Proposed Amendments to Prevention and Early Intervention Regulations

Dear Chair Wooten and Commission:

On behalf of the California Pan-Ethnic Health Network (CPEHN), I am writing in response to the proposed amendments to the Prevention and Early Intervention Regulations. CPEHN is a statewide multicultural advocacy organization that works to improve the health and mental health of communities of color. Our comments specifically concern the newly proposed §3560.010(d), "A county is not required to collect the demographic information required under subdivision (b)(5) of this section from a minor younger than 12 years of age."

Overly Broad Exception:

§3560.010(d) captures all demographic information, including race, ethnicity, primary language, sexual orientation, disability, veteran status, and gender/gender identity. While we would agree that it is illogical to require counties to capture veteran status for children, eliminating the requirement to capture any and all demographic data for children under age 12 is overly broad. From the limited Medi-Cal data available from the Department of Health Care Services, we know that non-White children continue to be underserved by county mental health programs, despite a federal entitlement to services for all children. For example, while White children have a penetration rate of 6.6% (at least one mental health visit), Latino children have a penetration rate of 3.8% and Asian and Pacific Islander children have a penetration rate of 1.6% (Statewide Aggregate Specialty Mental Health Services Performance Dashboard, December 2016, Department of Health Care Services). This kind of demographic data is critical in order to continue to monitor and improve programs.

In addition, we would note that while concerns were raised in the Commission's report regarding 1) conflicts with education and other privacy laws, and 2) capacity issues for small counties, both of these issues are addressed by separate sections of the proposed amendments. The need for the broad exception contained in §3560.010(d) is not clear.

Finally, we understand that the collection of sexual orientation and gender identity data from young children may require further study, development of best practices, and training and technical assistance for providers. This is critical demographic

information since the disparities for the LGBT community cannot be overstated. We would support an amendment to the regulations that provides for an exception to the collection of sexual orientation and veteran status information from children under the age of 12. However, we understand that gender identity information can be captured from most children and encourage the collection of this data.

Population Specific Approaches to Prevention Are Imperative:

Prevention approaches include outreach, stigma reduction, and community education. Cultural competence and humility are crucial to serving all California children with prevention programs. However, without testing and evaluating the efficacy on programs and messages in subpopulations, it will not be possible to understand how to reach communities of color and limited English proficient communities, among others.

Alignment with Other Agencies and Data Systems Is Necessary:

As discussed in the rationale for the proposed amendments, alignment with other agencies and data systems is necessary in order to have useful data from which conclusions regarding impacts and outcomes can be drawn. However, we would note that robust demographic data is available from a number of data sets across state government. The Department of Health Care Services and counties collect demographic data of children enrolled in Medi-Cal through the Medi-Cal Eligibility Data System (MEDS), including race, ethnicity, and language. We would also note that MEDS contains over 20 primary languages, well beyond the threshold languages required in the current regulation. California public school use several different systems and collect demographic data on their students that include race, disability, and English proficiency. This data is publicly reported alongside discipline, academic achievement, and funding information. If the Mental Health Services Oversight and Accountability Commission chooses not to collect this data, even for a specific age range, it will make comparisons with existing data sets impossible and impede our progress toward being able to meet the voter intent of the Proposition, evaluating and reducing negative outcomes like school failure, homelessness, and incarceration.

Thank you for your time and attention to our comments. Should you have any further questions or to direct your response, please contact me at 916-447-1299 or ksavage@cpehn.org.

Sincerely,

K Savage

Kiran Savage-Sangwan

Health Integration Policy Director

CPEHN

CPEHN
California Pan-Ethnic Health Network

September 28, 2017

Mental Health Services Oversight and Accountability Commission
1325 J Street, Suite 1700
Sacramento, CA 95814

CPEHN Comments RE: Proposed Amendments to Innovative Project Regulations

Dear Chair Wooten and Commission:

On behalf of the California Pan-Ethnic Health Network (CPEHN), I am writing in response to the proposed amendments to the Innovative Project Regulations. CPEHN is a statewide multicultural advocacy organization that works to improve the health and mental health of communities of color. Our comments specifically concern the newly proposed §3580.010(c), "A county is not required to collect the demographic information required under subdivision (a)(4) of this section from a minor younger than 12 years of age."

Overly Broad Exception:

§3580.010(c) captures all demographic information, including race, ethnicity, primary language, sexual orientation, disability, veteran status, and gender/gender identity. While we would agree that it is illogical to require counties to capture veteran status for children, eliminating the requirement to capture any and all demographic data for children under age 12 is overly broad. From the limited Medi-Cal data available from the Department of Health Care Services, we know that non-White children continue to be underserved by county mental health programs, despite a federal entitlement to services for all children. For example, while White children have a penetration rate of 6.6% (at least one mental health visit), Latino children have a penetration rate of 3.8% and Asian and Pacific Islander children have a penetration rate of 1.6% (Statewide Aggregate Specialty Mental Health Services Performance Dashboard, December 2016, Department of Health Care Services). This kind of demographic data is critical in order to continue to monitor and improve programs.

In addition, we would note that while concerns were raised in the Commission's report regarding 1) conflicts with education and other privacy laws, and 2) capacity issues for small counties, both of these issues are addressed by separate sections of the proposed amendments. The need for the broad exception contained in §3580.010(c) is not clear.

Finally, we understand that the collection of sexual orientation and gender identity data from young children may require further study, development of best practices, and training and technical assistance for providers. This is critical demographic

information since the disparities for the LGBT community cannot be overstated. We would support an amendment to the regulations that provides for an exception to the collection of sexual orientation and veteran status information from children under the age of 12. However, we understand that gender identity information can be captured from most children and encourage the collection of this data.

Innovative Projects Require Evaluation:

The primary purpose of the Innovation component of the Mental Health Services Act is to explore news ways of doing business, and to introduce potentially more effective methods into the mental health system. Evaluation is necessary to determine whether the innovative project met the stated goals and should be continued, as well as what other lessons can be drawn from the experimental program or application. It is difficult to imagine how innovation could happen for the age range in question, 0 to 12, without understanding how exploratory projects impact specific populations. For example, a project might use technology in a new way to help younger children develop coping and resilience skills. Without evaluate the efficacy of the tool for limited English proficient children as compared to children with English proficiency, we would have incomplete information from which to draw conclusions about the project.

Alignment with Other Agencies and Data Systems Is Necessary:

As discussed in the rationale for the proposed amendments, alignment with other agencies and data systems is necessary in order to have useful data from which conclusions regarding impacts and outcomes can be drawn. However, we would note that robust demographic data is available from a number of data sets across state government. The Department of Health Care Services and counties collect demographic data of children enrolled in Medi-Cal through the Medi-Cal Eligibility Data System (MEDS), including race, ethnicity, and language. We would also note that MEDS contains over 20 primary languages, well beyond the threshold languages required in the current regulation. California public school use several different systems and collect demographic data on their students that include race, disability, and English proficiency. This data is publicly reported alongside discipline, academic achievement, and funding information. If the Mental Health Services Oversight and Accountability Commission chooses not to collect this data, even for a specific age range, it will make comparisons with existing data sets impossible and impede our progress toward being able to meet the voter intent of the Proposition, evaluating and reducing negative outcomes like school failure, homelessness, and incarceration.

Thank you for your time and attention to our comments. Should you have any further questions or to direct your response, please contact me at 916-447-1299 or ksavage@cpehn.org.

Sincerely,

K Savage

Kiran Savage-Sangwan/CPEHN

California LGBT Health & Human Services Network

NorCal Mental Health America

September 28, 2017

Kayla Landry
Mental Health Services Oversight and Accountability Commission
1325 J St., Suite 1700
Sacramento, CA 95814

RE: Proposed Modification to MHSA Prevention and Early Intervention Regulations section 3560.010(d) and Proposed Modification to MHSA Innovative Projects section 3560.010(c)

Dear Kayla Landry and all concerned parties:

The California LGBT Health and Human Services Network and NorCal Mental Health America, co-directors of the MHSOAC LGBTQ Education, Advocacy, and Outreach Project, appreciate the opportunity to comment on the proposed modifications to MHSA Prevention and Early Intervention Regulations and MHSA Innovative Projects Regulations.

We are very pleased required demographic data collection from counties now includes sexual orientation and gender identity, as well as expanded categories for race and ethnicity. We are concerned, however, regarding the addition of the following exclusion:

(d) A county is not required to collect the demographic information required under subdivision (b)(5) of this section from a minor younger than 12 years of age.

We are concerned for the following reasons:

- The gender, race, ethnicity, primary language, and disability of those being served is vital information—including for those who are under the age of 12. This demographic data is crucial to continue to monitor and improve programs funded through MHSA.
- Gender is a concept that is formed very early in childhood. At the very least, most children who are verbal are able to state whether they are a boy or a girl. In addition, transgender children may state as soon as they are verbal that their gender is different than the one they were assigned at birth, even though others may not.
- Supportive parents of transgender/genderqueer children may want the opportunity for their child's current gender identity to be recognized and recorded. Although there currently is no research demonstrating how to ask parents about their child's transgender identity outside of clinical settings managed by researchers or transgender health practitioners, we do support the option for parents to identify their child's gender identity if they so desire.
- How to collect gender identity data in a manner that is developmentally appropriate for children under the age of 12 is a topic that still needs additional study. We recommend the Commission collect sex assigned at birth for youth under 12 using language recommended in the first step of the standard 2-step gender identity measure[1], and to update sexual orientation and gender identity (SOGI) data collection measures as more information becomes available. We are happy to offer technical assistance to the

[1] The Williams Institute, "Best Practices for Asking Questions to Identify Transgender and other Gender Minority Respondents on Population-Based Surveys," September 2014: https://williamsinstitute.law.ucla.edu/wp-content/uploads/geniuss-report-sep-2014.pdf

Commission to further refine the gender identity measures used for children under age 12.

- Public or county concerns about any demographic data question that would conflict with any privacy laws or other regulations will already be covered/protected by the proposed addition of:
  (c) For a program serving children or youth younger than 18 years of age, the demographic information required under subdivision (b)(5) of this section relating to children or youth younger than 18 years of age shall be collected and reported only to the extent permissible by California Education Code, Family Educational Rights and Privacy Act (FERPA), Health Insurance Portability and Accountability Act of 1996 (HIPAA), California Information Practices Act, and other applicable state and federal privacy laws.

Due to the concerns stated above, we recommend the following changes:
(d) A county is not required to collect ~~the~~ sexual orientation, current gender identity, or veteran status demographic information required under subdivision (b)(5) of this section from a minor younger than 12 years of age. All other data, including assigned sex at birth, that cannot be obtained directly from a minor younger than 12 years of age, may be obtained from the minor's parent/guardian or other authorized source.

We understand that many counties find the demographic data gathering challenging. We enthusiastically offer our support to any county who requires technical assistance in the gathering of sexual orientation and gender identity demographic data. Furthermore, we support the use of MHSA funds to study the best ways to collect SOGI data among youth, especially those under 12.

Thank you for providing this opportunity for public comment. If you have any questions or wish to discuss our recommendations further, please contact our project co-directors Poshi Walker pwalker@norcalmha.org and Amanda Wallner awallner@health-access.org.

Sincerely,

Poshi Walker, MSW
LGBTQ Program Director
NorCal Mental Health America

Amanda Wallner
Director, California LGBT Health & Human Services Network
Health Access Foundation

MAS Social Services Foundation
(MAS-SSF)

3820 Auburn Blvd, Suite 83
Sacramento, CA 95821
(916) 486-8626
www.mas-ssf-sac.org
masssfsac@yahoo.com

Dear Ms. Landry,

Greetings on behalf of the Muslim American Society-Social Services Foundation (MAS-SSF) of Sacramento, a private non-profit organization committed to advocating for and providing community-based, culturally, linguistically, spiritually/religiously appropriate services to the diverse Muslim community and others.

MAS-SSF supports the Racial and Ethnic Mental Health Disparities Coalition's (REMHDCO) proposed changes to the PEI and INN regulations. These proposed changes would require counties to collect all the demographic data (originally approved by the MHSOAC in October 2015) of children younger than 12 years of age served except for sexual orientation. Please feel free to contact me regarding this matter.

Regards,

Gulshan Yusufzai
Executive Director
MAS-SSF

Nejla Shifa
Board President
MAS-SSF

REMHDCO
Racial and Ethnic Mental Health Disparities Coalition

September 18, 2017

Mental Health Services Oversight and Accountability Commission
1325 J Street, Suite 1700
Sacramento, CA 95814

Re: Changes to the PEI Regulations

Dear Commissioners,

The Racial and Ethnic Mental Health Disparities Coalition (REMHDCO) would like to commend the Commission and the MHSOAC staff for their extraordinary efforts to develop the regulations for both Prevention and Early Intervention (PEI) and Innovations (INN) components of the Mental Health Services Act. For the most part, it has been a collaborative and open process, with efforts to accommodate the concerns of all government and community stakeholders.

However, REMHDCO must respectfully request that an additional amendment be made to the version of the regulations that were passed by the MHSOAC on July 27, 2017. The new version of the regulations does not require the counties to collect demographic information on any child under 12 years of age for served by either PEI or INN component. **REMHDCO strongly recommends that counties still be required to collect racial and ethnic demographic data, primary language, and gender identity of children under 12 years of age.**

The regulations are attached with the sections highlighted that we want amended, as well as a separate page with proposed changes to the current version of the regulations. With respect to the demographic information related to *sexual orientation*, we will support whatever the position the CA LGBTQ Health Network takes regarding this item. We understand requirements for collection of that information was removed for reasons that do not generally apply to the other

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demographic data.

The mandatory collection of disaggregated demographic data was a priority of REMHDCO and our individual community members throughout the development of the PEI and INN regulations. We faithfully attended the many meetings throughout the state to make sure this issue was addressed. Racial and ethnic communities have long considered PEI and INN programs to provide the best opportunities to serve our individuals and families and reduce mental health disparities for the entire system.

While over 60% of the population of California is non-White, it is known that the proportion non-White youth age 21 years and younger is even higher. REMHDCO believes that it is critical to collect the racial/ethnic demographic data in order to determine whether progress is being made in serving the younger people and their families from our communities.

Please do not hesitate to contact me if you have any questions or we can provide more information. Thank you.

Sincerely,

Beatrice Lee
President

cc: Toby Ewing, Executive Director, MHSOAC
Filomena Yeroshek, Chief Counsel, MHSOAC
Kayla Landry, Staff, MHSOAC

REMHDCO's Proposed Changes to Amended PEI and Innovations Regulations Adopted on July 27, 2017 by the MHSOAC

We offer this alternative language below but are open to other wording that accomplishes our objectives:

- **PEI Regulations** – page 5 of 18

Section 3560.010(d)

(d) A county is not required to collect the demographic information required under subdivision (b)(5)(E) of this section from a minor younger than 12 years of age.

- **Innovations Regulations** – page 4 of 4

Section 3580.010(c)

(c) A county is not required to collect the demographic information required under subdivision (a)(4)(E) of this section from a minor younger than 12 years of age.

What our alternative language does: *This requires to counties to collect all the demographic data (originally approved by the MHSOAC in October 2015) of children younger than 12 years of age served* ***except for sexual orientation***.

REMHDCO believes the all the other demographic data is important to collect in order to determine whether children in racial, ethnic, and cultural communities are being adequately served, and whether progress is being made in reducing disparities. Please note that this does not pertain to large outreach events or "one-touch" encounters in PEI or INN programs.

YOUNG MINDS ADVOCACY

September 25, 2017

Kayla Landry
Mental Health Services Oversight and Accountability Commission
1325 J St., Suite 1700
Sacramento, CA 95814
Kayla.Landry@mhsoac.ca.gov

Re: Comments on the Mental Health Services Oversight and Accountability Commission's (OAC) Proposed Rulemaking

Dear Ms. Landry,

I am writing on behalf of Young Minds Advocacy (YMA) to submit comments on the OAC's Notice of Proposed Rulemaking. YMA, based in San Francisco, is a nonprofit organization focused on ensuring full access to quality mental health care for children and youth across California and the western United States. There are two proposed provisions about which we would like to comment and provide possible solutions, discussed below:

1. **Proposed Amendment to California Code of Regulations Title 9 § 3560.010 (page 3 of proposed regulations):**

"Existing law requires the Annual Prevention and Early Intervention report to include demographic information on individuals served in each Prevention and Early Intervention Program. The proposed new subdivision (c) specifies that for programs that serve children and youth under 18 years of age the demographic information is to be collected and reported only to the extent permitted by federal and state privacy and education laws. The proposed new subdivision (d) specifies that a county is not required to collect demographic information from a minor younger than 12 years of age."

The potential issue YMA notes with this proposed rule is that, while it makes sense to clarify that the demographic information does not need to be collected "*from*" children under 12, YMA believes it is important that counties would still be required to report demographic information *about* children under 12. It is critical that the public has demographic information about children under 12 who have had contact with Prevention and Early Intervention (PEI) services in order for PEI programs to work effectively. Thus, YMA proposes that § 3560.010 include a provision requiring that demographic information about children under 12 be collected from their parents or other legal caretakers to the extent

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permissible under state and federal privacy laws.

2. **Proposed Amendment to California Code of Regulations Title 9 § 3560.010 (page 3 of proposed regulations):**

"Existing law requires the Annual Prevention and Early Intervention report to include demographic information on individuals served in each Prevention and Early Intervention Program. The proposed new subdivision (e) authorizes a county with a population under 100,000 according to the most recent projection by the California State Department of Finance to report the demographic information for the county's entire Prevention and Early Intervention Component instead of for each Prevention and Early Intervention Program or Strategy."

While YMA understands that small counties might experience challenges with respect to resources and reporting information on their PEI programs, we are concerned about the consequences that could result from this proposed rule. According to the November 2016 OAC report referenced in the proposed rules, there are 23 California counties that have a population under 100,000, meaning that 23 counties would only need to submit demographic information on their entire PEI "Component," rather than demographic information about each of the five individual required PEI programs that comprise each county's PEI "Component." The remaining counties *would* need to submit demographic information about each of the five distinct PEI programs.

This inconsistency in reporting requirements based on county size would make it challenging for the public to compare data on counties or regions to each other and to measure the effectiveness of each individual PEI program or service type for nearly half of California's counties. Thus, YMA recommends changing this proposed rule such that the counties would be required to collect and report the data, but the State would limit public release of the data to redacted or otherwise aggregated or amended reports to protect individual privacy. In this way, the State would have the ability to evaluate programs while also protecting confidentiality.

YMA thanks you for considering our comments, and we welcome further discussion. If you have any questions, please feel free to contact me at nisha@ymadvocacy.org or (415) 466-2991, ext. 702.

Sincerely,

/s/ Nisha Ajmani

Nisha Ajmani
Staff Attorney & Policy Advocate

Landry, Kayla@MHSOAC

From: Laurel Benhamida <laurelbenhamida@yahoo.com>
Sent: Thursday, September 28, 2017 12:59 AM
To: Landry, Kayla@MHSOAC
Subject: Support for REMHDCO's proposed changes to regulations

Dear Ms. Landry,

As a member of the REMHDCO Steering Committee I wish to express my strongest support for REMHDCO's proposed changes to the PEI and INN regulations. These proposed changes would require counties to collect all the demographic data (originally approvedyou by the MHSOAC in October 2015) of children younger than 12 years of age served except for sexual orientation.

California is home to over 5 million children under the age of twelve.

Counties have to collect data on this age group so that policymakers and advocates can do their work in planning quality services for those children in need of care.

Please feel free to contact me regarding this matter.

Regards,
Laurel Benhamida Ph.D.
Member,
REMHDCO Steering Committee.

COMMENTS OF MARY ANN BERNARD, Esq. ON PROPOSED AMENDMENTS TO THE PREVENTION/EARLY INTERVENTION REGULATIONS OF THE MENTAL HEALTH SERVICES ACT OVERSIGHT AND ACCOUNTABILITY COMMISSION
September 20, 2017

I am a resident of California and a retired licensed attorney. By virtue of 18+ years' experience as an Assistant Attorney General in another state where (among other things) I represented state mental hospitals and the Department of Human Services, working with counties, I have considerable experience with laws, regulations and policies relating to the severely mentally ill. I assisted Schiff, Hardin and MentalIllnessPolicy.org ("MIPO") with comments on the first round of PEI regulations, but these comments are solely on my own behalf. This is not because MIPO disagrees with them, but rather because MIPO is now preoccupied with critical issues involving the severely mentally ill at the national level, and has no time to devote to reviewing local California issues.

My concern is with proposed Section 3705, which I believe to be contrary to law. The Prevention and Early Intervention provisions in the Mental Health Services Act contain several mandatory provisions, *ie,* using the term, "shall." The Commission's proposals essentially change mandatory "shall" to permissive "may," which the Commission has no power to do.

The legitimate concerns of small counties can, however, be met within the statutory framework, by combining or eliminating "programs. " Related recordkeeping requirements would need to be amended accordingly. I recommend changes as follows:

1. While "access and linkeage" is mandatory, [1] it should never have been made a separate program to begin with. Rather, there should be access and linkeage within and between every program. That, after all, is what "access and linkeage" is. Small counties can accommodate this with policies ensuring that their personnel communicate with each other and with outside resources, like schools and the police. This is absolutely necessary to proper functioning of programs and relatively easy in small counties. They simply need to be given broader discretion in how to accomplish this goal.

2. Anti-stigma/discrimination programs are similarly mandatory,[2] but the huge expenditures in this area have been utterly wasted. Large counties shouldn't be doing this, and small counties cannot afford it. There is considerable data, available from Dr. E. Fuller Torrey at the Treatment Advocacy Center, showing that the best way to reduce stigma and discrimination is to help the sickest people, who are the ones who *cause* stigma and discrimination. Our state is now littered

[1] WIC Section 5840(b)provides, in relevant part: (b) The program *shall* include the following components:. . . . (2)Access and linkage to medically necessary care provided by county mental health programs for children with severe mental illness, as defined in Section 5600.3 , and for adults and seniors with severe mental illness, as defined in Section 5600.3 , as early in the onset of these conditions as practicable.
[2] *Id.* At Section 5840(b)(3), which provides : (b) The program *shall* include the following components:. . . . (3) Reduction in stigma associated with either being diagnosed with a mental illness or seeking mental health services. (4) Reduction in discrimination against people with mental illness.

with bulletin boards and pamphlets that feature well-dressed, smiling individuals who say, essentially, "There is nothing wrong with *us.*" While true, and perhaps a comfort to the "worried well" who now absorb obscene amounts of mental "health" money, this message offends most advocates for the most severely ill, whom it essentially ignores. The public is worried about the dirty, disheveled people screaming at strangers on our streets, not about the smiling people on those billboards. Small counties—indeed ALL counties—should therefore be permitted to fight stigma and discrimination by helping the sickest people, and doing press releases about the positive results of those efforts. This, again, costs virtually nothing, and will do far more good than current, wasteful programs.

3. Outreach to help people recognize the early signs of mental illness is also mandatory[3] and best accomplished through integrating outreach with the mandatory early intervention program, discussed below. In other words, 3705(a)(1) and (2) are easily combined, for large counties as well as small. The number of groups to whom "outreach" is mandated by 3715(c) is burdensome, stupid and unreasonable, even for large counties. It could certainly be pared down for smaller ones, by letting them choose what is meaningful in their specific settings. Eliminating the requirement entirely, however, is not legally permissible.

4. The "suicide prevention" program permitted by 3705(b)(1) is nowhere required by statute and has been a tremendous waste of millions, perhaps billions, of dollars. Rather than permitting small counties to run such a program, they should be required to preserve their resources for something mandated by law, and more sensible.

   There is evidence that the MHSA millions spent on suicide prevention—which should in any event have been focused on the severely mentally ill, and never has been—have done absolutely no good. Despite these expenditures, suicides continue to increase in California, as well as nationally.[4] Dr. Thomas Insel, former head of NIMH, has suggested that more research is needed to make suicide prevention programs work.[5] Thus it is simply not necessary, or even advisable, for every county to have a suicide prevention program. There are trained professionals running suicide hotlines nationally, accessible through 800 numbers, which is far preferable to have farmers' wives in small counties who are not properly trained dealing with such calls themselves.

   The best way to help the severely mentally ill avoid suicide-- and the only legitimate use for MHSA funds on suicide prevention-- is to incorporate suicide prevention in individual treatment plans, as needed. (The severely mentally ill, including not only the mood-disordered but also schizophrenics, attempt and commit suicide at rates far greater than the rates in the general

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[3] *Id.* At 5840(b)(1), which provides, "The program shall include the following components:. . . . 1) Outreach to families, employers, primary care health care providers, and others to recognize the early signs of potentially severe and disabling mental illnesses.

[4] See https://www.americashealthrankings.org/explore/2015-annual-report/measure/Suicide/state/CA.

[5] https://www.nimh.nih.gov/about/directors/thomas-insel/blog/2015/targeting-suicide.shtml

population. However, not all SMI's have a history/diagnosis of suicidality.) This all counties should be doing already.

5. Similarly, the "prevention" program, at least as defined in the existing regulations, has no basis in the statute and has been a scandalous waste of money. MHSOAC was thus correct to make it discretionary for small counties in existing regs. At this point, given the lack of statutory basis[6] and the long history of waste and scandal around this program,[7] small counties should not even be permitted to have a "prevention" program, as defined in existing regulations, with this exception: as further demonstrated at nn. 9-10 and below, *relapse prevention programs for individuals with severe mental illness ARE mandatory, have always been mandatory, and have never been required by MHSOAC despite this fact.*[8] The Office of Administrative Law should now take steps to make relapse prevention programs for the severely mentally ill mandatory for *all* counties, as required by law. Not only small counties, but all counties should be required to have such a program, whether it is called "prevention" or "early intervention. "[9] Because it is both.

This brings me to the essential PEI program, which *all* counties should be required to incorporate because it is the are the heart of the statute: Small counties are now required and should continue to be required to have an early intervention program, including a relapse prevention program, both of which are mandatory under MHSA.[10] Relapse prevention, and early intervention when relapses aren't prevented, are critical for the stability and survival of severely mentally ill individuals. Current early intervention regulations define the early intervention program as ". . . .treatment and other services and interventions to address and promote recovery and related functional outcomes for a mental illness early in its emergence, including the applicable negative outcomes listed in Welfare and Institutions Code Section 5840, subdivision (d) that result from untreated mental illness. . . . (e) Early Intervention program may include efforts to prevent relapse in an individual with early onset of a mental illness."

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[6] See MIPO comments to the existing PEI regulations dated July 16 and September 26, 2014 and part of the rulemaking record of the initial regulatory process.

[7] See MIPO comments to the existing PEI regulations, comment No. 1, dated June 27, 2014. See also, MentalIllnessPolicy.org, "California's Mental Health Service Act A Ten Year $10 Billion Bait and Switch An investigation of Proposition 63 by Mental Illness Policy Org and Individual Californians," https://mentalillnesspolicy.org/states/california/mhsa/mhsa_prop63_baitswitchsummary.html . (You can download the full report at this address.) *See also,* California Little Hoover Commission, "Promises Still to Keep: A Decade of the Mental Health Services Act" (No. 225, Jan. 2015) http://file.lacounty.gov/SDSInter/dmh/224072_LittleHooverReportonProp63.pdf, and their followup report," Promises Still to Keep: A Second Look at the Mental Health Services Act," Report #233, September 2016 found at https://mentalillnesspolicy.org/states/california/mhsa/little-hoover-commission-finds-massive-problems-mhsa-program-mhsoac-oversight.html. See Also, o Report No 2013-122 of the California State Auditor, "The State's Oversight Has Provided Little Assurance of the Act's Effectiveness, and Some Counties Can Improve Measurement of Their Program Performance," summarized at https://www.auditor.ca.gov/reports/summary/2012-122, full report at https://mentalillnesspolicy.org/states/california/mhsa/mhsa-state-auditor-report-pdf.html.

[8] See nn. 9 and 10.

[9] Unfortunately, and contrary to statute, relapse prevention was made discretionary in both the existing "prevention" and the existing "early intervention" regulations. Section 3720 subsection(d) provides, "Prevention program services *may* include relapse prevention for individuals in recovery from a serious mental illness." Similarly, Section 3710 (e) provides, "Early Intervention program may include efforts to prevent relapse in an individual with early onset of a mental illness."

[10] WIC Section 5840(c) provides, "The program *shall* include mental health services similar to those provided under other programs effective in *preventing mental illnesses from becoming severe*, and *shall also include* components similar to programs that have been successful in *reducing the duration of untreated severe mental illnesses* and assisting people in *quickly re*gaining productive lives.'

Section 3710(b) and (e). The use of "may" in 3710(e) should be changed to "shall," because the statute makes such programs mandatory, whether or not relapse occurs soon after onset, or far later in a severely mentally ill person's lifetime, see n. 10.

In sum, the Office of Administrative Law should take this opportunity to require MHSOAC to make relapse prevention programs for *all* severely mentally ill individuals mandatory for *all* counties, as required by law.

Landry, Kayla@MHSOAC

From: Rebecca Gonzales <rgonzales@naswca.org>
Sent: Wednesday, September 27, 2017 4:39 PM
To: Landry, Kayla@MHSOAC
Cc: christinashea@ramsinc.org; Stacie Hiramoto
Subject: REMHDCO Proposed changes to the regulations

Dear Ms. Landry,

I am the Director of Government Relations for the National Association of Social Workers, California Chapter which is a professional organization for social workers with a degree from an accredited school of social work. We support the Racial and Ethnic Mental Health Disparities Coalition's (REMHDCO) proposed changes to the PEI and INN regulations. These proposed changes would require counties to collect all the demographic data (originally approved by the MHSOAC in October 2015) of children younger than 12 years of age served except for sexual orientation. We feel that this data is crucial in order to develop programs that will best serve different racial and ethnic communities. Thank you and please let me know if you have any questions.

--

Rebecca Gonzales
Director of Government Relations and Political Affairs
National Association of Social Workers, California Chapter
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www.naswca.org

Landry, Kayla@MHSOAC

From: pete lafollette <plafollette@hotmail.com>
Sent: Thursday, August 17, 2017 12:03 PM
To: Landry, Kayla@MHSOAC
Subject: Prevention and Early Intervention Regs

Prevention and Early Intervention: I would support keeping these contracts as originally designed for MHSA. With the increasing and frequent school shootings, is is vital that mental ilness is recognized and treated at ealy stages and not as retroactive disease after a catastrophic incident. Society also needs to be spared the huge expense of non-recovery.

Part of meaningful input into decisions is education. The MHSA design was legislated to have MH recovery model working along side and augmenting medical treatment which continues to be given short shrift and failing outcome, and needs to be provided the same emphasis and classification as CA HCS and federal reform trends towards prevention and wellness along with the resources and funding to make this a practical reality given the public tax expense of non-recovery- disability, substance abuse, rehabilitation, incareration hospitalization, institutionalization, long list of atrophy. I suggest broader scope of purpose.
Stakeholder Suggestions:

Those elected at the county and state level will not be the ones to solve the issue without citizen watchdogs who have a plan with an expectation for results and nothing less. Where are all the families and clients??? Do they not realize that tax dollars are disappearing without results? Education is key. I find it maddening that people with mental illnesses are not taught to work at their mental health...exercise, relationship/communication skills are not taught or that good nutrition is not pushed or even part of the equation between client and doctor. Pills are pushed and the U.S. spends more money on medications than any other country in the world and we are no healthier for it. Money doesn't fix problems. Educating people with the truth to get to the root of the problem fixes problems.

Pete, the vital element you didn't mention is we must the current world we live in of segregated medical and mental health care. Once this segregation is ended we'll have truly integrated mental health into the medical setting, and medical care
into the specialty mental health setting for severe BH patients who die 25 yrs earlier than usual.

We have had for past 30 years a system where behavioral healthcare is totally separate, in both services delivery and provider payment, from the medical setting. This while 80%, yes, 80% of patients with BH conditions go to the medical sector for care. Some with SMI. People will simply not go to BH professionals in the
specialty BH setting where all the BH practitioners are and where they're paid. BH professionals don't get paid in medical
setting now because of managed behavioral health carve-out system delivering BH separately.

So we have this absurd system where 80% of our BH patients are in one setting (medical). and 90% of BH providers who could help them,
are in another (BH). A total mismatch of patients and providers! And we wonder why people aren't getting MH care!!

We must change the status quo in how mental health care is delivered and paid for. This means ending managed BH
carveouts, and integrating MH into medical sector and v.v. This is beginning to happen. Three models of integration
have developed: cross-referral which doesn't work b/c patients won't go to BH referrals; bi-directional model also doesn't
work b/c BH providers can't get paid as it still maintains two discrete non-communicating medical and BH sectors;
and full integration model, what NHMH is working towards.

If you'd like more info, lmk and am happy to share. Or visit our website, www.nhmh.org.

No Health Without Mental Health Home Page - NHMH

www.nhmh.org

There is widespread agreement among medical and behavioral health professionals, health policy makers and the broad public, that integration of effective behavioral ...

True full integration is the direction mental health care is inexorably moving towards. And about time!

Florence

Florence C. Fee., J.D., M.A.
Executive Director
NHMH - No Health without Mental Health

On Fri, Nov 6, 2015 at 9:40 AM, pete lafollette <plafollette@hotmail.com> wrote:

MSOAC- body language subtleties, groans when call office, toby ewing reaction when mtg 4 first time...

Other issue, if you remember our Spring phone conversation where you were touching upon various organizational change modules, if we can have another sometime over summer to flush out your points- I see it as emerging models having broad purpose...

-mechanism/check and balance/regroup organization/demonstrated outcome/redirection/ how reacting to bad reviews/ add up stats/educating health and mental health equity/note at office/state comtrollers office/mh expenditure report.

Stakeholder Suggestions:

Those elected at the county and state level will not be the ones to solve the issue without citizen watchdogs who have a plan with an expectation for results and nothing less. Where are all the families and clients??? Do they not realize that tax dollars are disappearing without results? Education is key. I find it maddening that people with mental illnesses are not taught to work at their mental health...exercise, relationship/communication skills are not taught or that good nutrition is not pushed or even part of the equation between client and doctor. Pills are pushed and the U.S. spends more money on medications than any other country in the world and we are no healthier for it. Money doesn't fix problems. Educating people with the truth to get to the root of the problem fixes problems.

I love this kind of opportunity for real collaboration. among those who can really make things better...professionals and clients on the same page.

There is power in solidarity of purpose and healing in the ability for folks to get together and share problem solving successes and help each other getting through the tough times.

Pete, the vital element you didn't mention is we must the current world we live in of segregated medical and mental health care. Once this segregation is ended we'll have truly integrated mental health into the medical setting, and medical care
into the specialty mental health setting for severe BH patients who die 25 yrs earlier than usual.

We have had for past 30 years a system where behavioral healthcare is totally separate, in both services delivery and provider payment, from the medical setting. This while 80%, yes, 80% of patients with BH conditions go to the medical sector for care. Some with SMI. People will simply not go to BH professionals in the
specialty BH setting where all the BH practitioners are and where they're paid. BH professionals don't get paid in medical
setting now because of managed behavioral health carve-out system delivering BH separately.

So we have this absurd system where 80% of our BH patients are in one setting (medical). and 90% of BH providers who could help them,

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carveouts, and integrating MH into medical sector and v.v. This is beginning to happen. Three models of integration
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work b/c BH providers can't get paid as it still maintains two discrete non-communicating medical and BH sectors;
and full integration model, what NHMH is working towards.

If you'd like more info, lmk and am happy to share. Or visit our website, www.nhmh.org.
True full integration is the direction mental health care is inexorably moving towards. And about time!

Florence

Florence C. Fee., J.D., M.A.
Executive Director
NHMH - No Health without Mental Health
San Francisco, CA - Arlington, VA

Thanks Peter, I agree it is vital that mental ilness is recognized and treated at ealy stages when treatment is more effective, saving both lives and dollars.

--Linda

To: Monosco, Karen; IRMellick@aol.com; loummatt@aol.com; NancyBSomis@aol.com; saraohringer@aol.com; suefuss@aol.com; vtnami@aol.com; gmware@att.net; coonsales@casapacifica.org; gkoenig@casapacifica.org; laaron@casapacifica.org; sperez@casapacifica.org; thurstonrc@dock.net; miguel.noriega@edwardjones.com; aguirre326@gmail.com; Dr Faye Hall; marktcarp@gmail.com; davidd51@hotmail.com; kaloramaCo@hotmail.com; kvnrt4mjnwy@hotmail.com; Robert.L.Dreamer@KP.org; adamob@live.com; latashataylor@mac.com; aolea@pacificclinics.org; jegomez@pacificclinics.org; patricia.ebner@recoveryinnovations.org; jmharris007@roadrunner.com; mmonica2@roadrunner.com; prubio81583@roadrunner.com; avengeme@rock.com; jsr755@sbcglobal.net; cporter@turningpointfoundation.org; creynolds@turningpointfoundation.org; ddeutsch@turningpointfoundation.org; Pyper, Amanda; Enriquez, Ana; Riddle, Angela; Catapusan, Anita; Flores, Anna;

Quintero, Barbara; Spring, Becky; Montiel, Bertha; Jacobsen, Candace; Hughes, Carol; Woods, Celia; Fox, Cheryl; Kelly, Colleen; Ford, Cris; Hicks, Daniel; David Hollinger; O'Connell, Dennis; Olivas, Dina; Augustine, Elaine; Aguila, Gabriela; McFarlane, Gil; Mercy, Helena; Villanueva, Henry; Scott, Ingrid; Kaplan, Janet; Miller, Jason; Dougherty, Jennifer; Putt, Jennifer; Romero, Jesus; StLouis, JoAnn; John Buettgen; Schipper, John; Roberts, Julie; Mulford, Kathy; Schuette, KerryAnn; Cox, Kevin; Prendergast, Kimberly; Kwock, Lennie; Gertson, Linda; Goff, Linda; Parks, Linda; Ranni, Lucianne; Tovar, Luis; Allport, Mary; Roy, Meloney; Leafman, Meredyth; Ashur, Ophra; Fisher, Pam; Zarate, Patrick; Yoshida, Patti; Pringle, Pete; Danish, Rajima; Ortiz, Raymond; Evans, Rebecca; Korb, Rebecca; McCloud, Rebecca; LaPerriere, Richard; Gonzalez, Robert; Mendoza, Robert; Boscarelli, Robin; Manzo, Salvador; Nelles, Sandra; Zanolini, Shanna; Sherry, Steve; Kelly, Susan; Luckey, Susan; Davis-Hess, Suzanne; Cole, Teresa; Cochran-Otis, Tia; filbmalmft@verizon.net; mholmboe@verizon.net; adsgracie@yahoo.com; cat416elf2000@yahoo.com; HGConstruction@yahoo.com; kmstuartmontemayor@yahoo.com; larry; lizziewarren04@yahoo.com; lwarner.ma@yahoo.com; ncstuartcls@yahoo.com; pastelwalker@yahoo.com; rexbelisle@yahoo.com; stuartk000@yahoo.com; karyn bates
Cc: Grist, Diane; Pham, Edith; Gloria McCoy; Evans, Heather; Anilao, Irma; Socorro Mauricio; Bucy, Victoria
Subject: Early Intervention RE School Shootings

- Are voter-approved and paid monies for through the Mental Health Services Act (Prop. 63) reaching targets?
- Transform California's mental health services approach by uniting California's diverse communities to embrace mental wellness and delivering the tools individuals need before they reach the crisis point.
- Provide an up-front investment that will pay off with sustained cost reductions in health, social services, education and criminal justice. Without proactive Recovery modelled progress, the hosptaiization, incarceration and institutionalization expense being spoke of will eliminate public tax dollars and MHSA from the state budget.

And to the law enforcement community so they can understand how their police officers, county sheriff Deputies and DAs became mental health providers while county mental health directors sit on the side lines passing out billions for car washes and those outrageous TV commercials . They should know what realignment did for the severely mentally ill and join us in protest in Sacramento.

Prevention and Early Intervention: I would support keeping these contracts as originally designed for MHSA. With the increasing and frequent school shootings, is is vital that mental ilness is recognized and treated at ealy stages and not as retroactive disease after a catastrophic incident. Society also needs to be spared the huge expense of non-recovery.

To: karen.monosco@ventura.org; irmellick@aol.com; loummatt@aol.com; nancybsomis@aol.com; saraohringer@aol.com; suefuss@aol.com; vtnami@aol.com; gmware@att.net; coonsales@casapacifica.org; gkoenig@casapacifica.org; laaron@casapacifica.org; sperez@casapacifica.org; thurstonrc@dock.net; miguel.noriega@edwardjones.com; aguirre326@gmail.com; dr.faye.hall@gmail.com; marktcarp@gmail.com; davidd51@hotmail.com; kaloramaco@hotmail.com; kvnrt4mjnwy@hotmail.com; robert.l.dreamer@kp.org; adamob@live.com; latashataylor@mac.com; aolea@pacificclinics.org; jegomez@pacificclinics.org; patricia.ebner@recoveryinnovations.org; jmharris007@roadrunner.com; mmonica2@roadrunner.com; prubio81583@roadrunner.com; avengeme@rock.com; jsr755@sbcglobal.net; cporter@turningpointfoundation.org; creynolds@turningpointfoundation.org; ddeutsch@turningpointfoundation.org; amanda.pyper@ventura.org; ana.enriquez@ventura.org; angela.riddle@ventura.org; anita.catapusan@ventura.org; anna.flores@ventura.org; barbara.quintero@ventura.org; becky.spring@ventura.org; bertha.montiel@ventura.org; candace.jacobsen@ventura.org; carol.hughes@ventura.org; celia.woods@ventura.org; cheryl.fox@ventura.org; colleen.kelly@ventura.org; cris.ford@ventura.org; daniel.hicks@ventura.org; david.hollinger@ventura.org; dennis.o'connell@ventura.org; dina.olivas@ventura.org; elaine.augustine@ventura.org; gabriela.aguila@ventura.org; gil.mcfarlane@ventura.org; helena.mercy@ventura.org; henry.villanueva@ventura.org; ingrid.scott@ventura.org; janet.kaplan@ventura.org; jason.miller@ventura.org; jennifer.dougherty@ventura.org; jennifer.putt@ventura.org; jesus.romero@ventura.org; joann.stlouis@ventura.org; john.buettgen@ventura.org; john.schipper@ventura.org; julie.roberts@ventura.org; kathy.mulford@ventura.org; kerryann.schuette@ventura.org; kevin.cox@ventura.org; kimberly.prendergast@ventura.org; lennie.kwock@ventura.org; linda.gertson@ventura.org; linda.goff@ventura.org; linda.parks@ventura.org; lucianne.ranni@ventura.org; luis.tovar@ventura.org; mary.allport@ventura.org; meloney.roy@ventura.org; meredyth.leafman@ventura.org; ophra.ashur@ventura.org; pam.fisher@ventura.org; patrick.zarate@ventura.org; patti.yoshida@ventura.org; pete.pringle@ventura.org; rajima.danish@ventura.org; ray.ortiz@ventura.org; rebecca.evans@ventura.org; rebecca.korb@ventura.org; rebecca.mccloud@ventura.org; richard.laperriere@ventura.org; robert.gonzalez@ventura.org; robert.mendoza@ventura.org; robin.boscarelli@ventura.org;

salvador.manzo@ventura.org; sandra.nelles@ventura.org; shanna.zanolini@ventura.org; steve.sherry@ventura.org; susan.kelly@ventura.org; susan.luckey@ventura.org; suzanne.davis-hess@ventura.org; teresa.cole@ventura.org; tia.cochran-otis@ventura.org; filbmalmft@verizon.net; mholmboe@verizon.net; adsgracie@yahoo.com; cat416elf2000@yahoo.com; hgconstruction@yahoo.com; kmstuartmontemayor@yahoo.com; hicks72@yahoo.com; lizziewarren04@yahoo.com; lwarner.ma@yahoo.com; ncstuartcls@yahoo.com; pastelwalker@yahoo.com; rexbelisle@yahoo.com; stuartk000@yahoo.com; tapdancer805@yahoo.com
CC: diane.grist@ventura.org; edith.pham@ventura.org; gloria.mccoy@ventura.org; heather.evans@ventura.org; irma.anilao@ventura.org; socorro.mauricio@ventura.org; victoria.bucy@ventura.org
Subject: The Public Eye/State MHSA News on Audit
Date: Tue, 27 Aug 2013 04:19:16 +0000

State Did Crummy Job of Tracking $7.4 Billion in Mental Health Aid

Back to News

Eight years after voters approved billions of dollars in new funding for mental health by passing Proposition 63, the state commission charged with making sure the money was properly spent finally adopted an evaluation plan in March.

Last week, the California State Auditor said that might have been a bit too long a delay in tracking the effects of the 2004 Mental Health Services Act and the $7.4 billion collected through its 1% tax on incomes over $1 million.

The report by State Auditor Elaine Howle said California's Department of Mental Health and the Mental Health Services Oversight and Accountability Commission provided "little oversight" of the implementation, or effectiveness, of 1,500 programs funded by the tax and run by counties. The state also failed to give the counties explicit direction in how to measure program performance.

"Functionally, it appears Mental Health treated the agreement as simply a means of providing MHSA funding to counties," the report said. The auditor studied four counties—Los Angeles, Sacramento, Santa Clara and San Bernardino—and found they all used different approaches to doling out the money.

The auditor took note that the range of programs, many innovative in nature, drew media attention and raised questions about whether funding yoga classes, acupuncture treatments, anti-bullying programs and the like was a good idea while more traditional mental health care was being eviscerated by a decade of brutal budget cuts.

That's why it was essential to measure the efficacy of programs in a way that could be independently checked. This is not to say the counties weren't reviewing the quality of their programs. The auditor said they were. They just weren't doing it using required methods that yielded trackable results.

Although the auditor felt the state failed at establishing accountability, she found the counties did comply with regulations governing program development and inclusion of various community stakeholders in the process.

-Ken Broder

To: IRMellick@aol.com; loummatt@aol.com; NancyBSomis@aol.com; saraohringer@aol.com; suefuss@aol.com; vtnami@aol.com; gmware@att.net; coonsales@casapacifica.org; gkoenig@casapacifica.org; laaron@casapacifica.org; sperez@casapacifica.org; thurstonrc@dock.net; miguel.noriega@edwardjones.com; aguirre326@gmail.com; dr.faye.hall@gmail.com; marktcarp@gmail.com; davidd51@hotmail.com; kaloramaCo@hotmail.com; kvnrt4mjnwy@hotmail.com; plafollette@hotmail.com; Robert.L.Dreamer@KP.org; adamob@live.com; latashataylor@mac.com; aolea@pacificclinics.org; jegomez@pacificclinics.org; patricia.ebner@recoveryinnovations.org; jmharris007@roadrunner.com; mmonica2@roadrunner.com; prubio81583@roadrunner.com; avengeme@rock.com; jsr755@sbcglobal.net; cporter@turningpointfoundation.org; creynolds@turningpointfoundation.org; ddeutsch@turningpointfoundation.org; Amanda.Pyper@ventura.org; Ana.Enriquez@ventura.org; Angela.Riddle@ventura.org; Anita.Catapusan@ventura.org; Anna.Flores@ventura.org; Barbara.Quintero@ventura.org; Becky.Spring@ventura.org; Bertha.Montiel@ventura.org; Candace.Jacobsen@ventura.org; Carol.Hughes@ventura.org; Celia.Woods@ventura.org; Cheryl.Fox@ventura.org; Colleen.Kelly@ventura.org; Cris.Ford@ventura.org; Daniel.Hicks@ventura.org; David.Hollinger@ventura.org; Dennis.O'Connell@ventura.org; Dina.Olivas@ventura.org; Elaine.Augustine@ventura.org; Gabriela.Aguila@ventura.org; Gil.McFarlane@ventura.org; Helena.Mercy@ventura.org; Henry.Villanueva@ventura.org; Ingrid.Scott@ventura.org; Janet.Kaplan@ventura.org; Jason.Miller@ventura.org; Jennifer.Dougherty@ventura.org; Jennifer.Putt@ventura.org; Jesus.Romero@ventura.org; JoAnn.StLouis@ventura.org; John.Buettgen@ventura.org; John.Schipper@ventura.org; Julie.Roberts@ventura.org; Kathy.Mulford@ventura.org; KerryAnn.Schuette@ventura.org; Kevin.Cox@ventura.org; Kimberly.Prendergast@ventura.org; Lennie.Kwock@ventura.org; Linda.Gertson@ventura.org; Linda.Goff@ventura.org; Linda.Parks@ventura.org; Lucianne.Ranni@ventura.org; Luis.Tovar@ventura.org; Mary.Allport@ventura.org; Meloney.Roy@ventura.org; Meredyth.Leafman@ventura.org; Ophra.Ashur@ventura.org; Pam.Fisher@ventura.org; Patrick.Zarate@ventura.org; Patti.Yoshida@ventura.org; Pete.Pringle@ventura.org; Rajima.Danish@ventura.org; Ray.Ortiz@ventura.org; Rebecca.Evans@ventura.org; Rebecca.Korb@ventura.org; Rebecca.McCloud@ventura.org; Richard.LaPerriere@ventura.org; Robert.Gonzalez@ventura.org; Robert.Mendoza@ventura.org; Robin.Boscarelli@ventura.org; Salvador.Manzo@ventura.org; Sandra.Nelles@ventura.org; Shanna.Zanolini@ventura.org; Steve.Sherry@ventura.org; Susan.Kelly@ventura.org; Susan.Luckey@ventura.org; Suzanne.Davis-Hess@ventura.org; Teresa.Cole@ventura.org; Tia.Cochran-Otis@ventura.org; filbmalmft@verizon.net; mholmboe@verizon.net; adsgracie@yahoo.com; cat416elf2000@yahoo.com; HGConstruction@yahoo.com; kmstuartmontemayor@yahoo.com; larry hicks72@yahoo.com; lizziewarren04@yahoo.com; lwarner.ma@yahoo.com; ncstuartcls@yahoo.com; pastelwalker@yahoo.com; rexbelisle@yahoo.com; stuartk000@yahoo.com; tapdancer805@yahoo.com
CC: Diane.Grist@ventura.org; Edith.Pham@ventura.org; Gloria.McCoy@ventura.org; Heather.Evans@ventura.org; Irma.Anilao@ventura.org; Socorro.Mauricio@ventura.org; Victoria.Bucy@ventura.org
Subject: Quality Improvement Committee (QIC) 5-17-11

The agenda has been revised.

Karen Monosco
Ventura County Behavioral Health
Quality Assurance
5740 Ralston #110

Ventura, CA
L # 4095
Phone: 805 289-3259
Fax: 805 339-2505

Landry, Kayla@MHSOAC

From: pete lafollette <plafollette@hotmail.com>
Sent: Thursday, August 17, 2017 12:09 PM
To: Landry, Kayla@MHSOAC
Subject: MHSOAC Rewriting PEI Regulations

The following pertains to the Office if Administrative Law's negative ruling to past proposed MHSOAC Rewriting PEI Regulations.

Further PEI Draft Regulations Response: The comments on PEI Reg proposals were submitted (twice) by a group,
This is an action item at (then) last week's MHSOAC Commission meeting.early in 2014. Since the phone lines are not open during the
MHSOAC Commission meetings, there is no way to incorporate public comments into the proceedings.
The rewriting of original PEI language represents co-opting of the original MHSA Innitative as
well as repeated lack of stakeholder inclusion, process from OAC Commission on policy decisions.
And my stats here are from then-recent (2014) Legislature Analysts

The MHSOAC currently is changing the contract language of Prevention Early Intervention and Innovations which moves treatment money away from Severely Mentally ill. This shifts MHSA resource responsibility to those outside agencies- hospital, jail, rehab, institution which is retroactive response and a HUGE revenue drain.

You can expect some (more) very bad MHSOAC publicity if that happens.

The changing of PEI regulation language away from recovery based practice, is leading to MHSOAC undoing of the requirements of original MHSA intent of law. I do not wish this process to happen without Prop 63 Stakeholders having someone stand up for them and shed light on this course that MHSOAC has taken. A Community Partners letter signed by a coalition of mental health providers recommended against changing of the language. Comments on PEI Reg proposals were submitted (twice) by the group, early in 2014. There was no regulatory process, or inadequate-evidenced by that drafted, signed letter. The rewriting of original PEI language represents co-opting of the original MHSA Innitative as well as repeated lack of stakeholder inclusion, process, from OAC Commission on policy decisions. Google:

New Regs proposed (8/14) to drive MHSA funds away from people ...

My history with the Mental Health Oversight and Accountability Commission (MHSOAC) goes back

to 2012 where I sat on the Services Committee for two years. My experience with then culture of OAC was they were doing me a favor by letting me attend. At the final term meeting, the majority of the committee members were requesting linkage to other OAC committees and outcomes, better access to the OAC Commission, more established and improved continuity between all committees, open lines of communications, and more collaborative less defensive process and more inclusion at all times.
These policies continues the status quo, prevent stakeholder engagement and progress, are both in need of restructuring and are repressive to MHSA stakeholders, which illustrates broad frustration in the lack of progress of the services act. Committee membership outvoted and out participated OAC staff on the policy and procedure discussion and by virtue of process, request more access to and inclusion in all meetings and outcomes. A fellow committee member, when asked about the recent staff changes at OAC-most have left, replied things are now getting worse, of the repression of systems outcome. All Committee meetings were cancelled the end of the 2015, The Commission meeting was cancelled- the OAC Commission resembles an entrenched closed system. The current director of the OAC office shared they are getting push-back from OAC Committee members to this shut down. The general OAC decision structure was top down autocratic.
- Then Commissioner Richard VanHorn spoke at lengthy policy debate with commission on their direction. He portrayed himself as leading the commission as in a football game or construction project- he mentioned competitive bids, that he used to contract $9 million construction projects. When asked about policy backtracking to establish positive outcomes: "You do not change halfway through the game." An Insensative inappropriate approach irrelevant to mental health recovery or even treatment. In meeting protocol he practiced bullying tactics, upon calling for vote,rushed the process, and attempted leading commission to a vote.
-May 2014 OAC meeting there was a Public Comment on how difficult for members of the public to access MHSOAC meeting through building lobby, that only the most determined can pass security. Chair Richard Van Horn responded that "Bureaucracy's can he hard to crack."
This comment from the Chairman was very revealing and a Freudian slip.

My experience seated with the MHSOAC agency Service Committee is that they obfuscate MHSA services delivery, making it incomprehensibly difficult to understand and know where and who the billion$ of dollars are actually reaching. The systems delivery are a very tangled web of where the funding is actually received, how they are not promoting recovery models, how they are not including stakeholder process, how there is no treatment of severely mentally ill, how tech and data driven business outcomes disregard MHSA law and eliminate broad stakeholder oversight and OAC Committee linkage to OAC Commission meetings.

ADDENUM

Commissioner Gordon,OAC
Hi David,

I did not get to speak with you RE this at Services meeting. At the recent OAC Commission meeting, the chair explained how committee member findings go to commissioners who include reject in motions.This precludes stakeholder

process since only one seated Commissioner is a consumer with mh background.Also Commissioner chair comments on taking compliance back to county oversight for advisory board review: resulting in oversight being decentralized which removes oversight of state funding.

Part of meaningful input into decisions is education. The MHSA design was legislated to have MH recovery model working along side and augmenting medical treatment which continues to be given short shrift and failing outcome, and needs to be provided the same emphasis and classification as CA HCS and federal reform trends towards prevention and wellness along with the resources and funding to make this a practical reality given the public tax expense of non-recovery- disability, substance abuse, rehabilitation, incareration hospitalization, institutionalization, long list of atrophy. I suggest broader scope of purpose.

Pete LaFollette/Ventura County
Mental Health Recovery Advocate

Further PEI Draft Regulations ResponseThe comments on PEI Reg proposals were submitted (twice) by a group, early in 2014.

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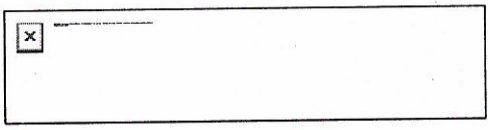
New Regs proposed (8/14) to drive MHSA funds away from people ...



Pete --

Right now, there are more people incarcerated in America than in any other country in the world.

The U.S. is home to less than five percent of the world's population, but almost 25 percent of the world's prisoners. There are people who deserve to be in prison, but too many are nonviolent offenders serving unfairly long sentences.

Mass incarceration is a community problem. Locking up that many people comes with consequences, and this epidemic is hurting us every day.

OFA supporters across the country are calling on their members of Congress to support legislation that makes our criminal justice system smarter, less expensive, and more effective.

Our system should be more than just a pipeline from underfunded schools to overcrowded jail cells. America is a nation of second chances, and when people make mistakes, they deserve to be given the chance to remake their lives.

Fortunately, there is a bipartisan effort in Congress to address some of these problems. But its chances of success depend on people like you speaking up for a fairer system.

Reforms to our criminal justice system are long overdue -- stand with OFA in telling Congress that it's time to act:

https://my.barackobama.com/Stand-For-Criminal-Justice-Reform

Thanks,

Sara

Sara El-Amine
Executive Director
Organizing for Action

you'd like to unsubscribe from these messages.
Organizing for Action, P.O. Box 618120 Chicago, IL 60661

Landry, Kayla@MHSOAC

From: pete lafollette <plafollette@hotmail.com>
Sent: Thursday, August 17, 2017 12:13 PM
To: Landry, Kayla@MHSOAC
Subject: CA HHS Guide on MHSA allocations/stakeholder input for PEI Regs Rewrite

CC Toby.Ewing@mhsoac.ca.gov

Guiding Principles for Stakeholder Input:
CHHS leaders established guiding principles that would inform the stakeholder process. The MHSA General Standards, listed below, have guided planning, decision-making, and the provision of mental health services since the passage of the Act. Department leadership recognize that these General Standards should continue to inform all activities associated with mental health services, including realignment of state mental health functions.
• Community collaboration
• Client and family-driven
• Cultural competence
• Well ness, recovery, and resilience focused
.. Integrated services experience

CHHS leaders also developed specific guiding principles for stakeholder recommendations and asked that stakeholders consider these guiding principles when providing input as part of the Community Mental Health Stakeholder process. The guiding principles are:

• Improve access to culturally appropriate services;
• rmprove quality of care;
• Improve state accountability and outcomes;
• Improve efficiency and effectiveness of community mental health system;
• Include realistic implementation strategies taking into consideration available resources; and

---

From: Jane.Adcock@cmhpc.ca.gov
To: plafollette@hotmail.com

Mr. Lafollette,

Staff at the California Mental Health Planning Council received your below email last week. We thank you for sharing your concerns over the use of MHSA funds and the lack of oversight. We plan to share your write-up (and those of your colleagues) with the Council members for their understanding of the issues you all raise and for their input into the conversation with the Department of Health Care Services and the Mental Health Services Oversight and Accountability Commission. These entities, along with the Council, have responsibilities to report on the use and effectiveness of the Mental Health Services Act funds and the mental health system overall. The Council is committed to fulfilling the mandates of the law and in promoting the integrity of the intent of the Mental Health Services Act.

On behalf of the Council, I thank you again for sharing your concerns with us.

Jane Adcock, Executive Officer
CA Mental Health Planning Council
(916) 319-9343
Jane.Adcock@cmhpc.ca.gov

From: pete lafollette [mailto:plafollette@hotmail.com]
Sent: Thursday, January 23, 2014 9:43 AM
To: Michael.gardner@dmh.ca.gov
Subject: CA DOF OAC comments on MHSA allocations

CC carla.castaneda@dof.ca.gov

Regarding this, there are NO compliance regulations.
We have 58 counties with 58 different program and spending plans.
The Prop 63 money isn't drying-up in California, it is wasted on power points, planning parties and policies that mean nothing. Each pot of county monies gets sent with no strings attached.

More to the point , there is established need for local MHSA governing authority, data management collection including county statistics from independent source, and baselines so counties would meet MHSA goals.

With no governing authorities for MHSA, the outcomes do not offer engaged stakeholder systems transformative process, but expands a two tier system.

Thank You,

Pete LaFollette
MHSA Stakeholder 1/23/14

FURTHER STAKEHOLDER COMMENTS:

Certain promises were made when prop 63 come into being. We were promised transparency and accountability.

I find with great interest your suggestion that local bureaucracy should be eliminated. The first step in this process will be to enforce ethnic diversity regulations on our local mental health boards. We spent million of dollars on ethnic diversity in services --- but no requirement concerning mental health boards.

I have already made a recommendation to OAC that programs should be set up and approved on a regional basis rather than a county basis. This will limit politics.

"Those who cannot remember the past are condemned to repeat it"
George Santayana

I remember the past because I am living it presently. I have watched my beloved son lost to the bowels of the state system because of the absolute criminal neglect of the community mental health system while MHSA funding is wasted on fluff...yes fluff. 40 5150s and a permanent conservatorship that has lasted 12 years because there is NO continuum of care to even give him a chance at recovery in the community. There never has been adequate "core funding" for a quality system that would allow a client to recover. That FACT was the basis of Prop 63. MHSA has not funded a quality PUBLIC MH system for anyone of any culture, ethnicity or sexual orientation. It is an expensive pilot project that has created a disgusting two tier system of haves and have nots.

The "sickest of the sick," to quote yesterday's defensive comments of Jessica Cruz, ED of NAMI CA are still in the past, present and will be in the future if there is not a reality based investigation to follow the money, track the waste and apply the original law to a course correction. I will fight for an audit and I will fight for the truth to protect the integrity of Prop 63 from special interest and politicians who lie.

I am a partner of consumers who attend wellness centers, have WRAP plans, have fought for their own recovery and those who are in the community. I was at Mental Health Consumer Concerns yesterday and saw my consumer friends exit the bus to spend a day with their peers in a warm, welcoming environment. I saw many of these same consumers attend the last Contra Costa Mental Heath Commission's Public Hearing on the current MHSA Annual Plan. They submitted over 70 comments that were valid and clear requests for improvements. They spoke of lack of access to appropriate housing, housing supports, transportation. They spoke of abusive treatment by Room and Board operators who lock the refrigerator and the front door to prevent consumers from food and shelter. Is that progress?

These same consumers have stood by my side in partnership and supported my personal fight for my son and all of those like my son. They are my heroes, my friends and my partners. Janet Wilson who has fought for my son and my family is my partner in the Bring Em Home campaign which is an effort to bring consumers home from out of county placements. She has also agreed to join me at the next BOD meeting of Disability Rights of California because she has not forgotten the past and does not want it to be repeated but she knows that we are not even close to transformation. She knows that the Toilet Assumption is still at play under MHSA. I am copying her on this chain along with Brenda Crawford, the Executive Director of MHCC. We are building a true consumer and family partnership in Contra Costa County and we won't leave out the "sickest of the sick."

I wrote the following blog post in May. I hope those of you on this email chain will consider my request to partner. Lets lay down the adversarial tools that protect the status quo and get this right. Lets stop the big lie together. Lets create a real consumer and family driven voice with no politics, no egos, no special interests, no discrimination. Just pure ethical health care based on the needs and wishes of the clients, the families and the staff who serve them both. I have seen it happen, it is possible.

tcpasquini May 7, 2012 at 3:30 am | **Reply**

Dear friends,

The recent video and story (http://on.myfox8.com/WDMdtlF) about the father of a young boy with autism sparked appropriate debate and outrage. His young disabled son was being cast as unruly and violent, behavior not consistent with the father's experience of his son. To find evidence of this behavior, the father placed a recording device with his son, which captured unspeakable abuse and unprofessional conduct. The father appeared to be seeking the truth and a just culture solution. He didn't want to sue and get rich off of a broken underfunded system. He wanted accountability. He wanted to fix the system, protect his son and all of those like his son.

I have often used these words to describe my passion and advocacy for change in the California mental health system. I want accountability. I want to fix the system, protect my son and all of those like my son. I wonder what I would hear if I placed a wire on my son at Napa State Hospital. Unfortunately, I cannot place a wire on my 29year old son who has been locked up and institutionalized his entire adult life because of a brain disability. I must rely on newspaper events, rumors or the confidential confessions of line staff that are often the brave whistleblowers. I am frightened to my core by the things that I read, hear and know based on my own lived experience. I am also frightened by the silence and the tendency to look the other way when we know that harm is being done.

Whistleblowers are heroes in our society. They are the brave individuals who challenge the status quo, demand accountability and seek justice for the public, our communities and our most vulnerable. I have described Rose

King as a hero to me. She spoke out about the waste and failed implementation of Prop 63. She formally blew the whistle in a complaint filed with the California State Auditor. The lack of public response was stunning. The silence was frightening.

Behind closed doors or in trusted conversations people were championing Rose's complaints. But, the wagons were circled, public relations campaigns were launched, myths about system transformation were perpetuated and the status quo remained. I know that there are heroes among us who are living in silence out of fear of retaliation, stigma or shame. We need you to join us.

We have family members who go to support groups and describe crisis level trauma that exists for their loved ones and their families but many are too exhausted or frightened to take their pain public. They thought that Prop 63 was going to help them and their loved ones. They have had their children left in emergency rooms for days because inpatient beds were not available. They have watched their children discharged too soon. They have watched their children incarcerated. They have watched their children released in the dark of the night to the streets and disappear. They have watched their children die by suicide. They have watched their children and other people's children kept out of sight and out of mind.... literally.

We have line staff and administrators that go to work everyday to do good work in a public mental health system that has been "underfunded from the start"(Van Maren, 2000). They are tired, stressed, and afraid to speak out for fear of losing their jobs. They thought that Prop 63 was going to provide the extra staff to the crumbling system of care, increase access to their clients who are dying too young, provide more housing for less restricted care, more supports for their clients who have no family. Have they seen the funds used appropriately? Have they been given respect for their service? I don't think so, but they still show up and do heroic work and hope that things will improve.

We have consumers who are experts in surviving the discrimination. They had the courage to stand their ground and demand change. They rightfully commanded, "Nothing About Us Without Us." They blew the whistle and they were heroes. Some of these survivors have lived in Napa State Hospital where my son lives today. They know the truth. They have watched their friends die while asking for help. They have stood before local leaders and respectfully stated, "We are not throw away people." But, were they heard? Was there sustained, measurable improvement? Has the core system been transformed after 8 years and 8 billion dollars of MHSA funding? Are ALL of their fellow consumers being given the necessary supports to recover in the community? In many cases, consumers and families are being propped up as mouthpieces to help maintain the status quo. Those who speak against the status quo often experience retaliation and are told, "It isn't the right time." When will it be the right time? If not now, when? Have we not waited long enough for equity in health? If we are to have the right care, at the right place, then it is the right time to speak up and tell our true stories.

My purpose is not to personally attack, play gotcha games or deny success and improvements. I acknowledge the efforts of many who have given their all to system improvement and I celebrate every recovery success. I will partner with all who seek equity, justice, continuous improvement and health for all. We are not even close and until we are, we must continue to respectfully challenge the status quo and never, ever give up.

Please join Rose King and I and share your FACTS on mitruestories.wordpress.com.

Create a unique Username in order to aid anonymity, if desired. Please be assured that identifiable information and emails are never published.

In Partnership,
Teresa Pasquini, Mom

On Wed, Aug 1, 2012 at 6:59 PM, king rose <rking2@surewest.net> wrote:
There has never been a respected consumer or family voice in the State Capitol. The state departments and politicians prop up this facade of stakeholder participation--sorry to report it is all very expensive theatre. It continues to enrich consultants, conference managers, and pricey staff to manage endless committees. The "stakeholder" industry is very rewarding for consumers and family members paid to show up and give credence to these empty performances.

My history in legislative work dates to Jerry Brown's first year term as governor in the 70's when I started with the Senate leadership, left several times, but required to know the Welfare and Institutions codes for many assignments, including lead consultant for the JOint Legislative Committee on Mental Health Reform. The Planning Council works for three years to produce a Master Plan -- a very thorough, quality document -- that has NEVER been the subject of legislative consideration.

As an acknowledged co-author of Prop 63, I recommend reading the law, including referenced sections of MHSA which thoroughly describe Systems of Care and target populations. Start with W&I code 5600.3
I am not sure why anyone would claim there is core funding--except to benefit Steinberg and Selix.

king rose
rking2@surewest.net
916-456-8103

On Aug 1, 2012, at 5:25 PM, Richard Hayes wrote:

Dear Friends of Mental Health:

Please review this very important document. Thank you. I would like for you to know that I have sent a written request to Jose Oseguera at the OAC. My written request was certified and it can be used in court. I am asking that OAC require every mental health board in every county - should have a legal and written policy and procedures concerning fiscal accountability in all programs.

President Obama is against waste and fraud in government. He has ordered the federal government to reaudit all grants which were issued within the past four years.

Richard Hayes

----- Original Message -----
From: Kathryn Trevino
To: ClientDiscussions@yahoogroups.com

Sent: Tuesday, July 31, 2012 11:30 AM
Subject: Re: [Client Discussions] Calif mental health dollars bypassing mentally ill - SFGate

"Those who cannot remember the past are condemned to repeat it"
George Santayana
The Mental Health Services Act (MHSA) was meant to focus on those who were thrown into the streets of cities throughout California from the State run psychiatric institutions. Many of these people were burdened with the most serious conditions. There was no core funding for that population at that time. The Community Service Act of 1963 was never adequately funded and left most to struggle in a sink or swim situation as they were cast onto street corners as "social wastage". The Federal government's SSI program started in 1963 also, but those fortunate enough to receive the disability funds were immobilized by the massive capitalistic Board and Care industry that sprung up as a result of the States deinstitutionalization, while most continued to sink. It was not until 1977 when involuntarily committed patients obtained the right to refuse medication and the Community Support Program (CSP) began with the National Institute of Mental Health (NIMH). However mental health consumers were not invited to participate with their input until 1979 and it was nine years later that the CSP funded the first consumer run demonstration projects. About 25 years later was the creation of The Mental Health Services Act under the proclamation of the "mental health systems in shambles". That same year, 1977, the U. S. President's Freedom Commission on Mental Health advocated a consumer-driven and recovery-oriented mental health system. Thus the MHSA was created. The MHSA was never intended to only "assist those with first experiences in psychiatric distress and the offering of new promising practices to assist entire family units during the early signs of chaos". Family advocates did not force most of the funding to go to those with serious diagnosis and symptoms, they have been pleading for some of the funds to go to those who have been oppressed and neglected by the mental health system.
The Legislature and State Administrators began stripping the MHSA budget of its money for core services and shifted billions in tax money on programs that have nothing to do with the direct services for those with a serious mental illnesses diagnosis. The illustration of this feeding frenzy is similar with the money generated by the Lottery, but not exactly true. Senator Steinberg amends the original proposition for specific people such as for organizations of MHSA Oversight and Accountability Commissioners and their friends, and gave nearly a million dollars of MHSA money to pay the State's years old defaulted Education debt. The MHSA funding has been diverted and misused, without any opposition from the organizations funded to protect and advocate for mental health consumers as these organizations were paid "hush" funds from the MHSA in the guise of "stigma busting". Disability Rights California (DRC), National Association for Mental Illness (NAMI), Mental Health Association (MHA), and the California Network of Mental Health Clients (CNMHC) were offered millions in MHSA funds to eradicate the very stigma they practice. It was an inside money grab by our advocacy organizations from those in the know as the Oversight and Accountability Commissioner, and Executive Director of San Francisco MHA, Eduardo Vega secretly informed DRC about these funds CalMHSA was giving away.
You do not know Rose King if you believe that all she advocates for is clinical treatment, psych drugs and hospitalization. These words are tactic to demonize those who expose the devastation and betrayal of their hopes founded on the intent and promises of the proposition 63. She does not speak for herself. She speaks for mental health consumers that have been neglected, traumatized and harmed by those calling themselves the leaders of the consumer movement, the administrators of the mental health system, and those who are, and have, held the "purse strings" of the MHSA.
It is true that "The first casualty was the removal of the client voice from the state level...", however it was those publically calling themselves "consumer leaders" and "the responsible ones" that ignited the fall of the CNMHC.

From: Michele Curran <micheledcurran@gmail.com>
To: ClientDiscussions@yahoogroups.com
Sent: Monday, July 30, 2012 4:16 PM
Subject: Re: [Client Discussions] Calif mental health dollars bypassing mentally ill - SFGate

The Mental Health Services Act was not meant to focus on those with the most serious conditions. There was already 'core funding' for that population. The MHSA was designed to assist those with first experiences in psychiatric distress and the offering of new promising practices to assist entire family units during the early signs of chaos. It was the DMH and family advocates that forced most of the funding to go to those with serious diagnosis and symptoms, not the Act itself. They got their way, so the Legislature and State Administration began stripping the MH budget of its money for core services and shifted the burden to the MHSA. A early illustration of this phenomenon was the Lottery $ that was to be a supplement to Education funding, but soon became the main source. So, while it is true that the MHSA funding has been diverted and misused, it is not as the story presents it. It was to be used for new approaches, voluntary, peer designed, non-traumatic services and entire programs based on wellness, resiliency, and healing. The examples given in the news story were ones of victory over old thinking and clinical ways. We who advocate for trauma-informed, wellness-based approaches are not the villains here. We fought hard to get programs for healing, and we received very few of them. The advocates for clinical treatment, psych drugs and hospitalization confused our message, made us sound like lunatics that had taken over the asylum and that we didn't know how sick we were. Now they want all of the money, as if they hadn't gotten money that wasn't meant for them in the first place....now they want what is left. So, they demonize us again, and the Legislature destroys the DMH, sends all the funding all across the state, and gives most of it to the counties, where the family and clinical supporters can terrify local Boards and threaten them with political repercussions if they don't give them more of what they want. More drugs, quieter patients, a return to locked facilities and fewer trauma-based healing. We are worse off than we were, for we got to see a possible future, now it is being snatched away. The first casualty was the removal of the client voice from the state level, then planning bodies throughout the counties, now they denigrate the few programs that got funded. The next victim will be Hope, then we reinstate the back wards of the IMDs. In sorrow, Michele D. Curran, client advocate

On Sun, Jul 29, 2012 at 9:47 AM, pete lafollette <plafollette@hotmail.com> wrote:

There are 87 comments this first day in print--an AP story by Hannah Drier which investigates and reports on the misuse of Prop 63 funds. It will appear in many local papers in the state.

The story explains how as much as $1.2 billion in tax money has been spent on programs that have nothing to do with serious mental illnesses. Prop 63 promised to spend some of the tax money on new programs for people who have a serious mental illness and can benefit from prevention and early intervention services--the kind of services that help prevent their illness from becoming a lifelong disability, improve chances for quick recovery, and keep their conditions from becoming more severe. Voters were betrayed; mental health consumers, their families and dedicated front-line workers were devastated by the betrayal of their hopes.

Local and state politicians and bureaucrats take the money and say they have better ideas for how to use these taxes--they do not have to follow the law.
Statements from many people echo those made on my SFChronicle Commentary of July 7, 2012--- voters will not support another tax increase on the November ballot because they CANNOT TRUST STATE GOVERNMENT TO USE THE MONEY AS PROMISED. The June vote on Prop 29 reflected this growing mistrust.

Read the truth and expect more commentary and analysis of the indefensible "better ideas" funded by Prop 63.

http://www.sfgate.com/news/article/Calif-mental-health-dollars-bypassing-mentally-ill-3743239.php

king rose
rking1@surewest.net

keep

Landry, Kayla@MHSOAC

From: pete lafollette <plafollette@hotmail.com>
Sent: Tuesday, August 22, 2017 2:00 PM
To: Landry, Kayla@MHSOAC; MHSOAC
Subject: Addenum, Public Comment on MHSOAC Rewriting PEI Regulations

Are voter-approved and paid for through the Mental Health Services Act (Prop. 63) used for best outcome to:

- Transform California's mental health services approach by uniting California's diverse communities to embrace mental wellness and delivering the tools individuals need before they reach the crisis point?
- Provide an up-front investment that will pay off with sustained cost reductions in health, social services, education and criminal justice?

Mr. Lafollette noted that these individuals are so poorly served that they are at risk of situational effects including homelessness, institutionalization, incarceration or substance. A minimum of funds are provided to the severely mentally ill, the majority of funds are utilized to support new clients and programs such as the Innovations Project.

From: Landry, Kayla@MHSOAC <Kayla.Landry@mhsoac.ca.gov>
Sent: Monday, August 21, 2017 7:45 PM
To: 'pete lafollette'
Subject: RE: MHSOAC Rewriting PEI Regulations

Dear Pete Lafollette,

The Mental Health Services Oversight and Accountability Commission (MHSAOC) has received your below email on 8/17/2017. Thank you for sharing your concerns. The Commission will respond to your comments after the public comment period ends as part of the regulatory process.

On behalf of the MHSAOC, I thank you again for sharing your recommendations with us.

Sincerely,

Kayla Landry

Landry, Kayla@MHSOAC

From: Jorge Wong <jorgewong@ramsinc.org>
Sent: Wednesday, September 27, 2017 12:21 PM
To: Landry, Kayla@MHSOAC
Cc: Christina Shea; shiramoto@remhdco.org
Subject: RE: REMHCO proposed changes to regulations

Dear Ms. Landry,

Greetings on behalf of the Richmond Area Multi-Services (RAMS), a private non-profit behavioral health organization committed to advocating and providing community based, culturally competent, and consumer guided services to the Asian Pacific Islander and larger communities in San Francisco. RAMS supports the Racial and Ethnic Mental Health Disparities Coalition's (REMHDCO) proposed changes t the PEI and INN regulations. These proposed changes would require counties to collect all the demographic data (originally approved by the MHSOAC in October 2015) of children younger than 12 years of age served except for sexual orientation. Please feel free to contact me regarding this matter.

Regards,

Jorge Wong, Ph. D.
Clinical Psychologist, PSY# 21180
President and CEO
rams, Inc.
639 14th Ave.
San Francisco, CA 94118
(415) 800-0699 x206
(415) 751-7336 Fax
jorgewong@ramsinc.org
www.ramsinc.org

STATE OF CALIFORNIA

MENTAL HEALTH SERVICES

OVERSIGHT AND ACCOUNTABILITY COMMISSION

COMMISSION MEETING

REGULATION HEARING -

2. PROPOSED AMENDMENTS TO PREVENTION AND EARLY INTERVENTION (PEI) AND INNOVATION (INN) REGULATIONS

MHSOAC OFFICES

1325 J STREET, SUITE 1700

SACRAMENTO, CALIFORNIA

THURSDAY, SEPTEMBER 28, 2017

9:20 A.M.

Reported by: Ramona Cota

APPEARANCES

Commissioners

Tina Wooton, Chair

John Boyd, PsyD, Vice Chair

Lynne Ashbeck

Khatera Aslami-Tamplen

Sheriff Bill Brown

Keyondria Bunch, PhD

Itai Danovitch, MD

David Gordon

Kathleen Lynch

Gladys Mitchell

Larry Poaster, PhD

Deanna Strachan-Wilson

MHSOAC Staff

Toby Ewing, PhD, Executive Director

Filomena Yeroshek, Chief Counsel

APPEARANCES

Public Speakers

Poshi Walker
NorCal Mental Health America

Stacie Hiramoto
Racial and Ethnic Mental Health Disparities Coalition (REMHDCO)

Michele Violett
Nevada County

Elizabeth Oseguera
California Health+ Advocates
California Primary Care Association

Mandy Taylor
California LGBT Health & Human Services Network

Kiran Savage
California Pan-Ethnic Health Network

Nancy Callahan, PhD
IDEA Consulting

I N D E X

PROCEEDINGS

9:20 a.m.

2. Proposed Amendments to Prevention and Early Intervention (PEI) and Innovation (INN) Regulations

CHAIR WOOTON: We are moving right into our proposed amendments to Prevention and Early Intervention, PEI, and Innovation, the INN regulations. This is an information item on our agenda. This is an official hearing because it is the regulations so I am going to turn it over to Filomena at this time. Thank you.

CHIEF COUNSEL YEROSHEK: Good morning, Commissioners.

This next part of the Commission meeting, which is scheduled for one hour or as soon as there are no more public comments on the topic, so whichever occurs first, so if less than one hour there are no more comments the hearing will be closed.

So this is a quasi-legislative hearing. It is a little different than what you are used to because you are carrying out the rulemaking function that the Legislature delegated to you; this deals with amendments to the regulations.

Those of you who have been with the Commission for a few years know that after -- these amendments are coming after a six month public input on the proposed amendments

that were held by a subcommittee chaired by Commissioner Poaster and Commissioner Aslami-Tamplen as well as Commissioner Van Horn were members of at that time.

And then at the July Commission meeting the full Commission approved these proposed amendments to the Prevention and Early Intervention regulations and to the Innovation regulations.

We followed the Administrative Procedures Act and submitted the proposed regulations to the Office of Administrative Law, they were published. They were also published on our website and they were submitted and sent out to all parties who had informed us that they were interested in receiving notices to the regulations.

That started a 45 day public comment period. Today is the end of that 45 day period.

The hearing, like I said, is slated to last for an hour. However, the public comment period does not end until 5:00 p.m. today, so those individuals who could not make it today or who want to provide additional written comments can do so via -- they can just write it out and hand it to a staff member who is at the table or to me or they can email it to the Commission as set forth in the notice that has been posted on our website.

So this is the time where the Commission is sitting down and listening. It is not a dialogue time.

That dialogue in terms of the Commission responding to the comments will come depending on time constraints at either the October Commission meeting or at the November Commission meeting.

And what will happen then is that all of the written public comments as well as the oral comments that are made today at the hearing will be presented to you in their entirety and staff's proposed responses to those comments. So if there are comments suggesting tweaks or changes in the proposed language you will get an opportunity to decide whether you want to accept those comments and follow-up with additional changes or reject those comments. Either way you have to state a rationale for your decision. That all will be writing, presented to you either at the October meeting or at the November meeting, depending on the number of comments. So far we have not received a lot of comments. We have received a handful of them, which is helpful in terms of it being available for the October meeting.

If you decide to make additional changes to the proposed amendments, depending on what type of changes, if they are substantial changes that are related to the current proposed amendments those changes will go out for an additional 45 day public comment period and you get the opportunity to respond to those comments and the process

sort of keeps going.

Do you have any questions? We have gone through sort of the process multiple times at the Commission meeting but we do have brand new Commissioners and I want to make sure that the sometimes-confusing legal process is understood; so please don't hesitate to ask any questions.

COMMISSIONER ASHBECK: Tina, I have a question.

CHAIR WOOTON: Yes, Commissioner.

COMMISSIONER ASHBECK: So at the risk of having the silliest question of the day at 9:26, I don't know what the amendments are. I don't see them in the packet. This happened, I think, before I joined the Commission. Is there a summary? The link here took us to the rules but is there a way to see what those amendments are so as folks comment on them I'll know what the context is?

CHIEF COUNSEL YEROSHEK: Sure. We have copies of the proposed comments on the table and we will make sure that all the Commissioners that want one will get one.

COMMISSIONER ASHBECK: The proposed amendments.

CHIEF COUNSEL YEROSHEK: Sorry, proposed amendments.

COMMISSIONER ASHBECK: Not comments.

CHIEF COUNSEL YEROSHEK: Yes.

COMMISSIONER ASHBECK: Okay. That would be great. Since I don't know what they are that would be helpful.

Thank you.

CHIEF COUNSEL YEROSHEK: Yes. Yes.

COMMISSIONER ASHBECK: And there might be others here that would be in the same spot.

CHIEF COUNSEL YEROSHEK: Yes.

COMMISSIONER MITCHELL: And Fil, are you going to go over those amendments today?

CHIEF COUNSEL YEROSHEK: Not today.

COMMISSIONER MITCHELL: Okay.

CHIEF COUNSEL YEROSHEK: Today is the -- that's why I said it's unique. It's the quasi-legislative hearing so you are just to hear the comments, right? And then at the next meeting you will have the proposed amendments, the comments and the proposed responses to those comments.

And so we made extra copies because we knew that some people wouldn't bring, you know, like the public comments needed to refer -- we are going to ask individuals to refer to a specific code section.

But this is a time when you can just sit back and listen. But that is a very good point, thank you. I apologize for not providing it. We provided it to the public but not to the Commissioners, not a good thing.

Any other questions? Commissioner Poaster.

COMMISSIONER POASTER: Just one comment to make sure that I understand. The amendments that you are

referring to now are the amendments that were adopted by the Commission a couple of months ago, correct?

CHIEF COUNSEL YEROSHEK: Correct.

COMMISSIONER POASTER: Okay.

CHIEF COUNSEL YEROSHEK: So the amendments that you will be hearing comments on are the amendments that the full Commission heard and adopted in July.

COMMISSIONER POASTER: Right. So that any changes that come from other people then would be discussed in the following meeting.

CHIEF COUNSEL YEROSHEK: Exactly. This is not a time for, this is not a time for Commission discussion on this particular topic. That is why I was sort of trying to say it is a unique part of the Commission meeting. It is to just hone in on each of the comments, knowing that you will have multiple opportunities, especially in October, and any future opportunities if you decide to make additional changes.

CHAIR WOOTON: Any other comments for Filomena?

CHIEF COUNSEL YEROSHEK: No other questions?

COMMISSIONER GORDON: I have a question.

CHIEF COUNSEL YEROSHEK: Yes, Commissioner Gordon.

COMMISSIONER GORDON: Just a clarification. So these amendments were reviewed by the Commission and commented on at the time in the course of the discussion by

the Commission, so this is a second round, so to speak --

CHIEF COUNSEL YEROSHEK: Exactly.

COMMISSIONER GORDON: -- for comments on the changes that are proposed here.

CHIEF COUNSEL YEROSHEK: Exactly.

COMMISSIONER GORDON: Thank you.

CHIEF COUNSEL YEROSHEK: So the Commission -- Thank you for bringing that up. The Commission is unique in terms of being a body that has to follow the Bagley-Keene Open Meeting Act. So regulations done by a department would not have the layer of transparency and public comments, right? So yes, these are identical to what the Commission discussed, heard public comments on and voted to go with at that time. Okay.

CHAIR WOOTON: Okay. And this is, once again, just information only this morning.

Since this is an official hearing I am going to read a statement. I will be repeating mostly what Filomena just shared with us - good morning, Andrea - but I would like to go ahead and read this statement for official purposes, thank you.

Once again, as Filomena stated, this is a time to receive public comments on the proposed amendments to the PE&I and Innovation regulations.

Under the rulemaking provisions of the

Administrative Procedure Act, this is the time and place set for the presentation of statements and arguments orally or in writing, for or against the changes in the MHSOAC's regulations, notice of which was published in the California Regulatory Notice Register, on the OAC's website, and sent out by email to interested parties.

Witnesses presenting testimony at this hearing will not be sworn-in and the Commission will not engage in dialogue with the witnesses. The Commission will take under submission all the written and oral statements submitted by 5:00 p.m. today or made during this hearing. We will respond to these comments in writing.

The hearing is being recorded and the transcript of the hearing with all exhibits and evidence presented during the hearing will be made part of the rulemaking record. This hearing on the proposed amendments is scheduled to go to 10:15 or when there are no more comments, whichever occurs first.

As you entered this room, you were offered the attendance sheet to sign your name and indicate whether you wanted to stand up and make oral comments on the proposed regulations or if you just wanted to attend the hearing.

Do you need to fill out the attendance sheet if you don't wish to speak? Yes, if want to be notified of the final adoption of the changes or about any new additional

changes. Such notice will be sent to everyone who submits written comments during the written comment period, to everyone who testifies today, and to everyone that asks for such a notification. While no one may be excluded from participating in these proceedings for failure to identify themselves, the names and addresses on the attendance sheet will be used to provide the notice.

If you have not yet signed the attendance sheet and you now wish to do so, please go back to the table and sign in.

We will listen to oral comments in the order you signed the attendance sheet. After we hear from everyone who signed in, we will hear from any latecomers or anyone else who wishes to be heard.

When you come up to speak, we ask that you do certain things so that your comments are entered into the record. First we ask you to come to the podium when you are called to speak. Second, please begin by stating your name and identifying the organization your represent, if any, and tell us whether you are commenting on the PE&I or INN regulations and the section number you want to discuss. We have in the back table some copies of the proposed amendments to the PE&I and INN regulations for your convenience.

As I mentioned, these proposed amendments were

duly noticed more than 45 days prior to today's hearing. Copies of the notice, together with the regulations and the statement of reasons were posted on the Commission's website and sent to all interested parties who requested rulemaking notices.

And at this time may I have the attendance sheet, please? We will now take oral comments on the proposed regulations.

The first person is Poshi Walker. Can you please come to the podium.

Thank you, everyone.

MS. WALKER: Good morning. My name is Poshi Walker; I am with NorCal Mental Health America and the co-director of the brand new LGBTQ advocacy contract with the MHSOAC.

First, we want to strongly support those who will be speaking after me, specifically to the collection of race, ethnicity and primary language for minors younger than age 12. Our concern is focused on that same section which in your -- it's on page 5 of the PEI, letter D, a county is not required to collect the demographic information required under subdivision whatever, from a minor younger than 12 years of age.

We understand the tension between the need for data and the concerns for age-appropriate methodology. With

that in mind we consulted with the Williams Institute regarding best practices for collecting sexual orientation and gender identity data for individuals under the age of 12. We are concerned for the following reasons:

The gender, race, ethnicity, primary language and disability of those being served is vital information, including for those who are under the age of 12. This demographic data is crucial to continue to monitor and improve programs funded through MHSA.

Gender is a concept that is formed very early in childhood. At the very least most children who are verbal are able to state whether they are a boy or a girl. In addition, transgender children may state as soon as they are verbal that their gender is different than the one they were assigned at birth. There are also a growing number of supportive parents of transgender or genderqueer children who may want and may possibly demand the opportunity for their child's current gender identity to be recognized and recorded. Although there is currently no research demonstrating how to ask parents about their child's transgender identity we do support the option for parents to identify their child's gender identity if they so desire.

How to collect gender identity data in a manner that is developmentally appropriate for children under the age of 12 is a topic that still needs additional study, so

therefore we recommend the Commission collect sex assigned at birth for youth under 12, using language recommended, in the first step of the standard two-step gender identity measure.

Basically, this is what we are asking that section to be reworded as: A county is not required to collect sexual orientation, current gender identity or veteran status demographic information required under subdivision B.5 of the section from a minor younger than 12 years of age. All other data, including assigned sex at birth, that cannot be obtained directly from a minor younger than 12 years of age, may be obtained from the minor's parent, guardian or other authorized source.

We understand that many counties find the demographic data gathering challenging. We enthusiastically offer our support to any county who requires technical assistance in the gathering of SO/GI data.

Thank you very much for this opportunity. This will all be given to you in writing. Thank you.

CHAIR WOOTON: Thank you, Poshi.

The next person to the podium is Stacie Hiramoto, please. Good morning.

MS. HIRAMOTO: Good morning. Stacie Hiramoto with REMHDCO, the Racial and Ethnic Mental Health Disparities Coalition. And a very special welcome, especially to the

new Commissioners.

I would like to comment on both the PE&I and Innovation regulations in the same section that Poshi Walker referred to in the demographic data.

First of all I want, again, for most of the new members to understand that REMHDCO represents racial and ethnic communities all throughout the state, we represent individuals, families and organizations, and this was a very, very important issue to us in the PE&I and Innovation regs.

I hope I sent a letter to as many of you as I could and I hope for the other Commissioners, you will receive a copy of this letter. Although it may be changed slightly because we would like to support the position of the California LGBT Health and Human Services Network, Poshi's group and the others that received the contract from the OAC, because on this matter we agree with them strongly and want to support the way -- the collection of the SO/GI data.

But as far as race and ethnicity, we believe it is very important for children under 12 for this information to be noted because of, again, disparities are prevalent and we have got to understand if we are going to make a difference. If you stop collecting data on race and ethnicity how are you going to understand if you are reducing disparities?

We understand that this may involve I think more training, just as Poshi talked about.

We have heard stories about in the counties people being uncomfortable asking this data from parents or from students and actually either guessing by looking or guessing by the name. And that's understandable, let's face it, race and ethnicity are sometimes uncomfortable to talk about and that's why REMHDCO exists.

Again I want to stress that our position is that this aggregated data on race and ethnicity and the other information is demographic information, is collected. We understand that that can be challenging but we don't understand, particularly for race and ethnicity, why this would make a difference for children under 12. We think most parents or most family members want that information known in case, again, they want to deal with certain issues, and a child's racial and ethnic identity is important. Thank you.

CHAIR WOOTON: Thank you, Stacie, thank you.

The next person up is Michele Violett, please.

MS. VIOLETT: Michelle Violett with Nevada County. I just want to give an example of where the challenge is as a county perspective, a small county perspective.

We have a Second Step program, this is a prevention program where a teacher goes into and teaches

preschool teachers how to do the Second Step program and they're modeling it and they're doing it in front of preschool students and the parents aren't necessarily there to ask, they're modeling to the teacher and then the teacher does it to the three and four-year-olds. So this regulation is a very big challenge for us to implement because we don't necessarily have the parents engaged in the actual interaction.

So that is just an example that yes, I do feel it is important but there can be some challenges. So depending on what the program is, the regulations need to be flexible in that. Thank you.

CHAIR WOOTON: Thank you, Michele, thank you.

And now Elizabeth Oseguera, can you come to the podium, please.

MS. OSEGUERA: Hello, Elizabeth Oseguera with the California Health+ Advocates, who is the advocacy arm for the California Primary Care Association.

And I wanted to echo the comments made by Stacie and others around demographic information collection, making sure that this information is collected, it is very important that we know if these services are reaching everybody within the community and that includes children under the age of 12. However, we understand the conflicts and issues going on with the LGBTQA community and support

their recommendations as well. Thank you.

CHAIR WOOTON: Thank you, Elizabeth.

Mandy Taylor, please. Good morning.

MS. TAYLOR: Good morning. Mandy Taylor from the LGBT Health & Human Services Network; and we are, along with NorCal MHA, a part of the LGBTQ advocacy grant.

And so that's what we are doing, we are here advocating, right? And what we are advocating for is that you do collect appropriate data that is developmentally accurate and part of that is collecting race, ethnicity, primary language from children. We are in full support of REMHDCO in those recommendations.

And we also understand that requesting sexual orientation for children under the age of 12 could put them in some -- could, unfortunately, have some ramifications if their parents have access to their information. So we are saying, yes, please don't collect for folks under 12.

And then we contacted the Williams Institute, which is on the leading edge of research in this area, and they have established best practices. And we are asking that this Commission use those best practices that they found, which is when children are under the age of 12 ask them their sex assigned at birth and allow them to let you know their gender identity but don't require it because they don't always know and/or it may not be safe at that age.

However, their parents certainly would be able to. And anybody who was doing prevention work being in a room with a child would most likely be able to observe that information.

So again, we are asking that you change the regulation to include race, ethnicity and language and that you exclude gender identity and sexual orientation for those that are under the age of 12. Thank you.

CHAIR WOOTON: Thank you, Mandy.

The next person is Kiran -- Sosage? I'm sorry. Maybe you could state your name, please.

MS. SAVAGE: I will do so, thank you. Kiran Savage, California Pan-Ethnic Health Network. Thank you for your time, good morning.

My organization, CPEHN, is a statewide multi-cultural health policy organization and we work on access to health care including mental health care through a variety of methods.

And wanted to be here along with our colleagues with a similar perspective, a similar concern in the same section, and wanted to kind of note that we are talking about two components of the Mental Health Services Act, the Innovations and the Prevention and Early Intervention, which are two components where we are really trying to develop I think new and more effective strategies and so would like to note that's an area where it's particularly important that

we are looking at disparities and looking at different populations specifically and how our methods and how our programs are impacting those populations. So I wanted to kind of pull us back and highlight that.

Also that we have spent a lot of time at this Commission talking about how we are achieving the voter intent of Proposition 63 and looking at the big goals about school outcomes and criminal justice. And we are doing work in other parts of California and other sectors to look at this same kind of data. So in our Medi-Cal program we are finally getting data, including on children, that looks at outcomes and race and ethnicity to do with mental health. And so in order to have this data be able to line up with that data it is really important that we continue to collect the race, ethnicity and primary language data.

And on the primary language piece I do also want to just note that these regulations only require data in threshold languages by county, which is actually very little data, so most counties' threshold languages, with the exception of Los Angeles, are usually only English and Spanish, which we would generally argue is not enough. But just to say, that's very little data and shouldn't be a problem for the most part. And our Medi-Cal system actually allows us to collect data on 26 languages, so we actually have even more data in other systems that we would be able

to compare to and we would hate to lose that data just for children under 12.

And our school district systems do have us collecting race, ethnicity and language data including for disciplinary records. And again back to the goals of the MHSA, we would really like to be able to compare that data and see how our programs are impacting discipline records to be able to see the difference that we are making in the state.

So thank you again for your time. We really encourage counties to collect this data and encourage just that change in the regulations, so thank you.

CHAIR WOOTON: Thank you, Kiran, thank you.

There are no other names on the list here. Is there anyone else that wishes to speak or respond to the proposed amendments to the regulations? Anyone else?

(No response.)

CHAIR WOOTON: Okay. Hearing no requests, I close this oral hearing.

However, we will receive comments, written comments by email, into our office until 5:00 pm today.

So thank you everyone and thank you for your comments. Thank you.

(The meeting continued on to Item 3 but was not transcribed.)

General Public Comment - First Opportunity

CHAIR WOOTON: Nancy, Nancy Callahan, hello.

DR. CALLAHAN: Chairwoman Wooton, so nice to see you, Commissioners. So I am Nancy Callahan with IDEA Consulting. Very brief, I know I only have three minutes.

I was Chief of Planning and Evaluation for Sacramento County from '87 to 1990 and started my consulting business in 1990. I have worked with many different counties around evaluation, writing grants, and have done a lot of work around PEI so I was -- I'm sorry I didn't pull this off the website earlier but I was just reading this report that is required.

And I just want to please caution the Commission to be wise about the data. I am a data person, I love data. I encourage you to collect data.

But these requirements are very extensive for small counties and small providers.

I work with Placer County, we have been doing PEI data collection around your regulations for the last four years.

Speaking of paper, the amount of paper and forms that are required to collect this data is huge.

Even bigger counties have small providers and so they're required to collect a lot of information that is very complex.

So you are wanting reports now, which is great, I'm all happy about that, but some of the items in this around written referrals is very difficult for small providers to collect. That would mean that I would need to write down when I refer Nancy to a provider. I believe you only want written referrals to mental health providers, but you also want to follow-up with them to see if they make it to the agency. That is all great logic but then if I am only doing a brief contact with the person am I supposed to call them back and see if they get followed up? I can't follow-up with the agency they get referred to.

So some of these regulations are really complex. That they sound really good in the beginning, but I worry about the data that you will get in the end will be very small and really not reflective of the great work that is going out there.

The other comment I wanted to make is around your access and linkage. You are asking about people with SMI, Serious Mental Illness. Access and linkage programs typically don't work with Serious Mental Illness. Their prevention and early intervention -- this is not the early intervention. For most people it is only up to a year. These small providers in small counties don't have the staff doing PEI where they have someone, a clinician who can diagnose clients. But then you're supposed to follow-up

with them, you're supposed to say what type of referral you made and what type of treatment that they are being referred to. That is really not within the capacity of a lot of PEI programs so really closely consider the data requirements that you have done.

I know you are pretty well along in this process and I appreciate you continually trying to make it stronger, but I would be happy to, you know, meet with any of you to talk further about some of my concerns around getting data that really makes sense for you, because I really want you to have data that really shows the great efforts that's happening out there. But that's doable. Thank you for your time.

CHAIR WOOTON: Thank you, Nancy, and thank you for thinking about us and our PE&I program, thank you. Thank you. Okay.

(The meeting continued but was not transcribed.)

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CERTIFICATE OF REPORTER

I, Ramona Cota, an Electronic Reporter and Transcriber, do hereby certify that I am a disinterested person herein; that I recorded the foregoing Mental Health Oversight and Accountability Commission meeting and that I thereafter transcribed the recording.

I further certify that I am not of counsel or attorney for any of the parties to said meeting, or in any way interested in the outcome of said matter.

IN WITNESS WHEREOF, I have hereunto set my hand this 29th day of September, 2017.

Ramona Cota

RAMONA COTA, CERT 478

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AGENDA ITEM 5

Information

October 26, 2017 Commission Meeting

Innovation (INN) Update

Summary: The Mental Health Services Oversight and Accountability Commission will receive an update from the Innovation Team which will include the activities of the Subcommittee on Innovation and the Innovation Summit.

Presenters: Sharmil Shah, Psy.D. Chief of Program Operations

Enclosures: None

Handouts:

- Innovation Framework Decision Tree
- MHSOAC Innovation Review Process
- Innovative Project Recommended Template
- Presentation Guidelines

Recommended Action: Information Item Only

AGENDA ITEM 06

Action

October 26, 2017 Commission Meeting

San Diego County Innovation Plans

Summary: The Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission) will consider approval of San Diego County's request to extend the funding and project duration for two (2) Innovative projects; Urban Beats and Cognitive Rehabilitation and Exposure/Sorting Therapy (CREST) Mobile Hoarding Units, for a total amount of $5,172,606 (see below for project breakdown) and approve one (1) new project proposal, Telemental Health, in the amount of $5,253,376. The extension request for the first two projects is 2 years and the new program's duration is five (5) years.

(A) Urban Beats - $2,259,447-EXTENSION

(B) Cognitive Rehabilitation and Exposure/Sorting Therapy (CREST) Mobile Hoarding Units – $2,913,159-EXTENSION

(C) Telemental Health - $5,253,376-NEW

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 is requesting an extension of time and funds so that the Urban Beats, a multi-tiered approach to mental health through artistic expression, social media workshops and one to one coaching, can address the needs of the previously unaddressed areas of North County and the East African Community in San Diego.

Additionally, the additional funds will be used to assist with transportation barriers identified in the first stages of the program and allow for additional clinical staff.

- San Diego is also requesting an extension of time and funds so that the CREST (Mobile Hoarding Units) can expand county-wide and include bilingual social workers. It had been limited previously due to budgetary constraints from being able to meet the need identified in the first stages of this program.
- Finally, San Diego is proposing to increase access to behavioral health services after a psychiatric emergency to those psychiatric patients who traditionally, have not followed up with services and who have increased recidivism within 30-90 days post discharge. The County will hire staff and provide technology to increase contact with this population.

Presenter(s):

- Alfredo Aguirre, LCSW, Director of Behavioral Health Services of San Diego County.
- Piedad Garcia Ed.D., LCSW, Deputy Director for the County of San Diego, Adult and Older Adult Behavioral Health Services (AOABHS).
- Yael Koenig, LCSW, Deputy Director for the County of San Diego, Health and Human Services Agency, Behavioral Health Services, Children Youth and Families (CYF) System of Care.
- Eileen Quinn-O'Malley, LMFT, Behavioral Health Program Coordinator for the County of San Diego, Health and Human Services Agency, Behavioral Health Services, Children Youth and Families (CYF) System of Care.
- Cecily Thornton-Stearns, MFT, Behavioral Health Program Coordinator for the County of San Diego, Adult and Older Adult System of Care.
- Connie German-Marquez, LMFT, Behavioral Health Program Coordinator for the County of San Diego, Adult and Older Adult Behavioral Health Services (AOABHS).

Enclosures (7): (1) Biographies for San Diego County Innovation Presenters (2) Staff Summary, Urban Beats; (3) County Project Brief, Urban Beats (4) Staff Summary, Cognitive Rehabilitation and Exposure/Sorting Therapy (CREST) Mobile Hoarding Units; (5) County Project Brief, CREST (6) Staff Summary, Telemental Health (7) County Project Brief, TH

Handout (1): A PowerPoint will be presented at the meeting

Additional Materials (1): Link to the County's complete Innovation Plans are available on the MHSOAC website at the following URL:

Urban Beats
http://mhsoac.ca.gov/document/2017-10/san-diego-county-inn-plan-description-urban-beats-inn-16

CREST
http://mhsoac.ca.gov/document/2017-10/san-diego-county-inn-plan-description-crest-inn-17

Telemental Health
http://mhsoac.ca.gov/document/2017-10/san-diego-county-inn-plan-description-telemental-health-inn-19

Proposed Motion: The MHSOAC approves San Diego County's request for $2,259,447 additional funding and extension of time for its Urban Beats Innovation Plan previously approved by the Commission on February 26, 2015 as follows:

Name: Urban Beats

Additional Amount: $2,259,447 for a total INN project budget of $3,467,935

Additional Project Length: 2 years for a total project duration length of five (5) years

Proposed Motion: The MHSOAC approves San Diego County's request for $2,913,159 additional funding and extension of time for its Cognitive Rehabilitation and Exposure/Sorting Therapy (CREST) Mobile Hoarding Units Innovation Plan previously approved by the Commission on February 26, 2015 as follows:

Name: Cognitive Rehabilitation and Exposure/Sorting Therapy (CREST) Mobile Hoarding Units

Additional Amount: $2,913,159 for a total INN project budget of $4,245,077

Additional Project Length: 2 years for a total project duration length of five (5) years

Proposed Motion: The MHSOAC approves San Diego County's Innovation Project as follows:

Name: Telemental Health

Amount: $5,253,376

Project Length: Five (5) years

Biographies for San Diego County Presenters

Alfredo Aguirre, LCSW

Alfredo Aguirre, LCSW, is the Director of Behavioral Health Services of San Diego County and has served in the capacity of Mental Health Director since 1999. He serves on the Board of Directors of the National Network of Social Work Managers and as a co-chair of the Cultural Competence, Equity, and Social Justice Committee of the California Mental Health Directors Association. He also serves on the Child, Adolescent and Family Branch Council, a national advisory committee to the Children's Branch of the Center for Mental Health Services under SAMHSA. Mr. Aguirre has worked in the mental health field for over 37 years as a psychiatric social worker, staff supervisor, manager, and executive. He is the recipient of many prestigious awards, including Mental Health Person of the Year in 2008, the 2011 Hope Award for his leadership in the County of San Diego's Mental Health Stigma Reduction Media Campaign, "It's Up to Us," and the 2014 NAMI California Outstanding Mental Health Director.

Piedad Garcia Ed.D., LCSW

Piedad Garcia Ed.D., LCSW is the Deputy Director for the County of San Diego, Adult and Older Adult Behavioral Health Services (AOABHS). Dr. Garcia oversees the mental health and substance use disorders system of care for adult and older adults across the County. She has implemented biopsychosocial rehabilitation and recovery programs for individuals with serious mental illness and co-occurring disorders. 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.

Yael Koenig, LCSW

Yael Koenig, LCSW, is the Deputy Director for the County of San Diego, Health and Human Services Agency, Behavioral Health Services, Children Youth and Families (CYF) System of Care. She has over 20 years of experience working with children, youth and families in a variety of settings, including juvenile justice and mental health. She is responsible for overseeing over 100 contract and County operated programs with a budget of over $141 million dollars. She received her Bachelors of Arts in Social Work from Michigan State University and a Master of Social Work from the University of Tennessee. She holds a Clinical Social Worker license from the State of California.

Eileen Quinn-O'Malley, LMFT

Eileen Quinn-O'Malley, LMFT, is a Behavioral Health Program Coordinator for the County of San Diego, Health and Human Services Agency, Behavioral Health Services, Children Youth and Families (CYF) System of Care. She has 18 years of experience working with children, youth and families as a County contractor managing mental

health programs in group home settings and the County children's shelter. She is currently responsible for monitoring County contracts for service delivery. She received her Bachelors of Arts in Sociology from San Diego State University and a Master of Marriage and Family Therapy from United States International University. She holds a Marriage and Family Therapist license from the State of California.

Cecily Thornton-Stearns, MFT

Cecily Thornton-Stearns, MFT is a Behavioral Health Program Coordinator for the County of San Diego, Adult and Older Adult System of Care. Mrs. Thornton-Stearns has been working in the public behavioral health system since 1991 and currently oversees TAY, Adult and Older Adult services in the Central Region of San Diego, with additional oversight of TAY services, programming and TAY Council for the County. Mrs. Thornton-Stearns has been the Co-Chair of the CBHDA TAY subcommittee since 2015 and a board member of the City of San Diego's Therapeutic Recreational Services since 2013.

Connie German-Marquez, LMFT

Connie German-Marquez, LMFT is a Behavioral Health Program Coordinator for the County of San Diego, Adult and Older Adult Behavioral Health Services (AOABHS). Mrs. German-Marquez has been working in the public behavioral health system since 1996. Mrs. German-Marquez monitors programs in both the mental health and substance use disorders system of care for adult and older adults across the County. She is also the Lead for both the Older Adult system of care and Strengths Based Case Management/Assertive Community Treatment and Full Service partnership (SBCM/ACT/FSP).

Mental Health Services
Oversight & Accountability Commission

STAFF INNOVATION SUMMARY—SAN DIEGO

Name of Innovative (INN) Project: INN -16 Urban Beats (Extension)

Extension Funding Requested for Project: $2,259,447

Duration of Extension: 2 years

Review History

MHSOAC Original Approval Date: 02/26/2015

- Original Program Dates: 7/1/2015 through 6/30/2018 (3 years)
- New Program Dates: 7/1/2018 through 6/30/2020 (2 years)
- Original Budget with Evaluation: $1,208,488
- New Total Budget with Evaluation Costs: $3,467,935

Approved by the County Board of Supervisors: April 25, 2017

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

MHSOAC Consideration of INN Project: October 26, 2017

Project Introduction:

The County is requesting an extension of time and funding for this Innovation. Initially approved in 2015 as a three-year project, Urban Beats was designed as a behavioral health program using a multi-tiered approach to mental health including artistic expression, social media workshops, and one on one coaching to promote all of the following: education, wellness, leadership development and employment readiness for Transition Aged Youth (TAY) in lieu of traditional behavioral health services.

In the first year of the program, 94 TAY enrolled in the program and 234 TAY attended 5 community performances and completed a 2 page survey. By FY 2016/17 the program had surveyed 983 TAY who had attended 29 performances. In addition, there were significant social media contacts (i.e. Facebook, 16,122; website visits, 3,940, Facebook likes, 326). Since its inception and despite initial positive results, some barriers have presented themselves, including, a limited amount of time to gather meaningful data, a lack of clinical staff, transportation problems and an additional identified need in North County and in the East African community since this particular community felt there were no culturally competent or relevant services available to their TAY.

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

Typically, Transitional Aged Youth (TAY) are disconnected from traditional methods of receiving behavioral health services, possibly because of stigma related to needing/receiving mental health services but also due to the developmental and unique needs of this population. In 2011, the County's total population was just over 3.1 million, TAY representing approximately 16% of the total.[1] As a way to address all of the age and behavioral health issues related to TAY, the County developed the Urban Beats Program.

According to the County, Urban Beats "delivers a customized service targeting SED/SMI and at-risk TAY that incorporates artistic creativity with therapeutic, stigma-reducing, cultural expression, and social justice messaging to the TAY community" (p. 1). This expansion/extension is intended to address insufficiencies identified in the first years of the program, as well as develop a third "academy" with cultural competence and responsiveness to address the needs of the East African community. Additionally, the County proposes to add a therapist to address clinical issues and lease a van to allow TAY to gain access to the program and be transported to venues across the central and north-central regions of San Diego.

The Response

The County indicates the Urban Beats program is designed to increase the engagement and retention rates in the treatment of severely emotionally disturbed (SED) or serious mental illness (SMI) TAY consumers. Additionally, the County believes the incorporation and inclusion of artistic messages through artistic expression and social marketing and media resonate with at-risk TAY, and are considered therapeutic and seem to reduce the stigma associated with mental health.

With this extension request, the County hopes to increase TAY participation by adding an additional region, thereby increasing the opportunity to learn from a larger group of TAY individuals, with the ultimate hope of decreasing stigma and reducing the number of those requiring emergency services by learning coping skills from participating in Urban Beats.

Since Urban Beats was implemented, members of the East African community have voiced concern over the increase in gang activity and need for mental health services

[1] Due to the age breakdown as provided by the county website, some TAY appear to be counted in the 25-44 age group.

within the community. As a result, stakeholders requested the County to develop culturally sensitive services to assist the needs of this County which ultimately prompted Urban Beats to branch out to the East African TAY to create the third academy, specifically for the purpose of attaining culturally competent services as well as engagement with the East African TAY community.

One of the problems that the County encountered was a lack of transportation which limited access to the program and performances. As part of this extension request, the County would like to include the lease of a van into the budget which would allow more participation in the program.

The County anticipates enrolling 200 TAY in the academies and outreach to approximately 1400 additional TAY via social media and who will attend performances and complete surveys. Some of the increase in the numbers of TAY served are as a result of expanding the program into new geographic and cultural communities.

The Community Planning Process

During early Fall 2016, the County had more than 650 community members participate in the community engagement process. Over 500 people attended 12 regional forums and more than 100 representatives of cultural populations, including justice partners, male and female incarcerated individuals and peer workers participated in 6 focus groups. An outside consultant was retained to facilitate the forums and focus groups, and questions related to strengthening the system capacity were discussed. The discussion focused on four topics: children's behavioral health, unserved/underserved, care coordinators and all proposed concepts for the Innovation projects (developed from previous community planning processes). Fifteen themes emerged from the facilitated meetings and access and services, continuum of care, and education and awareness were deemed to be used when making decisions regarding expansion and/or extension of existing Innovation programs.

In addition, the County's stakeholder-led monthly meetings as well as the Adult System of Care Council, the Older Adult Council, the Children, Youth and Family System of Care and the Housing Council were asked their input and a to complete a community feedback questionnaire. Finally, the Innovation proposals were sent to a stakeholder listserv and posted to the County's website with a Survey Monkey link for feedback.

Learning Objectives and Evaluation

During FY 15/16, San Diego reports that 23.8% of TAY enrolled in the academies had a reduction in emergency services, and approximately 80% of the 94 TAY that were enrolled reported satisfaction with the program, although there has not been enough time to gather sufficient data since the program was implemented. The County indicates that the results of FY 16/17 are not yet available.

This expansion/extension request will yield no changes in how data will be collected and evaluations will continue to be collected annually in order to assess that learning goals

are being met. In addition, the County will perform evaluations at monthly intervals throughout the implementation in order to gather extensive baseline data and to allow follow up with Urban Beats participants.

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 amount that was requested and approved by the Commission was for $1,208,488 for a 3-year project. This extension request would increase project length by 2 years for a total of a 5-year project. The proposed extension amount requested is $2,259,447 for a grand total of $3,467,935. With the expansion of the North Central and East African region, the total evaluation cost has increased and is $286,214 (12.7%). Most of the budget being requested for the extension is comprised for expansion of the program into the North Central part of San Diego and in the East African community. In addition to taking the program into two new communities, expansion costs will also include the lease of a van and hiring an onsite therapist.

The County indicates that if Urban Beats proves to be effective, alternative funding streams may be considered.

County may wish to provide clarity on the total budget, including the evaluation line tem, as totals specified by Fiscal Year do not align with their budget total.

Additional Regulatory Requirements

The proposed project appears to meet the minimum requirements listed under MHSA Innovation regulations**.**

References

https://www.google.com/search?source=hp&q=population+demographics+of+san+diego+county&oq=population+demographics+of+san+diego+county&gs_l=psy-ab.3..0.1823.23654.0.23984.66.54.5.0.0.0.475.7445.0j34j6j2j1.43.0....0...1.1.64.psy-ab..20.45.6850.0..46j35i39k1j0i67k1j0i131k1j0i46k1j0i20i264k1j0i10k1j0i5i10i30k1j0i20i263k1j0i22i30k1j33i22i29i30k1.0.c684fQRemq8

https://www.sandiego.gov/economic-development/sandiego/population

https://www.sdurbanbeats.org/classes

Urban Beats (INN 16) Project Overview

Original Duration: July 1, 2015 through June 30, 2018
Proposed Extension and Expansion: July 1, 2018 through June 20, 2020

Purpose
To assist transition age youth (TAY) in engaging or investing in behavioral health services and/or identifying mental health symptoms and reducing stigma by connecting with TAY through artistic expression.

How
Project 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.

Why
Stakeholders expressed that TAY have long been difficult to engage and retain in mental health services. This approach provides wellness activities and messaging in an innovative way that proposes to reach TAY who otherwise would remain disconnected from or prematurely leaves our system of care. Urban TAY often encounter stigma within their community regarding both accessing and maintaining behavioral health services. Transition age youth often report feeling disconnected from traditional services and the people providing them.

Where
This program is currently being offered in the Central Region and the expansion is to include the North Central Region and the East African Community.

Who
Transition age youth experiencing SMI or are at-risk of behavioral health conditions. Extension and expansion to increase TAY enrolled in "academies" to 200 annually and a target total of 1,400 TAY who attend performances.

Innovative Components
This project is an adaptation to existing similar programs and it is designed to test whether a culturally sensitive program that focuses on engagement via multiple models of artistic expression is successful at engaging TAY with a SMI that are currently enrolled in behavioral health programs as well as at-risk TAY who may develop behavioral health conditions.

Proposed Change
The MHSOAC-approved primary purpose of Urban Beats is to increase access to mental health services to underserved groups. The current annual target is 100 enrolled participants providing outreach and engagement via performance to 600 individuals who complete surveys. The proposed change will increase the annual target to 200 enrolled participants and 1400 individuals surveyed. 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 Fiscal Year 2015-16 (n=94), limited number of performances (five), and the short time frame of one year, the outcomes (however promising) cannot be cited as definitive evidence that the program model works. Therefore, expansion into the North Central Region of San Diego County is essential. One of the learnings from year one is that TAY lack readily available transportation, limiting access to the program academies and performances. The addition of a van addresses this barrier. An additional learning in year one was that the program consistently encountered TAY with mental health needs requiring additional support in the program and in transitioning to ongoing care. While creating art and performances, TAY often discussed their own experience with trauma and mental illnesses. The addition of a therapist addresses both the in-the-moment mental health needs and allow for a clinical assessment, consultation, short-term treatment and a warm and overlapping referral to resources in the community

Additionally, since the original inception of Urban Beats, stakeholders, particularly the East African community, have advocated for culturally sensitive services geared towards their youth. It is the intent of this expansion is to add a third academy track through a subcontract, specifically for the purpose of attaining culturally competent services in the East African TAY community through cultural brokers.

Research Questions

- To learn whether engaging TAY in a youth friendly and artistic manner improves outcomes by enhancing wellness, coping strategies, access to care, Independent Living Strategies (ILS), and ability to socialize in a positive healthy manner, while imparting a message of wellness to other TAY.
- To learn if the purposeful integration of elements of artistic expressions and culture facilitated in a therapeutic setting increases access or acceptance of services and increases the level of functioning by participating in meaningful activities.
- To evaluate alternative strategies that can be integrated into our traditional TAY service array and used to engage SMI and at-risk TAY in mental health services more consistently and effectively.
- To evaluate whether the inclusion of a therapist on staff increases connection to services.
- To evaluate if this innovative model will work with specific populations (East African TAY)

Budgeting and Timeline

URBAN BEATS PROJECTED COST						
Annual Budget: $964,837 (200 Enrolled Participants, 100 Performances, and 1400 Surveyed Participants)			**Total Project Cost: $ 3,467,935**			
Project Duration: 5 Years						
Budget	**FY 15/16**	**FY 16/17**	**FY 17/18 (November expansion)**	**FY 18/19**	**FY 19/20**	**Total**
Salaries & Benefits	$134,564	$134,564	$303,609	$424,356	$424,356	$1,421,449
Operating Cost	$204,947	$204,947	$259,370	$298,243	$298,243	$1,265,750
Indirect Cost	$44,166	$44,166	$79,932	$105,449	$105,449	$379,163
Other Expenditures: East African Component			$51,083	$88,547	$88,547	$228,177
Evaluation*	$20,194	$20,194	$36,526	$48,242	$48,242	$173,398
Projected Annual Budget	**$403,871**	**$403,871**	**$730,520**	**$964,837**	**$964,837**	**$3,467,935**
* Evaluation is 5% of total annual budget cost						

TARGET DATES	KEY MILESTONES
November, 2017	Existing contract amended to include new region and scope of services.
December, 2018	Initiation of subcontract and hiring of staff for East African component.
June, 2018	Completion of site visit to verify compliance with terms of contract.
July, 2018- June 2020	Continuation of regular contract monitoring activities, including review of invoices, performance, and quality standards. Completion of annual evaluations reviewed by Behavioral Health Services to gauge effectiveness of the program specific to the target population and planned interventions.
June, 2020	End of program.
November, 2020	Evaluation of total program to include all years concluded. Results to be disseminated.

Mental Health Services
Oversight & Accountability Commission

STAFF INNOVATION SUMMARY—SAN DIEGO

Name of Innovative (INN) Project: INN -17 Cognitive Rehabilitation and Exposure/Sorting Therapy (CREST) Mobile Hoarding Units (Extension)

Extension Funding Requested for Project: $2,913,159

Duration of Extension: 2 years

Review History

MHSOAC Original Approval Date: 02/26/2015

- Original Program Dates: 7/1/2015 through 6/30/2018 (3 years)
- New Program Dates: 6/30/2018 through 6/30/2020 (2 years)
- Original Budget with Evaluation: $1,331,919
- Total New Budget with Evaluation: $ 4,245,077

Approved by the County Board of Supervisors: 4/25/2017

County Submitted Innovation (INN) Project: 9/08/2017

MHSOAC Consideration of INN Project: 10/26/2017

Project Introduction:

The County is requesting an extension of time and funding for this Innovation. Initially approved in 2015 as a three year project, and formerly known as the Innovative Mobile Hoarding Intervention Program, CREST Mobile Hoarding Units (CREST) was designed to reduce hoarding, improve health and safety, quality of life and housing stability to older adults suffering from serious mental illness, with hoarding behaviors and who may be at risk for homelessness.

The program development was delayed as the result of contracting processes and clients were not seen until 2016. At the onset, due to budgetary constraints, the program saw clients in the Central and North regions of the county. At this time, the County is requesting an extension of time and funding to allow it to expand the program county-wide, include bi-lingual social workers, and two HUBs for the East/South regions. Additionally, this expansion will include a collaboration with community partners responsible for financial, debt, code enforcement, cleaning, waste removal, pest/vector control and wraparound services to avoid homelessness on the part of the participants.

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 provides information regarding the serious health and behavioral problems related to hoarding. Using data from the International Obsessive Compulsive Foundation, (IOCF) it reports that the acquisition of items in rooms reduces the room's intended functions and that 45% of persons who hoard 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. Further, persons with hoarding disorder (HD) were at a higher risk for having fires in their homes, falling, having unsanitary conditions, were on fixed incomes, could not pay for extra storage, and were at risk of being evicted.

During the first year that the County's Innovation plan was being implemented 33 clients were enrolled; 27 clients had multiple eviction risk factors, and 21 were in the process of eviction. All eviction processes were stopped as the result of the CREST intervention. In the time since the program's inception, an additional 149 older adults contacted the CREST program. Nearly a quarter of these contacts met the diagnostics criteria for the program, however, were not currently residing in the eligible zip code regions for the County project. The County believes that expanding the parameters of the program will facilitate the development of this as a promising practice allowing it to be replicated.

The demographics provided indicate that older adults (over 60) are predominantly at risk for hoarding behaviors especially in conjunction with behavioral health issues of isolation, low income, lack of awareness, depression. Approximately 12% of the County's residents are over 65.[1]

Additionally, because over 32% of the residents in San Diego County identify as being Hispanic/Latino the County would like to add bilingual staff to implement and test the CREST program's viability in a bilingual environment (p. 2).

The Response

The original project plan, approved by the Commission on February 26, 2015, was to serve a population of older adults in an effort to address hoarding behaviors for those who meet Severe Mental Illness (SMI) criteria.

[1] The San Diego County's website age group specifications includes 60-64 year olds in the age grouping 44-64 and so the estimate of possible age appropriate participants could increase.

Since the time the original project was implemented, a total of 33 clients in Northern and Central San Diego regions were enrolled in the CREST program. Of those 33 clients, 82% had histories of multiple evictions and 21% were in the process of being evicted. As a result of the program, the County indicates they were able to work closely with landlords which resulted in zero evictions.

Although this may be considered successful, the County states only a few have been enrolled in the program, compared to the actual need. Between March 2016 and June 2017, 149 older adults contacted CREST but could not be enrolled because they did not live in a zip code that was eligible to receive services because they lived outside of Northern and Central San Diego.

This extension request is to allow expansion of CREST countywide in order to provide services for more clients and would permit additional time for data to be collected and analyzed. Additionally, due to the large Hispanic/Latino population, the extension also requests the addition of bilingual therapists who may assist those who may be monolingual Spanish speakers.

Previously, 33 clients were serviced by CREST; however, with this expansion/extension request, the County's goal is to serve 90 clients countywide.

The Community Planning Process

During early Fall 2016, the County had more than 650 community members participate in the community engagement process. Over 500 people attended 12 regional forums and more than 100 representatives of cultural populations, including justice partners, male and female incarcerated individuals and peer workers participated in 6 focus groups. An outside consultant was retained to facilitate the forums and focus groups and questions related to strengthening the system capacity were discussed. The discussion focused on four topics: children's behavioral health, unserved/underserved, care coordinators and all proposed concepts for the Innovation projects (developed from previous community planning processes). Fifteen themes emerged from the facilitated meetings and access and services, continuum of care, and education and awareness were deemed to be used when making decisions regarding expansion and/or extension of existing Innovation programs.

In addition, the County's stakeholder-led monthly meetings as well as the Adult System of Care Council, the Older Adult Council, the Children, Youth and Family System of Care and the Housing Council were asked their input and a to complete a community feedback questionnaire. Finally, the Innovation proposals were sent to a stakeholder listserv and posted to the County's website with a Survey Monkey link for feedback.

Learning Objectives and Evaluation

The County states there will be no changes regarding the purpose or expected outcomes. The project will continue to be evaluated each fiscal year. Data will be drafted into reports for review by stakeholders and address questions or concerns that arise through the

evaluation process. San Diego's Internal Performance Outcomes team will then review reports.

The Budget

The original CREST project was approved for $1,331,919. San Diego County is asking for an additional amount of $2,913,158 to be able to provide services to clients throughout the County for a total project budget of $4,245,077. The new budgeted amount for the evaluation of this proposal is $212,254 (5%).

The County specifies that this extension does not raise the cost per client, which will remain at the previously approved amount of $14k per client. The increase in personnel budget will cover the cost of adding 2 full-time bilingual Licensed Clinical Social Workers per region and two HUBS (Eastern HUB and Northern HUB).

County states increase in budget will allow 90 clients to be served countywide and if CREST project remains successful, alternative funding streams will be considered.

Additional Regulatory Requirements

The proposed project appears to meet the minimum requirements listed under MHSA Innovation regulations.

References

https://hoarding.iocdf.org/

http://www.sandiegocounty.gov/hhsa/programs/phs/documents/CHS-Demographics_NorthCentral.pdf

CREST Mobile Hoarding (INN 17) Project Overview - formerly IMHIP

Original Duration: January 1, 2016 through December 31, 2018
Proposed Extension and Expansion: January 1, 2018 to June 30, 2020

Purpose
Improve health, safety and quality of life, decrease hoarding behaviors, and decrease housing instability in older adults.

How
The project diminishes hoarding behaviors long term in older adults with serious mental illness (SMI) 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. Change adds bilingual staffing, will serve more clients countywide and will add two additional hubs in East and North County regions and extends services until June 30, 2020.

Why
Hoarding is particularly dangerous for older persons, 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. 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, or housing fires. Older adults are at risk for eviction or premature relocation to less desirable housing.

Where
Residential homes of referred clients.

Who
Older adults with serious mental illness referred for hoarding behaviors that impact daily living and risk for eviction. Current program serves 30 clients in the Central/North Central Regions. The program will expand countywide to serve an additional 60 clients.

Innovative Components
The mobile nature of the project increases access to services for a population of older adults with serious mental illness who tend to be isolated and who have many times lost their social contacts and family connections due to the hoarding behaviors. There are few trained professionals that have specialized expertise in this area or are able to make house calls to coach individuals to de-clutter and/or teach them new skills to manage compulsive hoarding. This program design addresses these issues and further, provides case management, peer support, family services, collaboration with the older adult's other treatment professionals, linkage to additional community services and aftercare services with the goal of increasing the number of clients served Countywide, decrease in evictions, decrease at risk of homelessness or homelessness and increase in long-term coping skills to avoid hospitalizations and legal issues. In addition, being that the Hispanic/Latino population is the largest minority group in San Diego County (33%) with the South County region having 61% of the population identified as Hispanic/Latino with 19% monolingual Spanish speakers, and

36.5% bilingual it is requested that CREST have bilingual Spanish/English staff to enable the program to implement and test CREST bilingually.

Proposed Change

The proposed expansion to the program will serve 90 clients countywide and will cover the cost of adding full-time bilingual Spanish/English Licensed Clinical Social Workers per region and two hubs (one for East/South Region and one for North Region). Neither has fiscal impact on the already cost per client. In order to establish the effectiveness of CREST we will randomize clients to the active community treatment as usual control group. After six months of ongoing monthly assessments the clients will be offered the CREST program.

Research Questions

- What is an effective model to treat hoarding behaviors in older adults with serious mental illness?
- What are the most effective ways to engage an older adult to participate in interventions geared for hoarding behaviors?
- Are peer supports and family services effective with older adults who have hoarding behaviors either individually and/or as part of an aftercare support group?
- What is the effectiveness of the CREST program compared to community treatment as usual?
- Can CREST be effectively delivered in a bilingual/bicultural (Spanish/English, Hispanic/Latinos) format?

Budgeting and Time Frame

CREST PROJECTED COST						
Annual Budget: $ 1,342,853 (90 clients)			**Total Project Cost: $ 4,245, 077**			
Project Duration: 4.5 Years						
Budget	**FY 15/16 (Half year only)**	**FY 16/17**	**FY 17/18 (Half year expansion)**	**FY 18/19**	**FY 19/20**	**Total**
Salaries & Benefits	$ 93,334.00	$ 340,732.00	$ 608,689.00	$ 876,646.00	$ 876,646.00	$ 2,796,047.00
Operating Cost	$ 93,348.00	$ 26,028.00	$ 98,981.00	$ 76,341.00	$ 76,341.00	$ 371,039.00
Indirect Cost	$ 24,204.00	$ 55,014.00	$ 51,185.00	$ 142,947.00	$ 142,947.00	$ 416,297.00
Other Expenditures (hubs)			$ 89,888.00	$ 179,776.00	$ 179,776.00	$ 449,440.00
Evaluation*	$ 11,098.00	$ 22,199.00	$ 44,671.00	$ 67,143.00	$ 67,143.00	$ 212,254.00
Projected Annual Budget	**$ 221,984.00**	**$ 443,973.00**	**$ 893,414.00**	**$ 1,342,853.00**	**$ 1,342,853.00**	**$ 4,245,077.00**
* Evaluation is 5% of total annual budget cost						

TARGET DATES	KEY MILESTONES
January, 2018	Existing contract amended to include new regions and scope of services [two full-time bilingual staff per Region and two hubs (one in East/South Region and one in North Region) to serve 90 clients countywide].
February, 2018	Target for completion of hiring of staff for amended positions.
June, 2018	Completion of site visit to verify compliance with terms of contract.
July, 2018 - June, 2020	Continuation of regular contract monitoring activities, including review of invoices, performance, and quality standards. Completion of annual reports to include all data elements year to date; analysis of the barriers and successes of the project and recommendations based on lessons learned thus far for the countywide expansion and the use of bilingual staff (Spanish/English). Annual evaluations reviewed by Behavioral Health Services to gauge effectiveness of the program, specific to the target population.
June, 2020	End of pilot program and services.
December, 2020	Evaluation by Behavioral Health Services to determine results and feasibility of integrating into existing programs or replication. Evaluation of total program to include all years concluded. Results to be disseminated.

STAFF INNOVATION ANALYSIS— SAN DIEGO

Name of Innovative (INN) Project: Telemental Health

Total INN Funding Requested for Project: $5,253,376

Duration of Innovative Project: 5 years

Review History

Approved by the County Board of Supervisors: April 25, 2017

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

MHSOAC Consideration of INN Project: October 26, 2017

Project Introduction:

The County proposes to increase access to behavioral health services after a psychiatric emergency by providing Telemental Health[1] services to a specific population of psychiatric patients who do not follow up with mental health services after their discharge in order to reduce recidivism. This new treatment modality provides clients utilizing crisis services with a telecommunication device (including training on the device) prior to their discharge. The county has traditionally referred these clients for a face to face follow-up but has noted that there is a remarkable percentage of discharged clients who do not follow up with services and re-enter psychiatric facilities within 30-90 days after their initial discharge. This approach assures that there is a continuity of care for populations with high rates of recidivism in utilizing emergency services. The Telemental Health project proposes to hire three (3) FTE Licensed (or licensed eligible) clinicians, with a minimum of one (1) bilingual clinician, and five (5) FTE case managers who will conduct initial screenings for willingness and appropriateness for the service.

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? Will the proposed evaluation allow the county to make any conclusions regarding their learning objectives? In addition, the MHSOAC checks to see that the Innovation meets regulatory requirements that the proposed project must align with the core MHSA principles, promote learning, funds exploration of a new and/or

[1] The research appears to use this term interchangeably with telepsychiatry, as a treatment modality, this is not true in this case.

locally adapted mental health approach/practice, and targets one of the four allowable primary purposes.

The Need

San Diego County states that the number of children, youth and adults that accessed psychiatric emergency services in emergency screening units, county psychiatric hospital (adults) and Rady's CAPS psychiatric hospital in FY 16/17 was approximately 8,918 adults and 1,248 children and youth. Of these 9,949 utilizers of psychiatric emergency services, approximately 1,250 (12%) did not follow-up for mental health service, however, a large percentage ended up accessing emergency psychiatric services again. The County's data reveals that recidivism for hospitalization or crisis services frequently occurs 30-90 days after a client's discharge from hospital or crisis intervention services. The current post crisis treatments/programs are provided through community based services at the client's residence or at outpatient clinic, and rely on face to face contact with a provider.

Data related to the County shows that they rank first out of the 58 counties in California for the highest rate of hospitalizations resulting from self-inflicted injury for children and youth age 5-20. San Diego also ranks 3rd out of the 58 counties for completed suicide for children and youth (Data source kidsdata.org). San Diego County conducted a review of client follow-up post emergency services (FY16/17 CO-19 report) and the results indicated that 76 children and youth (5-17 years old), did not access services after discharge. 1,155 adults (18 years and older), did not access follow-up services after discharge.

One report indicates that "our readmission rate is 25 percent within 30 days. That's a problem," said Dr. Michael Plopper, chief medical officer of Sharp Behavioral Health Services. "Something isn't working in the community. Otherwise, they wouldn't be coming to the emergency departments to get care."

These statistics led San Diego County to propose developing Telemental Health as innovation project that seeks to increase access to follow-up mental health services following a psychiatric emergency service.

The Response

San Diego County states that it has a high rate of access for psychiatric emergency hospitalizations resulting from self-inflicted injury for children and youth. Out of the 10,166 consumers who accessed psychiatric services in FY 16/17, 12% did not seek follow-up treatment; however, they were subsequently hospitalized for additional psychiatric needs within the next 30 days.

The County states that this project will increase access to follow-up behavioral health services for clients after being hospitalized, screened in an emergency room, or accessing crisis response services. The County's goal is to reduce recidivism rates for consumers who utilize emergency services when another crisis occurs by providing

Telemental Health services for those who are experiencing barriers in receiving follow-up treatment.

Literature review conducted by San Diego found that Europe has had success with providing Telemental Health services by utilizing specific service components to ensure success. Additionally, the County found information indicating that using Telemental Health as a service/treatment modality is a practical way of treating adults who may not follow-up with referrals to specific needs and resources because of various factors that can ultimately become barriers in seeking appropriate help.

The reviews supported the effectiveness of this service delivery by incorporating:

- The use of Evidence based practices for specific mental health needs
- The applied interventions that should be evaluated and endorsed by clinical experts
- Clients who are able to access the resources, and the intervention should be individualized to meet the needs
- The ability to track client's goals through oversight monitoring, and
- Interventions that should be evaluated on a regular basis.

As the result of its research, San Diego found that Telemental Health is not well documented for clients who do not follow-up with behavioral health services after they have been discharged, thus creating a gap in service data. The County would like to study Telemental Health for those that have been recently discharged from psychiatric emergency settings with the hypothesis that providing Telemental Health immediately following, (or even prior to discharge), a psychiatric crisis would reduce the high rate of returning to a psychiatric emergency setting. Additionally, San Diego County believes that the need for these services will also benefit patients living in rural and underserved communities.

During the discharge process, clients will be screened by an onsite case manager. If clients are determined to be viable candidates; capable of utilizing the telecommunication devise, they will be provided the appropriate resources for access and participation in the follow-up sessions. The potential end users will be evaluated by the case managers who will then also provide appropriate training on the device's use. Eligible clients will be provided information at that time along with completion of consent for treatment forms and signing release of information documents. If the client does not have access to an electronic device, one will be provided to them. Follow-up appointments will be scheduled.

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.

The County engaged 551 community members and providers at 12 regional forums and more than 100 representatives from targeted populations. Participants provided commentary through a group process that asks questions aimed at strengthening system capability by focusing on productive potential. The County's stakeholder led monthly councils provide a forum for council representatives and the public to stay informed of MHSA programs and offer input. MHSA Coordination team presented the proposed expansion and extension to the Adult System of Care (ASOC) Council, the Older Adult Council, the Children, Youth and Family System of Care (CYESOC) Council, and the Housing Council for their input. The County utilized an expansive, stakeholder email to distribute the Innovation proposals and provide recipients a Survey Monkey link for their electronic feedback. The County posted the proposed Innovation programs on their website along with this link for feedback. The County developed the concept of the plan based on the feedback received from local stakeholders that Telemental Health Service provision be easily accessible in rural areas and be a viable option to support clients who have difficulty physically accessing services.

Learning Objectives and Evaluation

The County has identified their target population consisting of Children, Youth, TAY, Adult, and Older Adults who are not connected to services following a psychiatric hospital or crisis stabilization setting. The county describes a number of different settings: emergency department, psychiatric hospital, crisis stabilization, emergency screening, crisis services, etc. **The County may wish to clarify how these individuals will be contacted through these access points.** .

The data that will be collected by the County matches their intended learning goals, and include:

1) Number of individuals screened for appropriateness of Telemental Health services and the number of individuals referred for this service.
2) Gender, ethnicity, age and diagnosis of those utilizing Telemental Health services
3) Percentage of clients linked utilizing Telemental Health to outpatient services
4) Percentage of clients utilizing Telemental Health services who require another psychiatric emergency services
5) Number of clients, and length of time, clients are assisted by the Telemental Health program while awaiting linkage to ongoing supports

The county will compare Telemental Health participants' with previously collected data from the psychiatric emergency centers to identify if there is a reduction in usage and

increased access to services as compared to previously collected data and demographics.

The Budget

The County is requesting funding for a five (5) year project and a total budget of $5,253,376. Approximately 77% of total budget is allocated for personnel. $230,890 (or 4.3% of the total budget) is allocated for evaluation. The County reports in the text of their proposal that they intend to hire five (5) FTE licensed or license eligible clinicians and three (3) case managers (page 4), however in the budget report, salaries are for four (4) FTE clinicians and 5 case managers. **The county may want to clarify what their staffing requirements will be.**

Further, given the potential for various types of personal telecommunication equipment (rentals, purchases, Wi-Fi set ups) and the potential costs for rural implementation of this plan, there does not seem to be any differentiation in the budget between routine office costs and what the potential or anticipated costs would be for the Innovation equipment. **Since the bulk of this innovation relies on telecommunication, the county may want to present more specific budget line items as to the anticipated costs.**

Additional Regulatory Requirements

The proposed project does appears to meet the minimum requirements listed under MHSA Innovation regulations.

References

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3662387/

https://www.ncbi.nlm.nih.gov/pubmed/21553998

http://www.sandiegouniontribune.com/news/watchdog/sdut-county-amasses-mental-health-funds-amid-need-2015aug22-htmlstory.html

Telemental Health (INN 19) Project Overview

January 1, 2019 through December, 2023

Proposal

1. To enhance access to aftercare mental health treatment for an identified subset of clients who receive psychiatric emergency care, yet are not connected to traditional outpatient mental health services ("unconnected" clients), and are therefore at risk to relapse back to emergency services.
2. To utilize an existing practice of Telemental Health and apply it to a specific subset of "unconnected" clients to offer outpatient care and prevent need for subsequent psychiatric emergency services.
3. To reduce barriers for "unconnected" clients accessing mental health services through augmenting current service modalities (face to face, office, clinic, home, or school based) to increase access and connection to outpatient mental health treatment.

How

Proposal is to initiate services prior to discharge from psychiatric hospital or crisis stabilization unit by an on-site Case Manager who would screen the client for appropriateness and amenability for receiving Telemental Health services. When the client is assessed to be a good fit for the service, the first Telemental Health appointment would be scheduled and client coached through the electronic connection. When needed, tablets will be provided. The program would consist of a Program Manager, Case Managers and Telemental Health Therapists.

Why

There are over 10,000 youth and adults who access psychiatric emergency services on an annual basis. Approximately 12% of these individuals do not access follow-up mental health services and return to an emergency psychiatric setting within 30 days. Research and feedback from existing providers have identified specific barriers in accessing follow up treatment for this subset population which include: feeling overwhelmed by mental health needs, limited insight or motivation, stigmatization for seeking mental health treatment, presence of co-occurring diagnosis such as anxiety, challenges with transportation and/or childcare, and caregiver burnout. Telemental Health has the potential to offer ease of care that could overcome identified barriers in order to enhance access to follow-up care for unconnected clients.

Where

1. Services will be initiated at the psychiatric hospital or crisis stabilization unit prior to discharge.
2. Telemental Health services by design are offered through a secure network.
3. Client will receive Telemental Health services at their preferred safe location, and when needed supported with devise.

Who

1. Youth with serious emotional disturbances (SED) and adults with serious mental illness (SMI);
2. Youth and adults who have accessed emergency psychiatric services and are unconnected to a mental health treatment provider;
3. Youth and adults who are experiencing barriers to accessing outpatient treatment and express interest in this modality.
4. Proposed clients served annually: 250 (75 youth and 175 adults).

Innovative Components

The project intends to utilize Telemental Health in a new way, which would be to a subset population; clients receiving psychiatric emergency services and are not connected to traditional outpatient services. The program would aim to increase access to aftercare treatment for these clients that are at risk to return to psychiatric emergency services. Telemental Health would be offered to clients of all age ranges that are screened to be amenable for the service. The program will offer devices and connectivity when needed, utilizing technology that ensures compliance with privacy requirements. The utilization of Telemental Health is a promising approach and a potential solution for overcoming barriers that prevent clients from accessing mental health treatment upon discharge from an emergency psychiatric service.

Research Questions

- Will Telemental Health lead to increased engagement in outpatient mental health services post discharge from a psychiatric hospital/crisis unit for clients that are not already connected to treatment?
- Will Telemental Health decrease re-admission to psychiatric emergency services?
- Do some subpopulations (based on age, gender, racial/ethnic, linguistic, diagnosis or cultural determinants) respond best to technology driven services?
- For those who utilize Telemental Health what specific needs or barriers to treatment does it meet?

Budgeting and Timeline

Cycle 4 INN - 19 Telemental Health

Innovative Project Budget by FISCAL YEAR (FY)

Budget	FY 18/19 (1/2 year)	FY 19/20	FY 20/21	FY 21/22	FY 22/23	FY 23/24	Total
Salaries & Benefits	$ 447,460	$ 894,920	$ 894,920	$ 894,920	$ 894,920	$ -	$ 4,027,140
Operating Cost	$ 107,177	$ 82,270	$ 82,270	$ 82,270	$ 82,270	$ -	$ 436,257
Indirect Cost	$ 67,848	$ 122,810	$ 122,810	$ 122,810	$ 122,810	$ -	$ 559,089
Annual Program Budget	$ 622,485	$ 1,100,000	$ 1,100,000	$ 1,100,000	$ 1,100,000	$ -	$ 5,022,486
Annual Evaluation Cost	**$ 23,089**	**$ 46,178**	**$ 46,178**	**$ 46,178**	**$ 46,178**	**$ 23,089**	**$ 230,890**
Total Project Budget	**$ 645,574**	**$ 1,146,178**	**$1,146,178**	**$1,146,178**	**$1,146,178**	**$ 23,089**	**$ 5,253,376**
Total Project Cost: $ 5,253,376							**Project Duration: 5 Years**
S&B Rate to Annual Budget	72%	81%	81%	81%	81%	0%	80%
Operating Cost Rate to Annual Budget	17%	7%	7%	7%	7%	0%	9%
Indirect Rate based on Annual Budget	11%	11%	11%	11%	11%	0%	11%

TARGET DATES	KEY MILESTONES
January, 2018	Statement of Work developed.
March, 2018	Initiation of contracting process; target release of Request for Proposals through Department of Purchasing and Contracting.
April, 2018	Deadline for submittals of contract proposals.
July, 2018	Selection of highest quality, best value proposal through public Source Selection Committee process.
September, 2018	Initiate negotiations with selected provider.
January, 2019	Target date to initiate program operations.
March, 2019	Completion of site visit to verify compliance with terms of contract.
July, 2019	Continuation of regular contract monitoring activities, including review of invoices, performance, and quality standards.
January, 2020	Completion of annual evaluations reviewed by Behavioral Health Services to gauge effectiveness of the program specific to the target population and planned interventions.
January, 2023	Evaluation by Behavioral Health Services to determine, results and feasibility of integrating into existing programs or replication.
June, 2023	End of pilot program.
December, 2023	Evaluation concluded. Results to be disseminated.

AGENDA ITEM 7

Action

October 26, 2017 Commission Meeting

Criminal Justice and Mental Health Report

Summary: The Mental Health Services Oversight and Accountability Commission (MHSOAC) will consider adopting the criminal justice and mental health final report submitted by the Criminal Justice and Mental Health Project Subcommittee.

The MHSOAC Criminal Justice and Mental Health Project began in spring 2016. The goal of the project was to reduce the number of adults with mental health needs who become involved with the criminal justice system while improving outcomes for those in custody and upon release to the community.

To achieve its mission and develop recommendations, the Commission created a project subcommittee, chaired by Commissioner and Santa Barbara County Sheriff Bill Brown, and including Commission Chair Tina Wooton and former Commissioner Richard Van Horn, whose term ended just as the project neared completion. The subcommittee consulted with local, state, and national experts on barriers and best practices, solicited input from diverse communities, and reviewed current mental health research, policy, and practice.

To develop a shared understanding of the problem, the subcommittee held a series of meetings, public hearings, and community forums around the state over a period of 10 months. These gatherings allowed commissioners to hear from community members, people with lived experience, experts in the fields of mental health, public safety, and social services, as well as from state and county leaders, service providers, and other Californians. The meetings sought to incorporate a broad range of perspectives and experiences to support the development of shared knowledge, ensuring that any proposed recommendations address the needs and interests of affected communities throughout California. To enhance information gathered through its research and public meetings, the Commission visited several sites in California and other states, including Florida, Pennsylvania, and Texas.

The draft criminal justice and mental health project final report was released publicly on September 22, 2017. The Criminal Justice and Mental Health Project Subcommittee met on September 29, 2017 to discuss, hear public comment, and consider revisions to the report. The subcommittee directed staff to make several revisions to the draft, and the subcommittee voted

unanimously to send the revised draft to the Commission to consider for adoption.

The revised draft criminal justice and mental health project final report containing the findings and recommendations that were approved by the subcommittee are enclosed for your review and consideration.

Presenter: Ashley Mills, Senior Researcher and Project Staff Lead

Enclosures: Criminal Justice and Mental Health Project final report, as revised during the September 29, 2017 subcommittee meeting

Handout: A PowerPoint will be presented at the meeting.

Proposed Motion: The MHSOAC adopts the report submitted by the Criminal Justice and Mental Health Project Subcommittee.

Mental Health Services
Oversight & Accountability Commission

Together We Can

REDUCING CRIMINAL JUSTICE INVOLVEMENT FOR PEOPLE WITH MENTAL ILLNESS

SECOND DRAFT TO THE COMMISSION DURING ITS MEETING ON OCTOBER 26, 2017

FIRST DRAFT APPROVED WITH REVISIONS BY THE SUBCOMMITTEE ON SEPTEMBER 29, 2017 SUBCOMMITTEE MEETING

MHSOAC
Mental Health Services
Oversight & Accountability Commission

ABOUT THE MENTAL HEALTH SERVICES OVERSIGHT AND ACCOUNTABILITY COMMISSION

The Mental Health Services Oversight and Accountability Commission, an independent state agency, was created in 2004 by voter-approved Proposition 63, the Mental Health Services Act. The 16-member Commission is composed of one Senator, one Assemblymember, the State Attorney General, the State Superintendent of Public Instruction, and 12 public members appointed by the Governor. By law, the Governor appointees are people who represent different sectors of society including individuals with mental health needs, their family members, law enforcement, education, labor, business, and the mental health profession.

California voters created the Commission to provide oversight, accountability and leadership to guide the transformation of the California mental health system. The Commission fulfills this charge by advising the Governor and Legislature, conducting research and evaluation, administering mental health triage personnel grants, and reviewing and approving county innovation projects.

Other Commission responsibilities include:

- Ensuring public mental health funds are spent in the most cost-effective manner and that services are provided in accordance with recommended best practices
- Developing strategies to eliminate the stigma associated with mental illness
- Ensuring that the perspectives of California's diverse communities, as well as people suffering from mental illness and their families, are included in all Commission deliberations and actions
- Undertaking special research projects to document problems with California's mental health care delivery system and produce recommendations for reform

Commissioners

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Chair

JOHN BOYD, Psy. D.
Vice Chair

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Former Commissioner

Executive Director
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October 12, 2017

One of the greatest public policy failures of our time has been the dismantling of our state mental health care institutions without the provision of adequate community-based treatment in their stead. As a result, we have seen marked increases in severely mentally ill persons – often suffering from co-occurring substance abuse disorders and homelessness – coming into contact with law enforcement. These confrontations are frequently disruptive, dangerous and, sometimes, deadly. More often than not, these encounters serve as a gateway for mentally ill persons to enter the criminal justice system.

Provided here for the review of law enforcement executives, mental health leaders, county executives, members of boards of supervisors, state legislators, the governor and interested persons alike is the Final Report, Findings and Recommendations of a Sub-Committee of the State of California's Mental Health Services Oversight and Accountability Commission that looked at the intersection of mental illness and the criminal justice system. We believe this report, which we wanted to be succinct enough to be actually read and acted upon, encapsulates the problem and contains a creative and achievable plan to reduce the number of mentally ill persons entering California's jails, and a roadmap to providing better mental health care and treatment for those who must be kept in custody.

We recognize that fiscal and human resources in all forms of government are in short supply, and that in many cases they are stretched to the limit. But we have seen how communities facing similar challenges came together to solve parts of this vexing problem. Their approaches were varied, but what they had in common was a collaborative sprit of good will and a resolve to combine forces, share their resources and solve the problem collectively.

We strongly believe that now is the time to implement these recommendations. While not every county can do everything suggested in this report, we recommend taking a strong look at three priorities:

- *Collaborating and combining resources to effectively address the problem.* The Stepping Up Initiative is a proven vehicle that can help communities come together to facilitate these efforts.

- *Provide crisis services and other alternatives to custody for mentally ill persons.* This requires having appropriate places and/or programs that people suffering from mental illness can be diverted to.
- *Expand jail-based and community-based restorative services for persons found Incompetent to Stand Trial (IST).* This is a state-wide problem that congests our courts and overcrowds our jails.

Lastly, I want to thank my fellow Commissioners, Committee Members and the many mental health stakeholders who provided valuable input to this project. I also want to extend my appreciation to MHSOAC Executive Director Toby Ewing and his talented staff – especially Senior Researcher Ashley Mills, whose yeoman effort on this report was at the forefront – for the hard work, collaborative spirit and positive attitudes that they invested into this worthy project. They exemplified the title of this report and the means to achieving collective success in this quest: *Together We Can*.

Sincerely,

BILL BROWN
Sheriff, Santa Barbara County & Commissioner, MHSOAC
Committee Chair

Acknowledgements

The Mental Health Services Oversight and Accountability Commission is grateful for the invaluable contributions and support it received throughout this project. From the launch of this initiative in May 2016, a wide range of people and organizations committed time and resources to produce a plan for reducing the number of people with mental health needs who enter California's criminal justice system – and better serving those who do become incarcerated.

These contributors include mental health consumers, their family members, advocates, researchers, elected officials, educators, law enforcement officials, and people from the mental health profession. This project would not have been possible without their extensive knowledge, experience, and commitment to improving the lives of one of California's most vulnerable populations.

The Commission also recognizes and thanks senior researcher and project lead Ashley Mills, whose dedication to this initiative pushed it across the finish line. Also instrumental in producing this report were contributions from Commission staff members Cynthia Burt, Wendy Desormeaux, Katherine Elliott, Ph.D., and Kayla Landry.

Although the Commission benefitted from the contributions of many individuals and organizations, the conclusions and recommendations in this report are the Commission's own.

This report is dedicated to the men and women with mental health needs who are unnecessarily caught in the criminal justice system, as well as their families and the professionals on the front lines of a national crisis.

Table of Contents

> ***No one expected it – not his parents, not his brother, not his friends. One day, David (fictitious name) was a straight-A high school student who loved sports and had tons of friends. The next, a switch flipped and David was hearing voices and behaving erratically – a completely different kid. Therapists prescribed tough love, and his parents obliged. But while he managed to graduate and land a job as an EMT, David's mental health needs intensified, and soon he was using recreational drugs to quiet the voices in his head.***
>
> ***Next came a suicide attempt. That opened doors to the mental health system, but help was elusive. Finally, his parents were encouraged to have David arrested, a desperate move that authorities hoped might clear a path to a treatment bed. Frantic and out of options, his family consented, but jail made everything worse. David told a psychiatrist he was contemplating suicide, a fact other inmates confirmed. And soon after, he took his own life, alone in his cell.***

Executive Summary

For decades, communities have struggled with a vexing question: how to reduce the number of people with unmet mental health needs who enter the criminal justice system, at times to tragic end. Inspired by heartbreaking incidents, professionals and advocates have advanced innovative approaches and promising practices. But despite their good intentions and earnest efforts, the inmate population, violent street encounters with police, and the costs – in human and fiscal terms – continue to increase.

There is little disagreement about the need for change, or even the preferred direction of that change – in California and nationwide.

Bryan Desloge, a commissioner from Leon County, Florida, and president of the National Association of Counties, could have been speaking for county supervisors in California when he said:

"We all need to be working toward lowering the number of people in our jails and looking at our laws to identify options other than jail for low-level offenders [with mental health needs]. It's a huge, huge crisis for our country today."

In response to this crisis, California's Mental Health Services Oversight and Accountability Commission in 2016 launched a review of current policies and practices and an exploration of emerging approaches. The goal was to develop an action agenda for reducing the number of, and improving outcomes for, mental health consumers involved in the criminal justice system.

Under the leadership of Commissioner and Santa Barbara County Sheriff Bill Brown, the Commission sought input from national and local leaders and convened public hearings and community forums where consumers and family members shared stories and insights alongside public officials and practitioners.

Details of the Commission's yearlong investigation are outlined in the pages ahead. But overall, the commission concluded that California's response must match the scale of the crisis. Californians must no longer accept the reality that a person's unmet mental health needs too often lead to a downward spiral toward time behind bars.

While jail can be a traumatic experience for anyone, imagine the impact of incarceration on Californians with unmet mental health needs – people like David. Despite the best efforts of administrators, jails are

often crowded, chaotic, and understaffed, resulting in dangerous environments. In many cases, jails and the dedicated people who staff them also are ill-equipped to effectively manage inmates with mental health and substance use needs. Most jails in California were built to provide short-term (less than one year) custody and were never designed to hold people suffering from mental illness. Not surprisingly, interruptions in medication and other treatment are common, symptoms intensify, and profound suffering – for the incarcerated as well as their loved ones – is often the tragic result.

Release from jail should bring relief, but that is often not the case. Many people with mental health needs fail to receive transitional assistance with housing, treatment, and other community services that can help them find stable footing outside jail walls. As a result, many struggle, run afoul of the law again, and cycle back into custody. And the costs – to individuals, families, and taxpayers – multiply.

To resolve this wrenching dilemma, California must make a bold commitment. Specifically, the Commission recommends that the state undertake a concerted and coordinated effort that aligns resources and services in a strategic and sustained way to prevent people with mental health needs from getting into the criminal justice system in the first place – and effectively treating those who do.

As part of its review, the Commission took a close look at people with mental health needs in the justice system. Above all, one impression stood out: this is a group with complex and challenging needs. Frequently homeless, their lives are often complicated by longstanding physical health and mental health needs, along with chronic addictions to drugs and alcohol. Some do not believe they have a mental health need or have struggled to find appropriate care. Thus, they have difficulty with treatment – or the treatment that is available.

While recovery for many of these Californians - if not all - is possible, it often requires substantial resources and time. In a system with misaligned or inadequate resources, a jail bed is often the only solution available.

It should not take a tragedy to promote policies and practices that lead to better outcomes. Nevertheless, suicides in jails and costly lawsuits over conditions of confinement have prompted several counties to make investments and program changes to prevent incarceration where possible and provide quality in-custody care when required.

Nationally, innovative practitioners have developed effective private-public partnerships and co-located services, leveraging the expertise of those with lived experience in both mental health and criminal justice systems. The result is an inventory of promising practices that, if deployed system wide – through the management of data, integrated services, and cross-professional training – could be transformative.

The Commission's recommendations were developed through engagement with consumers, families, counties, and state agencies. In tackling this project, the Commission made a deliberate effort to model the collaboration needed to develop a shared understanding of the challenge before us and the effective responses needed to meet it.

In releasing its recommendations, the Commission acknowledges that the challenges facing California are historic, chronic, and seemingly intransigent. The problem is daunting and complex, and we may never have all the answers. Yet as the crisis grows, so does the potential for new approaches and new technologies to fuel a renewed effort.

To take reforms to a fully operational and statewide scale – to move from work arounds and "one-offs" to full system change – state and county leaders must unite to align programs and objectives, integrate services, leverage funding, and use data and other technologies to improve decisions and assess performance. Holistic, lasting change will require a sustained effort to develop the capacity and culture for continuous improvement. Just as importantly, moving forward will require candid confrontation of preconceived notions and honest assessments of whether our allocation of resources is producing the best possible results.

Criminal justice involvement can be devastating to people and their families, but it can be deadly for those living with unmet mental health needs. Reforming our approach to better serve these Californians, both in custody and in the community, won't be easy. But failing to do so will perpetuate the tragedies that characterize our system today.

And, as many have expressed throughout this project, "It's just the right thing to do."

Recommendation 1

California's mental health agencies, in partnership with law enforcement and others, should have a comprehensive, prevention-focused plan that reduces the incarceration of mental health consumers in their communities.

Too many mental health consumers, particularly those from diverse communities, end up in jail because of unmet needs and system inequities. A robust, prevention-oriented system can reduce this unnecessary harm. The commitment to diversion should continue but there also must be a focus on preventing contact with the criminal justice system. Local services should be aligned through comprehensive planning to address unmet needs before they reach the attention of law enforcement. Community-based programs and facilities must be available and accessible to support diversion.

Recommendation 2

The Board of State and Community Corrections should facilitate a collaborative effort with counties to identify, develop, and deploy services and strategies that improve outcomes for mental health consumers in jail, including universal screening for mental health needs at booking and enhanced training for custody staff.

California's jails are not equipped to serve mental health consumers. Diversion should be prioritized but counties need more effective in-custody options to ensure they can provide appropriate and necessary services for those who cannot be diverted.

Recommendation 3

To reduce the backlog of people found incompetent to stand trial, California must maximize diversion from the criminal justice system. For people who cannot be diverted and are found incompetent to stand trial, the state and counties should expand options for restoring competency.

A large and growing number of people found incompetent to stand trial because of unmet mental health needs are forced to spend months in jail awaiting services necessary for their cases to proceed. The state and counties should have an array of options to provide competency restoration services to people found incompetent to stand trial so that these Californians do not wait unnecessarily in jail.

Recommendation 4

The Council on Criminal Justice and Behavioral Health should fortify its efforts to champion collaboration among state agencies to support local prevention and diversion of mental health consumers in the criminal justice system.

California has not put in place a statewide, systemic approach for prevention and diversion to reduce criminal justice involvement for mental health consumers and improve outcomes. California's counties are well-positioned to develop more effective responses to the increased number of people with unmet mental health needs in jails. Yet the state should clear the path for more effective responses, by providing clarity regarding state and federal law, facilitating information sharing, promoting best practices, and identifying and addressing barriers to innovation, among other tasks.

Recommendation 5

The California Health and Human Services Agency should reduce or eliminate barriers so that data and information technology are used to drive decision-making, identify service gaps, and guide investments in programs to reduce the number of people with mental health needs in the criminal justice system.

Data is a critical tool in decision-making and service delivery, but state and local agencies are not effectively harnessing its power to improve outcomes for those in need. The state should develop solutions that allow agencies to integrate and leverage data to build responsive systems, provide better case management, and continuously improve services.

Recommendation 6

The State, in partnership with the counties, should expand technical assistance resources to improve cross-professional training, increase the use of data and evaluation, and advance the dissemination of best practices, including community-driven and evidence-based practices.

To build effective prevention and diversion systems, professionals in the criminal justice and mental health fields will need new knowledge, skills, and abilities to better serve mental health consumers and their communities. The state and counties should jointly improve training and technical assistance to ensure professionals are trained and cross-trained to provide appropriate responses and quality services reflecting the needs and diverse cultures of clients. Evaluation and dissemination of effective practices are essential to continuous quality improvement.

About the Project

The Criminal Justice and Mental Health Project began in spring 2016. The goal of the initiative was to reduce the number of adults with mental health needs who become involved with the criminal justice system while improving outcomes for those in custody and upon release to the community. To achieve its mission and develop recommendations, the Commission created a project subcommittee. This subcommittee is chaired by Commissioner and Santa Barbara County Sheriff Bill Brown, Commission Chair Tina Wooton, and former Commissioner Richard Van Horn, whose term ended just as the project neared completion. The subcommittee consulted with local, state, and national experts on barriers and best practices, solicited input from diverse communities, and reviewed current mental health research, policy, and practice.

Community Engagement and Site Visits

To develop a shared understanding of the problem, the subcommittee held a series of meetings, public hearings, and community forums around the state over a period of 10 months. These gatherings allowed commissioners to hear from community members, people with lived experience, experts in the fields of mental health, public safety, and social services, as well as from state and county leaders, service providers, and other Californians. The meetings were generally open to the public and sought to incorporate a broad range of perspectives and experiences to support the development of shared knowledge, ensuring that any proposed recommendations address the needs and interests of affected communities throughout California.

Special efforts were made to include the perspectives of diverse communities, including people with lived experience who belong to communities of color and LGBTQ communities. Members from communities disproportionately represented in jails were invited to provide testimony about their experiences as people with mental health needs interfacing with the criminal justice system. Project staff reached out to leaders and cultural brokers from diverse communities to conduct additional meetings that were specifically aimed at providing a safe and welcoming environment for people from diverse communities to share their experiences.

Subcommittee Meetings

The first subcommittee meeting was held in Sacramento on June 30, 2016, to introduce the project to stakeholders and solicit feedback on the proposed project framework and scope. This meeting clarified that the project would focus on community mental health and local corrections, and that it would focus on Californians 18 and older.

The second subcommittee meeting was held in Los Angeles on September 21, 2016, to explore current and former efforts to address the intersection of mental health and the criminal justice system, discuss how these efforts should shape future policy choices, and identify gaps requiring further exploration.

Public Hearings

Public hearings before the full Commission were scheduled to support the Commission's understanding of challenges and opportunities for diverting people with mental health needs from the criminal justice system. Hearings included people with lived experience, subject matter experts, and policy leaders to

provide the Commission with a breadth of knowledge and first-person experiences. The agenda included time for discussions between presenters and Commissioners.

The Commission held its first project-related public hearing in Los Angeles on September 22, 2016. The session explored service needs and gaps, how the Commission could help improve outcomes, and the proper roles of the state and counties in reducing the number of people with mental health needs who become involved in the justice system.

The Commission held its second project-related public hearing in San Diego on March 23, 2017, to hear presentations on best practices in custody and reentry and how local leaders are initiating systems-wide change to connect people with services to prevent or reduce incarceration.

Community Forums

The subcommittee held two open community forums to engage clients, family members, professionals, and other stakeholders in a dialogue about the intersection between the criminal justice and mental health systems. Presentations and breakout sessions were held to explore local challenges and barriers as well as solutions and innovative strategies. Driven by public comments made during subcommittee meetings and hearings, the subcommittee organized the community forums to explore two areas: 1) service needs and gaps in local communities, and 2) racial/ethnic disparities.

The subcommittee held its first community forum in Modesto on December 9, 2016, gathering testimony from residents of Stanislaus County as well as those who work in public safety, behavioral health, and related fields. The forum highlighted needs and service gaps, prevention efforts that could reduce the number of people with mental health needs in the justice system, and proposals to break the cycle of incarceration by promoting recovery.

The subcommittee held its second community forum in San Francisco on April 29, 2017. The forum was organized by members of the African American community to focus on cultural barriers and a path toward a more equitable system featuring less incarceration and more community-based treatment and support.

Site Visits

To enhance information gathered through its research and public meetings, the Commission visited several sites in California and other states.

In July 2016, the subcommittee and project staff traveled to Los Angeles County to examine several innovative programs and hear presentations organized by the Council on Criminal Justice and Behavioral Health, including:

- A presentation by Amity Foundation on the Amity Model to Support Community Reintegration
- A presentation on housing strategies by the Los Angeles County Office of Diversion and Reentry
- A meeting with the Los Angeles Police Department's Mental Evaluation Unit and Crisis Response team
- A visit to Exodus Eastside Urgent Care Center

In August 2016, Commissioner Brown traveled to Allegheny County, Pennsylvania, to meet with representatives of a variety of programs, including those that improve housing and service coordination, use administrative data to identify people for supportive services, provide benefits coordination in the jail, and improve the process for dispensing medication upon release from jail. Allegheny County was

recommended to the Commission by representatives of the National Association of Counties during a meeting in Washington, D.C.

On September 21, 2016, the Commission toured the Twin Towers Correctional Facility in Los Angeles, often referred to as the largest mental health facility in the United States.

The Commission was invited by the National Institute of Corrections to send a delegation of California leaders to visit sites in Bexar County, Texas, and Miami-Dade County, Florida, from September 26-30, 2016. The tour provided information on strategies to enhance local agency collaboration and strategic planning. Also covered on the tour were strategies for developing alternatives for people who are experiencing a behavioral health crisis and are detained by law enforcement, expanding crisis intervention training, using peers to support treatment and recovery, improving the use of data and technology, and developing and using public and private partnerships to improve access, care, and outcomes.

On March 22, 2017, the Commission and representatives from the National Institute of Corrections and the Substance Abuse and Mental Health Services Administration toured sites in San Diego, including the Community Transitions Center and Vista Balboa Crisis Center. The visit included a meeting with representatives from psychiatric emergency response teams.

Project staff traveled to Santa Clara County in July 2017 to tour sites and hear presentations organized by the Council on Criminal Justice and Behavioral Health, including:

- Presentations on diversion efforts and housing by Santa Clara County leaders
- A visit to the Santa Clara County Behavioral Health Court
- Presentations on San Mateo County diversion efforts and the Drug Medi-Cal Organized Delivery System
- A visit to Santa Clara County's Crisis Stabilization Unit and Crisis Residential Center

Local and National Initiatives

The Commission also participated in local and national efforts to reduce the number of people with mental health needs who become involved in the criminal justice system. These included the Stepping Up Initiative, the Data-Driven Justice Initiative, and Words to Deeds, a project of the Forensic Mental Health Association of California.

Commissioner Brown and project staff participated in workshops in Washington, D.C., hosted by the Data-Driven Justice Initiative, a project of the White House Office of Science and Technology Policy that focused on local data exchanges, diversion, and data-driven risk assessment tools. The Commission sponsored a convening of California counties engaged in the initiative during the November 2016 Words to Deeds Conference, held in Sacramento. Words to Deeds holds an annual conference to promote best practices for ending the criminalization of mental illness and improving collaboration among courts, criminal justice agencies, mental health professionals, and governmental and nongovernmental organizations.

Commissioner Brown participated in the National Stepping Up Summit in April 2016 in Washington, D.C., and participated in a focus group to develop a Stepping Up Technical Assistance Needs Self-Assessment supported by the Bureau of Justice Assistance and the National Institute of Corrections in July 2017. Commissioner Brown and project staff participated in the Stepping Up Initiative during California's Summit in Sacramento on January 18 and 19, 2017. The Summit was designed to provide support to

government officials and others committed to reducing the number of people with mental health needs in jail. Approximately 400 people attended, representing 53 counties and other entities.

Small Group Discussions

At the start of the project, Commission staff consulted with cultural brokers and conducted a literature review, which highlighted the need to address communities affected by disparities in mental health and criminal justice, most notably African Americans, Latinos, Native Americans, and LGBTQ communities, particularly transgender people.

Members of diverse communities often may mistrust government agencies and may be reluctant to participate in stakeholder and public engagement meetings due to histories of oppression. From December 2016 through April 2017, the Commission organized small group discussions with people identifying as members of African American, Latino, Native American, and Transgender communities. Through existing relationships with community leaders, staff identified community-based organizations working in these communities to host meetings, recruit participants, and coordinate conversations.

Each of these targeted group discussions had between seven and 12 participants. To keep them informal and focused, Commissioners were not present. These discussions were based on methods used to conduct focus groups, and were not open to the public. A discussion of the findings can be found in the "Diverse Communities and System Inequities" section of this report.

Filling in Data Gaps

Throughout this project, the Commission sought to leverage state-level data describing criminal justice involvement of those with mental health needs. The Commission intended to link criminal justice and mental health data to conduct a series of analyses, including providing foundational information on the justice involvement of people receiving community mental health services. Unfortunately, the Commission was not able to access such data in time for the material to be included in this report. More information about opportunities to better use existing data can be found in the "Findings and Recommendations" section of this report.

Incorporating Previous Assessments

To supplement its public process, the Commission reviewed numerous studies and data sources. Project activities and discussions were based on recommendations from past efforts, such as the California Judicial Council's Task Force for Criminal Justice Collaboration on Mental Health Issues, the Criminal Justice / Mental Health Consensus Project led by the Council of State Governments, annual reports by the Council on Criminal Justice and Behavioral Health,[1] a report authored by the former California Corrections Standards Authority, and the California Reducing Disparities Project.[2] Local and national experts from mental health, substance use, and public safety agencies also provided invaluable guidance throughout the project.

Background

"Jails are not good for the mentally ill and the mentally ill are not good for jails."

- Dr. Aris Alexander, Psychiatry Professor Emeritus, University of Wisconsin at Madison, and Clinical Consultant, Wisconsin Division of Corrections

Public concern about the inappropriate incarceration of people with serious mental health needs is not new. After witnessing horrific conditions experienced by "sick and insane" Americans in prisons, Dorothea Dix – a 19th Century teacher turned reformer of psychiatric care – and other advocates pushed for more humane treatment. By the late 1800s, the federal government funded 75 state psychiatric hospitals around the country.[3] While inspired by good intentions, these hospitals were plagued by a lack of money and limited staff. Conditions were appalling. As a result, by the mid-1900s the deinstitutionalization movement was born.

Many observers have pointed to this movement, or, more specifically, the closing of state psychiatric hospitals, as the primary cause of the increasing incarceration of people with mental health needs. Even recently, the number of acute psychiatric beds in California has been drastically reduced, limiting the traditional option for serving people with mental health needs. Experts say communities should have between 40 to 60 psychiatric beds per 100,000 residents to meet needs.[4] In California in 1995, there were 29.5 beds for every 100,000 people in the state.[5] Most recent data suggest that California had 17.44 beds per 100,000 residents in 2013, representing a decrease of roughly 40 percent since 1995.[6]

Another dynamic in play in the mid- to late 1900s was the proliferation of "tough on crime" and "war on drugs" policies, which became popular both nationally and in California. These policies disproportionately affected African American communities, resulting in a dramatic increase in the incarceration of African American men, which, some have argued, has had the pervasive effect of systemic oppression.[7] Between 1970 and 2014, the number of people incarcerated in jails nationwide quadrupled, from 157,000 to 690,000.[8] As the number of laws criminalizing substance use and homelessness grew, so did the population of those with mental health needs in behind bars.[9]

Demographic studies offer some insight into the potential mechanism at play. People with mental health needs or experiences of trauma often have addictions to drugs or alcohol and are vulnerable to poverty and homelessness.[10] "Like dolphins among tuna" in a fisherman's net, people with mental health needs can become entangled in the justice system largely due to substance use.[11] California laws criminalizing homelessness are also on the rise.[12] These laws prohibit camping, sleeping, and resting in public spaces, and they disproportionately affect people with mental health needs and substance use disorders.[13]

One consequence is a criminal justice system that is overwhelmed by a population it was never designed to serve. It is estimated that one in five adults in the United States will experience a mental illness, with five percent meeting the criteria for a serious mental illness.[14] Of those incarcerated in local jails, approximately 17 percent have a serious mental illness, a rate more than three times that of the general population.[15]

Factors that Increase Contact with the Justice System

Despite a common misperception, having a mental illness alone does not increase a person's chance of becoming involved with the criminal justice system. There are cases when people with mental health needs do commit violent acts. However, research indicates that people with mental health needs are more likely to be victims of violence than perpetrators.[16] Amy Barnhorst, M.D., Assistant Clinical Professor from the Department of Psychiatry and Behavioral Sciences at the University of California, Davis, offers more details on the relationship between mental illness and violence:

> *"Studies show that the amount of community violence attributable to mental illness alone is approximately four percent. That means that 96% of community violence is due to other known risk factors, like substance abuse, poverty, and additional social stressors. Much of the association between mental illness and violence documented in studies is explained by the fact that substance abuse is an independent risk factor for violence, and people with mental health needs are more likely to abuse substances than people without such needs. When substance abuse is corrected for in such studies, the increased risk of violence among people with mental health needs is minimal.*
>
> *Despite that reality, media coverage of mass shootings often incorrectly implies that the perpetrators of such acts are people with unmet mental health needs. In fact, the majority of such attacks are carried out by people who do not have confirmed histories of serious mental illness. This misconception sways public opinion and also influences legislators, leading to increased stigma against people with mental health needs as well as violence prevention bills targeting a group whose contribution to community violence is small."*[17]

As Dr. Barnhorst points out, mental illness interacts with other factors that increase a person's likelihood of engaging in violence and becoming involved in the criminal justice system. Studies show that only one in 10 people with mental health needs commit crimes as a direct consequence of mental illness symptoms.[18] Instead, people with mental health needs typically collide with the criminal justice system because of other risk factors for offending, such as substance use, poverty, and homelessness.[19] Still, addressing mental health needs alone does not reduce the likelihood of returning to the justice system.[20] Some of these factors, and how people with mental health needs are more vulnerable to these factors, are discussed in greater detail below.

Substance Use and Other Personal Risk Factors

Mental illness often co-occurs with substance use disorders. According to the latest National Survey on Drug Use and Health, 8.1 million people who abused drugs or alcohol in the past year had a mental health need, but only seven percent received treatment for both.[21] One study estimated that half of those with mental health needs who were arrested also had a substance use disorder.[22] In addition, as many as nine out of ten people with mental health needs who become involved with the criminal justice system will have experienced a substance use disorder during their lifetime.[23] Prevalence rates of substance use

disorders has declined for whites but has remained stable or increased among African Americans and Latinos.[24]

California is testing a new model of delivering a continuum of substance use services and providing integrated behavioral health and physical health care. The new model seeks to provide more intensive services to hard to reach populations, such as people involved in the justice system. This model, developed under the Drug Medi-Cal Organized Delivery System (DMC-ODS) 1115 waiver, is a five-year demonstration pilot project that includes a continuum of care, increased local control and accountability, greater administrative oversight through utilization control, evidence-based practices, and coordination with other systems of care.[25] Treatment services include outpatient treatment, intensive outpatient treatment, medication-assisted therapy, perinatal residential services, and detoxification. The goal is to increase recovery of those receiving services while reducing costs in other systems, such as the criminal justice system.

In addition to substance use, other personal factors may increase the likelihood a person becomes involved with the criminal justice system. Static factors include criminal history, criminal history in the family, and the number of times a person has been incarcerated. Other factors influencing one's likelihood of engaging in criminal behavior are dynamic, or subject to change.[26] These factors have a more direct link to offending. Of the dynamic factors listed below, the first four are most predictive of criminal behavior:[27]

- Criminal thinking, justifying criminal behavior, or lack of remorse
- Criminal friends or associates, peer influence to engage in criminal behavior, or lack of positive involvement with the community
- Criminal or antisocial behavior, especially at an early age
- Criminal personality marked by low self-control, impulsivity, or inability to control anger
- Low levels of participation or engagement at school or work
- Dysfunction in the family, lack of family support or positive communication
- Criminal recreation or leisure activities
- Substance abuse, or inability to stop drug and alcohol use[28]

Effective models for improving outcomes for people with mental health needs involved in the criminal justice system use assessments of the above risk factors in addition to assessing for mental health needs.[29] These assessments allow administrators to place needs along a continuum - low to high - to determine the best course of intervention and correctional supervision.[30] For example, people with higher risks to offend should be prioritized for more intensive in-custody and community supervision when released.[31] People with lower risks to offend can be harmed by too much correctional supervision or by being placed with people at a higher risk to offend.[32] Risk factors, mental health needs, and substance use needs should be assessed using validated tools, and should be assessed as early as possible in the criminal justice trajectory, and then reassessed over time to capture changes.[33]

Recovery through Mental Health and Court Collaboration

Jeremy Sorensen is a Sacramento County Mental Health Court success story. With a bi-polar disorder and a history of self-medication with drugs and alcohol, he had been in and out of the criminal justice system most of his life. But one day last year Sorensen was pulled over for driving under the influence of methamphetamine. The arrest could have cost him custody of his son. Instead, it changed his life.

Thanks to his treatment provider, Sorensen was referred to the Mental Health Court, a program that offers diversion and a clean record to participants who agree to treatment. For Sorensen, it was the perfect fit, providing structure and accountability as well as a medication he says "has been phenomenal" and "changed my way of thinking."

Judge Lawrence Brown, who supervises the program for Sacramento County Superior Court, says Sorensen is typical of those who appear before him – inconsistent with medications while battling addictions to illegal drugs. The Mental Health Court, he says, keeps participants on track with a rigorous schedule of meetings, appointments, and conferences with a judge. Brown says it blends "the treatment approach with the criminal justice system."

"It's an extraordinarily compassionate approach to the justice system," Brown said. "It's almost inhumane to have a seriously mentally ill person incarcerated if they otherwise could be in the community, have treatment, have access to their medication, and be held accountable."

It worked for Sorensen. He "graduated" from Mental Health Court in a year, the minimum possible time, and now volunteers as a mentor and peer support counselor at a mental health service provider.

Poverty and Other Environmental Risk Factors

People living in poverty are more likely to live in environments that support risk factors for offending – and are more likely to become involved in the criminal justice system.[34] Approximately four in 10 Californians are living at or near the poverty level.[35] Communities of color are disproportionately affected, with 28.8 percent of Latinos and 20.2 percent of African Americans living at or near the poverty line, compared to 14 percent of whites.[36] Research has consistently demonstrated that the lower a person's socioeconomic status, the higher that person's risk for developing a mental illness.[37]

In some cases, poverty leads to homelessness, and housing is consistently identified as a critical and missing link in preventing justice involvement of those with mental health conditions. Despite the expansion of evidence-based supportive housing practices in many communities, homelessness remains a major problem for those in the criminal justice system and those with unmet mental health needs. According to some estimates, as many as 50 percent of homeless people are estimated to have been incarcerated at some point.[38] Further, people in jail have experienced homelessness 7.5 to 11.3 times more than people in the general population.[39]

Other statistics show that:

- An estimated one-third of the homeless population has an unaddressed mental health need.
- Roughly three out of four homeless people experience some form of serious mental illness.
- Among all homeless people, an estimated 23 percent will have co-occurring mental health and substance use conditions.[40]

California is recognizing the importance of supportive housing in addressing mental health and substance use needs, and the state is making investments. For example, the state recently authorized a $2 billion supportive housing bond program called No Place Like Home.[41] This program is designed to invest in permanent supportive housing for homeless people with mental health needs. The program will use a *Housing First* strategy, guided by the theory that people need their basic needs met before tackling chronic health challenges. These bonds are repaid using Mental Health Services Act funds.

Making Progress through Law Enforcement and Clinician Partnership

The Los Angeles Police Department was one of the first law enforcement agencies in the nation to integrate mental health workers into their field operations. Efforts began more than two decades ago, and the department is constantly improving its approach to better help officers and community members alike.

Lt. Brian Bixler oversees the department's Mental Evaluation Unit and says the LAPD has "a five-pronged approach" in its management of field encounters involving people with mental illness. "Our first piece is training, our second piece is triage, then there's the crisis response piece, and then there's follow-up and community outreach engagement," Bixler said.

Training begins at the LAPD's academy, where cadets learn how to de-escalate a mental health crisis on the streets. After graduating, many officers participate in an additional four-day program that further prepares them to respond to mental health challenges in the field.

Most of the department's interventions are provided through crisis response teams, which consist of a specially-trained LAPD officer and a clinician from the Los Angeles County Department of Mental Health. The teams can be called to a scene that involves a person in a mental health crisis, and, after the situation is de-escalated, team members can transport the individual to a county hospital or one of several community-based treatment centers.

The LAPD has dedicated 17 supervisors and 75 officers to its System-wide Mental Assessment Response Team, or SMART.

Follow-up is provided by another team, the CASE Assessment Management Program, or CAMP, that includes a county mental health clinician who can link individuals with housing, treatment, and other interventions designed to keep people stable and out of the criminal justice system.

In all, the county Department of Mental Health provides five supervisors and 33 clinicians to the LAPD.

Social determinants, or "the conditions in which people are born, grow, live, work and age," play an important role in determining mental health outcomes and criminal justice involvement.[42] Recent research has identified links between mental health and the built environment, including housing insecurity, unemployment, adverse childhood experiences, discrimination and social exclusion, and poverty.[43] Similarly, a large body of research connects criminal behavior with neighborhood characteristics, poverty, and economic opportunity. For example, Social Disorganization Theory suggests that the availability of institutional assets and community cohesion, degree of residential mobility, and economic status have an influence on crime rates.[44] These parallel areas of research suggest that a portion of mental health needs and criminal behavior can be explained by social and economic factors largely outside of a person's control.

Inequities in social and economic conditions contribute to the observed disparities in mental health and criminal justice outcomes. People from communities of color and other historically marginalized groups are more likely to be affected by social and economic disadvantage. These communities are more likely to experience conditions of daily living characterized by unemployment, residential and food insecurity, racism and discrimination, neighborhood violence, exposure to adverse childhood experiences, poverty, and other adverse social and economic conditions.

Diverse Communities and System Disparities

People of color are more likely to experience poverty, homelessness, job insecurity, and other adverse social and economic determinants of mental illness and criminal justice involvement. People of color, particularly from African American and Latino communities, and members of LGBTQ communities experience greater exposure to risk and trauma, less access to prevention and intervention services, and greater exposure to racism and discrimination. These challenges increase the likelihood that people of color with mental health needs will be arrested.[45] In a vicious cycle, mental health consumers from communities of color spend more time incarcerated, which erects barriers to their care, thus reducing the likelihood that they will receive treatment and support upon reentry into communities.[46]

A few statistics help illustrate this problem. While they account for 6.5 percent of the general population in California, African Americans represent 28.9 percent of the state prison population.[47] Latinos, meanwhile, make up 41.1 percent of the prison population and 38.8 percent of the general population.[48] Data from the Center for American Progress suggest that individuals identifying as LGBTQ or gender non-conforming also are overrepresented in criminal justice systems.[49] Trans women, especially from communities of color, are particularly vulnerable to entering the criminal justice system through engaging in sex work.[50] Trans women sex workers experience significant trauma, including physical, sexual, and emotional abuse, and frequently engage in high-risk behaviors, such as substance use.[51]

Substantial disparities also exist for communities of color and LGBTQ communities within the mental health system. Members of communities of color – specifically Latino, African American, Native American, and some Asian American communities - tend to experience greater exposure to poverty, discrimination, homelessness, and violence, and many also lack access to mental health services.[52] Mental health service usage data suggest that Latinos have among the lowest rates for access to care, and that these low rates have persisted for decades.[53]

While service usage rates for African Americans tend to be commensurate or slightly higher than those for non-Latino Whites, many researchers suggest these numbers reflect access to care in coercive or emergency settings rather than supportive and appropriate care.[54] For example, research indicates that African Americans are more likely to receive mental health services as a result of involvement with the criminal justice system, a child welfare agency, or hospital emergency departments. This dynamic suggests that African Americans are less likely to have access to treatment that could potentially *prevent* involvement in each of these settings.[55] Native Americans,[56] refugee groups, [57] and members of groups based on sexual orientation and gender identity also are less likely to receive mental health services.[58]

Additional work is needed to identify other disparity populations and to understand the needs in these communities. For example, people with intellectual disabilities are overrepresented in the criminal justice system and may present with mental health needs. Special efforts should be made to gather information on the needs and opportunities to intervene with people with intellectual disabilities. Refugee

communities may also disproportionately suffer from mental health needs, most notably Post-Traumatic Stress Disorder. These communities may face specific barriers when encountering law enforcement or navigating the criminal justice system.

A Need for Culturally Competent Services

Frankie Guzman was first arrested at age 15 and sent to the California Youth Authority with a 15-year sentence. "I was depressed, certainly most of my life, living in an environment where there's no hope and a whole lot of danger and the only support you get from government is jail."

For minorities with mental health needs, barriers to treatment can be significant and surface early in life. "At the general level in the Latino community and the African American community, mental health providers are viewed with a lot of skepticism and a lot of distrust," said Guzman.

He was released early, but like many people with unmet mental health needs, he returned to prison. When he was released again at age 21, Guzman attended community college, transferred to UC Berkeley and then obtained his law degree from UCLA. Today he is an attorney for the National Center for Youth Law, advocating for children involved in the criminal justice system.

One solution may lie in community settings with culturally competent services that also incorporate alternative methods not based on pharmaceuticals. "That's not to say that people don't need it, but I've heard from a number of people that they're totally turned off when a mental health provider offers medicine as a first resort."

Small Group Discussion Findings

During small group discussions held for this project, participants identified trauma as a key factor contributing to their mental health needs and criminal justice involvement. Participants spoke of early childhood trauma, including experiences of sexual and physical abuse, family and neighborhood violence, and parental incarceration, that left them feeling different, alone, scared, and vulnerable to exploitation. For transgender participants, experiences of childhood molestation and sexual assault were ubiquitous.

> "*I think that it happened during my childhood years because I was raped. So I had all this trauma going on in my life that I couldn't be like other people. Not other people – children … I grew up afraid, with a lot of fear of living*."
>
> - *Native American Participant*

> *"When I left home at age 14, I was studying in high school but I had to leave because I had my first rejection and abuse because of my gender by my family. I arrived in the street. In San Salvador at the time there was a street that was known as the 'Traviana.' It was a zone for trans women. It was a place for prostitution."*
>
> - *Transgender Participant*

Native American participants said the experience of intergenerational trauma – trauma that is transmitted through generations related to historical race-based oppression and violence – had played a key role in the development of mental health problems and criminal justice involvement.

"Because I work in Native communities, how do you tell them there is something wrong when all that has been normalized for so many years? Because if you go in there and tell them something is wrong they will feel it is really disrespectful. Like who are you? My dad taught me this, my grandfather did this, and uncles did this. We are talking about sexual abuse, domestic violence, suicide, mass incarceration, addiction of everything. That's all on our plate all at one time."

- *Native American Participant*

African American and Transgender participants, in particular Transgender participants of color, identified racial discrimination as a factor affecting criminal justice involvement and mental illness in their communities. Participants discussed recent police shootings, some said they felt unjustly targeted by law enforcement. Based on their experiences in their neighborhoods and families, as well as with mental health, law enforcement, and other public programs, participants expressed despair, hopelessness, anger, fear, and mistrust.

Many participants said that while incarcerated, they felt their mental health and addiction needs were not addressed or were made worse by isolation and confinement. Participants also said that medication had not helped them resolve problems that had existed since early childhood. Across small group discussions, all participants spoke of the experiences of trauma while incarcerated, stemming from solitary confinement, exposure to violence and assault, and lack of access to adequate food and medical care. Participants described feeling like they were not seen or treated as human beings, and suggested that this dehumanization contributed to their mental health needs. Some said incarceration had deeply changed them, rendering them unable to relate to others normally.

"Being in prison locked up makes it worse. You don't come out the same … I don't like talking a lot because the hurt is there. I used to talk a lot. Now I don't have no words for nothing. I am very closed inside."

- *African American Participant*

Participants also described many challenges they faced post-incarceration. These included an inability to obtain proper mental health services and help with reintegration into the community. Many participants discussed the lack of opportunities to pursue employment and to gain financial independence. A large portion of participants were living below the poverty line and had experienced or were currently experiencing homelessness. Participants who were connected with programs through local community-based organizations credited these programs with helping them regain independence, financial stability, and mental health.

"I think race has a lot to do with not seeking help. Because we have a lot of pride. Especially with the men. We have a lot of pride."

- *Latino Participant*

"I think it is important not to treat the mental health problems of trans women with medications, instead with recreational therapies, social therapies where we can vent and we can hear each other's stories. Because hearing everyone's stories here, it's like they are telling the biography of my life. The same story."

- *Transgender Participant*

Stigma and Implicit Biases

People with mental health needs, particularly members of LGBTQ communities and communities of color, are often affected by the explicit and implicit biases of others. Explicit biases are deliberately formed attitudes based on stereotypes.[59] Implicit biases, on the other hand, are unconscious and automatic associations made between stereotypes and groups of people.[60] These stereotypes can be about race, gender, age, religion, sexual orientation, or health status, including mental illness.[61]

Stigma and Discrimination

People with mental health and substance use needs are often stigmatized by others. Stigmatizing beliefs are based on prejudices, stereotypes, and discrimination, including beliefs that people with mental health needs are violent, incompetent, or irresponsible.[62] Stigma and discrimination often prevent people with mental health needs from seeking treatment, especially when combined with other forms of discrimination that are based on race, ethnicity, or sexual identity.[63]

Stigma and discrimination also can be experienced as coercive or segregated treatment. Mental health stigma can be social, such as prejudicial attitudes and discriminating behavior directed at people with mental health needs, often causing feelings of despair, shame, guilt, distress, and hopelessness. Stigma can also be directed at the self, as a person with mental health needs may internalize discrimination from others, resulting in isolation or apprehension about seeking or accepting services. The U.S. Surgeon General's report on mental health further addresses stigma by stating:

> *"Stigmatization of people with mental disorders has persisted throughout history. It is manifested by bias, distrust, stereotyping, fear, embarrassment, anger, and/or avoidance. Stigma leads others to avoid living, socializing or working with, renting to, or employing people with mental disorders, especially severe disorders such as schizophrenia.[64] It reduces patients' access to resources and opportunities (e.g., housing, jobs) and leads to low self-esteem, isolation, and hopelessness. It deters the public from seeking, and wanting to pay for, care. In its most overt and egregious form, stigma results in outright discrimination and abuse. More tragically, it deprives people of their dignity and interferes with their full participation in society."*[65]

Stigma and discrimination can affect the ability of people with mental health needs to obtain or retain employment, especially for those with criminal history.[66] It can also prevent or hinder the development of necessary housing and treatment facilities in certain areas that may need services the most. NIMBYism ("Not in my backyard") is one prime example. Within the context of this report, NIMBYism refers to opposition by community members to having housing or other facilities for mental health consumers or people with criminal histories in their neighborhoods, and it "has deep roots in fear, racism, classism, ableism, and growing antidevelopment reactions."[67]

Community resistance is usually based on negative stereotypes about people with mental health or substance use needs, and is made worse by the additional stigma of previous involvement with the criminal justice system. Earlier this year, NIMBYism was identified as a factor that was preventing the development of crisis residential and stabilization programs under the Mental Health Wellness Act of 2013, SB 82.[68] So much so that the grant had to be extended to give counties more time to address opposition and other obstacles.[69]

Implicit Bias

Implicit bias theory has been used to explain disparities in criminal justice. Implicit biases occur outside of conscious awareness and often may not be consistent with a person's overt or conscious beliefs. Race-based bias can affect every encounter people have within the criminal justice system, including initial encounters with law enforcement, arrests, sentencing, and decisions while in custody. Studies suggest that people are more likely to perceive African Americans as a threat and to associate African Americans with criminal behavior. In computer simulations, participants are more likely to shoot an unarmed African American man than an unarmed white man.[70]

While there has been less research exploring the link between implicit biases and mental illness, existing studies suggests that people tend to hold negative unconscious biases towards people with mental health needs.[71] Implicit biases can be addressed through explicit efforts to reduce stereotypes. Strategies such as increasing awareness of implicit bias, increasing exposure to groups that are the target of stereotypes, and explicitly practicing changing one's overt thought processes may reduce the influence of implicit bias in decision-making. Implicit bias training was recommended by the President's Task Force on 21st Century Policing and has been implemented in many law enforcement agencies across the country.[72]

Mental Health Services Act

What is the Mental Health Services Act?

The Mental Health Services Act, or Proposition 63, passed by voters in 2004, is funded through a 1% tax on personal income over $1 million. In 2017, it will generate an estimated $2 billion for mental health services in California.

The Mental Health Services Act is built around five key components:

COMMUNITY SERVICES & SUPPORT (CSS)

The CSS component provides services for people with severe mental illnesses using a client-centered and family-driven, wellness, and recovery- focused approach.

Considerations for how services similar to those delivered using the Mentally Ill Offender Crime Reduction Grant Program should be made when planning for CSS services. (Welfare and Institutions Code §5813.5(f))

When programs and services include collaboration with the criminal justice system, any law enforcement function or any function that supports a law enforcement purpose shall not be funded. (Title 9, California Code of Regulations § 3610(e))

CSS Funding Categories:

- **Full Service Partnership:** program to provide a full spectrum of direct mental health services for people with serious mental illness through an approach known as "whatever it takes" to support recovery, including housing, employment, and education services and supports.
- **General System Development:** program to improve the mental health service delivery system for all clients.
- **Outreach and Engagement:** program to reach, identify, and engage unserved people with serious mental illness so they receive appropriate services.
- **Mental Health Services Act Housing Program:** program to acquire, rehabilitate or construct permanent supportive housing for clients with serious mental illness.

PREVENTION & EARLY INTERVENTION (PEI)

The PEI component focuses on providing an early response to mental health needs before they become severe and disabling, particularly for underserved communities. PEI programs strive to prevent homelessness, incarceration, school failure, suicide, unemployment, prolonged suffering, and removal of children from their homes that can result from untreated mental health needs.

INNOVATION (INN)

The INN component is designed to discover unique ways of operating in the mental health landscape. The goal is to increase access to services, especially for underserved communities, increase quality of services, and promote interagency collaboration. The MHSOAC approves funding for projects in this component.

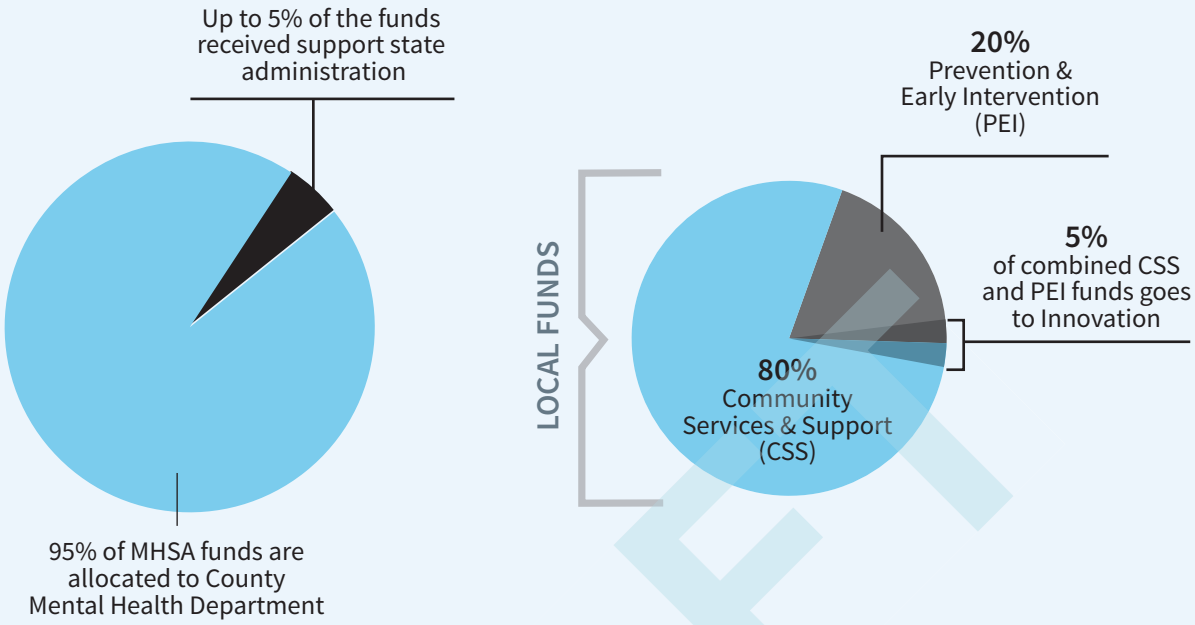
CAPITAL FACILITIES AND TECHNOLOGICAL NEEDS (CFTN)

The CFTN component provides one-time funding for infrastructure and technology to support the mental health care system.

WORKFORCE EDUCATION AND TRAINING (WET)

The WET component includes funds for employment and training to bring in more qualified people to work in the field of mental health.

Q How are Mental Health Service Act dollars allocated?



Q How are Mental Health Services Act funds prioritized?

Spending priorities are set through a Community Program Planning Process, which is driven by input from stakeholders.

Stakeholders, as defined by Welfare and Institutions Code §5848, include adults and seniors with severe mental illness, families of children, adults, and seniors with severe mental illness, providers of services, law enforcement agencies, education, social services agencies, veterans and their representatives, providers of alcohol and drug services, and health care organizations, and other community members.

Q Can Mental Health Services Act funding be used for people involved in the criminal justice system?

Mental Health Services Act – funded programs and services have the potential to divert people with mental health needs from various stages of the criminal justice system. Examples are found throughout this report.

The MHSA explicitly prohibits use of funds for services for people incarcerated in prison or parolees from state prison (Welfare and Institutions §5813.5(f)). While the Mental Health Services Act prohibits the use of funds for programming or treatment in detention settings, such funds can be used for discharge planning and connecting people with local community-based services prior to release.

People on probation, including probationers under Public Safety Realignment (AB 109, chapter 15, Stats. 2011), are not prohibited from MHSA funding. However, MHSA should be used to expand mental health services and not to supplant existing state or county funds to provide mental health services. (Welfare and Institutions §5891(a))

Planning for Prevention and Diversion

"Fragmentation is at the heart of the ineffectiveness of our increasingly frantic efforts to nurture improvement."

- Kurt C. Stange, M.D., Ph.D., from "The Problem of Fragmentation and the Need for Integrative Solutions"

In passing the Mental Health Services Act in 2004, voters called for the transformation of California's mental health system from a "fail first" to a "help first" system. In short, that directive means that instead of rationing care to those with the greatest need, perhaps following a crisis or a person's incarceration, California should emphasize prevention and early intervention. The goal of the Act is to transform California's mental health system into an outcome-focused system of care. One specific objective is to reduce the incarceration of people with mental health needs.

It is worth stating that incarceration can be detrimental to a person's ability to manage his or her mental health needs. Jail can be a frightening place for anyone, and particularly for a person with unmet mental health needs. Incarceration often also results in traumatization that can exacerbate symptoms. People with mental health needs require services in the community, such as appropriate and culturally responsive treatment that addresses housing deficits, substance use, trauma, risk factors for offending, and other dynamics that diminish recovery. Often, however, such treatment is distributed through multiple public programs and agencies, often referred to as "silos." One agency might address a person's housing needs, while another might treat a person's risk factors for offending and a third might provide addiction counseling. As siloed services, these efforts often are not coordinated, might promote conflicting strategies, and frequently result in inadequate care.

"Significant investments by state and community partners are needed on upstream efforts such as crisis intervention and prevention to reduce law enforcement involvement. The importance of partnerships with these efforts cannot be overstated. All local partners are critical to success."
- Donnell Ewert, Shasta County Behavioral Health Director

The variety of funding streams and eligibility requirements for disparate agencies complicate the coordination of service delivery and make it difficult to fill gaps in services and capacity. Typically, funding structures require counties to develop programs and services that fit within specific parameters, an approach that does not necessarily involve doing what it takes to meet the needs of the population. This challenge has been understood for decades and has frustrated efforts to focus on people rather than programs.

The long-sought solution often is cross-system collaboration. Better communication can identify a person at risk before they become a person in crisis. Better coordination among agencies can lead to more effective responses. Collaboration among agencies can make the best use of available funds, staffing, and facilities. Mapping available programs and services and engaging community members can help county agencies develop a shared understanding of available resources and how best to coordinate them.

Identifying Opportunities for Prevention and Diversion

In recent months, more than half of California's counties have signed resolutions under the Stepping Up Initiative to reduce the number of people with mental health needs in local jails through prevention and diversion.[73] That commitment reflects both the imperative and the opportunity. The imperative is driven by mounting costs, crowded facilities, and a moral awareness that jails should not be the default provider of mental health services. Fortunately, the need for change is aligned with promising conditions for change.

Practitioners and researchers are equipped with lessons learned from nearly a generation of system change efforts around the country. Governance and policy changes have provided counties with more responsibilities and resources. And new technologies are powering emerging innovations in integrated service delivery. The potential to carry out significant system change that will control costs and improve outcomes now matches an ambition long held by policy makers, program administrators, practitioners, family members, and consumers.

Pushing for local commitment, collaboration, and planning, The Stepping Up Initiative was established in 2015 to work with local leaders to safely reduce the number of people with mental health needs involved in the criminal justice system.[74] The national initiative is a partnership led by the Council of State Governments Justice Center, American Psychiatric Association Foundation, and the National Association of Counties.[75]

"Yolo County is fully committed to reducing the numbers of mentally ill in our criminal justice system. Our Board of Supervisors has adopted this as a key initiative in our three-year strategic plan along with fully embracing the Stepping Up movement. We are excited to work with our other state and county partners toward achieving these outcomes statewide."

- Karen Larsen, Yolo County Behavioral Health Director

The initiative encourages counties to adopt resolutions – a formal commitment by county leaders – to reduce the number of people with mental health needs in jail, commit to sharing lessons learned with other counties, and encourage county officials and community members to participate. Counties agree to convene decision-makers, collect data, analyze treatment and service capacity, and develop plans to measure outcomes and track progress over time. To date, over 30 California counties, representing over 70 percent of the state's jail population, have passed the resolution.[76]

As part of their nationwide effort, the Stepping Up Initiative produced a framework for a collaborative, data-driven approach. The framework organizes county efforts around six key questions to help counties assess their community's existing efforts to reduce the number of people with mental health needs in local jails and better understand service needs and system gaps.[77]

These six questions are:

1. **Is our leadership committed?** Counties should establish a planning team or committee to foster cross-system collaboration.
2. **Do we conduct timely screening and assessment?** Counties need a clear and accurate understanding of the prevalence of mental illnesses in their jail populations to track progress over time and guide quality improvement.
3. **Do we have baseline data?** Baseline data provides counties benchmarks to evaluate progress and determine whether key outcomes are being realized. The Council of State Governments Justice Center has identified four key outcome measures for developing a baseline and tracking progress:
    - Reduction in the number of people with mental illness booked into jail
    - Shorter jail stays for people with mental illnesses
    - Increase in the percentage of people with mental illnesses in jail who are connected to the right services and supports once released
    - Lower rates of recidivism
4. **Have we conducted a comprehensive process analysis and inventory of services?** Each county should create a comprehensive plan for prevention and diversion, based on an inventory of current services to identify gaps. The Sequential Intercept Model can help counties collaborate across departments and begin compiling an inventory of services to map the existing landscape. See below for more information about the Sequential Intercept Model.
5. **Have we prioritized policy, practice, and funding improvements?** County leaders should provide guidance to the planning team on how to make policy recommendations and budget requests that are practical, concrete, and aligned with the fiscal realities and budget process of the county.
6. **Do we track progress?** Using data to track outcomes is essential to continuous quality improvement, and can help justify future funding and expansion of effective programs.

The Sequential Intercept Model

The Sequential Intercept Model is one strategy available to help counties map available programs, and begin to develop a shared understanding of available resources and how best to coordinate them. The Sequential Intercept Model was developed in the 1990s in response to the high prevalence of mental illness in people involved in the criminal justice system.[78] The model provides a comprehensive framework for identifying points of intervention that may reduce criminal justice involvement of those with mental health needs. Fresno, Kern, Los Angeles, San Francisco, and San Luis Obispo counties, as well as the City of Long Beach and the Yurok Tribe in far Northern California, are jurisdictions that have created Sequential Intercept Models.[79]

"Fresno County has invested in sequential intercept mapping (SIM) and it has proven to be a highly valuable tool for understanding and assessing our current system. In our county, buy-in by all criminal justice partners has been imperative for utilizing SIM to both increase opportunities for diversion and strategize solutions for filling gaps along the continuum."

- Dawan Utecht, Fresno County Behavioral Health Director

Under the model, interventions occur along a continuum, beginning with crisis services and progressing to a call to law enforcement or emergency services, initial detention and court hearings, jail and prison, re-entry into communities, and, finally, community supervision.[80] The goal is to improve mental health and prevent deeper involvement in the criminal justice system.

Intercept Zero: Community

According to Sequential Intercept Model developers, the "ultimate intercept," or "Intercept Zero," is "an accessible, comprehensive, effective mental health treatment system focused on the needs of individuals with serious and persistent mental disorders …" and "… is undoubtedly the most effective means of preventing the criminalization of people with mental illness."[81] The goal is to create a system that is responsive to the greatest range of possible needs, one that connects people to available services to either prevent a mental health crisis or catch a crisis early, before there is a law enforcement response. Robust crisis response models and proactive responses are essential at this intercept.[82]

Further, consumers with repeat hospitalizations can be referred to assisted outpatient treatment programs in counties that are implementing such programs, and possibly prevent incarceration if connected to appropriate community-based treatment.[83] Assisted outpatient treatment refers to civil court-ordered community-based mental health services for people unable to voluntarily access needed services.[84] Assisted outpatient treatment could be utilized at any intercept to divert people from the criminal justice system who require intensive outpatient services, including intensive Full Service Partnership-type programs with higher staff to client ratios, or those "stepping down" from inpatient care.[85]

"How do we work with the systems that exist and build new systems where these people – maybe they're service-resistant – can get the help they need and they may not have to call 911? People with mental illness aren't criminals. Mental health emergencies are medical emergencies."

- Lt. Brian Bixler, Los Angeles Police Department

Intervening at Intercept Zero also means providing enhanced prevention services, especially for communities of color and LGBTQ communities. Exposure to adverse childhood experiences and trauma can increase vulnerability to the development of mental health needs, substance abuse, and criminal justice involvement in people from communities of color.[86] Programs that decrease exposure to adverse childhood experiences and help people cope with trauma may divert the trajectory toward criminal justice involvement.[87] One example of a community-defined practice at this intercept is the Harmonious Solutions program in San Diego County. The program provides young African American men culturally competent support for conflict resolution and positive interpersonal relationships based on African-centered values and practices.[88] In addition, recent efforts by the California Reducing Disparities Project to implement community-defined practices hold promise for reducing criminal justice involvement through more "upstream" approaches to prevention.[89]

Exciting innovations for non-law enforcement crisis response are emerging nationally and in California. In Eugene, Oregon, the Crisis Assistance Helping Out on the Streets program provides mobile crisis intervention using teams consisting of a medic – either a nurse or EMT – and a mental health crisis worker

to stabilize, assess, refer to services, and, at times, transport to treatment people in crisis.[90] As part of California's Community Paramedicine Pilot Project, specialty trained paramedics in Stanislaus County were dispatched via 911 calls believed to be behavioral health emergencies to assess and transport people in crisis to services.[91] The pilot saw positive outcomes in both cost and effectiveness, but efforts were hampered by lack of treatment capacity and by services that could not address substance use needs, in addition to mental health needs.[92]

The Investment in Mental Health Wellness Act of 2013 was enacted to increase the continuum of mental health crisis services throughout California, and it is another strategy to help communities build what might be characterized as Intercept Zero in California.[93] Key objectives of the act include expanding access to services, such as crisis intervention services, reducing unnecessary hospitalization, and mitigating law enforcement expenditures on mental health crises. The act funds local grants to support capital development and mobile crisis response, and to expand crisis triage personnel. The purpose of these grants is to increase the number of personnel to provide crisis intervention, crisis stabilization, mobile crisis support, and intensive case management and linkage to services.

California counties are investing in mental health services to support prevention at Intercept Zero

- ***Butte County | The Crisis Connect Program***

Butte County is using Investment in Mental Health Wellness Act (SB 82, 2013) grant funding to station crisis triage staff at specific access points to expand current crisis services and help consumers avoid higher levels of care. These access points include hospital emergency rooms and local homeless service centers. The Crisis Connect team facilitates consumer movement through the crisis continuum; this includes coordinating placements, discharge planning, monitoring, and follow-up case management.[94]

- ***San Bernardino County | Triage, Engagement and Support Teams***

San Bernardino County is using Investment in Mental Health Wellness Act (SB 82, 2013) grant funding to expand the county's crisis system of care, and link crisis services to outpatient and community resources. Triage Teams utilize intensive case management services to link consumers with needed resources for ongoing stability, providing case management services for up to 60 days or longer to ensure engagement. The Triage Teams are community based and are co-located in 18 crucial points of access, such as the Department of Probation and sheriff and police stations. The primary goal for the Triage Teams is consumer stability in the least restrictive environment, sustained over a significant period.[95]

- ***Napa County | Mental Health Triage Personnel Grant***

Napa County is using Investment in Mental Health Wellness Act (SB 82, 2013) grant funding to expand the crisis continuum of care to meet the needs of people at risk of needing mental health crisis intervention. The grant strengthens three components of the crisis continuum of care by: (1) funding a crisis worker to be on-site at the local emergency department to improve the timeliness of crisis interventions and provide immediate help with de-escalating a crisis situation; (2) expanding on-call hours of the SPIRIT Crisis Center Peer Counselors, who provide support to people and their families during a crisis; 3) funding the Insight Respite Center, a four-bed, peer-run program that provides an alternative to higher levels of care within a supportive, recovery-oriented community setting. The Insight Respite Center offers an alternative to crisis services and a "step down" after inpatient hospitalization to help individuals stabilize and manage their illness in a safe, welcoming, environment.[96]

Intercept One: Law Enforcement

The first intercept in this model is the initial encounter with law enforcement. Police officers are often called to respond to situations involving a person with mental health needs. Programs and strategies at Intercept One seek to improve the ability of officers to effectively address these situations by providing them with training from mental health providers. Strategies may include special protocols for dispatchers to improve early identification of mental illness and strengthen dispatchers' communication to first responders, as well as training to help law enforcement combat the effects of implicit bias in high-stress situations.

Programs and strategies typically seek to help officers recognize symptoms of mental illness, de-escalate crisis situations, identify and reduce cultural bias in policing, and connect those with mental health needs with appropriate community resources. Alternatively, some pre-arrest strategies incorporate a mental health provider at the outset, pairing mental health practitioners with law enforcement in the community or in law enforcement settings. Some crisis situations cannot be deescalated or addressed in the field. To effectively divert at this intercept, communities must have alternatives to jail available and accessible in the community, including supportive services, housing, and a full array of crisis services. In Los Angeles County, for example, officers are able to directly refer people they frequently come into contact with to Assisted Outpatient Treatment, and other programs and services, as an alternative to arrest and incarceration.[97]

Crisis intervention training and co-responder approaches have gained the most traction in terms of wide scale implementation and evaluation efforts. Crisis intervention training involves law enforcement personnel who are specially trained to respond to calls involving a person with mental health needs. The Memphis Crisis Intervention Team, also referred to as the "Memphis Model," is the most well-known and widely used training program for first responders, particularly law enforcement, who encounter people experiencing a mental health crisis. The training better prepares them for these encounters.[98] Most studies at this intercept have focused on crisis intervention training programs. The use of crisis intervention trainings has been correlated with increased access to mental health services, including emergency psychiatric care.[99]

More recent crisis intervention training approaches have focused on just policing and implicit bias.[100] A multi-site project – which includes the Stockton Police Department – conducted by the National Initiative for Building Community Trust and Justice, aims to improve law enforcement in diverse communities by providing training on procedural justice, implicit bias, and fostering reconciliation with communities.[101] These practices hold promise for improved relationships with communities, and enhanced opportunities to respond to mental health crises in diverse communities through law enforcement.

California counties are investing in mental health services to support diversion at Intercept One

- ***Fresno County | Law Enforcement Field Clinician***

In Fresno County, the Law Enforcement Field Clinician serves as a liaison with county law enforcement to provide training, outreach, and direct field response to residents with mental health needs. The program provides outreach, education, and consultation to law enforcement agencies, including direct field response to support law enforcement and addressing mental health crisis calls.[102]

- ***Kings County | Crisis Intervention Team Training***

Kings County offers training modeled after a nationally recognized, evidence-based program known as the Crisis Intervention Training - Memphis Model, which trains law enforcement and other first responders to recognize the signs of mental illness when responding to a person experiencing a mental health crisis. The course teaches trainees the signs and symptoms of a mental illness as well as coaching techniques for responding appropriately and compassionately to individuals or families in crisis.[103]

- ***Sacramento County | Mobile Crisis Support Teams***

Sacramento County is providing law enforcement with assistance during encounters with people experiencing a mental health crisis. Each team is comprised of a police officer or sheriff deputy trained in crisis intervention training, a licensed mental health clinician, and a peer support provider. After initial contact with the person in crisis, the clinician and peer collaborate to provide continued support and access to appropriate services.[104]

Intercept Two: Initial Detention or Court Hearing

The second opportunity for diversion is during initial detention and court hearings. Strategies at this stage include jail diversion programs that offer conditional release and referral to community mental health services. At this intercept, approaches are considered post-booking as they occur after arrest but prior to sentencing.

Numerous jail diversion programs are in use nationwide, and they vary widely in terms of key characteristics and eligibility criteria. For example, some jail diversion programs use a formal screening procedure to determine when a person has a mental illness, while others rely on referrals by social workers, family members, or others. In addition, legal alternatives vary widely and may include deferred prosecution, deferred sentencing, reduced charges, or dismissal of charges.

Programs may offer referrals to services and case management or treatment that is monitored or mandated by the court. Despite this wide variation, key criteria of post-booking diversion programs include, (1) a process for the identification and screening of candidates for mental health interventions, and (2) negotiation among prosecutors, defense attorneys, courts, and providers to identify a plan that addresses both public safety and mental health needs. Strategies include intensive case management and services, including connections to housing, public benefits, and day treatment programs.

Empirical research on the effectiveness of jail diversion programs has focused on reductions in re-arrests, recidivism, psychiatric symptoms, homelessness, emergency room visits, and the number of days in jail. The results are mixed. Some studies demonstrate positive outcomes and others find no significant changes for diverted participants. These mixed results may be due in part to different strategies and interventions used across programs as well as different eligibility requirements for participants. Some research suggests that people with the highest mental health needs may show the greatest benefits.

Nonetheless, research supports a handful of best practices in jail diversion programs, including, (1) structured screening for identifying people with mental health needs, (2) engagement and collaboration with criminal justice stakeholders, and, (3) effective connections with mental health services.[105] Consistent with evidence of effectiveness for mental health practices, jail diversion strategies should include culturally responsive assessments and plans to address mental health needs, including recognition of the role of cultural discrimination and utilization of strategies that build on cultural or ethnic pride.

California counties are investing in mental health services to support diversion at Intercept Two

- ***Marin County | Support and Treatment After Release***

Marin County is providing comprehensive assessment, individualized client-centered service planning, and access to services and supports for those released from the criminal justice system. This program was formerly funded with a Mentally Ill Offender Crime Reduction Grant, and is now funded with Mental Health Services Act funds.[106]

- ***Los Angeles County | Mental Health Court Linkage Program***

Los Angeles County has established a recovery-based program staffed by a team of mental health clinicians who are co-located at courts countywide. This program serves adults with a mental illness or co-occurring disorder who are involved with the criminal justice system. It also offers community reintegration services to help participants maintain stability and avoid re-arrest.[107]

- ***San Francisco | UCSF Citywide Case Management Forensics***

In San Francisco, adults with mental health needs who become involved with the criminal justice system can receive case management and consultation, as well as mental health services, screening, assessment, and other services through the Behavioral Health Court.[108]

Intercept Three: Courts

Intercept Three describes interventions that take place after initial hearings in the jails and courts. Collaborative courts, which are common in California, offer treatment or social services in lieu of jail time. Collaborative courts focus on drug use, mental health needs, veterans, people charged with a DUI, the needs of older adults, and homelessness, among other issues and populations. Drug courts are the most common of these collaborative courts and nearly every county in California has at least one.[109]

Mental Health Court programs typically provide a comprehensive range of psychosocial services with the goal of improving long-term mental health. There are over 30 California counties operating adult mental health courts.[110] In 2008, the Council of State Governments proposed 10 essential elements that characterize effective Mental Health Courts, including:[111]

- Planning and administration of the court by relevant stakeholders
- Eligibility criteria to identify an appropriate target population and whether services are available
- Timely participant identification and linkage to services
- Terms of participation that are clear, individualized, promote public safety, and lead to positive legal outcomes for people who successfully complete the program
- Informed choice to participate in program before agreeing to terms
- Treatment supports and services in the community based on individual needs
- Confidentiality is protected when sharing a person's health and legal information
- Court team of criminal justice and mental health staff receive specialized and ongoing training
- Monitoring adherence to court requirements, and modification of treatment as necessary
- Sustainability using data to demonstrate the impact of the court

Evaluations of collaborative courts have been hampered by design challenges, including the lack of random assignment and adequate comparison groups. Despite these limitations, initial findings suggest that the use of drug courts and mental health courts results in decreased recidivism and re-arrest rates. One study reported less recidivism and improved access to treatment for mental health court participants.[112] Data on access to collaborative courts for communities of color and transgender people is also limited. Given the lack of access identified in other service sectors, collaborative courts should ensure that communities most affected by disparities are receiving equal access to these diversion programs.[113] Program administrators should take into account feelings of mistrust, especially of governmental programs, by diverse communities as barriers to taking advantage of diversion opportunities through collaborative courts.[114]

California counties are investing in mental health services to support diversion at Intercept Three

- ***Monterey County | Adult Mental Health Court***

Monterey County delivers intensive case management, psychiatric care, probation supervision, and therapeutic mental health services to people who are 18 years and older and have a history of criminal justice involvement and mental health needs. The Adult Mental Health Court is a combined effort between the Sheriff's Office, the courts, Behavioral Health, Probation, and Law Enforcement.[115]

- ***Orange County | Mental Health Court (Probation Services)***

Orange County uses a team approach that includes voluntary programs, such as Opportunity County and Recovery Court and Whatever It Takes Court. These efforts provide people with chronic mental health needs with counseling, opportunities to meet with a probation officer and health care coordinator, a chance to appear in court, and access to specialized services.[116]

- ***Santa Barbara County | Justice Alliance***

Santa Barbara County provides competency restoration services to people charged with misdemeanor crimes but who are found incompetent to stand trial, as well as case management to people receiving outpatient competency restoration services in supportive housing facilities.[117]

Intercept Four: Reentry

Intercept Four encompasses interventions that take place during incarceration and upon release. Most research on Intercept Four has focused on programs for reentry into communities. For jail stays, reentry programs must be adapted to the brief periods between confinement and release and, potentially, re-arrest. This rapid turnaround creates challenges for planning and providing mental health care upon release and for ensuring the delivery of coordinated and continuous care. Loss of eligibility for some programs during incarceration, such as Medi-Cal services, may further complicate access to care.[118]

Several effective models exist to guide counties in providing services following incarceration. They include:

- **ASSESSMENT, PLANNING, IDENTIFICATION, AND COORDINATION MODEL**: Under this model, staff members assess a person's clinical and social needs and public safety risks, prepare a plan for treatment and services, identify required community and correctional programs

responsible for post-release services, and coordinate the transition plan to ensure implementation and avoid gaps in care. [119]

- **RISK-NEED-RESPONSIVITY MODEL**: Three core principles of this model are matching the level of service to the offender's risk to re-offend, assessing needs and targeting those needs in treatment, and maximizing the person's ability to learn from a rehabilitative intervention by providing cognitive behavioral treatment and tailoring the intervention to the learning style, motivation, abilities, and strengths of the person. [120]

- **ACTION APPROACH**: This collaborative approach brings together the criminal justice, mental health, and substance abuse treatment systems to promote recovery of incarcerated people with co-occurring disorders who are re-entering into the community. The model relies on education, facilitated strategic planning, and follow-up technical assistance to reduce re-incarceration. [121]

One strategy that helps people navigate the transition from custody to community successfully is what practitioners call a "warm hand-off." Ideally, a warm hand-off involves connecting people leaving county jails with a range of community resources to ensure their needs are met immediately upon release.

Transitioning People from Jail into Services

Creating warm hand-offs for jail inmates in Riverside County has been a key objective of a year-long collaboration between the Riverside County Sheriff's Department and the Riverside University Health System's Behavioral Health Department.

Carlee Antillon, a Riverside County Behavioral Health specialist, leads discharge planning at the county's Robert Presley Detention Center. Antillon said the process begins about six months before inmates are scheduled for release and includes helping them acquire housing, transportation, employment, clinical appointments, and medication.

Before the collaboration produced improvements in the county's discharge procedures, inmates were typically released at random times of day or night and with little more than a packet of information. Now, county staff provide significant support, including the scheduling of appointments, Antillon said, or even a ride "straight to the clinic to be seen" upon release.

If a person qualifies, he or she can also access care at clinics funded through AB 109, California's public safety realignment act. Services at those clinics include group therapy and care coordination through a case manager. Also available is the Full Service Partnership Program at the Jefferson Wellness Center, which provides recovery-based services to homeless people with a mental health diagnosis.

Fred Osher and Christopher King identified multiple promising practices for people with mental health needs released from confinement.[122] These approaches include, (1) identification of individuals in need of mental health services and assessment of mental health needs, (2) cognitive behavioral and skill-building interventions, as well as psychiatric follow-up when needed, (3) coordination of care, (4) providing care in an ethical manner that takes into account supervision needs as well as freedom of choice in treatment, and, (5) team-based case management.

The Council of State Governments has developed a "Reentry Clearinghouse" website that summarizes the research on reentry programs.[123] Through an extensive literature search conducted in 2010 and again in 2015, the authors identified several studies examining the effectiveness of reentry programs. Studies are

categorized in terms of methodological rigor, such as High Rigor or Basic Rigor, as well as the effectiveness of programs in reducing recidivism.

Other research has explored the effectiveness of specific programs on outcomes other than recidivism. Osher and King found mixed results during their review of Assertive Community Treatment, Intensive Case Management, and forensic transition team approaches.[124] Initial findings suggest that Assertive Community Treatment may be effective for communities of color.[125] An example of community-driven practice at Intercept Four is The Warrior Down Program in Sacramento County, which provides relapse prevention and recovery support services for Native Americans who are completing treatment, returning to the community from incarceration, or who have been on their recovery journey using traditional methods or 12 Step Medicine Wheel Teaching Methods.[126]

California counties are investing in mental health services to support diversion at Intercept Four

- ***Lake County |Forensic Mental Health Partnership***

Lake County assists consumers in addressing their mental health needs, navigating the legal process, and planning during transition from jail to community. The Partnership also provides consumers with support in the community after release through service coordination, clinical services, and a Full Service Partnership program that pursues a "whatever it takes" approach.[127]

- ***San Luis Obispo County |Forensic Re-entry Services (FRS) Team***

San Luis Obispo County provides a "reach-in" strategy in the county jail, to plan the aftercare needs for persons leaving jail. This support comes in the form of assessment and referral to all appropriate health and community services as well as short-term case management during this transition.[128]

- ***San Diego County | Project In-Reach***

San Diego County provides discharge planning and short-term transition services to community-based treatment for at-risk African American and Latino inmates with serious mental health needs.[129]

Intercept Five: Community Supervision

Intercept Five encompasses interventions that occur in the context of community supervision. According to one estimate at the end of 2008, one in every 45 adults in the United States were under either parole or probation, also referred to as community supervision.[130] Further, approximately 70 percent of people under the supervision of the criminal justice system are under community – as opposed to in-custody – supervision.[131] Statistics like these have lead researchers and advocates to explore what they see as an overreliance on community supervision, and some have argued that community supervision is quite punitive.[132] Complying with the terms of conditions of probation can be challenging for people with mental health needs, especially if they are unsupported. Often mental health services are a required condition of probation, which raises concerns about the voluntary nature of treatment or whether people are able to have a say in which particular program and services are selected for them.[133] Not participating in required services could result in a "technical violation," leading to reincarceration or other punitive responses.

To improve outcomes at this intercept, specialty probation approaches hold the most promise.[134] Under this strategy, probation officers receive specialized training in mental health and are assigned a reduced caseload of people with mental health needs. This model enables probation officers to collaborate with mental health providers and establish a problem-solving, rather than punitive, approach to managing transgressions. In addition, many jurisdictions pair specialized probation programs with Forensic Assertive Community Treatment, which focuses on reducing recidivism.

"County behavioral health systems continue to promote a paradigm shift wherein local leaders – including county supervisors, law enforcement, and courts – view treatment for individuals living with mental illness or addiction as a measure that promotes public safety."

- Yvonnia Brown, Merced County Behavioral Health Director

Research on these interventions is still limited. Jennifer Skeem and colleagues compared outcomes for probationers receiving specialty probation services and found improvements in recidivism and access to mental health services.[135] Another review suggests that the effectiveness of specialty probation programs may be influenced by relationships with probation officers.[136] Clients who had reported positive relationships with probation officers tended to have better outcomes in terms of both mental health and recidivism.[137]

Participants in small group discussions held for this project reiterated the role of trauma, especially early childhood trauma, in their involvement with the criminal justice system. Addressing trauma and improving symptoms of depression, post-traumatic stress disorder, and anxiety stemming from trauma are critical steps toward reducing reoffending rates.[138] Strong case management – involving coordinated and integrated services that address trauma and other mental health needs, substance use disorder, and other factors – is one of the most effective ways to reduce justice involvement.[139]

California counties are investing in mental health services to support diversion at Intercept Five

- ***Contra Costa County | Forensic Team***

Contra Costa County has established a multi-disciplinary team that provides mental health services, alcohol and drug treatment, and housing services to people who are on probation and at risk of re-offending. Efforts include assessing referrals for serious mental illness, providing rapid access to a treatment plan, and using a team approach to provide appropriate services.[140]

- ***Stanislaus County | Integrated Forensic Team***

Stanislaus County provides comprehensive mental health and co-occurring services for adults who are on probation and/or have frequent contact with law enforcement. Available services include case management, crisis response, family support, housing and employment assistance, medication, and peer support.[141]

- ***Solano County |Forensic Assertive Community Treatment***

Solano County provides intensive case management and community-based services to improve the quality of life and reduce recidivism, homelessness, and hospitalization for people with mental health needs who are involved with the criminal justice system.[142]

Community Collaboration and Blending Funds

The Sequential Intercept Model and the Stepping Up Initiative's Six Questions provide frameworks for counties to supplement existing planning processes. Those counties that have created a diversion plan have done so by using federal grants, Mental Health Services Act funds, AB 109 planning dollars, and other existing funds.

The criminal justice and mental health systems have similar planning processes. County probation departments use the Community Corrections Partnership process to engage stakeholders on the allocation of AB 109 funding, among other community corrections planning initiatives. AB 109, the 2011 public safety realignment measure, shifted responsibility for certain offenders to the counties.[143] Counties received state funds that could be used for law enforcement supervision and custody, mental health, substance use, and other social services. County mental or behavioral health departments use a required Community Program Planning Process to engage stakeholders on how to spend funds from the Mental Health Services Act. Counties can spend up to five percent of their local allocation on planning.[144] How counties implement these planning processes varies widely.

Local Collaboration and Private-Public Funding

When it comes to keeping people with unmet mental health needs out of jail, Bexar County, Texas, is widely recognized as a national leader. In 2003, stakeholders from throughout the county's criminal justice and mental health systems teamed up to launch the county's Jail Diversion Program, and since then, more than 20,000 people with mental health needs have been diverted from jail into treatment.

Under the program, interventions occur at multiple points through three phases. In the first phase, the focus is on diverting people in crisis before they are arrested or booked in the county jail. In the second phase, the program provides screening and recommendations for alternative dispositions, such as release to a treatment facility or "mental health bond." The third phase emphasizes providing appropriate and continuous services upon release from jail or prison.

Key to the program's success is the strong collaboration among its 34 different partners, including law enforcement, courts, mental health services, hospitals, and community stakeholders. The program employs 146 multidisciplinary staff, with annual funding of approximately $9 million provided by a blend of federal, state, and local funds.

Between 2011 and 2016, the Jail Diversion Program saved Bexar County more than $50 million and helped resolve the serious overcrowding problem in its jail. Savings have been realized through investments in community mental health services, hiring more professionals to provide treatment, and focusing resources on rehabilitation, housing, and employment assistance.

In developing the Jail Diversion Program, county partners acknowledged that people with mental health, substance use, and housing needs contributed to jail overcrowding and excessive law enforcement overtime, and that these people could better be served by community-based services. Partners also

> recognized the need to stretch existing dollars by blending funding streams, and that required trust and the willingness to collaborate across systems.
>
> In conjunction with the Jail Diversion Program, Bexar County is also the home of Haven for Hope, a campus-style resource for addressing homelessness. Since Haven for Hope opened in 2010, the homeless population in downtown San Antonio has dropped approximately 80 percent, and nine out of ten of those receiving a housing placement have not returned to homelessness within one year. Approximately 61 percent ($100 million) of the construction costs to build Haven for Hope came from the private sector.

Well-intentioned grant programs and pilot projects have funded system improvements in pieces, often with short-term funding and no long-term strategy. Below is a partial list of grants and pilots in California and a table showing which grants are operating in which county. These grants and pilots fund programs and services targeting the formerly incarcerated and people at risk of incarceration, or programs that intervene with vulnerable populations, such as people experiencing homelessness or people in crisis. Currently, it is difficult – if not impossible – to determine the collective impact of these funds on the people they intend to benefit, especially in counties that are receiving multiple grants from different state administrating agencies and different local recipients.

- **Investment in Mental Health Wellness Act (SB 82, 2013) | Administered by the California Health Facilities Financing Authority (CHFFA) | Approximately $143 million over three years | Competitive Grant**

The grants from CHFFA support capital improvement, expansion, and limited start-up costs. Funding is limited to the following specific programs: crisis stabilization, crisis residential treatment, mobile crisis support teams, and peer respite.[145]

- **The Mental Health Wellness Act (SB 82, 2013) Grant | Administered by the Mental Health Services Oversight and Accountability Commission (MHSOAC) | Approximately $96 million over three years | Competitive Grant**

The purpose of the triage grant is to increase the number of personnel to provide crisis intervention, crisis stabilization, mobile crisis support, and intensive case management and linkage to services. These funds provide the opportunity for counties, counties acting jointly, and city mental health departments to reduce the costs associated with long stays in emergency departments, link to services for those released from jails, and reduce the time spent by law enforcement on mental health crisis calls.[146]

- **Law Enforcement Assisted Diversion (LEAD) Grant | Administered by the Board of State and Community Corrections (BSCC) | Approximately $15 million for three sites over three years | Competitive Grant**

LEAD grants allow law enforcement officers to redirect people suspected of committing low-level offenses to community-based services rather than to jail, addressing underlying factors that drive criminal justice contact. The program is not exclusively focused on providing addiction treatment or mental health treatment. For some participants, housing and reliable access to food may be the most pressing needs.[147]

- **Mentally Ill Offender Crime Reduction (MIOCR) Grant | Administered by the Board of State and Community Corrections (BSCC) | Approximately $17 million over 3 years | Competitive Grant**

The purpose of MICOR grant is to support appropriate prevention, intervention, supervision, and incarceration-based services through promising and evidence-based strategies to reduce recidivism and improve quality of life outcomes for juvenile and adult offenders with mental health needs in California.[148] In 2015, 21 projects in 17 counties were awarded funding. An evaluation of the first round of funding identified 10 best practice strategies:[149]

- Interagency collaboration
- Intensive case management
- Involvement with the court
- Mental health courts
- Assistance in securing benefits
- Assistance arranging housing
- Medication management
- Use of a center or clinic
- Assistance with transportation
- Peer support

- **Safe Neighborhoods and Schools Act (Proposition 47, 2014) and AB 1056 (2015) | Administered by the Board of State and Community Corrections (BSCC) | Approximately $104 million over three years | Competitive Grant**

The purpose of this grant is to invest funds generated by state prison savings into local prevention programs in schools, victim services, and behavioral health services. These monies support programs and services that reduce recidivism by people convicted of less serious crimes and those who have behavioral health needs. Assembly Bill 1056 (Statutes of 2015, Chapter 438) requires public agencies to leverage other funding streams to maximize grant dollars, specifically the Mental Health Services Act, among others.[150]

- **The Whole Person Care (WPC) Program | Administered by the California Department of Health Care Services | Approximately $1.5 billion in federal funding over five years | Competitive Pilot**

WPC is a network designed to bring together health, behavioral health, and social services agencies to provide efficient and effective resources to Medi-Cal recipients who are frequent users of the health care system. Through this funding, Medi-Cal 2020 waiver identified populations that WPC pilot programs can target and allowed the programs to further distinguish vulnerable populations based on community needs.[151] Almost all of the designated pilot programs have the same target population, specifically, high utilizers, residents who are homeless or at risk of homelessness, and people with mental health or substance use disorders.[152] Most programs set similar goals, such as assisting the homeless, improving coordinated care, and disseminating patient data between health systems.[153]

SELECTED GRANTS AND PILOTS BY COUNTY

✓ = grant recipient

	CHFFA	MHSOAC	BSCC			DHCS
	SB 82 *Grantee: County Mental Health*[154]	SB 82 Triage *Grantee: County Mental Health*[155]	LEAD *Grantee: Varies*[156]	Adult MIOCR *Grantee: Varies*[157]	Proposition 47 *Grantee: Varies*[158]	Whole Person Care *Grantee: Varies*[159]
Alameda	✓	✓		✓	✓	✓
Butte	✓	✓				
Calaveras		✓				
Contra Costa	✓				✓	✓
Fresno	✓	✓				
Imperial	✓					
Kern	✓					✓
Kings	✓					✓
Lake	✓	✓				
Los Angeles	✓	✓	✓	✓	✓	✓
Madera		✓		✓		
Marin	✓	✓			✓	✓
Mariposa		✓				✓
Mendocino	✓					✓
Merced	✓	✓			✓	
Monterey	✓				✓	✓
Napa	✓	✓				✓
Nevada	✓	✓				
Orange	✓	✓			✓	✓
Placer		✓			✓	✓
Plumas					✓	✓
Riverside	✓	✓			✓	✓
Sacramento	✓	✓				✓
San Benito						✓
San Bernardino	✓	✓			✓	✓
San Diego	✓				✓	✓
San Francisco		✓	✓	✓	✓	✓
San Joaquin	✓				✓	✓
San Luis Obispo	✓			✓		
San Mateo	✓					✓
Santa Barbara	✓	✓				
Santa Clara	✓			✓		✓
Santa Cruz	✓			✓		✓
Shasta	✓					✓
Solano	✓			✓	✓	✓
Sonoma	✓	✓				✓
Tehama					✓	
Trinity	✓	✓				
Tuolumne		✓				
Ventura	✓	✓				✓
Yolo	✓	✓			✓	

Through local stakeholder planning processes and others, some counties are blending mental health and criminal justice funding - including grant funding - to develop programs and services to meet the needs of a population that spans multiple agencies. Below are examples of current programs and services with blended criminal justice and mental health funding.

- **Alameda County | ACProp47 Program |Funded with Proposition 47, Mental Health Services Act, AB 109, and other funds**

ACProp47 supports residents who are involved in the justice system and who have a mental health issue and/or substance use disorder. Specifically, funds will be used to: 1) implement a new, county-wide, intensive, multidisciplinary reentry team model to provide service for members in the target population who are experiencing moderate to severe mental health issues and/or substance use disorders; 2) augment contracts with existing community based providers to increase the number of people in the target community who receive their services; and 3) launch a new grant program designed to increase the number and ability of organizations in the county to provide comprehensive housing supports.[160]

- **Merced County | Adult Mental Health Court and Reentry Program | Funded with Mental Health Services Act and AB109 funds**

The Mental Health Court and Re-entry Program provides case management to qualified adult probation clients. The program uses a team of four professionals to ensure participants receive all community resources during rehabilitation and reintegration and include families as partners in the recovery process.[161]

- **Riverside County | Whole Person Care | Grant match funds provided by the Mental Health Services Act, housing and hospital funds**

The Whole Person Care Pilot aims to create a pathway for early identification of needs and provide linkages and interventions to a high risk, high need population. The goal is to decrease expensive and unneeded emergency room visits and hospital usage, and to reduce criminal behavior and jail recidivism by increasing each individual's self-sufficiency and efficacy through care coordination. The pilot screens new probationers, at their first visit following release from incarceration, for serious mental illness and other needs, and then provides warm hand offs to services that will help them successfully reintegrate back into the community. Registered nurses are placed in eight probation sites to screen probationers for: behavioral, physical, and social service needs, and then link them to services.[162]

- **Santa Clara County | Faith-based Collaboration | Former Mental Health Services Act Innovation, now funded with AB 109 and Mental Health Services Act Community Services and Supports funds**

Faith-based Collaboration is a group of multi-faith religious institutions, community organizations, and volunteers established to provide transitional services and offer trust, accountability, and spiritual support to individuals reentering the community and returning to their families after incarceration. [163]

- **Solano County | Mentally Ill Offender Crime Reduction Program| Funded with Mental Health Services Act and Mentally Ill Offender Crime Reduction Grant funds**

The Solano County Mentally Ill Offender Crime Reduction Program created a county-wide response for the justice-involved mentally ill by forming collaborative teams to divert low level community offenders, provide prisoners with and without a sentence post-assessment, jail-based mental health programs, and offer participants reentry planning along with case management aftercare services pre- and post-release through Critical Time Intervention, an evidence-based practice.[164]

Findings and Recommendations

While the challenge of reducing the number of Californians with mental health needs in the criminal justice system is not new, the time to affirm our commitment to resolving this vexing problem is now. Momentum at the national and state level to address this crisis is at a tipping point. Advances in innovative approaches, technology, and shifts toward system integration have created opportunities for change that cannot be ignored.

California must focus on protecting people with unmet mental health needs from engagement with the criminal justice system. Local services should be aligned through comprehensive planning to address unmet needs before they reach the attention of law enforcement. When prevention efforts fall short, counties should have more effective in-custody options to ensure they can provide appropriate and necessary services for those who cannot be diverted. Counties should have an array of options to provide competency restoration services to people found incompetent to stand trial so that people do not wait unnecessarily in jail.

California's counties are well-positioned to develop more effective responses to the increased number of people with unmet mental health needs in jails. The state should clear the path for effective responses by providing clarity regarding state and federal law, facilitating information sharing, and identifying and addressing barriers to innovation, among other tasks.

The state should also examine barriers and develop solutions to integrating and leveraging data to build responsive systems, provide better case management, and continuously improve services. The state and counties should work together to improve training and technical assistance to ensure professionals are trained and cross-trained to provide appropriate responses and quality services to clients. Evaluation and dissemination of effective practices are essential to continuous quality improvement.

The Commission recognizes its responsibility to help establish a vision and a strategy, as well as to work with state and county agencies to pursue that vision. The following principles emerged from the Commission's review and are the foundation for the specific findings and recommendations that follow.

Findings and recommendations are organized by local reform (Findings and Recommendations 1, 2, and 3), state reform (Finding and Recommendation 4), and the tools necessary to support these reforms (Findings and Recommendations 5 and 6). County projects funded through the Mental Health Services Act Innovation Component are highlighted under each recommendation to demonstrate how counties are already developing innovative practices in their communities.

Guiding Principles

The Commission developed the following principles based on information and insight gathered through its review to guide its recommendations outlined below. Each principle builds off others, so there will be natural overlap.

PREVENTION: A relatively small number of people commit offenses as a direct consequence of mental illness alone. Most become involved in the criminal justice system due to a complex combination of unmet needs. Incarceration and involvement in the justice system can be prevented by treatment and support that address the full range of needs, including supportive housing and employment, co-occurring mental health and substance use disorder treatment, services that address trauma, early detection and treatment of mental illness, positive social supports and relationships, and structured activities to build connections to the community.

DIVERSION: People with mental health needs are inappropriately overrepresented in the criminal justice system. Following an arrest, screening and assessment should be conducted as soon as possible to identify people with mental health and substance use needs, and these assessments should be used in diversion decisions. Validated risk assessment tools should be mandatory. When appropriate, people with mental health needs should be diverted out of the justice system as soon as possible and into person-centered, culturally competent services.

TREATMENT: Improving access to mental health treatment alone does not necessarily reduce the likelihood that people with mental health needs will reoffend. When diversion is not possible, people with mental health and substance use needs should receive in-custody treatment and services that adequately address such needs. Release planning for people with mental health needs should occur as soon as possible, and should include potential community providers and peers or people with lived experience. People who have been in correctional settings must be active participants in developing treatment plans.

LEADERSHIP: Change requires executive-level leadership that empowers everyone in an organization and a community to contribute to improvement efforts. State and local leaders must model collaboration when required to improve outcomes, and must collaborate with community leaders and cultural brokers. All leaders must be willing to support a culture of ongoing assessment, and investment based on those assessments. Community members, especially people with lived experience and families, should be empowered as change agents and should work side-by-side with organizational leaders to identify systemic barriers and creative solutions.

CAPACITY: There are insufficient resources along the continuum for people with mental health and substance use needs, resulting in the over-utilization of jails and emergency departments. Local communities must leverage existing funding from public and private sources, and use funding in the most cost-effective manner based on community needs.

COLLABORATION: Mental health needs are among many needs that must be met to increase recovery and decrease involvement with the criminal justice system. Improving outcomes for people with mental health needs in the justice system cannot be the responsibility of a single public entity. Collaboration requires shared responsibility. Collaboration should include people with lived experience in the criminal justice and mental health systems, as well as family members. Local collaboration must occur among

public health and public safety leaders. State collaboration must model local collaboration to support and sustain change over time.

EQUITY: An equitable system is built on just approaches that offer people an equal opportunity to obtain services regardless of race or ethnicity, gender identification, socioeconomic status, or sexual orientation. Longstanding mental health disparities exist for people in diverse communities, and incarceration rates in those communities continue to climb. More must be done to understand these trends, the impacts of historical marginalization and oppression, and to reduce disparities using culturally-competent outreach, engagement, training, and service delivery.

INTEGRATION: An integrated approach is required to address the complex needs of people with mental health needs involved in the justice system. Mental health and other services addressing unmet needs should be integrated into the same program and with the same provider/clinician. When program integration is not possible, information and data on people receiving services from different providers must be exchanged to coordinate care and track progress over time.

FINDING ONE:

Too many mental health consumers, particularly those from diverse communities, end up in jail because of unmet needs and system inequities. A robust, prevention-oriented system can reduce this unnecessary harm.

People with mental health needs who become involved with the criminal justice system tend to have challenging, complex needs. They are often homeless, may have long-standing physical health needs, exposure to multiple traumas and adverse childhood experiences, and may battle chronic addictions to drugs and alcohol. Diverse communities are affected by long-standing inequities in social determinants of health, including education, physical environment, and employment and other economic opportunities. These inequities, combined with other needs, contribute to disproportionate contact with law enforcement and confinement in jail.

For some people, mental health recovery can take months, years, or decades. Some people do not believe they have mental health needs or may have had multiple unpleasant experiences with the mental health system, and thus may understandably resist treatment. Some move toward recovery for periods of time but then may struggle for various reasons, including discontinuing medication use or experiencing new challenges or trauma.

During its review, the Commission heard that a large number of Californians with mental health needs often receive treatment for the first time in the criminal justice system. As many experts see it, the criminal justice system has become a de facto outreach and engagement strategy to connect people with care. Stories the Commission heard include:

- Prosecutors and public defenders who believe that keeping a person with mental health needs in the court system is the best or only way to connect them with services
- Members of the public who call 911 when they see a person on the street arguing with him or herself as a strategy to obtain help
- Parents of an adult child who is refusing treatment and are encouraged to have their child arrested as a strategy to obtain mental health services in custody

Yet calling law enforcement as an access strategy is expensive, can complicate efforts to provide effective mental health services (resulting in poorer outcomes), and distracts law enforcement personnel from their primary focus. Once a person enters the criminal justice system, considerable costs follow. These include the cost of housing such individuals and providing treatment for mental health, substance use, and physical health needs, as well as the costs associated with court proceedings and community supervision for those released on probation. In addition to added costs, involvement in the criminal justice system can inflict new trauma on people with mental health needs, making their condition worse. Involving law enforcement in mental health care often results in a criminal record, which can create another barrier to care by preventing eligibility for mental health services.

Establishing a comprehensive, community-based system focused on preventing contact with the criminal justice system must be prioritized. Creating and sustaining such a system cannot be the responsibility of a single department. It will require collaboration among county health and safety partners, including the

sharing of data across agencies to understand gaps and leveraging all available funding to maximize capacity. Several key areas consistently emerged from the Commission's work as gaps in the current delivery system, including housing, integrated care for co-occurring needs, disparities in access and utilization of services by diverse communities, and a lack of options for people transitioning out of the highest levels of mental health care.

HOUSING CAPACITY: A shortage of available housing remains one of the biggest challenges facing those with mental health and substance use needs who become involved in the criminal justice system. Affordability and availability of housing in California are challenges statewide, especially for diverse communities, and these challenges are complicated by community opposition to housing for the formerly incarcerated, especially those with mental health needs. Stigma towards people living with mental illness who are involved with the criminal justice system increases the unwillingness to develop housing in certain neighborhoods. NIMBYism ("Not in my backyard") is a major barrier to the expansion of housing, and will continue to prevent or hinder the ability to meaningfully provide needed services and supports if not addressed.

SERVICE INTEGRATION: Integrated mental health and substance abuse treatment is essential for the successful care of people with co-occurring disorders. Unfortunately, a lack of available co-occurring disorder treatment programs, combined with a shortage of appropriately trained clinicians, limits access to integrated treatment in both outpatient and inpatient mental health settings. Therefore, the systems for treatment of mental health and substance use disorder are currently separate, which makes integrated care challenging. Most publicly funded programs are not integrated and provide only mental health or substance abuse treatment.

DISPARITIES: Disparities in access to mental health services and outcomes for diverse communities remain a challenge. The Mental Health Services Act values cultural and linguistic competence and the reduction of disparities in access to services. In order to achieve the objectives of the act, state and local officials must ensure that people are served, (1) in ways that are congruent with and respectful of differing cultural views and traditions, (2) in ways that eliminate disparities in access to treatment and quality of care, and (3) in ways that create successful outcomes for all consumers and families served.

Throughout this project, the Commission heard from stakeholders that communities of color are reluctant or afraid to seek help from those outside their culture or communities. Language access continues to be a problem. Service providers and administrators need to work in cooperation with diverse communities to identify culturally and linguistically appropriate treatment and outreach strategies and to increase workforce diversity. Steve Fields, Executive Director of the Progress Foundation, recently stated, "Our workforce must reflect the look, reality and experience of the people we are hoping to serve. We need to better understand why consumers struggle with traditional and new treatment strategies, particularly medication."[165] Programs and services are not addressing the environment in which people live, stigma and discrimination in the cultures people grow up in, and the traumatizing effects of neighborhood or family violence, intergenerational incarceration, and poverty and homelessness that disproportionately impact diverse communities.

LACK OF "STEP DOWN" OPTIONS: Another challenge facing people who need care is the shortage of services for acute needs and lack of "step down" options as people transition from higher levels of care, such as Full Service Partnerships, into less intensive services. California has seen a reduction in the

availability of inpatient acute psychiatric hospital beds. In response, counties have developed alternative strategies to fill the gap, such as crisis residential centers and crisis stabilization units. These are short term solutions to reduce use of hospitalization and jails. Longer term solutions are still needed for people who need more intensive services and a higher level of care, and for those who are transitioning out of care.

RECOMMENDATION ONE:

California's mental health agencies, in partnership with law enforcement and others, should have a comprehensive prevention-focused plan that reduces the incarceration of mental health consumers in their communities.

Local mental health and public safety departments should collaborate to develop a continuum of care and strategies to deliver services to reduce involvement and improve outcomes for people with mental health and substance use needs who become involved in the criminal justice system. Developing these strategies should start with an analysis of needs and gaps in care. Counties should explore the use of public health models that incorporate social determinants of health to identify prevention opportunities for communities disproportionately confined in local jails, including members of African American, Latino, Native American, and transgender communities. Strategies identified through the California Reducing Disparities Project may offer culturally and linguistically responsive options for engaging and serving communities of color and LGBTQ communities.[166]

Counties should build programs, services, and facilities that have demonstrated effectiveness, and should measure performance over time to ensure quality improvement. Counties should make better use of data and information to guide their investments in programs and services that reduce the number of people with mental health needs in the justice system. They should also use such data to connect people needing services with appropriate community-based care.

To support local commitments to diverting those with mental health needs from the justice system, counties should have culturally and linguistically competent programs and services available that address the issues that put people at risk, such as housing instability, trauma, and inequities in education, employment, and health care. Planning should include programs that are "one-stop-shops," with co-located mental health, substance use, and physical health services and coordinated case management to make meaningful referrals for available services in the community. These strategies should be trauma-informed and should take into account consumer experiences of cultural discrimination.

Counties should leverage the expertise of those with lived experience, including family members, when designing prevention and diversion strategies that are trauma-informed and take into account racial and cultural discrimination. Counties should continue expanding the array of crisis services, such as 23-hour crisis stabilization/observation beds, short-term crisis residential services and crisis stabilization, mobile crisis services, 24/7 crisis hotlines, warm lines, and peer crisis services.

The ubiquitous experience of trauma for people with criminal justice involvement and mental health needs cannot be ignored. Increasing access to programs that address trauma, particularly for communities of color and LGBTQ communities, is critical. Specific and concerted efforts must be made to identify the

mental health and substance use needs of ethnic and cultural minorities. These efforts should include improving access to care and quality of mental health services. Engaging new and diverse partners and building relationships with community leaders and professionals will be a critical step in addressing inequities in the mental health and criminal justice systems.

One way to identify system gaps and disconnects is by conducting formal needs assessments as part of each county's required Community Program Planning process.[167] Counties should make use of data and information to guide investments in programs and services that reduce the number of people with mental health needs in the justice system. Data also can support the community consultation process regarding public investments and can help to leverage funding streams that come from different sources and are allocated to different agencies. Needs assessments could help fill system gaps, but models for a continuum of care that addresses a full range of mental health and substance use needs is still needed.

The lack of standards for a mental health continuum of care is receiving national attention. Recently, the Substance Abuse and Mental Health Services Administration's Center for Mental Health Services convened some two dozen experts to advise the agency on the development of a model mental health continuum of care. Consensus was reached that guidelines were needed, as the nature and quality of mental health care varied so greatly by community. In the convening, experts noted that services were fragmented, and often incomplete. The Commission can support these efforts by working with county mental health leaders, peers, providers, and others to develop standards as part of its review of local plans.[168]

MHSA Innovation Highlight – Advancing Mental Health Urgent Care Models in California

Sacramento County | Mental Health Crisis/Urgent Care Clinic

The Sacramento County Division of Behavioral Health Services is implementing an innovative project to adapt urgent care models used in other counties to meet the needs of the community. This adaptation will include integration of wellness and recovery principles in service delivery. Innovative adaptions include an after-hours outpatient treatment program operation to allow for more flexible staffing patterns, direct linkage to behavioral health services, and a screening tool that allows staff to screen for physical health issues, expediting care coordination.

https://www.dhhs.saccounty.net/BHS/Documents/Reports--Workplans/MHSA-Reports-and-Workplans/RT-2016-17-MHSA-Annual-Update--Sacramento-County.pdf

FINDING TWO:

California's jails are not equipped to serve mental health consumers. Diversion should be prioritized, but counties need more effective in-custody options to ensure they can provide appropriate and necessary services to those who cannot be diverted.

Each county must prioritize diversion to ensure that no one ends up incarcerated because of unmet mental health needs. Despite those efforts, some people with mental health needs will inevitably become incarcerated in local jails. Unlike state prisons, jails were not designed or intended to house people for long periods of time. Prior to criminal justice realignment, jails mostly held people awaiting trial and those serving sentences for up to one year. Jails today house and treat people serving lengthy sentences, including people with complex, long-term unmet mental health, substance use, and physical health needs.

The challenges of effectively serving people with mental health needs in jail are well documented. Jails lack appropriate treatment space due to their physical design, and inadequate staffing and training are common. People with mental health needs tend to stay in jail longer, return to jail more often, and cost local jurisdictions more money while incarcerated.[169] More frequently than not, people with mental health needs are jailed for minor offenses, such as trespassing, disorderly conduct, disturbing the peace, or illicit drug use.[170] Jail staff are challenged with how to manage people with mental health needs in custodial settings, which are often crowded, brightly lit, and loud. People with mental illness may be hypersensitive to this environment, and may exhibit behaviors that jail staff struggle to control.

Mental Health Services in Local Jails

California Code of Regulations, Title 15, outlines the standards for local detention facilities, including standards for mental health screening and treatment. Below is an overview of several regulations related to jail mental health.

- Screening for mental health needs by licensed health personnel or trained facility staff should occur at the time of intake, and a written plan developed for those who appear at screening to need mental health services.[171] Health care providers develop written individualized treatment plans for people receiving mental health services in jail, including referrals to treatment after release if recommended by treatment staff.[172]
- Local facility administrators have the responsibility of ensuring emergency and basic mental health care.[173] Each facility establishes policies and procedures to provide mental health services, including:
  - Identification and referral of inmates with mental health needs
  - Mental health treatment programs provided by qualified staff
  - Crisis intervention services
  - Basic mental health services provided to inmates as clinically indicated
  - Medication support services
  - The provision of health services sufficiently coordinated such that care is appropriately integrated, medical and mental health needs are met, and the impact of any of these conditions on each other is adequately addressed.[174]

- Written policies and procedures are developed to govern the use of psychotropic medications.[175] Medication may only be administered involuntarily on an emergency basis if a person is found by a physician to be a danger to him/herself or others by reason of a mental illness.[176]
- Written plans for informed consent of inmates in a language understood by the inmate are developed, and all examinations, treatments, and procedures affected by informed consent standards in the community are likewise observed for inmate care.[177] Absent informed consent in non-emergency situations, a court order is required before involuntary medical treatment can be administered to an inmate.[178]
- Each facility develops a comprehensive suicide prevention program to identify, monitor, and provide treatment to those at risk of suicide.[179]

While some inmates serve lengthy sentences, for others, the time from intake to release can be as short as a few hours. Treatment initiated in custody is frequently terminated when a person is released, and care typically does not resume once that person enters the community. This "churning" of people with complex mental health and substance use needs often makes it difficult, and in some cases impossible, to complete thorough assessments of a person's mental health history or current needs, provide effective treatment, and develop appropriate discharge plans before release.

Uncertainty about a person's release date is another challenge, one that makes coordination of services difficult. The criminal justice system lacks a consistent, adequate method for connecting inmates to appropriate services upon release, a gap that aggravates behavioral health conditions and contributes to subsequent encounters with law enforcement. On the front end in California, mental health screenings are required at initial booking in local jails. But jails face an array of challenges that delay those screenings. Challenges include people too agitated for screening or under the influence of drugs or alcohol, unavailability of trained staff, and a large number of bookings at the same time.[180]

Mental Health Training for Jail Staff

The Board of State and Community Corrections is reviewing and updating core training requirements for Adult Corrections Officers, Juvenile Corrections Officers, and Probation Officers.[181] Each classification has specific courses and hours for mental health training.[182] The last major content revision to the Adult Corrections Officer curriculum was effective in 1998.[183] The curriculum includes 6.5 hours dedicated to mental health – 2.5 hours on mental health issues and four hours on suicide issues. Another 26 hours of related courses, such as principles of use of force, booking inmates, and interpersonal communications, include mental health as a learning objective.[184]

Local departments are offering crisis intervention training to custody staff in addition to law enforcement in the community. For example, Santa Clara County developed a custody-specific, 16-hour Behavioral Health Concepts and De-Escalation Techniques curriculum in partnership with the local behavioral health department, which is now mandatory for all correctional deputies.[185]

Mental health advocates have expressed additional concerns, including lack of access to appropriate levels of care, medication-only approaches to treatment, overuse/misuse of solitary confinement, inadequate staff to deliver care, inaccurate and incomplete medical records, problematic medication practices, and failure to screen for and prevent suicide.[186]

The National Institute of Corrections assessed jails and the challenges sheriffs face in housing and treating those with mental health needs. They found:

CHALLENGES FOR INMATES

Many of the inmates with mental health needs have a dual diagnosis (co-occurring mental illness and substance abuse).	Lack of medication may have led to the behavior(s) which led to the arrest.	Inmates with mental health needs often returned to the community with no treatment plans or housing.
Inmates with mental health needs are overrepresented in segregated housing.	Incarceration exacerbates mental illness symptoms — segregation accelerates deterioration.	Inmates with mental health needs 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, people with mental health needs are often unable to comprehend or follow the correctional staff directions.	Inmates with mental health needs are often not able to recall their history (medication names or dosage, address, next of kin).	People with mental health needs are booked in after periods of not taking their medication.

CHALLENGES FOR JAIL STAFF

Correctional staff are not normally trained to intervene effectively with those with mental health needs, so they isolate them.	A use of force is traditionally used to get inmates with mental health needs 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.	Staff must determine if there was a lack of medication or noncompliance.	

BOTTOM LINE

Diversion to community-based care is a better option.	People with mental health needs are not suited for jail unless their behaviors are criminal in nature and demand incarceration.	They are better suited in the community with proper housing, case management, and medication.

Awareness of these concerns is increasing, and counties are developing strategies to address those with high levels of need who cannot be diverted from jail. In 2015, 15 California counties were awarded $500 million in funds from the state to improve local jail facilities.[187] Most, if not all, of these counties requested funds to build or renovate existing jail space to create an environment that would allow for better treatment and housing of those with behavioral health needs.[188] Sonoma County, for example, is investing $49 million in a 72-bed jail unit to provide improved behavioral health treatment services as well as an environment designed to promote social and therapeutic interactions.[189]

Mirroring models found in the community, county sheriffs are developing multi-tiered approaches to providing services that address a full continuum of mental health and substance use disorders. This approach ranges from providing intensive treatment in high-need, acute, inpatient "hospital-like" units to dispensing medication through appointments with licensed mental health clinicians. In March 2017, the Sacramento County Main Jail launched a 20-bed Intensive Outpatient Program. The program provides care to those with serious mental health needs who would benefit from the structure of a therapeutic environment and who require more frequent observation than inmates receiving mental health services in a jail's general population. The program serves as both a step-down from the jail's Acute Inpatient Unit and a step-up for inmates requiring more intensive mental health services than what is available in the general custody setting. Services are provided by a multidisciplinary team and include group and individual therapy, case management, medication evaluation and follow-up, and discharge planning.

Before counties can effectively design solutions, they should begin with an assessment of their jail population to understand the types of offenders under their custody. In 2016, Minnesota's Hennepin County conducted a one-day "snapshot" of people in its jail by performing full medical assessments on 640 of its 680 inmates. Officials found that over half of the people they assessed met the criteria for having a mental illness. In an interview following the assessments, Hennepin County Sheriff Rick Stanek said, "Now that we have better information about the extent of mental illness among jail inmates, we can begin working on better ways to provide the services they need and deserve."[190]

Using Data to Understand the Jail Population and Opportunities for Diversion

To help counties reduce costs and improve outcomes, California Forward developed the Justice System Change Initiative. [191] Through this initiative counties – including Riverside, San Bernardino, Santa Cruz, and El Dorado – take a system-change approach, beginning with data assessments of different aspects of the criminal justice system, including a jail utilization study. The studies reveal opportunities for reducing incarceration and developing more effective community-based alternatives. The analysis explores the reasons for booking, length of stay, and the typical daily population. It allows counties to assess high-utilizers, disparities, and bottlenecks in the judicial process that increase jail time and costs.

Riverside and San Bernardino counties accessed jail data about inmates with serious mental health needs. El Dorado accessed data via the referrals to mental health services and Santa Cruz retrieved data from a tallied process of jail entries and exits that were merged with data from the county's Behavioral Health Division. All counties found three major findings: inmates with mental health needs have double the number of bookings of the general jail population and twice the length of jail times for lesser crimes. The population with people with mental illness also has an increased likelihood to be in detention for causes other than a new offense, such as probation violations or court holds.

RECOMMENDATION TWO:

The Board of State and Community Corrections should facilitate a collaborative effort with counties to identify, develop, and deploy services and strategies that improve outcomes for mental health consumers in jail, including universal screening for mental health needs at booking and enhanced training for custody staff.

The California Board of State and Community Corrections was established in 2012 to provide leadership to the criminal justice system, administer public safety grant funding, deliver technical assistance on community corrections, and provide regulatory authority over local detention facilities.[192] The board is charged with ensuring that local detention facilities are meeting legislative mandates for enough space to deliver rehabilitation programs. The board should lead on promoting practices that will ensure people in jail with mental health and substance use needs are receiving services necessary for rehabilitation. To do this effectively, counties must use assessments of mental health, substance use, and risk factors for offending to determine appropriate levels of supervision and intervention.[193] All three must be assessed and addressed to reduce recidivism and increase mental health and substance use recovery.[194] In some cases, addressing serious mental health needs prior to addressing other risks related to offending could reduce future involvement with the criminal justice system.[195] Appropriately addressing mental health and substance use needs should be a viewed as a matter of public safety, and must be included with programming to address risks for offending.

Delivering interventions that will improve outcomes for mental health consumers begins with an initial screening at booking of every person entering local jails. Universal screening for mental health and substance use disorders at booking, along with timely follow-up assessments, must be mandatory. Efforts should identify barriers to conducting universal screening and assessment for mental health and substance use needs, and ways to overcome those barriers. Several promising screening tools have been identified, including the Brief Jail Mental Health Screen, the Correctional Mental Health Screen for Men, the Correctional Mental Health Screen for Women, the England Mental Health Screen, and the Jail Screening Assessment Tool.[196]

Efforts should review the use of isolation or solitary confinement, and explore promising developments in trauma-informed correctional care, as such practices have been proven effective in reducing criminal risk factors and supporting the effectiveness of mental health and substance use services in jail.[197] Efforts should also explore ways to deploy culturally and linguistically appropriate services in custody settings, inspired by community-defined practices for people from communities of color and LGBTQ communities.

Revisions to the mental health curriculum for correctional staff training should continue as well. Trainings should reflect crisis intervention training and mental health awareness training that many law enforcement jurisdictions are currently implementing in the community. All trainings should address issues of stigma, discrimination, and implicit biases, and should include training on cultural and religious diversity and ensuring language access – or how to assist people who communicate in languages other than English.

MHSA Innovation Highlight – Advancing Collaborative Strategies in California

Sutter-Yuba County | Improving Mental Health Outcomes via Interagency Collaboration and Service Delivery Learning for Supervised Offenders who are At Risk of or Have Serious Mental Illness

Sutter and Yuba Counties have a joint mental health system. The counties have developed an innovative project that embeds a mental health clinician within an existing multi-disciplinary probation team to provide mental health assessments, post-release recovery plans, and connections to ancillary services that contribute to positive mental health prior to release.

https://www.co.sutter.ca.us/contents/pdf/hs/mh/mhsa/pdf/Public%20Review%20Draft-2016-17%20MHSA%20Annual%20Update.pdf

FINDING THREE:

A large and growing number of people found incompetent to stand trial because of unmet mental health needs are forced to spend months in jail awaiting services necessary for their cases to proceed.

Many counties are reporting an increase in the number of people found incompetent to stand trial. Under state and federal law, all individuals who face criminal charges must be mentally competent to help in their defense. By definition, a person who is incompetent to stand trial lacks the mental competency required to participate in legal proceedings. Competency restoration to a large extent involves delivering mental health treatment, with additional education on the legal process. Responsibility for restoration of competency is bifurcated, with the State responsible for felony competency restoration and the counties charged with handling misdemeanor competency restoration.[198]

In California, there is a monthly statewide waitlist with an ongoing average of approximately 500 people who face felony charges and have been deemed by the courts to be mentally incompetent to stand trial. These individuals are waiting in jail for a bed to become available in a state hospital in order to undergo evaluation and receive treatment to restore them to competency. Once these people are housed at a state hospital, the state spends significant resources to provide treatment – approximately $170 million annually.[199]

In 2017, the California State Department of Hospitals conducted a national survey to determine whether other states were experiencing an increase in people found incompetent to stand trial, and what they were doing to meet increased demand.[200] They found that 38 of 47 responding states reported an increase in the number of referrals for competency evaluations.[201] The highest ranking potential cause of the increase was the inadequate number of inpatient psychiatric beds in the community.[202] Other potential causes included inadequate general mental health services, inadequate crisis services, and inadequate Assertive Community Treatment services in the community.[203] The majority of respondents cited jail diversion as the solution (55 percent), followed by increasing the number of state hospital beds (43 percent).[204]

For California, one expert suggests the trend may be related to changing attitudes in the legal community. “When I was a young lawyer, it was unheard of to declare a misdemeanant incompetent to stand trial because it resulted in so much of a longer time locked down in the county jail,” said Judge Peter Espinoza, director of the Los Angeles County Office of Diversion and Reentry. “Now,” he added, “the public defender’s office seems to have reached the conclusion that they’re doing their clients a better service by going through the mental health process, declaring their misdemeanant clients incompetent to stand trial so they can be properly diagnosed and receive services in an attempt to stop the recycling or churning of this population in the county jail.”[205]

According to the Department of Hospitals survey, potential solutions included developing jail-based competency restoration and outpatient or community-based competency restoration. In Fiscal Year 2007-2008, the former state Department of Mental Health received a $4.3 million budget allocation to begin pilot programs examining jail-based approaches to addressing the backlog in state hospitals. After several

years of delays, the department, working with a private vendor, established a pilot program in San Bernardino County to treat people accused of a felony and found incompetent in the county jail instead of a state hospital. Jail-based competency restoration is expanding, and is now found in Mendocino, Riverside, Sacramento, San Diego, and Sonoma counties, and elsewhere in California.

For various reasons cited in this report, jails are challenging places for people with mental health needs, including those waiting or receiving competency restoration services. Like other states, California has explored strategies to improve competency restoration outside of state hospital settings. While California has focused on strategies for jail-based approaches, other states have explored expanded community-based approaches. Some 39 states allow outpatient restoration of competency, 16 of which operate formal outpatient competency restoration programs.[206] In their review of such programs, Disability Rights of California found the following features and benefits: [207]

- Intensive case management, including housing, psychosocial rehabilitation, and voluntary medication
- Individualized treatment
- Longer lengths of stay in outpatient settings because of less pressure to transition out of inpatient care prematurely
- "Freed up" inpatient bed space
- Less costly compared to inpatient programs, at times 20 percent savings
- Less restrictive and more recovery-oriented

Recognizing the ongoing need for improved access to competency restoration services, California should expand similar options.

RECOMMENDATION THREE:

To reduce the backlog of people found incompetent to stand trial, California must maximize diversion from the criminal justice system. For people who cannot be diverted and are found incompetent to stand trial, the state and counties should expand options for restoring competency.

Effective prevention and early diversion strategies have the potential to reduce the number of people found to be incompetent to stand trial because there will be fewer people brought to trial. Among other alternatives, counties should explore community-based competency restoration programs with supportive housing for misdemeanants and low-risk felons. Using jail cells to hold defendants who are incompetent to stand trial is costly and often ineffective. Just as counties are expanding pre-trial community-based services, counties can expand community-based restoration programs. Both strategies can reduce jail overcrowding and potentially reduce future criminal involvement. Risk assessment tools can help identify people who can be safely managed in the community and can determine the appropriate level of community supervision and services.

One way the state can reduce the number of people waiting for services from a state hospital is to fund a community-based pilot program to connect people needing competency restoration services with

intensive services in the community, such as Forensic Assertive Community Treatment. Data from the California Department of State Hospitals demonstrates that many people coming into their care for competency restoration are compiling crimes at a faster rate and almost half (47 percent) are homeless.[208] Community-based supportive services have the potential to address factors, such as housing, that are likely contributing to the increasing number of people with unmet mental health needs being found incompetent to stand trial.

The state should encourage counties to utilize Mental Health Services Act Innovation funds to address this need.

MHSA Innovation Highlight – Expanding Community-based Competency Restoration

El Dorado County | Community-based Competency Restoration

El Dorado County launched this innovative project to determine if providing competency restoration services in an outpatient setting to misdemeanants will reduce the cost of restoration and strengthen misdemeanants' ties to the mental health treatment system. This project provides participants with supportive mental health services, including wellness center activities, and encourages family and friends to participate in the restoration to competency process.

https://edcgov.us/government/mentalhealth/mhsa%20plans/documents/FY%202016-17%20MHSA%20Plan%20Update%20ADOPTED%206-13-16.pdf

FINDING FOUR:

California has not put in place a statewide, systemic approach for prevention and diversion to reduce criminal justice involvement for mental health consumers and improve outcomes.

Under criminal justice and mental health realignment policies, counties have responsibility for delivering a large proportion of California's mental health services and criminal justice strategies. California's counties are well-positioned to develop more effective responses to the increased number of people with unmet mental health needs in jails. The state should clear the path for such effective responses, by providing clarity regarding state and federal law, facilitating information sharing, and identifying and addressing barriers to innovation, among other tasks.

County by county, progress is happening. But each individual innovation also has the potential to accelerate statewide improvements – if the lessons learned are communicated beyond county borders. Counties are being asked to collaborate and integrate services, and the state should follow suit. California needs clear and consistent champions to sustain change and momentum over time.

Significantly improving results will require more than new programs. Lasting, transformative change will require developing the ability within public agencies to methodically improve day-to-day operations. System-level change requires collaboration among local agencies serving and interacting with community members. It requires state agencies to coordinate the guidance and regulation they provide county agencies. And just as leadership is essential to changing organizations, partnerships are essential to changing systems. State agencies have three primary responsibilities in effecting system-level change:

- State agencies must provide clear, consistent, and reliable information regarding obligations and requirements in federal and state law. State agencies must clear the ambiguity that can paralyze local managers and frustrate innovations.
- State agencies must facilitate the sharing of information to encourage innovations and the replication of best practices. They must align their discretionary authority and resources to support proactive local managers and help build capacity in all counties.
- State agencies must identify barriers to innovation – in law, regulations, or bureaucratic procedures – and align formal policies and organizational culture to support continuous improvement.

State entities will need to work together to support transformational change within counties. While there is more than one way to structure a collaborative effort, three attributes will be required for it to be successful:

- The charge for the collaborative effort must be clearly articulated in desired outcomes with explicit metrics for measuring progress.
- The agencies must be accountable for their collective and individual efforts to the Governor and the Legislature.
- The collaborative must have dedicated leadership and organize its activities to include relevant agencies, and it must build trust over time as a result of meaningful progress toward shared goals.

California's Council on Criminal Justice and Behavioral Health - formerly the Council on Mentally Ill Offenders[209] - has a clear leadership role in promoting coordination among criminal justice and behavioral health systems. That coordination should focus on strategies to improve outcomes. The council has largely been underfunded, understaffed, and underutilized. The statute that created the council was written prior to the current mental health and criminal justice realignment structure, and does not reflect the current, largely locally-driven service and correctional systems.

Currently, the council is housed within the Office of the Secretary of the California Department of Corrections and Rehabilitation.[210] The council has 12 members:

- The Secretary of the Department of Corrections and Rehabilitation
- The Director of State Hospitals
- The Director of Health Care Services
- Nine other appointees:
    - The Governor appoints three members, at least one representing behavioral health.
    - The Senate appoints two members, one representing law enforcement and one representing behavioral health.
    - The Assembly appoints two members, one representing law enforcement and one representing behavioral health.
    - The Attorney General appoints one member.
    - The Chief Justice of the California Supreme Court appoints a superior court judge.

The statutory goal of the council is to investigate and promote cost-effective approaches to meeting the long-term needs of behavioral health consumers who are at risk of becoming involved with or who have a history of involvement with the criminal justice system. The council has the following areas of focus:

- Identifies strategies for preventing people with behavioral health needs from becoming offenders
- Identifies strategies for improving the cost-effectiveness of services for people with behavioral health needs who have a history of offending
- Identifies incentives to encourage state and local systems to adopt cost-effective approaches for serving people with behavioral health needs who are likely to offend or who have a history of offending

The council considers strategies that:

- Improve service coordination among state and local behavioral health, criminal justice, and juvenile justice programs
- Improve the ability of offenders with behavioral health needs to transition successfully between corrections-based and community-based treatment programs

Every year the council submits a report to the Legislature detailing its activities, including recommendations for improving the cost-effectiveness of behavioral health and criminal justice programs.

RECOMMENDATION FOUR:

The Council on Criminal Justice and Behavioral Health should fortify its efforts to champion collaboration among state agencies to support local prevention and diversion of mental health consumers in the criminal justice system.

In addition to the council, several state agencies play an important role in financing, regulating, and supporting county agencies responsible for community-level mental health services and criminal justice functions. The Board of State and Community Corrections was re-chartered to set standards for and distribute funds to local agencies.[211] The California Department of Corrections and Rehabilitation manages and operates the state's prison system, and delivers mental health and rehabilitative services, such as job training, to prison inmates and people on parole in local communities.[212] The Mental Health Services Oversight and Accountability Commission was established to promote transformational change in California's mental health system to improve outcomes, including reducing incarceration.[213] Originally established to manage Medi-Cal health benefit programs in California, the Department of Health Care Services now also oversees community substance use and mental health programs.[214] The Department of State Hospitals oversees California's state hospital system, which provides mental health services and competency restoration services for people charged with felonies and found incompetent to stand trial.[215]

As part of its responsibilities, the council should identify how other state and local agencies – including the Commission – should collaborate. Under this recommendation, the Council on Criminal Justice and Behavioral Health would need additional funding to perform its expanded role.

The Council on Criminal Justice and Behavioral Health should be charged with:

- Housing a Behavioral Health and Justice Center of Excellence, including a clearinghouse on best practices. These would include evidence-based and community-defined practices for diverse communities.
- Leading a collaborative effort to develop a statewide diversion plan, and an annual update, driven by data, to promote continuous quality improvement
- Promoting information sharing and developing clear outcomes and data to support measurement
- Identifying and removing barriers to funding, clarifying what can be done with funding, and sharing what others are doing with funding to ensure dollars are used most effectively
- Identifying and addressing barriers to best practice implementation
- Continuing to build state and local capacity for ongoing improvement, including expanding approaches with a track record of effectiveness

Interagency collaborations fail more often than they succeed. To ensure its success, state collaboration will need:

- Clear goals articulated as desired outcomes with explicit metrics for measuring progress
- Accountability to the Governor and the Legislature for collective and individual efforts
- Dedicated leadership committed to solving problems and working toward system change

FINDING FIVE:

Data is a critical tool in decision-making and service delivery, but state and local agencies are not effectively harnessing its power to improve outcomes for those in need.

In California today, it is impossible to accurately describe the number of people with mental health needs housed in county jails. A lack of accurate, up-to-date information on consumers, coupled with inconsistent data collection practices and definitions, is a significant barrier to efforts to keep people with mental health needs out of the criminal justice system. Without data, it is difficult to understand not only the scope of the problem, but its multiple dimensions and potential solutions.

Community-based treatment providers do not consistently share information with correctional health care providers, and vice versa. Program costs and outcomes often are not tracked. Community consultation processes often do not include data to monitor outcomes and the quality of services. Data regarding race, ethnicity, sexual orientation, and gender identity is lacking, making the task of identifying, tracking, and monitoring disparities within the system challenging.

Data can be a powerful tool to identify gaps and disconnects, guide management decisions, and drive continuous improvement efforts. Information technology also is providing better methods for integrating services, coordinating the efforts of public agencies, and informing real-time decisions by professionals.

At the local level, data can support the coordination of services in the community and in custody. Data can help administrators allocate resources across systems. Even small scale efforts can benefit by using data to measure shared outcomes. By understanding needs and whether programs are meeting those needs, data could support funding decisions and program improvements. Improving data collection and utilization also could help shape a strategic plan for future investments. When data is not collected or available, people within a system become invisible and problems are minimized. Data can help an individual be "seen" and consequently reached and served.

Some collaborative efforts have relied on team approaches, with behavioral health and criminal justice staff meeting frequently to discuss shared clients. This approach can work well for individual clients. But a system approach must be predicated on using data to develop a better understanding of challenges and opportunities.

Local governments nationally spend at least $22 billion to incarcerate approximately 11 million people each year.[216] By using data, communities can fully understand the cost of a relatively small number of people cycling in and out of their publicly funded systems. San Diego County's Project 25, for example, identified 28 people who alone consumed $3.5 million in public resources in 2010.[217] In Miami-Dade County, Florida, 97 people with serious mental health needs accounted for $13.7 million in services over four years, spending more than 39,000 days in county jails, emergency rooms, state hospitals, or psychiatric facilities.[218]

Over the last year or so, state and national efforts have pushed local communities to use data to better understand "high utilizers" of public systems. Such efforts seek to demonstrate that if agencies can

identify a small number of people using the majority of public resources, potential cost savings can be realized through targeted outreach, engagement, and service delivery.

The small Fresno County city of Selma is a case in point. Police Chief Greg Garner said that for years, police officers and other emergency service workers were frustrated by repeatedly encountering the same community members struggling with the same problems. “The genesis of their problems is mental illness, but traditionally, they’ve just been hidden away in an ER or jail cell,” Garner said. “That not only costs a lot of money, their problems never get addressed.”

Now, under a Fresno County triage program that dispatches mental health workers to help police in the field, disruptive individuals with mental health needs are receiving referrals and treatment, Garner said. “Having trained mental health clinicians respond in the field with our officers has been a godsend. And for the people we encounter, the program means they get plugged into support services rather than deposited in the criminal justice system.”[219]

At the national level in 2016, the White House launched the Data-Driven Justice Initiative to promote state and local practices to identify people with physical and behavioral health needs served through the criminal justice and health care systems. With such data, agencies can target scarce resources toward the greatest needs and identify those falling through the cracks. Los Angeles, San Diego, San Francisco, and Santa Clara counties joined the Initiative. Participating counties agreed to facilitate data sharing, implement pre-arrest diversion, and use data-driven risk assessment tools.

Along with the potential to use data comes the barriers to sharing data. There are technological barriers, such as antiquated systems in incompatible formats or data kept in paper files. There are cultural barriers, such as mistrust of how data will be used, interpreted, or modified by others outside programs or agencies. Then there are legal barriers, which can be real – such as restrictions defined by law – and perceived, perhaps a misunderstanding of complicated privacy rules and restrictions. The number one barrier identified by stakeholders to sharing data was confusion or fear around violating client confidentiality, or, more directly, violating the Health Insurance Portability and Accountability Act (HIPAA), which protects confidential medical information.

While the need for privacy is generally understood and accepted in the field, professionals also express frustration over the lack of clarity around what type of information can be shared, who may receive the information, and how it may be distributed. The California Office of Health Information Integrity, within the California Health and Human Services Agency, is responsible for ensuring compliance with HIPAA and other privacy laws. In July 2017, the agency, in collaboration with an advisory group, released a document to clarify laws and regulations using common scenarios, including three specific to the justice-involved population with behavioral health needs.[220]

RECOMMENDATION FIVE:

The California Health and Human Services Agency should reduce or eliminate barriers so that data and information technology are used to drive decision-making, identify service gaps, and guide investments in programs to reduce the number of people with mental health needs in the criminal justice system.

The California Health and Human Services Agency is engaged in several efforts related to promoting data integration and improving care coordination. In addition to housing the Office of Health Information Integrity, the agency oversees departments and offices that provide a wide range of services in the areas of health care, mental health, public health, alcohol and drug treatment, income assistance, social services and assistance to people with disabilities, and the state-level data that is collected on each. Additionally, the Department of Health Care Services is charged with administering the Whole Person Care Pilot, which has the overarching goal of service coordination, and data sharing and integration to support that coordination.[221] The department is also collaborating with the Council on Criminal Justice and Behavioral Health to study patterns of health care service utilization among former offenders released from state prison. To achieve the study's goals, the department's health care information will be linked with the California Department of Corrections and Rehabilitation's prison data.[222]

Data is a valuable tool for providing person-centered, culturally competent, and community-based care, especially through the integration of services provided by multiple local agencies and providers. Further, collecting data on race, ethnicity, sexual orientation, and gender identity will enable researchers and policy makers to better understand and address the nature and extent of disparities within the mental health and criminal justice systems. The agency could lead in advancing the statewide use of emerging technology to integrate data while ensuring protection of confidential health information. The agency should support efforts to ensure that screening and assessment and care coordination become standard operating procedure in California.

Key outcome measures previously mentioned in this report – reduction in the number of people with mental illness booked into jail, shorter jail stays for people with mental illnesses, increase in the percentage of people with mental illnesses in jail connected to the right services and supports once released, and lower rates of recidivism – also seek to track and improve progress on diversion efforts, but more must be done to understand missed prevention opportunities. Related to these key outcomes are two questions counties must ask to identify ways to improve prevention opportunities: (1) How many people in jail have a mental health need?, and (2) How many of those people were actively receiving mental health services at the time of booking?

Asking these questions can help community-based service providers and administrators identify gaps in efforts to reach and engage unserved and underserved consumers and enhance efforts to prevent incarceration. Answering these questions may require integrating community-based mental health data and jail data. The agency should support data integration efforts. The Commission could support the agency's efforts by demonstrating the value of integrated data through the linking and analyzing of mental health and criminal justice data.

MHSA Innovation Highlight – Using Technology to Improve Outcomes during Emergencies

Kern County |Special Needs Registry – Smart 911

Kern County is making use of technology to give consumers the ability to decide what information they would like first responders to know in case of a crisis. Rave Mobile Safety, Inc. founded Smart 911, a web program registry available on personal technology devices and in kiosks located at each Kern Behavioral Health Recovery Services treatment facility. The registry allows residents and Kern Behavioral Health clients to create a free, secure special needs profile providing dispatchers and first responders access to critical information. The effort creates improved interagency partnerships among fire, police, and other public safety entities during emergencies.

http://docs.wixstatic.com/ugd/2d0775_0a4c6a2c60804548a740e75367760114.pdf

FINDING SIX:

To build effective prevention and diversion systems, criminal justice and mental health professionals will need new knowledge, skills, and abilities to better serve mental health consumers and their communities.

Throughout the criminal justice system, public safety professionals are increasingly interacting with people with unmet mental health and substance use needs, often in roles they may not have been trained to fulfill. Law enforcement officers are often called to respond to behavior resulting from unaddressed or under-addressed mental health needs, and many lack training to manage such situations. In dangerous or high stress situations, the effects of implicit bias are particularly pronounced.[223] New approaches for training law enforcement to recognize and ameliorate the effects of implicit bias hold promise for improving policing in communities of color.[224] These strategies also may serve to improve law enforcement responses to people with mental health needs.

Behavioral health professionals also often feel ill-equipped to address risks and needs associated with a client's likelihood of committing crime, such as criminal thinking. Public safety realignment has increased the number and variety of situations requiring mental health professionals to work with individuals with significant criminal justice involvement. As people are being assessed for mental health needs, mental health professionals are often in a position to identify risk factors known to increase the likelihood a person will become involved with the criminal justice system. While mental health curricula teach students to evaluate clients and help strengthen their support systems, such curricula do not routinely provide guidance on identification of risk factors for justice involvement or best practices for intervention.

Public safety professionals need sufficient training to feel confident in decisions to divert people to available resources in the community. Law enforcement officers, judges, district attorneys, public defenders, and probation officers must have confidence in determining appropriate responses. Public safety and behavioral health partners and providers must be made aware of available programs and services, as well as county protocols for diverting people out of the justice system.

Some counties working to reduce the number of people with mental health needs in jails are struggling with how or where to start. Counties recognize the importance of having a local leader or champion for their efforts, but it is not always clear who that champion is or should be. In some counties, the district attorney fulfills the role. In others, the local champion is a judge. Whoever is designated, a local leader is essential to sustaining the commitment to diversion.

California has made strides in recent years in the delivery of more crisis intervention training to law enforcement, better equipping officers for mental health crisis encounters. For example, in 2015, the Santa Barbara County Sheriff's Office recognized the need for a specialized unit to address community needs involving law enforcement's response to calls for service involving mentally ill persons, including those in crisis. The Sheriff's Behavioral Sciences Unit (B.S.U.) was formed to oversee cases involving mental illness, to develop a Crisis Intervention Team, and to build community partnerships that adopted restorative justice principles and diverted people from the criminal justice system into appropriate services.

Since its establishment, the B.S.U. has collaborated with Santa Barbara County's mental health agency, local hospitals, the local chapter of the National Alliance on Mental Illness, other private non-profit support groups, and other local law enforcement agencies. The B.S.U. has assisted these agencies by developing and facilitating training on how to better handle these challenging calls for service. The result has been improved communication and collaboration with the community and other allied agencies.

The B.S.U. is staffed with a part-time coordinator, volunteer psychologists, and collaterally-assigned sheriff's personnel, including deputies, detectives, custody deputies and dispatchers. The B.S.U. developed 8-hour and 40-hour Commission on Peace Officer Standards and Training-approved Crisis Intervention Team courses, and to date has trained over 650 law enforcement officers, custody deputies and dispatchers, including all sworn sheriff's personnel. The unit has also trained members of all but one of county's police departments, and other staff from enforcement agencies within and outside Santa Barbara County.

Consistent with Santa Barbara's model, an increasing number of local law enforcement agencies are incorporating Crisis Intervention Team training, resulting in improved inter-agency relationships, de-escalation of critical incidents, and a greater understanding of how to effectively help people in crisis.

Despite this successful example, other training and technical assistance efforts that span the boundaries of criminal justice and mental health professionals are often delivered in siloes and, in some cases, are underfunded given the demand. Below are examples of assistance being delivered in California.

SUPPORT FOR CRIMINAL JUSTICE PARTNERS: The Judicial Council receives Mental Health Services Act funding to provide technical assistance for new or expanding mental health courts and to provide support for council advisory committees charged with implementing the Mental Health Issues Implementation Task Force recommendations.[225] The task force was created to advise the council on how recommendations to improve the responses of the criminal justice system for people with mental health needs should be implemented. Recommendations focus on improving criminal court cases outcomes and administration of justice, and improving access to treatment for those moving through the criminal justice system.

SUPPORT FOR LOCAL DIVERSION EFFORTS: Over the last year, the Council of State Governments, as part of the Stepping Up Initiative in California, has provided targeted technical assistance to California counties. In partnership with county associations, the council surveyed all California counties and asked what would have the greatest impact on improving county capacity for diversion.[226] The majority (49 counties) identified resources to collect and track data, followed by research-based interventions for people involved with the justice system who have behavioral health needs (46 counties), and information about strategies and solutions that work (43 counties).[227]

Technical assistance efforts since have included participation in local Stepping Up meetings, including in Calaveras, Imperial, Los Angeles, Orange, San Diego, Santa Barbara, Santa Clara, and Yolo counties, facilitation of peer-to-peer learning among California Stepping Up project coordinators, and ongoing assistance focused on screening and assessment and data collection in Calaveras, Imperial, and Orange counties. Technical assistance has been made possible by funding from public and private funding, such as from the American Psychiatric Association Foundation, Bureau of Justice Assistance, United States Department of Justice, and The California Endowment.

SUPPORT FOR LEADERS IN DIVERSION: Words to Deeds, a project of the Forensic Mental Health Association of California, has been leading efforts to bring together key decision-makers to develop strategies to reduce the incarceration of people with mental health needs. Through conferences utilizing a peer-to-peer model, leaders from state and local government, the courts, criminal justice, corrections, and mental health organizations come together to identify challenges and explore strategies that reduce the number of, and improve outcomes for, people with mental health needs in the criminal justice system.

RECOMMENDATION SIX:

The State, in partnership with the counties, should expand technical assistance resources to improve cross-professional training, increase the use of data and evaluation, and advance the dissemination of best practices, including community-driven and evidence-based practices.

The state and counties should improve training and technical assistance to ensure appropriate responses to mental health consumers are delivered and that continuous improvements are made over time. Training and technical assistance must include efforts to address disparities and cultural biases, including disseminating information on system inequities. The state should evaluate barriers to data sharing and promote way to share data while ensuring confidentiality of health information, including how counties are developing universal consent forms.[228] The state should review all available funding – including private sources – that could be directed to delivering strategic and cost-effective technical assistance to counties seeking to prevent the incarceration of mental health consumers and divert those in the criminal justice system into community-based services. Training and technical assistance efforts should focus on three primary areas: strategic cross-professional training, evaluation, and dissemination.

STRATEGIC CROSS-PROFESSIONAL TRAINING: Training and technical assistance must be made available to ensure professionals are cross-trained to meet diversion program objectives and goals. Law enforcement officers, judges, district attorneys, public defenders, and probation officers should receive training on mental illness specific to their respective roles. Mental health professionals should receive training on risk factors for offending so they can recognize these signs early in the course of providing care. Training should be targeted based on the role of each professional within the system, and the programs and services that are being provided.

DATA COLLECTION AND EVALUATION: Training and technical assistance must include a research and evaluation component. Support should be available to counties so that data collection and analysis become common practice, where it is not already. Programs and services must be evaluated regularly to track progress over time, to communicate what works and what does not work, and to ensure continuous quality improvement. Training on sound evaluation methods should be flexible to fit county and program size. Technical assistance should be available to address barriers to data collection, integration, and analysis as they arise. While the field of evidence-based practices continues to grow, there is a greater need for culturally congruent research, and expansion of community-defined practices that reduce mental health disparities *and* reduce or prevent criminal justice involvement, specifically for members of African

American, Latino, Native American, and transgender communities. Ongoing qualitative, participatory action research, or community-based participatory research will help to address gaps in current research.

DISSEMINATION: Training and technical assistance must include dissemination of best practices, including community-driven and evidence-based practices. Resources should be consolidated into one, easily accessible web-based location. Counties should have an online forum for sharing lessons learned and promising approaches. Counties should be able to share program outcomes for the benefit of administrators and providers, but, more importantly, for the public.

MHSA Innovation Highlight – Leveraging Cross-Professional Collaboration

Glenn County | System-Wide Mental Assessment Response Team (SMART)

The Glenn County System-Wide Mental Assessment Response Team (SMART) was among the first communities to foster police/mental health co-responder teams that assist in monitoring safety at school as well as the community during crisis situations, provide and link individuals to ongoing clinical services, co-occurring treatment, or probation services, offer suicide evaluation along with prevention through evidence-based practices, and educate school staff on victimization prevention.

http://www.countyofglenn.net/sites/default/files/Behavioral_Health/Glenn%20MHSA%20FY%2017-20%20Three%20Year%20Plan%2006-19-17%20FINAL%20AS%20POSTED.pdf

Summary of Findings and Recommendations

FINDING 1	Too many mental health consumers, particularly those from diverse communities, end up in jail because of unmet needs and system inequities. A robust, prevention-oriented system can reduce this unnecessary harm.
California's mental health agencies, in partnership with law enforcement and others, should have a comprehensive prevention-focused plan that reduces the incarceration of mental health consumers in their communities.	**RECOMMENDATION 1**
FINDING 2	California's jails are not equipped to serve mental health consumers. Diversion should be prioritized but counties need more effective in-custody options to ensure they can provide appropriate and necessary services for those who cannot be diverted.
The Board of State and Community Corrections should facilitate a collaborative effort with counties to identify, develop, and deploy services and strategies that improve outcomes for mental health consumers in jail, including universal screening for mental health needs at booking and enhanced training for custody staff.	**RECOMMENDATION 2**
FINDING 3	A large and growing number of people found incompetent to stand trial because of unmet mental health needs are forced to spend months in jail awaiting services necessary for their cases to proceed.
To reduce the backlog of people found incompetent to stand trial, California must maximize diversion from the criminal justice system. For people who cannot be diverted and are found incompetent to stand trial, the state and counties should expand options for restoring competency.	**RECOMMENDATION 3**
FINDING 4	California has not put in place a statewide, systemic approach for prevention and diversion to reduce criminal justice involvement for mental health consumers and improve outcomes
The Council on Criminal Justice and Behavioral Health should fortify its efforts to champion collaboration among state agencies to support local prevention and diversion of mental health consumers from the criminal justice system.	**RECOMMENDATION 4**
FINDING 5	Data is a critical tool in decision-making and service delivery, but state and local agencies are not effectively harnessing its power to improve outcomes for those in need.
The California Health and Human Services Agency should reduce or eliminate barriers so that data and information technology are used to drive decision-making, identify service gaps, and guide investments in programs to reduce the number of people with mental health needs in the criminal justice system.	**RECOMMENDATION 5**
FINDING 6	To build effective prevention and diversion systems, criminal justice and mental health professionals will need new knowledge, skills, and abilities to better serve mental health consumers and their communities.
The State, in partnership with the counties, should expand technical assistance resources to improve cross-professional training, increase the use of data and evaluation, and the dissemination of best practices, including community-driven and evidence-based practices.	**RECOMMENDATION 6**

Conclusion

Experts suggest more and more people with mental health needs are booked into jails across California each year. The influx is overwhelming our jails and the people who run them, because jails were not designed to house or serve those with mental illness. Despite the best efforts of administrators, jails are often crowded, chaotic, and understaffed – a dangerous mix – and it is not surprising that people with mental health needs often do not receive the services they need. Upon release, many find care in the community elusive as well. Thus, a large percentage collide with law enforcement again and cycle back into custody.

While this problem is daunting and complex, it is not intractable. Throughout this project, the Commission was heartened and inspired by the good work and promising initiatives already underway across California and the nation. Now we must build upon that foundation through a unified, integrated approach, with all community members taking responsibility for their share of the solution. As we move forward, we must examine all available funding sources, including those in the private sector, and be willing to share fiscal and human resources. We must help communities modernize their playbooks and translate research into effective practice. We must collaborate and share experience to perpetuate success. And we must harness data and technology to improve decision-making and track results.

Holistic change will certainly take time, and without a firm commitment to prevention and diversion – and swift action to support that commitment by the state and counties – success is not guaranteed. But California has the tools and knowledge needed to undertake meaningful reform now, along with local and national momentum to help see it through. Lasting change will not be realized by the valiant efforts of one person or a single agency, but by a unified dedication to produce real results. Alone we simply cannot ensure that fewer Californians with mental illness tumble tragically into the criminal justice system.

But together we can.

Endnotes

[1] The Council on Mentally Ill Offenders was changed to the Council on Criminal Justice and Behavioral Health (Chaptered by Secretary of State. Chapter 269, Statutes of 2017).
[2] California Corrections Standards Authority, Mentally Ill in Jails Workgroup. *Jails and the Mentally Ill: Issues and Analysis.* Available online: http://www.sfsuperiorcourt.org/sites/default/files/pdfs/2338%20Jails%20and%20the%20Mentally%20Ill.pdf.
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[163] For more information, please see: https://www.sccgov.org/sites/bhd/AboutUs/MHSA/Documents/2017/mhsa-fy17-ann-update-plan-new-inn-proj-07-14-17.pdf.
[164] For more information, please see: http://www.solanocounty.com/civicax/filebank/blobdload.aspx?blobid=25478.
[165] Statements made during a One Mind Initiative at Work event on September 14, 2017 in Saint Helena, CA.
[166] For more information, please see: https://www.cdph.ca.gov/Programs/OHE/Pages/CRDP.aspx.
[167] Welfare and Institutions Code Section 5847.
[168] Welfare and Institutions Code Sections 5845(d)(6), 5846(c), and 5847(a).
[169] Kim, K., Becker-Cohen, M., & Serakos, M. (2015). *The Processing and Treatment of Mentally Ill Persons in the Criminal Justice System: A Scan of Practice and Background Analysis*. Washington, D.C.: Urban Institute.
[170] Ibid.
[171] California Code of Regulations, Title 15, Section 1207.
[172] California Code of Regulations, Title 15, Section 1210.
[173] California Code of Regulations, Title 15, Section 1200.
[174] California Code of Regulations, Title 15, Section 1209.
[175] California Code of Regulations, Title 15, Section 1217.
[176] Ibid.
[177] California Code of Regulations, Title 15, Section 1214.
[178] Ibid.
[179] California Code of Regulations, Title 15, Section 1030.
[180] California Corrections Standards Authority, Mentally Ill in Jails Workgroup. *Jails and the Mentally Ill: Issues and Analysis.* Available online: http://www.sfsuperiorcourt.org/sites/default/files/pdfs/2338%20Jails%20and%20the%20Mentally%20Ill.pdf.
[181] For more information, please see: http://www.cdcr.ca.gov/COMIO/Uploadfile/pdfs/2016/Aug17/BSSC%20Training%20and%20Mental%20Health%20.pdf.
[182] Ibid.
[183] Ibid.
[184] Ibid.
[185] For more information, please see: file:///C:/Users/oacashleymills/Downloads/Timetable%20for%20the%20Provision%20of%20Crisis%20Intervention%20Training%20to%20all%20Custody%20Staff.pdf.
[186] Correspondence from Disability Rights California to the Commission dated July 25, 2017.
[187] For more information, please see: http://www.bscc.ca.gov/downloads/SB%20863%20PR%2011.12.15.pdf.
[188] Ibid.
[189] Ibid.
[190] Minnesota Public Radio. http://blogs.mprnews.org/newscut/2016/09/hennepin-survey-shows-link-between-jail-inmates-and-mental-illness/.
[191] California Forward is a bipartisan governance improvement organization that advances innovative ideas and sound analysis to develop, enact and implement pragmatic solutions that are needed to grow jobs, promote cost-effective public services and create accountability for results.
[192] Penal Code Sections 6024-6025.

[193] Osher, F., D'Amora, D., Poltkin, M., Jarrett, N., Eggleston, A. (2012). *Adults with behavioral health needs under correctional supervision: A shared framework for reducing recidivism and promoting recovery*. Council of State Governments Justice Center. Criminal Justice/Mental Health Consensus Project.
[194] Ibid.
[195] Bonta, J., Law, M., & Hanson, C. (1998). The prediction of criminal and violent recidivism among mentally disordered offenders: A meta-analysis. *Psychological Bulletin, 123*, 123-142.
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[197] Miller, N. A., & Najavits, L. M. (2012). Creating trauma-informed correctional care: a balance of goals and environment. *European Journal of Psychotraumatology, 3*, 10.3402/ejpt.v3i0.17246. http://doi.org/10.3402/ejpt.v3i0.17246.
[198] Pursuant to California Penal Code Section 1970.
[199] Legislative Analyst's Office. (2013). *An Alternative Approach: Treating the Incompetent to Stand Trial*. Available online: http://www.lao.ca.gov/reports/2012/hlth/ist/incompetent-stand-trial-010312.aspx.
[200] Warburton, K. "National IST Trends." June 2017. Microsoft PowerPoint file.
[201] Ibid.
[202] Ibid.
[203] Ibid.
[204] Ibid.
[205] Statements made during an interview conducted for this report.
[206] Sixteen states operate formal outpatient competency restoration programs: Arkansas, Colorado, Connecticut, Florida, Georgia, Hawaii, Louisiana, Michigan, Nevada, Ohio, Rhode Island, Tennessee, Texas, Virginia, Washington, D.C., and Wisconsin.
[207] Disability Rights California. *Placement of Individuals Found Incompetent to Stand Trial: A review of competency programs and recommendations*. Available online: http://www.disabilityrightsca.org/pubs/CM5201.pdf.
[208] Warburton, K. "National IST Trends." June 2017. Microsoft PowerPoint file.
[209] Chaptered by Secretary of State. Chapter 269, Statutes of 2017.
[210] Penal Code Section 6044, which originally set forth a sunset date of December 31, 2006. In 2006, SB 1422 (Chapter 901, Statutes of 2006) eliminated the sunset date.
[211] For more information, please see: http://www.bscc.ca.gov/.
[212] For more information, please see: http://www.cdcr.ca.gov/.
[213] For more information, please see: http://www.mhsoac.ca.gov/.
[214] For more information, please see: http://www.dhcs.ca.gov/services/Pages/default.aspx.
[215] For more information, please see: http://www.dsh.ca.gov/.
[216] The White House, Office of the Press Secretary. (2016). Launching the Data-Driven Justice Initiative: Disrupting the Cycle of Incarceration. Available online: https://obamawhitehouse.archives.gov/the-press-office/2016/06/30/fact-sheet-launching-data-driven-justice-initiative-disrupting-cycle.
[217] Fermanian Business and Economic Institute at Point Loma Nazarene University. (2015). Project 25: Housing the Most Frequent Users of Public Services among the Homeless. Available online: https://uwsd.org/files/galleries/Project_25_Report.pdf.
[218] The White House, Office of the Press Secretary. (2016). Launching the Data-Driven Justice Initiative: Disrupting the Cycle of Incarceration. Available online: https://obamawhitehouse.archives.gov/the-press-office/2016/06/30/fact-sheet-launching-data-driven-justice-initiative-disrupting-cycle.
[219] Statements made during an interview conducted for this report.
[220] The document can be accessed here: http://www.chhs.ca.gov/OHII/Pages/shig.aspx.
[221] For more information, please see: http://www.dhcs.ca.gov/services/Pages/WholePersonCarePilots.aspx
[222] For more information, please see: http://www.cdcr.ca.gov/COMIO/docs/02022017meeting/Project_Update_020217.pdf
[223] Bertrand, M., Chugh, D., & Mullainathan, S. (2005). Implicit Discrimination. *The American Economic Review, 95(2),* 94–98.
[224] For more information, please see: https://trustandjustice.org/.
[225] California Department of Health Care Services (2017). *Mental Health Services Act Expenditure Report – Governor's Budget Fiscal Year 2017-18.* Available online: http://www.dhcs.ca.gov/formsandpubs/Documents/Legislative%20Reports/Mental%20Health/MHSAExpenditureReport_Jan2017.pdf.
[226] Partnering county associations include the California State Sheriffs' Association, County Behavioral Health Directors Association of California, and Chief Probation Officers of California.
[227] Thompson, M. and Fader-Towe, H. (2016). *Best Practices: Mentally Ill Offender Crime Reduction Grants Adult Programs 2015.* Council of State Governments, Justice Center. Microsoft PowerPoint file available online: http://www.fmhac.net/Assets/Documents/W2D/W2DX/W2D10.Day1-MikeThomsponSlides.pdf.
[228] For more information, please see: http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/PDF%20F/PDF%20FinePrintExchangingBehavioral.pdf.

AGENDA ITEM 08

Information

October 26, 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: (1) Motions summary from the September 28, 2017 Commission Meeting; (2) Evaluation Dashboard Summary; (3) Evaluation Dashboard; (4) Calendar of Commission activities; and (5) Innovation Review Outline.

Handout: None

Recommended Action: Information item only

Mental Health Services
Oversight & Accountability Commission

WELLNESS • RECOVERY • RESILIENCE

Motions Summary

Commission Meeting
September 28, 2017

Motion #: 1

Date: September 28, 2017

Time: 9:20 AM

Text of Motion:

The Commission approves the August 24, 2017, Meeting Minutes.

Commissioner making motion: Commissioner Ashbeck
Commissioner seconding motion: Commissioner Aslami-Tamplen

Motion carried 7 yes, 0 no, and 5 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 Bunch	☐	☐	☒
9. Commissioner Danovitch	☐	☐	☒
10. Commissioner Gordon	☐	☐	☒
11. Commissioner Madrigal-Weiss	☐	☐	☐
12. Commissioner Lynch	☒	☐	☐
13. Commissioner Mitchell	☒	☐	☐
14. Commissioner Poaster	☒	☐	☐
15. Commissioner Ridley-Thomas	☐	☐	☐
16. Commissioner Strachan-Wilson	☐	☐	☒

Motion #: 2

Date: September 28, 2017

Time: 11:05 AM

Text of Motion:

The MHSOAC elects Commissioner Boyd as Chair for 2017.

Commissioner making nomination: Commissioner Danovitch
Commissioner seconding nomination: Commissioner Aslami-Tamplen

Motion carried 11 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 Bunch	☒	☐	☐
9. Commissioner Danovitch	☒	☐	☐
10. Commissioner Gordon	☒	☐	☐
11. Commissioner Madrigal-Weiss	☐	☐	☐
12. Commissioner Lynch	☒	☐	☐
13. Commissioner Mitchell	☐	☐	☐
14. Commissioner Poaster	☒	☐	☐
15. Commissioner Ridley-Thomas	☐	☐	☐
16. Commissioner Strachan-Wilson	☒	☐	☐

Motion #: 3

Date: September 28, 2017

Time: 11:10 AM

Text of Motion:

The MHSOAC elects Commissioner Aslami-Tamplen as Vice Chair for 2017.

Commissioner making nomination: Commissioner Poaster
Commissioner seconding motion: Commissioner Vice Chair Boyd

Motion carried 11 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 Bunch	☒	☐	☐
9. Commissioner Danovitch	☒	☐	☐
10. Commissioner Gordon	☒	☐	☐
11. Commissioner Madrigal-Weiss	☐	☐	☐
12. Commissioner Lynch	☒	☐	☐
13. Commissioner Mitchell	☐	☐	☐
14. Commissioner Poaster	☒	☐	☐
15. Commissioner Ridley-Thomas	☐	☐	☐
16. Commissioner Strachan-Wilson	☒	☐	☐

Motion #: 4

Date: September 28, 2017

Time: 11:44 AM

Text of Motion:

The MHSOAC approves Mono County's Innovation Plan as follow:

Name: Eastern Sierra Strengths Bases Learning Collaborative
Amount: $259,046
Project Length: Two (2) Years

Commissioner making motion: Commissioner Ashbeck
Commissioner seconding motion: Commissioner Brown

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

Name	Yes	No	Abstain
1. Chair Wooton	☒	☐	☐
2. Vice-Chair Boyd	☒	☐	☐
3. Commissioner Anthony	☐	☐	☐
4. Commissioner Ashbeck	☒	☐	☐
5. Commissioner Aslami-Tamplen	☒	☐	☐
6. Commissioner Beall	☐	☐	☐
7. Commissioner Brown	☒	☐	☐
8. Commissioner Bunch	☒	☐	☐
9. Commissioner Danovitch	☒	☐	☐
10. Commissioner Gordon	☐	☐	☐
11. Commissioner Madrigal-Weiss	☐	☐	☐
12. Commissioner Lynch	☒	☐	☐
13. Commissioner Mitchell	☐	☐	☐
14. Commissioner Poaster	☒	☐	☐
15. Commissioner Ridley-Thomas	☐	☐	☐
16. Commissioner Strachan-Wilson	☒	☐	☐

Motion #: 5

Date: September 28, 2017

Time: 12:01 PM

Text of Motion:

The Commission authorizes the Executive Director to enter into a contract to develop a strategic statewide suicide prevention plan, per Section 18 of Assembly Bill 114 (Chapter 38, Statutes of 2017).

Commissioner making motion: Commissioner Ashbeck
Commissioner seconding motion: Commissioner Aslami-Tamplen

Motion carried 9 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 Bunch	☒	☐	☐
9. Commissioner Danovitch	☒	☐	☐
10. Commissioner Gordon	☐	☐	☐
11. Commissioner Madrigal-Weiss	☐	☐	☐
12. Commissioner Lynch	☒	☐	☐
13. Commissioner Mitchell	☐	☐	☐
14. Commissioner Poaster	☒	☐	☐
15. Commissioner Ridley-Thomas	☐	☐	☐
16. Commissioner Strachan-Wilson	☒	☐	☐

Motion #: 6

Date: September 28, 2017

Time: 3:48 PM

Text of Motion:

The MHSOAC approves Napa County's four (4) Innovation projects as follows:

Name: Napa Adverse Childhood Experiences (ACEs)
Amount: $438,869
Project Length: 18 months

Name: Native American Historical Trauma and Traditional Healing Innovation Project
Amount: $479,518
Project Length: 18 months

Name: Understanding the Mental Health Needs of the American Canyon Filipino Community
Amount: $461,016
Project Length: 18 months

Name: Work for Wellness
Amount: $309,250
Project Length: 18 months

Commissioner making motion: Commissioner Aslami-Tamplen
Commissioner seconding motion: Chair Wooton

Motion carried 8 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 Bunch	☐	☐	☐
9. Commissioner Danovitch	☐	☐	☐
10. Commissioner Gordon	☒	☐	☐
11. Commissioner Madrigal-Weiss	☐	☐	☐
12. Commissioner Lynch	☒	☐	☐
13. Commissioner Mitchell	☐	☐	☐
14. Commissioner Poaster	☐	☐	☐
15. Commissioner Ridley-Thomas	☒	☐	☐
16. Commissioner Strachan-Wilson	☒	☐	☐

AGENDA ITEM

Information

October 26, 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

- **Assessment of System of Care for Older Adults** *The Regents of the Univ. of California, University of California, Los Angeles*
  Update: Total contract amount changed. Deliverable 5.2 added. Deliverable 4 and 5.1 due date changed.

- **Classify FSPs & Provide Evaluation Support** *Mental Health Data Alliance*
  Update: Total spent changed. Deliverable 9 status changed to complete.

Enclosures: MHSOAC Evaluation Dashboard
Recommended Action: None
Presenter: None
Motion: None

MHSOAC Evaluation Dashboard October 2017

(updated 10/18/17)

Current MHSOAC Evaluation Contracts & Deliverables

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: Brian Sala

Active Dates: 06/01/15 – 06/30/18

Total Budget: $469,000

Total Billed To Date: $368,292

Objective: Assess progress made in implementing an effective system care for older adults with serious mental illness & identify methods to further statewide progress. This assessment shall involve gauging the extent to which counties have developed & implemented services tailored to meet the older adult population's needs, including un/underserved diverse older individuals, recognizing the unique challenges & needs faced. 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 specifically on mental health issues for older adults; these indicators shall be developed with the intention of incorporating them into future data strengthening & performance monitoring efforts. The Contractor shall also document the challenges & barriers to meeting the unique needs of this population, & strategies to overcome these challenges. Lessons learned, resultant policy & practice recommendations for improving & support older adult mental health programs at the State & local levels shall be developed & presented to the Commission.

Deliverables & Due Dates

Contract Duration		September 2015 – June 2018					
1	Proposed Research Methods	09/07/15					
2	Data Elements, Indicators, Policy Recommendations		06/30/16				
3	Summary/Analysis of Secondary/Key Informant Interview Data			02/28/17			
4	Focus Group Data Summary & Policy Recommendations including identification of findings specific to Spanish-language focus groups and English/Spanish comparisons				12/30/17		
5.1	Policy Brief & Fact Sheet(s)					12/30/17	

Legend: Deliverable Not Started | Deliverable In Progress | Deliverable Under Review | Deliverable Complete

*Material highlighted in red indicates updates to the information * Indicates that a deliverable has undergone a status change

MHSOAC Evaluation Dashboard October 2017

(updated 10/18/17)

Mental Health Services
Oversight & Accountability Commission

5.2	**Policy Brief #2 and Fact Sheets #2 (English) and #3 (Spanish)**						**12/30/17**

Legend: Deliverable Not Started Deliverable In Progress Deliverable Under Review Deliverable Complete

*Material highlighted in red indicates updates to the information * Indicates that a deliverable has undergone a status change

MHSOAC Evaluation Dashboard October 2017

(updated 10/18/17)

Mental Health Services
Oversight & Accountability Commission

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

Community Services & Supports (CSS) Tracking, Monitoring, & Evaluation System Toolkit (16MHSOAC016)

MHSOAC Staff: Brian Sala

Active Dates: 08/15/16 – 08/14/17

Total Contract Amount: $99,000

Total Spent: $99,000

Objective: Assist county behavioral health departments in assessing the feasibility of adopting & implementing a Community Services & Supports (CSS) Tracking, Monitoring, & Evaluation System designed to enable providers, counties, & the State to understand the clinical & functional status of clients within individual CSS programs/services, & 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, & compare CSS program outcomes.

Deliverables & Due Dates

Contract Duration		October 2016 – July 2017			
1	**Work Plan**	**10/02/16**			
2	**Draft County Toolkit**		**02/15/17**		
3	**Regional Meetings Report**			**05/15/17**	
4	**Final County Toolkit Implementation/Report on Recommendations**				**07/31/17**

Legend: Deliverable Not Started | Deliverable In Progress | Deliverable Under Review | Deliverable Complete

*Material highlighted in red indicates updates to the information * Indicates that a deliverable has undergone a status change

MHSOAC Evaluation Dashboard October 2017

(updated 10/18/17)

Mental Health Services
Oversight & Accountability Commission

Mental Health Data Alliance

Enhanced Partner-Level Data (ELPD) Templates (16MHSOAC018)

MHSOAC Staff: Pu Peng

Active Dates: 09/01/16 - 06/30/17

Total Contract Amount: $58,000

Total Spent: $58,000

Objective: Provide individual counties with the ability to import, link, view, and generate reports for Full-Service Partnership Data Collection and Reporting System data. The EPLD template, originally designed with MS Access, had data limitations of 2GB, which made processing of statewide FSP DCR data challenging and inefficient. MHSOAC seeks to have the existing EPLD template data migrated from MS Access to MS implementation of Structural Query Language server. This would allow for automation of the data reporting processes such that statewide and county-level reports could be created by the MHSOAC.

Deliverables & Due Dates

Contract Duration		December 2016 – May 2017		
1	**Migration of EPLD data from MS Access to MS SQL**	**12/30/16**		
2	**Migration of EPLD Queries, Scripts & Reports from MS Access to MS SQL**		**05/26/17**	
3	**Automating reports to produce Statewide reports for ten (10) selected, existing EPLD reports- EPLD Report Automation**			**05/26/17**

Legend: Deliverable Not Started | Deliverable In Progress | Deliverable Under Review | Deliverable Complete

*Material highlighted in red indicates updates to the information * Indicates that a deliverable has undergone a status change

MHSOAC Evaluation Dashboard October 2017

(updated 10/18/17)

Mental Health Services
Oversight & Accountability Commission

Mental Health Data Alliance

DOJ Criminal Data Linkage & Analysis (16MHSOAC027)

MHSOAC Staff: Pu Peng & Ashley Mills

Active Dates: 01/01/17 - 12/31/17

Total Contract Amount: $98,450

Total Spent: $0

Objective: The purpose of the project is to (1) identify the level of criminal justice involvement among those served in public mental health programs; (2) evaluate the quality of self-report of arrests for individuals who participate in the Full Service Partnership programs; and (3) evaluate longitudinal changes in criminal justice involvement for populations served by public mental health programs.

Deliverables & Due Dates

Contracts		October 2017 – March 2018				
1	Statewide Criminal Justice Data Linkage Report	10/31/17				
2.1	County Participation Confirmation Report		11/30/17			
2.2	Select County-Specific Criminal Justice Data Linkage Report			03/01/18		
3.1	Quarterly Progress Report 1Q2017				01/15/18	
3.1	Quarterly Progress Report 2Q2017					03/15/18

Legend: Deliverable Not Started | Deliverable In Progress | Deliverable Under Review | Deliverable Complete

*Material highlighted in red indicates updates to the information * Indicates that a deliverable has undergone a status change

MHSOAC Evaluation Dashboard October 2017

(updated 10/18/17)

Mental Health Services
Oversight & Accountability Commission

Mental Health Data Alliance

CSI & DCR Data Analysis & Standardize Reporting (16MHSOAC036)

MHSOAC Staff: Pu Peng

Active Dates: 02/15/17 - 02/14/18

Total Contract Amount: $149,980

Total Spent: $123,156

Objective: The purpose of this project is to (1) develop an SQL server database backup and recovery strategy for Full Service Partnership (FSP) data collection and reporting and Client and Service Information (CSI) data and (2) provide training and guidance to support MHSOAC staff in analyzing FSP and CSI data for standardized reporting and evaluation.

Deliverables & Due Dates							
Contracts		March 2017 – February 2018					
1.1	**SQL Server Environment Specification Report**	**03/31/17**					
1.2	**SQL Server Environment Specification Recovery Model Implementation Report**		**05/31/17**				
1.3	**Training and Documentation**			**06/30/17**			
2.1	**Initial, Updated, & Final Knowledge Transfer Report**				**04/07/17**		
2.2-2.10	**9 monthly updates to the Initial Knowledge Transfer Report (4) Complete**					**01/15/18**	
2.11	**Final Knowledge Transfer Report**						**02/14/18**

Legend: Deliverable Not Started | Deliverable In Progress | Deliverable Under Review | Deliverable Complete

*Material highlighted in red indicates updates to the information * Indicates that a deliverable has undergone a status change

MHSOAC Evaluation Dashboard October 2017

(updated 10/18/17)

Mental Health Services
Oversight & Accountability Commission

Mental Health Data Alliance

Classify FSPs & Provide Evaluation Support (14MHSOAC008)

MHSOAC Staff: Marijoyce Naguit

Active Dates: 11/01/14 - 06/30/17

Total Contract Amount: $548,938

Total Spent: $548,938

Objective: The purpose of this evaluation effort is to assess Full Service Partnerships (FSPs) on a statewide level in order to classify them in a meaningful and useful fashion that should ultimately enable clients, family members, providers, counties, other stakeholders, and the State to further understand the diversity of FSPs across California and com pare those that are comparable.

Deliverables & Due Dates

Contracts		February 2015 – April 2017								
1	**Preliminary Statewide FSP Classification System Presentation From Focus Groups &/or Interviews**	**02/27/15**								
2	**Report of Proposed Statewide FSP Classification System Based on Stakeholder Input**		**08/31/15**							
3	**Report on Final Statewide FSP Classification System Based on Public Comment**			**10/30/15**						
4	**Report on Online Statewide FSP Classification System Website 1.0 Design Specification**				**02/29/16**					
5	**OAC Web Application Configuration Support & Documentation- 10 Progress Reports**					**09/30/16 - 06/30/17**				

Legend: Deliverable Not Started | Deliverable In Progress | Deliverable Under Review | Deliverable Complete

*Material highlighted in red indicates updates to the information * Indicates that a deliverable has undergone a status change

MHSOAC Evaluation Dashboard October 2017

(updated 10/18/17)

Mental Health Services
Oversight & Accountability Commission

6	**Fiscal Transparency Component Acceptance Support**						**10/31/16**			
7	**NAMI Data Augmentation – Program Addresses**							**03/24/17**		
8	**NAMI Data Augmentation – Program Providers**								**03/31/17**	
9	**NAMI Data Augmentation – Three-Year Plan & Annual Update Data Element Extraction**									**04/30/17**

Legend: Deliverable Not Started | Deliverable In Progress | Deliverable Under Review | Deliverable Complete

*Material highlighted in red indicates updates to the information * Indicates that a deliverable has undergone a status change

MHSOAC Evaluation Dashboard October 2017

(updated 10/18/17)

Mental Health Services
Oversight & Accountability Commission

The iFish Group

Cloud Platform for SAS & Performance Monitoring (14MHSOAC012)

MHSOAC Staff: Pu Peng

Active Dates: 05/07/15 - 12/31/17

Total Contract Amount: $777,239

Total Spent: $607,094

Objective: The contract was executed for the iFish Group, Inc. as the Contractor to provide a Cloud Platform as a Service (PaaS) to the MHSOAC. The PaaS should include support for SAS Office Analytics, Microsoft SQL Server, as well as other software as deemed necessary by the MHSOAC for data reporting activities.

Deliverables & Due Dates		
Contracts		December 2017
1	**PaaS Virtual Private Cloud Environment With Supported Software Programs**	**12/31/17**

Legend: Deliverable Not Started | Deliverable In Progress | Deliverable Under Review | Deliverable Complete

*Material highlighted in red indicates updates to the information * Indicates that a deliverable has undergone a status change

MHSOAC Evaluation Dashboard October 2017

(updated 10/18/17)

Mental Health Services
Oversight & Accountability Commission

The iFish Group

Visualization Configuration & Publication Support Services (16MHSOAC021)

MHSOAC Staff: Marijoyce Naguit

Active Dates: 10/31/16 - 12/31/17

Total Contract Amount: $1,000,000

Total Spent: $250,000

Objective: To make data from reports on programs funded under the Mental Health Services Act, available to the public via a Visualization Portal. The portal will provide transparency through the publication of information and statistics to various stakeholders. Resources will be provided to allow MHSOAC staff to evaluate, merge, clean, and link all relevant datasets; develop processes and standards for data management; identify and configure analytics and visualizations for publication on the MHSOAC public website; and manage the publication of data to the open data platform.

Deliverables & Due Dates					
Contracts		October 2016 – July 2018			
1	**Fiscal Transparency Tool 1.0- (Design specs, Configuration & Related Datasets, Test Results, Visualization & Dataset Deployed)**	**10/31/16**			
2	**Full Service Partnerships Tool 1.0- (Design specs, Configuration & Related Datasets, Test Results, Visualization & Dataset Deployed)**		**1/27/18**		
3	**Providers, Programs, and Services Tool 1.0- (Design specs, Configuration & Related Datasets, Test Results, Visualization & Dataset Deployed)**			**04/28/18**	
4	**Fiscal Transparency Tool 2.0- (Design specs, Configuration & Related Datasets, Test Results, Visualization & Dataset Deployed)**				**07/28/18**

Legend: Deliverable Not Started | Deliverable In Progress | Deliverable Under Review | Deliverable Complete

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MHSOAC Evaluation Dashboard October 2017

(updated 10/18/17)

Mental Health Services
Oversight & Accountability Commission

The iFish Group

Web-based Tools & Advice (16MHSOAC022)

MHSOAC Staff: Marijoyce Naguit

Active Dates: 12/20/16 - 12/20/17

Total Contract Amount: $325,000

Total Spent: $225,000

Objective: To provide Virtual Private Cloud Visualization Portal (VP) Platform as a Service(PaaS) which includes the design, development, integration, test, and operations services to support and maintain visualization applications developed for MHSOAC. Services to extract, transform, and validate data from external data sources will also be provided prior to making it available to MHSOAC visualization applications.

Deliverables & Due Dates		
Contracts		**December 2017**
1	**Support of Maintenance & Operations of PaaS**	**12/20/17**

Legend: Deliverable Not Started | Deliverable In Progress | Deliverable Under Review | Deliverable Complete

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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, November 16, 2017 Sacramento	**Commission Meeting** TBD
Thursday, December 28, 2017 No Meeting	**Commission Meeting** TBD
rev 10/19/2017	

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