Commission Packet

Commission Meeting
November 16, 2017

Monterey Peninsula Unified School District
District Services Center Board Room
540 Canyon Del Rey Blvd
Del Rey Oaks, CA 93940

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

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

1325 J Street, Suite 1700
Sacramento, California 95814

Commission Meeting Agenda

November 16, 2017
9:00 A.M. – 4:45 P.M.

Monterey Peninsula Unified School District
District Services Center
540 Canyon Del Rey Blvd.
Del Rey Oaks, CA 93940

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.

Approximate Times

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

9:05 AM **Welcome**

9:10 AM **Announcements**

9:20 AM **Action**
1: Approve October 26, 2017 MHSOAC Meeting Minutes

The Commission will consider approval of the minutes from the October 26, 2017 MHSOAC meeting.

- Public Comment
- Vote

9:30 AM **Action**
2: 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

10:30 AM **Action**
3: Santa Clara County Innovation Plans
Presenters: Toni Tullys, MPA, Director, Behavioral Health Services; Steve Adelsheim, MD, Director, Stanford Center for Youth Mental Health and Wellbeing; Jeanne Moral, Senior Health Care Program Manager, System Initiatives; Evelyn Tirumalai, MPH, Senior Mental Health Program Specialist, MHSA Coordinator; Lily Vu, MSW, Mental Health Program Specialist II, MHSA Innovations Coordinator

The Commission will consider approval of four Innovation Projects for Santa Clara County.

- Public comment
- Vote

11:45 AM **Action**

4: San Bernardino/Riverside Innovation Plan

Presenters: Angela Igrisan, Assistant Director, Programs; David Schoelen, Mental Health Services Administrator; Roderick Verbeck, Mental Health Services Administrator, Crisis; Suzanna Juarez-Williamson, Supervising Research Specialist, Evaluations.

The Commission will consider approval of a joint Innovation Project for San Bernardino and Riverside counties.

- Public Comment
- Vote

12:30 PM **General Public Comment**

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

12:45 PM **Lunch Break**

1:45 PM **Action**

5: Award of Transition Age Youth (TAY) Stakeholder Contracts

Presenters: Tom Orrock, Chief of Commission Operations and Grants; Angela Brand, Stakeholder Lead

The Commission will consider awarding a TAY stakeholder contract in response to the Request for Proposals released by the Commission in Octobert 2017.

- Public Comment
- Vote

2:00 PM **Action**

6: Schools and Mental Health Project Proposal

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

The Commission will consider a proposal to create a funding mechanism for integrated services to address children's mental health needs in schools.

- Public Comment
- Vote

2:45 PM **Action**

7: 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

3:30 PM **Information**

8: Innovation Sub-Committee Update

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

3:45 PM **Action**

9: Contract Authorziation

Presenter: Norma Pate, Deputy Director

The Commission will consider authorizing the Executive Director to enter into an Information Technology contract to further support the hosting and maintaining of the integrated web application and database of MHSA providers, programs, and services.

- Public comment
- Vote

4:15 PM **Information**

10: 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 October 26, 2017 Commission Meeting; (2) Evaluation Dashboard; (3) Calendar of Commission activities; and (4) Innovation Review Outline.

4:30 PM **General Public Comment**

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

4:45 PM **Adjourn**

AGENDA ITEM 1

Action

November 16, 2017 Commission Meeting

Approve October 26, 2017 MHSOAC Meeting Minutes

Summary: The Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission) will review the minutes from the October 26, 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: October 26, 2017 Commission Meeting Minutes.

Handouts: None.

Recommended Action: Approve October 26, 2017 Meeting Minutes.

Proposed Motion: The Commission approves the October 26, 2017 Meeting Minutes.

State of California

MENTAL HEALTH SERVICES
OVERSIGHT AND ACCOUNTABILITY COMMISSION

Minutes of Meeting
October 26, 2017

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

866-817-6550; Code 3190377

Members Participating:

Tina Wooton, Chair
John Boyd, Psy.D., Vice Chair
Khatera Aslami-Tamplen
Sheriff Bill Brown
Keyondria Bunch, Ph.D.
Itai Danovitch, M.D.
Mara Madrigal-Weiss
Gladys Mitchell
Assemblymember Sebastian Ridley-Thomas
Deanna Strachan-Wilson

Members Absent:

Reneeta Anthony
Lynne Ayers Ashbeck
Senator Jim Beall
Dave Gordon
Kathleen Lynch
Larry Poaster, Ph.D.

Staff Present:

Toby Ewing, Ph.D., Executive Director
Filomena Yeroshek, Chief Counsel
Norma Pate, Deputy Director
Sharmil Shah, Psy.D., Chief of Program Operations
Tom Orrock, Chief of Commission Operations and Grants

CONVENE

Chair Tina Wooton called the meeting of the Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission) to order at 9:39 a.m. and welcomed everyone. Filomena Yeroshek, Chief Counsel, called the roll and confirmed the presence of a quorum.

Announcements

Chair Wooton reviewed the meeting protocols. She stated the Commission will be touring programs in areas around Los Angeles tomorrow. Staff will report on the site visits at the next meeting.

The next Community Forum is scheduled for October 28th at Los Angeles City College at 9:30 a.m. The next MHSOAC meeting is scheduled for November 16th at a location yet to be determined.

ACTION

1: Approve September 28, 2017, MHSOAC Meeting Minutes

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

The Commission approves the September 28, 2017, Meeting Minutes.

Motion carried 8 yes, 0 no, and 1 abstain, per roll call vote as follows:

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

The following Commissioner abstained: Commissioner Madrigal-Weiss.

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

Commissioner Bunch recused herself from the Los Angeles section of the discussion and decision-making with regard to this agenda item pursuant to Commission policy.

Chair Wooton stated this agenda item is only for the Los Angeles and Kern County proposal. The Mono and Fresno County innovation plans are not on the agenda at this time.

Jonathan E. Sherin, M.D., Director, Los Angeles County Department of Mental Health, introduced three proposed projects to increase access to mental health services and supports utilizing a suite of technology-based mental health solutions through passive real-time data collection, real-time human support, and real-time virtual treatment. These projects can help demonstrate through the cross-county collaborative how to simplify processes.

Debbie Innes-Gomberg, Ph.D., Deputy Director, Los Angeles County Department of Mental Health, provided an overview, accompanied by a slide presentation, of the goals and objectives, target populations in Los Angeles County, and key features of the proposed suite of technology-based projects.

Bill Walker, LMFT, Director, Kern County Behavioral Health and Recovery Services, stated the need for all counties, regardless of size, to leverage technology in ways they could not on their own. He thanked Los Angeles County for taking the lead in looking at something that would be difficult for small counties to do, if not impossible. He stated the ability to standardize care across systems and provide a quality of care that can be monitored to a certain level is difficult in counties with diverse geography. He shared how Kern County is already engaging in a robust stakeholder process and preparing for upgraded technological systems.

Bradley Cloud, Psy.D., Deputy Director of Special Clinical Services, Kern County Behavioral Health and Recovery Services, continued the slide presentation and discussed the demographics, proposed technology suite, stakeholder process and feedback, and target populations in Kern County.

Dawan Utecht, Director, Fresno County Behavioral Health, stated one of Fresno County's greatest challenges is care coordination. She continued the slide presentation and discussed the demographics, proposed technology suite, stakeholder interest, and target populations in Fresno County. She stated this approach will allow counties to have true evaluation of the effectiveness of interventions.

Robin Roberts, Director, Mono County Behavioral Health, continued the slide presentation and discussed the demographics, proposed technology suite, stakeholder interest, and target populations in Mono County.

Dr. Innes-Gomberg finished the slide presentation by discussing how the proposed project is innovative. She also discussed the approaches to implementation sustainability, and disseminating learning. Dr. Innes-Gomberg then discussed the evaluation measurements and the project duration and budget.

Commissioner Questions

Chair Wooton asked Vice Chair Boyd, head of the Subcommittee on Innovations, to comment on today's presentation.

Vice Chair Boyd thanked the mental health directors of adjoining counties for attending and adding to the rich discussion. He provided a brief background for new Commissioners on innovation and the Commission and stated this proposal has been the best he has seen in demonstrating the value that can be offered through partnership and collaboration. It is the largest proposal brought before the Commission thus far that brings a virtual secondary system of care, fully maximizing the value of innovation and technology in real-time.

Commissioner Danovitch asked how the counties are thinking about the challenges of selecting, developing, implementing, evaluating, and scaling this suite of interventions. Dr. Sherin stated the county has entities such as this Commission and the California Mental Health Services Authority (CalMHSA) to allow the counties to move in the directions they want to move. He stated there is a wealth of information that can be

gleaned by looking at passive and active data. Using the proposed technology keeps people out of hospitals. The county's major role is funding the project, contracting with companies that will be penetrating the access points, coordinating, and collecting and analyzing the data. He stated the need as a group to identify companies that are the best of the private sector to do the work and connect them into the system. The proposed three-year project will develop the infrastructure, collaboration, and communications to each component independently, and then, hopefully, the suite, which may grow over time.

Dr. Innes-Gomberg agreed that this is the perfect opportunity for counties to learn how to work together.

Commissioner Danovitch suggested looking for milestones to show the project is on track in its implementation. Milestones such as establishing the partnerships and signing the contracts because those are the measures that indicate the pilot can be implemented, as opposed to only measuring the end goals that the companies and partnerships will facilitate.

Commissioner Aslami-Tamplen stated she appreciated the stakeholder involvement and support and the voluntary engagement piece. She asked how many unduplicated individuals will be served and how many peers will be hired for peer chatting. She suggested including peers for community engagement and development. Mr. Walker stated the need to monitor overuse or misuse of technology. He agreed that good product development has a strong component of user product evaluation in a noncritical moment for objective feedback. This is part of the rigorous goal.

Dr. Sherin stated the expectation is not that every consumer will want to be a part of this project. He stated this project may not be applicable to all populations. He stated he is in the process of hiring a chief over the peer division. One of the division's tasks will be to participate in the identification, training, certification, and pipeline development for a network of peers.

Commissioner Mitchell stated the proposed project is wonderful. She asked about individuals who do not come in for treatment or use phones or technology. She stated the need for marginalized individuals to be included, but they typically will not be at a university or the other places mentioned in the presentation. Dr. Sherin stated the focus is on the most vulnerable individuals. He stated the hope that, over time, technology will become a part of mental health operating activity and not seen as something that is foreign or scary.

Commissioner Madrigal-Weiss asked about strategies to engage schools and how to measure success in reaching students. Dr. Innes-Gomberg stated there are opportunities to strategically begin working with schools and colleges to get the word out. She stated Los Angeles County will continue to go school district by school district and college by college gathering feedback to enhance the program. Success will be measured in numbers of students reached and in the data that comes out of the project.

Dr. Sherin stated passive data collection will assess wellbeing and patterns. This is another channel to look at for outcomes.

Commissioner Brown commended the counties for their forward thinking but stated Internet access may be a challenge. He stated there is much content on the Internet

that is counterproductive to mental health. He asked how to ensure the fidelity of the information that the clients access through this program. He asked if policies have been developed for individuals and organizations that will have access to the chatrooms and other vehicles used to connect individuals to ensure that the right information is getting out. He asked how a balance will be achieved between free speech and censorship and appropriate information to individuals in the mental health community.

Mr. Walker stated companies and software technologies will be selected and will be a closed system implementation, which will be vetted as part of the process to provide safety and connection for users.

Chair Wooton stated her concern that the material in the meeting packet does not list peers as part of the staff the regional director will oversee. Dr. Innes-Gomberg stated peers will be threaded throughout the project.

Chair Wooton stated it is small things like this that make peers feel left out. Mr. Walker stated it was an error, because peer specialists are listed in the Kern County plan and the plans are aligned.

Chair Wooton asked about the small amount of funds allotted for a researcher and scientist in the evaluation section of the budget template. Dr. Cloud agreed that the figure is low. He stated additional funding will be moved from other parts of the budget into evaluation.

Public Comment

Karen Stockton, Director, Modoc County Health Services, spoke in support of the proposed project. She stated Modoc County would love to be a part of it. She suggested including CalMHSA, which has a history of contracting for process and outcome measures, and evaluating how this database would overlap with EBHS. It is important to look for redundancies.

Samantha Fusselman, Deputy Mental Health Director, Yolo County Health and Human Services Agency, spoke in support of the proposed project. She stated Yolo County looks forward to collaborating with Los Angeles, Kern, and many other counties across the state to pilot these innovative solutions.

Andrea Crook, Access California, Advocacy Director, Mental Health America of Northern California (NorCal MHA), spoke in support of the proposed project. She questioned the number of peers that will be hired and stated the hope that they would be representative of the individuals who are part of the project. She asked about the stakeholder process and how much clients were involved in the plan design. She suggested including a client representative on the panel as the project is presented to the Commission. She asked how the most severely mentally ill populations can truly give informed consent and how it will be explained to them that basically their every waking move will be monitored.

John Aguirre, NorCal MHA, ceded his time to Poshi Walker, LGBTQ Program Director, NorCal MHA, and Co-Director, Out for Mental Health. Ms. Walker stated the need for continuity of care and consistency in peer relationships, and that those peer relationships stay within the county system with local peers who are paid a wage that represents their value and not a volunteer position from an online contractor. She stated

the need to ensure that peer training is included for virtual encounters and is part of the approved budget. She stated her concern about triggering; informed consent is important. She stated she would like to see a true disaggregation of the data to see who this project does and does not help, and suggested staying away from gendered terms such as “brothers and sisters.”

Karen Macedonio stated the need to acquire an innovative skill set to deal with what will be found through the passive data collection process and to educate the mainstream population, not just the participants in the proposed project.

Mariko Kahn, Executive Director, Pacific Asian Counseling Services, spoke in support of the proposed project. She stated 30 percent of Cambodian clients have smartphones and would welcome this kind of application. The proposed project would be helpful in areas where social isolation and transportation are issues and can be a way to stay in contact with recovered consumers.

Robb Layne, Director of Communications and External Affairs, County Behavioral Health Directors Association (CBHDA), echoed the data sharing and efficiency comments made by the previous speakers. He emphasized the voluntary aspect of the project and that this tool can be used to intervene sooner.

Lindsay Walter, Deputy Director for Administration and Operations, Santa Barbara County Department of Behavioral Wellness, spoke in support of the proposed project, especially for transition age youth (TAY). She stated the hope that private sector partners and other counties will participate in the project.

Mandy Taylor, Health Access, California LGBT Health and Human Services Network, stated her concern about technology access for homeless communities. She stated one out of the six free LifeLine phones for low-income families is a smartphone with limited storage. She stated the importance of training and paying peer support specialists.

Commissioner Discussion

Vice Chair Boyd moved to approve the plan for Los Angeles County.

Chair Wooton asked the members of the panel if they would be willing to provide an update in three months and then every six months after implementation.

Commissioner Danovitch suggested amending the motion to approve the innovation plan with the recommendation to establish implementation milestones, which would include the intervals to report back to the Commission.

Vice Chair Boyd accepted Commissioner Danovitch’s friendly amendment.

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

The MHSOAC approves Los Angeles County’s Innovation Plan as presented and recommends that Los Angeles County establish implementation milestones and provides status updates to the Commission at specified intervals, such as three and six months, 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

Motion carried 9 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, Danovitch, Madrigal-Weiss, Mitchell, Ridley-Thomas, and Strachan-Wilson.

Commissioner Bunch rejoined the Commissioners at the dais. She asked the representatives from Kern County about research in the field that points to therapeutic alliance as being an indicator of positive outcomes regardless of treatment modality. She also asked about research that shows there is no negative response for technology-based interventions. She asked if the veteran community will be involved in the proposed project.

Dr. Cloud stated veterans are a part of Kern County’s steering committee and will be part of the implementation. He stated he is unaware of research on virtual supportive counseling.

Commissioner Bunch asked if behavioral health coordinators are therapists. Dr. Cloud stated it is a bachelor’s or peer-level position. Mr. Walker stated there may be therapists or peer counselors through the technology suite.

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

The MHSOAC approves Kern County’s Innovation Plan as presented and recommends that Kern County establish implementation milestones and provides status updates to the Commission at specified intervals, such as three and six months, 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

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 Aslami-Tamplen, Brown, Bunch, Danovitch, Madrigal-Weiss, Mitchell, Ridley-Thomas, and Strachan-Wilson.

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

Jenine Miller, Psy.D., Director, Mendocino County Behavioral Health and Recovery Services, introduced the members of her team who were present. She provided an overview, accompanied by a slide presentation, of the topography, demographics, and challenges of Mendocino County.

Frank Tuttle, Clinical Psychology Intern, Round Valley Indian Health Center, discussed the historical trauma of the Native American community in Mendocino County.

Karen Lovato, Acting Deputy Director, Mendocino County Behavioral Health and Recovery Services, continued the slide presentation and discussed innovation in a rural small county, stakeholder process, goals and objectives, and implementation process of the proposed project.

Commissioner Questions

Commissioner Mitchell asked for further details about the project rather than the process. Ms. Lovato stated the hope that the process will lead to the project. The learning process will help discover how to have the conversation about what is needed and to slowly build it, test it, bring in trainings, identify resources, figure out how those fit best with existing services, and then build upon those.

Mr. Tuttle stated Mendocino County is not dealing with the regular consumer because of the unvoiced historical trauma. These issues have yet to be addressed.

Commissioner Brown stated the presentations were nebulous about what the county proposes to do with the funding and how achievements toward the goals will be measured. He asked what is stopping the county from working on the trust issues now.

Mr. Tuttle stated the county continues to work on the trust issues on the community, county, and statewide levels. He stated a part that is lacking is the humanness of what the presenting problems are. It was only during the stakeholder process for this innovation plan that the issue of historical trauma was brought to the surface. The county would like the opportunity to address this issue.

Otis Brotherton, Director of Human Services and Substance Abuse Counselor, Yuki Trails, Round Valley Indian Health Center, stated drug and alcohol issues are prevalent at Yuki Trails. He stated part of the treatment process is to get consumers to the mental health side of the field because there are always underlying issues. The mistrust that Mr. Tuttle is referring to with the county and institutional resources is that the tribal community has never been able to come forward with their issues and concerns. Part of the process is using natural helpers, such as family members or neighbors who can serve as the voice of reason, can be looked up to in the community, and can have more trust and concern. He stated natural helpers help bridge the gap and build trust. More feedback is given to natural helpers on needed services and what it will take to get these individuals to that mistrusted higher level of care.

Commissioner Brown asked what is stopping the natural helpers from helping now. Mr. Brotherton stated they have existed in the past. The proposed project will bring them into the program to utilize them.

Commissioner Brown stated it was not clearly stated in the proposal that the funding would be used for natural helpers. Ms. Lovato stated the project is two-fold. The project will help the county understand how and why it has not worked as a collaboration

before, and, once moving toward implementation, a crisis response network potentially will be proposed and will have full-time, round-the-clock staff through a warmline or call center made up of natural helpers, the community liaisons who will build trust and support. The natural helpers will be a part of a larger, formalized system of care that can help connect consumers to local services or higher levels of treatment. She stated some of the networks are unknown until testing is done.

Commissioner Brown stated the need to define and present clear goals and paths to measure those goals. He suggested identifying what the county plans to do with the funding and how it will be different from current activities. Dr. Miller agreed that the presentation is nebulous but the county has learned that it does not work well to design a program without community input. The county will work with the community to learn how to work with historic trauma and distrust for the government and build a program that works for them, builds trust, and includes natural, cultural practices that are healing for those communities. A detailed plan would build a government program, not trust.

Commissioner Aslami-Tamplen stated she hoped to see that the proposal included training for the rest of the community, especially training that addresses historical trauma and mistrust within the Native American community that can benefit other counties statewide. She asked what percentage of staff will come from the local Native American community.

Ms. Lovato stated the reason much of today's proposal is nebulous is the county wants to get through the formalization of the collaboration with more of the community stakeholders in learning how to best communicate. The proposals that have come up thus far are that most of the funding will go to the community providers. The county's role will be in oversight and evaluation.

Public Comment

Kate Gaston, Mendocino County Behavioral Health Advisory Board, stressed the poverty of Mendocino County. She stated the first year of the proposed project will be testing to see what works.

Amanda Wallner, Director, California LGBTQ Health and Human Services Network, commended Mendocino County for the work they put into identifying and addressing disparities in the community. LGBTQ communities experience many similar disparities to Native communities. She stated the hope that the project implementation, how the funds are spent, and how effective the programs are will be transparent.

Mr. Aguirre commended the county for their innovative approach of having honest conversations with Tribal members. He suggested intersecting communities in the stakeholder process, such as the LGBT communities and Tribal elders, and ensuring that tools for assessments are culturally appropriate. He asked who can participate in the program.

Commissioner Discussion

Commissioner Mitchell suggested the county withdraw their proposal and come back when they have more specifics about the project.

Chair Wooton offered technical assistance from staff to the county until they return with an updated plan.

Commissioner Mitchell agreed and stated the Commission wants to see them succeed.

Dr. Miller stated they have had three rounds of Commission staff over several years providing technical assistance. She stated the county presented today because staff felt they were ready. She asked what would be changed by continuing to speak with staff. The proposal has already been changed multiple times and was originally more of a project design, but prior staff told them it needed to be more of a learning experience.

Vice Chair Boyd stated it is not about what is on paper but is about the fact that the Commissioners' questions have not been fully answered.

Commissioner Brown agreed with Commissioner Mitchell that the Commission wants to help and wants the project to be successful. He stated the need for more clarity to help the Commission approve the project and help the county have a stronger project and roadmap. He stated the budget calls for a project manager and for additional staff, but there is no indication of who those additional staff would be or what they would do or even if the project manager is assigned to this project full-time. He stated the proposed project just needs some minor tweaks.

Commissioner Aslami-Tamplen asked if the county would consider doing a training from what is learned that can be shared with others as a model to replicate. Mr. Tuttle outlined current trainings done by the county.

Chair Wooton proposed that staff go to Mendocino County to provide technical assistance to the county.

Commissioner Mitchell stated the motion is backwards and inconsistent with other county innovation plans.

Commissioner Brown agreed that the motion puts the cart before the horse. The plan should be presented to the Commission on how to address an issue. He suggested that the county come back and present at a future Commission meeting.

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

The MHSOAC approves Mendocino County's Innovation Plan with the recommendation that Commission staff provide technical assistance to the county and the County provide an update on the project at a future Commission meeting:

Name: Round Valley Crisis Response Services

> *Amount: $1,124,293*
>
> *Project Length: Three (3) Years*

Motion carried 6 yes, 3 no, and 0 abstain, per roll call vote as follows:

The following Commissioners voted "Yes": Chair Wooton, Vice Chair Boyd, and Commissioners Aslami-Tamplen, Bunch, Madrigal-Weiss, and Ridley-Thomas.

The following Commissioners voted "No": Commissioners Brown, Danovitch, and Mitchell.

ACTION

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

Presenter: Filomena Yeroshek, Chief Counsel

Chair Wooton tabled this item until the next Commission meeting.

INFORMATION

5: Innovation Sub-Committee Report Out

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

Chair Wooton tabled this item until the next Commission meeting.

GENERAL PUBLIC COMMENT

Jim Gilmer, Racial and Ethnic Mental Health Disparities Coalition (REMHDCO), stated he submitted his comments to staff. He stated innovation funds should be used for new programs and approaches for racial and ethnic communities to reduce disparities. He suggested working closely with the Office of Health Equity (OHE), California Reducing Disparities Project (CRDP) and to invite them to present at a future Commission meeting. He asked if diverse stakeholders will be involved in the upcoming innovation summit.

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)

Urban Beats

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

Alfredo Aguirre, LCSW, Director, San Diego County Behavioral Health Services, provided an overview, accompanied by a slide presentation, of the demographics and population characteristics of San Diego County and the community program planning process for the proposed projects.

Piedad Garcia, Ed.D., LCSW, Deputy Director, San Diego County AOABHS, continued the slide presentation and discussed identified problems, program description,

outcomes, proposed changes, innovative components, and budget for the expansion of the Urban Beats (INN 16) project. She played a sample video of a TAY community performance.

Commissioner Questions and Discussion

Commissioner Aslami-Tamplen stated she looked forward to engaging the East African community to focus on TAY.

Commissioner Mitchell stated her appreciation for a clear plan early on for a program that is specific with this cohort.

Commissioner Brown asked about the approximate size of the East African TAY cohort and how many individuals are expected to be involved with the program. Cecily Thornton-Stearns, MFT, Behavioral Health Program Coordinator, San Diego County Adult and Older Adult System of Care, stated the proposed number to be served is about 200 annually.

Commissioner Bunch asked how many individuals are currently enrolled in the existing program and how many were anticipated. Ms. Thornton-Stearns stated approximately 60 individuals are enrolled in the academy component by this point in the fiscal year. The program anticipated approximately 100 individuals in the last fiscal year; with the expansion, this can increase to 200. The current goal to reach 600 youth in the community through performances has been exceeded.

Commissioner Danovitch asked what will sustain the program if it is successful for the pilot period. Mr. Aguirre stated this is a unique program that the community is excited to support. Dr. Garcia stated staff is already evaluating funding and outcomes.

Public Comment

Jama Mohamed, Program Manager, Making Connection Initiative, United Women of East Africa (UWEA), stated the Making Connection Initiative allows minority communities to develop strategies to improve the wellbeing of boys and men. He spoke about the increasing struggles the community faces and urged the Commission to support changes to improve the lives of young people.

Rosetta Nsonga, UWEA, stated the concern that most of the young men are from war-torn areas and lose hope. She requested that the project look at preventive measures, including aid with skills and language barriers, and at expanding into new structures to reach further into the community.

Commissioner Bunch asked, given the public comment, what type of cultural training is planned prior to starting the pilot project. Mr. Aguirre stated all services along the continuum must be responsive to all communities.

Dr. Garcia stated she recently attended a suicide prevention training for the East African community in San Diego. She recommended pairing expert trainers with members of the East African community to teach a course like this. She also spoke about the cultural competence training academy, which delivers intensive skill-based training for multiple communities; the plan is to do one for East Africans, as well.

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

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: Two (2) years for a total project duration length of five (5) years

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

The following Commissioners voted "Yes": Chair Wooton, Vice Chair Boyd, and Commissioners Aslami-Tamplen, Brown, Bunch, Danovitch, and Mitchell.

<u>Cognitive Rehabilitation and Exposure/Sorting Therapy (CREST) Services</u>

Dr. Garcia continued the slide presentation and discussed identified problems, program description, outcomes, and proposed changes for the expansion of the Cognitive Rehabilitation and Exposure/Sorting Therapy (CREST) Services (INN 17) project.

Commissioner Questions and Discussion

Commissioner Bunch asked about the lengths of time for the treatment and aftercare. Connie German-Marquez, LMFT, Behavioral Health Program Coordinator, San Diego County AOABHS, stated the program is 16 weeks; the aftercare is for as long as needed.

Commissioner Danovitch asked if this project goes through a county institutional review board (IRB). Ms. German-Marquez stated she did not know.

Commissioner Danovitch stated one of the questions is to evaluate an effective model to treat behavior and includes a control group. There is an imperative, if there is a research study, that there is an IRB mechanism. The point of the IRB is to ensure that the participants have their interests safeguarded. Mr. Aguirre stated he will ensure that an IRB process is incorporated.

Commissioner Danovitch asked about the sustainability plan. Mr. Aguirre stated there are TAY and older adult specialists in the clinics. Sustainability will be incorporated into their work, which would require additional resources. The county has other programs that support caregivers.

Public Comment

Mr. Layne stated his appreciation that the county is tapping into communities that have not recently or ever been tapped into before.

Elizabeth Lou, Founder and CEO, Nile Sisters Development Initiative, stated she works with refugees and immigrants in San Diego. She discussed the differences of homelessness within the refugee community versus the general homeless population. She suggested a provision be made to accommodate refugees and that refugees be served under this program.

Chair Wooton read the comment card provided by Awichu Akwaya, who supports the proposed plan.

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

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: Two (2) years for a total project duration length of five (5) years*

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

The following Commissioners voted "Yes": Chair Wooton, Vice Chair Boyd, and Commissioners Aslami-Tamplen, Brown, Bunch, Danovitch, and Mitchell.

<u>Telemental Health</u>

Yael Koenig, LCSW, Deputy Director, San Diego County Health and Human Services Agency, Behavioral Health Services, Children Youth and Families (CYF) System of Care; continued the slide presentation and discussed identified problems, program description, outcomes, and budget for the Telemental Health (INN 19) project.

Commissioner Questions and Discussion

Chair Wooton asked if peer support workers will be hired for this project. Ms. Koenig stated the county is interested in having peers as part of the staffing makeup.

Commissioner Bunch asked if this program will be offered to all individuals who present to the hospital frequently and are unconnected as part of discharge planning. Ms. Koenig stated the intent is to include individuals who are on their second inpatient or crisis stabilization visit.

Commissioner Aslami-Tamplen stated there was a piece missing in the description of "unconnected" and about the trauma experienced in psychiatric emergency rooms. She stated sometimes clients refuse to follow up due to trauma experienced within the system.

Commissioner Aslami-Tamplen asked if discharge from the psychiatric hospital would be impacted if clients refused to be a part of this project. Ms. Koenig stated it would be part of discharge planning and the discharge team would need to clinically evaluate each case. The county has other programs that work with clients who may not be ready to accept treatment. Mr. Aguirre stated these clients have already been identified as ready for discharge and refusal to participate in this program would not change the discharge.

Commissioner Mitchell asked if the clinician is housed at the hospital. Ms. Koenig stated they will be available remotely, such as by tablet or cell phone. The case managers are onsite and will teach clients how to use the device and will schedule the first appointment with the client.

Mr. Aguirre stated this project offers another option for clients who are not comfortable seeking treatment in more conventional forms.

Public Comment

Ms. Crook stated it would be helpful for client advocates to hear from an individual in a leadership position who is also a client advocate. She spoke in support of Telemental Health, especially for rural communities; however, she stated her concern about the target population for this project and the importance of connecting to peer support. She stated Telemental Health may be better used for medication management.

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

The MHSOAC approves San Diego County's Innovation Plan as follows:

Name: Telemental Health

Amount: $5,253,376

Project Length: Five (5) years

Motion carried 6 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, Bunch, Danovitch, and Mitchell.

ACTION

7: <u>Criminal Justice and Mental Health Report</u>

Presenter: Ashley Mills, Senior Researcher and Project Staff Lead

Commissioner Brown introduced the Criminal Justice and Mental Health Project and stated the resulting report, Together We Can, Reducing Criminal Justice Involvement for People with Mental Illness, is not meant to be a comprehensive report on the convergence of mental health and criminal justice. It is a report that would be read, used, and acted upon by the target audience - law enforcement administrators, county CEOs, members of boards of supervisors who are ultimately in charge of funding programs for the diversion of individuals from the system, the Legislature, and the Governor of California.

Commissioner Brown suggested briefly going over the findings and recommendations, opening it up for public comment, making changes based on feedback, and reviewing and voting on the revised report at the next Commission meeting. He stated the importance of not losing the momentum and putting out a report in time to be considered and utilized during the next session of the Legislature in January.

Ashley Mills, Senior Researcher and Project Staff Lead, provided an overview, accompanied by a slide presentation, of the background, goal, subcommittee and

stakeholder process, and findings and recommendations of the Criminal Justice and Mental Health Project.

Commissioner Questions and Discussion

Commissioner Mitchell stated this was great work.

Chair Wooton suggested using language other than "persons with mental illness," which is stigmatizing. She suggested changing the title of the report to "Reducing Criminal Justice Involvement for Persons with Mental Health Needs." She referred to page 29 in the report and stated "persons accessing assisted outpatient treatment" is a controversial subject and hopes can emphasize the importance of continuing to look at areas where individuals can be helped in the least restrictive environments.

Public Comment

Ms. Wallner agreed with the importance of this report and stated her appreciation for the extra time the Commission is giving to ensure the report includes the best information possible. She agreed with Chair Wooton to make changes to reduce stigma. She stated she will submit written comments to staff on the content of the report.

Cullen Fowler-Riggs, OHE, CRDP, ceded his time to Mr. Gilmer. Mr. Gilmer stated the Office of Health Equity would like to collaborate with the Commission and to weigh in, particularly on racial and ethnic disparities. He stated REMHDCO submitted recommendations to staff. He stated the report lacked emphasis on people of color - issues of people of color must be included in the discussion on criminal justice. More can be done to reduce disparities by specifically calling out racial and ethnic groups that are having difficulty.

Phyllis shared the story of her family in law enforcement and of her son who begged for help for his mental health issues and ultimately took his life while in jail. She stated this is not a diversity problem; it is a people problem. She stated the criminal justice system failed to provide the help they promised her and her son. Mental health is a disease and does not discriminate.

Steve Leoni stated Phyllis's testimony reminds everyone why the right kind of difference needs to be made. He spoke about unintended consequences. He thanked Chair Wooton for bringing up the assisted outpatient treatment issue. He stated there is an undue prominence in the report for that, particularly the CSS component. He stated the forgotten piece is outreach.

Herman Debose, Professor, California State Northridge, and a member of the MHSOAC Cultural and Linguistic Competence Committee, stated the root causes related to mass incarceration, immigration detention centers, and homelessness are missing, especially for the African American community and other communities of color. Although the report mentions people of color on pages 14 and 19 through 23, it fails to address the effects of colonialism, upholding white supremacy, capitalism, sexism, ableism, and sanism. The report mentioned words such as oppression and historically marginalized groups without implicating the systems of power and control most responsible for carrying out the oppression and creating the conditions that historically marginalized specific groups of people. The unwritten goal of the report is to create more services to heal those affected by the harmful system without seeking accountability or reparation from that

system. He asked that the updated report be sent to members of the Cultural and Linguistic Competence Committee prior to their next committee's meeting on November 8th.

Linnea Koopmans, Senior Policy Analyst, CBHDA, spoke in support of the existing recommendations but suggested language to strengthen them. She stated the CBHDA provided written comments to staff. She suggested creating a catalog of county Mental Health Services Act (MHSA) programs serving the criminal justice population and outcomes from those programs, emphasizing the role that housing plays in diversion and reentry planning, and using existing data reporting.

Ms. Walker echoed Professor Debose's comments. She stated the needs of lesbian, gay, and bisexual individuals, particularly youth, are not addressed in this report. She stated, although the juvenile justice system is beyond the scope of this report, the disparities that lead to incarceration and engagement with the criminal justice system often begin with the school-to-prison pipeline and/or placement in foster care.

Ms. Walker discussed strength-based language and "mental health" versus "mental illness." She suggested modeling strength-based and inclusive language such as "people with mental illness" rather than "mentally ill persons." That way "mental illness" would still come up on a search. She suggested "people who are living with mental illness" instead of "suffering from mental illness," naming the populations addressed rather than using the term "minorities," and "people" or "individuals" instead of "men and women."

Ms. Taylor stated the expansion between the first and second drafts of the report was only made to the main part of the document, not to the executive summary or recommendations. She asked staff to be more explicit in the recommendations, particularly Recommendations 1 and 6 around issues of marginalized communities. She referred to pages 47 and 56 and asked that the language be more like the Sequential Intercept Model One that mentioned specific training on implicit bias, rather than saying mental health training in general. It is important to state that it would be training on mental health, implicit bias, and vulnerable communities.

Kit Wall, Project Director, Words to Deeds, suggested ongoing study and using the report to delve deeper into these issues. She announced that Words to Deeds presents a Paradigm Award representing individuals who are champions in shifting the paradigm between criminal justice and mental health and has selected Chair Wooton for the 2017 Paradigm Award to be presented on November 8th.

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

The MHSOAC authorizes the chair of the subcommittee to take the comments heard today and received in writing, to incorporate changes, and to put out a revised report to Commissioners within two weeks, and that adoption of the revised report be voted on at the November meeting.

Motion carried 6 yes, 0 no, and 0 abstain, per roll call vote as follows:

The following Commissioners voted "Yes": Chair Wooton, Vice Chair Boyd, and Commissioners Brown, Bunch, Madrigal-Weiss, and Mitchell.

INFORMATION

8: Executive Director Report

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

Chair Wooton tabled this item until the next Commission meeting.

GENERAL PUBLIC COMMENT

Richard Van Horn provided public comment for Ms. Stockton who had to leave. He stated Ms. Stockton supports the adoption of staff recommended responses to public comments for the PEI and INN Regulations.

ADJOURN

There being no further business, the meeting was adjourned at 5:07 p.m.

AGENDA ITEM 2

Action

November 16, 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 as revised to be consistent with the Commission's direction at the October 26, 2017 meeting.

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.

The draft criminal justice and mental health project final report was released publicly on September 22, 2017. The 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 was presented during the October 26, 2017 Commission meeting. The Commission received written comments prior to the meeting and heard testimony on the revised draft during the meeting.

The Commission voted to authorize the chair of the subcommittee to direct revisions to the report based on public comment submitted to the Commission. The report was revised consistent with the Commission’s direction and is enclosed for your review and consideration.

Presenter: Ashley Mills, Senior Researcher and Project Staff Lead

Enclosures: Revised criminal justice and mental health project final report.

Handout: PowerPoint presentation, Written public comment, if any.

Proposed Motion: The MHSOAC adopts the criminal justice and mental health project report as revised to be consistent with the Commission’s direction at the October 26, 2017 meeting.

Together We Can

REDUCING CRIMINAL JUSTICE INVOLVEMENT FOR PEOPLE WITH MENTAL ILLNESS

DRAFT

THIRD DRAFT TO THE COMMISSION ON NOVEMBER 16, 2017

SECOND DRAFT TO THE COMMISSION ON OCTOBER 26, 2017

FIRST DRAFT APPROVED WITH REVISIONS BY THE SUBCOMMITTEE ON SEPTEMBER 29, 2017

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

TINA WOOTON**
Chair

JOHN BOYD, Psy. D.
Vice Chair

RENEETA ANTHONY

LYNNE ASHBECK

KHATERA ASLAMI-TAMPLEN

JIM BEALL
Senator

BILL BROWN*
Sheriff

KEYONDRIA BUNCH, Ph.D.

ITAI DANOVITCH, M.D.

DAVID GORDON

KATHLEEN LYNCH

MARA MADRIGAL-WEISS

GLADYS MITCHELL

LARRY POASTER, Ph.D.

SEBASTIAN RIDLEY-THOMAS
Assemblymember

DEANNA STRACHAN-WILSON

RICHARD VAN HORN**
Former Commissioner

Executive Director
TOBY EWING

* Subcommittee Chair
** Project Subcommittee Member

All correspondence should be addressed to the Commission at:
1325 J Street, Suite 1700, Sacramento, CA 95814 | MHSOAC@MHSOAC.ca.gov | (916) 445-8696

DRAFT

STATE OF CALIFORNIA
EDMUND G. BROWN JR., Governor

TINA WOOTON
Chair

JOHN BOYD, PsyD
Vice Chair

RENEETA ANTHONY
Commissioner

LYNNE ASHBECK
Commissioner

KHATERA ASLAMI-TAMPLEN
Commissioner

JIM BEALL
Senator
Commissioner

BILL BROWN
Sheriff
Commissioner

KEYONDRIA D. BUNCH, Ph.D.
Commissioner

ITAI DANOVITCH, M.D.
Commissioner

DAVID GORDON
Commissioner

KATHLEEN LYNCH
Commissioner

GLADYS MITCHELL
Commissioner

LARRY POASTER, Ph.D.
Commissioner

MARA MADRIGAL-WEISS
Commissioner

SEBASTIAN RIDLEY-THOMAS
Assembly Member
Commissioner

DEANNA STRACHAN-WILSON
Commissioner

TOBY EWING
Executive Director

November 16, 2017

Dear Governor Brown, members of the California Legislature, county and city officials, and people of the State of California,

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 spirit of good will and a resolve to combine forces, share their resources and solve the problem collectively.

MENTAL HEALTH SERVICES OVERSIGHT AND ACCOUNTABILITY COMMISSION
1325 J Street, Suite 1700, Sacramento, CA 95814 • Phone: 916.445.8696 • Fax: 916.445.4927 • www.mhsoac.ca.gov

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. Effective prevention and early diversion strategies can reduce the number of people found incompetent to stand trial. Counties should also consider implementing or expanding both community-based and jail-based competency restoration programs.

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

MENTAL HEALTH SERVICES OVERSIGHT AND ACCOUNTABILITY COMMISSION
1325 J Street, Suite 1700, Sacramento, CA 95814 • Phone: 916.445.8696 • Fax: 916.445.4927 • www.mhsoac.ca.gov

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 people 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.

DRAFT

Table of Contents

Executive Summary ... 6

About the Project ... 10

Community Engagement and Site Visits ... 10

Filling in Data Gaps ... 13

Incorporating Previous Assessments ... 13

Background ... 14

Factors that Increase Contact with the Justice System ... 15

Diverse Communities and System Disparities ... 19

Stigma and Implicit Biases ... 22

Planning for Prevention and Diversion ... 26

Identifying Opportunities for Prevention and Diversion ... 27

The Sequential Intercept Model ... 28

Community Collaboration and Blending Funds ... 38

Findings and Recommendations ... 43

Guiding Principles ... 44

Finding One ... 46

Recommendation One ... 48

Finding Two ... 51

Recommendation Two ... 55

Finding Three ... 57

Recommendatin Three ... 58

Finding Four ... 60

Recommendation Four ... 62

Finding Five ... 63

Recommendation Five ... 65

Finding Six ... 67

Recommendation Six ... 69

Summary of Findings and Recommendations ... 71

Conclusion ... 72

Endnotes ... 73

DRAFT

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, alone in his cell, he died by suicide.

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

DRAFT

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.

But positive outcomes will not be achieved without addressing the systemic stigma and resulting discrimination that people with mental health needs face daily.

Mental illness does not discriminate. It can have devastating impacts on people of every race, gender identity, sexual orientation, and socioeconomic status, affecting them, their families, friends, coworkers, and communities. As part of its review, the Commission took a close look at people with mental health needs in the criminal 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.

There are also long-standing racial/ethnic and cultural disparities in both the criminal justice and mental health systems. Communities of color and LGBTQ communities experience greater exposure to racism, discrimination, and trauma, and often have less access to needed services, thereby increasing the likelihood of criminal justice involvement.

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 option available. Absent additional investments by the state or elsewhere, counties must recruit all existing resources, including strengthening partnerships with hospitals, local nonprofits, and faith-based communities.

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.

DRAFT

Collaboration between two very different systems – criminal justice and mental health – is difficult, but essential. 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 African American, Latino, Native American, and LGBTQ 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. Universal screening for mental health and substance use disorders at booking, along with timely follow-up assessments, must be mandatory. Revisions to the mental health curriculum for correctional staff training should continue, and should include strategies to support correctional staff mental health and address issues of stigma, discrimination, and implicit biases.

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. When data is not collected or available, people within a system become invisible and problems are minimized, especially for people disproportionately impacted by criminal justice involvement, such as members of African American, Latino, Native American, and LGBTQ communities. However, there are significant technological, cultural, and legal barriers to sharing data in ways that protects confidentiality. The state should develop solutions that allow agencies to legally 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 best practices, including community-driven and evidence-based practices, are essential to continuous quality improvement.

DRAFT

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.

Project staff made presentations before the Commission's Client and Family Leadership Committee and Cultural and Linguistic Competency Committee on October 13, 2016 and July 12, 2017.[1] Committee members were made aware of the September 29th meeting to review the first draft of the report on September 5, 2017.[2] The first draft of the final report was sent to committee members and other members of the public on September 25, 2017.[3] Public comment on the draft was heard during a subcommittee meeting on September 29, 2017.[4]

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

DRAFT

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

DRAFT

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,[5] a report authored by the former California Corrections Standards Authority, and the California Reducing Disparities Project.[6] 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.[7] 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.[8] In California in 1995, there were 29.5 beds for every 100,000 people in the state.[9] 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.[10] This decrease highlights the need for additional inpatient hospital care but also for robust community-based alternatives.

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.[11] Between 1970 and 2014, the number of people incarcerated in jails nationwide quadrupled, from 157,000 to 690,000.[12] As the number of laws criminalizing substance use and homelessness grew, so did the population of those with mental health needs in behind bars.[13]

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.[14] "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.[15] California laws criminalizing homelessness are also on the rise.[16] These laws prohibit camping, sleeping, and resting in public spaces, and they disproportionately affect people with mental health needs and substance use disorders.[17]

DRAFT

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.[18] 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.[19]

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.[20] 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."*[21]

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.[22] 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.[23] Still, addressing mental health needs alone does not reduce the likelihood of returning to the justice system.[24] 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.[25] One study estimated that half of those with mental health needs who were arrested also had a substance use disorder.[26] 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.[27] Prevalence rates of substance use

DRAFT

disorders has declined for whites but has remained stable or increased among African Americans and Latinos.[28]

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.[29] 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.[30] These factors have a more direct link to offending. Of the dynamic factors listed below, the first four are most predictive of criminal behavior:[31]

- 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[32]

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.[33] These assessments allow administrators to place needs along a continuum - low to high - to determine the best course of intervention and correctional supervision.[34] For example, people with higher risks to offend should be prioritized for more intensive in-custody and community supervision when released.[35] 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.[36] 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.[37]

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.[38] Approximately four in 10 Californians are living at or near the poverty level.[39] 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.[40] Research has consistently demonstrated that the lower a person's socioeconomic status, the higher that person's risk for developing a mental illness.[41]

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.[42] Further, people in jail have experienced homelessness 7.5 to 11.3 times more than people in the general population.[43]

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.[44]

DRAFT

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.[45] 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.[46] 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.[47] 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.[48] 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.

DRAFT

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.[49] 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.[50]

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.[51] Latinos, meanwhile, make up 41.1 percent of the prison population and 38.8 percent of the general population.[52] Data from the Center for American Progress suggest that people identifying as LGBT or gender non-conforming also are overrepresented in criminal justice systems.[53] Factors driving overrepresentation include discrimination and stigma which may push LGBT people - youth especially - into homelessness and to engage in crimes of survival, such as sex work.[54] Trans women, especially from communities of color, are particularly vulnerable to entering the criminal justice system through engaging in sex work.[55] Trans women sex workers experience significant trauma, including physical, sexual, and emotional abuse, and frequently engage in high-risk behaviors, such as substance use.[56]

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.[57] 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.[58]

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.[59] 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.[60] Native Americans,[61] refugee groups, [62] and members of groups based on sexual orientation and gender identity also are less likely to receive mental health services.[63]

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*

DRAFT

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.[64] Implicit biases, on the other hand, are unconscious and automatic associations made between stereotypes and groups of people.[65] These stereotypes can be about race, gender, age, religion, sexual orientation, or health status, including mental illness.[66]

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.[67] 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.[68]

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.[69] 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."[70]*

Stigma and discrimination can affect the ability of people with mental health needs to obtain or retain employment, especially for those with criminal history.[71] 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."[72]

DRAFT

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.[73] So much so that the grant had to be extended to give counties more time to address opposition and other obstacles.[74]

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.[75]

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.[76] 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.[77]

DRAFT

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)

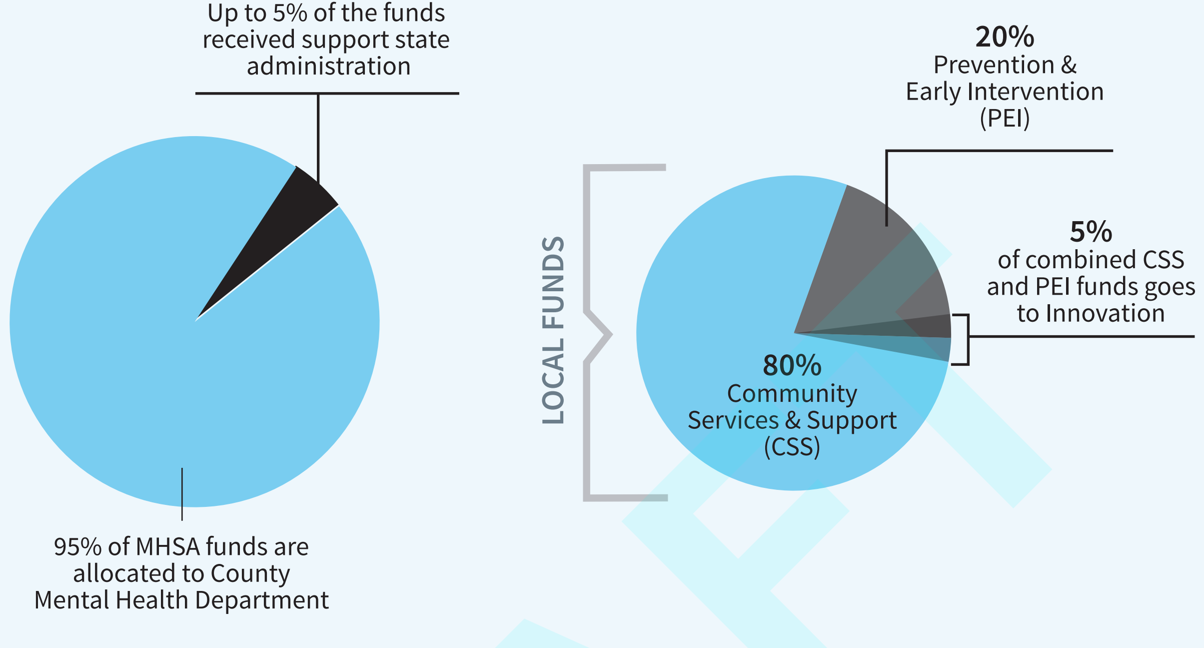
The CFTN component provides one-time funding for infrastructure and technology to support the mental health care system.

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.

DRAFT

How are Mental Health Service Act dollars allocated?



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.

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))

DRAFT

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.[78] 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.[79] 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.[80]

"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.[81]

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.[82]

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.[83] 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.[84]

"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

DRAFT

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.[85] 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.”[86] 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.[87]

Preventing a mental health crisis or catching a crisis early can begin with effective outreach and engagement strategies that “meet the person where they are,” and develop rapport, trust, and hope over time.[88] When engaging hard to reach populations – people who are most at risk of criminal justice involvement – outreach should incorporate patience, persistence, understanding, respect, and non-threatening contact with people with mental health needs.[89] Outreach should not be limited to people experiencing homelessness. Outreach can extend to people in jails, hospitals, and their homes. San Diego County’s In-Home Outreach Team is an example of a program that uses a “person-centered, non-coercive, non-agenda setting approach” in the home to engage people with mental health needs, and their families and caregivers, who have chosen in the past not to participate in treatment.[90]

When voluntary outreach and services do not meet needs, 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.[91] Assisted outpatient treatment refers to civil court-ordered community-based mental health services for people unable to voluntarily access needed services.[92] 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.[93]

“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.[94] Programs that decrease exposure to adverse childhood experiences and help people cope with trauma may divert the trajectory toward criminal justice

DRAFT

involvement.[95] 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.[96] 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.[97]

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.[98] 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.[99] 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.[100]

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.[101] 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.[102]

- ***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.[103]

- ***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.[104]

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.[105]

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.[106] 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.[107]

More recent crisis intervention training approaches have focused on just policing and implicit bias.[108] 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.[109]

DRAFT

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.[110]

- ***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.[111]

- ***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.[112]

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.

DRAFT

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.[113] 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.[114]

- ***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.[115]

- ***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.[116]

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.[117]

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.[118] In 2008, the Council of State Governments proposed 10 essential elements that characterize effective Mental Health Courts, including:[119]

DRAFT

- 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.[120] 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.[121] 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.[122]

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.[123]

- ***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.[124]

- ***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.[125]

DRAFT

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.[126]

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. [127]

- **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. [128]

- **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. [129]

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.

DRAFT

Fred Osher and Christopher King identified multiple promising practices for people with mental health needs released from confinement.[130] 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.[131] 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.[132] Initial findings suggest that Assertive Community Treatment may be effective for communities of color.[133] 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.[134]

> **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.[135]
>
> - ***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.[136]
>
> - ***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.[137]

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.[138] Further, approximately 70 percent of people

DRAFT

under the supervision of the criminal justice system are under community – as opposed to in-custody – supervision.[139] 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.[140] 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.[141] 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.[142] 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.[143] Another review suggests that the effectiveness of specialty probation programs may be influenced by relationships with probation officers.[144] Clients who had reported positive relationships with probation officers tended to have better outcomes in terms of both mental health and recidivism.[145]

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.[146] 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.[147]

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.[148]

- ***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.[149]

- ***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.[150]

Community Collaboration and Blending Funds

Counties should consider blending stable public funding, such as public safety and mental health realignment dollars, with private funding sources, such as hospital, faith-based organizations and other nonprofits, individual philanthropic donors, and foundations, to develop or expand prevention and diversion efforts, including planning. The Sequential Intercept Model and the Stepping Up Initiative's Six Questions provide frameworks for counties to supplement existing planning processes of ongoing funding streams. 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.[151] 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.[152] 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.

DRAFT

> 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.[153]

- **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.[154]

- **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

DRAFT

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.[155]

- **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.[156] In 2015, 21 projects in 17 counties were awarded funding. An evaluation of the first round of funding identified 10 best practice strategies:[157]

- 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.[158]

- **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.[159] 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.[160] Most programs set similar goals, such as assisting the homeless, improving coordinated care, and disseminating patient data between health systems.[161]

DRAFT

SELECTED GRANTS AND PILOTS BY COUNTY

✓ = grant recipient

	CHFFA	MHSOAC	BSCC			DHCS
	SB 82 *Grantee: County Mental Health*[162]	SB 82 Triage *Grantee: County Mental Health*[163]	LEAD *Grantee: Varies*[164]	Adult MIOCR *Grantee: Varies*[165]	Proposition 47 *Grantee: Varies*[166]	Whole Person Care *Grantee: Varies*[167]
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.[168]

- **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.[169]

- **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.[170]

- **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. [171]

- **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.[172]

DRAFT

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.

DRAFT

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. Absent additional significant resources from the state or elsewhere, 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

DRAFT

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.

DRAFT

FINDING ONE:

Too many mental health consumers, particularly those from African American, Latino, Native American, and LGBTQ 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. Such a system should include effective strategies for identifying,

DRAFT

reaching, and engaging people with mental health needs before a crisis, hospitalization, or criminal justice contact by building trust and "meeting people where they are." 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 other 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. 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."[173] 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

DRAFT

family violence, intergenerational incarceration, and poverty and homelessness that disproportionately impact diverse communities.

LACK OF "STEP DOWN" OPTIONS: Some people with mental health needs may require structure, predictability, and stability to achieve recovery and avoid criminal justice involvement.[174] 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 have an opportunity to leverage an estimated $274 million in unspent funds and other Mental Health Service Act funding, such as Innovation and Prevention and Early Intervention allocations, to build or expand capacity in the community to reduce criminal justice involvement for mental health consumers.[175]

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. Counties should build programs, services, and facilities that have demonstrated effectiveness, and should measure performance over time to ensure quality improvement. Planning should take into account the needs of people most at risk, such as community members with mental health and substance use needs returning from incarceration or "stepping down" from hospitalization, to protect again homelessness, use of emergency services, and reoccurring jail and hospital admissions.

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.

Connecting people with services may mean building or strengthening relationships with community non-profits and faith-based communities. There is a rich history of organizations, such as the Salvation Army, being positive new or continued partners. For example, the Restorative Justice Ministry of the Archdiocese of San Francisco works with formerly incarcerated people as they return to the community and reintegrate.[176] Outreach to and collaboration with these partners can be effective in preventing contact

DRAFT

with the criminal justice system and promoting restorative practices among people with mental health needs and at-risk behaviors.[177]

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. 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.

Addressing the housing needs of people with mental health and substance use needs is a key factor to successfully preventing incarceration and diverting people from the criminal justice system. Recognizing there are many barriers to housing, the state and counties must collaborate to expand the range of housing options, from rental assistance to sober living to permanent supportive housing.

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 diverse communities. 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.

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 LGBTQ 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.[178]

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.[179] 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

DRAFT

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.[180]

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

DRAFT

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.[181] 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.[182] 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.[183] 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.[184]
- Local facility administrators have the responsibility of ensuring emergency and basic mental health care.[185] 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.[186]
- Written policies and procedures are developed to govern the use of psychotropic medications.[187] 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.[188]

- 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.[189] Absent informed consent in non-emergency situations, a court order is required before involuntary medical treatment can be administered to an inmate.[190]
- Each facility develops a comprehensive suicide prevention program to identify, monitor, and provide treatment to those at risk of suicide.[191]

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. [192] 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.[193]

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.[194] Each classification has specific courses and hours for mental health training.[195] The last major content revision to the Adult Corrections Officer curriculum was effective in 1998.[196] 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.[197]

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.[198]

Correctional staff are, at times, at risk of experiencing negative impacts on their own mental health due to the challenging nature of their jobs. One study found that correctional officers have a 39 percent higher chance of suicide compared to the average for other occupations.[199] This elevated risk for suicide may be due to work stress and its impact on family life, leading to divorce and separation.[200] Another study found that 27 percent of correctional officers experienced post-traumatic stress disorder.[201] This rate rivals rates documented for combat-related post-traumatic stress disorder among military personnel and veterans.[202]

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.

DRAFT

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.[203] 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.[204] 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.[205]

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."[206]

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. [207] 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.[208] 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.[209] All three must be assessed and addressed to reduce recidivism and increase mental health and substance use recovery.[210] 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.[211] 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.[212]

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.[213] 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.[214]

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. Trainings should incorporate strategies to support correctional staff mental health, including stress management techniques and peer support. 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

DRAFT

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 competency required to participate in legal proceedings. Lack of competency may be due to an unmet mental health need or have nothing to do with mental illness at all. Lack of competency could be due to a developmental or cognitive disability from a traumatic brain injury or other condition. Competency restoration to a large extent involves delivering mental health or other health care services, 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.[215]

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.[216]

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.[217] They found that 38 of 47 responding states reported an increase in the number of referrals for competency evaluations.[218] The highest ranking potential cause of the increase was the inadequate number of inpatient psychiatric beds in the community.[219] Other potential causes included inadequate general mental health services, inadequate crisis services, and inadequate Assertive Community Treatment services in the community.[220] The majority of respondents cited jail diversion as the solution (55 percent), followed by increasing the number of state hospital beds (43 percent).[221]

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."[222]

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 awaiting 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.[223] In their review of such programs, Disability Rights of California found the following features and benefits: [224]

- 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

California should prioritize expanding similar options, recognizing the ongoing need for improved access to competency restoration services and the resulting backlog of people waiting unnecessarily in jail. However, prioritizing solutions to addressing this backlog also means prioritizing diversion to community-based services as early as possible in the criminal justice trajectory.

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.[225] 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. Restoring competency in the community may require partnership with other local health care plans and providers for people with developmental or cognitive disabilities, including traumatic brain injury.

The state should encourage counties to utilize Mental Health Services Act Innovation funds to address this need for people needing competency restoration services due to unmet mental health needs.

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

DRAFT

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.

DRAFT

California's Council on Criminal Justice and Behavioral Health - formerly the Council on Mentally Ill Offenders[226] - 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.[227] 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.[228] 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.[229] 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.[230] 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.[231] 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.[232]

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 with state and local agencies and community members to develop a statewide diversion plan, and annual updates, 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

DRAFT

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.[233] 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.[234] 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.[235]

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.”[236]

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.[237]

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.[238]

DRAFT

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.[239] 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.[240]

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.

DRAFT

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

DRAFT

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.[241] New approaches for training law enforcement to recognize and ameliorate the effects of implicit bias hold promise for improving policing in communities of color.[242] 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.[243] 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.[244] 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).[245]

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.[246] 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.

The Commission has not assessed the first or second phase of the California Reducing Disparities Project, however, community members have advocated for additional resources to expand community-defined practices for communities of color and LGBTQ communities. The legislature may want to explore additional investment in the California Reducing Disparities Project, or similar efforts, specifically to expand the pool of community-driven practices that reduce criminal justice involvement for people with mental health needs from African American, Latino, Native American, and LGBTQ communities.

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

DRAFT

Summary of Findings and Recommendations

FINDING 1	Too many mental health consumers, particularly those from African American, Latino, Native American, and LGBTQ 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.

The conversation does not stop at this paper – or the next. 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.

DRAFT

Endnotes

[1] Meeting agendas can be found online at http://www.mhsoac.ca.gov/all-events.
[2] Brand, A., staff to MHSOAC committees (email communication, September 5, 2017).
[3] Brand, A., staff to MHSOAC committees (email communication, September 25, 2017).
[4] The subcommittee meeting agenda and supporting materials can be found here: http://www.mhsoac.ca.gov/event/criminal-justicemental-health-subcommittee-september-2017.
[5] 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).
[6] 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.
[7] Torrey, E. F. (1997). *Out of the Shadows: Confronting America's Mental Illness Crisis.* Chapter 3. New York: John Wiley & Sons.
[8] La, E. M., Lich, K. H., Wells, R., Ellis, A. R., Swartz, M. S., Zhu, R., & Morrissey, J. P. (2016). Increasing access to state psychiatric hospital beds: Exploring supply-side solutions. *Psychiatric Services, 67*, 523–528.
[9] California Hospital Association. (2016). *California's Acute Psychiatric Bed Loss*. Available online: http://www.calhospital.org/sites/main/files/file-attachments/6_-_psychbeddata.pdf.
[10] Ibid.
[11] Weatherspoon, F. D. (2007). The Mass Incarceration of African-American Males: A Return to Institutionalized Slavery, Oppression, and Disenfranchisement of Constitutional Rights. *Texas Wesleyan Law Review, 13(2),* 599-618.
[12] Subramanian, R., Henrichson, C., & Kang-Brown, J. (2015). *In our Own Backyard: Confronting growth and disparities in American jails.* New York: Vera Institute of Justice. Available online: https://storage.googleapis.com/vera-web-assets/downloads/Publications/in-our-own-backyard-confronting-growth-and-disparities-in-american-jails/legacy_downloads/incarceration-trends-in-our-own-backyard-fullreport.pdf.
[13] Mueser, K. T., & Drake, R. E. (2007). *Comorbidity: What have we learned and where are we going?* Washington, DC: American Psychological Association.
[14] Lurigio, A. J. (2009). *Comorbidity*. In N. A. Piotrowski (Ed.), Encyclopedia of psychology and mental health (pp. 439-442). Pasadena, CA: Salem Press.
[15] Lurigio, A. J., & Swartz, J. A. (2000). *Changing the contours of the criminal justice system to meet the needs of persons with serious mental illness*. In J. Horney (Ed.), NIJ 2000 Series: Policies, processes, and decisions of the criminal justice system (Vol. 3, pp. 45-108). Washington, DC: National Institute of Justice.
[16] Selbin, J., Campos-Bui, S., Feldstein, S., Fisher, M., & Miller, N. (2016). *California's New Vagrancy Laws: The growing enactment and enforcement of anti-homeless laws in the golden state* (2016 Update). UC Berkeley Public Law Research Paper No. 2794386. Available at SSRN: https://ssrn.com/abstract=2794386 or http://dx.doi.org/10.2139/ssrn.2794386.
[17] Ibid.
[18] National Institute of Mental Health. *The Numbers Count – Mental Disorders in America*. Available online: www.nimh.nih.gov/publicat/numbers.cfm.
[19] Steadman, H. J., Osher, F. C., Clark Robbins, P., Case, B., & Samuels, S. (2009). Prevalence of serious mental illness among jail inmates. *Psychiatric Services, 60(6)*, 761-765.
[20] Teplin, L. A., McClelland, G. M., Abram, K. M., & Weiner, D. A. (2005). Crime Victimization in Adults with Severe Mental Illness: Comparison with the National Crime Victimization Survey. *Archives of General Psychiatry, 62(8),* 911–921.
[21] Barnhorst, A. (personal communication, September 13, 2017).
[22] Skeem, J., Manchak, S., Peterson, J.K. (2011). Correctional policy for offenders with mental illness: creating a new paradigm for recidivism reduction. *Law & Human Behavior*, *35*, 110-126.
[23] Andrews, D., & Bonta, J. (Eds.). (2010). *The Psychology of Criminal Conduct* (5th Edition ed.). New Providence, NJ: Matthew Bender & Company, Inc., Lexis Nexis Group.
[24] Draine, J., Wilson, A., & Pogorzelski, W. (2007). Limitations and potential in current research on services for people with mental illness in the criminal justice system. *Journal of Offender Rehabilitation, 45*, 159-177.
[25] Center for Behavioral Health Statistics and Quality. (2016). *Key substance use and mental health indicators in the United States: Results from the 2015 National Survey on Drug Use and Health* (HHS Publication No. SMA 16-4984, NSDUH Series H-51). Retrieved from http://www.samhsa.gov/data/.
[26] Soderstrom, I. A. (2007). Mental Illness in offender populations: Prevalence, duty and implications. *Journal of Offender Rehabilitation, 45*, 1-17.
[27] Ibid.
[28] Schmidt, L., Greenfield, T., & Mulia, N. (2006). *Unequal Treatment: Racial and Ethnic Disparities in Alcoholism Treatment Services*. National Institute on Alcohol Abuse and Alcoholism.
[29] For more information, please see: http://www.dhcs.ca.gov/provgovpart/Pages/Drug-Medi-Cal-Organized-Delivery-System.aspx.
[30] Andrews, D.A., Zinger, I., Hoge, R.D., Bonta, J., Gendreau, P., & Cullen, F.T. (1990). Does Correctional treatment work? A psychologically informed meta-analysis. *Criminology*, 28, 369-404.
[31] Andrews, D.A., & Bonta, J. (2006). The Psychology of Criminal Conduct (4th ed.). Newark, NJ: LexisNexis
[32] Andrews, D., & Bonta, J. (Eds.). (2010). The Psychology of Criminal Conduct (5th Edition ed.).
New Providence, NJ: Matthew Bender & Company, Inc., Lexis Nexis Group.

[33] 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. Available online: https://www.bja.gov/Publications/CSG_Behavioral_Framework.pdf.
[34] Ibid.
[35] Ibid.
[36] Ibid.
[37] Ibid.
[38] Graif, C., Gladfelter, A. S., & Matthews, S. A. (2014). Urban Poverty and Neighborhood Effects on Crime: Incorporating Spatial and Network Perspectives. *Sociology Compass*, *8*(9), 1140–1155.
[39] Bohn, S., & Danielson, C. (2017). *Just the Facts: Poverty in California*. Retrieved from http://www.ppic.org/content/pubs/jtf/JTF_PovertyJTF.pdf.
[40] Ibid.
[41] Hudson, C. G. (2005). Socioeconomic status and mental illness: Tests of the social causation and selection hypotheses. *American Journal of Orthopsychiatry, 75(1)*, 3-18.
[42] Metraux, S., & Culhane, D. (2006). Recent incarceration history among a sheltered homeless population. *Crime and Delinquency, 52(3):*504-517.
[43] Greenberg, G., & Rosenheck, R. (2008). Jail incarceration, homelessness, and mental health: a national study. *Psychiatry Services, 59(2)*:170-177.
[44] Center for Behavioral Health Statistics and Quality. (2016). *Key substance use and mental health indicators in the United States: Results from the 2015 National Survey on Drug Use and Health* (HHS Publication No. SMA 16-4984, NSDUH Series H-51). Retrieved from http://www.samhsa.gov/data/.
[45] For more information, please see: http://www.hcd.ca.gov/grants-funding/active-funding/nplh.shtml.
[46] For more information, please see: http://www.who.int/topics/social_determinants/en/.
[47] Compton, M. T., & Shim, R. S. (2015). The social determinants of mental health. *Focus*, *13*(4), 419-425.
[48] Sampson, R. J., and Byron Groves, W. (1989). Community structure and crime: Testing social-disorganization theory. *American journal of sociology, 94(4),* 774-802.
[49] Smith, R. J., & Levinson, J. D. (2011). Impact of Implicit Racial Bias on the Exercise of Prosecutorial Discretion. *The Seattle University Law Review, 35*, 795.
[50] Woods, L. N., Lanza, A. S., Dyson, W., & Gordon, D. M. (2013). The role of prevention in promoting continuity of health care in prisoner reentry initiatives. *American Journal of Public Health, 103 (5),* 830-838.
[51] California Department of Corrections (2013). *Prison Census Data as of December 31, 2012*. http://www.cdcr.ca.gov/Reports_Research/Offender_Information_Services_Branch/Annual/Census/CENSUSd1312.pdf.
[52] Ibid.
[53] Center for American Progress & Movement Advancement Project (2016). *Unjust: How the broken criminal justice system fails LGBT people*. Denver, CO: Movement Advancement Project. Available online: http://www.lgbtmap.org/file/lgbt-criminal-justice-unjust.pdf.
[54] Ibid.
[55] Center for American Progress & Movement Advancement Project (2016). Unjust: How the broken criminal justice system fails transgender people. Available online: http://www.lgbtmap.org/file/lgbt-criminal-justice-trans.pdf.
[56] Nadal, K. L., Vargas, V., Meterko, V., Hamit, S., & McLean, K. (2012). Transgender female sex workers: Personal perspectives, gender identity development, and psychological processes. In M. A. Paludi (Ed.), *Managing diversity in today's workplace: Strategies for employees and employers: Vol. 1. Gender, race, sexual orientation, ethnicity, and power* (pp. 123–153). Santa Barbara, CA: Praeger.
[57] Holden, K., McGregor, B., Thandi, P., Fresh, E., Sheats, K., Belton, A., Mattox, G., & Satcher, D. (2014). Toward Culturally Centered Integrative Care for Addressing Mental Health Disparities among Ethnic Minorities. *Psychological Services, 11 (4),* 357–368. http://doi.org/10.1037/a0038122.
[58] Behavioral Health Concepts (2017). *Medical Specialty Mental Health: External Quality Review FY 2016-2017*. Available online: http://caleqro.com/data/reports_and_presentations/Fiscal%20Year%202015-2016%20Reports/CalEQRO_Statewide-Annual-Report_FY15-16.pdf.
[59] Chow, J. C. C., Jaffee, K., & Snowden, L. (2003). Racial/ethnic disparities in the use of mental health services in poverty areas. *American Journal of Public Health, 93 (5)*, 792-797.
[60] Woods, D. V., King, N., Hanna, S. M., & Murray, C. (2012). *We Ain't Crazy! Just Coping With a Crazy System Pathways into the Black Population for Eliminating Mental Health Disparities*. African American Strategic Population Workgroup Report. Available online: https://archive.cdph.ca.gov/programs/Documents/African_Am_CRDP_Pop_Rept_FINAL2012.pdf.
[61] Native American Strategic Population Workgroup Report (2012). *Native Vision: A Focus on Improving Behavioral Health Wellness for California Native Americans*. Available online: http://www.nativehealth.org/sites/dev.nh.edeloa.net/files/native_vision_report_compressed.pdf.
[62] California Mental Health Services Act Multicultural Coalition (2014). *State of the State 4; 2013-2014: Reducing Disparities in Mental Health, Refugee/Asylees and Individuals with Intellectual Disabilities.* Available online: http://remhdco.org/wp-content/uploads/2013/05/State-of-the-State-IV-RefugeeAsylees-Individuals-with-IntellectualDevelopmental-Disabilities-FINAL.pdf.
[63] Lesbian Gay, Transgender, Queer and Questioning Strategic Population Report (2012). *First Do No Harm: Reducing Disparities for Lesbian Gay, Transgender, Queer and Questioning*. Available online: https://archive.cdph.ca.gov/programs/Documents/LGBTQ_Population_Report.pdf.
[64] For more information, please see: https://perception.org/research/explicit-bias/.
[65] For more information, please see: https://perception.org/research/implicit-bias/.
[66] Stier, A., & Hinshaw, S. P. (2007). Explicit and implicit stigma against individuals with mental illness. *Australian Psychologist, 42,* 106–117.
[67] Corrigan, P.W. & Watson, A.C. (2002). Understanding the impact of stigma on people with mental illness, *World Psychiatry, 1(1):*16-20.
[68] Ibid.

[69] Penn, D. L., & Martin, J. (1998). The stigma of severe mental illness: Some potential solutions for a recalcitrant problem. *Psychiatric Quarterly, 69*, 235-247.
[70] U.S. Department of Health and Human Services. (1999*). Mental Health: A report of the Surgeon General*. Rockville, MD: Author.
[71] Brohan, E., &, Thornicroft, G. (2010). Stigma and discrimination of mental health problems: workplace implications. *Occupational Medicine, 60(6*), 414–415. https://doi.org/10.1093/occmed/kqq048.
[72] Iglesias, T. (2002). Managing local opposition to affordable housing: A new approach to NIMBY. *Journal of Affordable Housing and Community Development, 12(1)*, 78-121.
[73] Memo from the California Behavioral Health Directors Association to the legislature. Dated March 23, 2017. Available online: http://www.cbhda.org/wp-content/uploads/2014/12/CBHDA-Memo-CHFFA-SB-82-extension_Final-32317.pdf.
[74] California Budget Fiscal Year 2017-18 included an extension of the Investment in Mental Health Wellness Grant Program until December 31, 2021. For more information, see AB 97 (2017): https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201720180AB97.
[75] Spencer, K. B., Charbonneau, A. K., & Glaser, J. (2016). Implicit Bias and Policing. *Social and Personality Psychology Compass, 10(1)*, 50-63.
[76] Robb, J., & Stone, J. (2016). Implicit bias toward people with mental illness: A systematic literature review. *Journal of Rehabilitation, 82(4)*, 3-13.
[77] President's Task Force on 21st Century Policing (2015). *Final Report of the President's Task Force on 21st Century Policing*. Washington, DC: Office of Community Oriented Policing Services. Available online at http://www.cops.usdoj.gov/pdf/taskforce/TaskForce_FinalReport.pdf.
[78] For more information, please see: https://stepuptogether.org/.
[79] Ibid.
[80] Ibid.
[81] Adams, D., & Siggins, E. (2017). *Understanding and Improving Key Measures to Reduce the Number of People with Mental Illnesses in Jail: Stepping Up California Efforts*. Council of State Governments, Justice Center. Presentation publicly available here: http://www.cdcr.ca.gov/COMIO/Meetings.html.
[82] Haneberg, R., Fabelo, T., Osher, F., & Thompson, M. (2017). *Reducing the Number of People with Mental Illness in Jail: Six Questions county Leaders Need to Ask*. Available online: https://stepuptogether.org/wp-content/uploads/2017/01/Reducing-the-Number-of-People-with-Mental-Illnesses-in-Jail_Six-Questions.pdf.
[83] Munetz, M. R., & Griffin, P. A. (2006). Use of the sequential intercept model as an approach to decriminalization of people with serious mental illness. *Psychiatric Services*, *57(4),* 544-549.
[84] Case, B., Policy Research Associates (personal communication, April 5, 2017).
[85] Munetz, M. R., & Griffin, P. A. (2006). Use of the sequential intercept model as an approach to decriminalization of people with serious mental illness. *Psychiatric Services*, *57(4),* 544-549.
[86] Ibid.
[87] For more information, please see: https://www.prainc.com/wp-content/uploads/2016/11/Intercept-0-Infographic-2.pdf.
[88] Recovery to Practice: Resources for Behavioral Health Professionals and Substance Abuse and Mental Health Services Administration (2015). Practicing Recovery: Outreach and Engagement, 4. Available online here: http://www.ahpnet.com/files/Newsletter_4_Sept_2015.pdf.
[89] California Mental Health Planning Council, Policy Platform, 2017. For more information, please see: http://www.dhcs.ca.gov/services/MH/Documents/PolicyPlatform_2017.pdf.
[90] For more information, please see: http://www.telecarecorp.com/ihot/.
[91] Lamb H. R., Weinberger L. E. (2013). Some perspectives on criminalization. *The Journal of the American Academy of Psychiatry and the Law, 41,* 287-293.
[92] Welfare and Institutions Code (WIC) Sections 5345-5349.5
[93] K. Bunch. Psychologist with the Los Angeles County Mental Health Department and MHSOAC Commissioner (personal communication, October 11, 2017).
[94] Levenson, J., & Grady, M. (2016). Childhood adversity, substance abuse, and violence: implications for trauma-informed social work practice. *Journal of Social Work Practice in the Addictions, 16(1-2),* 24-45.
[95] Woods, D. V., King, N., Hanna, S. M., & Murray, C. (2012). *We Ain't Crazy! Just Coping With a Crazy System Pathways into the Black Population for Eliminating Mental Health Disparities*. African American Strategic Population Workgroup Report. Available online: https://archive.cdph.ca.gov/programs/Documents/African_Am_CRDP_Pop_Rept_FINAL2012.pdf.
[96] For more information, please see: http://www.harmoniouslifesolutions.org/.
[97] For more information, please see: https://www.cdph.ca.gov/Programs/OHE/Pages/CRDP.aspx.
[98] White Bird Clinic, CAHOOTS, http://whitebirdclinic.org/cahoots/.
[99] Coffman, J. M., Wides, C., Niedzwiecki, M., & Geyn, I. (2017). Evaluation of California's Community Paramedicine Pilot Project. Healthforce Center at UCSF. Available online here: https://healthforce.ucsf.edu/sites/healthforce.ucsf.edu/files/publication-pdf/Evaluation%20of%20California%C2%B9s%20CP%20Pilot%20Program_final2%5B1%5D.pdf.
[100] Ibid.
[101] For more information, please see: http://mhsoac.ca.gov/triage-homepage.
[102] For more information, please see: https://www.buttecounty.net/Portals/5/Administration/MHSA/ButteCountyMentalHealthServicesAct(MHSA)2017-2020ProgramandExpenditurePlan.pdf.
[103] For more information, please see: http://www.sbcounty.gov/uploads/DBH/content/MHSA_Three_Year_Plan%202017_18-2019_20.pdf.
[104] Citation forthcoming.
[105] For more information, please see: http://dmh.lacounty.gov/wps/portal/dmh/our_services/countywide?1dmy&page=dept.lac.dmh.home.services.countywide.detail.hidden&urile=wcm%3Apath%3A/dmh+content/dmh+site/home/our+services/countywide+services/countywide+services+detail/aotla.
[106] For more information, please see: http://cit.memphis.edu/aboutCIT.php.

[107] Reuland, M., & Yasuhara, K. (2015). Law Enforcement and Emergency Services. In Griffin, P. A., Heilbrun, K., Mulvey, E. P., DeMatteo, D., & Schubert, C. A. (Eds.), *The sequential intercept model and criminal justice: Promoting community alternatives for individuals with serious mental illness (p.40)*. New York, NY: Oxford University Press, USA.
[108] Implicit bias refers to an unconscious and automatic association made between stereotypes and groups of people. These stereotypes can be about race, gender, age, religion, sexual orientation, or health status, including mental illness.
[109] See National Initiative for Building Community Trust and Justice: https://trustandjustice.org/about/mission.
[110] For more information, please see: http://www.co.fresno.ca.us/uploadedFiles/Departments/Behavioral_Health/MHSA/Approved%20Three-Year%20Plan%20-%20Book.pdf.
[111] For more information, please see: http://www.kcbh.org/uploads/2/6/2/9/26293851/kingsmhsa_-3yearplan-final_20141219-stc__1_.pdf.
[112] For more information, please see: https://www.dhhs.saccounty.net/BHS/Documents/Reports--Workplans/MHSA-Reports-and-Workplans/RT-2016-17-MHSA-Annual-Update--Sacramento-County.pdf.
[113] Griffin, P. A., Heilbrun, K., Mulvey, E. P., DeMatteo, D., & Schubert, C. A. (Eds.). (2015). *The Sequential Intercept Model and Criminal Justice: Promoting Community Alternatives for Individuals with Serious Mental Illness*. Oxford University Press, USA.
[114] For more information, please see:
https://www.marinhhs.org/sites/default/files/libraries/2016_12/12.6.16_bos_approved_mhsa_annual_update_for_fy16-17_fy14-15_services_and_outcomes_-_final.pdf.
[115] For more information, please see: http://file.lacounty.gov/SDSInter/dmh/1017240_MHSA3YearPlanFY17-181-23-17.pdf.
[116] For more information, please see: https://www.sfdph.org/dph/files/CBHSdocs/MHSAdocs/FY2016-2017_AnnualUpdate.pdf.
[117] Judicial Council. *Fact Sheet: Collaborative Justice Courts, July 2017*. Available online:
http://www.courts.ca.gov/documents/CollaborativeCourts_factsheet.pdf.
[118] Ibid.
[119] Thompson, M., Osher, F., & Tomasini-Joshi, D. (2008). *Improving responses to people with mental illnesses: The essential elements of a mental health court*. New York: Council of State Governments Justice Center. For more information, including an up-to-date Mental Health Court Curriculum, please see: https://learning.csgjusticecenter.org/.
[120] Redlich, A. D., & Cusack, K. J. (2010). Mental health treatment in criminal justice settings. Ment*al Health Services: A Public Health Perspective*, *3*, 421-440.
[121] Agency for Healthcare Research and Quality (2015). *National Healthcare Quality and Disparities Report and 5th Anniversary Update on the National Quality Strategy*. http://www.ahrq.gov/research/findings/nhqrdr/nhqdr15/index.html
[122] George, S., Duran, N., & Norris, K. (2014). A systematic review of barriers and facilitators to minority research participation among African Americans, Latinos, Asian Americans, and Pacific Islanders. *American Journal of Public Health, 104(2)*, e16-e31.
[123] For more information, please see: https://www.co.monterey.ca.us/home/showdocument?id=15387.
[124] For more information, please see: http://cams.ocgov.com/Web_Publisher/Agenda05_24_2016_files/images/O00316-000634A.PDF.
[125] For more information, please see: https://www.countyofsb.org/behavioral-wellness/asset.c/3173.
[126] Regenstein, M., & Christie-Maples, J. (2012). *Medicaid coverage for individuals in jail pending disposition: opportunities for improved health and health care at lower costs*. Washington, DC: Department of Health Policy, School of Public Health and Health Services, George Washington University. Available online: http://www.cochs.org/files/GWU/MedicaidCoverage.pdf.
[127] Osher, F. C., Steadman, H. J., & Barr, H. (2002). *A Best Practice Approach to Community Re-Entry from Jails for Inmates with Co-occurring Disorders: The APIC Model*. Delmar, NY: The National GAINS Center.
[128] Bonta, J., & Andrews, D. A. (2007). Risk-need-responsivity model for offender assessment and rehabilitation. *Rehabilitation, 6*(1), 1-22.
[129] Vogel, W. M., Noether, C. D., & Steadman, H. J. (2007). Preparing communities for re-entry of offenders with mental illness: The ACTION approach. *Journal of Offender Rehabilitation, 45(1),* 167–188.
[130] Osher, F., & King, C. (2015). Intercept 4: Reentry from jails and prisons. In Griffin, P. A., Heilbrun, K., Mulvey, E. P., DeMatteo, D., & Schubert, C. A. (Eds.), *The sequential intercept model and criminal justice: Promoting community alternatives for individuals with serious mental illness (p.95)*. New York, NY: Oxford University Press, USA.
[131] Council of State Governments (2016). What Works in Reentry Clearinghouse. https://whatworks.csgjusticecenter.org/evaluation/sacks-et-al-2012-2.
[132] Osher, F., & King, C. (2015). Intercept 4: Reentry from jails and prisons. In Griffin, P. A., Heilbrun, K., Mulvey, E. P., DeMatteo, D., & Schubert, C. A. (Eds.), *The sequential intercept model and criminal justice: Promoting community alternatives for individuals with serious mental illness (p.95)*. New York, NY: Oxford University Press, USA.
[133] Cusack, K. J., Morrissey, J. P., Cuddeback, G. S., Prins, A., & Williams, D. M. (2010). Criminal Justice Involvement, Behavioral Health Service Use, and Costs of Forensic Assertive Community Treatment: A Randomized Trial, *Community Mental Health Journal, 46(4),* 356–363.
[134] For more information, please see: https://www.cibhs.org/sites/main/files/file attachments/cimh_fsp_adult_cr_final.pdf.
[135] For more information, please see: http://www.co.lake.ca.us/Assets/Mental+Health_AODS/docs/MH/Updates/2016-2017+Annual+Update.pdf.
[136] For more information, please see:
http://agenda.slocounty.ca.gov/agenda/sanluisobispo/4911/TUhTQSAyMDE1LTE2IEFubnVhbCBVcGRhdGVfRmluYWwucGRm/12/n/47105.doc.
[137] For more information, please see:
http://www.sandiegocounty.gov/content/dam/sdc/hhsa/programs/bhs/homepage/MHSA/MHSA%20FY2016-17%20Annual%20Update%20FULL%20REPORT%20.pdf.
[138] Glaze, L. E., & Bonczar, T. P. (2009). Probation and parole in the United States, 2008 (Bureau of Justice Statistics Bulletin No. NCJ 228230).Washington, DC: US Department of Justice.
[139] Ibid.
[140] Phelps, M., & Curry, C. (2017-04-26). Supervision in the Community: Probation and Parole. *Oxford Research Encyclopedia of Criminology*. Retrieved 2 Oct. 2017, from http://criminology.oxfordre.com/view/10.1093/acrefore/9780190264079.001.0001/acrefore-9780190264079-e-239.
[141] Ditton, P. (1999). *Mental health and treatment: Inmates and probationers*. Washington, DC: Bureau of

Justice Statistics.
[142] Skeem, J. L., Manchak, S., & Montoya, L. (2017). Comparing public safety outcomes for traditional probation vs specialty mental health probation. *JAMA Psychiatry, 74(9),* 942–948. doi:10.1001/jamapsychiatry.2017.1384.
[143] Louden, J. E., Manchak, S., O'Connor, M., & Skeem, J. L. (2015). Applying the sequential intercept model to reduce recidivism among probationers and parolees with mental illness. In Griffin, P. A., Heilbrun, K., Mulvey, E. P., DeMatteo, D., & Schubert, C. A. (Eds.), *The sequential intercept model and criminal justice: Promoting community alternatives for individuals with serious mental illness (118-131).* New York, NY: Oxford University Press, USA.
[144] Ibid.
[145] Ibid.
[146] Wallace, B. C., Conner, L. C., & Dass-Brailsford, P. (2011). Integrated trauma treatment in correctional health care and community-based treatment upon reentry. *Journal of Correctional Health Care, 17(4),* 329-343.
[147] Lurigio A. J. (2011). People with serious mental illness in the criminal justice system causes, consequences, and correctives. *The Prison Journal, 91(3 suppl):* 66S–86S.
[148] For more information, please see: https://cchealth.org/mentalhealth/mhsa/pdf/2017-0316-three-year-plan.pdf.
[149] For more information, please see: http://www.stanislausmhsa.com/pdf/public/annualupdates/annualupdatefy16-17.pdf.
[150] For more information, please see: http://www.solanocounty.com/civicax/filebank/blobdload.aspx?blobid=25478.
[151] Public Safety Realignment (AB 109, Chapter 15, Stats. 2011) is the 2011 Governor-initiated legislation that keeps non-violent, non-serious, non-sexual offenders in local jails and on probation or in treatment programs instead of sending them to state prisons.
[152] California Code of Regulations, Title 9, Section 3300, subdivision (d).
[153] For more information, please see: http://www.treasurer.ca.gov/chffa/imhwa/.
[154] For more information, please see: http://mhsoac.ca.gov/triage-homepage.
[155] For more information, please see: http://www.bscc.ca.gov/s_cppleadgrant.php.
[156] For more information, please see: http://www.bscc.ca.gov/s_cppmiocr.php.
[157] California Board of Corrections. (2005). *Mentally Ill Offender Crime Reduction Grant Program: Overview of Statewide Evaluation Findings.* Not paginated. Available online: http://sd15.senate.ca.gov/sites/sd15.senate.ca.gov/files/7b.pdf.
[158] For more information, please see: http://www.bscc.ca.gov/s_bsccprop47.php.
[159] For more information, please see: http://www.dhcs.ca.gov/services/Pages/WholePersonCarePilots.aspx.
[160] Pagel, L., Schwartz, T., & Ryan, J. (2017). *The California Whole Person Care Pilot Program: County partnerships to improve the health of Medi-cal beneficiaries*. Harbage Consulting. Available online: http://harbageconsulting.com/wp-content/uploads/2017/02/WPC-Summary_Final_02282017.pdf.
[161] Ibid.
[162] For more information, please see: http://treasurer.ca.gov/chffa/meeting/staff/2016/20160922/8.pdf
[163] For more information, please see: http://mhsoac.ca.gov/triage-homepage
[164] For more information, please see: http://www.bscc.ca.gov/s_cppleadgrant.php
[165] For more information, please see: http://www.bscc.ca.gov/news.php?id=65
[166] For more information, please see: http://www.bscc.ca.gov/s_bsccprop47.php
[167] For more information, please see: http://www.dhcs.ca.gov/provgovpart/Documents/WPCApplicationStats.pdf. The Small County Whole Person Care Collaborative consists of Plumas, Mariposa, and San Benito Counties.
[168] For more information, please see: http://www.bscc.ca.gov/downloads/2017-8-29%20Prop%2047%20Project%20Summaries.pdf.
[169] For more information, please see: http://web2.co.merced.ca.us/pdfs/mentalhealth/mhsa/mhsa_annual_update_2015_2016.pdf.
[170] For more information, please see: http://rivcocob.org/agenda/2016/09_27_16_files/03-24.pdf.
[171] 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.
[172] For more information, please see: http://www.solanocounty.com/civicax/filebank/blobdload.aspx?blobid=25478.
[173] Statements made during a One Mind Initiative at Work event on September 14, 2017 in Saint Helena, CA.
[174] Lamb H. R., Weinberger L. E. (2013). Some perspectives on criminalization. *The Journal of the American Academy of Psychiatry and the Law, 41,* 287-293.
[175] Pursuant to AB 114, Chapter 38, Statutes of 2017, counties have until July 1, 2018 to develop a three year plan to spend an estimated $274 million in unspent Mental Health Services Act funds. For more information, please see: https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201720180AB114.
[176] For more information, please see: https://sfarchdiocese.org/rjministry.
[177] Mitry, R. (public comment submitted October 22, 2017).
[178] For more information, please see: https://www.cdph.ca.gov/Programs/OHE/Pages/CRDP.aspx.
[179] Welfare and Institutions Code Section 5847.
[180] Welfare and Institutions Code Sections 5845(d)(6), 5846(c), and 5847(a).
[181] 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.
[182] Ibid.
[183] California Code of Regulations, Title 15, Section 1207.
[184] California Code of Regulations, Title 15, Section 1210.
[185] California Code of Regulations, Title 15, Section 1200.
[186] California Code of Regulations, Title 15, Section 1209.
[187] California Code of Regulations, Title 15, Section 1217.
[188] Ibid.
[189] California Code of Regulations, Title 15, Section 1214.
[190] Ibid.

[191] California Code of Regulations, Title 15, Section 1030.
[192] 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.
[193] Correspondence from Disability Rights California to the Commission dated July 25, 2017.
[194] For more information, please see: http://www.cdcr.ca.gov/COMIO/Uploadfile/pdfs/2016/Aug17/BSSC%20Training%20and%20Mental%20Health%20.pdf.
[195] Ibid.
[196] Ibid.
[197] Ibid.
[198] For more information, please see: file:///C:/Users/oacashleymills/Downloads/Timetable%20for%20the%20Provision%20of%20Crisis%20Intervention%20Training%20to%20all%20Custody%20Staff.pdf.
[199] Stack, S. J., & Tsoudis, O.(1997). Suicide Risk among Correctional Officers: A Logistic Regression Analysis. *Archives of Suicide Research, 3(3),* 183-186.
[200] Brower, J. (2013). *Review and Input of Correctional Officer Wellness & Safety Literature Review*. OJP Diagnostic Center. Office of Justice Programs.
[201] Spinaris, C. G., Denhof, M. D., & Kellaway, J. (2012). *Posttraumatic Stress Disorder in United States Correctional Professionals: Prevalence and Impact on Health and Functioning*. Florence, CO: Desert Waters Correctional Outreach. Available online: http://www.correctionsfatigue.com/images/PTSD_Prevalence_in_Corrections_2012.pdf.
[202] Richardson, L. K., Frueh, B. C., & Acierno, R. (2010). Prevalence Estimates of Combat-Related PTSD: A Critical Review. *The Australian and New Zealand Journal of Psychiatry*, 44(1), 4–19. http://doi.org/10.3109/00048670903393597.
[203] For more information, please see: http://www.bscc.ca.gov/downloads/SB%20863%20PR%2011.12.15.pdf.
[204] Ibid.
[205] Ibid.
[206] Minnesota Public Radio. http://blogs.mprnews.org/newscut/2016/09/hennepin-survey-shows-link-between-jail-inmates-and-mental-illness/.
[207] 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.
[208] Penal Code Sections 6024-6025.
[209] 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.
[210] Ibid.
[211] 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.
[212] Martin, M. S., Colman, I., Simpson, A. I., & McKenzie, K. (2013). Mental health screening tools in correctional institutions: a systematic review. *BMC Psychiatry, 13*, 275. http://doi.org/10.1186/1471-244X-13-275.
[213] 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.
[214] For more information, please see: https://www.cdph.ca.gov/Programs/OHE/Pages/CRDP.aspx.
[215] Pursuant to California Penal Code Section 1970.
[216] 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.
[217] Warburton, K. "National IST Trends." June 2017. Microsoft PowerPoint file.
[218] Ibid.
[219] Ibid.
[220] Ibid.
[221] Ibid.
[222] Statements made during an interview conducted for this report.
[223] 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.
[224] 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.
[225] Warburton, K. "National IST Trends." June 2017. Microsoft PowerPoint file.
[226] Chaptered by Secretary of State. Chapter 269, Statutes of 2017.
[227] 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.
[228] For more information, please see: http://www.bscc.ca.gov/.
[229] For more information, please see: http://www.cdcr.ca.gov/.
[230] For more information, please see: http://www.mhsoac.ca.gov/.
[231] For more information, please see: http://www.dhcs.ca.gov/services/Pages/default.aspx.
[232] For more information, please see: http://www.dsh.ca.gov/.
[233] 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.

DRAFT

[234] 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.
[235] 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.
[236] Statements made during an interview conducted for this report.
[237] Sharing data must occur within existing privacy laws and regulations, including Health Insurance Portability and Accountability Act, the Lanterman-Petris-Short Act, Title 42 Code of Federal Regulations Part 2, and the California Medical Information Act.
[238] The document can be accessed here: http://www.chhs.ca.gov/OHII/Pages/shig.aspx.
[239] For more information, please see: http://www.dhcs.ca.gov/services/Pages/WholePersonCarePilots.aspx
[240] For more information, please see: http://www.cdcr.ca.gov/COMIO/docs/02022017meeting/Project_Update_020217.pdf
[241] Bertrand, M., Chugh, D., & Mullainathan, S. (2005). Implicit Discrimination. *The American Economic Review, 95(2),* 94–98.
[242] For more information, please see: https://trustandjustice.org/.
[243] 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.
[244] Partnering county associations include the California State Sheriffs' Association, County Behavioral Health Directors Association of California, and Chief Probation Officers of California.
[245] 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.
[246] For more information, please see:
http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/PDF%20F/PDF%20FinePrintExchangingBehavioral.pdf.

DRAFT

AGENDA ITEM 03

Action

November 16, 2017 Commission Meeting

Santa Clara County Innovation Plans

Summary: The Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission) will consider approval of Santa Clara County's request to fund the following four (4) new Innovative projects for a total amount of $7,394,896 (see below for project breakdown).

(A) **Client and Consumer Employment Project - $2,525,148**

(B) **Faith Based Training and Supports Project - $608,964**

(C) **Headspace - $572,273**

(D) **Psychiatric Emergency Response Team (PERT) - $3,688,511**

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.

- Santa Clara County is proposing to implement an employment program for clients with mental health conditions as well as those with co-occurring disorders by implementing the Individual Placement and Support Supported Employment (IPS/SE) model in an effort to assist clients to acquire a position of their choice.
- Santa Clara County is proposing to develop a customized training program for faith/spiritual leaders among five (5) target populations in an effort to engage and provide outreach to those targeted populations who may need services but are not currently referred to behavioral health specialists by their faith/spiritual leader.
- Santa Clara County is also proposing to implement the *headspace* model, based out of Australia, in an effort to provide youth between

the ages of 12-25 years old with coping skills and support systems to allow successful transition into adult-hood and may also provide early identification and intervention related to the signs of mental illness and suicide.

- Lastly, Santa Clara County is proposing to implement a model, originally developed in San Diego, which will teach law enforcement to recognize mental health issues and diffuse crisis situations without using force by including a licensed mental health clinician to accompany law enforcement on emergency calls and the use of peer support to offer post-crisis services.

Presenter(s):

- Toni Tullys, MPA; Director, Santa Clara County Behavioral Health Services
- Jeanne Moral; Senior Health Care Program Manager, System Initiatives
- Evelyn Tirumalai, MPH; Senior Mental Health Program Specialist, MHSA Coordinator
- Lily Vu, MSW; Mental Health Program Specialist II, MHSA Innovations Coordinator
- Steve Adelsheim, MD; Director, Stanford Center for Youth Mental Health and Wellbeing, Stanford Department of Psychiatry

Enclosures (9): (1) Biographies for Santa Clara County Innovation Presenters; (2) Client and Consumer Employment Project Brief (3) Client and Consumer Employment Staff Analysis (4) Faith Based Training and Supports Project Brief (5) Faith Based Training and Supports Staff Analysis (6) Headspace Project Brief (7) Headspace Staff Analysis (8) Psychiatric Emergency Response Team (PERT) Project Brief (9) Psychiatric Emergency Response Team (PERT) Staff Analysis.

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:

http://mhsoac.ca.gov/document/2017-11/santa-clara-county-inn-plan-description-client-and-consumer-employment-project

http://mhsoac.ca.gov/document/2017-11/santa-clara-county-inn-plan-description-faith-based-training-and-supports-project

http://mhsoac.ca.gov/document/2017-11/santa-clara-county-inn-plan-description-headspace

http://mhsoac.ca.gov/document/2017-11/santa-clara-county-inn-plan-description-psychiatric-emergency-response-team-pert

Proposed Motion: The MHSOAC approves Santa Clara County's Innovation Projects, as follows:

Name: Client and Consumer Employment Project
Amount: $2,525,148
Project Length: Three (3) Years

Name: Faith Based Training and Supports Project
Amount: $608,964
Project Length: Two (2) Years

Name: Headspace
Amount: $572,273
Project Length: Eight (8) Months (Ramp-up Period Only)

Name: Psychiatric Emergency Response Team (PERT)
Amount: $3,688,511
Project Length: Two (2) Years

Toni Tullys, MPA
Director, Department of Behavioral Health Services
Since December 2014, Ms. Tullys has been the Behavioral Health Services Director in the Santa Clara Valley Health and Hospital System. Ms. Tullys has an extensive career in health care, having held a number of leadership roles, and has worked in the mental/behavioral health field for the past twelve years. Prior to joining Santa Clara County, she served as Alameda County's Deputy Director of Behavioral Health Care Services. Ms. Tullys is committed to improving the health status of the residents and communities served by Behavioral Health Services and supporting the vision of "Better Health for All." She earned her BS at California State University East Bay and her Master's in Public Administration at the University of Southern California.

Steven Adelsheim, MD
Director, Stanford Center for Youth Mental Health and Wellbeing
Clinical Professor & Associate Chair for Community Engagement
Stanford's Department of Psychiatry and Behavioral Sciences
Dr. Adelsheim's work focuses on developing and implementing early detection/intervention programs for young people in school-based and community settings, including programs for those with depression, anxiety, and early psychosis, as well as work in youth suicide prevention, mental health policy, tele-behavioral health and tribal mental health. Dr. Adelsheim has worked for many years in developing early intervention programs for adolescents and young adults in schools, school-based health centers, via tele video and other community settings. Dr. Adelsheim received his BA from Harvard College and his Medical Doctor degree from the University of Cincinnati, College of Medicine.

Jeanne Moral
Senior Health Care Program Manager
Jeanne has held the position of the Mental Health Services Act (MHSA) Coordinator, working closely with Leadership, Finance, Division Managers, Contracts and a broad array of community stakeholders. As a Senior Manager, she provides support to BHSD Director and Leadership on integration efforts and organizational initiatives.

Evelyn Castillo Tirumalai, MPH
MHSA Coordinator
Evelyn previously coordinated the work of multiple workgroups and community collaborators in the implementation of the Santa Clara County Suicide Prevention Strategic Plan. Evelyn has over 20 years of experience working in non-profit and county program management, implementation and evaluation. She led community-participatory research at the Stanford Prevention Research Center for large-scale, multi-setting, interdisciplinary prevention studies.

Lily Vu, MSW
MHSA Innovations Coordinator
Lily was recently appointed MHSA Innovations Coordinator. Lily joined Santa Clara County in 2011 as Prevention Program Analyst in the Behavioral Health Services Department. She helped establish strong community-school networks through School Linked Services and provided oversight and guidance to service contractors within the Families and Children's Division. Lily brings over 15 years of community serving experience in project coordination and stakeholder engagement in supporting Santa Clara County students, families, and consumers.

Title: Client and Consumer Employment and Supports (INN-11)

Statement of Need

Advancing recovery initiatives for mental health consumers is a current focus and aim of Behavioral Health Services Department. Having a job contributes to a person's overall sense of well-being and can be a significant contributor toward achieving and maintaining recovery from mental illness. Employment brings stability as well as tools for managing life circumstances and symptoms. From FY11/12 to FY14/15, the Department of Rehabilitation (DOR) reported placements for SMI clients/consumers has been between 31%-47%. This is 20% less than reported rates of placements among counties utilizing the Individual Placement & Support Supported Employment (IPS/SE). Current DOR services operate on a passive recruitment model for referrals (presentations at agencies for staff to refer); employment goals are not systematically normalized as an expected treatment goal; irregular discussions on clients'/consumers' employment related services and goals; primary emphasis on long-term employment placements (as opposed to customized job placements based on client/consumer need and availability due to motivation or circumstance), among others. Due to these factors, clients/consumers wishing to work sometimes wait up to 5 months before employment support is provided.

Proposed INN Project

The Client and Consumer Employment Project aims to engage clients and consumers to identify their employment goal(s) as part of their treatment plan. The project will adapt the Individual Placement & Support Supported Employment (IPS/SE) model to a new setting, Santa Clara County, with the intention of transforming how the overall system views employment and start recognizing employment as a wellness goal for behavioral health consumers and an element of their treatment. Until the development of the IPS/SE model, there were no alternatives to the traditional delivery of employment supports specifically targeted for people with serious mental illness (SMI). This model is an evidence-based practice developed to significantly increase employment outcomes. The IPS/SE model reflects zero exclusion in the employment program model. The project will create the foundation for Santa Clara County's employment based programming for SMI clients/consumers by including employment as a component of their treatment plan.

Learning and Evaluation

- Through the project, BHSD intends to change how the overall system views employment and start recognizing employment as a wellness goal for clients/consumers. Evaluation of the project will occur throughout the term of the project. This project seeks to test and measure to what extent does the new employment approach impact those in the County system who are currently unemployed in the following measures:
    - Percentage of program participants who participate in IPS/SE
    - Percentage of program participants with identified employment goals
    - Average number of hours worked per week
    - Total hours worked during the year

- Total earnings during the year
- Total months employed
- What are the overall outcomes identified by Santa Clara County clients/consumers participating in IPS/SE?

Consumer-centered outcome measures for this project have the potential for statewide learning by providing clear wellness indicators employment specialists and those working with clients/consumers can incorporate in treatment plans and follow up with SMI populations.

Community Planning Process

Three employment idea concepts were received from three separate community based organizations in Santa Clara County serving the following priority populations: Transition Age Youth and Adult/Older Adults communities with SMI. All concept ideas emphasized the need for increased employment opportunities for persons with SMI who want to work.

Additionally, a focus group was held on April 7, 2016 to gather input on project aim and design. Service providers as well as consumers and client groups participated in the meeting and endorsed the project concept. Additional meetings were held with the MHSA Stakeholder Leadership Committee, representative of a diverse group of stakeholders, consumers and family members, before the formal 30-day public review process was started. The public hearing held in early September 2017 provided additional opportunities for input resulting in supportive comments regarding the project from target population. The County Board of Supervisors unanimously approved and adopted this project on September 26, 2017.

Budget

The total project budget is $2,525,148 which includes external evaluation for a three-year project. The County plans to procure and release a request for proposal (RFP) in the amount of $2,375,148 for services to be provided in three communities: TAY, Adult, and Older Adult with SMI. Approximately 82% of the funds will go to pay personnel to hire 6 full time vocational generalist positions (employment specialists), and three .25 clinical management supervisors at three service centers. Overhead costs represent 15% of the total budget. $150,000 has been allocated for evaluation services.

STAFF INNOVATION ANALYSIS— SANTA CLARA

Name of Innovative (INN) Project: Client and Consumer Employment Project

Total INN Funding Requested for Project: $ 2,525,148

Duration of Innovative Project: Three (3) Years

Review History

- Approved by the County Board of Supervisors: 9/26/2017
- County Submitted Innovation (INN) Project: 7/18/2017
- MHSOAC Consideration of INN Project: 11/16/2017

Project Introduction:

The County proposes to increase the quality of services, including better outcomes for TAY, adults, and older adults with mental health conditions as well as those with co-occurring disorders. The County will accomplish this by implementing the Individual Placement and Support Supported Employment (IPS/SE) model. The IPS/SE model is a supported employment evidence-based practice that helps clients acquire a position of their choice in the community with rapid job-search and placement services. Services involve individualized follow-along services and do not follow a specific time schedule. The model emphasizes that work is not the result of treatment and recovery, but integral to both. By implementing this program, the County will include employment as a wellness goal for behavioral health clients. The County will implement IPS/SE at three (3) different sites with each site including two (2) Full Time Equivalent (FTE) Employment Specialists and one (1) 0.25 FTE Clinical Management Supervisor. The employment specialists will be an integral part of the client's service team to ensure employment goals are reinforced. Ideally, employment services will be provided faster, more clients will be provided services, and services will be specific to each client. The County specifies the innovative element of this program is the adaptation of the model to a new setting (Santa Clara County) with the intention of transforming how the system views employment to recognize employment as a wellness goal for behavioral health clients.

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 aligns 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

Beginning in 1992, the County contracted with the Department of Rehabilitation (DOR) to implement employment services to people living in Santa Clara County. While the DOR program has been stable for over 25 years the County expresses it is the only employment service option for people living with a serious mental illness. The County states that the system the DOR uses is based on a model that is not effective for clients with serious mental illnesses. Many clients with a serious mental illness are screened out of the program due to not meeting the criteria, even though they want to work. For those who do make it past the screening process, the County states their placement is only successful between 31%-47% of the time. The County believes the issue with low success rates is because employment is not seen as a treatment goal for clients receiving mental health services. Further, the eligibility process is lengthy and not individualized for the client.

The County believes there is a broader need to recognize employment as a goal for clients receiving mental health services. The County references that 2/3 of people with a mental illness want to work, however there is an employment rate of 8.3% for adults with a mental illness in California. The County claims that employment will play a significant factor in a person's recovery from mental illness. Employment leads to structure, self-worth, financial freedom, among other criteria the County states are vital for recovery. **The County may wish to provide specific information as to how this was a demonstrated need in their community.**

The Response

The County is seeking to support SMI clients' desire to participate in employment programs and see it as a methodology for increasing service quality and better outcomes. As part of this Innovation project, Santa Clara would like to adapt the Individual Placement & Support Supported Employment (IPS/SE) model to a new setting, Santa Clara County. This employment model has been researched and is proven to be evidence-based to significantly increase employment outcomes for people who have a mental illness.

Individual Placement and Support (IPS) is an approach to helping people with SMI achieve employment based on eight principles which have proven to be successful both in and outside of the United States. In studies conducted, nearly 56% of IPS participants were able to obtain employment compared to 23% who were in control groups (Bonds, et al., 2012). The IPS/SE model is designed to not

exclude SMI clients by incorporating employment, at a job of their choosing, into their treatment goals. The County indicates that the IPS modality works in collaboration with DOR counselors, utilizing a multi-disciplinary approach to providing individualized services for SMI clients, however the county states that these outcomes have changed as a result of the changes made to the DOR's screening criteria.

The County will target transitional aged youth (TAY), adults, and older adults with mental health conditions, including those with co-occurring disorders. Santa Clara County will implement the IPS/SE model in three (3) sites with the County with the goal of engaging clients and consumers in incorporating employment as part of their treatment plan. It is expected the County will place 240 clients annually over the three-year period.

As part of this project, the County would like to hire two (2) FTE employment specialists as well as a part time clinical management supervisor for each program site, three (3) sites in total. Santa Clara County states the project introduces a new practice or approach to the overall mental health system by hiring employment specialists to incorporate employment as a component of their treatment goal for SMI clients seeking employment.

The County may wish to explain the screening criteria that was amended by the local DOR office which resulted in screening out "many" SMI clients, and clarify their ongoing relationship with DOR Counselors.

The Community Planning Process

The County submitted a total of four (4) Innovation projects. For this particular Innovation project, the County described how stakeholders and the public were involved during the Community Planning Process (CPP) of Innovation project. Beginning in 2015, the County held an MHSA Stakeholder Leadership Committee (SLC) meeting to explain the Innovation Planning Process to stakeholders and the public. The innovation plans were selected through two separate "submission windows", where stakeholders and the public could electronically submit their innovation ideas. During the first submission window, stakeholders and the public were asked to consider six guiding principles the county believed represent MHSA values.

1. Consumer and Family member involvement;
2. Culturally responsive approaches;
3. Life span focus (across ages);
4. Innovative care practices;
5. Strategic care transitions;
6. Meaningful outcomes.

Following the submission window, another MHSA SLC meeting was held to share which three (3) submissions the County would pursue. The County held one (1) focus group

for each of the three (3) projects, and from the input received the County refined each project concept.

For the second submission window, the County identified four (4) additional principals to consider for the final project that would support clients, consumers, families, and communities.

1. Culturally responsive trainings/outreach designed by diverse communities;
2. Outreach and engagement for older adults with linkage to behavioral health services;
3. New and emerging prevention services for children;
4. TAY support and care.

Following the submission window, another SLC meeting was held and attendees participated in the selection of the final innovation plan.

The Client and Consumer Employment Innovation Plan identifies transitional age youth, adults, and older adults with mental health conditions as well as those with co-occurring disorders as the target populations. **The County may wish to discuss how the target population was included in the development of this innovation project.**

Learning Objectives and Evaluation

The overall goal of Santa Clara County's Innovation project is to improve the quality of current services surrounding employment by adapting the Individual Placement & Support Supported Employment (IPS/SE) model into individual wellness and recovery treatment plans. The target populations for this project are transitional aged youth, adults, older adults with mental health conditions, as well as individuals with co-occurring disorders. Throughout the duration of the project, the County intends on serving 240 placements out of 400 clients at three sites with a 60% placement goal.

Santa Clara will measure the overall goal of the project by tracking increases in the number of referrals, number of clients served, placements, and successful case closures. To do so, the County will collect the following data elements: number of participants, number of people who achieved job placement, length of time to secure employment, hours worked and earnings for each participant, length of time to obtaining employment using IPS/SE model versus traditional services provided by the Department of Rehabilitation. These data will be compared to employment outcome information provided by the Department of Rehabilitation in order to understand the impact the IPS/SE model has had on employment among the target population. These outcomes, measurements, and data elements are appropriate for evaluative purposes. **The County may wish to clarify how the outcomes of this project will contribute to statewide learning.**

The Budget

The proposed budget for this Innovation Project is $2,525,148 over three (3) years. The majority of the costs (82%) are for salary and benefits ($1,827,037) to hire six (6) full-time employment specialists and three (3) .25 FTE clinical management supervisors.

The County lists operating and overhead expenditures as $274,056, which is 15% of the total budget for each line item. The evaluation component will be contracted out and the County has allotted $150,000 (6%) of the total budget.

Santa Clara is funding this Innovation Project with MHSA Innovation funds entirely and will not be utilizing other federal funding sources. The County indicates once the project has concluded, the evaluation report will be reviewed and will then develop recommendations regarding the future of the project.

Additional Regulatory Requirements

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

References

Bonds, G., Drake, R., Becker, D. (2012). Generalizability of the Individual Placement and Support (IPS) model of supported employment outside the US. Retrieved October 16, 2017 from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3266767/

http://www.dor.ca.gov/VRED/Am-I-Eligible-4-VR-Services.html

https://www.bls.gov/cps/cps_htgm.pdf

Title: Faith Based Training and Supports Project (INN-10)

Statement of Need

According to a 2015 study by the Center for Religion and Civic Culture at the University of Southern California, about 40% of Santa Clara County's population stated belonging to a faith group. This percentage represents over 670,000 residents. From a populations-health perspective, faith community leaders are gatekeepers or "first responders" when individuals and families face behavioral health problems. In that role they can help dispel misunderstandings, reduce stigma associated with mental illness and treatment, and facilitate access to treatment for those in need. "…for many who seek mental health support, spirituality significantly influences their internal and external lives and are an important part of healing," according to the American Psychiatric Association (APA). Faith and spirituality often play a vital role in healing, people experiencing mental health concerns often turn first to a faith leader as described in the APA report.

The need in Santa Clara County for faith-based behavioral health trainings has been demonstrated through existing faith-based service providers as well as faith community input in the community planning process. Santa Clara County's existing faith-based support systems, known as re-entry services, work to create supportive environments for individuals entering society from incarceration. The focus of these services are for felt-needs as a primary goal. According to the Faith Based Collaborative, other than providing for basic necessities, these centers don't always have a comprehensive understanding of the signs and symptoms that may require accessing appropriate professional help. In a recent annual report, four re-entry centers indicated providing fellowship and connections to faith community as a service component to criminal justice-involved participants at the participants' request. Additionally, a Self Sufficiency Matrix tool revealed that being *Connected to Spiritual Community* was a top 10 domain to achieving self-sufficiency among re-entry participants.

In 2016, the Santa Clara Faith Formation Conference organized by the Diocese of San Jose sponsored mental health promotion workshops and hosted a suicide prevention training for youth pastors and leaders by request from congregants. The increased need for a formal, standardized faith leader training on "behavioral health 101" is growing and, similarly, is the increased need for behavioral health direct care providers to adopt faith and spirituality into their practice as recommended by the Substance Abuse and Mental Health Services Administration's (SAMHSA) Faith-Based and Community Initiatives (FBCI) project.

Proposed INN Project

The primary goal of the Faith-Based Training and Supports Project is to increase access to services by implementing customized faith-based behavioral health training plans that would provide faith community leaders with skills for appropriate, supportive responses to those seeking their help due to behavioral health challenges. Additionally, the project would develop faith-informed behavioral health workshops for behavioral health direct care providers. The dual benefit would be to further decrease stigma about help-seeking behaviors by normalizing behavioral health linkages and referrals to County services. The American Psychiatric Association's

handbook of diagnostic classification (DSM-5) addresses religion and spirituality as factors that may affect the diagnosis, course, prognosis, or treatment of a patient's mental disorder and as such deserve attention in the course of treatment. A behavioral health provider's understanding of faith and spirituality is critical to the client/consumer's progress in recovery and wellness goals. This initiative would bring both faith community leaders and behavioral health direct care providers to the table to create and facilitate the intersection of faith in recovery goals. Furthermore, the project seeks to build a partnership through an Advisory Group to foster respectful, collaborative relationships between mental health professionals and faith community leaders that would lead to improved quality of care for individuals facing mental health challenges. Community connectedness and support, like that found in faith-based organizations, are important to the long-term recovery of people living with mental illnesses.

Current *canned* educational interventions are designed for mainstream populations. Even some of these evidence-based approaches have added supplements for specific needs such as law enforcement or primary care settings, none exist for customized faith-based behavioral health promotion, identification and referral. Additionally, whereas there is trauma-informed and culturally appropriate approaches to behavioral health delivery and treatment, all come short of a faith-informed approach.

Led by a Community-Based Organization working with faith communities, focus groups will be created by direct solicitation of the faith-based resource centers providing faith-based services to county consumers. To ensure the priority target groups are clearly represented, deliverables for the independent implementation and outcomes evaluator, would include establishing focus group selection criteria with direct input from target groups to ensure a fair and unbiased process.

There are over 450 temples, mosques, churches and places of worship in the County of Santa Clara representing over 670,000 persons of faith. A faith community leader cohort recruitment of 150-200 during the length of the project, would cover 30% of these locations with a potential to positively affect over 1500 adherents in their communities. A cohort of approximately 15-20 behavioral health direct care service providers would create a foundation for faith-informed behavioral health supports and treatment to test out the training workshop components.

Learning and Evaluation

Faith-Based Training and Supports Project aims to provide sound field work discovery of customized faith-based behavioral health training curricula with a focus on increasing access to services, normalizing treatment and improving recovery goals among those receiving referral linkages from spiritual leaders. In turn, the project seeks to learn the impact this approach has on improved health status of clients and consumers receiving treatment using faith-informed recovery plans and interventions.

Focus groups would provide opportunities to analyze the characteristics that are at the very core of faith communities. According to www.faith-hope-life.org, these characteristics include: promoting hope; building healthy social connections; providing answers to life's challenging questions; recognizing and celebrating the myriad reasons for living and the value of each member in the community, no matter how young or old, weak or strong, healthy or ill. These elements would be critical in designing training tools geared toward supporting those who face mental health challenges and/or problems with misuse of alcohol and other drugs, as they seek adequate supports (from faith leaders) and effective treatment (from behavioral health direct care providers).

The impact of this approach would contribute to statewide learning as we explore and measure the following questions:

1. Does a comprehensive faith-based behavioral health training improve faith community leaders' knowledge, attitudes and behavior in the identification, support and referral of individuals with behavioral health conditions?
2. To what extent is stigma reduced among faith communities participating in faith-based trainings?
3. How does a faith-based training workshop series impact behavioral health direct care providers' work with clients/consumers?

Community Planning Process

The County's Innovations Ideas solicitation process resulted in this concept idea from faith community members including, Wesley Mukoyama, LCSW. Mr Mukoyama, a founding member of Santa Clara County's Faith Based Collaborative, along with other faith community leaders in the Behavioral Health Board. A stakeholder community focus group was held on April 16, 2016 to address the concept idea, clarify project goals and solicit target population guidance and feedback. Additional meetings were held with the MHSA Stakeholder Leadership Committee, representative of a diverse group of stakeholders, consumers and family members, before the formal 30-day public review process was started. The public hearing held in early September 2017 provided additional opportunities for input resulting in supportive comments regarding the project from target population. The County Board of Supervisors unanimously approved and adopted this project on September 26, 2017.

Budget

The total project budget will be $608,964 which includes external evaluation costs. $391,510 (64%) of the funds will go to pay personnel. A cohort of 5 project coordinators from the diverse communities in Santa Clara County will be employed in the project at half time for a cost of $304,875 during the 24 months duration of the project. Operations costs will include fees for specialized trainings on basic mental health 101 and related meeting costs at a total operating and overhead cost of $117,453. A cost of $100,000 for project evaluation is also included in this budget.

STAFF INNOVATION ANALYSIS— SANTA CLARA

Name of Innovative (INN) Project: Faith Based Training and Supports Project

Total INN Funding Requested for Project: $ 608,964

Duration of Innovative Project: Two (2) Years

Review History

- Approved by the County Board of Supervisors: 9/26/2017
- County Submitted Innovation (INN) Project: 7/18/2017
- MHSOAC Consideration of INN Project: 11/16/2017

Project Introduction:

The County proposes to increase access to services by developing a customized "Behavioral Health 101" (BH 101) training program for faith/spiritual based leaders. Faith leaders will in turn develop a training for Behavioral Health specialists, County staff, and service providers on the role of spirituality in wellness and recovery. The primary goal is to determine if the project will help engage and outreach target populations and provide the populations needed services through faith based leader referrals. The County identified the African-American, Chinese, Filipino, Latino, and Vietnamese communities as targets for the innovation project. The County will develop customized training programs for each of the selected communities. The secondary goal is to see if technical assistance training from spiritual leaders will result in the behavioral health specialists better understanding clients who see faith as a part of their recovery.

The County will be making a change to an existing mental health practice by adapting the Mental Health Safety First (MHSF) model to include two innovative processes. First, the County will develop customized training plans tailored to the faith/spiritual communities in the County. Second, the faith and spiritual leader participants will provide technical assistance and training to the County's behavioral health specialists. The "BH 101" program proposes to hire one 0.50 FTE coordinator for each of the five target populations and one 0.25 FTE coordinator to manage the efforts of the five coordinators.

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 aligns with the core MHSA principles, promote learning, funds exploration of a new and/or locally adapted mental health approach/practice, and targets one of the four allowable primary purposes.

The Need

The County states that individuals and families in mental health distress, more often than not, first seek help from faith or spiritual leaders who may not be aware of services in the area. The County cites a study conducted in 2010 that found 38% of Santa Clara County (SCC) residents were linked to a religious/spiritual group. Furthermore, SCC states many faith leaders do not have the skill set or understanding to respond appropriately to their parishioners in mental health distress. Faith leaders also may shy away from discussing mental health issues, including suicide related issues/prevention. The county rationalizes that access to services will increase by mitigating the lack of mental health skills and understanding among faith leaders in five target populations: African-American, Chinese, Filipino, Latino, and Vietnamese. Santa Clara County also suggests that behavioral health specialists do not have a satisfactory understanding of faith as a part of the client's recovery, when the consumer includes faith as part of their identity. The county believes the faith leaders could play a part in educating behavioral health specialists about the importance of faith with some consumers.

Our research discovered statistics that validate some of the county's findings related to consumers reaching out to faith based leaders. The Mental Health Ministries: Resource/Study Guide for Clergy and Communities of Faith stated over 40% of Americans with mental health issues first turn to a faith based leader. A Los Angeles County Department of Mental Health brochure on mental health and religion/spirituality stated over 70% of mental health consumers/family members in California want to discuss spiritual concerns with behavioral health specialists upon request.

The County may wish to provide specific information as to how this was a demonstrated need in their community.

The Response

Santa Clara County states that this innovative project will increase access to services by providing education to faith and spiritual leaders so that they may be able to assist their parishioners more effectively, and if necessary, make referrals to resources within the Santa Clara County Behavioral Health Services Department (BHSD). The County states they are diverse and rich in cultural history and as a result, there are several faith groups that are attended predominantly by members within their community. The County references a report based on data in 2010, generated from the Center for Religion and Civic Culture at University of Southern California which listed the ten largest faith groups for Santa Clara County. The report was able to link approximately 38% of Santa Clara County's population to specific faith groups. It is the belief of the County that by educating faith and spiritual leaders about the availability of certain behavioral health services for their religious community members may be able to receive behavioral health services more immediately since the County states that more people in mental health distress seek help from their faith or spiritual leaders first. Additionally, Santa Clara County also claims that some spiritual and faith leaders may shy away from mental health issues such as suicide. For this reason, the County would like to create an educational training program which will be tailored and implemented for use by faith and spiritual leaders within the County.

Santa Clara County states the development of the education training will involve five (5) identified target populations: African-American, Chinese, Filipino, Latino, and Vietnamese. Initially, focus groups consisting of faith and spiritual leaders will be given an assessment to determine their knowledge pertaining to their behavioral health knowledge. Based on these findings, a behavioral health training program will be developed and created by an outside contractor which will be hired by the County. The County states that faith and spiritual leaders will also provide tutelage and technical assistance trainings to licensed behavioral health professionals, County staff and contract service providers on the role that faith and spiritual leaders play in the wellness and recovery of their constituents. **The County may wish to elaborate on how the focus groups will be created and how the spiritual leaders will be selected to ensure unbiased and fair solicitation/selection of participants.**

As part of the County's research, Santa Clara states that Orange County has an innovation project ("Religious Leaders Behavioral Health Training Services") that utilizes a standardized training program without specifically targeting any particular group or community. Santa Clara County claims their project is innovative in that it will involve the creation and development of a customized behavioral training program tailored to faith and spiritual communities targeting the five (5) populations (African-American, Chinese, Filipino, Latino, and Vietnamese). **The County may wish to provide clarity on the number of persons in each target population they intend to serve.**

The Community Planning Process

The County detailed the inclusion of how stakeholders and the public were involved during the Community Planning Process (CPP). This is one of the four (4) proposed innovation plans. Beginning in 2015, the County held an MHSA Stakeholder Leadership

Committee (SLC) meeting to explain the innovation planning process to stakeholders and the public. The innovation plans were selected through two (2) separate "submission windows", where stakeholders and the public could electronically submit their innovation ideas. During the first submission window, stakeholders and the public were asked to consider six (6) guiding principles the county believed represent MHSA values.

1. Consumer and Family member involvement;
2. Culturally responsive approaches;
3. Life span focus (across ages);
4. Innovative care practices;
5. Strategic care transitions;
6. Meaningful outcomes.

Following the submission window, another MHSA SLC meeting was held to share which three (3) submissions the County would pursue. The County held one (1) focus group for each of the three (3) projects, and from the input received the County refined each project concept.

For the second submission window, the County identified four (4) additional principals to consider for the final project that would support clients, consumers, families, and communities.

1. Culturally responsive trainings/outreach designed by diverse communities;
2. Outreach and engagement for older adults with linkage to behavioral health services;
3. New and emerging prevention services for children;
4. TAY support and care.

Following the submission window, another SLC meeting was held and attendees participated in the selection of this Innovation plan.

The County may wish to discuss how the target population was included in the development of this innovation project.

Learning Objectives and Evaluation

The County has identified increasing access to services as their intended outcome for this project. To do so, the County will implement a behavioral health training plan for faith and spiritual leaders, with the intent that these plans will better help these leaders assist in linking individuals in their community with referrals to County behavioral health services. The target population of this project includes faith/spiritual leaders serving in the African-American, Chinese, Filipino, Latino, and Vietnamese communities of Santa Clara County. While the intent is to provide spiritual leaders with appropriate training that is spiritually competent, **the County may wish to clarify how their current training plans are insufficient.**

In order to develop their behavioral plan, Santa Clara County will hold focus groups to gather data on baseline knowledge among faith/spiritual leaders relative to mental health and substance use. Results from these focus groups will be used to create a behavioral health training plan to meet the needs "determined by the pre-test." Here, it is unclear what types of needs, information, and outcomes the County expects to gather from the focus groups. **The County may wish to clarify what type of information is expected to come out of these focus groups and how they will inform the development of a behavioral health training plan.**

Once behavioral training plans have been developed and faith/spiritual leaders have been trained, the County will provide a post-test to these leaders to test their current knowledge. It is unclear at what point the post-test will be administered and the County is advised to allow for enough time in between pre- and post-test in order to better understand the impact the training plan had on the faith/spiritual leaders.

Throughout the project, the County plans on not only tracking the behavioral health knowledge among faith/spiritual leaders, but also the number of referrals provided to individuals in the community. Here, it is expected that the increase in knowledge among faith/spiritual leaders due to the developed training plan will lead to an increase in referrals to services among consumers in their respective communities. Without an identified comparison—whether it is a group, or past referral history—it is unclear how the County will gain an understanding as to whether the behavioral health training plan had a true impact on increasing access to services. Similarly, it is unclear if the outcome is simply a referral to a service or if the County plans on tracking disposition and whether or not the consumer made use of the referral to services. **The County may wish to develop a method to compare the outcomes of their training plan to current referral methods along with past training plans in order to test the intended impact of the project and how it will contribute to statewide learning.**

<u>The Budget</u>

Santa Clara County's budget for this innovation plan is $608,964 for a total of two (2) years in duration. A total of $391,510 (64%) of the budget is allocated for personnel expenses. The County states they will hire 5 half-time coordinators (one for each faith-based target population) and one (1) part time position to provide coordination for the five (5) half-time coordinators for this project. For FY 18/19, personnel costs will be $192,625. For FY 19/20, personnel costs increase to $198,885.

Operating and overhead expenses each total $58,727, which is 10% of the budget. The evaluation component totals $100,000 ($50,000 per each fiscal year) and is approximately 16% of budget total. The County wishes to utilize MHSA Innovation Funds and will not seek to use any other type of funding.

Additional Regulatory Requirements

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

References

http://www.mentalhealthministries.net/resources/study_guide/mental_illness_study_guide.pdf

http://www.mentalhealthministries.net/resources/brochures/lacounty_mentalhealth/LACounty_spirituality.pdf

Center for Religion and Civic Culture, Religious Demographics for Santa Clara County. Retrieved October 21, 2017 at https://crcc.usc.edu/santaclara/

Title: *headspace (INN-13)*

Statement of Need

According to the U.S. Census in July 2015, the estimated population of Santa Clara County was 1,918,044. Approximately 23% of the population was under the age of 18. Fifty six percent (56%) of the population was White, 36% Asian, 26% Latino or Hispanic, some White and some non-White, and 3% African American. Additionally, traditionally marginalized youth, such as youths who identify themselves as Lesbian, Gay, Bisexual, Transsexual and Queer (LGBTQ), foster and homeless youth, and youth whose primary language is not English have been historically not captured in most data analysis and traditional systems of care may not appropriately address their needs.

Young people with emerging mental health issues have difficulty finding timely, appropriate treatment and a service system that can respond to their needs. Where support is available, young people rarely receive holistic services even though mental health problems often coexist with other physical, social and emotional problems. Young people often reach our health, social service, or justice systems until their mental health problems have become more severe and often more difficult and costly to treat. This can lead to devastating outcomes for young people as demonstrated by a recent thorough review of youth suicide issues in Santa Clara County by the CDC and SAMHSA, known as the Epi-Aid process. The full report and PowerPoint documents are available at this website: https://www.sccgov.org/sites/phd/hi/hd/epi-aid/Pages/epi-aid.aspx. One of the report's recommendations was to increase access to evidence-based, confidential and comfortable youth services in order to decrease suicide risk.

Additionally, beginning in the Fall of 2014, with funding from the Robert Wood Johnson Foundation, Stanford Psychiatry Center for Youth Mental Health and Wellbeing conducted a feasibility study to assess the feasibility of successfully importing a "one-stop shop" model of care for youth, ***headspace*** from Australia, to the United States. This study concluded that, while financial modeling for a wholistic service model for youth in the US is certainly complicated, there is clear value in developing one in the United States. Currently, there is no similar public mental health structure for emerging behavioral health conditions in place for young people in the US.

Proposed INN Project

Santa Clara County's ***headspace*** Project seeks to make 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 {Division 5 of the Welfare and Institutions Code, 5830 (b)(2)(B)}. This includes a community-driven approach that has been successful in a national health insurance model to be adapted in a public/private health insurance setting with a primary focus on emerging mental illness and other behavioral health issues. The population to be served are youth ages 12-25 years of age, who will receive services whether they are on MediCal, private insurance or are underinsured or uninsured. BHSD recognizes that this program could address a significant service gap, support Santa Clara County's youth with early signs of mental health issues, result in a new model for public/private billing, and provide a new service model for other counties and states.

headspace would be rolled out in two phases: Ramp Up (8 months) and Implementation (40 months). The primary aim of the ramp up phase is to design a framework for the implementation plan and sustainability components to adapt and replicate ***headspace*** in Santa Clara County. This new framework would provide an innovative approach to mental health services and supports for young people ages 12-25. The framework will also provide guidance on the complicated financial modeling required in a system that is not a national healthcare model, as it exists in Australia, Canada and

some countries in Europe. This adaptation would address issues related to the multi-service components of two centers, as well as the need for a public/private insurance structure to support all youth regardless of their insurance coverage. BHSD intends to follow a "no wrong door approach" without exclusion, supporting youth needs and limiting interruptions to care in the ***headspace*** centers.

The primary aim of the ramp up phase is to design a framework for the implementation plan and sustainability components to adapt and replicate ***headspace*** in Santa Clara County. This new framework will provide an innovative approach to mental health services and supports for young people ages 12-25.

Given the County's commitment to fiscal responsibility, BHSD must allocate time to finalize the project components of the Ramp Up Phase, which include:

1. **Finalize services that will be provided at the *headspace* centers:** based on input from youth advisory groups, the centers will display welcoming youth ambiance as well as youth-centered services addressing the core services of the Australian model through a Santa Clara County youth centered lens. Also, in tandem, BHSD will develop the scope of work that will be included in the RFP for direct services to provide substance use treatment services, mental health services, etc.
2. **Identify *headspace* centers**: The intended service areas of the centers, Central San Jose and North County (Palo Alto/Mountain View). BHSD will work with the County's Facilities and Fleet (FAF) Team in collaboration with Stanford to scout and identify potential sites for ***headspace***, determine/finalize plan designs based on input from youth advisors, and develop renovation plans for the sites as needed.
3. **Develop Staffing Infrastructure at the *headspace* centers:** In collaboration with Stanford, BHSD will finalize the staffing mix at the sites to include, but not limited to: psychiatry, psychology, primary care, substance use treatment, and other mental health services in order to maintain fidelity with the original ***headspace*** model.
4. **Develop a billing and financing model for the *headspace* program**: The project is intended to provide services to youth ages 12- 25, regardless of insurance coverage, Medi-Cal population, commercially-insured youth. The Australian ***headspace*** model is based on a universal health care system and this project provides an opportunity for BHSD and the County to develop a billing mechanism that will enable all payor types for the services provided at the sites.
5. **Develop the Data Management System for the project:** Develop a data agreement for data collection and data management and identify and address contract requirements by County Counsel and Stanford Counsel. ***headspace*** evaluation will be conducted by an independent consultant with strong implementation science background.

Completion of this initial phase ensures the County has conducted its due diligence and research to ensure the success of the ***headspace*** project rollout. The intent is to return to the MHSOAC in Spring 2018 with a ***headspace*** framework for adaptation and replication in Santa Clara County which will detail specific plans covering the five items above.

Community Planning Process

In the Summer of 2016, the Stanford Department of Psychiatry and Behavioral Health Sciences' Center for Youth Mental Health and Wellbeing conducted two focus groups among youth ages 14-19 and two focus groups among parents of youth in Santa Clara County. The aim was to understand perceptions of attitudes and barriers and the types of mental health resources and interventions that youth aged 14-19 and parents of youth aged 14-19 in Santa Clara want and/or value. The findings underscored the need for coordinated, accessible, confidential, reliable, and youth-friendly mental health outreach and services in Santa Clara County and how including the voices of local youth and parents is vital to making programs and services relevant and meaningful.

Source:
http://med.stanford.edu/content/dam/sm/psychiatry/documents/CntrforYouth/MajorThemesFindingsFinalReport.pdf

One core component of the ***headspace*** model is that it is youth-centered and guided by a Youth Advisory Group which informs the decision-making process from the initiation to implementation of the centers. During the Ramp Up Phase, Youth Advisors will meet monthly to address decisions relating to marketing campaigns, the look and feel of the centers, and the provision of services. Focus groups with youth sub-groups (e.g. LGBTQ, Asian-American, young men) will be an integral component of the process. The adapted model for Santa Clara County will include family members in the young person's treatment, when appropriate, in order to address the needs of youth and the family systems supporting youth that are struggling.

Additionally, a focus group was held on June 2017 to gather input on project aim and design. Service providers as well as consumer groups and clients participated in the meeting and endorsed the project concept. Additional meetings were held with the MHSA Stakeholder Leadership Committee, representative of a diverse group of stakeholders, consumers and family members, before the formal 30-day public review process was started. The public hearing held in early September provided additional opportunities for input resulting in supportive comments regarding the project from target population. The County Board of Supervisors unanimously approved and adopted this project in September 26, 2017.

Learning and Evaluation

The learning goals of the Ramp Up Phase are focused on the BHSD-Stanford Team collaboration in designing a comprehensive, data collection system and plan to systematically capture information from both private and public sector services. This is the expected outcome of the process evaluation during the Ramp UP phase:

1. Plan, implement and evaluate program outcomes and conduct sustainability analysis for the following ***headspace*** components:
   a. Service activity (for youths and parents);
   b. Client profile;
   c. Program/service outcomes/effectiveness;
   d. Program/service awareness;
   e. Services integration;
   f. Increased accessibility for marginalized youth clients; and
   g. Cost/financial sustainability.
2. Develop data collection and data management systems for each component of ***headspace***, as well as the overall evaluation system.
3. Develop evaluation plans related to marketing campaigns and peer support models.
4. Develop evaluation plan to understand efficacy of integrated service experiences for clients and their families (by collaborating with current school-linked services and community groups/resources).
5. Other evaluation services determined by BHSD and Stanford consultants.

Budget

The budget for the Ramp Up phase is $572,273. This cost includes a technical assistance contract with Stanford Psychiatry's Center for Youth Mental Health and Wellbeing at $140,000 (24%), County staff operations at $53,328 (10%), and $90,000 (16%) for evaluation services to strategize and develop implementation science measures before launch period begins. Marketing, travel, and one-time facility improvements and 6 months of rent at a cost of $289,200 (50%).

STAFF INNOVATION ANALYSIS— SANTA CLARA

Name of Innovative (INN) Project: *HEADSPACE* Project

Total INN Funding Requested for Project: $ 572,273 (for ramp-up period only)

(Total Project estimated between $7 million to $8.5 million)

Duration of Innovative Project: Initial: Eight (8) Months

Total Project: Four (4) Years

Review History

- Approved by the County Board of Supervisors: 9/26/2017
- County Submitted Innovation (INN) Project: 7/18/2017
- MHSOAC Consideration of INN Project: 11/16/2017

Project Introduction:

The County proposes to increase access to services for individuals 12-25 years old by implementing the *headspace* model for treating youth with emerging mental health needs. The *headspace* model is an Australian national network of centers that function as a 'one-stop-shop' for youth to ensure they have the coping skills and support systems in place to successfully transition into adulthood. The County states that incorporating the *headspace* model will lead to better identification of the early warning signs of mental illness and suicide. The County plans to present the plan to the commission and ask for funding to support an initial 8 months (ramp up phase) of the project to be used for initial startup and planning costs. The County will focus the ramp up phase on research, site visits, programmatic planning, and facility procurement. The County will return to the Mental Health Services Oversight & Accountability Commission (MHSOAC) to request the augmentation of the budget in order to begin the remaining 40 months (implementation phase) of the *headspace* project. The innovative element of the project is a change to an existing mental health practice that has not yet been demonstrated to be effective. The County will achieve this innovation by adapting the *headspace* model from functioning in the national healthcare system in Australia to a public/private healthcare system in the United States. The Santa Clara model will also be primarily focused on prevention and early intervention. **The County may wish to explain why PEI Funds are not being utilized for this project.**

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 aligns with the core MHSA principles, promote learning, funds exploration of a new and/or locally adapted mental health approach/practice, and targets one of the four allowable primary purposes.

The Need

The County states the Innovation project is a result of the Community Planning Process (CPP). The County solicited ideas for Innovation projects from the community which resulted in four (4) needs that were identified by the community. Two of the areas identified by community stakeholders focused on Transitional Aged Youth (TAY) and their wellness to prevent involvement in the child welfare and juvenile justice system, and ensure successful transitions into the community. More specifically, Santa Clara County states that young people with emerging mental health issues have difficulty accessing timely and appropriate services because the current mental health system is unresponsive to their needs. As a result of the lack of access to mental health systems early on, youth do not receive services until their mental health issues are severe. Early detection and treatment of mental illness has proven to reduce the burden of mental illness in the United States. The County also states that a focus on the above areas of need is in response to the call from national leaders to shift education and healthcare to address the national crisis in youth mental health.

Our research validates the County's findings of nationwide identified goals. Studies show that only about half of all children and TAY in need of mental health services receive them. Furthermore, in 2009 the Congressional Research Service published a report with policy discussion items to address the lack of access to competent services in rural and some urban areas, and the issue of mental health services not being integrated with other services. The report demonstrates how the service mechanism is not conducive to access of appropriate and timely services, and that national leaders are working to address the issue. **The county may wish to provide evidence on how the stated need was determined for Santa Clara County.**

The Response

As a result of stakeholder input, Santa Clara County has come forward with an Innovation Project which is an adaptation of the *headspace* model, specifically targeting

children and Transitional Aged Youth (TAY). Created in Australia, *headspace* was designed to provide early intervention for children and TAY between 12-25 years of age. Australia developed *headspace* in an effort to address mental health in children and TAY as mental health issues were affecting about 1 in 4 children and TAY. Additionally, suicide was the leading cause of death for young people, about one-third of all deaths.

Santa Clara County states that bringing the *headspace* model into the Unites States would be valuable in that it would provide early detection for children and TAY with the hopes of reducing the mental health population, ultimately 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.

With funding from Robert Wood Johnson Foundation, the Stanford Psychiatry Center for Youth Mental Health and Wellbeing conducted a feasibility study to assess whether *headspace* could be incorporated in the United States. The study indicated that developing the model in the United States would be valuable; however, it may be complicated because Australia has national healthcare whereas the United States does not. Bringing the *headspace* model into the United States would incorporate an early intervention structure for young people that has not yet been introduced.

Santa Clara Behavioral Health Services Department will partner with Stanford Psychiatry Center for Youth Mental Health and Wellbeing to conduct the initial feasibility study in the United States on how to replicate *headspace* in Santa Clara County. The designing of the framework and plan for implementation will be developed during the first phase of this project, the “ramp-up” period which the County anticipates will be eight (8) months long. The second phase of the project will be the actual implementation of the plan. Ramp-up period and implementation is expected to last four (4) years.

The ramp-up period will allow the designing of a framework to work-around the variance in healthcare systems between the United States and Australia. The County intends to create Santa Clara County *headspace* in an effort to support all youth, regardless of their insurance coverage and will follow a “no wrong door approach” with zero exclusion. Santa Clara Behavioral Services Department leads will be accompanied by Stanford leads to conduct site visits of new *headspace* centers that have opened in British Columbia.

The County states the ramp-up period will encompass in-depth research, site visits, planning and input from two (2) youth advisory groups (approximately 24 founding members of the County’s *headspace* center), which will serve as the foundation for the implementation portion of this project. As part of the ramp-up period, a Youth Support Specialist will be hired as well as a Supported Employment and Education Specialist. The Youth Support Specialist will assist in the development of a Youth Advisory Board to assist in the marketing and the running of the focus groups to seek input in the *headspace* development and evaluation. The Supported Employment and Education Specialist will ensure that the youth receiving treatment will be able to coordinate treatment plans with their educational and employment goals. Santa Clara states that

the hiring of these two (2) positions are one-time funds and contingent upon the opening of the first *headspace* center within the County.

At the end of the ramp-up period, Santa Clara County will return to MHSOAC to submit a budget augmentation pending the successful implementation of the eight (8) month ramp up period. After completing the County's approval process and submitting a request for a budget augmentation, the County hopes to begin the implementation phase of the *headspace* project. The County states that they estimate that 1,000 children and TAY will seek services from each of the two (2) headspace centers, serving a total of 2,000 children and TAY between ages 12-25 annually. **The county may consider explaining to the Commission why this is a two part process/request for the same Innovation project.**

Santa Clara County indicates there are other states (New York, Michigan, Illinois) who have expressed interest in the development of *headspace* sites in their own state, along with counties here in California who may wish to replicate this model in their own community. For this reason, the County would like to ensure the building of a sustainable model so that it can be successfully replicated state and nation-wide.

The Community Planning Process

The County detailed the inclusion of how stakeholders and the public were involved during the Community Planning Process (CPP) of the four proposed innovation plans. Beginning in 2015, the County held an MHSA Stakeholder Leadership Committee (SLC) meeting to explain the Innovation planning process to stakeholders and the public. The Innovation plans were selected through two separate "submission windows", where stakeholders and the public could electronically submit their innovation ideas. During the first submission window, stakeholders and the public were asked to consider six guiding principles the County believed represent MHSA values.

1. Consumer and Family member involvement;
2. Culturally responsive approaches;
3. Life span focus (across ages);
4. Innovative care practices;
5. Strategic care transitions;
6. Meaningful outcomes.

Following the submission window, another MHSA SLC meeting was held to share which three (3) submissions the County would pursue. The County held one focus group for each of the three (3) projects, and from the input received the County refined each project concept.

For the second submission window, the County identified four (4) additional principals to consider for the final project that would support clients, consumers, families, and communities.

1. Culturally responsive trainings/outreach designed by diverse communities;

2. Outreach and engagement for older adults with linkage to behavioral health services;
3. New and emerging prevention services for children;
4. TAY support and care.

Following the submission window, another SLC meeting was held and attendees participated in the selection of the final innovation plan, *headspace*.

The *headspace* innovation plan identifies individuals 12-25 years old as the target population. **The County may wish to discuss how the target population was included in the development of this innovation project.**

Learning Objectives and Evaluation

Santa Clara County has proposed implementing the *headspace* model for treating youth with emerging mental health needs. Because it is a large scale project, the County proposes developing a process evaluation that will be completed following their 8-month ramp-up period. This process evaluation will better inform the full implementation of *headspace* within Santa Clara County. The ramp-up and full implementation of the project will be conducted in collaboration with the Stanford Psychiatry Center for Youth Mental Health and Wellbeing.

During the ramp-up period, the County intends on finalizing the services to provide at *headspace* centers, identify *headspace* centers, develop staffing infrastructure, develop a billing and financing model, and develop a data management system for the project. The County states that they will use a variety of measurements during the ramp-up period to assess the ramp-up period. **The County may wish to clarify these measurements and expected outcomes of the process evaluation.**

Both the process and outcome evaluation will be completed by a contracted evaluator. The County will use a variety of methods to collect quantitative and qualitative data for their final evaluation. Quantitative data will be collected using electronic surveys to be completed by participants and staff. Qualitative data will be gathered through focus groups that will be conducted at the conclusion of the program. No specific outcomes or measurements of the final project have been identified by the County.

Although outcomes and measurements will be finalized during the ramp-up period, the County is encouraged to locate past process and outcome evaluations of the *headspace* program to identify lessons learned, and specific goals/outcomes that their project hopes to replicate or improve upon once the *headspace* program is fully implemented. **The County may wish to identify a contingency plan should the process evaluation suggest full implementation is not feasible as proposed.**

The Budget

The “ramp-up” period for this Innovation project is for eight (8) months with a total budget of $704,155; however, only MHSA Innovation funds are being utilized for a total of

$572,273. A total of $53,328 (7.5%) is being allocated to Santa Clara Behavioral Health Services Department, under the direction of the Family and Children Services Program, to provide oversight/administration of the contract as well as maintain stakeholder input throughout the process.

A total of $271,627 is budgeted for Stanford Psychiatry Center for Youth Mental Health and Wellbeing to cover personnel expenditures ($100,320), overhead costs ($26,083), travel expenses to British Columbia ($13,342), and a total of $131,882 from the County General Fund to offset personnel expenditures for FY 17/18. Additional travel expenses are budgeted for the Director and Project Leads for travel to British Columbia in the amount of $6,000 and marketing materials totaling $30,000.

The evaluation component is $90,000 and is approximately 13% of the total budget for the ramp-up period. After the ramp-up period, the County will submit a budget augmentation to MHSOAC for the remainder of the project duration (40 months). It is estimated that the entire project will cost between $7-8.5 million over a four (4) year period. During the ramp-up phase, the complete budget will be developed and submitted with the budget augmentation request.

Additional Regulatory Requirements

Although it appears that the proposed project meets the minimum requirements listed under MHSA Innovation regulations, the County may wish to provide information regarding the measurements and expected outcomes of the evaluation component.

References

https://www.*headspace*.org.au/about-us/who-we-are/

Adelsheim, S., Tanti, C., Harrison, V., and King, R. (2015). *headspace*: US Feasibility Report.

Merikangas, K. R., He, J., Burstein, M. E., Swendsen, J., Avenevoli, S., Case, B., Georgiades, K. Olfson, M. (2011). Service utilization for lifetime mental disorders in U.S. adolescents: Results from the National Comorbidity Survey Adolescent Supplement (NCS-A). Journal of the American Academy of Child and Adolescent Psychiatry. 50(1), 32–45.

https://www.google.com/search?q=conducive&oq=conducive&aqs=chrome..69i57j0l5.3887j0j8&sourceid=chrome&ie=UTF-8

Title: Psychiatric Emergency Response Team (PERT) and Peer Linkage (INN-12)

Statement of Need

In recent years, there has been a high number of suicide clusters by young adults in the City of Palo Alto in Santa Clara County. In November 2015, the California Department of Public Health, on behalf of the Santa Clara County Public Health Department, requested assistance from the Centers for Disease Control and Prevention (CDC) to conduct an investigation with the aim to help Santa Clara County better understand youth suicide occurrences in the County. In partnership with the Substance Abuse and Mental Health Services Administration (SAMHSA), the CDC conducted an Epi-Aid investigation on Santa Clara County youth suicide. The preliminary report prepared by the Epi-Aid team was based on Santa Clara County data for 2005 to 2015 (2016) and reflects the following:

- 203 suicide deaths occurred among youth ages 10-24.
- About 6 in 10 decedents (62%) were ages 20-24.
- The average age of decedents was 20.2 years.
- Majority of the youth suicides were among male youths ages 20-24.
- About 1 in 3 decedents (29%) had a history of suicide attempts.

The majority of Emergency Psychiatric Services (EPS) visits are handled by law enforcement in Santa Clara County. These EPS visits are increasing year-to-year as described in the CDC/SAMHSA report. The literature also indicates that hospitalization due to mental health conditions may pose an increased risk for suicidality within the first 48 hours after release without post-care follow-up or warm hand off.

Proposed INN Project

This project seeks to decrease EPS admits by law enforcement (20%) and create a distinctive warm handoff, peer linkage structure after PERT encounter for individuals ages 18-25. In maintaining the primary objective of the PERT model, the project would provide effective crisis intervention to individuals in mental health crises, de-escalate crisis situations, provide the appropriate behavioral health service referrals when necessary and avoid hospitalizations. The Santa Clara County PERT and Peer Linkage Project's linkage component would provide peer support services post-crisis to assist client/consumers with their recovery and prevent future suicide attempts. Based on the Epi-Aid Team's preliminary report regarding youth (ages 10-24) suicides, about one in three decedents (29%) had a history of suicide attempts with the average age of decedents at 20.2 years. By linking individuals ages 18-25 to rapid connection to behavioral health services coupled with peer support services post-crisis, the expected outcome is to increase access to services and decrease future suicide attempts. Following best-practice models for peer support, the peer linkage arm of the project will incorporate the five core competencies identified as effective features of peer support (i.e. recovery oriented, person-centered, voluntary, relationship-focused, and trauma-informed).

During 2012-2016, a monthly average of 290 patients were admitted to EPS from law enforcement. This project aims to decrease the average admit rate by 20% during the first year.

This would be an estimated 696 patients diverted from EPS annually and provided with peer follow up and support.

Community Planning Process

Behavioral Health Services held an informational stakeholder/public meeting regarding the County's review and selection of the Innovations projects. Stakeholders participated in focus group meetings in April 15, 2016. Diverse numbers of individuals including consumers, family members, advocates, local non-profit staff, city law enforcement officials and the Sheriff's Office participated at this meeting and in additional planning sessions during the course of the project development. BHSD considered the input that was received at the focus group meeting as the department refined and finalized the PERT concept to include a Peer Linkage component. Additional meetings were held with the MHSA Stakeholder Leadership Committee, representative of a diverse group of stakeholders, consumers and family members, before the formal 30-day public review process was started. The public hearing held in early September 2017 provided additional opportunities for input resulting in supportive comments regarding the project from target population. The County Board of Supervisors unanimously approved and adopted this project in September 26, 2017.

Learning and Evaluation

The main learning goals to be evaluated include increased access to services for Transition Age Youth experiencing mental health crisis and improved recovery indicators as demonstrated by decreased Emergency Room visits, self-harm and suicide rates among this population in Santa Clara County. The specific aim of the project is to decrease EPS admits by law enforcement by 20% in the first year of the project's implementation. In addition to feasibility checks and tracking all project activities, client/consumer outcome impact will be prioritized to address the following learning goals:

- Can the measures show improved outcomes for youth participating in peer linkage project and how does this support increase help-seeking behavior?
- Can comparisons with existing stand-alone CIT efforts with PERT model show benefits of a combined approach?
- To what extent does SCC PERT improve law enforcement attitudes and abilities to safely respond to mental health related calls, link people to mental health services, and possibly reduce the number of persons with mental illnesses entering the front door of the criminal justice system?

A tool that is intended for evaluating individual measures include the standardized Columbia-Suicide Severity Rating Scale (C-SSR). The C-SSR Scale is a tool designed to systematically assess and track suicidal adverse events (behavior and ideation) throughout program implementation in a variety of settings. This tool was recently adapted for EPS in Santa Clara County. This may offer valuable comparison information among individuals receiving PERT and Peer Linkage support.

Budget

The budget for this two year project is $3,688,511. This is a County-operated project and seventy-five percent (75%) of budget costs would be on personnel. A (1) full time Health Care Program Manager II would oversee the project's four teams and a (1) .50 Health Service Representative will provide support to eight (8) Psychiatric Social workers embedded in teams throughout the county. The budget includes $150,000 dedicated for independent evaluator costs.

STAFF INNOVATION ANALYSIS - SANTA CLARA

Name of Innovative (INN) Project: Psychiatric Emergency Response Team (PERT) and Peer Linkage Project

Total INN Funding Requested for Project: $ 3,688,511

Duration of Innovative Project: Two (2) Years

Review History

- Approved by the County Board of Supervisors: 9/26/2017
- County Submitted Innovation (INN) Project: 7/18/2017
- MHSOAC Consideration of INN Project: 11/16/2017

Project Introduction:

The County proposes to increase access to services for individuals 18-25 years old by implementing the Psychiatric Emergency Response Team (PERT) model. PERT was developed in San Diego County and is modeled after the Crisis Intervention Training (CIT) program. CIT training teaches law enforcement personnel to recognize mental health issues and defuse crisis situations without using force. Each PERT "team" will include a licensed mental health clinician and a law enforcement officer. The project will also include a linkage component to peer support post-crisis services. The purpose of the project is to provide immediate assessment and referral to individuals experiencing a mental health episode in the community. The project intends to divert individuals away from Emergency Psychiatric Services (EPS), when appropriate, to community based services and peer support services post crisis. The county does not specifically connect high numbers of EPS admits and high numbers of suicides, but this is assumed from the project plan. Ideally, the project will assist individuals in their recovery and prevent suicide attempts. **The County may wish to describe the correlation between their high numbers of EPS users and the high incidence of suicide attempts in their county.**

The county states that the innovative element of the PERT project will involve the addition of a peer linkage component to support individuals post-crisis and ongoing with their recovery. The PERT project proposes to hire one (1) Full Time Equivalent (FTE) Health Care Program Manager II, one (1) half time Health Service Representative, and each team (four teams in all) will include two (2) Psychiatric Social Workers for a total of eight (8) Psychiatric Social Workers. **The County may also wish to describe further how their PERT Program innovatively increases access to services in comparison to the documented models already in existence in other counties.**

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 aligns with the core MHSA principles, promote learning, funds exploration of a new and/or locally adapted mental health approach/practice, and targets one of the four allowable primary purposes.

The Need

The County states that there has been a high number of suicides-suicide clusters by young adults in the City of Palo Alto and that suicide is the second leading cause of death for TAY. The data provided is comparable to CDC national statistics, which also rates suicide as the second leading cause of death for TAY. The County also provides statistics from an epidemiological assistance (Epi-Aid) investigation preliminary report by the CDC and SAMHSA on Santa Clara County youth suicides from 2005-2015. The CDC conducts Epi-Aid reports as a response to a request from officials dealing with public health problems. The statistics show that of the 203 suicide deaths (age 10-24 years old): 62% were ages 20-24 years old (majority male), average age was 20.2 years, and 29% had a history of previous suicide attempts. The CDC Epi-Aid report found that other counties in California had a similar rate of suicide to Santa Clara County (5.3 persons committed/attempted suicide per 100,000) (5.4 persons committed/attempted suicide per 100,000), respectively.

The County states that currently EPS and acute psychiatric hospitalization services are the two (2) main service options to residents experiencing acute mental health crises. Evidence is also provided showing an upward trend in EPS admits from 2012-2016 by law enforcement as a further demonstration of the need. With this evidence and the results of the Epi-Aid report in mind, the County expressed the need to expand community-based crisis services for individuals ages 18-25 years old. The County intends to create new diversion programs to reduce the utilization of EPS and acute psychiatric hospitalization services in the hopes that this will result in fewer suicides.

The Response

In an effort to reduce EPS, Santa Clara County would like to incorporate behavioral health services and embed Psychiatric Emergency Response Teams (PERT) into the community. The PERT model's primary purpose is to provide clinical support to law enforcement and the community for dispatch calls involving persons having a mental health crisis. PERT teams would consist of a licensed mental health clinician paired with a law enforcement officer. Additionally, a peer linkage component as part of this Innovation Project would support consumers post-crisis to ensure the consumer is

informed of available resources. The collaboration between law enforcement and the mental health system of care also assists in the facilitation of training for law enforcement on mental health issues to promote compassion for consumers experiencing a mental health crisis.

Prior to the implementation and rollout of the project, PERT staff will provide training to law enforcement on the PERT model as well as crisis intervention. Two (2) Law Enforcement Teams in Santa Clara will be making a site visit of San Diego's PERT program to discuss their shared challenges and how this model might help the community of Santa Clara.

During the initial six (6) month phase of the Innovation Project, Palo Alto Police Department will partner with Santa Clara County Sheriff's Department to disperse two (2) PERT teams to provide services in the County. After the pilot period, a determination will be made whether there is enough interest to expand the project to other jurisdictions within Santa Clara County. The County indicates they have a target goal of incorporating a total of four (4) PERT teams.

The Community Planning Process

The County detailed the inclusion of how stakeholders and the public were involved during the Community Planning Process (CPP). This is one (1) of four (4) proposed Innovation projects brought forth by Santa Clara. Beginning in 2015, the County held an MHSA Stakeholder Leadership Committee (SLC) meeting to explain the innovation planning process to stakeholders and the public. The innovation plans were selected through two separate "submission windows", where stakeholders and the public could electronically submit their innovation ideas. During the first submission window, stakeholders and the public were asked to consider six guiding principles the county believed represent MHSA values.

1. Consumer and Family member involvement;
2. Culturally responsive approaches;
3. Life span focus (across ages);
4. Innovative care practices;
5. Strategic care transitions;
6. Meaningful outcomes

Following the submission window, another MHSA SLC meeting was held to share the three (3) submissions the County would pursue. The County held one (1) focus group for each of the three (3) projects, and from the input received the County refined each project concept.

After reviewing the first round of submissions, the County identified four (4) additional principles for the second submission window that would support clients, consumers, families, and communities.

1. Culturally responsive trainings/outreach designed by diverse communities;
2. Outreach and engagement for older adults with linkage to behavioral health services;

3. New and emerging prevention services for children;
4. TAY support and care.

Following the submission window, another SLC meeting was held and attendees participated in the selection of the final innovation plan, PERT.

The County may wish to discuss how the target population was included in the development of this innovation project.

Learning Objectives and Evaluation

Santa Clara County proposes implementing the Psychiatric Emergency Response Team (PERT) model in order to reduce the use of emergency psychiatric services, acute psychiatric hospitalization services, and suicide rates. The target population is individuals 18-25 who are experiencing mental health crises. The overall goals/outcomes of the project are to provide behavioral health assessments on-the-scene in order to ensure clients are receiving needed services, divert these clients to community based treatment, and to also connect them to peer support services following a crisis.

The County may wish to clarify the total clients they intend to serve over the duration of the project. While the County intends on contracting with an outside evaluator to evaluate their project, **the County may wish to identify specific methods and measures that they intend to utilize to evaluate the impact, and contribute to statewide learning.**

The Budget

Santa Clara County's budget for this Innovation Project is $3,688,511 for a total of two (2) years in duration. A total of $2,760,393 (75%) of the budget is allocated for personnel expenses. The County states they will hire one (1) full time Health Care Program Manager II, a half-time Health Service Representative and a total of eight (8) Psychiatric Social Workers, two (2) for each PERT team. Budgeted amounts for FY 17/18 are smaller compared to the remaining fiscal years as the first two PERT teams are expected to be rolled out in April 2018, leaving only three (3) months remaining in FY 17/18 to expend funds.

Operating and overhead expenses each total $414,059, which is 11% of the budget. The evaluation component totals $150,000 and is approximately 4% of the proposed budget. The County wishes to utilize MHSA Innovation Funds and will not seek to use any other type of funding. **The County may wish to discuss sustainability if the program is successful, and provide clarity on the role of peers and indicate if they will be compensated.**

Additional Regulatory Requirements

Although it appears that the proposed project meets the minimum requirements listed under MHSA Innovation regulations, the County may wish to provide information regarding the measurements and expected outcomes of the evaluation component.

References

http://www.comresearch.org/pert.php

https://www.cdc.gov/injury/images/lc-charts/leading_causes_of_death_age_group_2014_1050w760h.gif

https://www.sccgov.org/sites/phd/hi/hd/epi-aid/Documents/epi-aid-report.pdf

AGENDA ITEM 4

Action

November 16, 2017 Commission Meeting

San Bernardino and Riverside Counties Innovation Project

Summary: The Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission) will consider approval of San Bernardino and Riverside Counties request to fund a new Innovative project: Inland Empire Psych Partners: Public Private Collaboration to Transform Emergency Psychiatric Services (I.E. PsychPartners) San Bernardino County is requesting a total of $24,124,391 over five (5) years. Riverside County is requesting a total of $21,782,701 over five (5) years. San Bernardino and Riverside Counties propose to introduce a new application to the mental health system of a promising community-driven practice by utilizing telehealth to create an interagency treatment team that includes a psychiatrist and specialized behavioral health case managers available 24 hours a day 7 days a week within Emergency Departments in San Bernardino and Riverside Counties.

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:

San Bernardino County

- Dr. Teresa Frausto, Chief Psychiatric Officer – Medical Services
- Michael Schertell, LMFT, Deputy Director – Children, Transitional Age Youth and Mental Health Services Act
- Dr. Georgina Yoshioka, Deputy Director – 24 Hour and Emergency Services
- Michelle Dusick, Administrative Manager – Mental Health Services Act

Riverside County

- Dr. Matthew Chang, Medical Director
- Angela Igrisan, LCSW, MPA, Assistant Director – Programs
- David Schoelen, LCSW, Mental Health Services Administrator – Mental Health Services Act
- Roderick Verbeck, Psy.D., MFT,
  Mental Health Services Administrator – Crisis
- Suzanna Juarez-Williamson
  Supervising Research Specialist – Evaluations
- Paul Gonzales, Administrative Services Manager – Budget and Analysis

Enclosures (3): (1) Biographies for San Bernardino and Riverside County Innovation Presenters (2) Staff Innovation Summary, and (3) County Project Summary San Bernardino and Riverside

Handout (1): PowerPoint Presentation

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

San Bernardino County plan
http://mhsoac.ca.gov/document/2017-11/san-bernardino-county-inn-plan-description-ie-psychpartners

Riverside County Plan
http://mhsoac.ca.gov/document/2017-11/riverside-county-inn-plan-description-ie-psychpartners

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

> **Name:** Inland Empire Psych Partners: Public Private Collaboration to Transform Emergency Psychiatric Services
> **Amount:** $24,124,391
> **Project Length:** Five (5) Years

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

> **Name:** Inland Empire Psych Partners: Public Private Collaboration to Transform Emergency Psychiatric Services
> **Amount:** $21,782,701
> **Project Length:** Five (5) Years

Biographies for Riverside County Presenters

Matthew Chang, M.D.
Dr. Matthew Chang is an Assistant Clinical Professor of Psychiatry at the UC Riverside School of Medicine and the Medical Director for Riverside University Health System-Behavioral Health. Born in Honolulu, Hawaii, Dr. Chang attended Yale University for his undergraduate degree, followed by a year of post-baccalaureate work at the University of Hawaii, Manoa. He then attended medical school at the University of Cincinnati College of Medicine. Dr. Chang conducted his residency in psychiatry and a fellowship child and adolescent psychiatry at Harbor-UCLA Medical Center, followed by a fellowship in forensic psychiatry at the University of Colorado, Denver. He is a member of the American Medical Association and the American Academy of Psychiatry and the Law. He is a diplomate of the American Board of Psychiatry and Neurology in general psychiatry and forensic psychiatry.

Angela Igrisan, LCSW, MPA
Angela Igrisan is the Assistant Director of Riverside University Health System – Behavioral Health. An advocate for mental health services to people with developmental disabilities, she started her professional career with the Macomb-Oakland Regional Center in 1991 in Michigan, then began her work in Riverside in 1999. Since this time, she was appointed to the California Department of Social Services' Wraparound Curricula Revision Team, served as advisor to the National Wraparound Initiative, managed local mental health site efforts for Federal disaster relief from the Southern CA fires of 2006 and Hurricane Katrina, and Co-chaired the CA Commercially Sexually Exploited Children Task Force- Multisystem and Data Coordination Subcommittee. Other areas of specialty and interest include Trauma Focused Cognitive Behavioral Therapy, Juvenile Justice, and the elimination of racial disparities.

David M. Schoelen, LCSW
David has been employed by Riverside University Health System – Behavioral Health for over 28 years. He has served in a continuum of clinical roles from student intern to administrative manager, and has worked with children, adults, and older adults. He has been an LCSW since 2000. His practice has included specializing in service to LGBT consumers, engaging people who experience psychosis, and in the application of law related to mental health risk. David has also been a guest lecturer at several local colleges and universities. He was awarded Field Instructor of the Year by the Inland Empire Clinical Education Collaborative in 2009 for his innovative work as a trainer and educator. He was Riverside County's first MHSA Workforce Education and Training Manager, and is currently the MHSA Administrator.

Biographies for Riverside County Presenters Continued

Roderick W. Verbeck, Psy.D., MFT

Dr. Roderick Verbeck is a Mental Health Services Administrator overseeing the Crisis Support System of Care and Long Term Care Contracts for Riverside University Health System-Behavioral Health. He holds a Doctorate Degree in Psychology from the California Graduate Institute-School of Professional Psychology, a Master Degree in Counseling from California State University, Fullerton. Dr. Verbeck is also licensed as a Marriage and Family Therapist and holds a professional Certificate in the Treatment of the Chemically Dependent Patient. He has 34 years of clinical experience in the mental health, substance use, chronic pain, psychiatric inpatient, psychiatric outpatient, managed care, and crisis fields. Dr. Verbeck is a Clinical Member of the California Association of Marriage and Family Therapists. He is a Volunteer Puppy Raiser for Guide Dogs for the Blind.

Suzanna Juarez-Williamson

Suzanna has been a Supervising Research Specialist for Riverside University Health Systems-Behavioral Health for 8.5 years, and has worked in the Research and Evaluations unit for 11 years. She was responsible for the development of PEI evaluations and has worked on multiple Innovations projects. She has also been the key staff training and developing MHSA FSP reports.

Paul Gonzales

Paul Gonzales is an Administrative Services Manager for Riverside University Health System – Behavioral Health (RUHS-BH). Paul has been with the department for over sixteen years. He is responsible for the development of Riverside County's Mental Health Services Act budgets for Community Services and Supports, Workforce Education and Training, Capital Facilities and Technology, Prevention and Early Intervention, and Innovation programs since their inception. Paul is currently the fiscal manager responsible for the development, maintenance and analyzes of the department's $400+ million budget. Paul has also been instrumental in enabling RUHS-BH as the second county in the State to start providing Drug Medi-Cal Waiver services. He has been responsible for the development of the department's ODS Rate Structure and Cost Sharing Plan. He worked diligently with the State to get our department's rates approved by CMS.

Biographies for San Bernardino County Presenters

Teresa Frausto, MD

Teresa Frausto, M.D. currently serves as the Chief Psychiatric Officer for the County of San Bernardino Department of Behavioral Health and Medical Director of the Alcohol and Drug Programs. In her 15 year tenure with San Bernardino County she has worked in the behavioral health outpatient clinics and as Clinic Medical Director for Juvenile Detention and Assessment Centers. She has also worked collaboratively with Inland Empire Health Plan, San Bernardino County Schools, Probation, Juvenile Courts, Coroner's Office, Child Death Review Team, and other community agencies. Her quality management activities led to the first accreditation by the National Commission on Correctional Health Care. Dr. Frausto also serves as Assistant Professor at Loma Linda University Medical School for the Department of Psychiatry and Clinical Faculty Member of Western University of Health Services. She is triple Board Certified in Adult, Child and Addiction Psychiatry.

Michael Schertell, LMFT

Children, Transitional Age Youth (TAY), and Mental Health Services Act (MHSA)
Michael Schertell, LMFC has been the Deputy Director for Children and TAY programs for the past nine years. These programs provide specialty behavioral health and intensive case management services for children, adolescents and young adults. He also manages the MHSA programs which reduce the long-term adverse impact on individuals, families and state and local budgets resulting from untreated serious mental illness through state-of-the-art, culturally competent programs that promote wellness, recovery and resilience for individuals and their families.
Caring for children, families and adults suffering with the difficulties of chronic mental illness has been the primary focus of Michael Schertell's professional career for over thirty years. After graduating from the University of California, Riverside and Chapman College, he has served the adolescent population of San Bernardino County as an Executive Director of a Boys and Girls Club of America, a Clinical Therapist, a Case Manager, a Clinician II, a Clinic Supervisor, a Program Manager II and as Deputy Director dedicated to improving the conditions of those afflicted with mental illness in our communities.

Georgina Yoshioka, DSW, LCSW, MBA

With 21 years of experience working in the field of social work, Dr. Georgina Yoshioka, DSW, LCSW, MBA specializes in the delivery of behavioral health services to diverse populations including criminal justice, behavioral health, and child welfare systems. She has held a variety of clinical and managerial positions throughout her career. Her vast experience as a pre-and-post licensed clinical social worker (LCSW) consists of providing individual and group psychotherapy and case management to adults diagnosed with a co-occurring disorder and/or chronic medical condition, children, and couples in outpatient and residential behavioral health treatment settings. As the Deputy Director of 24-Hour & Emergency Services for the San Bernardino County Department of Behavioral Health (DBH), Dr. Yoshioka oversees an array of centralized specialty County behavioral health programs including Community Crisis Services, Diversion Services, Centralized

Hospital Aftercare Services, the Crisis Intervention Training (CIT) program and manages DBH's Crisis Stabilization Units, Crisis Residential Treatment facilities and Crisis Walk-In Centers. Through these programs, facilities and partnerships, Dr. Yoshioka is an key contributor to DBH's mission of providing individuals, families, and communities' with access to services that promote prevention, intervention, wellness, recovery, and resiliency.

Michelle Dusick

Michelle Dusick is the MHSA Administrative Manager for San Bernardino County Behavioral Health. Her primary responsibilities include coordination and oversight for Mental Health Services Act (MHSA) programs across the county. She serves as an adjunct faculty member of the Human Services Department at San Bernardino Valley College, has served on the San Bernardino County First 5 Advisory Committee, and is the Co-chair for the Department of Behavioral Health's Community Policy Advisory Committee. Prior to joining the Department of Behavioral Health in 2004, Michelle worked in the health and human services field for providing services to transition aged foster youth, TANF recipients, and SSI applicants. As a family member of a person living with serious mental illness, she continues to volunteer as a support person for consumers and family members.

STAFF INNOVATION ANALYSIS
RIVERSIDE COUNTY and SAN BERNARDINO COUNTY

Name of Innovative (INN) Project: Inland Empire PsychPartners: Public-Private Collaboration to Transform Emergency Psychiatric Services (I.E. PsychPartners)

Total INN Funding Requested for Project:

Riverside: $21,782,701;

San Bernardino: $24,124,391

Duration of Innovative Project: Five (5) Years

Review History

San Bernardino:

Approved by the County Board of Supervisors: October 31, 2017

County Submitted Innovation (INN) Project: September 1, 2017

MHSOAC Consideration of INN Project: November 16, 2017

Riverside:

Approved by the County Board of Supervisors: Pending MHSOAC approval

County Submitted Innovation (INN) Project: August 31, 2017

MHSOAC Consideration of INN Project: November 16, 2017

Project Introduction:

Riverside University Health System Behavioral Health (RUHS-BH), San Bernardino County Department of Behavioral Health (SBC-DBH) and the Hospital Association of Southern California (HASC) will be working collaboratively to modify the ways in which their hospital systems interact with the public behavioral health systems providing care to patients seeking emergency psychiatric services in hospital emergency departments. They will be embedding psychiatric crisis trained staff and tele-psychiatry capacity in

emergency departments (ED), training ED physicians and creating order sets to assist ED physicians to better serve persons seeking emergency psychiatric services. An order set is a group of related orders that a physician can place that allows the physician to issue prepackaged groups of orders that apply to a specified diagnosis or a particular period of time.

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

The Need

Combined, Riverside and San Bernardino Counties create a geographical region called the Inland Empire. The Inland Empire is experiencing rapid population growth and limited resources. According to the United States Census Bureau the population percent increase between April 1, 2010 and July 1, 2016 was 5.2% in San Bernardino and 9.0% in Riverside County. This increase is compared to an overall rate increase of 4.7% in the United States. The Counties indicate that this population expansion has put additional stress on the emergency departments. In addition to the population growth affecting EDs, the California Health Care Foundation reports that Riverside County has just 6.7 psychiatrists per 100,000 people and San Bernardino County has just 10.7 per 100,000 people.

The I.E. PsychPartners project hopes to addresses the lack of expertise of emergency room doctors in treating behavioral health consumers. According to “Care of Psychiatric Patients: The Challenge to Emergency Physicians”, Emergency Physicians (EP) have little training in behavioral emergencies in emergency medicine (EM) residencies and few EM programs provide experience or training in emergency psychiatry. The American Board of Emergency Medicine board certification exam contains 4% or less of the questions pertain to behavioral issues. EPs across the nation complain about gaps in detecting patients with substance use disorder, lack of education in care of psychiatric patients and a shortage of services to treat these patients.

According to the National Hospital Ambulatory Medical Care Survey of 2013, the number of visits to the Emergency Departments across the Country was 130.4 million; 4,738,000 of these visits are for mental disorders; 419,000 are for psychoses, excluding major depressive disorder.

The Response

Riverside County and San Bernardino County seek to address barriers preventing appropriate treatment of emergency department consumers who are in need of

behavioral health care by changing the existing system of care. The Counties cite an increasing breakdown in prompt, quality care while also noting an increase in patients needing behavioral health care in the ED. This increase, coupled with a lack of psychiatrists, psychiatrically untrained ED staff, and lack of communication between hospital staff and County mental health staff has resulted in EDs experiencing overcrowding, increased wait times and a high-cost, acute setting that is not delivering high quality care for those in need of emergency psychiatric services.

This INN project proposes to construct a collaborative infrastructure between two public behavioral health departments (Riverside and San Bernardino) and the private Hospital Association of Southern California (HASC) to address the barriers preventing quality mental health care in the ED. The Counties feel that implementing a new regional approach to transforming psychiatric crisis response will bring about systems change. They will implement key innovative components to support the systems change, including: (1) build a broad infrastructure between emergency departments (EDs) and the two County behavioral health departments by utilizing the trusted relationship with the hospital association to enact systems level change; (2) develop regional training to improve capacity of ED staff to respond to persons in psychiatric crisis; and (3) improve communication and collaboration between County mental health plans and EDs by utilizing embedded hospital staff and telehealth technology.

Both Riverside County and San Bernardino County have existing programs with goals of providing crisis intervention and diversion from EDs for individuals needing psychiatric care.

Riverside County specifically states that their Regional Emergency Assessment at Community Hospital (REACH) teams has been underutilized, has limited operational hours, does not extend to rural areas and has not been successful at establishing a working relationship with ED medical teams. The County believes that this INN project will overcome the barriers preventing a working relationship by actually embedding behavioral health staff in the ED. The focus is on improving the care received by the patients who enter the ED instead of diverting patients away from the ED.

San Bernardino County also discusses two existing programs with related goals: Triage, Engagement & Support Teams (TEST) and Community Crisis Response Teams (CCRT). The TEST teams have limited availability and accompany agency staff on crisis calls to help connect individuals in need of behavioral health services with outpatient community-based services instead of hospitalization or incarceration. TEST staff also wait with individuals in the ED when diversion is not possible. CCRT is not co-located with any agency staff and operates 24/7 with the goal to reduce involuntary hospitalizations by providing community based crisis interventions.

Both Counties state that this INN proposal differs from the existing programs by seeking to achieve system wide transformative change through understanding how the shared emergency medical system can be improved and ED staff empowered to provide appropriate and immediate psychiatric care to those patients who cannot be otherwise diverted and require psychiatric care in the ED. Counties may wish to discuss how they will work with the existing crisis intervention programs to support the implementation of this INN project.

This project will provide funding to create multi-disciplinary, team-based psychiatric consultations in the ED, with the help of telehealth psychiatry and behavioral health nurses working with the ED physicians. A total of thirty (30) behavioral health nurses will be hired and embedded in the participating EDs across the Counties to support the team approach to psychiatric consultation. The team will have access to existing medication history, outpatient treatment history, previous discharge care plans, family and social supports, and linkages to important program and outpatient services that assist the consumer. Lastly, the funding will support the development of a regional training program and a standardized psychiatric workflow for all of the region's EDs, including the creation of order sets.

Counties may wish to provide more information as to the role of HASC in the actual day to day function of the INN proposal.

The Community Planning Process

Riverside County

Riverside University Health System- Behavioral Health (RUHS-BH) utilize their MHSA System of Care Planning Committee and monthly updates to the Behavioral Health Commission as their primary stakeholder process. The Cultural Competency/Ethnic Disparities Committee, and the Consumer Wellness Coalition Committee are the primary source for ethnic-specific and consumer family member perspectives in the planning process.

San Bernardino County

According to the County, San Bernardino stakeholders began discussing the need to improve emergency psychiatric care in 2005. Three priorities were identified 1) The need for programs that divert behavioral health consumers from hospital treatment to less restrictive forms of care 2) creating other options for residential out-patient care and 3) decrease long wait-times for behavioral health consumers seeking emergency psychiatric care in the local emergency departments. The County has been working on programs to address the first two priorities. The need to work on decreasing the long wait-times for behavioral health consumers in local emergency departments was reinforced through the fiscal year 2014/15 through 2016/17 Annual Update. In discussions with the Hospital Association of Southern California and Riverside County the concept of the I.E. Psych Partners was born.

The Learning Goals and Objectives

The following section addresses the degree to which the Counties have described what they intend to learn from their Innovation project and how they plan to evaluate their proposed project. Here, the County should address: (1) the overall learning goals of the Innovation project, (2) the expected outcomes of the Innovation project, (2) the methods that will be used to gather data and insight into these outcomes, (3) how each outcome will be measured, (4) how outcomes relate to the Innovation's primary purpose, and (4) how the County will assess which elements of the Innovation contributed to positive outcomes.

Riverside and San Bernardino County are submitting a collaborative plan between the public and private sectors. Specifically, the Counties seek to transform the way in which the private hospital system interacts with the public behavioral health system relative to psychiatric emergency services within hospital emergency departments. The target population for each project is those individuals presenting a psychiatric crisis in hospital emergency departments. **The counties may wish to identify the number of individuals they intend to serve with this project.**

While the counties have developed their own evaluation plans, their methods and overall learning goals/outcomes are similar. In both of their Innovation projects, Riverside and San Bernardino Counties hope to learn if and how a multiagency collaboration can:

(1) Improve care for consumers by increasing responses to psychiatric crises in hospital emergency departments
(2) Improve care for consumers by reducing wait times
(3) Improve care for consumers by training staff in de-escalation techniques, and quality crisis interventions
(4) Increase access and linkage to services for consumers within the target population

While each county has developed their own individual evaluation plan to address the learning goals/outcomes, most methods and measures mirror one another. In order to gather these data, each county has identified using both quantitative and qualitative data through a number of different methods. The methods that each county has proposed for gathering data to measure the overall learning goals/outcomes are appropriate and include: pre and post program implementation surveys, focus groups, a Net Promoter Score Study tool, as well as matching data from emergency department encounters with electronic health records. Specific measures identified by each county are also appropriate and will meet the evaluative needs of the program.

With little variations, both county's evaluation plans are similar. Each of the intended learning goals/outcomes will provide better insight into not only how a private-public collaboration between hospital emergency departments and behavioral health systems can be accomplished, but how and to what extent the collaboration can improve care for consumers. The Counties may wish to develop a way to measure whether each of these items, collectively improved overall care for consumers.

The Budget

HASC is the sole source contractor for both Counties in the collaboration. Funding will be provided to HASC who will then contract with hospitals and administer the funding to each participating hospital. Both Counties will equally share the operating expenses and fund HASC staff. HASC staff will include a 1.0 Full Time Equivalent (FTE) program manager, 1.0 FTE office assistant, 1.0 FTE data/business analyst and 1.0 FTE contract manager who will oversee the regional implementation of the project. Each County will also fund the telehealth psychiatry consultants through their consultant budget.

The counties present this project as a public-private partnership and **may wish to discuss how the private hospitals are contributing financially to the**

implementation of this project. The Counties may also wish to discuss any other potential funding sources that were considered in the development of this project.

Both Counties state that the decision to continue this project will depend on outcomes, funding and stakeholder feedback. Counties state that if the project is successful, they will look into continued partnership with HASC, and MHSA program expansion to deliver services to all EDs and funding from potential cost savings from hospitals. Counties state that they may explore partnerships with local health plans as part of sustaining a successful collaboration.

Budget Costs Specific to Riverside

The total budget for Riverside County's portion of the collaboration is $21,782,701 of INN funds over five (5) years. The budget includes $10,424,956 for personnel, $3,242,360 for operating costs, $1,980,246 for contingency, $210,139 for start-up costs and $5,925,000 for consultant contracts (Telehealth Psychiatrists). These totals include $2,970,368 for administration, $75,000 for evaluation and a $166,075 hospital subsidy to facilitate the participation of a remote hospital.

Personnel costs include the salaries and benefits of sixteen (16) 1.0 FTE behavioral health nurses, a 0.5 FTE nurse educator, 1.0 FTE research analyst, 0.1 FTE IT database administrator and a 0.5 FTE office assistant.

Riverside County may wish to clarify how their proposed budgeted amount for evaluation (less than 1% of the total INN proposal costs) will be sufficient given the learning goals described. Riverside County may also wish to explain the purpose of the $1.9 million listed as contingency.

Budget Costs Specific to San Bernardino

The total budget for San Bernardino County's portion of the collaboration is $24,124,391 of INN funds over five (5) years. The budget includes $13,998,124 for personnel, $218,725 for operating costs, $48,779 for start-up costs, and $190,825 for administrative fees for both HASC and DBH, and $9,667,938 for consultant contracts (Telehealth Psychiatrists). These totals include $2,488,797 for administration and $1,371,908 for evaluation.

Personnel costs include the salaries and benefits for eighteen (18) 1.0 FTE behavioral health nurses, two part-time behavioral health nurses and partial FTEs for administration and data collection at five (5) different hospitals for the duration of this project.

Evaluation funds include the staffing by HASC, SBC-DBH and Hospitals to collect, compile and analyze data for the project.

Counties may wish to discuss the justification for program administration funds and provide a breakdown of the portion being paid to HASC, SBC-DBH and RUHS-BH.

Additional Regulatory Requirements

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

References

National Hospital Ambulatory Medical Care Survey: 2013 Emergency Department Summary Tables.

Leslie Zun, MD, MBA 2016, Care of Psychiatric Patients: The Challenge to Emergency Physicians West Journal of emergency medicine2016 Mar, 17 (2): 173-176

“Mapping the Gaps: Mental Health in California.” California Health Care Foundation, http://www.chcf.org/publications/2013/07/data-viz-mental-health. Accessed 7 November 2017.

Name of Counties:	San Bernardino County & Riverside County
Innovation (INN) Project Name:	Inland Empire (I.E.) PsychPartners: Public-Private Collaboration to Transform Emergency Psychiatric Services
Duration of INN Project:	January 2018 – December 2022 (5 years)

INN Project Introduction:

I.E. PsychPartners is an INN project that creates a regional collaboration between the San Bernardino County Department of Behavioral Health (SBC-DBH), Riverside University Health System – Behavioral Health (RUHS-BH), and the Hospital Association of Southern California (HASC), with the goal of effecting regional, system-wide change that improves access to psychiatric consultations in local emergency departments (ED) for adults experiencing a psychiatric crisis. The project will focus on removing the following identified barriers that currently exist between the public behavioral health system and the local hospitals:

Barrier	I.E. PsychPartners Solution
Lack of standardized psychiatric workflow based on best practices.	• Introduce psychiatric consultative services (via telehealth) and a regional collaboration in the design of resources to support the ED physicians in treating psychiatric patients in local EDs with tools such as: o Standardized psychiatric workflows and the creation of standard physician order sets when assessing and diagnosing psychiatric patients o Pre-defined templates containing sets of recommended treatment options based on shared best practices
Lack of ED access to patient behavioral health treatment and medication history.	• Embed a behavioral health professional (eg. registered nurse or clinical therapist) to support medical decision making in the ED. • Provide access to patient medical history in the public health system, to inform medical decision process of physicians and care destination of ED patients. • Reduce stigma and improve the experience of patients experiencing a psychiatric crisis by training all ED staff on caring for and de-escalating patients in psychiatric crisis. • Reduce wait times experienced by psychiatric patients in local emergency rooms.
Lack of regional training model between hospitals and the public behavioral health department that allows for shared learning.	• Develop a regional training model that will allow the region to share best practices, increase awareness of behavioral health services within the region, and provide behavioral health trainings aimed at decreasing stigma and discrimination.
The total size of the Inland Empire prevents the sharing of resources.	• Use telehealth technology to improve interconnectivity and assist in alleviating region’s psychiatric workforce shortage.

Summary of Problem/Needs:

The primary set of challenges that this project seeks to address are as follows:

1. Even with Medi-Cal expansion, the volume of insured and uninsured people living on low-incomes is substantial in the region.
2. Emergency department utilization is increasing as traditionally, emergency rooms are the primary healthcare destination for uninsured and the newly insured.
3. There are not enough psychiatric beds in the region.
4. For psychiatric patients, new pathways are needed when they access local EDs to ensure they have access to care and avoid wait times.

Summary of Learning Goals/Objectives & Evaluation Plan:

	Learning Goal/Objective	Evaluation Plan
Learning Goal 1	**To determine which communication and feedback mechanisms are effective for establishing a collaborative care process between County mental health problems and local hospitals at the systems level.**	**Expected Outcomes:** Collaborative care process (physician standardized orders, or "Order Sets") established at participating hospitals. **Measured by:** Hospital policy/procedure and/or documentation on Order Set training, collaborative process feedback survey, focus groups, meeting minutes and observations.
Learning Goal 2	**To determine if telehealth technology used in the collaborative care process expedites psychiatric treatment interventions in the ED, decreases ED wait times, increases psychiatric services provided by the ED, and decreases recidivism to the ED.**	**Expected Outcomes:** Decreased ED wait times, increased psychiatric services in the ED, decreased recidivism to the ED. **Measured by:** ED records/forms documenting the volume of telehealth consultations, ED wait times, disposition at discharge and psychiatric services provided.
Learning Goal 3	**To determine if regional training in crisis de-escalation techniques and crisis interventions within an ED setting improves ED staff capacity to respond to psychiatric crisis in the ED.**	**Expected Outcome:** ED staff develop and/or improve their crisis intervention and crisis de-escalation techniques, increased effectiveness of behavioral health crisis de-escalation and intervention in the ED (from both staff and consumer perspectives). **Measured by:** Training evaluations, consumer experience survey.
Learning Goal 4	**To determine if access to outpatient care can be increased through the interagency collaboration of having behavioral health staff in the ED.**	**Expected Outcome:** Behavioral health staff access any existing behavioral health treatment plans/history in the MHP's system to inform the ED collaborative care process and link consumers in the ED to behavioral health community resources, consumers have an increase in use of outpatient behavioral health services. **Measured by:** ED records/forms documenting the volume of behavioral health staff cases, number of linkages made, and number of outpatient behavioral health services one year pre/post consumer's first experience with the collaborative care process.

Questions & Answers from MHSOAC Staff Innovation Analysis

Q: How will the existing crisis intervention programs support the implementation of this INN project?

A: The existing crisis intervention programs will support the implementation of I.E. PsychPartners by continuing to provide any post-ED visit linkage assistance, as appropriate or possible. Additionally, the learning both counties have achieved related to emergency psychiatric care was provided by the crisis intervention programs and helped shape the early conversations with HASC concerning the project's scope and objectives. Based on the information provided by the existing crisis intervention programs, this project seeks to strengthen local emergency room's ability to triage, assess, diagnose and treat patients in psychiatric crisis to ensure there is not an escalation of their symptoms and unnecessary transfers to higher levels of care when their psychiatric symptoms can be managed by the support of a behavioral health professional and in consultation with a psychiatrist via telehealth.

Q: What is the role of HASC in the actual day-to-day function of the INN proposal?

A: When determining the role of HASC, both counties took the lessons learned from our law enforcement collaborations that indicated there was greater acceptance of system-level change when there was a trusted cultural broker involved, especially when there is an outside agency involved in that change. HASC will be the cultural liaison and relationship navigator into the ED community. Both RUHS-BH and SBC-DBH are mindful of what "we do not know" about the day-to-day activities and expertise required in the management of the region's EDs and will rely on HASC to assist in the presentation of solutions in ways that align with the existing hospital structure. Additionally, HASC will provide administrative oversight of the contracts with each hospital, will serve as lead in the creation of a standardized emergency psychiatric workflow that meets the needs of both the individual hospitals and the public behavioral health system, and will work directly with the hospitals in the recruitment and hiring of the behavioral health professionals and the collection of evaluation data.

Q: How many individuals will be served with this project?

A: Approximately 4,000 – 4,500 individuals, per county, per year.

Q: How will this project measure whether each of these items, collectively improved overall care for consumers?

A: Both counties will utilize their existing stakeholder process to obtain continuous feedback from consumers that utilize our regional EDs. Additionally, the project will monitor ED wait-times, utilization of behavioral health outpatient services, and hospitalizations to determine if changes to the ED made by the project are positively impacting outcomes.

Q: How are private hospitals contributing financially to the implementation of this project? Were any other funding sources considered in the development of this project?

A: Each hospital who wishes to participate must provide the one-time start-up costs in the form of the required telehealth technology that is fully operational. This equipment and technology must be in place prior to implementation. Also, as part of the proposed contractual agreement to be part of this project, each hospital will participate in the project's sustainability discussions. Tentative discussion topics include understanding how the hospitals plan on using of the saving achieved by having a streamed-lined emergency psychiatric process and if this saving can be used to continue the successful portions of I.E. PsychPartners. Additionally, since each hospital's funding stream may be different, specific funding sources will be discussed after each hospital has committed to project participation.

Q: What is the justification for the program administration funds?

A: *Riverside:*

RUHS-BH administrative costs include the administrative oversight and support for the project. This cost is calculated at 15% of the budget and includes RUHS-BH administration, as well as HASC administration.

San Bernardino:

SBC-DBH administrative costs include administrative and executive oversight of the project for SBC-DBH staff and a proportional share of the time provided by the HASC Regional Vice President on this project.

Q: Riverside County: How will the proposed budgeted amount (less than 1% of the total costs) for evaluation be sufficient given the learning goals described?

A: RUHS-BH has a Research and Evaluation team who dedicate a portion of their time to innovations projects. Also, additional staff time has been isolated for the purposes of this project these allotments can be found in staff line items (including IT Database Administrator, Research Analyst, a portion of Program Administrator, and HASC Data Analyst). The evaluation costs line item is for any costs occurred in addition to the aforementioned allocation of staff time and data analysis (e.g. focus groups, etc.).

Budget Summary:

SBC-DBH: I.E. PsychPartners Project Budget by FY								
EXPENDITURES								
PERSONNEL COSTS *(Salary, Wages, Benefits)*		**FY 17/18[1]**	**FY 18/19**	**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23[1]**	**Total**
1.	Salaries	$735,445	$2,922,983	$2,938,232	$2,953,893	$2,969,977	$1,477,594	**$13,998,124**
2.	Direct Costs	$0	$0	$0	$0	$0	$0	**$0**
3.	Indirect Costs	$0	$0	$0	$0	$0	$0	**$0**
4.	Total Personnel Costs	$735,445	$2,922,983	$2,938,232	$2,953,893	$2,969,977	$1,477,594	**$13,998,124**
OPERATING COSTS		**FY 17/18[1]**	**FY 18/19**	**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23[1]**	**Total**
5.	Direct Costs	$19,682	$42,653	$42,653	$42,653	$42,653	$28,431	**$218,725**
6.	Indirect Costs	$0	$0	$0	$0	$0	$0	**$0**
7.	Total Operating Costs	$19,682	$42,653	$42,653	$42,653	$42,653	$28,431	**$218,725**
NON RECURRING COSTS *(equipment, technology)*		**FY 17/18[1]**	**FY 18/19**	**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23[1]**	**Total**
8.	One-time start-up costs[2]	$48,779	$0	$0	$0	$0	$0	**$48,779**
9.	-	-	-	-	-	-	-	-
10.	Total Non-Recurring Costs	$48,779	$0	$0	$0	$0	$0	**$48,779**
CONSULTANT COSTS/CONTRACTS *(clinical, training, facilitator, evaluation)*		**FY 17/18[1]**	**FY 18/19**	**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23[1]**	**Total**
11.	Direct Costs	$593,125	$2,016,625	$2,016,625	$2,016,625	$2,016,625	$1,008,313	**$9,667,938**
12.	Indirect Costs	$0	$0	$0	$0	$0	$0	**$0**
13.	Total Operating Costs	$593,125	$2,016,625	$2,016,625	$2,016,625	$2,016,625	$1,008,313	**$9,667,938**
OTHER EXPENDITURES		**FY 17/18[1]**	**FY 18/19**	**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23[1]**	**Total**
14.	Admin Fees	$17,964	$36,973	$38,049	$39,156	$40,297	$18,386	**$190,825**
15.	-	-	-	-	-	-	-	-
16.	Total Other Expenditures	$17,964	$36,973	$38,049	$39,156	$40,297	$18,386	**$190,825**
BUDGET TOTALS								
Personnel		$735,445	$2,922,983	$2,938,232	$2,953,893	$2,969,977	$1,477,594	**$13,998,124**
Direct Costs (2,5,& 11)		$612,807	$2,059,278	$2,059,278	$2,059,278	$2,059,278	$1,036,744	**$9,886,663**
Indirect Costs (3,6,& 12)		$0	$0	$0	$0	$0	$0	**$0**
Non-recurring Costs (10)		$48,779	$0	$0	$0	$0	$0	**$48,779**
Other Expenditures (16)		$17,964	$36,973	$38,049	$39,156	$40,297	$18,386	**$190,825**
TOTAL INNOVATION BUDGET		$1,414,995	$5,019,234	$5,035,559	$5,052,327	$5,069,552	$2,532,724	**$24,124,391**

1 - Project is funded for only 6 months during the FY.

2 - "One-time start-up costs" listed are for HASC and SBC-DBH only. Participating hospitals are responsible for any one-time costs (e.g. equipment and/or technology) associated with their participation of this project.

RUHS-BH: I.E. PsychPartners Project Budget by FY								
EXPENDITURES								
PERSONNEL COSTS *(Salary, Wages, Benefits)*		**FY 17/18[1]**	**FY 18/19**	**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23[1]**	**Total**
1.	Salaries	$620,398	$1,728,774	$2,222,351	$2,289,021	$2,357,692	$1,206,721	**$10,424,956**
2.	Direct Costs	$0	$0	$0	$0	$0	$0	**$0**
3.	Indirect Costs	$0	$0	$0	$0	$0	$0	**$0**
4.	Total Personnel Costs	$620,398	$1,728,774	$2,222,351	$2,289,021	$2,357,692	$1,206,721	**$10,424,956**
OPERATING COSTS		**FY 17/18[1]**	**FY 18/19**	**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23[1]**	**Total**
5.	Direct Costs	$118,753	$330,246	$428,466	$441,290	$641,944	$332,839	**$2,293,538**
6.	Indirect Costs	$53,145	$155,031	$203,854	$209,969	$216,268	$110,554	**$948,822**
7.	Total Operating Costs	$171,898	$485,277	$632,320	$651,259	$858,212	$443,393	**$3,242,360**
NON RECURRING COSTS *(equipment, technology)*		**FY 17/18[1]**	**FY 18/19**	**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23[1]**	**Total**
8.	One-time start-up costs	$210,139	$0	$0	$0	$0	$0	**$210,139**
9.	-	-	-	-	-	-	-	**-**
10.	Total Non-Recurring Costs	$210,139	$0	$0	$0	$0	$0	**$210,139**
CONSULTANT COSTS/CONTRACTS *(clinical, training, facilitator, evaluation)*		**FY 17/18[1]**	**FY 18/19**	**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23[1]**	**Total**
11.	Direct Costs	$325,000	$975,000	$1,300,000	$1,300,000	$1,300,000	$650,000	**$5,850,000**
12.	Indirect Costs	$0	$14,000	$14,000	$15,000	$15,000	$17,000	**$75,000**
13.	Total Operating Costs	$325,000	$989,000	$1,314,000	$1,315,000	$1,315,000	$667,000	**$5,925,000**
OTHER EXPENDITURES		**FY 17/18[1]**	**FY 18/19**	**FY 19/20**	**FY 20/21**	**FY 21/22**	**FY 22/23[1]**	**Total**
14.	Contingency	$132,744	$320,305	$416,867	$425,528	$453,090	$231,711	**$1,980,246**
15.	-	-	-	-	-	-	-	**-**
16.	Total Other Expenditures	$132,744	$320,305	$416,867	$425,528	$453,090	$231,711	**$1,980,246**
BUDGET TOTALS								
Personnel		$620,398	$1,728,774	$2,222,351	$2,289,021	$2,357,692	$1,206,721	**$10,424,956**
Direct Costs (2,5,& 11)		$443,753	$1,305,246	$1,728,466	$1,741,290	$1,941,944	$982,839	**$8,143,538**
Indirect Costs (3,6,& 12)		$53,145	$169,031	$217,854	$224,969	$231,268	$127,554	**$1,023,821**
Non-recurring Costs (10)		$210,139	$0	$0	$0	$0	$0	**$210,139**
Other Expenditures (16)		$132,744	$320,305	$416,867	$425,528	$453,090	$231,711	**$1,980,246**
TOTAL INNOVATION BUDGET		$1,460,179	$3,523,356	$4,585,537	$4,680,808	$4,983,995	$2,548,826	**$21,782,701**

1 - Project is funded for only 6 months during the FY.

AGENDA ITEM 5

Action

November 16, 2017 Commission Meeting

Award of Transition Age Youth (TAY) Stakeholder Contract

Summary: The Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission) will consider awarding a stakeholder contract in response to the Request for Proposal (RFP) for Transition Age Youth (TAY) released by the Commission in October 2016.

In August of 2016 the Commission authorized the Executive Director to issue a RFP for Transition Aged Youth advocacy using the additional 2016 budget dollars that were not included in the initial TAY RFP and award.

Scope of Work

Proposers were asked to outline a plan to conduct local community engagement events. Each event requires an outreach plan, a TAY focused outreach activity, and a presentation to the local mental health board or board of supervisors.

RFP Timeline

- October 10, 2017: RFP released to the public
- November 3, 2017: Deadline to submit proposals
- November 16, 2017: Results presented to the Commission

RFP Evaluation Process

The entire scoring process from receipt of proposals to posting of the Notice of Intent to Award is confidential. In accordance with the State of California standard competitive selection process, all proposals were evaluated in a multiple stage process.

Final selection is determined on the basis of the highest overall point score. The recommended award is to be made to the proposer receiving the highest overall point score.

RFP Award and Protest Process

Within five working days of the Commission's vote to award the contracts, unsuccessful proposers, wishing to protest the decision, must submit to the MHSOAC a letter of intent to protest. If a protest is filed within this timeframe, the RFP requires a letter of protest to describe the factors that support the protesting proposer's claim. For a protest to be successful the protesting proposer must prove one of the following:

1. The protesting proposer would have been awarded the contract had the MHSOAC correctly applied the prescribed evaluation rating standards in the RFP; or
2. The protesting proposer would have been awarded the contract had the MHSOAC followed the evaluation and scoring methods in the RFP.

As outlined in the RFP, the MHSOAC Executive Director reviews the grounds for protest and renders a final decision.

Enclosures: None

Handout: Power Point presentation will be made available at the Commission meeting.

Presenter: Tom Orrock, Chief, Angela Brand, Stakeholder Contract Lead

Recommended Action: Award the contract to the proposer receiving the highest overall point score and authorize the Executive Director to execute a contract for TAY upon the termination of the protest period.

AGENDA ITEM 6

Action
November 16, 2017 Commission Meeting

Schools and Mental Health Project Proposal

Summary: Earlier this year, the Commission authorized staff to release a competitive funding proposal to allocate Senate Bill (SB) 82 triage funds for crisis services. Available funds will be between $100 million and $150 million. The Commission directed staff to ensure that a minimum of 50 percent of those funds be dedicated to services for children and youth under the age of 21. Recognizing the opportunity to support the Commission's work on Schools and Mental Health, and what we learned from the Children's Crisis Services work, staff and the Schools and Mental Health Subcommittee are asking the Commission to modify its earlier direction. Staff is requesting the Commission to authorize up to $30 million of SB 82 funds to incentivize county-school partnerships that are consistent with the goals of SB 82, namely improving access to care, including crisis-oriented services. If approved, staff will work with the Schools and Mental Health Subcommittee to support an evaluation of that effort to better understand the barriers to School-Mental Health collaboration and ways to incentivize that collaboration on a statewide basis.

SB 82 Legislation

SB 82 enacted the Investment in Mental Health Wellness Act in 2013, which provides seed funds to expand crisis services. In February 2014, the Commission awarded SB 82 funds to 24 counties to implement SB 82 services. The Commission allocates $32 million per year for these services and provides funding to grantees on a three year basis. Based on the first round of county proposals that were awarded, 83 percent of the awarded funds were dedicated to services primarily directed to adults. Just 17 percent of these funds were dedicated to services specific to children and youth. For that reason, in July of 2017, the Commission directed staff to develop a competitive application process and to dedicate no less than 50 percent of the next round of SB 82 triage funds to children's crisis services, targeting children and youth, ages 0-21.

For this second round of SB 82 funding, the Commission has four sources of funding that can be made available through a competitive process: Core SB 82 dollars ($32 million per year for three years), reallocated SB 82 funds from prior years (potentially up to $50 million, depending on expenditure rates from counties awarded contracts), funding for children's crisis services ($1.5 million), and funding for parent training and support ($1.5 million).

In discussions with county leaders, we have heard that counties would prefer the option of competing for both adult and children/youth oriented grants. A sample of County Behavioral Health directors have expressed concern that if they are limited to competing for a single grant, many counties would elect to only apply for the adult funds based on the perception of greatest needs in their communities. To address that concern, staff recommends allowing counties to compete for adult funds separate from the competition for children and youth funds.

County-School Partnerships

Staff also recommend establishing a competitive program to provide seed funding to a small set of counties willing to invest in County-School mental health partnerships to improve access to care consistent with the direction of SB 82. Among other opportunities, as defined in SB 82 and proposed by the counties, the program would support strategies to: 1) build and strengthen partnerships between education and community mental health; 2) support school-based and community-based strategies to improve access to care; and 3) enhance crisis services that are responsive to the needs of children and youth, all with particular recognition of the educational needs of children and youth.

This request is informed by work being done on the Schools and Mental Health project, the Children's Crisis Services project, the lessons learned from the first round of SB 82 funding, and the MHSA goal of leveraging MHSA funds to improve educational outcomes for children. In sum, we have learned that many children experience a mental health crisis or seek help during school hours. We have learned that SB 82 funds can help build the trust and partnerships between community entities that have not historically collaborated. And we have learned that investing in operational strategies can help us understand what works, what is difficult, and how we can create incentives for counties to expand these strategies statewide.

Presenter: Toby Ewing, Executive Director

Enclosures: None.

Proposed Motion: Authorize staff consistent with this request to provide SB 82 funds in a competitive manner and that no less than $30 million of that amount be made available for county-school mental health partnerships.

AGENDA ITEM 7

Action

November 16, 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. 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 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/amendments;
- Reference: Do the regulations/amendments correctly reference the specific statute they implement, interpret or make specific;
- Consistency: Are the regulations/amendments consistent with the law;
- Clarity: Is the text of the regulations/amendments clear;
- Non-duplication: Are the regulations/amendments duplicative of the statute they implement, interpret or make specific;
- Necessity: Are the regulations/amendments 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.

<u>Proposed Motion</u>

The Commission accepts staff's recommendations to the public comments received during the 45-day public comment period and authorizes the Executive Director to take the necessary next steps.

Staff Recommended Responses to the Relevant 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 required 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, counties, consumers, family members, community mental health providers, and other stakeholders to address concerns regarding the implementation of the PEI and Innovation regulations issued in 2015.

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 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 seek 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. A copy of the July version of the proposed amendments to the PEI and Innovation regulations are included as Attachments 1 and 2, respectively. A copy of staff's recommended changes to the July proposed amendments to the PEI and Innovation regulations are included as Attachments 3 and 4, respectively.

Of the above listed seven categories of amendments, staff received written comments 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 each of the written comments and of the hearing transcript is included as Attachment 5. 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 require 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 adds 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 Attachment 3.) 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 under current law 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** currently required demographic information, including sexual orientation and gender identity from all individuals including children under 12 years old. (See Attachment 5 – comment from California Alliance.)
(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 caregivers to the extent permissible under state/federal privacy laws. (See Attachment 5 – comment from Young Minds Advocacy.)
(3) Modify the proposed amendment to require counties to report only certain demographic information from children under 12. Nine organizations/individuals 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. (See Attachment 5 – written comments from REMHDCO, California LGBT Health & Human Services Network, NorCalMHA, California Pan-Ethnic Health Network, California Health+ Advocates, Muslim American Society Social Services Foundation, California Chapter of the National Association of Social Workers, Richmond Area Multi-Service, and Laurel Benhamida. Also see testimony of Poshi Walker of NorCalMHA, Stacie Hiramoto of REMHDCO, Elizabeth Oseguera of California Health+ Advocates, Mandy Taylor of California LGBT Health & Human Services Network, and Kiran Savage of California Pan-Ethnic Health Network.)

Staff recommends modifying subdivision (d) of section 3560.010 in the PEI and section 3580.010 of the Innovative Project regulations consistent with the comments listed above in item (3). Chart 1 shows the demographic information 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 2015 Version (All ages)	7/2017 Version (Children under 12)	Recommended Modification to 7/2017 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 language in the PEI (3560.010(d)) and Innovative Project (3580.010(c)) regulations would be identical and would read as follows:

> 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, the Office of Administrative Law mandated that the regulations require counties to 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 their ability to collect 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 page 3 of Attachment 1.) 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 Attachment 1.)

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 to a program 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 are not within the county system. (See Attachment 5 – comment from California Alliance.)

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. Chart 2 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 July 2017 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 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:

(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 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 are 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 are 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 are 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 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 Attachment 1.)

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. (See Attachment 5 – comment from Young Minds Advocacy.)

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

V. <u>Opt-out of Access and Linkage to Treatment Program Requirement for Counties With Population Under 100,000: Section 3705(a)(4)(A) and (a)(4)(B)</u>

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. For example, 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 original, (2015) 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 Attachment 1.) The rationale 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. (See Attachment 5 – comment from California Alliance.)

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 Unrelated to The Proposed Amendments

In addition to the above discussed comments, staff received comments unrelated to the July proposed amendments. The comments deal with sections of the regulations that are not part of the proposed amendments or are about general issues of implementation of the Mental Health Service Act. Those comments, from Mary Ann Bernard, Esq, California Alliance, and Pete LaFollette are included in Attachment 5.

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 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.

Staff recommends responding to these comments by explaining that they are not related to the specific proposed amendments and, depending on the topic, may be revisited in future Commission discussion.

---

[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 <u>Prevention and Early Intervention</u> ~~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 <u>Prevention and Early Intervention</u> ~~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~~ <u>resolution</u> 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 as defined in subdivision (b)(3)(F) of section 3560.010 to treatment, and kind of treatment to which person was referred.
  (2) Number of persons who followed through on the referral as defined in subdivision (b)(3)(F) of section 3560.010 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) 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.

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

(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

BOARD OF DIRECTORS

Jacquie Anderson
Chief Operating Officer
Centering Healthcare Institute

Michelle Doty Cabrera
Healthcare and Research Director
California State Council of the Service Employees International Union

Kathy Ko Chin, MS
President and Chief Executive Officer
Asian & Pacific Islander American Health Forum

Tony Dang
Executive Director
California Walks

James Gilmer, MA
President
Cyrus Urban Network- Multicultural Community Ventures Initiative

Sharad Jain, MD
Professor of Medicine, UCSF
Staff Physician, SFGH

Nomsa Khalfani, PhD
Senior Vice President of Programs + Strategic Initiatives
Essential Access Health

Janet King, MSW
Program Manager of Policy and Advocacy
Native American Health Center

Mark LeBeau, PhD, MS
Executive Director
California Rural Indian Health Board

Tana Lepule

Nayamin Martinez, MPH
Director
Central California Environmental Justice Network (CCEJN)

Poki Namkung, MD, MPH

Jeffrey Reynoso
Executive Director
Latino Coalition for a Healthy California

Doretha Williams-Flournoy
Interim President/CEO
California Black Health Network

Sarah de Guia, JD
Executive Director

MAIN OFFICE
1221 Preservation Park Way, Suite 200
Oakland, CA 94612

SACRAMENTO OFFICE
1107 9th Street, Suite 410
Sacramento, CA 95814

LOS ANGELES OFFICE
3731 Stocker Street, Suite 201
Los Angeles, CA 90008

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

BOARD OF DIRECTORS

Jacquie Anderson
Chief Operating Officer
Centering Healthcare Institute

Michelle Doty Cabrera
Healthcare and Research Director
California State Council of the Service Employees International Union

Kathy Ko Chin, MS
President and Chief Executive Officer
Asian & Pacific Islander American Health Forum

Tony Dang
Executive Director
California Walks

James Gilmer, MA
President
Cyrus Urban Network- Multicultural Community Ventures Initiative

Sharad Jain, MD
Professor of Medicine, UCSF
Staff Physician, SFGH

Nomsa Khalfani, PhD
Senior Vice President of Programs + Strategic Initiatives
Essential Access Health

Janet King, MSW
Program Manager of Policy and Advocacy
Native American Health Center

Mark LeBeau, PhD, MS
Executive Director
California Rural Indian Health Board

Tana Lepule

Nayamin Martinez, MPH
Director
Central California Environmental Justice Network (CCEJN)

Poki Namkung, MD, MPH

Jeffrey Reynoso
Executive Director
Latino Coalition for a Healthy California

Doretha Williams-Flournoy
Interim President/CEO
California Black Health Network

—

Sarah de Guia, JD
Executive Director

—

MAIN OFFICE
1221 Preservation Park Way, Suite 200
Oakland, CA 94612

SACRAMENTO OFFICE
1107 9th Street, Suite 410
Sacramento, CA 95814

LOS ANGELES OFFICE
3731 Stocker Street, Suite 201
Los Angeles, CA 90008

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

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

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

7759 El Rito Way, Sacramento, CA 95831
(916) 705-5018 shiramoto@remhdco.org

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.

Board Members

Alex Briscoe
The Tipping Point Community

Chuck Fox, Chair
Oceans Five

Patrick Gardner, President
Young Minds Advocacy

Victor Geminiani
Hawaii Appleseed Center

Laurie Sobel
Kaiser Family Foundation

Staff Members

Nisha Ajmani
Staff Attorney & Policy Associate

Tara Ford[1]
Senior Attorney

Annabelle Gardner
Director of Communications & Development

Astrea Somarriba
Admin & Communications Coordinator

Aisa Villarosa
Associate Attorney

[1]Licensed in NM, Registered Legal Services Attorney in CA

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

275 5th Street
San Francisco, CA 94103
415-466-2991
info@ymadvocacy.org
www.ymadvocacy.org

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

[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."

---

[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* regaining 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
1016 23rd Street
Sacramento, CA 95816-4910
Direct line: 916-379-7597
Fax: (916) 442-2075
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,

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.
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 hosptaiizations, 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.

Since the phone lines are not open during the MHSOAC Commission
meetings, there is no way to incorporate public comments into the proceedings.
This is an action item at last week's MHSOAC Commission meeting.
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 recent (2014) Legislature Analysts

The MHSOAC currently is changing the contract language of PEI and INN 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 OAC 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 ...

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

PAID FOR BY ORGANIZING FOR ACTION

Contributions or gifts to Organizing for Action are not tax deductible.

This email was sent to: **plafollette@hotmail.com**.
If that is not your preferred email address, you can update your information here. We believe that emails are a vital way to stay in direct contact with supporters. Click here if

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

Reply to **sender** | Reply to **group** | Reply **via web post** | **Start a New Topic**
Messages in this topic (3)
RECENT ACTIVITY:
Visit Your Group
To visit your group on the web, go to:
http://groups.yahoo.com/group/ClientDiscussions/

Switch to: Text-Only, Daily Digest • Unsubscribe • Terms of Use

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

CONFIDENTIALITY NOTICE: This e-mail message (including any attachments) contains information which may be confidential and privileged. Unless you are the addressee (or authorized to receive for the addressee), you may not use, copy, distribute, or disclose any information contained in this message. If you have received this message in error, please immediately advise the sender by reply e-mail, and permanently delete all copies of the message and any attachments. Thank you for your cooperation.

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

A P P E A R A N C E S

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

A P P E A R A N C E S

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

		Page
2.	Proposed Amendments to Prevention and Early Intervention (PEI) and Innovation (INN) Regulations	5
	Public Comment	
	Poshi Walker	14
	Stacie Hiramoto	16
	Michele Violett	18
	Elizabeth Oseguera	19
	Mandy Taylor	20
	Kiran Savage	21
	Closure of Public Hearing	23
	Conclusion of Item	23
General Public Comment (related to Item 2)		
	Dr. Nancy Callahan	24
Certificate of Reporter		27

1 P R O C E E D I N G S

2 9:20 a.m.

3 **2. Proposed Amendments to Prevention and Early**

4 **Intervention (PEI) and Innovation (INN) Regulations**

5 CHAIR WOOTON: We are moving right into our

6 proposed amendments to Prevention and Early Intervention,

7 PEI, and Innovation, the INN regulations. This is an

8 information item on our agenda. This is an official hearing

9 because it is the regulations so I am going to turn it over

10 to Filomena at this time. Thank you.

11 CHIEF COUNSEL YEROSHEK: Good morning,

12 Commissioners.

13 This next part of the Commission meeting, which is

14 scheduled for one hour or as soon as there are no more

15 public comments on the topic, so whichever occurs first, so

16 if less than one hour there are no more comments the hearing

17 will be closed.

18 So this is a quasi-legislative hearing. It is a

19 little different than what you are used to because you are

20 carrying out the rulemaking function that the Legislature

21 delegated to you; this deals with amendments to the

22 regulations.

23 Those of you who have been with the Commission for

24 a few years know that after -- these amendments are coming

25 after a six month public input on the proposed amendments

1 that were held by a subcommittee chaired by Commissioner
2 Poaster and Commissioner Aslami-Tamplen as well as
3 Commissioner Van Horn were members of at that time.
4 And then at the July Commission meeting the full
5 Commission approved these proposed amendments to the
6 Prevention and Early Intervention regulations and to the
7 Innovation regulations.
8 We followed the Administrative Procedures Act and
9 submitted the proposed regulations to the Office of
10 Administrative Law, they were published. They were also
11 published on our website and they were submitted and sent
12 out to all parties who had informed us that they were
13 interested in receiving notices to the regulations.
14 That started a 45 day public comment period.
15 Today is the end of that 45 day period.
16 The hearing, like I said, is slated to last for an
17 hour. However, the public comment period does not end until
18 5:00 p.m. today, so those individuals who could not make it
19 today or who want to provide additional written comments can
20 do so via -- they can just write it out and hand it to a
21 staff member who is at the table or to me or they can email
22 it to the Commission as set forth in the notice that has
23 been posted on our website.
24 So this is the time where the Commission is
25 sitting down and listening. It is not a dialogue time.

1 That dialogue in terms of the Commission responding to the
2 comments will come depending on time constraints at either
3 the October Commission meeting or at the November Commission
4 meeting.
5 And what will happen then is that all of the
6 written public comments as well as the oral comments that
7 are made today at the hearing will be presented to you in
8 their entirety and staff's proposed responses to those
9 comments. So if there are comments suggesting tweaks or
10 changes in the proposed language you will get an opportunity
11 to decide whether you want to accept those comments and
12 follow-up with additional changes or reject those comments.
13 Either way you have to state a rationale for your decision.
14 That all will be writing, presented to you either at the
15 October meeting or at the November meeting, depending on the
16 number of comments. So far we have not received a lot of
17 comments. We have received a handful of them, which is
18 helpful in terms of it being available for the October
19 meeting.
20 If you decide to make additional changes to the
21 proposed amendments, depending on what type of changes, if
22 they are substantial changes that are related to the current
23 proposed amendments those changes will go out for an
24 additional 45 day public comment period and you get the
25 opportunity to respond to those comments and the process

1 sort of keeps going.
2 Do you have any questions? We have gone through
3 sort of the process multiple times at the Commission meeting
4 but we do have brand new Commissioners and I want to make
5 sure that the sometimes-confusing legal process is
6 understood; so please don't hesitate to ask any questions.
7 COMMISSIONER ASHBECK: Tina, I have a question.
8 CHAIR WOOTON: Yes, Commissioner.
9 COMMISSIONER ASHBECK: So at the risk of having
10 the silliest question of the day at 9:26, I don't know what
11 the amendments are. I don't see them in the packet. This
12 happened, I think, before I joined the Commission. Is there
13 a summary? The link here took us to the rules but is there
14 a way to see what those amendments are so as folks comment
15 on them I'll know what the context is?
16 CHIEF COUNSEL YEROSHEK: Sure. We have copies of
17 the proposed comments on the table and we will make sure
18 that all the Commissioners that want one will get one.
19 COMMISSIONER ASHBECK: The proposed amendments.
20 CHIEF COUNSEL YEROSHEK: Sorry, proposed
21 amendments.
22 COMMISSIONER ASHBECK: Not comments.
23 CHIEF COUNSEL YEROSHEK: Yes.
24 COMMISSIONER ASHBECK: Okay. That would be great.
25 Since I don't know what they are that would be helpful.

1 Thank you.
2 CHIEF COUNSEL YEROSHEK: Yes. Yes.
3 COMMISSIONER ASHBECK: And there might be others
4 here that would be in the same spot.
5 CHIEF COUNSEL YEROSHEK: Yes.
6 COMMISSIONER MITCHELL: And Fil, are you going to
7 go over those amendments today?
8 CHIEF COUNSEL YEROSHEK: Not today.
9 COMMISSIONER MITCHELL: Okay.
10 CHIEF COUNSEL YEROSHEK: Today is the -- that's
11 why I said it's unique. It's the quasi-legislative hearing
12 so you are just to hear the comments, right? And then at
13 the next meeting you will have the proposed amendments, the
14 comments and the proposed responses to those comments.
15 And so we made extra copies because we knew that
16 some people wouldn't bring, you know, like the public
17 comments needed to refer -- we are going to ask individuals
18 to refer to a specific code section.
19 But this is a time when you can just sit back and
20 listen. But that is a very good point, thank you. I
21 apologize for not providing it. We provided it to the
22 public but not to the Commissioners, not a good thing.
23 Any other questions? Commissioner Poaster.
24 COMMISSIONER POASTER: Just one comment to make
25 sure that I understand. The amendments that you are

1 referring to now are the amendments that were adopted by the
2 Commission a couple of months ago, correct?
3 CHIEF COUNSEL YEROSHEK: Correct.
4 COMMISSIONER POASTER: Okay.
5 CHIEF COUNSEL YEROSHEK: So the amendments that
6 you will be hearing comments on are the amendments that the
7 full Commission heard and adopted in July.
8 COMMISSIONER POASTER: Right. So that any changes
9 that come from other people then would be discussed in the
10 following meeting.
11 CHIEF COUNSEL YEROSHEK: Exactly. This is not a
12 time for, this is not a time for Commission discussion on
13 this particular topic. That is why I was sort of trying to
14 say it is a unique part of the Commission meeting. It is to
15 just hone in on each of the comments, knowing that you will
16 have multiple opportunities, especially in October, and any
17 future opportunities if you decide to make additional
18 changes.
19 CHAIR WOOTON: Any other comments for Filomena?
20 CHIEF COUNSEL YEROSHEK: No other questions?
21 COMMISSIONER GORDON: I have a question.
22 CHIEF COUNSEL YEROSHEK: Yes, Commissioner Gordon.
23 COMMISSIONER GORDON: Just a clarification. So
24 these amendments were reviewed by the Commission and
25 commented on at the time in the course of the discussion by

1 the Commission, so this is a second round, so to speak --
2 CHIEF COUNSEL YEROSHEK: Exactly.
3 COMMISSIONER GORDON: -- for comments on the
4 changes that are proposed here.
5 CHIEF COUNSEL YEROSHEK: Exactly.
6 COMMISSIONER GORDON: Thank you.
7 CHIEF COUNSEL YEROSHEK: So the Commission --
8 Thank you for bringing that up. The Commission is unique in
9 terms of being a body that has to follow the Bagley-Keene
10 Open Meeting Act. So regulations done by a department would
11 not have the layer of transparency and public comments,
12 right? So yes, these are identical to what the Commission
13 discussed, heard public comments on and voted to go with at
14 that time. Okay.
15 CHAIR WOOTON: Okay. And this is, once again,
16 just information only this morning.
17 Since this is an official hearing I am going to
18 read a statement. I will be repeating mostly what Filomena
19 just shared with us - good morning, Andrea - but I would
20 like to go ahead and read this statement for official
21 purposes, thank you.
22 Once again, as Filomena stated, this is a time to
23 receive public comments on the proposed amendments to the
24 PE&I and Innovation regulations.
25 Under the rulemaking provisions of the

1 Administrative Procedure Act, this is the time and place set
2 for the presentation of statements and arguments orally or
3 in writing, for or against the changes in the MHSOAC's
4 regulations, notice of which was published in the California
5 Regulatory Notice Register, on the OAC's website, and sent
6 out by email to interested parties.
7 Witnesses presenting testimony at this hearing
8 will not be sworn-in and the Commission will not engage in
9 dialogue with the witnesses. The Commission will take under
10 submission all the written and oral statements submitted by
11 5:00 p.m. today or made during this hearing. We will
12 respond to these comments in writing.
13 The hearing is being recorded and the transcript
14 of the hearing with all exhibits and evidence presented
15 during the hearing will be made part of the rulemaking
16 record. This hearing on the proposed amendments is
17 scheduled to go to 10:15 or when there are no more comments,
18 whichever occurs first.
19 As you entered this room, you were offered the
20 attendance sheet to sign your name and indicate whether you
21 wanted to stand up and make oral comments on the proposed
22 regulations or if you just wanted to attend the hearing.
23 Do you need to fill out the attendance sheet if
24 you don't wish to speak? Yes, if want to be notified of the
25 final adoption of the changes or about any new additional

1 changes. Such notice will be sent to everyone who submits
2 written comments during the written comment period, to
3 everyone who testifies today, and to everyone that asks for
4 such a notification. While no one may be excluded from
5 participating in these proceedings for failure to identify
6 themselves, the names and addresses on the attendance sheet
7 will be used to provide the notice.
8 If you have not yet signed the attendance sheet
9 and you now wish to do so, please go back to the table and
10 sign in.
11 We will listen to oral comments in the order you
12 signed the attendance sheet. After we hear from everyone
13 who signed in, we will hear from any latecomers or anyone
14 else who wishes to be heard.
15 When you come up to speak, we ask that you do
16 certain things so that your comments are entered into the
17 record. First we ask you to come to the podium when you are
18 called to speak. Second, please begin by stating your name
19 and identifying the organization your represent, if any, and
20 tell us whether you are commenting on the PE&I or INN
21 regulations and the section number you want to discuss. We
22 have in the back table some copies of the proposed
23 amendments to the PE&I and INN regulations for your
24 convenience.
25 As I mentioned, these proposed amendments were

1 duly noticed more than 45 days prior to today's hearing.
2 Copies of the notice, together with the regulations and the
3 statement of reasons were posted on the Commission's website
4 and sent to all interested parties who requested rulemaking
5 notices.
6 And at this time may I have the attendance sheet,
7 please? We will now take oral comments on the proposed
8 regulations.
9 The first person is Poshi Walker. Can you please
10 come to the podium.
11 Thank you, everyone.
12 MS. WALKER: Good morning. My name is Poshi
13 Walker; I am with NorCal Mental Health America and the co-
14 director of the brand new LGBTQ advocacy contract with the
15 MHSOAC.
16 First, we want to strongly support those who will
17 be speaking after me, specifically to the collection of
18 race, ethnicity and primary language for minors younger than
19 age 12. Our concern is focused on that same section which
20 in your -- it's on page 5 of the PEI, letter D, a county is
21 not required to collect the demographic information required
22 under subdivision whatever, from a minor younger than 12
23 years of age.
24 We understand the tension between the need for
25 data and the concerns for age-appropriate methodology. With

1 that in mind we consulted with the Williams Institute
2 regarding best practices for collecting sexual orientation
3 and gender identity data for individuals under the age of
4 12. We are concerned for the following reasons:
5 The gender, race, ethnicity, primary language and
6 disability of those being served is vital information,
7 including for those who are under the age of 12. This
8 demographic data is crucial to continue to monitor and
9 improve programs funded through MHSA.
10 Gender is a concept that is formed very early in
11 childhood. At the very least most children who are verbal
12 are able to state whether they are a boy or a girl. In
13 addition, transgender children may state as soon as they are
14 verbal that their gender is different than the one they were
15 assigned at birth. There are also a growing number of
16 supportive parents of transgender or genderqueer children
17 who may want and may possibly demand the opportunity for
18 their child's current gender identity to be recognized and
19 recorded. Although there is currently no research
20 demonstrating how to ask parents about their child's
21 transgender identity we do support the option for parents to
22 identify their child's gender identity if they so desire.
23 How to collect gender identity data in a manner
24 that is developmentally appropriate for children under the
25 age of 12 is a topic that still needs additional study, so

1 therefore we recommend the Commission collect sex assigned
2 at birth for youth under 12, using language recommended, in
3 the first step of the standard two-step gender identity
4 measure.
5 Basically, this is what we are asking that section
6 to be reworded as: A county is not required to collect
7 sexual orientation, current gender identity or veteran
8 status demographic information required under subdivision
9 B.5 of the section from a minor younger than 12 years of
10 age. All other data, including assigned sex at birth, that
11 cannot be obtained directly from a minor younger than 12
12 years of age, may be obtained from the minor's parent,
13 guardian or other authorized source.
14 We understand that many counties find the
15 demographic data gathering challenging. We enthusiastically
16 offer our support to any county who requires technical
17 assistance in the gathering of SO/GI data.
18 Thank you very much for this opportunity. This
19 will all be given to you in writing. Thank you.
20 CHAIR WOOTON: Thank you, Poshi.
21 The next person to the podium is Stacie Hiramoto,
22 please. Good morning.
23 MS. HIRAMOTO: Good morning. Stacie Hiramoto with
24 REMHDCO, the Racial and Ethnic Mental Health Disparities
25 Coalition. And a very special welcome, especially to the

1 new Commissioners.
2 I would like to comment on both the PE&I and
3 Innovation regulations in the same section that Poshi Walker
4 referred to in the demographic data.
5 First of all I want, again, for most of the new
6 members to understand that REMHDCO represents racial and
7 ethnic communities all throughout the state, we represent
8 individuals, families and organizations, and this was a
9 very, very important issue to us in the PE&I and Innovation
10 regs.
11 I hope I sent a letter to as many of you as I
12 could and I hope for the other Commissioners, you will
13 receive a copy of this letter. Although it may be changed
14 slightly because we would like to support the position of
15 the California LGBT Health and Human Services Network,
16 Poshi's group and the others that received the contract from
17 the OAC, because on this matter we agree with them strongly
18 and want to support the way -- the collection of the SO/GI
19 data.
20 But as far as race and ethnicity, we believe it is
21 very important for children under 12 for this information to
22 be noted because of, again, disparities are prevalent and we
23 have got to understand if we are going to make a difference.
24 If you stop collecting data on race and ethnicity how are
25 you going to understand if you are reducing disparities?

1 We understand that this may involve I think more
2 training, just as Poshi talked about.
3 We have heard stories about in the counties people
4 being uncomfortable asking this data from parents or from
5 students and actually either guessing by looking or guessing
6 by the name. And that's understandable, let's face it, race
7 and ethnicity are sometimes uncomfortable to talk about and
8 that's why REMHDCO exists.
9 Again I want to stress that our position is that
10 this aggregated data on race and ethnicity and the other
11 information is demographic information, is collected. We
12 understand that that can be challenging but we don't
13 understand, particularly for race and ethnicity, why this
14 would make a difference for children under 12. We think
15 most parents or most family members want that information
16 known in case, again, they want to deal with certain issues,
17 and a child's racial and ethnic identity is important.
18 Thank you.
19 CHAIR WOOTON: Thank you, Stacie, thank you.
20 The next person up is Michele Violett, please.
21 MS. VIOLETT: Michelle Violett with Nevada County.
22 I just want to give an example of where the challenge is as
23 a county perspective, a small county perspective.
24 We have a Second Step program, this is a
25 prevention program where a teacher goes into and teaches

1 preschool teachers how to do the Second Step program and
2 they're modeling it and they're doing it in front of
3 preschool students and the parents aren't necessarily there
4 to ask, they're modeling to the teacher and then the teacher
5 does it to the three and four-year-olds. So this regulation
6 is a very big challenge for us to implement because we don't
7 necessarily have the parents engaged in the actual
8 interaction.
9 So that is just an example that yes, I do feel it
10 is important but there can be some challenges. So depending
11 on what the program is, the regulations need to be flexible
12 in that. Thank you.
13 CHAIR WOOTON: Thank you, Michele, thank you.
14 And now Elizabeth Oseguera, can you come to the
15 podium, please.
16 MS. OSEGUERA: Hello, Elizabeth Oseguera with the
17 California Health+ Advocates, who is the advocacy arm for
18 the California Primary Care Association.
19 And I wanted to echo the comments made by Stacie
20 and others around demographic information collection, making
21 sure that this information is collected, it is very
22 important that we know if these services are reaching
23 everybody within the community and that includes children
24 under the age of 12. However, we understand the conflicts
25 and issues going on with the LGBTQA community and support

1 their recommendations as well. Thank you.
2 CHAIR WOOTON: Thank you, Elizabeth.
3 Mandy Taylor, please. Good morning.
4 MS. TAYLOR: Good morning. Mandy Taylor from the
5 LGBT Health & Human Services Network; and we are, along with
6 NorCal MHA, a part of the LGBTQ advocacy grant.
7 And so that's what we are doing, we are here
8 advocating, right? And what we are advocating for is that
9 you do collect appropriate data that is developmentally
10 accurate and part of that is collecting race, ethnicity,
11 primary language from children. We are in full support of
12 REMHDCO in those recommendations.
13 And we also understand that requesting sexual
14 orientation for children under the age of 12 could put them
15 in some -- could, unfortunately, have some ramifications if
16 their parents have access to their information. So we are
17 saying, yes, please don't collect for folks under 12.
18 And then we contacted the Williams Institute,
19 which is on the leading edge of research in this area, and
20 they have established best practices. And we are asking
21 that this Commission use those best practices that they
22 found, which is when children are under the age of 12 ask
23 them their sex assigned at birth and allow them to let you
24 know their gender identity but don't require it because they
25 don't always know and/or it may not be safe at that age.

1 However, their parents certainly would be able to. And
2 anybody who was doing prevention work being in a room with a
3 child would most likely be able to observe that information.
4 So again, we are asking that you change the
5 regulation to include race, ethnicity and language and that
6 you exclude gender identity and sexual orientation for those
7 that are under the age of 12. Thank you.
8 CHAIR WOOTON: Thank you, Mandy.
9 The next person is Kiran -- Sosage? I'm sorry.
10 Maybe you could state your name, please.
11 MS. SAVAGE: I will do so, thank you. Kiran
12 Savage, California Pan-Ethnic Health Network. Thank you for
13 your time, good morning.
14 My organization, CPEHN, is a statewide multi-
15 cultural health policy organization and we work on access to
16 health care including mental health care through a variety
17 of methods.
18 And wanted to be here along with our colleagues
19 with a similar perspective, a similar concern in the same
20 section, and wanted to kind of note that we are talking
21 about two components of the Mental Health Services Act, the
22 Innovations and the Prevention and Early Intervention, which
23 are two components where we are really trying to develop I
24 think new and more effective strategies and so would like to
25 note that's an area where it's particularly important that

1 we are looking at disparities and looking at different
2 populations specifically and how our methods and how our
3 programs are impacting those populations. So I wanted to
4 kind of pull us back and highlight that.
5 Also that we have spent a lot of time at this
6 Commission talking about how we are achieving the voter
7 intent of Proposition 63 and looking at the big goals about
8 school outcomes and criminal justice. And we are doing work
9 in other parts of California and other sectors to look at
10 this same kind of data. So in our Medi-Cal program we are
11 finally getting data, including on children, that looks at
12 outcomes and race and ethnicity to do with mental health.
13 And so in order to have this data be able to line up with
14 that data it is really important that we continue to collect
15 the race, ethnicity and primary language data.
16 And on the primary language piece I do also want
17 to just note that these regulations only require data in
18 threshold languages by county, which is actually very little
19 data, so most counties' threshold languages, with the
20 exception of Los Angeles, are usually only English and
21 Spanish, which we would generally argue is not enough. But
22 just to say, that's very little data and shouldn't be a
23 problem for the most part. And our Medi-Cal system actually
24 allows us to collect data on 26 languages, so we actually
25 have even more data in other systems that we would be able

1 to compare to and we would hate to lose that data just for
2 children under 12.
3 And our school district systems do have us
4 collecting race, ethnicity and language data including for
5 disciplinary records. And again back to the goals of the
6 MHSA, we would really like to be able to compare that data
7 and see how our programs are impacting discipline records to
8 be able to see the difference that we are making in the
9 state.
10 So thank you again for your time. We really
11 encourage counties to collect this data and encourage just
12 that change in the regulations, so thank you.
13 CHAIR WOOTON: Thank you, Kiran, thank you.
14 There are no other names on the list here. Is
15 there anyone else that wishes to speak or respond to the
16 proposed amendments to the regulations? Anyone else?
17 (No response.)
18 CHAIR WOOTON: Okay. Hearing no requests, I close
19 this oral hearing.
20 However, we will receive comments, written
21 comments by email, into our office until 5:00 pm today.
22 So thank you everyone and thank you for your
23 comments. Thank you.
24 (The meeting continued on to Item 3
25 but was not transcribed.)

1 **General Public Comment - First Opportunity**
2 CHAIR WOOTON: Nancy, Nancy Callahan, hello.
3 DR. CALLAHAN: Chairwoman Wooton, so nice to see
4 you, Commissioners. So I am Nancy Callahan with IDEA
5 Consulting. Very brief, I know I only have three minutes.
6 I was Chief of Planning and Evaluation for
7 Sacramento County from '87 to 1990 and started my consulting
8 business in 1990. I have worked with many different
9 counties around evaluation, writing grants, and have done a
10 lot of work around PEI so I was -- I'm sorry I didn't pull
11 this off the website earlier but I was just reading this
12 report that is required.
13 And I just want to please caution the Commission
14 to be wise about the data. I am a data person, I love data.
15 I encourage you to collect data.
16 But these requirements are very extensive for
17 small counties and small providers.
18 I work with Placer County, we have been doing PEI
19 data collection around your regulations for the last four
20 years.
21 Speaking of paper, the amount of paper and forms
22 that are required to collect this data is huge.
23 Even bigger counties have small providers and so
24 they're required to collect a lot of information that is
25 very complex.

1 So you are wanting reports now, which is great,
2 I'm all happy about that, but some of the items in this
3 around written referrals is very difficult for small
4 providers to collect. That would mean that I would need to
5 write down when I refer Nancy to a provider. I believe you
6 only want written referrals to mental health providers, but
7 you also want to follow-up with them to see if they make it
8 to the agency. That is all great logic but then if I am
9 only doing a brief contact with the person am I supposed to
10 call them back and see if they get followed up? I can't
11 follow-up with the agency they get referred to.
12 So some of these regulations are really complex.
13 That they sound really good in the beginning, but I worry
14 about the data that you will get in the end will be very
15 small and really not reflective of the great work that is
16 going out there.
17 The other comment I wanted to make is around your
18 access and linkage. You are asking about people with SMI,
19 Serious Mental Illness. Access and linkage programs
20 typically don't work with Serious Mental Illness. Their
21 prevention and early intervention -- this is not the early
22 intervention. For most people it is only up to a year.
23 These small providers in small counties don't have the staff
24 doing PEI where they have someone, a clinician who can
25 diagnose clients. But then you're supposed to follow-up

1 with them, you're supposed to say what type of referral you
2 made and what type of treatment that they are being referred
3 to. That is really not within the capacity of a lot of PEI
4 programs so really closely consider the data requirements
5 that you have done.
6 I know you are pretty well along in this process
7 and I appreciate you continually trying to make it stronger,
8 but I would be happy to, you know, meet with any of you to
9 talk further about some of my concerns around getting data
10 that really makes sense for you, because I really want you
11 to have data that really shows the great efforts that's
12 happening out there. But that's doable. Thank you for your
13 time.
14 CHAIR WOOTON: Thank you, Nancy, and thank you for
15 thinking about us and our PE&I program, thank you. Thank
16 you. Okay.
17 (The meeting continued but was not transcribed.)
18
19
20
21
22
23
24
25 .
26

1 CERTIFICATE OF REPORTER

2

3 I, Ramona Cota, an Electronic Reporter and
4 Transcriber, do hereby certify that I am a disinterested
5 person herein; that I recorded the foregoing Mental Health
6 Oversight and Accountability Commission meeting and that I
7 thereafter transcribed the recording.
8 I further certify that I am not of counsel or
9 attorney for any of the parties to said meeting, or in any
10 way interested in the outcome of said matter.
11 IN WITNESS WHEREOF, I have hereunto set my hand
12 this 29th day of September, 2017.
13
14
15
16
17 RAMONA COTA, CERT 478
18
19
20
21
22
23
24
25 .

AGENDA ITEM 8

Information

November 16, 2017 Commission Meeting

Innovation Sub-Committee 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:

- Innovation Framework Decision Tree
- MHSOAC Innovation Review Process
- Innovative Project Recommended Template
- Presentation Guidelines

Handouts: None

Recommended Action: Information Item Only

Innovation Framework Decision Tree

Start:

Need identified by the County.

Does County currently have strategy for identified need?

Yes, current strategy is sufficient

No.

OR

Yes, but...

current strategy is too expensive

OR

current strategy is not effective

OR

current strategy is ineffective with some consumers

Conduct broad research components including, but not limited to, literature review, consultations and county collaborations to identify existing alternative strategies that will address the issue.

Can other funds (excluding innovation funds) be used to address issue?

Innovation Funds not needed.

Is the County willing to utilize Innovation funds to address the current issue?

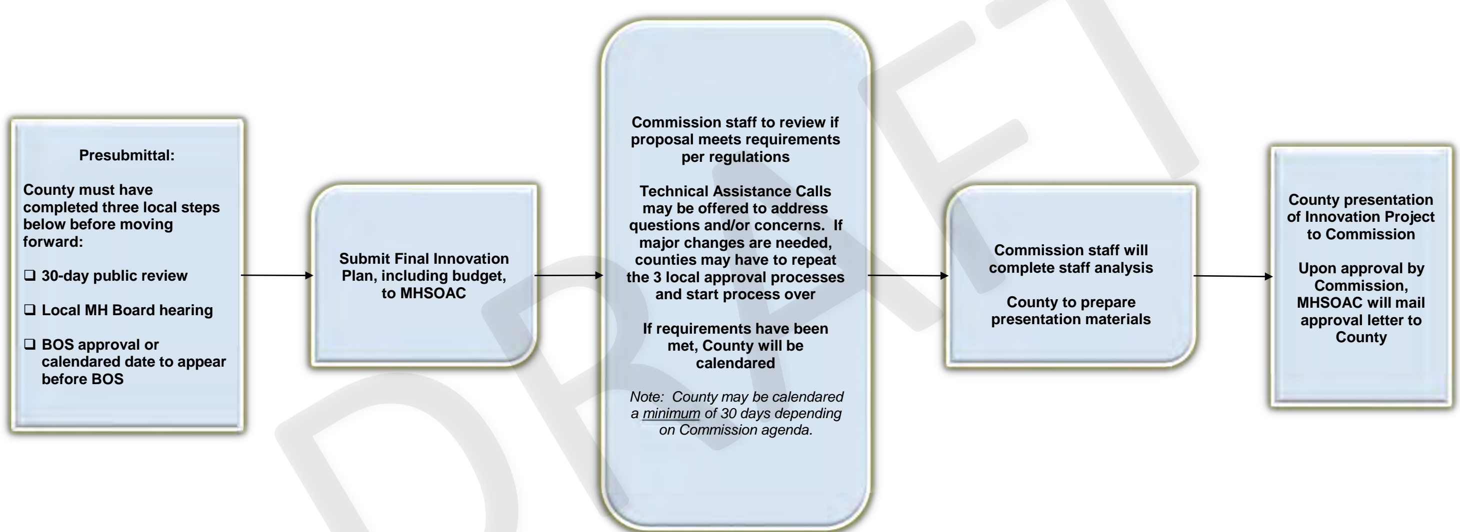
Will this innovative approach contribute to significant learning, collaboration or create opportunities to partner with other

Develop Innovation Program Plan and Logic Model while drawing upon previously gathered research, technical calls, ultimately leading to informed decision making

Submit Proposal to the State and prepare for calendaring

DRAFT

MHSOAC Innovation Review Process



INNOVATIVE PROJECT PLAN
RECOMMENDED TEMPLATE

COMPLETE APPLICATION CHECKLIST
Innovation (INN) Project Application Packets submitted for approval by the MHSOAC should include the following prior to being scheduled before the Commission:
☐ Final INN Project Plan with any relevant supplemental documents and examples: program flow-chart or logic model. Budget should be consistent with what has (or will be) presented to Board of Supervisors. (*Refer to CCR Title9, Sections 3910-3935 for Innovation Regulations and Requirements)*
☐ Local Mental Health Board approval Approval Date: ___________
☐ Completed 30 day public comment period Comment Period: ___________
☐ BOS approval date Approval Date: ___________ If County has not presented before BOS, please indicate date when presentation to BOS will be scheduled: ____________________ *Note: For those Counties that require INN approval from MHSOAC prior to their county's BOS approval, the MHSOAC may issue contingency approvals for INN projects pending BOS approval on a case-by-case basis.*
Desired Presentation Date for Commission: ________________________ ***Note: Date requested above is not guaranteed until MHSOAC staff verifies <u>all requirements</u> have been met.***

DRAFT

County Name:

Date submitted:

Project Title:

Total amount requested:

Duration of project:

Purpose of Document: The purpose of this template is to assist County staff in preparing materials that will introduce the purpose, need, design, implementation plan, evaluation plan, and sustainability plan of an Innovation Project proposal to key stakeholders. *This document is a technical assistance tool that is recommended, not required.*

Innovation Project Defined: As stated in California Code of Regulations, Title 9, Section 3200.184, an Innovation project is defined as a project that "the County designs and implements for a defined time period and evaluates to develop new best practices in mental health services and supports". As such, an Innovation project should provide new knowledge to inform current and future mental health practices and approaches, and not merely replicate the practices/approaches of another community.

Section 1: Innovations Regulations Requirement Categories

Choose a General Requirement:

An Innovative Project must be defined by one of the following general criteria. The proposed project:

- ☐ Introduces a new practice or approach to the overall mental health system, including, but not limited to, prevention and early intervention.
- ☐ Makes a change to an existing practice in the field of mental health, including but not limited to, application to a different population
- ☐ Applies a promising community driven practice or approach that has been successful in a non-mental health context or setting to the mental health system.

Choose a Primary Purpose:

An Innovative Project must have a primary purpose that is developed and evaluated in relation to the chosen general requirement. The proposed project:

- ☐ Increases access to mental health services to underserved groups
- ☐ Increases the quality of mental health services, including measured outcomes
- ☐ Promotes interagency and community collaboration related to Mental Health Services or supports or outcomes.
- ☐ Increases access to mental health services

DRAFT

Section 2: Project Overview

Primary Problem

What primary problem or challenge are you trying to address? Please provide a brief narrative summary of the challenge or problem that you have identified and why it is important to solve for your community. Describe what led to the development of the idea for your INN project and the reasons that you have prioritized this project over alternative challenges identified in your county.

Proposed Project

Describe the INN Project you are proposing. Include sufficient details that ensures the problem identified and potential solutions are clear. In this section, you may wish to identify how you plan to implement the project, the relevant participants/roles within the project, what participants will typically experience, and any other key activities associated with development and implementation.

A) *Provide a brief narrative overview description of the proposed project*

B) *Identify which of the three general specified above [per CCR, Title 9, Sect. 3910(a)] the project will implement.*

C) *Briefly explain how you have determined that your selected approach is appropriate. For example, if you intend to apply an approach from outside the mental health field, briefly describe how the practice has been historically applied.*

D) *Estimate the number of individuals expected to be served annually, and how you arrived at this number.*

E) *Describe the population to be served, including relevant demographic information (age, gender identity, race, ethnicity, sexual orientation, and/or language used to communicate).*

Research on INN component

A) *What are you proposing that distinguishes your project from similar projects that other counties and/or providers have already tested or implemented?*

B) *Describe the efforts have you made to investigate existing models or approaches close to what you're proposing. Have you identified gaps in the literature or existing practice that your project would seek to address? Please provide citations and links to where you have gathered this information.*

Learning Goals/Project Aims

The broad objective of the Innovative Component of the MHSA is to incentivize learning that contributes to the expansion of effective practices in the mental

DRAFT

health system. Describe your learning goals/specific aims and how you hope to contribute to the expansion of effective practices.

A) *What is it that you want to learn or better understand over the course of the INN Project, and why have you prioritized these goals?*

B) *How do your learning goals relate to the key elements/approaches that are new, changed or adapted in your project?*

Evaluation or Learning Plan

For each of your learning goals or specific aims, describe the approach you will take to determine whether the goal or objective was met. Specifically, please identify how each goal will be measured and the proposed data you intend on using.

Section 3: Additional Information for Regulatory Requirements

Contracting

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

Community Program Planning

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

MHSA General Standards

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

A) *Community Collaboration*

B) *Cultural Competency*

C) *Client-Driven*

D) *Family-Driven*

E) *Wellness, Recovery, and Resilience-Focused*

F) *Integrated Service Experience for Clients and Families*

DRAFT

Cultural Competence and Stakeholder Involvement in Evaluation

Explain how you plan to ensure that the Project evaluation is culturally competent and includes meaningful stakeholder participation.

Innovation Project Sustainability and Continuity of Care

Briefly describe how the County will decide whether or not it will continue with the INN project in its entirety, or keep particular elements of the INN project without utilizing INN Funds following project completion.

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

Communication and Dissemination Plan

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

A) How do you plan to disseminate information to stakeholders within your county and (if applicable) to other counties? How will program participants or other stakeholders be involved in communication efforts?

B) KEYWORDS for search: Please list up to 5 keywords or phrases for this project that someone interested in your project might use to find it in a search.

Timeline

A) Specify the expected start date and end date of your INN Project

B) Specify the total timeframe (duration) of the INN Project

C) Include a project timeline that specifies key activities, milestones, and deliverables—by quarter.

Section 4: INN Project Budget and Source of Expenditures

Budget Narrative:

Budget by Fiscal Year and Specific Budget Category

DRAFT

Presentation Guidelines

In order to facilitate the County's presentation to the Commission, please provide the supporting documents and materials described below. The County Brief is an opportunity for the Counties to explain, showcase and highlight the Innovation Project Proposal by addressing the need and stating the desired learning objectives. The PowerPoint Presentation will assist the County in highlighting key points of their innovation project plan and the biographies of presenters provides background information for the Commissioners.

1. County Brief
   a. Recommend 2-4 pages total and should include the following 3 items:
      i. Summary of Innovation Plan / Project
      ii. Budget
      iii. Address any areas indicated in MHSOAC Staff summary
   b. Submit brief to MHSOAC 10 days prior to presentation to Commission

2. PowerPoint Presentation
   a. Recommend 5 slides and include the following 5 items:
      i. Program Overview (goal, primary purpose, learning objective)
      ii. Presenting Problem / Need
      iii. Proposed Solution
      iv. Evaluation Components (questions and outcomes)
      v. Innovation Budget
   b. Submit PowerPoint to MHSOAC 10 days prior to presentation to Commission

3. Biography of Presenters
   a. Recommend brief 1-2 sentences for the County staff who will be presenting in front of the Commission
      i. Include specific names, titles, and areas of expertise in relation to Innovation Plan / Project
   b. Submit bio to MHSOAC 10 days prior to presentation

Please note: Presentation documents should be received 10 days prior to presentation to allow preparation of materials for public distribution. If the County is unable to submit their materials by the due date for the Commission meeting, the County must make at least 50 copies and bring the handouts / documents to the Commission meeting for the Commissioners and the public.

The MHSOAC strongly recommends encouraging community stakeholders to attend Commission meetings and support the presentation with public comments.

DRAFT

AGENDA ITEM 9

Action

November 16, 2017 Commission Meeting

Contract Authorization

Summary: The Commission will consider authorizing the Executive Director to enter into an Information Technology contract to further support the hosting and maintaining of the integrated web application and database of MHSA providers, programs, and services, not to exceed $500,000.

This contract would continue services provided under two existing, expiring contracts, supporting “behind the firewall” data activities (concerning Protected Health Information databases and analytical tools) and “in front of the firewall” data activities (concerning public display databases and analytical/data visualization tools), respectively. By consolidating two separate contracts and architectures into a single contract and common architecture, this contract provides better coordination and oversight of contracted MHSOAC data infrastructure with enhanced support services at a more efficient price point than the prior contracts.

Presenter: Norma Pate, Deputy Director for Administration and Legislation

Enclosures: None.

Handouts: A PowerPoint presentation will be made available at the meeting.

Proposed Motion: The Commission authorizes the Executive Director to enter into one or more contracts, not to exceed $500,000, to further support the hosting and maintenance of databases and applications in support of the MHSOAC’s data transparency agenda.

AGENDA ITEM 10

Information

November 16, 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 October 26, 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

Motions Summary

Commission Meeting
October 26, 2017

Motion #: 1

Date: October 26, 2017

Time: 9:48 am

Text of Motion:

The Commission approves the September 28, 2017, Meeting Minutes.

Commissioner making motion: Commissioner Aslami-Tamplen
Commissioner seconding motion: Commissioner Strachan-Wilson

Motion carried 8 yes, 0 no, and 1 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: October 26, 2017

Time: 11:56 am

Text of Motion:

The MHSOAC approves Los Angeles County's Innovation Plan as presented and recommends that Los Angeles County establish implementation milestones and provides status updates to the Commission at specified intervals, such as three and six months, 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

Commissioner making motion: Commissioner Boyd
Commissioner seconding motion: Commissioner Aslami-Tamplen

Commissioner Bunch recused herself. 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 #: 3

Date: October 26, 2017

Time: 12:01 pm

Text of Motion:

The MHSOAC approves Kern County's Innovation Plan as presented and recommends that Kern County establish implementation milestones and provides status updates to the Commission at specified intervals, such as three and six months, 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

Commissioner making motion: Commissioner Brown
Commissioner seconding motion: Commissioner Wooton

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 #: 4

Date: October 26, 2017

Time: 1:14 pm

Text of Motion:

The MHSOAC approves Mendocino County's Innovation Plan with the recommendation that Commission staff provide technical assistance to the county and the county provide an update on the project at a future Commission meeting as follows:

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

Motion carried 6 yes, 3 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: October 26, 2017

Time: 3:14 pm

Text of 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 project budget of $3,467,935
Additional Project Length: 2 years for a total project duration length of five (5) years

Commissioner making motion: Commissioner Mitchell
Commissioner seconding motion: Commissioner Aslami-Tamplen

Commissioner Madrigal-Weiss recused herself. Motion carried 7 yes, 0 no, and 0 abstain, per roll call vote as follows:

Name	Yes	No	Abstain
1. Chair Wooton	☒	☐	☐
2. Vice-Chair Boyd	☒	☐	☐
3. Commissioner Anthony	☐	☐	☐
4. Commissioner Ashbeck	☐	☐	☐
5. Commissioner Aslami-Tamplen	☒	☐	☐
6. Commissioner Beall	☐	☐	☐
7. Commissioner Brown	☒	☐	☐
8. Commissioner 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: October 26, 2017

Time: 3:34 pm

Text of 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
> Amount: $2,913,159 for a total INN project budget of $4,245,077
> Project Length: 2 years for a total project duration length of five (5) years

Commissioner making motion: Commissioner Aslami-Tamplen
Commissioner seconding motion: Commissioner Mitchell

Commissioner Madrigal-Weiss recused herself. Motion carried 7 yes, 0 no, and 0 abstain, per roll call vote as follows:

Name	Yes	No	Abstain
1. Chair Wooton	☒	☐	☐
2. Vice-Chair Boyd	☒	☐	☐
3. Commissioner Anthony	☐	☐	☐
4. Commissioner Ashbeck	☐	☐	☐
5. Commissioner Aslami-Tamplen	☒	☐	☐
6. Commissioner Beall	☐	☐	☐
7. Commissioner Brown	☒	☐	☐
8. Commissioner 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 #: 7

Date: October 26, 2017

Time: 3:58 pm

Text of Motion:

The MHSOAC approves San Diego County's Innovation projects as follows:

Name: Telemental Health
Amount: $5,253,376
Project Length: Five (5) years

Commissioner making motion: Commissioner Aslami-Tamplen
Commissioner seconding motion: Commissioner Wooton

Commissioner Madrigal-Weiss recused herself. Motion carried 6 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 #: 8

Date: October 26, 2017

Time: 5:04 pm

Text of Motion:

The MHSOAC authorizes the chair of the subcommittee to take the comments heard today and received in writing, to incorporate changes, and to put out a revised report to Commissioners within two weeks, and that adoption of the revised report be voted on at the November meeting.

Commissioner making motion: Commissioner Wooton
Commissioner seconding motion: Commissioner Mitchell

Motion carried 6 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	☐	☐	☐

MHSOAC Evaluation Dashboard

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: All deliverables are under review.

- **DOJ Criminal Data Linkage & Analysis** *Mental Health Data Alliance*
  Update: Deliverable 1 status date changed.

- **CSI & DCR Data Analysis & Standardize Reporting** *Mental Health Data Alliance*
  Update: Deliverable 1.2 and 1.3 dates changed.

MHSOAC Evaluation Dashboard November 2017
(updated 11/7/17)

Current MHSOAC Evaluation Contracts & Deliverables

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 November 2017
(updated 11/7/17)

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 November 2017

(updated 11/7/17)

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 November 2017

(updated 11/7/17)

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**	**11/14/17**				
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 November 2017
(updated 11/7/17)

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		02/14/18				
1.3	Training and Documentation			02/14/18			
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 November 2017
(updated 11/7/17)

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 November 2017

(updated 11/7/17)

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

*Material highlighted in red indicates updates to the information * Indicates that a deliverable has undergone a status change

MHSOAC Evaluation Dashboard November 2017
(updated 11/7/17)

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

*Material highlighted in red indicates updates to the information * Indicates that a deliverable has undergone a status change

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