WELLNESS • RECOVERY • RESILIENCE

Mental Health Services
Oversight & Accountability Commission

February 22, 2018
PowerPoint Presentations and Handouts

Tab 2:	•	**PowerPoint:**	**Los Angeles County MHSA Innovation Plans**
	•	**PowerPoint:**	**Driving Access to Behavioral Health Care Thru Innovation: "The Technology Suite"**
Tab 3:	•	**PowerPoint:**	**Mono County MHSA Innovation Plans**
Tab 4:	•	**PowerPoint:**	**Kern County MHSA Innovation Plans**

COUNTY OF LOS ANGELES-DEPARTMENT OF MENTAL HEALTH
Program Development & Outcomes Bureau

Mobile Transcranial Magnetic Stimulation

Marc Heiser MD PhD
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Assistant Clinical Professor
Department of Psychiatry and Bio-Behavioral Sciences
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LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
hope. recovery. wellbeing.

The Need: Treatment Refractory Depression

LAC DMH: 40,000 People Treated for Depression (2016-17)

↓

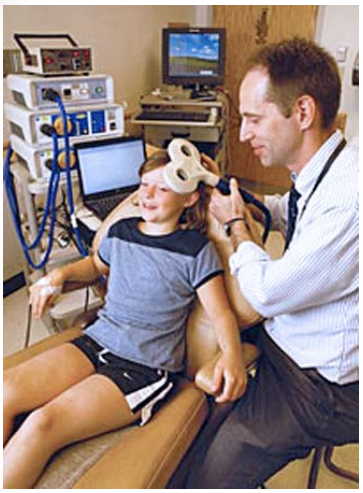
~15,000 With Refractory Symptoms

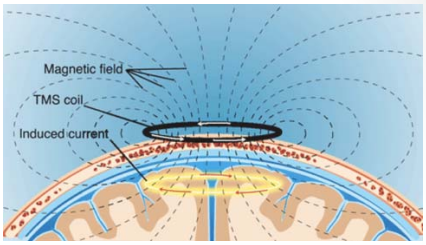
↓

~1,000 People With Refractory Depression Live in Board & Care Facilities

How can we help these individuals?

Transcranial Magnetic Stimulation (TMS)



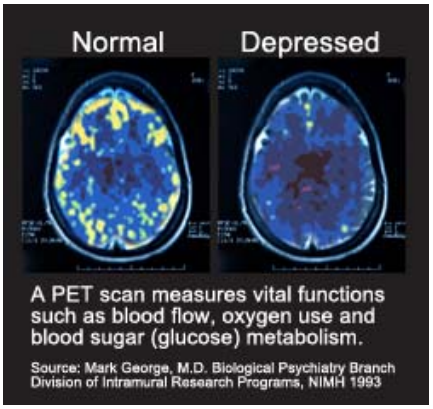


- Uses strong magnetic fields to stimulate brain
- Effective for treatment resistant depression
- Safe, non-invasive, focal treatment
- It is not “shock therapy!”

TMS Variables

- Where – location of coil
- When – timing of pulses
- How strong – intensity of magnetic pulses
- How many – number of pulses

TMS for Depression



- Altered cortical activity in depressed patients
- Hypofunctioning of DLPFC
- Enhance activation using rTMS

TMS: FDA Approval

- Approved for patients with depression who have failed at least 1 antidepressant
- 3 large RCT – two industry sponsored, one NIH, numerous smaller trials
- More recent meta-analyses show about 30% response and 19% remit (placebo 10, 5%), NNT 6 and 8 (Berlim 2014)
- 5 devices now available

Long Term Efficacy and Safety

- Pain – decreases over course of treatment (Brockhardt 2013)
- Seizure risk – 1:30,000 treatments
- Durability – at 12 months 62% of initial responders remained, 36% had more TMS (Dunner 2013)
- Improvement in quality of life and functional status acutely and at 6 months (Solvason 2014)

TMS Has Become Standard Practice

- American Psychiatric Association: Best practice guidelines for treatment of depression
- Department of Veterans Affairs: National evidenced-based rTMS rollout for treatment of depression
- TMS for depression is now covered by most private insurance and Medicare
- Not offered by public mental health providers

Other Uses

- Bipolar depression (Nahas 2003)
- Suicidal crisis (George 2014)
- Schizophrenia (Slotema 2014)
- OCD (Berlim 2013)
- Substance use disorders (Enokibara 2016)
- PTSD (Karsen 2014)
- Autism
- Cognitive impairment/Traumatic brain injury

Current Barriers to TMS

- Access – not provided by community psychiatrists
- Adherence – the treatment requires 5 days per week x 6 weeks

Solution To Barriers: Mobile TMS

Project Goal: Mobile TMS

- Create a network of mobile TMS treatment centers
- Bring an effective treatment for depression directly to people of LAC
- Start by treating individuals with depression who reside in Board & Care facilities

Why Board & Care Residents?

- Some of the most symptomatic individuals in the county
- Often tried many medications
- Remain impaired in spite of great efforts to ameliorate symptoms
- Difficulty with treatment adherence
- Treatment with TMS is warranted but barriers exist – mobile TMS may overcome these

Plan

- Obtain TMS device and customized van
- Outreach and education with B&C facilities throughout LAC in order to recruit individuals with depression
- Evaluate referred patients
- Clinical treatment with TMS
- Measure treatment outcomes
- Analyze data and disseminate results
- Expand program as appropriate

Conclusions

- TMS is a safe, effective treatment for depression and may be beneficial for other psychiatric disorders
- Many patients in B&C have depression among other symptoms and may benefit from TMS
- Mobile TMS will bring this treatment directly to these patients and into public mental health!

Questions & Feedback

Proposed Motion

MHSOAC approves Los Angeles County's Innovation Project as follows:

Name:	Mobile Transcranial Magnetic Stimulation
Amount:	$ 2,388,268
Project Length:	Three (3) Years

Driving Access to Behavioral Health Care Thru Innovation:

"The Technology Suite"

An Update to the MHSA Oversight and Accountability Commission

The collaborative approach

Among vendors

Across the state, county-level participation

Our principles and aims for collaboration

1. Create choice for participating counties
2. Link the individual technologies to support a 'greater whole'
3. Capitalize on shared learning to advance the scope, coverage and effectiveness of the suite
4. Involve end users, peers and stakeholders throughout development and operationalizing of individual applications
5. Utilize data to evaluate impact and inform services/supports for individuals and populations - and the suite as a whole
6. Maintain accountability to and transparency with stakeholders, county boards of supervisors, and the MHSA Oversight and Accountability Commission

Creating Choice

- Build a 'menu' of technology options / 'apps'
  - All qualified vendors remain on the list of available technology providers to participating counties
  - Additional vendors can be qualified in order to be added to the technology options
- County selection of vendors and associated 'apps' from the menu
  - As counties join, they may elect to 'purchase' the same package that Kern/LA have developed; or
  - They may create their own package from the qualified vendors (including new vendors they prefer and qualify)

Involving Peers

- Paid peers will be recruited in each participating county (to the level and scope specified by the county)
- Peers and end-users will be engaged throughout implementation and operation to assure local needs are met (language, ethnicity, geography, etc.)
- Local computer labs and consumer/peer centers will be leveraged to support above activities

Progress and plans for implementation

Vendor Selection (for Los Angeles and Kern)

- Initial vendors qualified in 5 components/areas
  - Peer Chat and Digital Therapeutics
  - Virtual Evidence-Based Therapy Utilizing an AVATAR
  - Digital Phenotyping Using Passive Data for Early Detection and Intervention
  - Outreach and Marketing
  - Evaluation
- Vendor selection and readiness
  - Orientation of vendors (2/13)
  - Detailed demonstration by each vendor (2/19, 2/22)
  - Preferred (initial) vendors selection (by end of February)
  - Vendor contracting with CalMHSA (March/April)
  - Collaborative planning and prep with vendors

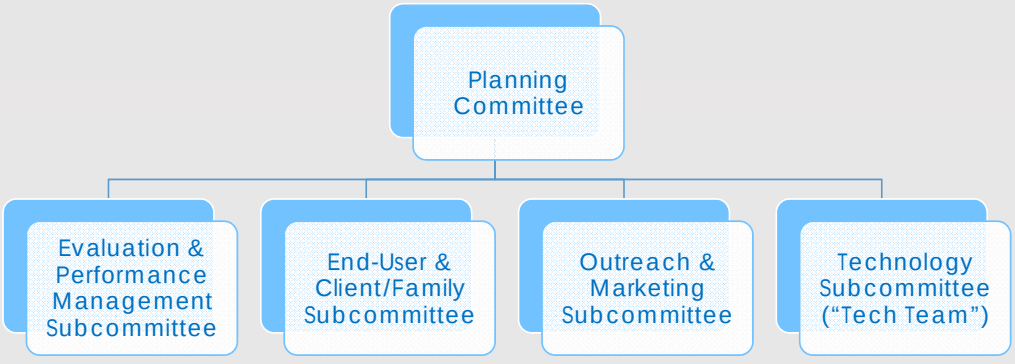
Participation Agreements

- CalMHSA Participation Agreements with Los Angeles and Kern Counties
  - Agreements prepared
  - County Board of Supervisor presentation for approval: February 2018
  - County funding to CalMHSA: end of February 2018

Shared Learning

- Creating a toolkit and sharing resources/learning
  - Consolidating methods, references and learning from individual counties to support future counties
  - Linking counties who can learn from each other
  - Regular communication with MHP directors and MHSA Coordinator
- Recent and upcoming opportunities for shared learning
  - Overview presentation to CBHDA Governing Board (2/14)
  - Webinar to share approaches to stakeholder engagement (February)
  - Demos by vendors for interested MHPs to learn about current technology options and populations they serve (March or April)

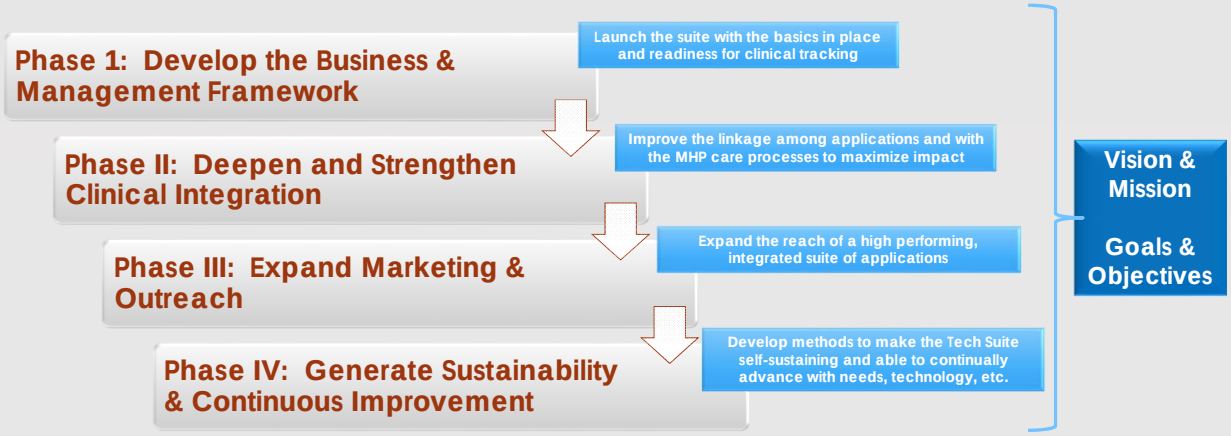
Collaborative Planning Structure (with participating county representatives)



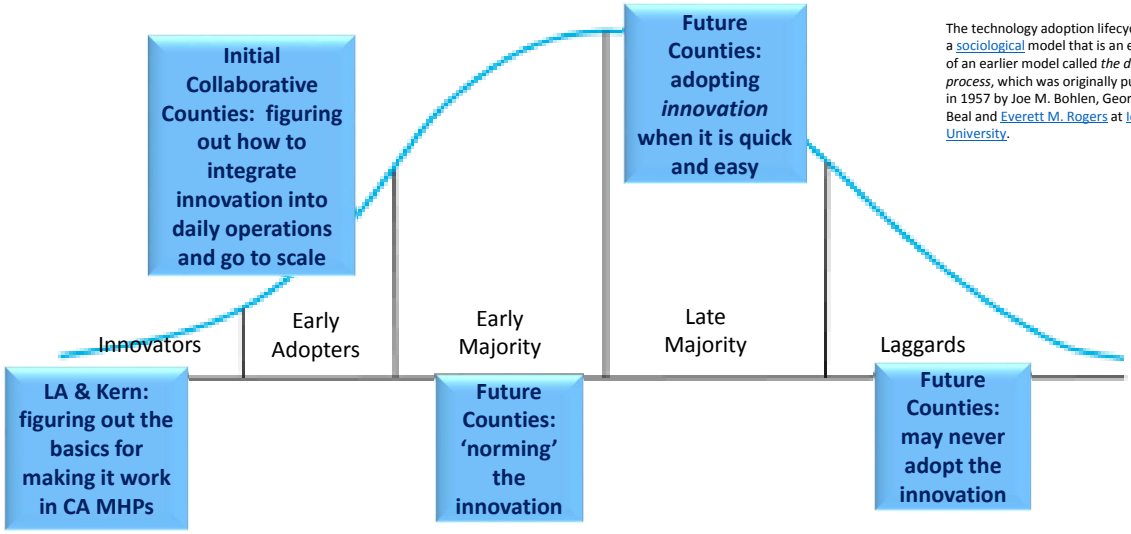
Functional areas for collaboration

- Application Management & Advancement
- End User Experience & Guidance
- Outreach & Marketing
- Clinical Integration
- Evaluation & Performance Management
- Work Force Development Support
- Privacy & Security Monitoring, Safeguards
- Accounting & Contract Management

Preliminary Implementation Phases



The Long View of Development & Implementation to Gain State-wideness: Technology Adoption Lifecyle



The technology adoption lifecycle is a sociological model that is an extension of an earlier model called *the diffusion process*, which was originally published in 1957 by Joe M. Bohlen, George M. Beal and Everett M. Rogers at Iowa State University.

Questions?

County Behavioral Health Technology Collaborative

Thank You!

County Behavioral Health Technology Collaborative

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

MONO COUNTY BEHAVIORAL HEALTH | FY 17-19 | INNOVATION PLAN

Robin K. Roberts, MFT | Amanda Greenberg, MPH

Mono County Technology Suite Overview

- **Program Goals**
  - Detect mental illness earlier, including depression, psychosis, and bipolar disorder.
  - Intervene earlier to prevent mental illness and improve client outcomes.
  - Provide alternate modes of engagement, support and intervention.
- **Target Population in Mono County**
  - Individuals in remote, isolated areas of the county
  - Students attending Cerro Coso Community College
- **Value of Multi-County Collaboration**
  - Our contribution as a small county
- **Funding & Timeframe**
  - $85,000 over 17 months

The Need for the Technology Suite in Mono County

- **Mono County has 13,900 people across 3,000 square miles**
- **One "major population center" of 8,000 people**
- **MCBH has a staff of 16 people**
- **Community members identified isolation and lack of social support was a top mental health need**
- **Local Cerro Coso officials and students have identified a need for increased engagement on campus**
- **Behavioral Health Advisory Board consistently asking how we can better serve and engage community members in our outlying areas**

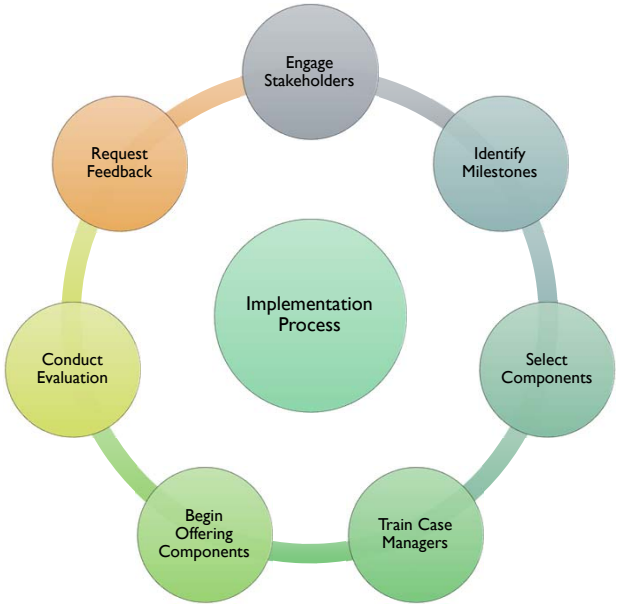
Who will this Innovation Project serve?

- Individuals in remote, isolated areas, for example:
  - Walker: Seniors
  - Benton: Utu Utu Gwaitu Paiute Tribe
  - June Lake/Lee Vining: Latino Community
  - Frontier land: MCBH suspects that a number of people with undiagnosed SMI have moved to very isolated areas to avoid contact with others, but would be open to tech-based interaction
- Students attending Cerro Coso Community College in Mammoth Lakes
  - Primarily transition age youth
  - MCBH specifically hopes to identify early signs of mental illness and first episode psychosis

Development of the Technology Suite

- MCBH has been involved since the early stages of this project
- MCBH will participate in collaborative process, including CalMHSA
- The proposed components of the suite include:
  - Peer Chat and Digital Therapeutics
  - Virtual Evidence-Based Therapy Utilizing an AVATAR
  - Digital Phenotyping Using Passive Data for Early Detection and Intervention
- MCBH will choose the components that will best meet the target population's identified needs
- MCBH has already seen increased engagement from Cerro Coso Community College and stigma reduction on campus

Implementation of the Technology Suite



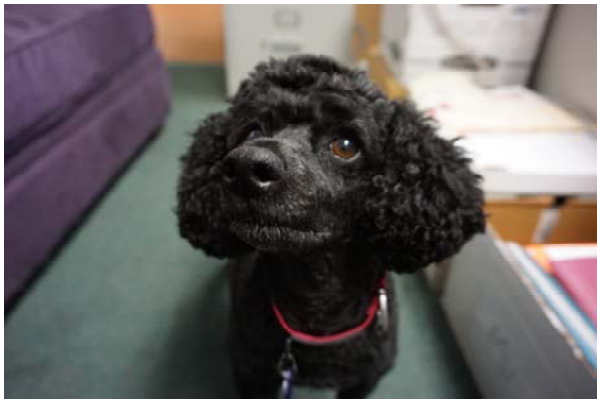
Evaluation of the Technology Suite

- Participate in multi-county collaborative evaluation efforts
- Example target outcomes include:
  - Increased purpose, belonging, and social connectedness, especially for users living in remove, isolated areas
  - Increased ability for users to identify cognitive, emotional, and behavioral changes and act to address them, especially among Cerro Coso students
- Contribute in-kind staff time for any local data collection required
- Collect and use data in a way that's meaningful for our target populations and the stakeholders involved
- Mono County's small size makes us uniquely situated to share consumer and family members' stories

Mono County Technology Suite Budget

Expenditures	FY 17/18 (5 months)	FY 18/19 (12 months)	Total (17 months)
Personnel Costs: Salaries	$5,600	$11,400	$17,000
Operating Costs: Travel	$2,800	$5,700	$8,500
Non-Recurring Costs: Technology	$18,200	$37,050	$55,250
Administrative Costs: CalMHSA	$1,400	$2,850	$4,250
Total Innovation Budget	$28,000	$57,000	$85,000

Questions & Discussion



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Amanda Greenberg, MPH
MHSA Coordinator
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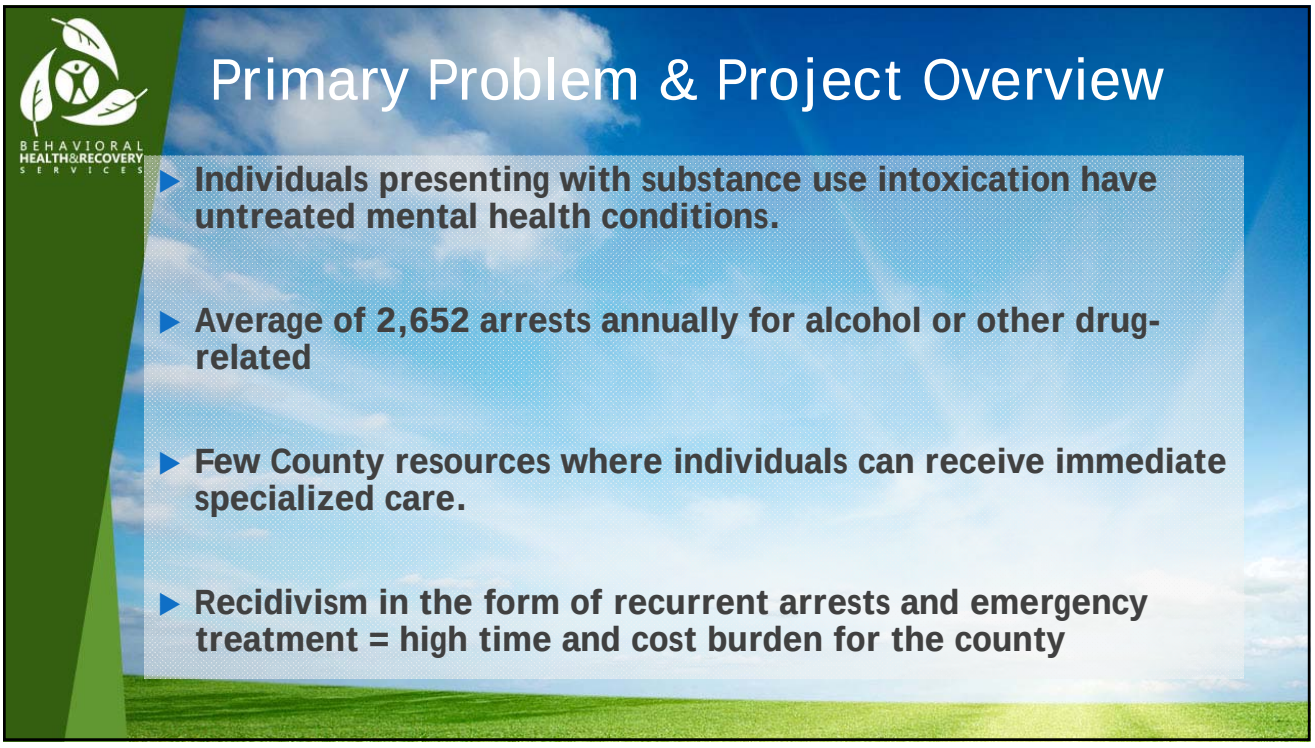
PROPOSED MOTION

MHSOAC approves Mono County's Innovation plan as follows:

- Name: Increasing Access to Mental Health Services and Supports Utilizing a Suite of Technology-Based Mental Health Solutions
- Amount: $85,000
- Project Length: Seventeen (17) Months


BEHAVIORAL
HEALTH&RECOVERY
SERVICES
Kern Innovative Proposal:
The Healing Project – Recovery Stations


BEHAVIORAL
HEALTH&RECOVERY
SERVICES
Primary Problem & Project Overview
Individuals presenting with substance use intoxication have untreated mental health conditions.
Average of 2,652 arrests annually for alcohol or other drug-related
Few County resources where individuals can receive immediate specialized care.
Recidivism in the form of recurrent arrests and emergency treatment = high time and cost burden for the county

Barriers for co-occurring disorders

- Kern County is roughly 8,163 square miles
- Stigma
- Geographic
- Transportation
- Crisis and other services currently not integrated to address both acute mental health and substance use needs concurrently.

Innovative Solution

- The Healing Project - first program to integrate elements of a sobering station with mental health screening and access to care.
- No other program exists to address immediate intoxication needs, to screen and address undiagnosed mental health conditions.
- Incorporate mental health and substance use disorder screening tools and treatment focus.
- The Healing Project focus on peer-led intervention and services designed to encourage engagement and resolve toward seeking help for mental health issues and sobriety.

Innovation and Learning

- Evaluate the benefits of utilizing peer-led services in early intervention environments
- Evaluate the benefits of short-term recovery stations toward engagement in follow up services
- Determine the impact of a recovery station for individuals, as an alternative to arrests and crisis medical and mental health services.

Evaluation Components

- Client Surveys for program effectiveness
- Screening Tools to determine underlying mental health care needs
- The PEC to provide data on clients entering the facility under the influence, and;
- Law Enforcement to provide data on number of DUI and public intoxication bookings vs referrals for recovery station services

Intended Outcomes

- **Reduction in arrests and Psychiatric Evaluation Center admissions.**
- **75% positive feedback from clients on the impact of services provided and led by Peer staff, on their likelihood of engaging in follow up treatment.**
- **25% of those entering the Healing Project recovery stations engaged in follow up treatment after first admission.**

Project Budget – Summary of Expenditures

Personnel	**$ 9,137,768**
Evaluation	$1,020,167
Operating	$ 1,750,000
Non-Recurring	$ 229,500
Administration	$ 2,548,075
TOTAL PROPOSED EXPENDITURES Estimated total amount of MHSA INN Funds for the duration of the project	$14,685,510


BEHAVIORAL
HEALTH&RECOVERY
SERVICES
PROPOSED MOTION
The MHSOAC approves Kern County's Innovation plan as follows:
Name: The Healing Project
Amount: $14,685,510
Project Length: Five (5) Years

California Association of Mental Health Peer-Run Organizations
2000 Embarcadero Cove, Suite 400, Box 80, Oakland CA 94606
510 681 6165 sallyzinman@gmail.com
www.camhpro.org

February 19, 2018

Re: Los Angeles County MHSA Innovation 4 Project
Mobile Transcranial Magnetic Stimulation (TMS)

Dear Chairperson John Boyd and Mental Health Services Oversight and Accountability Commissioners;

The California Association of Mental Health Peer Run Organizations (CAMHPRO) has serious concerns about Los Angeles County's Innovation proposal "to implement a mobile TMS program for individuals residing in Board and Care facilities for individuals suffering from depression that has not be responsive to antidepressant medication or therapy." We urge the Mental Health Services Oversight and Accountability Commission to reject this proposal or at a minimum address the issues raised in this letter.

Our major concerns are listed below:

1. Because of an institutional (although community based) and controlling environment as well as their disability, Board and Care residents are often least likely to be familiar with and practice informed consent. Many Board and Care residents have conservators who will make the decision for them, leaving the individual directly affected out of the decision-making process. Although considered *less* invasive than ECT, TMS is nevertheless an invasive brain procedure and needs to adhere to the highest level of informed consent that may not be possible within the environment of Board and Care homes.

2. The stated Innovative nature of this learning project is to bring TMS from the private mental health system, where it has been used in private practice and academic centers, to the Specialty Public Mental Health system, where it has not been used. In California, the population of the public mental health system is different from the private mental health system. The public mental health system serves "severely mentally ill" individuals. The private system serves people diagnosed as having mild to moderate mental illness. Has there been research to support the safety and sufficient positive benefits to justify the use of TMS for this new population? Are people living in Board and Care homes a captive and submissive group of people for an experimental

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treatment? As human subjects of a learning project, what protections will Board and Care residents have? What if TMS is not only not effectives, but harmful for this population? Experiencing an electromagnetic coil on one's head and hearing a tapping sensation on the head for 10-45 minutes for 5 consecutive days a week for 4- 8 weeks, with 50% chance of having headaches, will likely increase the trauma that most people with severe mental health issues have experienced.

3. TMS is not innovative in the general sense of the word innovative. TMS is in the same traditional medical model tract of other invasive brain interventions, from lobotomy, which was replaced by ECT with and without anesthesia, to the older thorazine type pharmaceuticals, to the new generation pharmaceuticals, and now TMS, each being heralded as best practice and less harmful than the preceding treatment. Synonyms of innovation are change, alteration, revolution, upheaval, transformation, metamorphosis, and breakthrough. TMS in not a paradigm shift; it is the same conventional thinking, with a different technique.

CAMHPRO has always believed that the mission of the Mental Health Services Act (MHSA) is to transform the behavioral health system. It grew out of the holistic philosophy of rehabilitative and comprehensive services, including addressing the medical and quality of life needs that lead to and exacerbate mental health challenges, including poverty, lack of housing, employment, friends, and community. Innovative services more than any of the components of the MHSA should lead the way to the future, not repeat the past.

$2,388,268 dollars would be better used for person-centered and culturally aware services that empower individuals with mental health challenges, whatever the severity.

Sally Zinman
Executive Director
California Association of Mental Health Peer Run Organizations
(This letter represents the concerns of CAMHPRO's Board of Directors and Public Policy Committee.)

CC: Toby Ewing, Executive Director

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Commissioners:

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Reneeta Anthony
Mayra Alvarez
Lynne Ashbeck
Senator Jim Beall
Bill Brown
Keyondria Bunch
Itai Danovitch
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Gladya Mitchell
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ADVANCING BRAIN HEALTH POLICY & INSPIRING LEADERSHIP

February 20, 2018

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

Dear Honorable Commissioners,

The Steinberg Institute is in strong support of Mono County's Innovation Proposal, which we are confident will increase access to mental health services through the use of groundbreaking technologies. We commend Director Roberts and her staff for their interest in investing in creative and new approaches to outreach and engagement and joining a cohort of counties including Los Angeles and Kern. This model of cross county collaboration is exactly what we want to see in Innovation proposals.

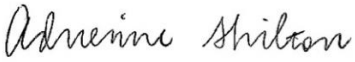
This project seeks to test out the use of a suite of technology tools to identify individuals who may need mental health care and to reach these individuals who need to be engaged in a different way. In Mono County, the population of 14,000 people is spread over 3,000 square miles. Many individuals are isolated in the county's wide geographic spread. Mono County worked with their community members who also identified isolation and lack of social support as one of the county's top three mental health needs.

This Innovation proposal that Mono County has brought forward, at its core, aims to intervene and treat mental illness well before it derails lives and families. In order to make a greater impact in reducing the duration of untreated mental illness and disparities in mental health treatment, outreach and engagement strategies must evolve, as Mono County has identified.

Early intervention can make all the difference, and we look forward to the learning possibilities that this project will provide us.

Should you have any questions about our support, please don't hesitate to contact us at (916) 553-4167 or maggie@steinberginstitue.org and adrienne@steinberginstitute.org

Sincerely,



Maggie Merritt
Executive Director

Adrienne Shilton
Government Affairs Director

CC: Toby Ewing, Mental Health Services Oversight and Accountability Commission
Robin Roberts, Mono County Department of Behavioral Health