Commission Packet

Commission Meeting
February 22, 2018

MHSOAC
1325 J Street, Suite 1700
Sacramento, CA 95814

<u>Additional Public Locations</u>

2600 Sand Dunes Dr. Monterey, CA 93940	420 E 3rd St Los Angeles, CA 90013
315 N Camino Del Remedio Santa Barbara, CA 93110	7775 North Palm Ave Fresno, CA 93711

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

John Boyd, Psy.D.
Chair
Khatera Aslami-Tamplen
Vice Chair

1325 J Street, Suite 1700
Sacramento, California 95814

Commission Teleconference Meeting Agenda

February 22, 2018
MHSOAC
1325 J Street, Suite 1700
Sacramento, CA 95814

9:00 AM – 3:00 PM

Additional Public Locations

2600 Sand Dunes Dr
Monterey, CA 93940

420 E 3rd St
Los Angeles, CA 90013

315 N Camino Del Remedio
Santa Barbara, CA 93110

7775 North Palm Ave
Fresno, CA 93711

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 Lester Robancho at (916) 445-8774 or email at mhsoac@mhsoac.ca.gov.

John Boyd, Psy.D.	AGENDA	Khatera Aslami-Tamplen
Chair	February 22, 2018	Vice Chair

Approximate Times

9:00 AM **Convene and Welcome**

Chair John Boyd, Psy.D., will convene the Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission) Meeting. Roll call will be taken.

9:20 AM **Action**

1: Approve January 25, 2018 MHSOAC Meeting Minutes

The Commission will consider approval of the minutes from the January 25, 2018 meeting.

- Public Comment
- Vote

9:30 AM **Action**

2: Los Angeles Innovation Plan and Update

Presenters: Jonathan E. Sherin, M.D., Ph.D., Director, LA County Dept. of Mental Health; Marc Heiser, M.D., Ph.D., Psychiatrist, LA County Dept. of Mental Health; Alex Silva, Ph.D., Supervising Psychologist, LA County Dept. of Mental Health; Bill Walker, LMFT, Director, Kern County Behavioral Health and Recovery Services; Debbie Innes-Gomberg, Ph.D., Deputy Director, LA County Dept. of Mental Health; Karin Kalk, Technology Suite Project Manager; Brad Cloud, Deputy Director, Kern County Behavioral Health and Recovery Services

The Commission will consider approval of a new Innovation Plan for Los Angeles County and will hear an update from Los Angeles County and Kern County on the Innovation Project previously approved by the Commission on October 26, 2017.

- Public Comment
- Vote

10:30 AM **Action**

3: Mono County Innovation Plan

Presenters: Robin K. Roberts, MA, MFT, Director of Mono County Behavioral Health; Amanda Fenn Greenberg, MPH, MHSA Coordinator

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

- Public Comment
- Vote

11:00 AM **Action**

4: Kern County Innovation Plan

Presenters: Bill Walker, LMFT, Director of Kern Behavioral Health and Recovery Services; Bradley Cloud, Psy.D., Deputy Director of Kern Behavioral Health and Recovery Services

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

- Public Comment
- Vote

11:30 AM **Information**

5: 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:
(1) The Motions Summary from the January 25, 2018 Commission Meeting; (2) Evaluation Dashboard; (3) Calendar of Commission activities; and (4) Innovation Review Outline

12:00 PM **General Public Comment**

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

12:15 PM **Lunch Break**

(Closed Session – Government Code Section 11126(a) related to personnel)

1:30 PM **Report Back from Closed Session**

Chair John Boyd, Psy.D., will report back on any reportable action taken during closed session.

1:35 PM **Action**

6: Legislation

Presenters: Toby Ewing, Ph.D., Executive Director; Norma Pate, Deputy Director

The Commission will consider whether to support legislation related to mental health services under the Mental Health Services Act.

- Public Comment
- Vote

2:05 PM **Information**

7: Innovation Summit Update

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

The Commission will be presented with an update on the Innovation Summit held on February 2, 2018.

- Public Comment

2:25 PM **Action**

8: Contract Authorization for Innovation Incubator Business Plan

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

The Commission will consider approval of a contract of approximately $150,000 for the development of a business plan for an Innovation Incubator.

- Public Comment
- Vote

2:45 PM **General Public Comment**

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

3:00 PM **Adjourn**

AGENDA ITEM 1

Action

February 22, 2018 Commission Meeting

Approve January 25, 2018 MHSOAC Meeting Minutes

Summary: The Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission) will review the minutes from the January 25, 2018 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.

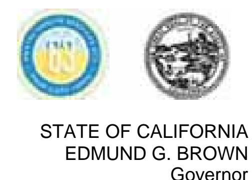
Presenter: None.

Enclosures: January 25, 2018 Commission Meeting Minutes.

Handouts: None.

Recommended Action: Approve January 25, 2018 Meeting Minutes.

Proposed Motion: The Commission approves the January 25, 2018 Meeting Minutes.



STATE OF CALIFORNIA
EDMUND G. BROWN
Governor

John Boyd, Psy.D.
Chair
Khatera Aslami-Tamplan
Vice Chair
Toby Ewing, Ph.D.
Executive Director

State of California

MENTAL HEALTH SERVICES
OVERSIGHT AND ACCOUNTABILITY COMMISSION

Minutes of Meeting
January 25, 2018

Sacramento County Office of Education
David P. Meaney Education Center, Board Room
10474 Mather Boulevard
Mather, California 95655

866-817-6550; Code 3190377

Members Participating:

John Boyd, Psy.D., Chair
Khatera Aslami-Tamplen, Vice Chair
Reneeta Anthony
Sheriff Bill Brown
Keyondria Bunch, Ph.D.
Itai Danovitch, M.D.
David Gordon
Mara Madrigal-Weiss
Gladys Mitchell
Larry Poaster, Ph.D.
Tina Wooton

Members Absent:

Jim Beall
Mayra Alvarez
Lynn Ayers Ashbeck

Staff Present:

Toby Ewing, Ph.D., Executive Director
Filomena Yeroshek, Chief Counsel
Norma Pate, Deputy Director, Program, Legislation, and Technology
Brian Sala, Ph.D., Deputy Director, Evaluation and Program Operations
Kristal Antonicelli, Health Program Specialist and RFA Lead
Ashley Mills, Senior Researcher and Project Lead
Tom Orrock, Chief, Commission Operations and Grants
Sharmil Shah, Psy.D., Chief of Program Operations

CONVENE AND WELCOME

Chair John Boyd called the meeting of the Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission) to order at 9:00 a.m., welcomed everyone, and took a moment to:

- Recognize the individuals who have suffered from the number of recent disasters throughout the state of California
- Highlight the importance of doing a better job as counties, as a state, and as a country, at offering psychological first aid effectively, especially during times of disaster
- Thank Commissioners Brown and Wooton for their leadership in Santa Barbara County

Chair Boyd stated the public comment cards have been updated to include preferred pronouns. An explanation of pronouns is available next to the cards at the sign-in table. Chair Boyd asked Norma Pate, Deputy Director, Program, Legislation, and Technology to provide more information on the revised comment cards. Deputy Director Pate introduced Poshi Walker, Co-Director, Out for Mental Health, Lesbian, Gay, Bisexual, Transgender, Queer (LGBTQ) Program Director, Mental Health America of Northern California (NorCal MHA) who stated that Out for Mental Health produced a fact sheet on common gender inclusive pronouns, such as xe/xyr/xyrs. There are also some individuals who prefer to use their name with no pronoun. Deputy Director stated that the fact sheet is on the table alongside the comment cards.

Chair Boyd welcomed Mayra Alvarez to the Commission. Commissioner Alvarez fills the seat of the Attorney General designee.

Sharmil Shah, Psy.D., Chief of Program Operations, introduced Reem Shahrouri and Jeffery Kukral of the Plan Review and Program Operations team.

Filomena Yeroshek, Chief Counsel, called the roll and confirmed the presence of a quorum.

Chair Boyd stated Commissioner Wooton has been on the Commissioner for almost ten years and has been an incredible advocate of talented individuals, including talented individuals who also have lived experience. Chair Boyd presented a resolution from the California Legislature and Assembly Member Todd Gloria thanking Commissioner Wooton for the years of service with the Commission and for assisting in establishing a policy fellowship for mental health consumers through Assembly Bill (AB) 1134.

Commissioner Wooton thanked the California Legislature, Assembly Member Gloria, the Commission, and stakeholders for their support over the years and congratulated Chair Boyd and Vice Chair Aslami-Tamplen for their new leadership roles with the Commission.

ACTION

1: Approve November 16, 2017, MHSOAC Meeting Minutes

Public Comment

Poshi Walker stated that page 13 of the minutes did not correctly reflect the public comment. The speaker asked staff to review the meeting audio to more accurately state the comment against augmenting the transition age youth (TAY) stakeholder contract that had been awarded because it had gone through a competitive bid process. The speaker had voiced concern as an advocate, taxpayer, and mother that, if the Commission moves forward with this, there would have to be another Request for Proposal (RFP), and the TAY population would therefore be split amongst three contracts with administrative fees, et cetera. Poshi Walker had recommended that the TAY contract not be awarded because the proposer had not followed the instructions to fulfill the entire amount of the RFP dollars allotted. The speaker strongly urged that the minutes be changed to reflect the comments made that day.

Rory O'Brien, LGBTQ Program Coordinator, NorCal MHA, Project Coordinator, Out for Mental Health, was in attendance at the November meeting and seconded Poshi Walker's comments.

Commissioner Questions and Discussion

Chair Boyd stated staff will review the audio and make changes as necessary. He asked about the process for approving the minutes when corrections need to be made to ensure that additions are made appropriately.

Filomena Yeroshek stated the Commission may approve the minutes as amended to reflect Poshi Walker's comments as heard on the audio file.

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

The Commission approves the November 16, 2017, Meeting Minutes, as amended to more accurately reflect Poshi Walker's public comment.

Motion carried 8 yes, 0 no, and 3 abstain, per roll call vote as follows:

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

The following Commissioners abstained: Vice Chair Aslami-Tamplen and Commissioners Danovitch and Poaster.

INFORMATION

2: Overview of Governor's Proposed Budget for 2018-19

Presenters: Kris Cook, Budget Analyst; Elena Humphreys, Budget Analyst, Department of Finance

Elena Humphreys, Budget Analyst, Department of Finance (DOF), provided Commissioners with the following brief summary of the projections of the revenues for the Mental Health Services Fund (MHSF) for the 2018-19 fiscal year (FY), the administrative cap, and the Governor's budget for 2018-19:

- MHSF revenues have increased by approximately $26 million.
- There is an estimated $62.3 million within the state administrative cap. The estimate will be updated once the tax year closes as part of the May Revision process of the Governor's budget.
- The primary causes for the increase in the administrative cap are a drop-off of old appropriations and the increased MHSF revenue estimates.
- The Governor's budget included one proposal for the Commission for $2.5 million in FY 2018-19 and another $2.5 million in 2019-20 to contract with a consulting entity to assist in the development of counties' innovation plans.
- The state continues to allocate unreserved funds from the MHSF on a monthly basis. For FY 2016-17, the state allocated approximately $1.8 billion to counties. For FY 2017-18, the state allocated approximately $1.1 billion.

The presenters provided as a handout a chart showing the administrative cap.

Commissioner Questions

Chair Boyd stated the DOF handout will be posted on the MHSOAC website as soon as possible.

Commissioner Brown asked for a brief overview of the $2.5 million proposal. Executive Director Ewing stated staff has been working with the California Health and Human Services Agency (CHHS), the DOF, and the Governor's office on the proposal and has been working with counties over the past year and a half to understand some of the challenges to most appropriately using Innovation funds. Staff discussed with the administration the need to create a venue that allows counties to collaborate around innovation, support counties' ability to innovate with more technical assistance, strengthen the learning goals into the evaluation of the innovation, and disseminate the lessons learned across counties so that the lessons learned through individual county innovation investments extend beyond that county's borders into the state as a whole.

Executive Director Ewing stated that simultaneously, the state has been struggling with issues of the numbers of individuals declared incompetent to stand trial and, through Commissioner Brown's leadership in the work to reduce criminal justice involvement, staff proposed using some state administrative funds to launch an incubator to contract out services to provide technical assistance and value for counties to come together.

$5 million is proposed in the Governor's budget across two years as a way to set up an innovation incubator, working with a private entity. Staff has looked at programs worldwide and is developing a business plan for what incubator would look like.

Executive Director Ewing stated the proposal will bring a resource to counties to help them pull together subject matter experts on thematic issues starting with reducing criminal justice involvement as a way to release pressure on the Department of State Hospitals as they struggle with the backlog of consumers declared incompetent to stand trial. The proposal must go through the legislative budget process. Staff is working with the Chair to identify a consultant that can do some of the business planning and are working closely with CHHS and the DOF as the business plan starts to roll out so there will be a proposal as the budget is signed. That way staff can implement quickly to help the state and the counties marshal the $100 million per year that is available for innovation under the Mental Health Services Act (MHSA). Further explanation on this issue will be presented during the Executive Director Report later in the agenda.

Chair Boyd thanked the Governor and the Governor's office for including the proposed $5 million to support a Mental Health Innovation Center for California.

Public Comment

Steve Leoni, consumer and advocate, stated the Workforce Education and Training (WET) program, a component of MHSA funding, is due to sunset this year. The California Mental Health Planning Council (CMHPC) is working with several partners to draft legislation to extend the funding. There is an overall $19 billion surplus estimated in the state budget this year and the CMHPC plans to submit a one-time request for funding for the additional year that was unfunded on the five-year plan. This is not the Commission's piece but it should be tracked as part of the MHSA. The justification for WET funding in the original legislation was the anticipated increased needs because of the implementation of the MHSA. One of the reasons funding is still required is because the Affordable Care Act (ACA) also has expanded needs.

Chair Boyd stated Executive Director Ewing has been in discussion with the Office of Statewide Health Planning and Development (OSHPD) on this issue.

Poshi Walker, as a member of the OSHPD WET Advisory Group, spoke in support of Steve Leoni's comment and recommendation. WET does not end after ten years; new individuals continually enter the workforce and they still need to be trained. The speaker asked if there has been an analysis done regarding the new federal tax bill and how that might affect or add to those that fall into the millionaire category for individuals taxed for the MHSA.

Commissioner Discussion

Commissioner Anthony asked if WET funding will be included in future budgets or discussions and what kind of action is ongoing.

Kris Cook, Budget Analyst, DOF, stated the Governor's budget does not currently assume any additional funding for the WET program for OSHPD. However, discussions have begun about the possibility of including additional funds in further proposals.

Commissioner Wooton stated WET dollars lead to recovery; there is no empowerment without employment. She stated she was the first consumer hired at the Department of Mental Health with administration dollars under the MHSA. It was helpful to advocate for WET activities in the counties. She suggested considering an extension or additional funding for the WET program.

Chair Boyd asked about the federal landscape or what other tax relief may have in terms of MHSOAC dollars. Kris Cook stated the Governor's budget currently assumes no impact from the federal tax bill. As demographic reviews and analyses are ongoing, the DOF will refine estimates to reflect those changes.

Commissioner Poaster thanked Chair Boyd and public commenters for bringing up their concerns. Proposition 63 is one percent of income tax. To any degree the plans develop to lessen the burden of the federal act with various schemes being discussed, it potentially could reduce the income tax. The Proposition 63 revenues will reflect the decrease or increase in the income tax.

INFORMATION

3: Assembly Bill 114 Progress Report

Presenters: Brenda Grealish, Acting Deputy Director, Mental Health and Substance Use Disorder Services; Chuck Anders, Assembly Bill 114 Technical Lead, Department of Health Care Services

Brenda Grealish, Acting Deputy Director, Mental Health and Substance Use Disorder Services (MHSUDS), Department of Health Care Services (DHCS), stated the DHCS posted on its website an Information Notice giving an overview of AB 114 and giving counties instructions. The Department has calculated draft reversion numbers for all counties and sent each county its draft reversion estimates. Responses from the counties are required by the end of March. No appeal notifications have been received.

Commissioner Questions

Chair Boyd asked what the Department's current estimate of unspent MHSA funds is that will be deemed reverted under AB 114. Brenda Grealish stated the reversion estimate is approximately $220 million statewide calculated back to FY 2005-06. Counties will submit plans on how to spend those funds.

Commissioner Anthony asked where the numbers can be accessed. Brenda Grealish stated the draft reversion estimates will be posted on the DHCS website soon. Those preliminary estimates are subject to appeal by the counties.

Commissioner Poaster asked about the time period reviewed. Brenda Grealish stated it was calculated back to FY 2005-06 using the MHSA Annual Review and Expenditure Reports (RER) submitted by counties

Chuck Anders, Assembly Bill 114 Technical Lead, DHCS, stated the years reviewed were FY 2005-06 through 2013-14.

Commissioner Poaster asked staff to calculate the total dollars received over that same period of time versus what is left in the balance.

Chair Boyd asked when FY 2014-15 numbers were due and if they should be included in the reversion estimates. Brenda Grealish stated they were due on December 31, 2015. They should be included in the reversion estimates. Chuck Anders stated the FY 2016-17 RERs are needed to calculate the FY 2014-15 reversion. The FY 2016-17 RERs were due on December 31, 2017. Brenda Grealish stated the DHCS has received 16 RERs for FY 2016-17. Over 40 counties have yet to submit their FY 2016-17 RERs.

Chair Boyd asked when the final numbers are expected. Brenda Grealish stated there are a couple of things at play here. Counties are working feverishly but some counties had expressed to the DHCS in late November that there were some dependencies between the Cost Report and the RER. It is more efficient for counties to complete their Cost Report templates prior to completing their RERs, although RERs can be completed without it. The DHCS is working with counties to help them submit their RERs as soon as possible. The RER template was posted on the website in October of 2017.

Chair Boyd stated it appears that there are some counties that, during the years covered, have not submitted their reports. He asked the reasons why and asked about the processes in place to ensure that speakers have what they need when they come before the Commission to meet their obligation and effectively report out.

Brenda Grealish stated that it is unknown as to why some counties are not submitting their reports. The DHCS has a process in place to reach out monthly to counties for updates on their RERs and to offer assistance. The DHCS has the ability to withhold funds with the performance contract and AB 114. To date, the DHCS has been hesitant to withhold funding from counties due to the great need, but there is a point when it may be necessary to move in that direction. Part of the hesitation is because the Audit and Appeals regulations are not in place for counties to appeal. The Audit and Appeals regulations have been drafted and will go through the approval process this year.

Chair Boyd stated this inconsistency has been present for years and is now hindering the process to give the DHCS the tools required to get the information this many years out.

Chair Boyd asked for the names of the counties that have not submitted their reports beyond the most recent due date in 2017. Brenda Grealish provided the following:

- 2013-14: Lake and Sutter-Yuba Counties
- 2014-15: Lake, Monterey, Nevada, Santa Cruz, and Sutter-Yuba Counties
- 2015-16: Kern, Lake, Los Angeles, Madera, Monterey, Nevada, Plumas, Santa Cruz, Sierra, Sutter-Yuba, and Yolo Counties

Brenda Grealish stated Lake County has not submitted an RER since 2013. The former DHCS Deputy Director reached out to Lake County, which has undergone management changeovers. The DHCS plans to provide special assistance to help them complete their RERs. Brenda Grealish stated AB 114 is time-sensitive, which provides a monetary incentive for counties to comply.

Commissioner Bunch asked if counties have to explain the reason their funding was left unspent. Brenda Grealish stated there may be confusion about how and when to spend the funds for Innovation and Prevention and Early Intervention (PEI) programs, but spending down Community Services and Supports (CSS) programs at a proper rate is not an issue.

Commissioner Mitchell stated, the last time the DHCS updated the Commission on reversion, she felt frustrated and irritated and today she feels the same way. She appreciates the work being done but is insulted that the individuals in this state who need services still are not getting those services. There are a lot of schools that could use that money for PEI. Commissioner Mitchell asked if there is anything the Department or the state can do to help counties understand that. She understands the Cost Report difficulty and that counties want some cushion, but, nevertheless, the monies are given to provide the services. The funding should not be coming back when people have needs. Commissioner Mitchell asked the state to put some fire under the counties to get the work done for the individuals who need the services. The need is not being met. She asked that, the next time the DHCS provides an update, they bring a plan of how the state will put fire and accountability to get results. People need these services.

Brenda Grealish stated she understands that frustration and stated the Commission, the state, and the counties are trying to figure all these things out. The CSS dollars are unhindered; the blockage occurs with Innovation and PEI funding. AB 114 is the state doing something. It mandates that, if counties do not submit a plan for those funds by the July 1, 2020 due date, those funds will revert, go back into the pot, and be redistributed. It is important to address the Innovation and PEI components because reverted funding will continue to be distributed to them.

Brenda Grealish stated two things will help with that: the draft Fiscal regulations have been submitted to the Office of Regulations and are expected to get to the Office of Administrative Law (OAL) by June of 2018. Those regulations will bring clarity to how funds are to be spent. Also, right on the heels of that, the Audit and Appeals regulations will come out. With the two regulation packages moving forward, this will add clarity for the counties and the state to have oversight to clearly know what the expectations are for those funds. AB 114 will deal with what has happened to date and the clear regulations will help prevent what has happened in the past.

Chair Boyd stated the DHCS has current responsibility to hold counties accountable and the DHCS sets the dates. He stated what was just explained is not good enough. He stated the need to come before the Commission prepared to present what is being done to enforce compliance. Other counties managed to figure out how to work around potential obstacles going back five years; there are just a few county outliers. He asked what message the DHCS is indirectly sending to the other counties that also have transitions in leadership, multiple priorities, and a small number of staff to scramble to get done what is asked for. Now there is a new bill to help support the authority and responsibility the DHCS already has and processes that seem to either be lingering or not effective. He stated that would not be a sufficient explanation for any state agency.

He stated the public and the Commission are confused by why they are in the situation they currently are in.

Commissioner Poaster appreciated Chair Boyd's comments and added that counties are held accountable to regulations. The Department did not issue regulations until this bill enforced it. A good part of the mess that has occurred is because of how late it has been with regard to the development of regulations. He was disappointed that the denominator was not provided.

Public Comment

Adrienne Shilton, Government Affairs Director, Steinberg Institute, stated the Steinberg Institute worked hard on AB 114 with the legislative staff to ensure that there is a reversion policy, that it is implemented, and that counties have the guidance they need to follow that law. According to the most recent homeless counts, there are 135,000 individuals sleeping on the streets every night in Sacramento. To have $220 million to $250 million in limbo is not acceptable.

Adrienne Shilton stated the Steinberg Institute is also particularly concerned about the current practice to ensure that counties have clear guidance to submit their annual fiscal reports on time and that there is an accurate accounting of MHSA expenditures. The speaker thanked the Commission for their work on fiscal transparency and for agendizing this item. The Steinberg Institute will continue to monitor this work closely and looks forward to further conversations.

Chair Boyd thanked the Steinberg Institute for their work on this issue.

Robb Layne, Director of Communications and External Affairs, California Behavioral Health Directors Association (CBHDA), stated $220 million is a lot of money. The CBHDA appreciates the Commission spotlighting this issue. There are two pools of accountability in this conversation. Many counties do not have available reversion dollars. There are counties that are good actors in this process, but also certain counties that have not submitted their RER forms.

Robb Layne stated it is important to use individual county names rather than referring to counties as a whole and to highlight the great work that counties do. Many counties did submit their RER forms for 2015-16 even though there was confusion with the form that had almost doubled in size from previous years. The CBHDA is providing technical assistance on but not supporting Senate Bill (SB) 688 (Morlach) that will help counties streamline this process. The speaker asked for the Commission's support on that concept and stated the CBHDA looks forward to working with the Department to help counties submit their RERs and to help get those dollars into the communities.

Chair Boyd stated he appreciated Robb Layne's comments and concerns. Chair Boyd stated the Commission is against county bashing and feels the same way. That is why he asked Brenda Grealish to read the outlier counties. The job of the Commission is oversight and accountability. The questions asked are to help Commissioners exercise their responsibility as it relates to oversight and accountability of DHCS and other processes in California.

Heidi Strunk, California Association of Social Rehabilitation Agencies (CASRA), thanked the Department for presenting and the Commission for their attention, push, and questions regarding this matter because CASRA would like to see these monies pushed out to the individuals who need that help. The speaker echoed Robb Layne's comments to highlight the counties that are doing a great job and to focus increased technical support to assist counties with the RER forms. The speaker encouraged the Commission to continue to push this issue.

Elizabeth Oseguera, Senior Policy Analyst, California Primary Care Association (CPCA), stated the CPCA represents more than 1,300 community clinics throughout the state. The speaker echoed comments made by the Commission and members of the public. As the DHCS is reviewing these proposals on how reversion funds will be utilized, it is important to remember that much of these funds come from PEI and that counties need to partner with other stakeholders, including clinics, in spending these funds.

Jan McGourty, Chair, Mental Health Advisory Board, Mendocino County, was disturbed that Lake County was on all three of the lists. Most of these funds are Innovation funds and PEI funds. This Commission has control over approving plans. Mendocino County's experience was that, after four years of trying to get an Innovation plan on board and two years of staff consulting, finally it was approved. The speaker suggested turning to the staff of this Commission to help counties get their Innovation plans going so they can spend the money.

Monica Nepomuceno, Education Programs Consultant, Mental Health Services Program, California Department of Education (CDE), thanked the Commission for taking the stand to make counties accountable and agreed with not criticizing but stated counties are accountable for these funds. The speaker encouraged the Commission to include schools as partners as counties are coming up with their plans. The speaker commended Commissioner Mitchell for bringing students and school mental health into the mix.

Barbara Longo, Health and Social Service Director, Lassen County, thanked the Commission for including this issue on the agenda. The speaker agreed with the frustration about these unspent funds. The speaker stated Lassen County received a letter at the beginning of January from the Department and immediately took it to heart. The speaker, in a small, rural county, pulled together some people and they are rolling up their sleeves and will dive at full speed ahead to pull together a good, strong plan. The speaker stated the county was not here to make excuses. As a rural county, Lassen County struggles with jumping in and being excited about innovative ideas. They get staff together, they train them, and then there is turnover and they have to start over again and again. The speaker wanted the Commission to know that Lassen County is taking this seriously and will come up with a sustainable plan that does not count on training a few people but spreading that out, and come back to the Department with a viable, sustainable plan.

Commissioner Discussion

Commissioner Madrigal-Weiss asked what percentage of the unspent funds are Innovation dollars versus PEI dollars. Brenda Grealish promised to get that information to the Commission.

Vice Chair Aslami-Tamplen asked when the Audit and Appeals regulations will be completed and when the counties can expect to receive them. Brenda Grealish stated the Audit and Appeals regulations have been drafted and will go through the approval process this year. They are expected to be approved in the summer or fall of 2018.

Commissioner Gordon stated this is an embarrassment at the local level and asked if it is necessary to wait for the regulations to be in place prior to clarifying the process to counties. He suggested someone give the struggling counties a telephone call to find out what is going on and when they will be in a position to move the system to get the money spent or send the money back so someone else can use it.

Brenda Grealish agreed that it is not necessary to wait until regulations are promulgated to find out what is going on. Since last year, the DHCS has been making monthly telephone calls to counties. Chuck Anders agreed that counties do not have to wait for the regulations to spend the funding. The DHCS plans to implement site reviews in the near future that may give a better opportunity to bring understanding at the local level of what is happening and why counties may not be developing programs. Site reviews will help the DHCS to better understand programs that have been developed and are doing well and may be able to better connect counties together to have conversations about things that they may be able to do.

ACTION

4: <u>San Joaquin County Innovation Plans (2)</u>

Presenters: Tony Vartan, Behavioral Health Director, San Joaquin County Behavioral Health Services; Frances Hutchins, Assistant Behavioral Health Director; Kayce Rane, Behavioral Health Consultant, Rane Community Development; Ruth Shim, M.D., Ph.D., Psychiatrist and Researcher, University of California, Davis Behavioral Health Center of Excellence; Christine Noguera, Chief Executive Officer, Community Medical Centers; John Foley, Chief Executive Officer, Stockton Self-Help Housing; Miguel Villapudua, District 1, San Joaquin County Board of Supervisors, Katherine Miller, District 2, San Joaquin County Board of Supervisors, Benjamin Morrison, M.D., Chief Medical Officer, Community Medical Centers

Tony Vartan, Director, San Joaquin County Behavioral Health Services, provided an overview, accompanied by a slide presentation, of the demographics, strategic priorities, and 2017 MHSA community program planning of San Joaquin County. The speaker thanked the Commission for its help in developing best practices and guidelines and introduced the members of the presentation team.

Assessment and Respite Center Innovation Project

Miguel Villapudua, District 1, San Joaquin County Board of Supervisors, stated the Assessment and Respite Center Innovation Project responds to the priorities identified by the San Joaquin County Board of Supervisors and aligns closely with countywide efforts to improve the health, safety, and wellbeing of the community.

Kayce Rane, Behavioral Health Consultant, Rane Community Development, continued the slide presentation and discussed the justification of need, program overview, and proposed solution of the Assessment and Respite Center Innovation Project. Community Medical Centers (CMC), a federally qualified health center, is an amazing partner that will help create a process of seamless, bidirectional entry into care. This project transforms the assessment process and makes it more client-paced.

Ruth Shim, M.D., Ph.D., Psychiatrist and Researcher, University of California, Davis Behavioral Health Center of Excellence, stated her career is devoted to evaluating mental health disparities and inequities and the social determinants of health. Dr. Shim continued the slide presentation and discussed the evaluation components and budget of the Assessment and Respite Center Innovation Project.

Christine Noguera, Chief Executive Officer, CMC, stated the CMC is committed to ensuring access to primary and preventive health services through a coordinated system of 70 neighborhood centers, including school-based centers and a robust Health Care for the Homeless program. The CMC knows what works – taking services to communities in need and providing care in an environment that is trusted, with culturally-competent, bilingual staff in a respectful manner. That is what is seen in the Assessment and Respite Center Innovation Project.

Commissioner Questions

Commissioner Danovitch stated that the presentation provided a compelling statement of need and asked what is innovative about the Assessment and Respite Center project. The innovative mechanism is meant to encourage truly new, innovative projects that produce learning. The question is what is innovative and how is success of that innovation judged in a way to allow other counties to implement and sustain it.

Kayce Rane stated, in preparation of the planning process, the county reached out to a number of federally-qualified health centers and partners in other counties. While many public mental health systems were working with community clinics around creating a better front door to their system of care, it was often targeted to families and neighborhood-based services. This project develops a new assessment process that works better for a tricky target population. The focus on redesigning the assessment process is targeting homeless individuals and individuals with co-occurring mental health and substance use disorders who are continually in and out of systems of care. People are struggling with this issue and how to sustain engagement with individuals who are picked up by law enforcement.

Commissioner Danovitch asked what the new assessment process is. Kayce Rane stated the new assessment process was developed in partnership with clinicians and will be a multi-phase process beginning with Triage that happens at the Center, clinical

needs, and daily living needs. It addresses needs by offering a range of services prior to the psycho-social assessment process. It bridges early intervention and treatment services that is more responsive to individual needs.

Commissioner Bunch stated she appreciates flipping the assessment process, starting services to sustain engagement, and not getting caught up in the idea of medical necessity. She asked how the county plans to sustain engagement.

Kayce Rane stated some will be learned in real time, but the big idea now is in the use of care partners and individuals with lived experience being part of the sustained engagement team. All of this happens in cooperation and collaboration with other projects such as the Progressive Housing Innovation Project, which will be discussed next. Streamlining linkages to housing and placing individuals somewhere where they can continue to engage in the assessment and get comfortable with the treatment process is a component. Part of it is having the right people in the room, being culturally competent, being respectful of the kinds of questions and conversations that there are, having the general approach in caring, and engaging stakeholders. What keeps individuals engaged is taking care of what they need, not what someone else thinks they need.

Vice Chair Aslami-Tamplen stated, as assessment is redesigned, she did not hear comments about tracking patient satisfaction of services, which is important. She asked what is being done to address stigma and discrimination, which is prominent throughout the mental health system. Dr. Shim stated the county will measure client satisfaction and evaluate that throughout the process and will be using multiple tools, specifically the Adult Needs and Strengths Assessment Tool. Stigma is complicated and complex. One important piece is the system not being responsive to the needs of the clients. One of the most effective ways to address stigma in the population that is not engaging is to provide the appropriate services.

Commissioner Mitchell asked how long individuals can stay at the respite. Kayce Rane stated respite can happen over a lengthy period at the CMC site and, if respite needs to continue, then they can seamlessly be moved into a safe place such as offered by the Progressive Housing Innovation Project.

Kayce Rane asked Benjamin Morrison, M.D., Chief Medical Officer, CMC, to answer Commissioner Mitchell’s question. Dr. Morrison stated it is based on the needs of each person.

Commissioner Bunch asked if the county is referring to stabilization before transitioning into the housing component. Dr. Morrison stated that is what the county is looking at. It depends on the patient and the partners. Long-term housing is not offered in the clinic.

Commissioner Wooton stated Michael Fields, Executive Director, Peer Recovery Services, San Joaquin County, is in the audience today and should have been included as a presenter of this Innovation project. She asked if the county will use the Milestones of Recovery Scale (MORS) as well as the Adult Needs and Strengths Assessment. Dr. Shim stated the county could use the MORS scale but has not finalized anything at this point.

Progressive Housing Innovation Project

Katherine Miller, District 2, San Joaquin County Board of Supervisors, stated the Progressive Housing Innovation Project not only incorporates recommendations from the Homelessness Task Force but also aligns with the strategic priorities that have been identified by the Board of Supervisors. The project will rapidly increase the housing that is available to individuals who are homeless or are at risk of becoming homeless. It also provides a new approach to housing individuals with co-occurring disorders or who are struggling with recovery. This project also launches a new partnership with Sacramento Self-Help Housing. This project is feasible, impactful, and necessary.

Chair Boyd thanked Miguel Villapudua and Katherine Miller for the engagement and support of the County Board of Supervisors. It is a wonderful model for other counties to engage their Boards of Supervisors.

Kayce Rane continued the slide presentation and discussed the justification of need, program overview, and evaluation components of the Progressive Housing Innovation Project. The speaker stated Housing First is a great strategy to get individuals off the streets, which is a good start but not enough to move the recovery benchmarks forward. This project takes the Housing First model to get individuals off the street, but puts them together so they can benefit from peer support and learn independent living skills.

John Foley, Chief Executive Officer, Stockton Self-Help Housing, stated Stockton Self-Help Housing is excited about this project, mainly because of the evaluation piece.

Public Comment

Carena Lane, Director of Occupancy and Housing Compliance, Housing Authority, San Joaquin County, spoke in support of the Progressive Housing Innovation Project and about the background and current activities of the Housing Authority to help families in San Joaquin County.

Tasso Kandris, San Joaquin County Behavioral Health Board and a parent of an adult child living with a mental illness, spoke in support of the Assessment and Respite Center Innovation Project and stated both projects match what has been heard from consumers and family members for years.

Gertie Kandris, National Alliance on Mental Illness (NAMI) San Joaquin County and parent of an adult child living with a serious mental illness and substance use disorder, stated San Joaquin County has seen the closure of over a dozen board and care homes and has experienced a high influx from Bay Area residents trying to find affordable housing. More housing options are needed immediately for people with mental illness and co-occurring disorders to support their recovery. The speaker spoke in support of the Progressive Housing Innovation Project.

Dr. Morrison has seen firsthand the failures of the system, not because there is no care available but because it is not always where the patients need it to be. Dr. Morrison spoke in support of the Progressive Housing Innovation Project.

Michael Fields, Executive Director, Peer Recovery Services, the first peer-run organization in San Joaquin County, spoke in support of the Progressive Housing Innovation Project.

Kathleen Wilson-Parish, Chief Mental Health Clinician, San Joaquin County Behavioral Health Services, spoke in support of the Assessment and Respite Center and the Progressive Housing Innovation projects. Significant mental health service gaps remain unaddressed, particularly for individuals with co-occurring disorders whose mental health concerns are emerging or do not yet meet the criteria for serious mental illness. The proposed Innovation projects will help fill those gaps.

Jaime Nunez, LCSW, Interim Psychiatric Facility Manager, San Joaquin County Behavioral Health Services, spoke in support of the Assessment and Respite Center and the Progressive Housing Innovation projects.

Karen Ivy, consumer, San Joaquin County Behavioral Health Board, Consumer Advisory Council, spoke in support of the Progressive Housing Innovation Project.

Stacie Hiramoto, Director, Racial and Ethnic Mental Health Disparities Coalition (REMHDCO), was impressed with the San Joaquin County Innovation proposal and with the MHSOAC staff analysis. The speaker thanked Commissioner Danovitch for asking what is innovative about the Assessment and Respite Center Innovation Project and commended the county for mentioning a report from the California Reducing Disparities Project (CRDP) and for partnering with the CMC, which is an effective access point and is important for underserved communities.

Poshi Walker stated LGBTQ individuals fall under unserved, underserved, and inappropriately served populations who are reluctant to seek services, not just due to stigma but due to fear of being harmed when accessing services. LGBTQ individuals are also overrepresented in homeless, substance abuse, and co-occurring populations. When focusing on intersection of Latinx, African-American, and people of color in general who are also LGBTQ, the LGBTQ CRDP research found that these populations stated that finding providers who are affirming of sexual orientation and gender identities and knowledgeable about racial and ethnic and LGBTQ needs were among top barriers to accessing appropriate services. Primary care physicians are the second most rejecting providers that they named. The speaker strongly recommended that the clinic be physically welcoming with rainbow signs and affirming of LGBTQ, especially transgender individuals, and that culturally-competent staff who are knowledgeable in needs of intersectional identities will be hired and ancillary staff will be trained in LGBTQ affirming care in order to reach the goals of this project.

Elizabeth Oseguera thanked San Joaquin County for their willingness to collaborate with federally qualified health centers who already work to serve underserved, diverse populations and spoke in support of the proposed projects. The speaker referred to page 3 of the proposal that lists research findings by county and clarified that research focused on how services were provided, not necessarily if they were provided. This is not clear in the proposal. Federally qualified health centers do provide services listed, such as preventative treatment, working with the homeless population and those

recently released from incarceration, drug management, and psychosocial assessments. The speaker offered the CPCA as a resource for further research questions from the MHSOAC or other counties.

Heidi Strunk thanked the county for outlining the community program planning to help advocates understand the stakeholder process for the projects and for incorporating and recognizing the importance of peers from the onset and how that contributes to sustained engagement.

Heidi Strunk stated respite is defined in statute as 30 days, which is in line with the values of the MHSA. The Assessment and Respite Center project needs to adhere to statute.

Cary Martin, San Joaquin County Behavioral Health Board member, veteran, and psychiatric technician, spoke in support of the proposed Innovation projects, which will help fill gaps with better linkages between the county mental health department and primary care clinics. They are innovative, necessary, and will lead the state.

Robb Layne spoke in support of the proposed Innovation projects.

Commissioner Discussion

Commissioner Anthony stated the proposal lacks an evaluation of the department or system of care and there is no reflection of the measurement of public bias of the system. Agency bias is a significant problem. System staff may have bias. This needs to be looked into.

Frances Hutchins, Assistant Behavioral Health Director, stated the county system has been working for years on ways to engage populations. There are many groups that do outreach into communities, but certain populations do not come to public mental health.

Commissioner Anthony asked how the county plans to measure the public stigma of the agency, staff, and system. Dr. Shim stated measuring implicit bias of the providers within the system is complicated.

Commissioner Anthony asked if it is going to be measured. Dr. Shim stated no plans are currently in place to measure implicit bias. Based on the data of implicit bias, there is 100 percent certainty that there is implicit bias within the system. It is an important piece that should be measured, but may be outside of the scope of this proposal.

Commissioner Anthony stated the amount of money for training and staff education was lacking. Kayce Rane stated the county has been discussing training and staff education as a need, especially with regards to implicit bias, but hoped to address it outside the scope of this project.

Commissioner Bunch asked about the mental health treatment within the Progressive Housing Innovation Project. Kayce Rane stated it is outside of the scope of the Innovation budget. The county assumes that mental health treatment is addressed through behavioral health services. Individuals with serious mental illness will be treated through the existing system of care. The entire mental health system of care wraps around the client in the Progressive Housing Innovation Project.

Commissioner Bunch asked if there is substance abuse treatment or mental health treatment provided onsite for the individuals who live there. Kayce Rane stated the county envisions transportation and case management components that come to the facility. A shuttle will provide transportation to services and supports so individuals feel engaged with the community, while case managers and psychiatric technicians will provide medication management and group sessions at the facility on a regular basis.

Commissioner Bunch asked if the services are required. Kayce Rane stated they are not, especially not at the precontemplation phase.

Commissioner Bunch asked how the proposed project is different from a board and care. Frances Hutchins stated it is different because there is not a board and care operator and medications are not monitored. It is similar to independent living using a Housing First model that engages individuals where they are and gives them an opportunity to become more stable and achieve recovery.

Chair Boyd stated one of things he thought about during his time on the Commission is what the value is of the Chair and Vice-chair voting first, because the way the Commission works as a body is not one that works on parties. Commissioners hold different seats for different specialized knowledge. To reflect that, Chair Boyd asked that roll call for votes to be taken in alphabetical order with the Chair and Vice-chair voting last.

Chair Boyd stated each of the San Joaquin County Innovation projects will be voted on separately.

Action: Commissioner Mitchell made a motion, seconded by Commissioner Gordon, that:

The MHSOAC approves San Joaquin County's Innovation Project as follows:

> *Assessment and Respite Center*
> *Amount: $11,216,688*
> *Project Length: Five (5) Years*

Motion carried 10 yes, 1 no, and 0 abstain, per roll call vote as follows:

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

The following Commissioner voted "No": Commissioner Danovitch

Commissioner Gordon recused himself from the decision-making with regard to the Progressive Housing Innovation Project and left the room pursuant to Commission policy.

Action: Commissioner Mitchell made a motion, seconded by Commissioner Bunch, that:

The MHSOAC approves San Joaquin County's Innovation Project as follows:

> *Progressive Housing*
> *Amount: $6,461,517*
> *Project Length: Five (5) Years*

Motion carried 9 yes, 1 no, and 0 abstain, per roll call vote as follows:

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

The following Commissioner voted "No": Commissioner Anthony.

Chair Boyd asked Dr. Shim to work with Commission staff to present on health disparities and mental health as a separate agenda item at a future Commission meeting. He asked Dr. Shim to connect with Norma Pate.

Chair Boyd stated the above discussion brought up the issue of cultural and linguistic competency. Chair Boyd appointed Commissioner Mitchell as Chair of the Cultural and Linguistic Competency Committee. Chair Boyd agreed with Commissioner Mitchell's condition that the Committee will focus on health disparities.

INFORMATION

5: Implementation of Assembly Bill 1315

Presenters: Norma Pate, Deputy Director, Program, Legislation, and Technology; Tom Orrock, Chief of Commission Operations and Grants

Tom Orrock, Chief of Commission Operations and Grants, provided a brief overview of AB 1315, the Early Psychosis Intervention Plus (EPI Plus) Program. This bill requires the Commission to implement a competitive process for counties to bid for funds, and to establish an Advisory Committee to assist with implementation of the grant program. Mr. Orrock provided an overview, accompanied by a slide presentation, of the responsibilities of the Advisory Committee.

Norma Pate, Deputy Director, Program, Legislation, and Technology, continued the slide presentation and discussed funding challenges and next steps to implement the EPI Plus Program. Per the legislation, regulations for the program are due in January of 2019.

Commissioner Questions

Commissioner Danovitch described a content area that could be addressed through this mechanism or potentially through the innovation mechanism. In November of 2016, California legalized cannabis and, as of January of 2018, commercial sales of legal cannabis became possible. There likely will be significant increases in consumption among youth. Cannabis consumption among individuals with a specific vulnerability to develop psychotic disorders is one of the modifiable risk factors that can make a

difference in the early development, masking, or the worst course of illness for that disorder. There is a tremendous opportunity in California to evaluate that and to deliver targeted interventions that, in addressing that problem, have a real impact on unmasking the development of psychotic disorders in California's youth.

Commissioner Anthony shared her personal experience of her son with lived experience who began exhibiting symptoms following his use of marijuana. Taxing revenues for cannabis would be appropriate.

Public Comment

Adrienne Shilton thanked the Commission for working collaboratively with the Steinberg Institute, who authored the bill, on the implementation of AB 1315. The Steinberg Institute has begun the fundraising process in earnest for the special account and is dedicated to doing everything it can to ensure the Commission has the administrative support and resources needed to implement this new law. Any individual or organization can make a donation in care of the MHSOAC for deposit into this special account.

INFORMATION

6: Executive Director Report Out

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

Executive Director Ewing presented his report as follows:

Personnel

Two staff members have been hired since the last Commission meeting.

Consulting Psychologist and Research Director positions remain unfilled but progress is being made.

Jennifer Whitney, Communications Director, has announced her retirement and requested that the Commission not celebrate her friendship and contributions. She will be dearly missed.

Budget

The Commission continues to be clear and transparent in terms of the budget. The DOF presented today and Commissioner Brown asked for clarification on the $5 million the Governor proposed to go into the Commission budget.

Staff is in discussion with the Legislature about funding in terms of the audit that is underway and the work the DHCS is doing around AB 114. It is anticipated that there will be recommendations that come out of the audit, which should come out in late February or early March, around enhancing oversight of the funds.

There are counties that are sitting on unspent MHSA funds for a couple of years and beginning to spend the funding in the third year. This is another area of frustration. The unspent funds are not affected by AB 114 because those funds are not subject to reversion. Staff is working to learn the amount of funding that is available to counties. It is anticipated that staff will be asked to testify before the Assembly and Senate Budget

Committees on the $5 million budget request and the broader issue of mental health funding and how it is and is not being spent.

Commissioner Questions

Commissioner Brown asked about the mechanics, where the consultant will come into this, and if there will be an opportunity to receive any of that funding or if this is just to establish the incubator, get the consultant, and provide the technical expertise with no pilot programs. Commissioner Brown asked for clarification that it is strictly for the development of a mechanism to better distribute the technical advice.

Executive Director Ewing stated the proposal is $2.5 million in the coming FY and another $2.5 million in the following FY. The rules allow the Commission to spend the funds over a four-year period. Staff is exploring the possibility of allowing the Commission to work with an entity that would begin to provide those services to counties. These funds would be focused on supporting counties to develop their Innovation proposals.

Executive Director Ewing stated it is anticipated that part of the community planning process would be done in that incubator environment but that counties would take proposals back that are generated. The MHSOAC will facilitate counties' development of their proposals in a collaborative, cross-county environment. County proposals would be approved by their local Boards of Supervisors before presenting before the Commission. The funding to pay for the Innovations will be the local mental health funds.

Executive Director Ewing stated staff indicated to the Governor's office that the Commission should explore the option to authorize counties to use a portion of their Innovation dollars for planning purposes, which would create the opportunity for counties to pay for some of the up-front funding. This has been described as a market test – that the $5 million will allow the incubator to provide services for a period of time while building support and figuring out how to do it well. When that funding is gone, counties would have the revenue stream of their Innovation planning dollars to support that service to the extent that it has proven useful to them. While the Commission would have a primary role in launching the incubator and after 5, 6, or 7 years the Commission would step away. After several years, the incubator will be driven by and responsive to the needs of the counties as the counties define the concerns that they have.

Executive Director Ewing stated the other question staff is considering is if we build it, will they come? In terms of the work that Chair Boyd and Commissioner Danovitch have led on the Innovation event and the subcommittee, we know that some counties are ready to go right now and others are hesitant and not sure that there is a need. Staff has discussed opportunities for the Commission to incentivize utilization of the incubator by adopting a standard practice – that if the incubator certifies a county's plan as meeting the standards, then it would receive fast-track approval and consent. There are many ways to incentivize counties to move into that space.

Executive Director Ewing stated staff is at the stage of talking to others who have done this work to help staff think about incentives and resources. This is seed money – start-

up funds to launch an incubator, but then, over time, it will be owned by community mental health with the counties at the center of it.

Commissioner Brown asked about the expectation or requirement that the designation incompetent to stand trial be at the forefront of this. Executive Director Ewing stated it would be a primary focus, based on conversations with the Governor's office, but not the only focus. In that conversation, staff emphasized that the vision is not about innovative approaches to restore competency but would be about approaches to direct individuals into intercept zero diversions. It is the idea of taking pressure off the incompetent to stand trial population through upstream intervention and diversion strategies. Recognizing that this needs to be responsive to the needs of the counties, which is to be determined. Community-based competency restoration has not been defined, but the intent is for the emphasis to be on PEI models as the most cost-effective strategies to reduce the number of individuals in the pipeline as opposed to changing practices that might happen in a state hospital environment. The budget process has just begun so there is much to work out.

Commissioner Brown encouraged everyone connected to this to recognize that there truly is a need for both upstream prevention and the switch in how business is being done now. It is important to look for new programs that would partner to come up with a model that could get individuals out of jail and into community-based treatment that would restore competency and allow for their charges to be addressed in the criminal justice system and for their long-term health and welfare to be improved.

Commissioner Danovitch applauded the proposal. It exemplifies what is meant by innovative initiatives because, if it works, it creates value by taking advantage of other resources, structures, and processes and leveraging them together. Like all innovation proposals, it will be important to measure it against that goal and there are many good measures. Commissioner Danovitch applauded the effort and the example it sets.

Innovation Summit

On Friday, February 2, in partnership with Verily Life Sciences, the California Healthcare Foundation, Sutter, and a number of key county directors, the Commission is hosting an Innovation Summit. Friday's conversation will be the launch of this different way of supporting and thinking about the opportunity that is there. One of the metrics that needs to be considered is the number of new partners who are joining with community behavioral health leaders to think about innovation and how this works.

MHSA Audit

In response to the work the Commission did on fiscal reversion, Senator Beall called for an audit of the MHSA. The primary focus of the audit was around fiscal accountability and transparency. The Commission is subject to that audit including an entrance interview, a series of questions and engagements and information sharing, and an exit interview. The auditor gives the Commission a redacted draft of their report including information from the audit about the Commission and the Commission has an opportunity to formally respond. The written response goes into the audit report and the auditor has the option of responding to the Commission's response. The formal audit of

the Commission's efforts around oversight and accountability will be received on February 5th and the due date for the Commission's formal written response is 5:00 p.m. on February 9th. The law allows the Commission to hold a closed session to review the audit and, under the state's rules regarding the audit, the information in the audit is confidential. Staff is working with the Chair to determine a date and time that a majority of Commissioners can be present.

A copy of the findings cannot be distributed to Commissioners. The closed session will be scheduled as a teleconference; only Commissioners in the room can view a hard copy of the audit information, but it can be read to Commissioners attending by teleconference. Staff will draft a proposed response as a starting point for Commissioners to modify and adopt. The formally-adopted written response will be returned to the auditor by the due date. The Commission teleconference meeting is tentatively scheduled for Thursday, February 8th.

Commissioner Questions

Commissioner Mitchell asked if staff has an idea of what is in the audit.
Executive Director Ewing stated the auditor shared key points with staff, but they are confidential.

Committees

Staff is working with the Chair to appoint Commissioners to lead the Committees.

Assembly Member Gloria's bill to create the fellowship requires the creation of an Advisory Committee to do that. There are fellowships for a Mental Health Practitioner and a Mental Health Consumer. One or two Advisory Committees will be created.

Project Updates

Children's Crisis Services

The Children's Crisis Services report is being drafted. A full draft will be presented to the Chair within five days.

Criminal Justice and Mental Health

The Criminal Justice and Mental Health project will soon be implemented. A number of legislative offices have contacted staff for technical assistance and guidance. The Commission's rules of procedure allow staff to communicate the Commission's position if the Commission has taken a position. To the extent that legislation is consistent with the adopted report, the standard operating strategy is that the Commission will write a letter of support for that legislation. The Commission would have done that with one of the bills, which will be discussed later in the agenda, because of the direction the Commission took in the report. It is on the agenda to clarify the expectation that, if the Commission adopts a report with recommendations and the bill implements those recommendations, the Commission will automatically take a support position.

A tremendous amount of work has been done in order to implement the criminal justice work.

<u>Fiscal Reporting Tool</u>

Executive Director Ewing requested Brian Sala, Deputy Director, Evaluation and Program Operations to come up and provide a demonstration of the next version of the Fiscal Reporting Tool. Months of revenue on hand and the percentage of revenues earned has been added to the tool. The percentage in the table under the line graph shows that at the end of FY 2012-13 there was 107 percent of the MHSA revenues earned that year in the balance statewide. The cash-on-hand column indicates that none of the FY 2015-16 funds were spent and approximately half of their FY 2014-15 funds were spent.

Deputy Director Sala cautioned that Commissioners are viewing staff's development website. Testing has not been completed on the materials posted. Deputy Director Sala advised that the numbers are for demonstration purposes only.

Given the need in the community, the Commission wants to facilitate community conversations about what an appropriate balance is, contextualized by the level of need and the level of cash each county has.

The federal financial participation from the 1991 Realignment, 2012 Realignment, and other funds have been added to the tool as an effort to strengthen fiscal understanding of the overall MHSA funds.

The Fiscal Reporting Tool is 100 percent dependent on the data being up-to-date. The goal is that, because reports are due within six months of the close of the FY, the Commission could give the public a picture of the historical trend and that point in time, six months after the close of that FY, to support that robust community planning process that the MHSA requires.

Commissioner Questions

Commissioner Mitchell stated, since the intent of the Fiscal Reporting Tool is for the public the terms that are used should be addressed for the public. Commissioner Mitchell asked if the language about the MHSA closing balance is required language, if it is what the DOF uses, or if that is to be defined as unspent funds.

Executive Director Ewing stated staff has had these arguments amongst themselves over the balance between it being user friendly and publicly accessible. The words used are words the public can use while adhering to a high level of validity and reliability in terms of the official reports. Part of the reason why some of that language is there is because the reports provided by counties are point-in-time reports. This is one piece of a broader effort where the Commission wants to give the public information on funding. The second piece is the services that are in place and the third piece is metrics around outcomes. Staff is trying to find a balance between reliability and validity of the numbers with user-friendly language.

Commissioner Mitchell suggested including a footnote or asterisk that the closing balance numbers are at a point in time. Executive Director Ewing pointed out areas of the web page where staff has tried to work with those definitions and make it an easy tool to use. Staff anticipates conversation on the Fiscal Reporting Tool this year and

would like to talk to the Legislature about investing more to do community engagement, testing, and user experience work that has not been done to date due to the lack of funds. Although the Fiscal Reporting Tool is very good, it can get better.

Commissioner Madrigal-Weiss asked if PEI dollars can be separated out from the Innovation dollars. Deputy Director Sala stated the Fiscal Reporting Tool is separated by CSS, PEI, and Innovation components. Executive Director Ewing stated it is not up to date because of the late reports and the DHCS was only referring to reversion dollars in their presentation earlier today.

Commissioner Danovitch asked if the Fiscal Reporting Tool is available to the public. Deputy Director Sala stated there is an online extract from the database that will be made available to the public. Executive Director Ewing stated the source documents are currently available now but it is complicated because the structure of the tables change and contain hundreds of thousands of cells. The Fiscal Reporting Tool is an effort to create a point-and-click environment but it does not have the ability to do a county-to-county comparison. The Fiscal Reporting Tool contains only dollars currently – services will come next, and the outcomes will be added after that.

Issue Resolution

The issue resolution process is on hold.

PEI and INN Regulations

This item will be discussed later in the agenda.

Schools and Mental Health

The Schools and Mental Health subcommittee is working to put together another public hearing full Commission meeting in April. A lot of progress has been made in terms of the funding the Commission authorized staff to put in place for Schools and Mental Health projects. The subcommittee is currently framing out the challenges heard through the process. The April meeting will focus on the solutions that should be pursued.

Suicide Prevention Plan

The next subcommittee meeting will be in April or May. The Chair has appointed Chair Emeritus Wooton to lead that project. More information on this project will be heard later in the day.

Data Linkage

Data linking is a challenge, mostly because of procedural issues on the part of the departments that have the data. It is difficult to get Data Use Agreements in place. It is progressing slower than hoped for. Staff continues to work with the CHHS, the DHCS, and the Department of Justice and will engage the Chair to pick loose some of the permissions that need to be given to access some of this data.

Stakeholder Contracts

The stakeholder contracts are in place. A supplemental competitive application process was required because the initial funding for TAY was $500,000 and was augmented to $670,000, which left $170,000 to make available times three years. Two qualified applicants submitted proposals. The Commission authorized staff to enter into a contract with the winning bidder and the winning bidder has declined the contract. Staff is working through the process to make those funds available to the second qualified applicant, the California Youth Connection, the organization that received the original $500,000-per-year contract.

Strategic Planning

Three proposals have been received to help with strategic planning. Staff will work with Commissioner Ashbeck to prioritize the proposals before bringing one before the Commission.

Triage Grants

The Request for Applications (RFA) process has begun for the first component of the triage funding targeting TAY and adults. The RFAs for the children, and school-county partnership will go public in March.

GENERAL PUBLIC COMMENT

Adrienne Shilton stated the Steinberg Institute was part of the planning process for the upcoming Innovation Summit and is excited about the opportunity this presents to think about how to be bolder and bigger when it comes to innovation and what new partners can be brought to the table to engage in these conversations. The Steinberg Institute is supportive of IST programming and will support it through the budget policy process, as well.

Jan McGourty is also a member of the new Advisory Board for the MHSA in Mendocino County where sales tax will be collected to build health facilities. Cultural competency is important. It derives from the words that mean customs, institutions, and achievements of a particular nation of people, and the necessary skill or knowledge to do something successfully. Being culturally competent is one of the guiding principles of the MHSA. MHSOAC staff needs to respect that counties have their own culture, regulations, and rules and travel is one of them. Mendocino County requires travel requests 30 days in advance. The Commission, being competent and professional, should put together a calendar a year out.

Stacie Hiramoto stated a number of community stakeholders had concerns about the upcoming Innovation Summit but Executive Director Ewing attended the MHSA Partners Forum, a coalition that meets monthly between government and community stakeholders and attendees were appreciative that Executive Director Ewing answered questions about the Innovation Summit. The speaker hoped that the Innovation Summit is a success and asked that, for future projects and events, such as the Innovation Summit or the $5 million incubator, consumers, family members, and representatives of racial/ethnic and other underserved communities can be involved in the initial planning

and development of the project or event. This is the principle of the MHSA – consumer, family, and community-driven. The Commission should also take into consideration how reducing disparities will be addressed even if the project or program is not specifically focused on reducing disparities. It needs to include how to serve individuals from underserved racial/ethnic communities. It cannot be siloed.

Chair Boyd stated the subcommittee on Innovation met for several months and many of these issues were addressed there. Further, there was representation on the subcommittee regarding individuals with diverse backgrounds, including peers and consumers. Chair Boyd offered to follow up with Stacie Hiramoto offline.

Resolutions for former Commissioners Larry Poaster, Ph.D., and Richard Van Horn

Chair Boyd presented Commissioners Poaster and Van Horn with resolutions from the California Legislative Assembly in appreciation for their years of service with the Commission.

Commissioner Poaster thanked everyone and stated he has worked with 35 Commissioners over his ten and a half years with the Commission. It has been an incredible experience and magnificent honor. Commissioner Poaster stated there has never been a more gifted, committed groups of people then people who end up as Commissioners with the MHSOAC. He encouraged Commissioners and staff to protect the uniqueness of the Commission within the state government.

Commissioner Van Horn thanked Commissioners, staff, and the public. This has been an adventure. What started out as one person with a consultant is now a significant agency and independent of almost everything. It is that independence that gives the Commission the chance to do things that other entities cannot do around the state. It is worth protecting and critical for the oversight of the MHSA and the entire mental health system.

ACTION

7: Adoption of Amendments to the Prevention and Early Intervention and Innovation Regulations

Presenter: Filomena Yeroshek, Chief Counsel

Filomena Yeroshek thanked Commissioner Poaster, Vice Chair Aslami-Tamplen, and former Commissioner Richard Van Horn, who were the members of a subcommittee to implement the regulations. She also thanked MHSOAC staff members Angela Brand, Cynthia Burt, and Kayla Landry, who helped at different times on this project. Chief Counsel Yeroshek provided an overview, accompanied by a slide presentation, of the background and next steps of the PEI and Innovation regulations. If approved by the Commission and the Office of Administrative Law, the proposed amendments, which were provided in the meeting packet, will go into effect in July of 2018.

Public Comment

Stacie Hiramoto thanked the Commission and former MHSOAC Consulting Psychologist Dr. Deborah Lee for their work on these regulations. The process was welcoming and allowed stakeholders to work with staff and the Committee.

Poshi Walker echoed Stacie Hiramoto's comments and thanked the Commission for the inclusion of sexual orientation and gender identity and accepting feedback in the language around the age when those questions can be asked.

Elizabeth Oseguera thanked the Commission for the work done on this and for the changes that were accepted, particularly those changes around the demographic information being collected and documenting referrals made to noncounty partners in the community. This will help counties realize existing resources in their communities.

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

The Commission adopts the amendments to sections 3560, 3560.010, 3560.020, 3705, 3726, 3735, 3750, and 3755 of the PEI regulations and sections 3580 and 3580.010 of the Innovative project regulations as presented and authorizes the Executive Director to submit the rulemaking file to the Office of Administrative Law.

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

The following Commissioners voted "Yes": Commissioners Anthony, Brown, Bunch, Danovitch, Gordon, Madrigal-Weiss, Poaster, Wooton, Vice Chair Aslami-Tamplen, and Chair Boyd.

Commissioner Poaster commended Filomena Yeroshek for her work through this difficult process.

ACTION

8: <u>Authorization for the Triage Grant Program Evaluation Contracts</u>

Presenters: Tom Orrock, Chief of Commission Operation and Grants;
Kristal Antonicelli, Health Program Specialist and RFA Lead

Tom Orrock, Chief of Commission Operation and Grants, stated this agenda item is a follow-up to the Commission-approved statewide evaluation strategy for the Triage program. Mr. Orrock provided an overview, accompanied by a slide presentation, of the approved evaluation strategy and the 2014 to 2018 triage evaluation constraints. One of the lessons learned from round 1 of the grants was to improve the evaluation strategy.

Kristal Antonicelli, Health Program Specialist and RFA Lead, continued the slide presentation and discussed the round 2 evaluation goals and statewide evaluation opportunities. A statewide evaluation strategy will help to determine the best way to approach crisis intervention services.

Commissioner Questions

Commissioner Brown commended the work done on the Triage Grant Program. It is important to report not only on the cost savings elements but also on the cost avoidance elements.

Commissioner Bunch asked if the Commission will see different aspects of the evaluation prior to publishing the results. Executive Director Ewing stated part of the challenge is that the way the grants are made available allows counties wide discretion in how they deploy those funds so the evaluation cannot be designed up front. Similar triage investment evaluations may need to be sampled or grouped. The first steps are to award the grant funds and the evaluator contract. What the evaluation will look like will be developed over time.

Public Comment

Stacie Hiramoto suggested collecting demographic information in the evaluation on racial, ethnic, age, LGBT of who is served by this program.

Poshi Walker echoed Stacie Hiramoto's comments and stated the need to ensure that the evaluation include appropriate sexual orientation and gender identity demographic data. Also there is an opportunity to do some intersectionality and be able to say not only how many African Americans and lesbians, for example, were affected, but how many African American lesbians in the young adult age group were affected.

Elizabeth Oseguera echoed the comments made by the previous speakers in ensuring that the demographic information is collected and that there is an evaluation put in place. The speaker thanked MHSOAC staff for their work on this project and for adding the CPCA as a potential partner.

Jan McGourty stated having an evaluation of any kind and comparing statistics statewide is important, especially if it is separated into the demographics of the different-sized counties. Small counties have a different life than urban counties. She opined $10 million is excessive. The speaker asked if there is a way to be more fiscally responsible in doing these things.

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

The Commission authorizes the Executive Director to enter into one or more contracts for a total amount not to exceed $10,000,000.00 to assist the Commission in conducting statewide evaluation of the second round of SB 82 Triage grant programs.

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

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

ACTION

9: Legislative Priorities

Presenters: Toby Ewing, Ph.D., Executive Director; Donna Hardaker, Manager of Workplace Mental Health and Peer Relations, Sutter Health

Chair Boyd stated Executive Director Ewing will engage Commissioners in a conversation around what some legislative priorities could be this year and get some feedback, and discuss the work done specifically for workplace mental health.
Chair Boyd asked Commissioners to approve working on introducing legislation and providing leadership around workplace mental health.

Executive Director Ewing stated the Commission has begun to take an active role in policy making in recent years through projects such as the criminal justice and crisis services work. At the same time, staff is approached by lawmakers asking for the Commission's support for the legislation that they are putting together. Typically, staff would ask someone from the author's office to make a formal presentation. There are three bills listed in the agenda that are consistent with work the Commission has already done, so staff did not feel the need to ask those offices to come in and explain their legislation.

- SB 215 (Beall): Diversion – Mental Health Disorders is consistent with the work done on reducing the number of consumers involved in the criminal justice system. If the Commission decides to support that legislation, staff will develop a letter to the Senator, the relevant policy committees, and the Governor informing them that the Commission is in support of the legislation. It also authorizes staff to go to policy hearings and testify before the Legislature to encourage lawmakers to pass the bill.
- SB 688 (Moorlach): This bill clarifies some of the reporting provisions of the MHSA Revenue and Expenditure Reports. It requires the reports to be certified, which allows an apples-to-apples comparison across the categories of reporting in different fiscal documents. It is a nice bill that would strengthen fiscal reporting.
- SB 906 (Beall and Anderson): Peer Provider Certification. Last year, the Commission took a support position on Senator Leno's peer certification bill. SB 906 is consistent with the position the Commission took last year.

Executive Director Ewing stated there is other legislation that is working its way through the process but many of these bills either have not yet been introduced or they have just been introduced in a skeletal format. Staff intends to bring those bills before the Commission at the February and March Commission meetings to possibly take a position on those bills. Executive Director Ewing asked for Commission support on the above three bills so staff can inform policy makers that these are things the Commission is in favor of.

Commissioner Questions

Chair Boyd made a motion to support the three legislative priorities listed in the meeting packet and to allow the Executive Director to carry those things forward.

Vice Chair Aslami-Tamplen stated she and Commissioner Wooton will not give up on the peer certification bill and are excited about approving it.

Commissioner Madrigal-Weiss spoke in support of workplace mental health, especially working on projects around mental health in schools for both children and adults.

Commissioner Wooton stated SB 215 and SB 906 go hand in hand because it is difficult for peers who may have a criminal history, to be hired. These bills will blend nicely together.

Public Comment

Stacie Hiramoto was glad the Commission is working on legislation because of its important voice and suggested that a paper could be developed about legislative priorities and parameters and whether the three bills in the meeting packet are the priority or if they represent the priority subjects. It is important to support bills that reduce mental health disparities even though the Commission does not currently have projects on reducing disparities.

Heidi Strunk, CASRA, a member of the California Association of Mental Health Peer-Run Organizations (CAMHPRO), and Chair of California Coalition of Mental Health, asked the Commission to endorse and continue to support the peer certification, SB 906.

Adrienne Shilton stated the Steinberg Institute is supportive of the effort to look at mental health in the workplace and requests to be a key stakeholder in the advisory group that will be set up for that project. The Steinberg Institute is the sponsor of SB 906 to establish peer certification in California. It is jointly authored by Senators Anderson and Beall.

Poshi Walker is excited about Donna Hardaker's upcoming presentation. The speaker has been training mental health agencies on psychological health and safety in the workplace for a number of years. Donna Hardaker was the person who got the speaker started. Research on this subject comes from Canada. The United States is behind in this area. Psychological safety and mental health in the workplace is much more than just people who have mental illness, but rather that everyone in the workplace is at risk for poor mental health if the thirteen psychosocial factors in place at the workplace are not present and strong. It is surprising how many things can lead to mental and physical illness when there are problems in the workplace. This is also true for LGBTQ individuals. There are special psychological safety issues for queer and trans individuals. Poshi Walker would like to be considered a key stakeholder for the advisory group.

Suzanne Edises, mental health advocate, spoke in support of mental health in the workplace. It is important to think about how corporations can save money by looking into this issue.

Steve Leoni spoke about an issue that on its face has nothing to do with the MHSA directly. He spoke personally and not as a member of the CMHPC. The CMHPC had Committee meetings recently looking at institution for mental disease (IMD) facilities

and board and cares. Data on IMDs and board and cares are hard to get. The counties are on an individual case-by-case basis. There is no accounting as to whether it is a mental health bed or something else. The CMHPC recently asked one of the directors about his budget and he said 80 percent of his non-MHSA dollars were tied up in IMDs. One of the things about the MHSA is to get individuals out of places like that and provide resources in the community. The speaker suggested legislation to begin collecting data. Data is needed to understand statewide trends to know that something positive is being done about IMDs or board and cares.

Filomena Yeroshek clarified that the motion is to support the three bills listed in the meeting packet.

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

The MHSOAC supports Senate Bill 215 (Beall), Senate Bill 688 (Moorlach), and Senate Bill 906 (Beall & Anderson) and authorizes the Executive Director to communicate the Commission's support.

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

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

<u>Donna Hardaker Presentation</u>

Executive Director Ewing asked Donna Hardaker, Manager, Workplace Mental Health and Peer Relations, Sutter Health, to speak about the work that has been done in Canada. He asked Commissioners to allow staff to work with the Legislature to ideally sponsor legislation, for the Commission to work towards establishing a voluntary standard for workplace mental health. He also requested authority to bring key partners to the table to discuss how that would look in California and how it can be done to engage the business community in a variety of ways. This will help to better understand and address the issue of the economics of strengthening workplace mental health supports to reduce stigma. It is an access strategy in which the Commission can potentially find and improve access to care through the ways in which employers structure their employee benefit programs. This is a tremendous opportunity. Staff wants to learn from other places and that is why Donna Hardaker will present today.

Donna Hardaker stated psychological health and safety in the workplace is the next frontier in workplace mental health. It will broaden the dialogue and effect deep societal change. The speaker provided an overview, accompanied by a slide presentation, of the definition of psychological health and safety in the workplace, how poor workplace mental health contributes to loss of productivity, and what employers need to do to address this, beginning with prevention. A pamphlet was included in the meeting handouts and contained information about the Stability Network, a coalition of working professionals who have chosen to share their mental health conditions publicly.

Commissioner Discussion

In response to Commissioner Brown's question of what got the speaker back on track, Donna Hardaker stated it was social support.

Commissioner Anthony stated the awareness of how mental health is necessary in the workplace is helpful and provides for health in the workforce.

Commissioner Wooton offered the support of the MHSOAC in dismantling ongoing stigma.

Commissioner Bunch stated appreciation for the model, as there is rarely any discussion of vicarious trauma or built-in intervention.

Chair Boyd asked the Commission to take this on as a priority with the Steinberg Institute, One Mind at Work, and others, to establish the framework for mental health in the workplace for California, and to move forward in legislative language.

Executive Director Ewing stated the motion would authorize staff to sponsor legislation to establish this standard in California.

Commissioner Brown stated the information in the meeting materials indicates that part of that is to establish an advisory group.

Executive Director Ewing agreed and stated the first step is to establish legislation. Staff has asked Donna Hardaker to help the Commission ensure it is an employer of choice with a healthy place to work.

Action: Commissioner Danovitch made a motion, seconded by Commissioner Wooton, that:

The MHSOAC authorizes the Executive Director to work with the Legislature to sponsor legislation to establish a framework and voluntary standards in California for mental health in the workplace.

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

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

Executive Director Ewing stated staff will post Donna Hardaker's presentation slides on the website as soon as possible.

Commissioner Brown stated the Criminal Justice Project recommended that counties bring stakeholders together to find ways to keep individuals with mental illness out of the criminal justice system, but there is little or no funding for that advocacy stakeholder group. Commissioner Brown proposed requesting that the Budget Committee put additional funding into the Advocacy line item to include stakeholder groups for criminal justice for an additional $670,000.

Chair Boyd spoke in support of Commissioner Brown's recommendation.

Executive Director Ewing stated Commissioner Brown's proposal is consistent with the process that the Commission has taken in the past. Upon Commission approval, staff would go before the Budget Committee or work with the DOF to ask for funding.

Vice Chair Aslami-Tamplen spoke in support of Commissioner Brown's recommendation to focus on stakeholder advocacy contracts for individuals who have been impacted by the criminal justice system. Vice Chair Aslami-Tamplen proposed asking the Legislature to also provide stakeholder advocacy funds to meet the needs of immigrant and refugee populations.

Commissioner Anthony asked if these proposals are asking that funds be allocated and from what source.

Executive Director Ewing stated the Legislature has increased the Commission's budget in the past to make funds available for advocacy on behalf of different populations or issues. Currently, the funding is for stakeholder advocacy for education, training, and outreach to meet the mental health needs of veterans, LGBTQ population, children, families, TAY, reducing disparities, and consumers.

Commissioner Anthony made a motion to combine Vice Chair Aslami-Tamplen's and Commissioner Brown's proposals.

Public Comment

Stacie Hiramoto spoke in support of the motion. There is a need to clarify if the two additional stakeholder contracts are for $670,000 each.

Chair Boyd stated there would be two separate contracts of $670,000 each.

Poshi Walker spoke in support of the motion but was concerned that other groups did not have the opportunity to advocate for stakeholder advocacy funding since it was not on the agenda.

Chair Boyd asked Counsel to respond. Filomena Yeroshek stated the agenda item is for the Commission to vote on legislative priorities. Asking the Legislature to increase the budget for advocacy is a legislative priority.

Jan McGourty stated this is fantastic, but companies need to be aware of red marks and the things that create them. She shared that her daughter is a victim of sexual harassment, which caused her to leave her career. These kinds of actions are not acceptable in the workplace so they do not create mental health problems that cause employees to leave their professions.

Action: Commissioner Anthony made a motion, seconded by Commissioner Danovitch, that:

The MHSOAC authorizes the Executive Director to work with the Legislature and the Department of Finance to request funding for stakeholder advocacy for education, training, and outreach to reduce criminal justice involvement of individuals with mental health needs and to meet the mental health needs of immigrants and refugees. The requested amount is $670,000 per year for each of the two populations.

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

The following Commissioners voted "Yes": Commissioners Anthony, Brown, Danovitch, Gordon, Madrigal-Weiss, Wooton, Vice Chair Aslami-Tamplen, and Chair Boyd.

INFORMATION

10: Statewide Suicide Prevention Strategic Plan

Presenters: Brian Sala, Ph.D., Deputy Director, Evaluation and Program Operations; Ashley Mills, Senior Researcher and Project Lead

Deputy Director Sala directed Commissioners' attention to Section 18 of AB 114, which was included in the meeting packet. Section 18 states the Legislature provided the Commission with $100,000 in budget authority to support the development of a Statewide Suicide Prevention Strategic Plan. The success of this project depends critically on the staff and the leadership of the subcommittee. Staff is excited to work with Commissioner Wooton, who will chair the subcommittee and carry a robust, inclusive public process.

Ashley Mills, Senior Researcher and Project Lead, stated the proposed project Work Plan, included in the meeting packet, is an outline for the process that will be used to develop the Statewide Suicide Prevention Strategic Plan. Consistent with the MHSA and previous efforts of the Commission, the development of the plan will include a robust public engagement process, particularly highlighting the lived experiences of survivors of suicide attempts and survivors of suicide loss.

Ashley Mills provided an overview, accompanied by a slide presentation, of the goals, structure and activities, and next steps of the Statewide Suicide Prevention Strategic Plan. Chair Boyd has appointed Commissioner and former Commission Chair Tina Wooton to Chair a Suicide Prevention Subcommittee to lead this work. The Commission will work closely with the CHHS in the information gathering, development, and drafting of the statewide plan.

Vice Chair Aslami-Tamplen offered support and involvement in this project.

Public Comment

Anara Guard, private citizen, offered three hopes for this project since offering hope is an important part of suicide prevention:

- Additional funds beyond $100,000 will ultimately be allocated because $100,000 is woefully inadequate to accomplish the tasks, given the scope and size of the state to create a plan, implement it, and critically get buy-in statewide so that the plan will be adopted and move forward.
- Thought will be given to who is going to provide ongoing leadership and advocacy for the plan. It is not a task for a subcommittee. Given that California, unlike almost every other state in the nation, lacks a statewide office of suicide prevention, this is a compelling and critical issue to consider.

- The subcommittee will tap experts and experience moving forward, given that a core group of suicide prevention experts has been working closely with the California Mental Health Services Authority (CalMHSA) and counties during the past few years, including a person who helped draft the previous statewide plan.

Suzanne Edises shared her experience of losing a brother to suicide 35 years ago. The speaker's parents helped draft the strategic plan for the country and the original California plan. It has been frustrating to see that a lot of the work statewide has stopped. The Zero Suicide Initiative is a powerful systems-wide approach that health care organizations are using to work with their patient population to see how they can get to zero with their patients. There are other states looking at how they can use a Zero Suicide Initiative approach statewide. Suzanne Edises encouraged the Commission to also consider that amazing, powerful program.

Kit Wall, Project Director, Words to Deeds, a statewide collaborative that engages policy and decision makers to shift the paradigm between criminal justice and mental health, thanked the Commission for the work on the criminal justice project and for continuing the work with the suicide prevention project. There is a criminal justice component in the suicide prevention project with the at-risk population – homeless, veterans, LGBTQ, and TAY. The speaker also appreciated the presentation on mental health in the workplace and highlighted the criminal justice involved population – the custody officials and first responders. The speaker offered assistance in this project.

Adrienne Shilton spoke in support of this project. There is a public health crisis in this country when it comes to suicide. There needs to be attention, funding, a plan, and a research agenda looking at this issue.

Monica Nepomuceno is happy to see the strategic plan updated and hopes to see a larger piece related to student mental health and student suicides included in the new plan. The speaker echoed Anara Guard's comment hoping that more than $100,000 will be dedicated to this project. There are many experts in this state and in the Department of Education that can assist with this project.

Chair Boyd asked members of the public to email Ashley Mills, ashley.mills@mhsoac.ca.gov, or call the front desk at the Commission with the contact information of subject matter experts in the state who the Commission may wish to contact.

Rory O'Brien seconded the request made by Anara Guard of increasing the $100,000 funding for this project. There is a disproportionate burden of suicide and suicidality carried by LGBTQ individuals, especially youth. The plan should include not only a recognition of LGBTQ risk disparities for suicide but also recommendations, actionable steps, and funding to close suicide disparities that burden specifically LGBTQ adults and TAY. The speaker asked that the Out for Mental Health Project be included as members of the suicide strategic plan subcommittee to help draft the plan.

Commissioner Danovitch stated it is reasonable to believe that the huge and unacceptable number around suicides is understated, and, increasingly, there are thoughts that other dynamics, such as the opioid overdose epidemic, represent a

substantial portion of suicides. As the Commission thinks about a strategic plan, it is one of several other orientations to consider that may unleash opportunities for intervention beyond some of the standard repertoire.

Commissioner Wooton looks forward to chairing this project, working with everyone, hearing their stories, and bringing their expertise to the table. Commissioner Wooton shared personal stories of losing relatives and loved ones to suicide and hoped the Commission can leverage available resources to strengthen the suicide prevention plan in the state of California.

GENERAL PUBLIC COMMENT

Jan McGourty stated Mendocino County's Innovation plan addressed the lack of cultural competence in the Northern California Native American population. Native Americans are refugees; the United States government was the offender of their change of life. The speaker summarized the history of the genocide of Round Valley and the intergenerational trauma and mistrust experienced by the population today.

Jan McGourty stated MHSOAC staff plans to tour Round Valley for the first time, but county staff and MHSOAC staff are from the government. There are plans to meet separately with the tribe and not have county staff in the room, but, if the plan was to promote trust, then meeting separately so no one knows what is being said creates the same problem experienced at the beginning.

Andrea Crook, Director of Advocacy, Access California, thanked the Commission for their questions and analysis of the San Joaquin Innovation plans and AB 114. Struggles with PEI and Innovation plans go back to the stakeholder process. If counties truly go to the community and solicit feedback and compile it in a meaningful community planning process, California would not be where it is today. At the last Commission meeting, the speaker had requested time on the agenda for the February meeting. Access California is the new Client Advocacy Stakeholder Contract and would like to bring the 19 ambassadors who will be working throughout the state to introduce themselves to the Commission at the final General Public Comment portion of the meeting.

Steve Leoni added to Jan McGourty's comment by stating everyone outside the Tribe thinks they know, for very good and very compassionate reasons, what should be the case. The Tribal individuals should be consulted as to their preference on who should be in the room during the conversation.

Steve Leoni stated outreach and engagement is a component of the MHSA that was pioneered by the Village and talks about reaching individuals on the streets but now is used for reaching individuals in homes. It may take two years before individuals respond. It is an ideal way to reach individuals who are suspicious and have felt they have been burned by the system and do not want to engage. It has great results but it seems to be a disappearing component and has no statewide guidance. It needs to be revived.

ADJOURN

There being no further business, the meeting was adjourned at 3:35 p.m.

AGENDA ITEM 2

Action

February 22, 2018 Commission Meeting

Los Angeles County Innovation Plan and Los Angeles/Kern County Update

Summary: The Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission) will consider approval of Los Angeles County's request to fund the following Innovative (INN) project for a total amount of $2,388,268. Additionally, the County will be providing an update for their previous Innovation Project, in collaboration with Kern County, which was presented and approved at Commission Meeting held on October 26, 2017.

(A) **Mobile Transcranial Magnetic Stimulation - $2,388,268**

(B) **Project Update for Los Angeles and Kern County:** Increasing Access to Mental Health Services and Supports Utilizing a Suite of Technology-Based Mental Health Solutions

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.

- Los Angeles proposes to develop and implement a Mobile Transcranial Magnetic Stimulation (TMS) Program to reduce symptoms in clients with major depressive disorders living in Board and Care facilities who have a history of being treatment resistant.

- Los Angeles and Kern County will be providing an update for their Innovation Project which was approved by the Commission on October 26, 2017. Los Angeles proposed to work collaboratively with the Joint Powers Authority, CalMHSA, and multiple counties to develop a demonstration project to increase access to mental health

services to underserved groups by implementing a group of technology-based mental health solutions that utilize chat rooms and passive data collection to identify the early signal biomarkers for mental health symptoms and offer prompt intervention.

Presenters for Mobile Transcranial Magnetic Stimulation Project:

- Jonathan E. Sherin, M.D., Ph.D., Director, Los Angeles County Dept. of Mental Health
- Marc Heiser, M.D., Ph.D., Psychiatrist, Los Angeles County Dept. of Mental Health
- Alex Silva, Ph.D., Supervising Psychologist, Los Angeles County Dept. of Mental Health

Presenters for Update on Technology Suite:

- Jonathan E. Sherin, M.D., Ph.D., Director, Los Angeles County Dept. of Mental Health
- Bill Walker, LMFT, Director, Kern County Behavioral Health and Recovery Services
- Debbie Innes-Gomberg, Ph.D., Deputy Director, Los Angeles County Dept. of Mental Health
- Karin Kalk, Technology Suite Project Manager
- Brad Cloud, Deputy Director, Kern County Behavioral Health and Recovery Services

Enclosures (4): (1) Biographies for Los Angeles County Innovation Presenters; (2) Mobile Transcranial Magnetic Stimulation Project Brief (3) Mobile Transcranial Magnetic Stimulation Staff Analysis (4) Biographies for Los Angeles/Kern County Innovation Presenters.

Handout (1): A PowerPoint will be presented at the meeting

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

http://mhsoac.ca.gov/document/2018-02/los-angeles-county-inn-plan-description-mobile-transcranial-magnetic-stimulation

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

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

Biographies for Los Angeles County Presenters
Mobile Transcranial Magnetic Stimulation

Alex Silva, Ph.D.

Dr. Alejandro E. Silva is a licensed psychologist who has worked for the Los Angeles County Department of Mental Health for nearly 18 years. In the past five years, he has worked for the Mental Health Services Act (MHSA) Implementation and Outcomes Division as a Supervising Psychologist in an administrative capacity. He oversees the Prevention and Early Intervention (PEI) Outcomes Team; provides consultation on all matters related to PEI Outcomes; oversees the training and distribution plan for PEI outcomes; and serves as a subject matter expert in meetings related to the development and enhancement of the PEI Outcome Measures Application (PEI OMA).

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

Jonathan Sherin, M.D., Ph.D., is a longtime wellbeing advocate and – as of November 2016– the new Director of the Los Angeles County Department of Mental Health (LACDMH). In this role, he oversees the largest public mental health system in the United States with a budget approaching $2.5 billion and serving over 250,000 residents. Prior to joining LACDMH, Dr. Sherin was Chief Medical Officer and Executive Vice President of Military Communities for Volunteers of America, one of our nation's largest direct service non-profits. Over the years, he has also served in a variety of clinical, academic, teaching, and administrative leadership positions. In his last such post, Dr. Sherin directed mental health for the Miami VA Healthcare System and functioned as Vice-Chairman of the Department of Psychiatry at the University of Miami. As an expert on veteran issues, Dr. Sherin has testified to Congress on challenges faced by members of the military community, specifically as they relate to trauma, recovery, reintegration, and the risk of homelessness and suicide. As a researcher, Dr. Sherin has published in the fields of neurobiology and psychiatry – including a seminal article in "Science" magazine that features his work identifying a core sleep circuit in mammals (the "sleep switch"). He also received the prestigious Kempf Award from the American Psychiatric Association for his conceptual model of the psychotic process.
Dr. Sherin is currently a volunteer clinical professor of psychiatry and behavioral sciences at both UCLA and the University of Miami.

Marc Heiser, M.D.

Dr. Marc Heiser obtained his BA in English and Molecular and Cell Biology at UC Berkeley. He obtained his Medical Degree (MD) from UCSF where he also obtained a Ph.D. in Neuroscience. He then went on to complete his residency training in psychiatry and a fellowship in child and adolescent psychiatry at UCLA.

Dr. Heiser has been involved with Transcranial Magnetic Stimulation (TMS) research since 2003 and was trained to use TMS to treat psychiatric disorders as a clinical fellow at UCLA in the Neuromodulation Division. Dr. Heiser has received awards from the American Academy of Child and Adolescent Psychiatry and the Brain & Behavior Research Foundation for his research with TMS and his work has been published in a number of prestigious journals. Currently, Dr. Heiser works for the Los Angeles County Department of Mental Health in the Juvenile Justice Mental Health Program and is developing a clinical TMS program. He is an attending physician in the Mood Disorder Clinic at the Veterans Affairs Greater Los Angeles Health System where he is also helping to start at clinical TMS program. Finally, Dr. Heiser is a clinical faculty at UCLA where is teaches fellows in psychiatry.

MHSA Innovation 4 Project
Mobile Transcranial Magnetic Stimulation (TMS)

Los Angeles County Department of Mental Health (LACDMH) proposes to implement an FDA-approved treatment that has become a standard treatment in private practice and in academic centers but has not been used in public mental health settings, mobile Transcranial Magnetic Stimulation (TMS). *It should be noted that TMS is not at all related or similar to Electro-convulsive Treatment (ECT).*

TMS is FDA-approved for the treatment of depression and is a non-invasive treatment that can enhance or suppress the activity of neurons in targeted areas of the brain through the use of electromagnetic stimulation. According to the American Psychiatric Association best practice guidelines for the treatment of major depressive disorder, TMS is now a first-line treatment for depression that has not responded to one antidepressant medication (APA 2010) as well as being effective for treatment-resistant depression. In addition, recent clinical studies suggest that TMS can be an effective treatment for a number of other psychiatric disorders, including substance use disorders, schizophrenia, obsessive-compulsive disorder, and post-traumatic stress disorder.

TMS uses precisely targeted magnetic pulses similar to those used in Magnetic Resonance Imaging (MRI) to stimulate key areas of the brain that are underactive in patients with depression. The patient reclines comfortably in the treatment chair and is awake and alert during treatment. An electromagnetic coil is then placed directly to the target area of the brain where the device generates magnetic fields that alter the electrical activity of neurons. The enhancing or suppressing of neuron activity depends upon a number of variables including the frequency of the TMS pulses. During treatment, the patient hears a clicking sound and feels a tapping sensation on the head. The patient can go back to their normal activities immediately after treatment. Treatment can last between 10-45 minutes and is administered once per day for 5 consecutive days per week for 4-8 weeks.

LACDMH proposes to implement a mobile TMS program for individuals residing in Board and Care (B&C) facilities that suffer from treatment-resistant depression that is not responsive to antidepressant medication or therapy. The ultimate goal of this project is to reduce the burden of symptoms in this population and increase their social and occupational functioning. Treatment refractory depression often results in Board and Care facilities with residents who experience very poor qualities of life, do not progress in their recovery and spend hours each day engaging in unhealthy activities such as smoking. LACDMH estimates serving 384 clients a year across approximately 8 Board and Care facilities.

Innovation Primary Purpose

Overall, the primary purpose of this Innovation project is to improve the quality of mental health services and achieve greater outcomes by providing new and effective treatment to clients with chronic and severe mental illness.

Qualification as an Innovation Project

This project seeks to introduce a new approach or approach that is new to the overall mental health system, including, but not limited to, prevention and early intervention.

MHSA Innovation 4 Project
Mobile Transcranial Magnetic Stimulation (TMS)

The goals of this project include:

- Provide access to new and effective treatment to clients with chronic and severe mental illness
- Increase adherence to treatment by bringing the treatment to the client
- Reduce use of other resources (i.e., psychiatric hospitalization, Emergency Room visits, intensive supportive services, etc.)
- Improve social and occupational functioning that would lead to successful community reintegration
- Collect and analyze data to support treatment efficacy for treatment-resistant depression and other psychiatric conditions in this population

The project would be a 3 year demonstration project.

Target Population

The target population includes individuals residing in board and care facilities that have a depression as a major part of their psychiatric symptoms and ***one or more of the following***:

- Resistance to treatment with psychopharmacologic agents as evidenced by a lack of a clinically significant response to at least two psychopharmacologic agents in the current depressive episode; or
- Inability to tolerate psychopharmacologic agents as evidenced by two trials of psychopharmacologic agents from two different agent classes; or
- History of response to TMS in a previous depressive episode; or
- A history of response to ECT in a previous or current episode or an inability to tolerate ECT, or is a candidate for, but has declined ECT and TMS is considered a less invasive treatment option.

However, because of the nature of the TMS treatment, we would exclude individuals with a history of seizure disorder and those with metal implants in the head or upper torso (e.g., cardiac pacemakers).

Informed Consent Process
In order to ensure that each patient is freely participating in this treatment, the treating psychiatrist will obtain informed consent from the patient. This will require that the patient understand the nature of the treatment, its potential for benefit, and its potential risks, the treating psychiatrist will obtain informed consent for each patient. The procedure will be described in detail the procedures involved in the treatment including the use of a magnetic coil, the sensations associated with the treatment (tactile, auditory), the approximate duration of each session, the frequency of sessions, the approximate number of sessions and the potential need for maintenance treatments in order to prevent relapse.

Potential risks that will be discussed include the following:

- The potential for a tapping sensation that can be annoying or painful at the site of stimulation (reported by approximately one third of patients and usually improves over

course of treatment). The person administering the treatments may make adjustments in order to ensure that the treatment is tolerable for each patient.
- The treatment can also produce contractions of superficial facial or jaw muscles occurring only during the treatment and that do not persist after treatments.
- Headaches may also occur as a result of the treatment (reported in approximately 50% of patients). These usually improve over the course of treatment and can be alleviated by over-the-counter pain medication.
- TMS produces a loud clicking sound. Therefore we require patients to wear ear plugs during the treatments. There is no evidence that TMS permanently affects hearing if earplugs are worn.
- A seizure is the most serious risk associated with TMS. The risk of seizures, however, is exceedingly low (<1/30000 treatments).
- There is also a risk that the patient may not improve or may experience worsening mood or anxiety. If these issues arise, they will be addressed by the treating TMS psychiatrist.
- Finally, as with all treatments, there are unforeseeable risks that we do not yet know about or that are not currently recognized. If possible, we will continue to follow the cohort of patients in this project longitudinally in order to further define such as yet unknown risks.

Potential Benefits of TMS that will be discussed:

- TMS has been shown to lead to a remission of depressive symptoms in between 30-68% of patients with treatment refractory depression.
- TMS may also improve symptoms of other psychiatric disorders including PTSD, psychosis, substance use disorders, autism, and eating disorders. However, more studies are needed in order to know how likely TMS is to be effective for these issues.

The Unmet Need

Treatment refractory depression (TRD), defined as depression that has not responded to at least one antidepressant medication, affects approximately 4.2 million Americans. According to Los Angeles County Department of Mental Health (LACDMH) records, in the 2016-2017 fiscal year, approximately 42,000 individuals are being treated for major depressive disorder and an additional 23,000 individuals are receiving treatment for other disorders in which depression plays a key role (bipolar disorder and schizoaffective disorder). Based upon the literature, we estimate that at least 35% of these individuals have depressive symptoms that are treatment refractory. Among these individuals, people who reside in B&C facilities have some of the most severe, treatment refractory symptoms which prevent them from living independently. In LACDMH, there were approximately 4000 residents of B&C facilities who were receiving mental health services in 2016-2017. Of these, 24% had a primary diagnosis of major depressive disorder and 29% had primary diagnosis of either bipolar disorder or schizoaffective disorder. These numbers show that there are thousands of individuals within LA County, and especially in B&C facilities, who need for treatments to reduce symptoms that have not been alleviated by medications or therapy alone.

MHSA Innovation 4 Project
Mobile Transcranial Magnetic Stimulation (TMS)

Mobile TMS Implementation Process
The components of this Innovation project are as follows:

1. Purchase TMS device and accessories including modified van that will transport the treatment to contracted board and care facilities in Los Angeles County.

2. A lead psychiatrist will oversee initial TMS treatment sessions and track progress by collecting symptoms and functional outcomes that can, in turn, be used to judge the efficacy of this program.

3. Hire and train staff (Nurse, Psychiatric Technician) to operate equipment.

4. Identify Board and Care facilities with higher numbers of clients who meet criteria listed in *Target Population* above and engage and educate facility operators.

5. Engage Board and Care operators and clients at facilities through talks, videos and, after services start, using peers who have received treatment as engagers. Compensation would be in the form of stipends used for the Wellness Outreach Worker (WOW) program. Once clients have been identified and agree to treatment, they will be seen 1 time per day for 5 consecutive days per week for 4-8 weeks.

6. As clients begin treatment, client satisfaction, and reactions and weekly outcome data will guide use of TMS within each facility.

Evaluating the Efficacy of TMS
A depression outcome measure will be administered at the beginning of treatment and weekly throughout the course of treatment. Measures may include: Quick Inventory of Depressive Symptoms (QIDS-16, patient rated), the Hamilton Depression Rating Scale (HDRS, clinician rated), and a measure for adaptive daily living and quality of life. Additional rating scales may be used to track comorbid symptoms as appropriate. These assessment tools will enable clinicians to track improvements in depressive symptoms and functional outcomes that can, in turn, be used to judge the efficacy of this program.

Overarching Learning Questions

1. Will these individuals be adherent with a mobile TMS treatment program?
2. Is TMS an effective treatment for this population?
3. Does TMS for depression lead to improvement in comorbid symptoms (i.e., substance use, psychotic symptoms, etc.)?
4. If TMS is an effective treatment for this population, should the program be expanded to treat a larger part of the population?

Stakeholder involvement in proposed Innovation Project

LACDMH's stakeholder process meets Welfare and Institutions Code 5848 on composition of the System Leadership Team (SLT) and meaningful involvement of stakeholders related to mental health planning, policy, implementation, monitoring, quality improvement, evaluation and

budget allocations. The composition of the System Leadership Team meets California Code of Regulations Section 3300 on stakeholder diversity. Planning for this project began in the spring of 2017, but has been a focus of Dr. Sherin since becoming the Director of the Los Angeles County Department of Mental Health. A proposal was presented to the System Leadership Team on October 18, 2017 with a request for feedback. The feedback received was overwhelmingly positive. Stakeholders expressed an interest in expanding the target population to include other severely mentally ill individuals in other mental health settings than just B&C residents. In response to this feedback, it was explained that one of the goals of the project was to collect enough data to support an expansion of the target population. Feedback beyond that has been categorized in the following manner:

- Populations of interest:
    - Request to include FSP clients that have been identified as having more severe symptomatology
    - Individuals who may reside in Institutions of Mental Disease (IMD) who may benefit from TMS treatment
- Concern regarding painful side effects of the treatment
- Clarification and differentiation between Electroconvulsive Therapy (ECT) and TMS treatment
- Consider other funding sources to pay for TMS treatment

Feedback has been considered and much of it incorporated into the proposal or will be incorporated into the implementation phase of this project.

In addition, we plan to solicit peer involvement by engaging individuals with lived experience in our peer resource center and those who have undergone TMS treatment to assist others that may be contemplating this type of treatment.

The Department's Mental Health Commission Executive Committee will be briefed on January 11, 2018, with a formal presentation to the Commission on January 25, 2018. Board Deputy briefings were completed during January, 2018.

Timeframe of the Project and Project Milestones

Upon approval from the Mental Health Services Oversight and Accountability Commission, the Department will issue a solicitation to identify one or more companies with capacity to immediately initiate the deliverables in this project proposal including retrofitting a Transit Van with TMS medical device and accessories. The projected timeframe is as follows but, due to the innovative nature of this project, actual implementation steps may deviate in terms of sequence and/or timeframes:

- October 27, 2017: 30 Day Public Posting of Proposed Project
- February 22, 2018: Presentation to the MHSOAC
- May, 2018: Van retrofitting with TMS medical device
- May, 2018: Hire and train staff to administer treatment and collect outcome measures. In addition, identify eligible clients at board and care facilities that are willing to participate in TMS treatment.
- June, 2018: Launch project by beginning treatment and tracking progress weekly

MHSA Innovation 4 Project
Mobile Transcranial Magnetic Stimulation (TMS)

- FY 2018-2019: Development, testing and implementation of deliverables
- FY 2019-2020 through FY 2020-2021: Continued use, evaluation and scaling and a final evaluation to the Department

As with all components of the MHSA, implementation and preliminary outcomes will be reviewed with the LACDMH's SLT periodically and will be reported on in MHSA Annual Updates/MHSA Three Year Program and Expenditure Plans.

Budget

Fiscal Year 2017-18:

Modified Van:	$89,195	(One-time cost)
TMS Device (1):	$69,433	(One-time cost)
Laptop	$2,000	(One-time cost)
Van Maintenance Plan:	$3,000	
Mental Health Psychiatrist:	$158,388	(Salary and Employee Benefits)
Mental Health Counselor, RN:	$75,617	(Salary and Employee Benefits)
Clinical Psychologist II	$66,932	(Salary and Employee Benefits)
The Psychologist will assume responsibility for the evaluation		
Psychiatric Technician II:	$32,661	(Salary and Employee Benefits)
Intermediate Typist Clerk:	$51,014	(Salary and Employee Benefits)
Operating Cost for 1 clinical position:	$4000	(One-time cost)
Total Cost:	**$552,240**	

Fiscal Year 2018-19:

Van Maintenance Plan:	$6,000	
Mental Health Psychiatrist:	$316,775	(Salary and Employee Benefits)
Mental Health Counselor, RN:	$151,234	(Salary and Employee Benefits)
Clinical Psychologist II	$133,863	(Salary and Employee Benefits)
The Psychologist will assume responsibility for the evaluation		
Psychiatric Technician II:	$65,322	(Salary and Employee Benefits)
Intermediate Typist Clerk:	$51,014	(Salary and Employee Benefits)
Total Cost:	**$724,208**	

Fiscal Year 2019-20:

Van Maintenance Plan:	$6,000	
Mental Health Psychiatrist:	$316,775	(Salary and Employee Benefits)
Mental Health Counselor, RN:	$151,234	(Salary and Employee Benefits)
Clinical Psychologist II	$133,863	(Salary and Employee Benefits)
The Psychologist will assume responsibility for the evaluation		
Psychiatric Technician II:	$65,322	(Salary and Employee Benefits)
Intermediate Typist Clerk:	$51,014	(Salary and Employee Benefits)
Total Cost:	**$724,208**	

MHSA Innovation 4 Project
Mobile Transcranial Magnetic Stimulation (TMS)

Fiscal Year 2020-21 (July 1, 2020 thru December 30, 2020):

Van Maintenance Plan:	$3,000
Mental Health Psychiatrist:	$158,388 (Salary and Employee Benefits)
Mental Health Counselor, RN:	$75,617 (Salary and Employee Benefits)
Clinical Psychologist II	$66,932 (Salary and Employee Benefits)
The Psychologist will assume responsibility for the evaluation	
Psychiatric Technician II:	$32,661 (Salary and Employee Benefits)
Intermediate Typist Clerk:	$51,014 (Salary and Employee Benefits)
Total Cost:	**$387,612**

Summary by Fiscal Year:

FY 17-18 Estimated Cost	$552,240
FY 18-19 Estimated Cost	$724,208
FY 19-20 Estimated Cost	$724,208
FY 20-21 Estimated Cost (partial FY):	$387,612
Total 3 year Project Cost:	**$2,388,268**

Note *– The cost of the evaluation is the cost of the Psychologist conducting it: $401,590*

Budget Narrative:

(1) Mental Health Psychiatrist: The psychiatrist will participate in outreach and education in B&C facilities with staff, providers and potential patients. The psychiatrist will also perform in-person evaluations to determine if a referred patient meets criteria for and may benefit from TMS treatment. The psychiatrist will prescribe and manage the TMS treatments. Initially, the psychiatrist will be on site for treatments. However, the psychiatrist may be off site and manage daily TMS sessions via tele-psychiatry in conjunction with the mental health nurse and psychiatric technician who will always be on site.

(1) Mental Health Counselor, RN: The Mental Health Counselor, RN will deliver the daily TMS treatment sessions and perform daily assessments of the patient's symptoms and any side effects that will be communicated to the psychiatrist. They will also administer patient rating scales. This team member will also be trained to provide first-aid and Basic Life Support (BLS) in case of emergency.

(1) Clinical Psychologist II: The Clinical Psychologist will assume responsibility for the evaluation of this project and will establish a database into which rating scales and other clinical data will be entered in order to track patient progress/response to treatment, side effects, and treatment parameters. They will analyze this data which can then be de-identified and used for outcomes measurement reporting. The Clinical Psychologist will also provide outreach and education regarding outcomes of this project to other providers throughout L.A. County and the state of California.

MHSA Innovation 4 Project
Mobile Transcranial Magnetic Stimulation (TMS)

(1) Psychiatric Technician II: The Psychiatric Technician will be driving the mobile TMS unit to treatment sites throughout L.A. County, will assist the Mental Health Counselor, RN with setup of the TMS device for each treatment session, will help administer clinical rating scales and will interface with B&C staff regarding patient progress.

(1) Intermediate Typist Clerk: The Intermediate Typist Clerk will provide administrative support to the mobile TMS team. This includes, but is not limited to, securing TMS education presentation locations; preparing educational packets; registering attendees; sending registration confirmations; setting up the audio visual equipment for meetings; provide phone coverage for mobile TMS team; assist in the preparation of TMS related community meetings; responsible for maintaining records and the upkeep for the county TMS van; and serve as backup timekeeper and travel coordinator for the team.

STAFF ANALYSIS—LOS ANGELES COUNTY

Name of Innovative (INN) Project: **Mobile Transcranial Magnetic Stimulation**

Total INN Funding Requested: **$2,388,268**

Duration of Innovative Project: **Three (3) Years**

Review History:

Approved by the County Board of Supervisors: Pending MHSOAC Approval
County submitted Innovation (INN Project): December 5, 2017
MHSOAC consideration of INN Project: February 22, 2018

Project Introduction:

In order to reduce symptoms in clients with major depressive disorders, Los Angeles County proposes to develop and implement a Mobile Transcranial Magnetic Stimulation (TMS) Program for clients who have a history of being resistant to treatment and live in county contracted Board and Care (B&C) facilities within the County.

The County states that providing TMS treatment for those residing in B&C facilities allows residents to receive treatment, on a consistent basis without interruption, because the treatment would be brought directly to their place of residence. The goal of this project is to focus on B&C residents with treatment refractory depression with the hopes of increasing their social and occupational functioning. Treatment refractory depression, also known as treatment resistant depression, is a term used in clinical psychiatry to describe cases of major depressive disorder that do not respond adequately to appropriate courses of at least two antidepressants.

TMS treatment is still relatively new and there is still much to learn, and although it appears to be safe, it is uncertain whether or not side effects may present themselves in the future. **The County may wish to be prepared to discuss possible side effects that may develop in the future, if known.**

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 (4) allowable primary purposes.

The Need

Los Angeles County states that approximately 4.2 million Americans are diagnosed with treatment refractory depression (as defined above). The County indicates they treated approximately 42,000 individuals for major depressive disorder within Fiscal Year 16/17; and an additional 23,000 individuals received treatment in which depression was part of their primary mental health diagnoses.

The County estimates that approximately 35% (n=22,750) of the 65,000 individuals being treated for depression are in treatment refractory and do not respond to medication and/or therapy. Additionally, the County indicates there are about 4,000 individuals residing within B&C facilities who received mental health treatment during FY 16/17, and approximately 24% (n=960) have a primary diagnosis of major depressive disorder and another 29% (n=1160) had a primary diagnosis of either bipolar or schizophrenic disorder in which depression plays a factor.

The County states individuals with severe chronic mental illness need high levels of mental health care and as a result, some of these individuals are unable to care for themselves and require residing in B&C facilities to receive proper care and supervision. The County feels individuals living in B&C facilities would benefit from receiving TMS treatment due to their limited functioning. Furthermore, the mobility aspect of this project allows for adherence to treatment since the County will be providing treatment at the B&C where the individual resides.

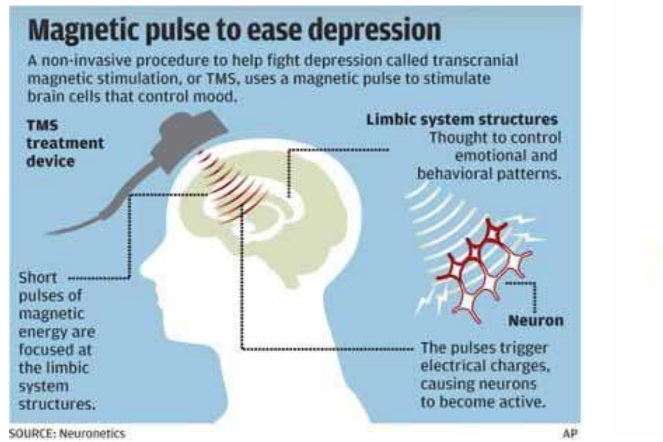
The Response

To address these issues, the County is proposing to implement Mobile Transcranial Magnetic Stimulation (TMS) in order to provide treatment for individuals living in B&C facilities who meet the criteria of being in treatment refractory. Los Angeles proposes to purchase a TMS device, accessories for the device, and a modified van that will transport the TMS equipment to those residing in B&C facilities that agree and volunteer to participate in treatment.

A lead psychiatrist will provide oversight of initial TMS treatment sessions, provide outreach and education at B&C facilities and determine if referred patients meet the

criteria to receive TMS treatment. The County will hire and train staff consisting of a Psychiatric Technician and a Nurse who will operate the equipment. The County indicates treatment sessions will typically last anywhere from 10-45 minutes and is administered once daily for five (5) consecutive days for a four (4) to eight (8) week period. Exact treatment protocols and durations will vary depending on the response to treatment.

During treatment, sedation or general anesthesia is not required, so the patient is awake and alert and will be in a seated/reclined position. The electromagnetic coil rests directly on the temporal lobe, where the TMS device generates magnetic fields that ultimately adjust the electrical activity of neurons. Patients will be required to remove any magnetic-sensitive objects and wear ear plugs as the patient will hear an audible clicking sound, similar to a Magnetic Resonance Imaging (MRI) machine, and may feel a rhythmic tapping sensation underneath the coil. After treatment, the patient may resume their normal daily activities immediately as there is no recovery time.



Research shows that the most serious risk of TMS treatment is seizures, although the risk is extremely low. The County states individuals with a history of seizure disorder or those with metal implants in the head or upper torso (such as a pacemaker), will be excluded from receiving TMS treatment due to the risks involved. Some reports indicate that although TMS may produce discomfort, it is safe and has proven to be effective. Typical side effects may include headache, scalp discomfort at the stimulation site, and tingling or twitching of facial muscles.

During the Community Planning Process, clarification was asked of the County to distinguish the difference between TMS and Electroconvulsive Therapy. Research provides stark differences between these two (2) types of treatments:

Electroconvulsive Therapy (sometimes referred to as shock therapy):

- Cranial therapy used to treat mental illness or mood disorders
- Utilizes an electric current
- Usually administered in a hospital setting
- Various side effects, some as serious as memory loss
- Patients are given muscle relaxants to prevent damage to muscles and bones
- Patient is under general anesthesia

Transcranial Magnetic Stimulation:

- Cranial therapy used to treat mental illness or mood disorders
- Non-invasive
- Usually administered in doctor's office or outpatient setting
- Typically has no side effects
- No medication is needed to relax patients
- Patient is alert and awake during therapy

The County states there were key factors in selecting the target population of individuals residing in B&C facilities. Individuals with serious mental health problems are unable to live independently and ultimately reside in a B&C facilities for support. The County indicates residents living in B&C facilities have difficulty adhering to treatment and access to TMS Treatment is another barrier that may be alleviated with this project. If this project proves to be effective and successful, the individuals residing in these B&C facilities may progress to live a life of independence without the symptoms of major depressive disorder. **County indicates approval from Institutional Review Board is not needed; however, the County may wish to be prepared to provide rationale for not seeking approval for study involving human subjects.**

The Community Planning Process

To facilitate culturally diverse stakeholder involvement, the County states they assembled a 58-member System Leadership Team (SLT) to provide input related to the various stages of planning surrounding innovation projects. The County indicated the planning of this project began in Spring 2017 and was presented to the SLT in October 2018, receiving positive feedback.

There was interest from stakeholders involving the expansion of this Innovation Project to include target populations beyond those currently residing in B&C facilities; however, it was explained that the possibility of expansion is determined upon the data collected and overall success of the project. Additional feedback received during the Community Planning Process (CPP) included concern regarding possible side effects of treatment, other viable funding sources, and the difference between TMS and Electroconvulsive Therapy (explained above).

The County states that substantive feedback was considered and incorporated into the Innovation Project, or will be incorporated during implementation of the project. Furthermore, Los Angeles states they will solicit peers from their peer resource center

who have undergone TMS treatment and have achieved positive results in an effort to provide information, support, and share their lived experience for those who are contemplating this type of treatment. **The County may wish to discuss and provide clarity on the role of peers and indicate if they will be compensated.**

The MHSOAC shared this Innovation Project with stakeholders beginning January 19, 2018 and received three (3) comments from the public in response, yielding both positive feedback in addition to general questions and concerns as summarized below:

- Feedback received indicating TMS treatment as promising but cautions that treatment is still new and potential long term side effects are not known at this time.
- Feedback received stating TMS treatment is innovative and appreciative that treatment is being made available to consumers in the public sector. Concern was expressed that the role of peers is marginalized in this plan and funds have not been allocated within the budget to support peer involvement.
- Feedback received with various questions including, but not limited to: cost per patient, rationale behind Innovation Project being mobile, type of TMS being utilized, cost of the TMS machine, program assessment during and after implementation, concern to ensure the reliability and validity of results, and the criteria used for the selection of patients to participate in the project.

Additionally, the MHSOAC shared the feedback that was received, in redacted form, with the County on February 1, 2018.

Learning Objectives and Evaluation

Los Angeles County has proposed implementing a Mobile Transcranial Magnetic Stimulation (TMS) program to treat psychiatric disorders within the county. The project outlined has been identified as a three (3) year demonstration project with a goal of improving the quality of mental health services for clients with chronic and severe mental illness who are medication resistant/refractory.

The County will provide TMS treatment in a modified van, enabling psychiatrists to meet and provide treatment to individuals residing in Board and Care facilities (B&C). The County will target individuals residing in B&C facilities with treatment refractory depression—defined as "having an inadequate response to at least two antidepressant medications at adequate dose and duration, or an inability to tolerate such medications." Additionally, the County will target individuals in B&C facilities that meet one or more of the following:

- Resistance to treatment with psychopharmacologic agents as evidenced by a lack of a clinically significant response to at least two psychopharmacologic agents in the current depressive episode; or
- An inability to tolerate psychopharmacologic agents as evidenced by two trials of psychopharmacologic agents from two different agent classes; or
- A history of response to TMS in a previous depressive episode; or
- A history of response to Electroconvulsive Therapy (ECT)

The County states that patients that are taking medications will not be excluded, and will continue their medications during treatment. **The County may wish to identify how any positive outcomes, as a result of treatment, can be attributed to TMS, current medications, or both.** The County estimates serving a total of 284 clients per year among 8 different B&C facilities.

The evaluation of the TMS program revolves around four main learning questions:

1. Will these individuals be adherent with a mobile TMS treatment program?
2. Is TMS an effective treatment for this population?
3. Does TMS for depression lead to improvement in comorbid symptoms (i.e., substance use, psychotic symptoms, etc.)?
4. If TMS is an effective treatment for this population, should the program be expanded to treat a larger part of the population?

In order to measure outcomes relative to the proposed learning questions, the County will utilize weekly symptom and functional based measures to track treatment progress. Specifically, the Mental Health Counselor, RN will administer the Quick Inventory of Depressive Symptoms (QIDS-16, patient rated), the Hamilton Depression Rating Scale (HDRS, clinician rated), and other measures for adaptive daily living, quality of life, and satisfaction with TMS. Outcomes from these tools will track:

- A reduction in depressive symptoms
- An increase in social and occupational functioning
- An increase in adherence to treatment
- A decrease in utilization of emergency services among high utilizers using data 6-months prior to TMS treatment and 6-months post TMS treatment.
- An increase in wellbeing as evidenced by an increase in social connectedness and engagement in meaningful activities.

The Budget

The proposed budget for this Innovation Project is $2,388,268 over a three (3) year project duration. The majority of the budget is allocated towards direct administrative personnel costs which accounts for $2,205,640 (92%) of the total budget. Staff required for this project will include a Mental Health Psychiatrist, a Mental Health Counselor (RN), a Clinical Psychologist II, a Psychiatric Technician II, and an Intermediate Typist Clerk.

The County will make one-time purchases totaling $164,628 (6.9%) to purchase a modified van ($89,195) that will transport the treatment equipment (TMS device: $69,433 ; laptop: $2,000) to contracted board and care facilities within Los Angeles County. The one-time purchase will also include an operating cost of $4,000 which will cover the cost of space, computer and equipment for the Clinical Psychologist II whose primary work station will not be in the van containing the treatment equipment. The budget costs for the maintenance of the van is $18,000 (0.75%), or $6,000 per fiscal year.

The County indicates the Clinical Psychologist II will be responsible for the collection, analysis, and dissemination of data that may contribute to statewide learning. Additionally, findings related to best practice guidelines and implementation efficacy will be shared with the mental health community with the desire to possibly expand the project within Los Angeles County, as well as other counties and states. The evaluation component will also be completed by the Clinical Psychologist II and is included as part salary ($401,590, 17% of total budget).

Los Angeles County indicates that progress and collected data will be analyzed by the steering committee and county staff, and if new populations are identified based on collected data, those target populations would be included during project implementation. **County may wish to address if they have sufficient funds allocated for the inclusion of a new target population during implementation of this project and if peers used in the project will be compensated.**

Regarding sustainability, the County states a final determination will be made at the end of the third year of the project and is contingent upon the overall success, effectiveness and evaluation of the project. The County indicates they may elect to continue services and staff through the use of MHSA Community and Services Supports (CSS) funds.

Additional Regulatory Requirements

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

Note: If Innovation Project is approved, the MHSOAC must receive certification of approval from the Los Angeles Board of Supervisors before any Innovation Funds can be spent.

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http://tmsmind.com/tms-therapy/tms/ect-vs-tms/

Biographies for Technology Suite - Milestones Update

Debbie Innes-Gomberg, Ph.D.
Dr. Innes-Gomberg received her PhD from CSPP-LA in 1992 and is the Deputy Director over Program Development and Outcomes for the Los Angeles County Department of Mental Health.

Over her 25 year career, she has assumed leadership roles in Jail Mental Health Services, Adult System of Care, served as a District Chief for the Long Beach/South Bay areas of Los Angeles County and oversees the administration of the Mental Health Services Act. Dr. Innes-Gomberg is the Co-Chair of the County Behavioral Health Directors' Association's (CBHDA) MHSA Committee, including a member of its Governing Board. She is a leader in LA County and across the State on the MHSA and on outcome and evaluation of mental health programs.

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

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

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

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

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

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

Karin Kalk:
Karin is Project Manager for the County Behavioral Health Technology Suite collaborative. She has also served as the director for Health Care Reform with the California Institute for Behavioral Health Solutions. Since 2001, Karin has been providing consulting services throughout California in both private and public managed care and service delivery organizations; these services have included project management, quality/process improvement, and service system design.

Prior to this work in the mental health field, Karin was Vice President and General Manager for ForHealth, Inc., a venture-capital funded company offering a specialized medical program for long term care residents through full and partial risk arrangements with senior health plans. Before joining ForHealth, she served as Vice President of Operations for AHI Healthcare Systems, a publicly traded managed care company serving over 200,000 members throughout the country.

Karin received her Master's degree in Health Administration from Duke University, her Bachelor of Arts degree in Animal Physiology from University of California, San Diego and has additional formal training in project management and IHI's Breakthrough Series improvement methodology.

AGENDA ITEM 3

Action

February 22, 2018 Commission Meeting

Mono County Innovation Project

Summary: The Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission) will consider approval of Mono County's request to fund a new Innovative (INN) project: MHSA Innovative Collaboration Project-Increasing Access to Mental Health Services and Supports Utilizing a Suite of Technology-Based Mental Health Solutions for a total of $85,000 over 17 Months. Mono County proposes to increase access to mental health services to underserved groups by working with the Joint Powers Authority, CalMHSA, to join Los Angeles County and Kern County in a multi-county demonstration project to implement a group of technology-based mental health solutions that utilize chat rooms and passive data collection to identify the early signal biomarkers for mental health symptoms and offer prompt intervention.

Mono County specifically plans to offer alternate modes of engagement to individuals in remote, isolated areas of the county and plans to coordinate with Cerro Coso Community College in Mammoth Lakes to engage students with the hope of predicting mental illness earlier.

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:

- Robin K. Roberts, MA, MFT, Director of Mono County Behavioral Health;
- Amanda Fenn Greenberg, MPH, MHSA Coordinator.

Enclosures (3): (1) Biographies for Mono County Innovation Presenters (2) Staff Innovation Summary, Increasing Access to Mental Health Services and Supports Utilizing a Suite of Technology-Based Mental Health Solutions and (3) County Project Brief.

Handout (1): PowerPoint Presentation

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

http://mhsoac.ca.gov/document/2018-02/mono-county-inn-plan-description-increasing-access-mental-health-services

Proposed Motion: The 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:** 17 Months

Biographies for Mono County Presenters
Increasing Access to Mental Health Services and Supports Utilizing a Suite of Technology-Based Mental Health Solutions

Robin K. Roberts, MA, MFT

Robin K. Roberts has served as the Director of Mono County Behavioral Health since 2012. She is also the co-chair of the CBHDA Small Counties Committee.

Amanda Fenn Greenberg, MPH

Amanda Fenn Greenberg has served as the MHSA Coordinator of Mono County Behavioral Health since 2016.

STAFF ANALYSIS— MONO COUNTY

Name of Innovative (INN) Project:	**Increasing Access to Mental Health Services and Supports Utilizing a Suite of Technology-Based Mental Health Solutions**
Total INN Funding Requested:	**$85,000**
Duration of Innovative Project:	**Seventeen (17) Months**

Review History:

Approved by the County Board of Supervisors:	February 20, 2018
County submitted Innovation (INN Project):	January 18, 2018
MHSOAC consideration of INN Project:	February 22, 2018

Project Introduction:

Mono County is proposing to join Los Angeles County and Kern County in a multi-county collaboration project to implement a group of technology-based mental health solutions that utilize a web-based network of trained, on-call, peers to chat 24/7 with individuals experiencing symptoms of mental illness; digital detection of emotional, thought and behavioral disturbances through passively collected data; and virtual, evidence-based on-line treatment protocols that use avatars to deliver clinical care.

The multi-county collaborative will utilize the Joint Powers Authority, California Mental Health Services Authority, and (CalMHSA), to act as the fiscal agent for all participating counties. CalMHSA will contract out with one or more technology vendors to implement the suite. It is anticipated that several other counties will be joining the collaborative. Los Angeles County and Kern County plans were approved by the MHSOAC on October 26, 2017.

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 (4) allowable primary purposes.

The Need

Mono County is a remote, rural county with a population of 14,000. This population is spread over 3,000 square miles. Mono County Behavioral Health (MCBH) reports that they have limited resources and because of the wide geographic spread, staff are challenged to provide consistent, high-quality services in all of Mono County's outlying areas. Mono County also reports a need to identify the onset of mental illness among transition age youth in the County.

Mono County community members echoed these challenges in the 2017 community planning process when they identified isolation, lack of social support/engagement and lack of access to services as the top mental health needs to be addressed with this population.

In addition, Cerro Coso Community College officials recently approached the MCBH, and asking for greater engagement around mental health services on their Mammoth Lakes campus in Mono County.

The Response

To address these issues, the County envisions joining Los Angeles County and Kern County in a multi-county collaboration project to address a shared need of increasing access to mental health services for unserved and underserved groups; to reduce stigma and increase early intervention. In order to address these shared needs, the collaboration proposes to partner with one or more technology-based mental health services with the goal to: (1) detect mental illness earlier; (2) intervene earlier to prevent mental illness and relapse and improve client outcomes; (3) provide alternate modes of engagement, support and intervention; and (4) test out the collection of passive data as a method to identify early signs of mental health symptoms.

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

Mono County specifically proposes to access technology products most likely to improve social support/engagement, improve access to care, and identify early onset of mental illness among users in small rural communities. These products will be chosen for use at the local community colleges and within the County Behavioral Health system. Both the Behavioral Health Director and MHSA coordinator state that they will work with the collaborative to ensure applications are appropriate for the needs of Mono County.

If this plan is approved, the County reports that virtual services will be launched at Cerro Coso Community College in Mammoth Lakes and that case managers will start working with clients in remote areas to build buy-in around and implement applications beginning in March 2018.

Mono County's proposed partnership with the local community college is in line with concerns raised by Commissioners during the original presentation of the technology suite of how to engage schools and measure success in reaching students.

County may wish to participate in collaborative meetings with CalMHSA and the project manager in order to encourage the inclusion of prior Commission recommendations including: hiring and compensating peers and establishing implementation milestones.

LA County defines passive data as "collected patterns of use without required participation from the user (devoid of content)" and plan to incorporate it into an interactive approach to digital phenotyping. Digital phenotyping is defined as, "using device usage patterns to identify behavior patterns that may be associated with mental health conditions, where the technology analyzes factors associated with cell phone usage (passive data) and interacts with the user via a pop-up or chat…" Additional research corroborates with the County's definition. In the article, *Digital Phenotyping, Technology for a New Science of Behavior*, Dr. Insel describes digital phenotyping as "…new approach to measuring behavior from smartphone sensors, keyboard interaction, and various features of voice and speech."

The County hopes that the use of the digital platform, including digital phenotyping, will support the user to increase understanding of how they are feeling and lead to earlier detection of mental health needs/problems and treatment options. Dr. Insel cautions that better data does not result in better care without an effective bridge. He states that smartphones can provide the tools for assessments and interventions in order to create a "learning mental health system" but that a set of standards and a consumer's guide for digital mental health in the public sector needs to be created.

Additional researchers have encouraged the development of procedures that, "… offer individuals better control of their diverse digital footprints with opportunities to control the information they wish to share" (Bidargaddi et al). This approach may build trust with individuals and avoid ethical challenges. There is an opportunity for the Counties

participating in this demonstration project to develop a set of standards and a consumer's guide to digital mental health as a dynamic contribution to statewide learning.

The Community Planning Process

The County reports that during their 2017 Community Program Planning process, community members identified isolation and lack of social support/engagement as one of the county's top three mental health needs, along with lack of access to services.

The County also reports receiving support to join the technology-based collaborative from the Mono County Behavioral Health Advisory Board (BHAB) after discussing the results of the needs assessment and community college discussions. County states that the BHAB was excited about the prospect and expressed support to pursue the project to help reduce isolation, increase access to services, and identify onset of mental illness sooner.

County may wish to discuss how consumers and family members can be included in the continued development and implementation of this innovation plan.

This Innovation Project was shared with MHSOAC stakeholders beginning January 22, 2018. No letters of opposition or support were received.

Learning Objectives and Evaluation

Mono County has proposed collaborating with Los Angeles County and Kern County in their implementation of their Innovation project titled, "Increasing Access to Mental Health Services and Supports Utilizing a Suite of Technology-Based Mental Health Solutions." The technology suite will be implemented to educate users on the signs and symptoms of mental illness, improve early identification of emotional and/or behavioral destabilization, and to increase access to mental health services among consumers. Specifically, Mono County seeks to access components of the technology suite that meet the need of their target population—namely, 1) individuals in remote, isolated areas of the county who have less access to social support and mental health services; and 2) students attending Cerro Coso Community College in Mammoth Lakes. Mono County estimates that they will serve approximately 350 consumers through their Innovation project.

The County has identified three main goals that will guide their Innovation project, particularly among Mammoth Lakes Cerro Coso Community College Students and individuals in remote, isolated areas:

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

Learning questions the County has identified match those laid out in Los Angeles County's original innovation plan, and have been revised to address their target

population as appropriate. In order to measure outcomes that address each learning question, the County will use passive data, as well as retrospective and prospective utilization of hospital resources from claims and medical records data. The data gathered will be analyzed by an outside evaluator who will complete the final evaluation report.

The Budget

The proposed budget for this Innovation Project is $85,000 over the course of 17 months.

Personnel costs total $17,000 and support the Behavioral Health Director, MHSA Coordinator, Director of Information Technology and case managers to plan and implement the Innovation project.

Operating costs total $8,500 and cover the cost of travel for planning and implementation meetings.

Non-recurring costs total $55,250 and will be Mono County's contribution towards the technology suite and access to products specifically designed to meet the needs of the target populations previously identified.

Direct administrative costs total $4,250 and will be paid to CalMHSA to oversee the multi-county administrative and financial components.

The County may wish to clarify what their financial contribution will buy.

The County may also wish to identify how the evaluation of their part of the collaborative will be funded.

If the project is deemed successful, Mono County will ensure that individuals have continued access to the applications and will consider utilizing a combination of CSS and PEI funds to sustain the project.

Additional Regulatory Requirements

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

References

https://www.census.gov/quickfacts/fact/table/monocountycalifornia/PST045216+

Insel TR. Digital PhenotypingTechnology for a New Science of Behavior. JAMA. 2017;318(13):1215–1216. doi:10.1001/jama.2017.11295

Bidargaddi, N., Musiat, P., Makinen, V.-P., Ermes, M., Schrader, G., & Licinio, J. (2017). Digital footprints: facilitating large-scale environmental psychiatric research in naturalistic settings through data from everyday technologies. Molecular Psychiatry, 22(2), 164–169. http://doi.org/10.1038/mp.2016.224

Mono County FY 17-19 Innovation Plan Brief

MHSOAC Commission Meeting: February 22, 2017

Name of County: Mono County

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

Total INN Funding Requested for Project: $85,000 | **Duration of INN Project:** 17 months

Brief Introduction to INN Project

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

Overall Goals

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

Summary of the Problem/Need

Mono County is a remote, rural county with a population of only 14,000. This population is spread over 3,000 square miles. Given the department's limited resources and wide geographic spread, staff are challenged to provide consistent, high-quality services in all of Mono County's outlying areas. Moreover, in the department's 2017 Community Program Planning process, community members identified isolation and lack of social support/engagement as one of the county's top three mental health needs, along with lack of access to services.

Additionally, Mono County Behavioral Health (MCBH) has identified a need for identification of onset of mental illness among transition age youth in the County. Local

Cerro Coso Community College officials recently approached MCBH asking for greater engagement around mental health services.

Components of the Technology Suite

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

1. Digital detection of emotional, thought and behavioral disturbances through passively collected data and sophisticated analyses that sense changes in the user interface known to correlate with social isolation, depression, mania, the early psychotic (prodromal) syndrome, and other indicators of either the onset of new mental illness or the recurrence of a chronic condition. As concerning signals are detected, communication to the user is generated through texts, emails, peers or clinician outreach to prompt care.
2. A web-based network of trained and certified peers available to chat 24/7 with individuals (or their family members/caregivers) experiencing symptoms of mental illness.
3. Virtual, evidence-based on-line treatment protocols using avatars to deliver clinical care. By their nature as virtual tools, this client-provider interface is available 24/7 and can be accessed in the home, clinical settings, and mobile devices.

Implementation Plan

MCBH and Departments of Mental Health in other counties will engage with one or more proven companies to engineer these technologies for use in the public mental health system. Identifying and reporting on milestones will be a key component of the implementation plan. In Mono County specifically, MCBH envisions accessing the components of the technology suite that meet the needs of two target populations: 1) individuals in remote, isolated areas of the county who have less access to social support and mental health services; 2) students attending Cerro Coso Community College in Mammoth Lakes. Following the development of the applications, MCBH plans to work with case managers and community partners at Cerro Coso to implement the products locally. Finally, the department plans to work closely with its Behavioral Health Advisory Board and other consumer and family member stakeholders to ensure ongoing satisfaction with this project.

Overarching Learning Questions

Please note: the following list of learning questions has been adapted from the list of learning questions proposed by other partners participating in this multi-county Innovation plan. MCBH has added verbiage to make these learning questions more specific to its own local climate. This verbiage is noted in [brackets].

1. Will [community college students and] individuals [living in remote, isolated areas] either at risk of or who are experiencing symptoms of mental illness use virtual peer chatting accessed through a website or through a phone application?
2. Will [community college students and] individuals [living in remote, isolated areas] who have accessed virtual peer chatting services be compelled to engage in manualized virtual therapeutic interventions?
3. Will the use of virtual peer chatting and peer-based interventions result in users [from both target populations] reporting greater social connectedness, reduced symptoms and increases in well-being?
4. What virtual strategies contribute most significantly to increasing an individual's capability and willingness to seek support [among both target populations]?
5. Can passive data from mobile devices accurately detect changes in mental status and effectively prompt behavioral change in users [among community college students]?
6. How can digital data inform the need for mental health intervention and coordination of care [among community college students]?
7. What are effective strategies to reduce time from detection of a mental health problem to linkage to treatment [among both target populations, but especially among community college students]?
8. Can we learn the most effective engagement and treatment strategies for patients from passive mobile device data to improve outcomes and reduce readmissions?
9. Can mental health clinics *effectively use early indicators of mental illness risk or of relapse to enhance clinical assessment and treatment [especially among community college students]?*
    a. *[Can MCBH effectively use data from the community college population to design and implement PEI programs for college instructors and staff?]*
10. *Is early intervention effective in reducing relapse, reducing resource utilization and improving outcomes and does it vary by demographic, ethnographic, condition, intervention strategy and delays in receiving intervention [especially among community college students]?*
11. Can online social engagement effectively mitigate the severity of mental health symptoms [especially among individuals living in remote, isolated areas]?
12. What are the most effective strategies or approaches in promoting the use of virtual care and support applications and for which populations?

Summary of the Evaluation Plan:

This project will be evaluated by tracking and analyzing passive data, reach of users, level of user engagement, changes in access to care and clinical outcomes. Furthermore, data from mobile devices would be analyzed to detect changes in mental status and responses

to online peer support, digital therapeutics and virtual care. Continuous assessment and feedback would drive the interventions. Specific outcomes are listed below.

Please note that as with the learning questions, the following list of evaluation outcomes has been adapted from the list of evaluation outcomes proposed by other partners participating in this multi-county Innovation plan. MCBH has added verbiage to make these evaluation outcomes more specific to its own local climate. This verbiage is noted in [brackets].

1. Increased purpose, belonging and social connectedness for users [especially for individuals living in remote, isolated areas].
2. Increased ability for users to identify cognitive, emotional and behavioral changes and act to address them [among both target populations].
3. Increases in quality of life, as measured objectively and subjectively (by user and by indicators such as activity level, employment, school involvement, etc.) [among both target populations].
4. For high utilizers of inpatient or emergency services, decreases in utilization for those services.
5. Reduced stigma of mental illness as reported by user [among both target populations].
6. Comparative analyses of population level utilization data [in Mono County] over the life of the project to determine impact on various types of service utilization.
    a. [Reach of technology products (number of users, demographics of users) in Mono County.]
7. For clients with particular sorts of biomarkers (characteristics identified either through history or digital phenotyping analysis), how many clients respond well to treatment options identified through this project?
8. What is the role of this technology as a source of information that can help guide the interventions provided by mental health clinicians [at MCBH]?
9. Examine penetration or other unmet need metrics to understand how the technology suite has impacted [MCBH's] ability to serve those in need.

User outcomes will be measured by analyzing retrospective and prospective utilization of hospital resources from claims data and medical records data. The analysis will incorporate disease risk stratification, digital phenotype and digital biomarker measurement, type of intervention and delay in receiving care. Quality of life impact will include school grades, graduation rates, job retention, absenteeism and presenteeism.

Budget by Fiscal Year and Category

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

AGENDA ITEM 4

Action

February 22, 2018 Commission Meeting

Kern County Innovation Project

Summary: The Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission) will consider approval of Kern County's request to fund a new Innovative project: The Healing Project for a total of $14,685,510 over five (5) Years. Kern County proposes to increase the quality of mental health services received by individuals living with co-occurring disorders by opening two recovery stations. These stations are aimed at providing individuals a peer-led, safe environment to "sober-up" while also offering mental health screening, access and comprehensive linkage to care.

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:

- Bill Walker, LMFT, Director of Kern Behavioral Health and Recovery Services;
- Bradley Cloud, Psy.D., Deputy Director of Kern Behavioral Health and Recovery Services.

Enclosures (3): (1) Biographies for Kern County Innovation Presenters (2) Staff Innovation Summary, The Healing Project and (3) County Project Brief.

Handout (1): PowerPoint Presentation

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

http://mhsoac.ca.gov/document/2018-02/kern-county-inn-plan-description-healing-project

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

Biographies for Kern County Presenters
The Healing Project

Bill Walker, LMFT

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

Bradley Cloud, Psy.D.

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

STAFF ANALYSIS— KERN COUNTY

Name of Innovative (INN) Project:	**The Healing Project**
Total INN Funding Requested:	**$14,685,510**
Duration of Innovative Project:	**Five (5) Years**

Review History:

Approved by the County Board of Supervisors:	12/05/2017
County submitted Innovation (INN) Project:	02/07/2018
MHSOAC consideration of INN Project:	02/22/2018

Project Introduction:

In order to address barriers preventing a large number of intoxicated individuals, who present themselves at various crisis access points, from accessing quality mental health care, Kern County proposes to open two recovery stations aimed at providing individuals a peer-led, safe environment to "sober up" while also offering mental health screening, access and comprehensive linkage to care.

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 (4) allowable primary purposes.

The Need

The County reports that a large portion of individuals presenting with substance use intoxication have untreated mental health conditions and estimate that 80 percent of individuals entering the Kern County Psychiatric Evaluation Center present as under the influence. Of the 80 percent, 50 percent are found not to be receiving treatment for either mental illness or substance use conditions. **County may wish to include more information to illustrate what 80 percent represents in terms of number of people.** The County also reports that an average of 2,652 arrests are related to alcohol or other drug-related intoxication each year county-wide. The County feels that the number of arrests is related to the number of individuals with untreated co-occurring mental illness and substance use. Research shows that nationwide, as many as 42% of adults ages 29 to 46 have a co-occurring mental illness and substance use disorder (SAMHSA, 2014). Additional research shows that individuals diagnosed with substance use disorders are twice as likely to also suffer from mood and anxiety disorders (NIH, 2010). **County may wish to identify any specific data to demonstrate that this is also true for Kern County.**

The County expresses that bias against individuals who abuse substances prevents trained staff from seeing the underlying mental health needs of those who are intoxicated and the opportunity to evaluate for mental health treatment is missed. This prejudice results in inadequate screenings and inadequate linkage to mental health care. The County states that there are few resources where these individuals can receive the immediate specialized care they require and are often arrested, and/or provided with brief interventions targeting mental health needs alone.

Additional barriers for individuals with co-occurring mental illness and substance use include: geographic and transportation barriers, as well as crisis and other service systems that are not integrated or designed to address both acute mental health and substance use needs concurrently.

The Response

To address these issues, the County is proposing to open a peer-led, 16-bed recovery station program providing screening, access and comprehensive linkage to care for individuals presenting with co-occurring mental illness and substance use needs. The Healing Project will include two recovery stations in Kern County, one in Bakersfield and another in Ridgecrest. Individuals will have the opportunity to “sober up” safely, receive basic necessities and then be evaluated for mental health services. The County believes that by casting a wide net, they will reach a previously unserved population.

The length of stay at the recovery station is anticipated to range between eight to ten hours. Both stations will be open 24/7. The recovery stations will be designated as a crisis access point within the Kern County System of Care and individuals transitioning from a recovery station will receive priority appointments with treatment teams. Recovery station staff will provide follow up support and linkage to ensure a “warm hand off”. Individuals

will be medically cleared before being referred by law enforcement, emergency departments, mental health crisis units, and behavioral health treatment teams.

The County states that the Healing Project is the first program to integrate elements of a sobering station with mental health screening and access. The County also believes that the project is innovative as it focuses on peer-led intervention and services, designed to encourage engagement and work towards seeking help for sobriety and related mental health issues. Peers will be paid staff. Additional staff will include clinical and other service staff. Peers in recovery will lead interventions with individuals visiting the facilities. The Healing Project recovery stations will aim to have a peer staff onsite during every shift. Project staff will be trained on mental health interventions and skills, including Motivational Interviewing, Brief Solution Focused Therapy, Cognitive Behavioral Therapy skills, Applied Suicide Intervention Skills Training (ASIST), and Aegis De-Escalation and Crisis Intervention Training. An onsite Licensed Practitioner of the Healing Arts (LPHA) will be available to provide interventions and for consultation.

The County is building upon learnings from their previous Innovation project, The Freise Hope House, which tested a peer-led model for individuals in a crisis residential setting. Based on findings that individuals reported high satisfaction and more relatability to peer staff, the model for the recovery stations was designed as peer-led.

In addition, the recovery station model was adapted from the sobering station models they researched and visited to include a focus on mental health screening, access and linkage to care, as well as staff, staffing mental health professionals.

Research conducted by the County shows that:

- There are 22 sobering stations in California as of 2017
- County staff visited 7 sobering stations in multiple states and learned that the programs are not designed to serve individuals with co-occurring mental health and substance use disorder conditions. When a mental health condition is identified, individuals are “screened out” to appropriate resources. Staffing within these facilities does not provide active mental health service engagement and interventions. In addition, no facility operates with a peer-led model, or integrates peer staff to the degree proposed within the Healing Project.

In 2008, the MHSOAC published a report containing recommendations to address the needs of individuals with co-occurring mental illness and substance abuse. The 19-member workgroup suggested that co-occurring disorders must be the expectation and not the exception. Goal 5 focused on individuals with co-occurring disorders receiving the “right care at the right time and in the right place.” Goal 6 recommended peer-based wellness and recovery services. Kern County’s Innovation proposal incorporates both of these goals.

The Community Planning Process

The County reports that MHSA Stakeholders, including consumers, family members, law enforcement, hospital staff, treatment providers, and other community members determined a need for recovery station services for those with co-occurring mental health and substance use disorders during the 2014 MHSA Community Planning Process. The County began research on sobering station models both statewide and throughout the country. Once the project was developed, it was ranked against seven other potential innovative programs. Stakeholders ranked recovery stations as the priority and The Healing Project proposal was eventually drafted.

During the 2016 and 2017 Community Planning Processes, The Healing Project received feedback from stakeholders participating in 24 community meetings. 243 meeting attendees provided feedback via surveys and 53 of them indicated that the Healing Project would be most beneficial for Kern County.

The County states that meaningful stakeholder participation has been achieved and will continue to be ensured through the annual Community Planning Process and MHSA Stakeholder meetings. Data and outcome measures will be reviewed during stakeholder meetings throughout the course of the project. Stakeholders will be given an opportunity provide feedback on whether ongoing evaluation measures capture the intent of the project or need to be modified to further determine fidelity to the program purpose and intent.

This Innovation Project was shared with MHSOAC stakeholders beginning December 18, 2017. No letters of opposition or support were received.

Learning Objectives and Evaluation

Kern County has proposed implementing a peer-led recovery station program that will combine screening, access and linkage to services for individuals that present co-occurring mental health and substance use disorder needs. Specifically, GAD-7, PHQ-9, and Audit-C screening tools will be used to refer individuals into the appropriate services. The target population for the Healing Project will be English and Spanish-speaking individuals who are intoxicated and referred by law enforcement, emergency departments, mental health crisis units, and behavioral health treatment teams. The County estimates that they will serve at total of 1500 individuals at the two locations annually.

The County Has identified three main learning goals:

1. Evaluate the benefits of utilizing peer-led services in early intervention environments such as the proposed Healing Project.
2. Evaluate the benefits of short-term recovery stations toward engagement in follow-up services.
3. Determine the impact to law enforcement and other County resources of a recovery station as an alternative to arrests and crisis medical and mental health services.

In order to measure outcomes relative to the proposed learning questions, the County will utilize data from law enforcement records (i.e. number of arrests), electronic health records, client engagement (i.e. date and duration of service), as well as client surveys (i.e. satisfaction and likelihood to seek follow-up treatment). Intended outcomes of the Healing Project include: a reduction in arrests; a reduction in psychiatric evaluation center admissions for individuals under the influence in Bakersfield and Ridgecrest; 75% positive feedback from clients relative to the impact peer led services had on their likelihood to engage in follow up treatment; and 25% engagement in follow up treatment after first admission among those entering the Healing Project recovery station. **County may wish to further discuss how the intersection of law enforcement and the mental health community will work in order to support the intended outcomes stated above**. Data for the Healing Project will be collected by project staff, and evaluation reports will be completed by an outside evaluator.

The Budget

The proposed budget for this Innovation Project is $14,685,510 over five (5) years.

The majority of the budget is going to the costs of personnel, which will be paid to mental health providers through a contractor to operate the two Recovery Stations.

Contracted personnel costs total $9,907,935.

Staff required for the Bakersfield Recovery Station include: one (1) Unit Supervisor, one (1) Mental Health Therapist (LPHA), five (5) Mental Health Recovery Specialists, three (3) Certified or Registered Alcohol and Drug Counselors, two (2) clerical Office Service Technicians and also includes the cost for a 0.3 FTE Planning Analyst to provide monitoring and evaluation.

Staff required for the Ridgecrest Recovery Station include: one (1) Unit Supervisor, one (1) Mental Health Therapist (LPHA), three (3) Mental Health Recovery Specialists, three (3) Certified or Registered Alcohol and Drug Counselors, one (1) clerical Office Services Technician and a 0.3 FTE Planning Analyst to provide monitoring and evaluation.

County may wish to indicate how many peers will be hired for each station and include their classification.

The County lists total administration costs as $2,548,075. The Administrative direct and indirect costs of $509,615 per year includes the reporting of program data and outcomes, including information from the Community Planning Process.

County personnel costs are limited to a 0.6 FTE Planning Analyst who will provide internal program monitoring and evaluation. Internal evaluation will include collecting data from the electronic medical record, including information on duration of untreated mental illness, screening results and severity of symptomology, as well

as, survey information and data from outside entities. The external evaluator will receive compiled information and then determine and report on outcomes for the County.

The evaluation component will be partially contracted out and the County has allotted $770,167 (5.2%) of the total budget ($520,167 for internal evaluation and $250,000 for external evaluation).

Additional costs include: operating expenditures ($1,750,000) and non-recurring expenditures ($229,500).

Regarding sustainability, outcomes from evaluation and stakeholder feedback will determine if the project proves to be a necessary and well-received benefit to the community. If outcomes and feedback are positive, the County will establish options for alternative funding sources including alternate MHSA component funding.

County may wish to indicate who will be responsible for the staff training component, for peers and non-peers, and how staff will be supported on an ongoing basis to serve individuals presenting with co-occurring disorders.

Additional Regulatory Requirements

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

References

SAMHSA. (2014). *Behavioral Health Trends in the United States: Results from the 2014 National Survey on Drug Use and Health.* Retrieved from: https://www.samhsa.gov/data/sites/default/files/NSDUH-FRR1-2014/NSDUH-FRR1-2014.pdf

NIH (2010).*Comorbidity: Addiction and Other Mental Illnesses.* Retrieved from: https://www.drugabuse.gov/sites/default/files/rrcomorbidity.pdf Publication Number 10-5771

MHSOAC Report on Co-Occurring Disorders (2008). *Transforming the Mental Health System Through Integration.* Retrieved from: http://archive.mhsoac.ca.gov/docs/Committees/CODReport101608.pdf

Proposed Project Summary – Healing Project

The Healing Project will be a peer-led 16-bed recovery station program providing screening, access and linkage to care for individuals presenting with co-occurring mental health and substance use disorder needs. The Healing Project will include two recovery stations in Kern County, one in Bakersfield and another in Ridgecrest. The Bakersfield facility will have ten beds to serve the metropolitan area and its immediate surrounds, and the Ridgecrest facility will have six beds to serve the East Kern region. The number of beds per facility was determined proportionally based on site visits of fully operational sobering stations and information gathered from the Psychiatric Evaluation Center on the number of positive toxicology screenings. The Healing Project recovery stations will be open 24/7 and will serve an estimated 1,600 consumers annually. Consideration has been given to anticipated population growth and needs over time with facility adaptability to expand as required.

The program will target individuals with untreated mental health conditions. Individuals referred to the recovery stations will be provided mental health and substance use screening using the GAD-7, PHQ-9, and Audit – C. These standardized tools will measure potential anxiety, depression, and substance use disorders, respectively. Additionally, staff will provide screening for symptoms relating to trauma. Staff will be provided training specific to administering these screening tools.

Prior to admission to the recovery stations all individuals will be provided a brief medical screening to ensure they are not in need of urgent medications and/or emergency services outside the scope of the program. The medical screening will be in the form of a questionnaire addressing items such as medical history, medication, serious or chronic illness, and hospitalizations. Persons presenting hostile, threatening behavior or considered at risk of harming self or others will be linked to other appropriate resources.

Upon entering a recovery station facility, individuals will be provided an opportunity for respite and offered comfort services, including clean clothes, laundry services, refreshments, and an opportunity to attend to personal hygiene needs. When determined appropriate, staff will provide screenings, using identified mental health and substance use disorder screening tools. Brief interventions will be provided as appropriate, and upon discharge, individuals will be linked to ongoing treatment services with a “warm hand off” between providers. For individuals who are not willing or prepared to engage with staff to complete the screening process, staff will attempt to continue the process via phone or in-person following the recovery station stay.

The two recovery stations are designed to improve engagement and accessibility to services for residents of Kern County who are experiencing co-occurring mental illness and substance use. The Healing Project will provide a peer-led safe environment for referred individuals where they will receive immediate detox and early mental health and substance use disorder screening and interventions. The Healing Project will not only fill a current gap in client care but also through its peer-led philosophy, provide a more comfortable environment for individuals with mental illness experiencing the acute stages of substance use.

The Healing Project includes two recovery stations designed to improve engagement and accessibility to services for residents of Kern County who are experiencing co-occurring mental illness and substance use.

Primary Problem to be Addressed:

The Kern Behavioral Health and Recovery Services Department (KernBHRS) recognizes that a large proportion of individuals presenting with substance use intoxication have untreated mental health conditions. These conditions often include anxiety, depression, or unresolved trauma. National data suggests that as much as 42 percent of adults aged 29 to 46 with a substance use disorder, have a co-occurring mental illness (SAMHSA, 2014). Approximately 80 percent of individuals entering the KernBHRS Psychiatric Evaluation Center (PEC) present as under the influence. In addition, Kern County experiences an average of 2,652 arrests related to alcohol or other drug-related intoxication each year.

Currently, there are few resources where these individuals can receive the immediate specialized care they require, as a result, they are often arrested, and/or provided with brief interventions targeting mental health needs alone. Moreover, recidivism in the form of recurrent arrests and emergency treatment incurs high time and cost burden for the County, straining already overloaded resources. The Healing Project will not only reduce the time and cost burden for the County but also provide a more effective and consumer focused, means of managing these serious and ever-increasing behavioral health concerns for the community.

Linkage to additional services after screening

This program was designed with a strong access and linkage to care component a "warm hand off". The Healing Project will have LPHAs on site to address the clinical needs of those with serious and persistent mental health conditions. The Healing Project will be designated as a crisis access point within the KernBHRS System of Care, and as such, individuals transitioning from The Healing Project locations will receive priority appointments with treatment teams. For those individuals determined to need additional services after screening, staff will provide the following referral options:

- In Bakersfield, individuals will be linked to the treatment teams within the KernBHRS System of Care, or the local mental health Crisis Walk-in Clinic for immediate mental health assessment. Clients in need of substance use disorder services, including residential treatment, will be connected by phone or in person to the KernBHRS Gateway program for a brief phone screening, and linkage to appropriate treatment.

- In Ridgecrest, referrals for care by geographic services providers will be made as appropriate, this includes providers for mental health and/or substance use disorder treatment.

- Individuals requiring inpatient mental health treatment will be referred to the nearest psychiatric evaluation center.

- Referrals and linkage will also include non-specialty treatment referrals, based individual need and preference. These may include primary care, non-specialty mental health treatment providers, Alcoholics Anonymous, Dual Recovery Anonymous, Narcotics Anonymous, Spanish language supports, faith-based supports, LGBTQ supports, and other community-based support agencies and groups.

- The Healing Project may also provide referrals for housing resources as appropriate.

Innovative Component:

The Healing Project will be the first program to integrate elements of a sobering station while continuously engaging and ultimately providing a warm link for those in need of mental health and substance use disorder care. No other program exists to address immediate intoxication needs, with the intent of screening and addressing untreated, undiagnosed

mental health conditions. With the incorporation of mental health and substance use disorder screening tools and treatment focus, the Healing Project will gain knowledge about the impact of the recovery station model on engagement and referrals to treatment for this underserved population.

The Healing Project is also innovative in its focus on peer-led intervention and services, designed to encourage engagement and identify potential previously undiagnosed mental illness, providing immediate support and linkage to mental health and substance use care. During Kern County's first Innovative Project, the Freise Hope House crisis residential program, it was determined that clients reported high satisfaction, feeling peer support staff were more able to relate to their experiences. The Healing Project will build on previous learning objectives to continue to gain knowledge about the impact of peer support in the recovery setting.

Learning Goals/Project Aims:

KernBHRS has identified the following Healing Project learning goals:

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

Intended outcomes:

- Reduction in arrests and Psychiatric Evaluation Center admissions for individuals under the influence in Bakersfield and Ridgecrest. Baseline information to be pulled from existing law enforcement and KernBHRS crisis service data.
- 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. This information would be collected through surveys provided at discharge and/or in follow up contact.
- 25% of those entering the Healing Project recovery stations will be engaged in follow up treatment after first admission.

Specific measures/indicators from surveys connecting to outcomes

Measures to be utilized for initial mental health symptom screening include the GAD-7 (Anxiety), PHQ-9 (Depression) and Audit – C (Alcohol use/misuse). Additionally, KernBHRS is researching appropriate screening tools to determine symptoms related to trauma and psychosis. Guests of the Healing Project also be asked to complete surveys indicating how and whether they felt peer engagement provided added support during their stay. Question examples may include, "There were staff or Peer Supporters that related to my experience," or, "When we talked about what was happening in my life, I felt like the staff understood what I was saying or were trying to understand."

***Budget Summary*:**

The Bakersfield Recovery Station proposes to include full time peer-integrated staff of: one Unit Supervisor, one Mental Health Therapists (LPHA), five Mental Health Recovery Specialists, three Certified or Registered Alcohol and Drug Counselors, two clerical Office Service Technicians and includes cost for 0.3 FTE Planning Analyst to provide monitoring and evaluation. Operating costs include supplies, linens, snacks, rent and utilities based on a space of approximately 7,800 square feet. Capital Improvements and outlay, as a subset of operating expenditures include one-time costs for client space furniture, appliances, office furniture and technological needs (phones, computers, network wiring). Additional funding for potential tenant improvements is included in the budget.

The Ridgecrest Recovery Station proposes to include full peer-integrated time staff of: one Unit Supervisor, one Mental Health Therapist (LPHA), three Mental Health Recovery Specialists, three Certified or Registered Alcohol and Drug Counselors one clerical Office Services Technician and 0.3 FTE Planning Analyst to provide monitoring and evaluation. Operating costs include supplies, linens, snacks, and utilities. One-time capital outlay costs include client furniture, appliances, office furniture and technological needs.

Staffing for the Recovery Stations will be provided under contract by mental health providers. Internal program monitoring and evaluation will be provided by KernBHRS staff, totaling 0.6 FTE Planning Analyst. Evaluation cost equates to approximately $104,124 annually. Internal evaluation will provide for collection of data from various sources including the electronic medical record, which will store information on duration of untreated mental illness for those referred for care, screening results and severity of symptomology and type of services the client to which the client is referred. This staff will also compile survey information and data on referrals from outside entities/agencies and the PEC. All compiled information will be provided to the external contracted evaluator, budgeted at $50,000 annually, who will determine and report on outcomes for the program.

Administration direct and indirect costs include reporting of program data and outcomes, including information utilized for the Community Planning and Stakeholder process. This is budgeted at approximately 27 percent of personnel cost, totaling $509,615. Non-recurring costs for equipping new employees with computers and start up equipment.

KernBHRS currently contracts with multiple evaluators on a variety of projects. To date, the evaluator has not been selected specifically for this project, however, staff may choose to add this program to an existing evaluation contract or seek an evaluator through a competitive bid process

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**

AGENDA ITEM 5

Information

February 22, 2018 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 January 25, 2018 Commission Meeting; (2) Evaluation Dashboard Summary; (3) Evaluation Dashboard; and (4) Innovation Review Outline.

Handout: None

Recommended Action: Information item only

Motions Summary

Commission Meeting
January 25, 2018

Motion #: 1

Date: January 25, 2018

Time: 9:30AM

Text of Motion:

The Commission approves the November 16, 2017, Meeting Minutes, as amended to more accurately reflect Poshi Walker's public comment.

Commissioner making motion: Commissioner Poaster
Commissioner seconding motion:

Motion carried 8 yes, 0 no, and 3 abstain, per roll call vote as follows:

Name	Yes	No	Abstain
1. Chair Boyd	☒	☐	☐
2. Vice-Chair Aslami-Tamplen	☐	☐	☒
3. Commissioner Anthony	☒	☐	☐
4. Commissioner Alvarez	☐	☐	☐
5. Commissioner Ashbeck	☐	☐	☐
6. Commissioner Beall	☐	☐	☐
7. Commissioner Brown	☒	☐	☐
8. Commissioner Bunch	☒	☐	☐
9. Commissioner Danovitch	☐	☐	☒
10. Commissioner Gordon	☒	☐	☐
11. Commissioner Madrigal-Weiss	☒	☐	☐
12. Commissioner Mitchell	☒	☐	☐
13. Commissioner Poaster	☐	☐	☒
14. Commissioner Strachan-Wilson	☐	☐	☐
15. Commissioner Wooton	☒	☐	☐

Motion #: 2

Date: January 25, 2018

Time: 11:52AM

Proposed Motion:

The Commission approves San Joaquin County's Innovation Plan as follows:

Name: Assessment and Respite Center
Amount: $11,216,688
Project Length: Five (5) Years

Commissioner making motion: Commissioner Mitchell
Commissioner seconding motion: Commissioner Gordon

Motion carried 10 yes, 1 no, and 0 abstain, per roll call vote as follows:

Name	Yes	No	Abstain
1. Chair Boyd	☒	☐	☐
2. Vice-Chair Aslami-Tamplen	☒	☐	☐
3. Commissioner Anthony	☒	☐	☐
4. Commissioner Alvarez	☐	☐	☐
5. Commissioner Ashbeck	☐	☐	☐
6. Commissioner Beall	☐	☐	☐
7. Commissioner Brown	☒	☐	☐
8. Commissioner Bunch	☒	☐	☐
9. Commissioner Danovitch	☐	☒	☐
10. Commissioner Gordon	☒	☐	☐
11. Commissioner Madrigal-Weiss	☒	☐	☐
12. Commissioner Mitchell	☒	☐	☐
13. Commissioner Poaster	☒	☐	☐
14. Commissioner Strachan-Wilson	☐	☐	☐
15. Commissioner Wooton	☒	☐	☐

Motion #: 3

Date: January 25, 2018

Time: 11:54AM

Proposed Motion:

The Commission approves San Joaquin County's Innovation Plans as follows:

Name: Progressive Housing
Amount: $6,461,517
Project Length: Five (5) Years

Commissioner making motion: Commissioner Mitchell
Commissioner seconding motion: Commissioner Bunch

Commissioner Gordon recused himself.

Motion carried 9 yes, 1 no, 1 abstain, and 1 recusal per roll call vote as follows:

Name	Yes	No	Abstain
1. Chair Boyd	☒	☐	☐
2. Vice-Chair Aslami-Tamplen	☒	☐	☐
3. Commissioner Anthony	☐	☒	☐
4. Commissioner Alvarez	☐	☐	☐
5. Commissioner Ashbeck	☐	☐	☐
6. Commissioner Beall	☐	☐	☐
7. Commissioner Brown	☒	☐	☐
8. Commissioner Bunch	☒	☐	☐
9. Commissioner Danovitch	☒	☐	☐
10. Commissioner Gordon	☐	☐	☐
11. Commissioner Madrigal-Weiss	☒	☐	☐
12. Commissioner Mitchell	☒	☐	☐
13. Commissioner Poaster	☒	☐	☐
14. Commissioner Strachan-Wilson	☐	☐	☐
15. Commissioner Wooton	☒	☐	☐

Motion #: 4

Date: January 25, 2018

Time: 1:55PM

Text of Motion:

The Commission adopts the amendments to sections 3560, 3560.010, 3560.020, 3705, 3726, 3735, 3750, and 3755 of the PEI regulations and sections 3580 and 3580.010 of the Innovative project regulations as presented and authorizes the Executive Director to submit the rulemaking file to the Office of Administrative Law.

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

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

Name	Yes	No	Abstain
1. Chair Boyd	☒	☐	☐
2. Vice-Chair Aslami-Tamplen	☒	☐	☐
3. Commissioner Anthony	☒	☐	☐
4. Commissioner Alvarez	☐	☐	☐
5. Commissioner Ashbeck	☐	☐	☐
6. Commissioner Beall	☐	☐	☐
7. Commissioner Brown	☒	☐	☐
8. Commissioner Bunch	☒	☐	☐
9. Commissioner Danovitch	☒	☐	☐
10. Commissioner Gordon	☒	☐	☐
11. Commissioner Madrigal-Weiss	☒	☐	☐
12. Commissioner Mitchell	☐	☐	☐
13. Commissioner Poaster	☒	☐	☐
14. Commissioner Strachan-Wilson	☐	☐	☐
15. Commissioner Wooton	☒	☐	☐

Motion #: 5

Date: January 25, 2018

Time: 2:09PM

Proposed Motion:

The MHSOAC authorizes the Executive Director to enter into one or more evaluation contracts for a total amount not to exceed $10,000,000.00 to assist the Commission in conducting statewide evaluation of the SB 82 Triage programs.

Commissioner making motion: Commissioner Brown
Commissioner seconding motion: Commissioner Gordon

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

Name	Yes	No	Abstain
1. Chair Boyd	☒	☐	☐
2. Vice-Chair Aslami-Tamplen	☒	☐	☐
3. Commissioner Anthony	☒	☐	☐
4. Commissioner Alvarez	☐	☐	☐
5. Commissioner Ashbeck	☐	☐	☐
6. Commissioner Beall	☐	☐	☐
7. Commissioner Brown	☒	☐	☐
8. Commissioner Bunch	☒	☐	☐
9. Commissioner Danovitch	☒	☐	☐
10. Commissioner Gordon	☒	☐	☐
11. Commissioner Madrigal-Weiss	☒	☐	☐
12. Commissioner Mitchell	☐	☐	☐
13. Commissioner Poaster	☐	☐	☐
14. Commissioner Strachan-Wilson	☐	☐	☐
15. Commissioner Wooton	☒	☐	☐

Motion #: 6

Date: January 25, 2018

Time: 2:28PM

Text of Motion:

The MHSOAC supports Senate Bill 215 (Beall), Senate Bill 688 (Moorlach), and Senate Bill 906 (Beall & Anderson) and authorizes the Executive Director to communicate the Commission's support.

Commissioner making motion: Commissioner Boyd
Commissioner seconding motion: Commissioner Danovitch

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

Name	Yes	No	Abstain
1. Chair Boyd	☒	☐	☐
2. Vice-Chair Aslami-Tamplen	☒	☐	☐
3. Commissioner Anthony	☒	☐	☐
4. Commissioner Alvarez	☐	☐	☐
5. Commissioner Ashbeck	☐	☐	☐
6. Commissioner Beall	☐	☐	☐
7. Commissioner Brown	☒	☐	☐
8. Commissioner Bunch	☒	☐	☐
9. Commissioner Danovitch	☒	☐	☐
10. Commissioner Gordon	☒	☐	☐
11. Commissioner Madrigal-Weiss	☒	☐	☐
12. Commissioner Mitchell	☐	☐	☐
13. Commissioner Poaster	☐	☐	☐
14. Commissioner Strachan-Wilson	☐	☐	☐
15. Commissioner Wooton	☒	☐	☐

Motion #: 7

Date: January 25, 2018

Time: 2:57PM

Text of Motion:

The MHSOAC authorizes the Executive Director to work with the legislature to sponsor legislation to establish a framework and voluntary standards for mental health in the workplace.

Commissioner making motion: Commissioner Danovitch
Commissioner seconding motion: Commissioner Wooton

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

Name	Yes	No	Abstain
1. Chair Boyd	☒	☐	☐
2. Vice-Chair Aslami-Tamplen	☒	☐	☐
3. Commissioner Anthony	☒	☐	☐
4. Commissioner Alvarez	☐	☐	☐
5. Commissioner Ashbeck	☐	☐	☐
6. Commissioner Beall	☐	☐	☐
7. Commissioner Brown	☒	☐	☐
8. Commissioner Bunch	☒	☐	☐
9. Commissioner Danovitch	☒	☐	☐
10. Commissioner Gordon	☒	☐	☐
11. Commissioner Madrigal-Weiss	☒	☐	☐
12. Commissioner Mitchell	☐	☐	☐
13. Commissioner Poaster	☐	☐	☐
14. Commissioner Strachan-Wilson	☐	☐	☐
15. Commissioner Wooton	☒	☐	☐

Motion #: 8

Date: January 25, 2018

Time: 3:09PM

Text of Motion:

The MHSOAC authorizes the Executive Director to work with the Legislature and the Department of Finance to request funding for stakeholder advocacy for education, training, and outreach to reduce criminal justice involvement of individuals with mental health needs and to meet the mental health needs of immigrants and refugees. The requested amount is $670,000 per year for each of the two populations.

Commissioner making motion: Commissioner Anthony
Commissioner seconding motion: Commissioner Danovitch

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

Name	Yes	No	Abstain
1. Chair Boyd	☒	☐	☐
2. Vice-Chair Aslami-Tamplen	☒	☐	☐
3. Commissioner Anthony	☐	☐	☐
4. Commissioner Alvarez	☐	☐	☐
5. Commissioner Ashbeck	☐	☐	☐
6. Commissioner Beall	☐	☐	☐
7. Commissioner Brown	☒	☐	☐
8. Commissioner Bunch	☐	☐	☐
9. Commissioner Danovitch	☒	☐	☐
10. Commissioner Gordon	☒	☐	☐
11. Commissioner Madrigal-Weiss	☒	☐	☐
12. Commissioner Mitchell	☐	☐	☐
13. Commissioner Poaster	☐	☐	☐
14. Commissioner Strachan-Wilson	☐	☐	☐
15. Commissioner Wooton	☒	☐	☐

MHSOAC Evaluation Dashboard

Summary: The Mental Health Services Oversight and Accountability 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: Contract complete

- **DOJ Criminal Data Linkage & Analysis** *Mental Health Data Alliance*
  Update: Contract end date changed. Total spent increased.

- **CSI & DCR Data Analysis & Standardize Reporting** *Mental Health Data Alliance*
  Update: Deliverable 1.1-1.3 status changed to complete.

- **Visualization Confirguration & Publication Support Services** *The iFish Group*
  Update: Total spent increased.

- **Hosting and Managed Services** *The iFish Group*
  Update: Contract (17MHSOAC022) number changed to (17MHSOAC024). Contract Manager changed. Total contract amount increased. Total spent increased. Deliverable 1 and 2 status changed to complete.

Enclosures: MHSOAC Evaluation Dashboard

Recommended Action: None

Presenter: None

Motion: None

MHSOAC Evaluation Dashboard February 2018
(updated 2/13/18)

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: $469,000

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 February 2018
(updated 2/13/18)

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 February 2018

(updated 2/13/18)

Mental Health Data Alliance

DOJ Criminal Data Linkage & Analysis (16MHSOAC027)

MHSOAC Staff: Pu Peng & Ashley Mills

Active Dates: 01/01/17 - 06/30/18

Total Contract Amount: $98,450

Total Spent: $27,976

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**			

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 February 2018
(updated 2/13/18)

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 February 2018
(updated 2/13/18)

The iFish Group

Visualization Configuration & Publication Support Services (16MHSOAC021)

MHSOAC Staff: Brandon McMillen

Active Dates: 10/31/16 – 7/28/18

Total Contract Amount: $1,000,000

Total Spent: $312,500

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 February 2018

(updated 2/13/18)

The iFish Group

Hosting and Managed Services (17MHSOAC024)

MHSOAC Staff: Pu Peng

Active Dates: 12/28/17 - 12/31/18

Total Contract Amount: $423,923

Total Spent: $273,943

Objective: To provide hosting and managed services (HMS) such as Secure Data Management Platform (SDMP) and a Visualization Portal where software support will be provided for SAS Office Analytics, Microsoft SQL, Drupal CMS 7.0 Visualization Portal, and other software products. Support services and knowledge transfer will also be provided to assist MHSOAC staff in collection, exploration, and curation of data from external sources.

Deliverables & Due Dates

Contracts		December 2017
1	Secure Data Management Platform	12/28/17
2	Visualization Portal	12/28/17
3	Data Management Support Services	12/31/18

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

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

AGENDA ITEM 6

Action

February 22, 2018 Commission Meeting

Legislation

Summary: The Commission will consider legislative priorities for the current legislative session.

The Commission is aware of the following bills that relate to mental health under the Mental Health Services Act that the Commission may wish to support:

- **Assembly Bill 2325 (Irwin): Mental health services: veterans:** This bill will prevent a county from denying an eligible veteran county or behavioral health services while the veteran is waiting for a determination of eligibility for, and availability of, mental or behavioral health services provided by the US Department of Veterans Affairs.

- **Senate Bill 1019 (Beall): Youth mental health and substance use disorder services:** This bill will amend the Investment of Mental Health Wellness Act of 2013 to require the Commission, when making the triage funds available, to allocate at least one half of those funds for services or programs targeted at children and youth 18 years of age and under.

The last day to introduce bills is February 16, 2018, and there may be other bill introduced and presented at the Commission meeting for consideration.

Presenter: Toby Ewing Ph.D., Executive Director; Norma Pate, Deputy Director Mental Health Services Oversight and Accountability Commission

Enclosures: (1) Assembly Bill 2325 (Irwin) and Senate Bill 1019 (Beall)

Handout: Any new legislation will be provided at the Commission Meeting.

Proposed Motion: The MHSOAC authorizes the Executive Director to pursue discussions with the Legislature consistent with the direction given by the Commission.

ASSEMBLY BILL No. 2325

Introduced by Assembly Member Irwin

February 13, 2018

An act to amend Section 5600.3 of the Welfare and Institutions Code, relating to mental health services.

legislative counsel's digest

AB 2325, as introduced, Irwin. County mental health services: veterans.

Existing law contains provisions governing the operation and financing of community mental health services for the mentally disordered in every county through locally administered and locally controlled community mental health programs. Existing law further provides that, to the extent resources are available, the primary goal of the use of funds deposited in the mental health account of the local health and welfare trust fund should be to serve specified target populations, including, among others, California veterans in need of mental health services who meet specified eligibility requirements. Existing law prohibits a county from denying county mental health services to an eligible veteran based solely on his or her status as a veteran. Existing law requires a county to refer a veteran to the county veterans service officer, if any, to determine the veteran's eligibility for, and the availability of, mental health services provided by the United States Department of Veterans Affairs or any other federal health care provider.

This bill would prevent a county from denying an eligible veteran county mental or behavioral health services while the veteran is waiting for a determination of eligibility for, and availability of, mental or

behavioral health services provided by the United States Department of Veterans Affairs. The bill would make specific findings and declarations about the county's duty to provide mental and behavioral health services to veterans.

Vote: majority. Appropriation: no. Fiscal committee: no. State-mandated local program: no.

The people of the State of California do enact as follows:

1 SECTION 1. (a) It is the intent of the Legislature to do both
2 of the following:
3 (1) Enact legislation to make statutory changes to address the
4 mental and behavioral health needs of veterans in California and
5 to explore the opportunities for meeting those needs by improving
6 access to mental health services for veterans in California.
7 (2) Improve access for veterans by connecting them to mental
8 and behavioral health care services closer to home regardless of
9 insurance coverage or eligibility for Medi-Cal or any other federal
10 health care services, including, but not limited to, federal Veterans
11 Administration eligibility.
12 (b) The Legislature finds and declares all of the following:
13 (1) Veterans in the counties are eligible for county mental and
14 behavioral health services in the same manner as any other adult
15 in the county, whether or not they are eligible for mental and
16 behavioral health services from the federal Department of Veterans
17 Affairs.
18 (2) The process of determining eligibility for services through
19 the federal Department of Veterans Affairs can sometimes be a
20 time-consuming process. Veterans should not have to wait to
21 receive needed mental and behavioral health care while they await
22 federal eligibility determination if another similarly situated adult
23 could receive those services in his or her county.
24 (3) Mental and behavioral health services may not be available
25 in a timely manner or in an accessible location when a veteran is
26 eligible for benefits from the federal Department of Veterans
27 Affairs. Veterans who need services in a county and cannot receive
28 them in an adequate, timely, or accessible manner from another
29 source should be treated like any other adult in the county and
30 provided with those services through county mental health.

(4) Veterans who are eligible for and in need of county mental and behavioral health services should be treated in the same manner as any other adult in need of those services and should be provided those services through county mental health programs, irrespective of funding source.

SEC. 2. Section 5600.3 of the Welfare and Institutions Code is amended to read:

5600.3. To the extent resources are available, the primary goal of the use of funds deposited in the mental health account of the local health and welfare trust fund should be to serve the target populations identified in the following categories, which shall not be construed as establishing an order of priority:

(a) (1) Seriously emotionally disturbed children or adolescents.

(2) For the purposes of this part, "seriously emotionally disturbed children or adolescents" means minors under the age of 18 years who have a mental disorder as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance use disorder or developmental disorder, which results in behavior inappropriate to the child's age according to expected developmental norms. Members of this target population shall meet one or more of the following criteria:

(A) As a result of the mental disorder, the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community; and either of the following occur:

(i) The child is at risk of removal from home or has already been removed from the home.

(ii) The mental disorder and impairments have been present for more than six months or are likely to continue for more than one year without treatment.

(B) The child displays one of the following: psychotic features, risk of suicide or risk of violence due to a mental disorder.

(C) The child has been assessed pursuant to Article 2 (commencing with Section 56320) of Chapter 4 of Part 30 of Division 4 of Title 2 of the Education Code and determined to have an emotional disturbance, as defined in paragraph (4) of subdivision (c) of Section 300.8 of Title 34 of the Code of Federal Regulations.

1 (b) (1) Adults and older adults who have a serious mental
2 disorder.
3 (2) For the purposes of this part, "serious mental disorder"
4 means a mental disorder that is severe in degree and persistent in
5 duration, which may cause behavioral functioning which interferes
6 substantially with the primary activities of daily living, and which
7 may result in an inability to maintain stable adjustment and
8 independent functioning without treatment, support, and
9 rehabilitation for a long or indefinite period of time. Serious mental
10 disorders include, but are not limited to, schizophrenia, bipolar
11 disorder, post-traumatic stress disorder, as well as major affective
12 disorders or other severely disabling mental disorders. This section
13 shall not be construed to exclude persons with a serious mental
14 disorder and a diagnosis of substance abuse, developmental
15 disability, or other physical or mental disorder.
16 (3) Members of this target population shall meet all of the
17 following criteria:
18 (A) The person has a mental disorder as identified in the most
19 recent edition of the Diagnostic and Statistical Manual of Mental
20 Disorders, other than a substance use disorder or developmental
21 disorder or acquired traumatic brain injury pursuant to subdivision
22 (a) of Section 4354 unless that person also has a serious mental
23 disorder as defined in paragraph (2).
24 (B) (i) As a result of the mental disorder, the person has
25 substantial functional impairments or symptoms, or a psychiatric
26 history demonstrating that without treatment there is an imminent
27 risk of decompensation to having substantial impairments or
28 symptoms.
29 (ii) For the purposes of this part, "functional impairment" means
30 being substantially impaired as the result of a mental disorder in
31 independent living, social relationships, vocational skills, or
32 physical condition.
33 (C) As a result of a mental functional impairment and
34 circumstances, the person is likely to become so disabled as to
35 require public assistance, services, or entitlements.
36 (4) For the purpose of organizing outreach and treatment options,
37 to the extent resources are available, this target population includes,
38 but is not limited to, persons who are any of the following:
39 (A) Homeless persons who are mentally ill.

1 (B) Persons evaluated by appropriately licensed persons as
2 requiring care in acute treatment facilities including state hospitals,
3 acute inpatient facilities, institutes for mental disease, and crisis
4 residential programs.
5 (C) Persons arrested or convicted of crimes.
6 (D) Persons who require acute treatment as a result of a first
7 episode of mental illness with psychotic features.
8 (5) California veterans in need of mental health services and
9 who meet the existing eligibility requirements of this section, shall
10 be provided services to the extent services are available to other
11 adults pursuant to this section. Veterans who may be eligible for
12 mental health services through the United States Department of
13 Veterans Affairs should be advised of these services by the county
14 and assisted in linking to those ~~services.~~ *services, but the eligible*
15 *veteran shall not be denied county mental or behavioral health*
16 *services while waiting for a determination of eligibility for, and*
17 *availability of, mental or behavioral health services provided by*
18 *the United States Department of Veterans Affairs.*
19 (A) ~~No~~ *An* eligible veteran shall *not* be denied county mental
20 health services based solely on his or her status as a ~~veteran.~~
21 *veteran, including whether or not the person is eligible for services*
22 *provided by the United States Department of Veterans Affairs.*
23 (B) Counties shall refer a veteran to the county veterans service
24 officer, if any, to determine the veteran's eligibility for, and the
25 availability of, mental health services provided by the United States
26 Department of Veterans Affairs or other federal health care
27 provider.
28 (C) Counties should consider contracting with community-based
29 veterans' services agencies, where possible, to provide high-quality,
30 veteran specific mental health services.
31 (c) Adults or older adults who require or are at risk of requiring
32 acute psychiatric inpatient care, residential treatment, or outpatient
33 crisis intervention because of a mental disorder with symptoms of
34 psychosis, suicidality, or violence.
35 (d) Persons who need brief treatment as a result of a natural
36 disaster or severe local emergency.

O

SENATE BILL No. 1019

Introduced by Senator Beall

February 7, 2018

An act to amend Section 5848.5 of, and to add Part 5.5 (commencing with Section 5920) to Division 5 of, the Welfare and Institutions Code, relating to youth mental health.

LEGISLATIVE COUNSEL'S DIGEST

SB 1019, as introduced, Beall. Youth mental health and substance use disorder services.

(1) Existing law establishes the Investment in Mental Health Wellness Act of 2013. Existing law provides that funds appropriated by the Legislature to the California Health Facilities Financing Authority and the Mental Health Services Oversight and Accountability Commission for the purposes of the act be made available to selected counties or counties acting jointly, except as otherwise provided, and used to provide, among other things, a complete continuum of crisis services for children and youth 21 years of age and under regardless of where they live in the state. The act requires the commission to allocate funds to triage personnel, as specified.

This bill would require the commission, when making these funds available, to allocate at least onehalf of those funds for services or programs targeted at children and youth 18 years of age and under.

(2) Existing law requires school districts, county offices of education, and special education local plan areas (SELPAs) to comply with state laws that implement the federal Individuals with Disabilities Education Act, in order that the state may qualify for federal funds available for the education of individuals with exceptional needs. Existing law requires school districts, county offices of education, and SELPAs to identify, locate, and assess individuals with exceptional needs and to

provide those pupils with a free appropriate public education in the least restrictive environment, and with special education and related services, including mental health services, as reflected in an individualized education program.

This bill would authorize a county, or a qualified provider operating as part of the county mental health plan network, and a local educational agency to enter into a partnership to create a program that includes, among other things, targeted interventions for pupils with identified social-emotional, behavioral, and academic needs and an agreement that establishes a Medi-Cal mental health provider that is county-operated or county-contracted for the provision of mental health and substance use disorder services to pupils of the local educational agency and in which there are provisions for the delivery of campus-based mental health and substance use disorder services through qualified providers or qualified professionals to provide on-campus support to identify pupils with an individualized education program (IEP), and pupils who do not have an IEP, but who a teacher believes may require mental health or substance use disorder services and, with parental consent, to provide those services to those pupils.

The bill would require the Mental Health Services Oversight and Accountability Commission, in consultation with the State Department of Education and the State Department of Health Care Services, to develop guidelines for the use of funds from the Mental Health Services Fund by a county for innovative programs and prevention and early intervention programs to enter into and support the above-mentioned partnerships. The bill would additionally require the commission to develop guidelines for the use of funds appropriated for the Investment in Mental Health Wellness Act of 2013 by a county to enter into and support these partnerships. The bill would create the County and Local Educational Agency Partnership Fund in the State Treasury, which would be available, upon appropriation by the Legislature, to the State Department of Education for the purpose of funding these partnerships, as specified, and would require the State Department of Education to fund these partnerships through a competitive grant program. The bill would also make related findings and declarations.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

The people of the State of California do enact as follows:

1 SECTION 1. The Legislature finds and declares all of the
2 following:
3 (a) Student mental health and substance use problems are often
4 manifestations of childhood trauma, such as exposure to family
5 and community violence.
6 (b) Included among the numerous long-term negative health,
7 social, and educational outcomes associated with childhood trauma
8 are special health care needs, suicide attempts and depression,
9 alcoholism and injection drug use, learning difficulties and delays
10 on cognitive and social-emotional indicators, low school
11 engagement and attendance problems, repeating a grade and
12 academic failure, bullying, dating violence, delinquent behavior,
13 physical fighting, and weapon carrying.
14 (c) Investing in helping students effectively cope with and
15 overcome trauma is particularly important for addressing substance
16 use problems given the strong link between early adversity and
17 substance use. For example, compared to individuals with zero
18 Adverse Childhood Experiences (ACEs), individuals with four or
19 more ACEs are 10.3 times as likely to have ever injected drugs,
20 7.4 times as likely to consider themselves an alcoholic, and 4.7
21 times as likely to have ever used illicit drugs.
22 (d) Mental illness and substance use disorders are so often
23 cooccurring that a joint statement by the American Psychiatric
24 Association and the American Society for Addiction Medicine
25 concluded that it should be the expectation and not the exception.
26 According to the Surgeon General, nearly 50 percent of people
27 with substance use disorders have a cooccurring mental illness.
28 The joint statement also concluded that when there is a cooccurring
29 condition, it should be treated in an integrated program that
30 simultaneously addresses both conditions.
31 (e) Schools are the best place for early identification and
32 alleviation of behavioral health challenges that are likely to lead
33 to serious mental illness or substance use disorders if not addressed
34 early in their onset.
35 (f) Multitiered models to improve school climate and culture
36 and to ensure prompt referral for support for students showing any
37 level of challenge and comprehensive integrated services for those
38 with serious emotional disturbances or substance use disorders

1 have been demonstrated to have the best outcomes in improving
2 student health and academic performance.
3 (g) These integrated models, when able to leverage public or
4 private health insurance funds, demonstrate that early investments
5 pay for themselves in reduced special education costs and improved
6 academic success with reducing school dropout rates and related
7 problems.
8 SEC. 2. Section 5848.5 of the Welfare and Institutions Code
9 is amended to read:
10 5848.5. (a) The Legislature finds and declares all of the
11 following:
12 (1) California has realigned public community mental health
13 services to counties and it is imperative that sufficient
14 community-based resources be available to meet the mental health
15 needs of eligible individuals.
16 (2) Increasing access to effective outpatient and crisis
17 stabilization services provides an opportunity to reduce costs
18 associated with expensive inpatient and emergency room care and
19 to better meet the needs of individuals with mental health disorders
20 in the least restrictive manner possible.
21 (3) Almost one-fifth of people with mental health disorders visit
22 a hospital emergency room at least once per year. If an adequate
23 array of crisis services is not available, it leaves an individual with
24 little choice but to access an emergency room for assistance and,
25 potentially, an unnecessary inpatient hospitalization.
26 (4) Recent reports have called attention to a continuing problem
27 of inappropriate and unnecessary utilization of hospital emergency
28 rooms in California due to limited community-based services for
29 individuals in psychological distress and acute psychiatric crisis.
30 Hospitals report that 70 percent of people taken to emergency
31 rooms for psychiatric evaluation can be stabilized and transferred
32 to a less intensive level of crisis care. Law enforcement personnel
33 report that their personnel need to stay with people in the
34 emergency room waiting area until a placement is found, and that
35 less intensive levels of care tend not to be available.
36 (5) Comprehensive public and private partnerships at both local
37 and regional levels, including across physical health services,
38 mental health, substance use disorder, law enforcement, social
39 services, and related supports, are necessary to develop and
40 maintain high quality, patient-centered, and cost-effective care for

1 individuals with mental health disorders that facilitates their
2 recovery and leads towards wellness.
3 (6) The recovery of individuals with mental health disorders is
4 important for all levels of government, business, and the local
5 community.
6 (b) This section shall be known, and may be cited, as the
7 Investment in Mental Health Wellness Act of 2013. The objectives
8 of this section are to do all of the following:
9 (1) Expand access to early intervention and treatment services
10 to improve the client experience, achieve recovery and wellness,
11 and reduce costs.
12 (2) Expand the continuum of services to address crisis
13 intervention, crisis stabilization, and crisis residential treatment
14 needs that are wellness, resiliency, and recovery oriented.
15 (3) Add at least 25 mobile crisis support teams and at least 2,000
16 crisis stabilization and crisis residential treatment beds to bolster
17 capacity at the local level to improve access to mental health crisis
18 services and address unmet mental health care needs.
19 (4) Add at least 600 triage personnel to provide intensive case
20 management and linkage to services for individuals with mental
21 health care disorders at various points of access, such as at
22 designated community-based service points, homeless shelters,
23 and clinics.
24 (5) Reduce unnecessary hospitalizations and inpatient days by
25 appropriately utilizing community-based services and improving
26 access to timely assistance.
27 (6) Reduce recidivism and mitigate unnecessary expenditures
28 of local law enforcement.
29 (7) Provide local communities with increased financial resources
30 to leverage additional public and private funding sources to achieve
31 improved networks of care for individuals with mental health
32 disorders.
33 (8) Provide a complete continuum of crisis services for children
34 and youth 21 years of age and under regardless of where they live
35 in the state. The funds included in the 2016 Budget Act for the
36 purpose of developing the continuum of mental health crisis
37 services for children and youth 21 years of age and under shall be
38 for the following objectives:
39 (A) Provide a continuum of crisis services for children and youth
40 21 years of age and under regardless of where they live in the state.

(B) Provide for early intervention and treatment services to improve the client experience, achieve recovery and wellness, and reduce costs.

(C) Expand the continuum of community-based services to address crisis intervention, crisis stabilization, and crisis residential treatment needs that are wellness-, resiliency-, and recovery-oriented.

(D) Add at least 200 mobile crisis support teams.

(E) Add at least 120 crisis stabilization services and beds and crisis residential treatment beds to increase capacity at the local level to improve access to mental health crisis services and address unmet mental health care needs.

(F) Add triage personnel to provide intensive case management and linkage to services for individuals with mental health care disorders at various points of access, such as at designated community-based service points, homeless shelters, schools, and clinics.

(G) Expand family respite care to help families and sustain caregiver health and well-being.

(H) Expand family supportive training and related services designed to help families participate in the planning process, access services, and navigate programs.

(I) Reduce unnecessary hospitalizations and inpatient days by appropriately utilizing community-based services.

(J) Reduce recidivism and mitigate unnecessary expenditures of local law enforcement.

(K) Provide local communities with increased financial resources to leverage additional public and private funding sources to achieve improved networks of care for children and youth 21 years of age and under with mental health disorders.

(c) Through appropriations provided in the annual Budget Act for this purpose, it is the intent of the Legislature to authorize the California Health Facilities Financing Authority, hereafter referred to as the authority, and the Mental Health Services Oversight and Accountability Commission, hereafter referred to as the commission, to administer competitive selection processes as provided in this section for capital capacity and program expansion to increase capacity for mobile crisis support, crisis intervention, crisis stabilization services, crisis residential treatment, and specified personnel resources.

1 (d) Funds appropriated by the Legislature to the authority for
2 purposes of this section shall be made available to selected
3 counties, or counties acting jointly. The authority may, at its
4 discretion, also give consideration to private nonprofit corporations
5 and public agencies in an area or region of the state if a county, or
6 counties acting jointly, affirmatively supports this designation and
7 collaboration in lieu of a county government directly receiving
8 grant funds.
9 (1) Grant awards made by the authority shall be used to expand
10 local resources for the development, capital, equipment acquisition,
11 and applicable program startup or expansion costs to increase
12 capacity for client assistance and services in the following areas:
13 (A) Crisis intervention, as authorized by Sections 14021.4,
14 14680, and 14684.
15 (B) Crisis stabilization, as authorized by Sections 14021.4,
16 14680, and 14684.
17 (C) Crisis residential treatment, as authorized by Sections
18 14021.4, 14680, and 14684 and as provided at a children's crisis
19 residential program, as defined in Section 1502 of the Health and
20 Safety Code.
21 (D) Rehabilitative mental health services, as authorized by
22 Sections 14021.4, 14680, and 14684.
23 (E) Mobile crisis support teams, including personnel and
24 equipment, such as the purchase of vehicles.
25 (2) The authority shall develop selection criteria to expand local
26 resources, including those described in paragraph (1), and processes
27 for awarding grants after consulting with representatives and
28 interested stakeholders from the mental health community,
29 including, but not limited to, the County Behavioral Health
30 Directors Association of California, service providers, consumer
31 organizations, and other appropriate interests, such as health care
32 providers and law enforcement, as determined by the authority.
33 The authority shall ensure that grants result in cost-effective
34 expansion of the number of community-based crisis resources in
35 regions and communities selected for funding. The authority shall
36 also take into account at least the following criteria and factors
37 when selecting recipients of grants and determining the amount
38 of grant awards:
39 (A) Description of need, including, at a minimum, a
40 comprehensive description of the project, community need,

population to be served, linkage with other public systems of health and mental health care, linkage with local law enforcement, social services, and related assistance, as applicable, and a description of the request for funding.

(B) Ability to serve the target population, which includes individuals eligible for Medi-Cal and individuals eligible for county health and mental health services.

(C) Geographic areas or regions of the state to be eligible for grant awards, which may include rural, suburban, and urban areas, and may include use of the five regional designations utilized by the County Behavioral Health Directors Association of California.

(D) Level of community engagement and commitment to project completion.

(E) Financial support that, in addition to a grant that may be awarded by the authority, will be sufficient to complete and operate the project for which the grant from the authority is awarded.

(F) Ability to provide additional funding support to the project, including public or private funding, federal tax credits and grants, foundation support, and other collaborative efforts.

(G) Memorandum of understanding among project partners, if applicable.

(H) Information regarding the legal status of the collaborating partners, if applicable.

(I) Ability to measure key outcomes, including improved access to services, health and mental health outcomes, and cost benefit of the project.

(3) The authority shall determine maximum grants awards, which shall take into consideration the number of projects awarded to the grantee, as described in paragraph (1), and shall reflect reasonable costs for the project and geographic region. The authority may allocate a grant in increments contingent upon the phases of a project.

(4) Funds awarded by the authority pursuant to this section may be used to supplement, but not to supplant, existing financial and resource commitments of the grantee or any other member of a collaborative effort that has been awarded a grant.

(5) All projects that are awarded grants by the authority shall be completed within a reasonable period of time, to be determined by the authority. Funds shall not be released by the authority until the applicant demonstrates project readiness to the authority's

satisfaction. If the authority determines that a grant recipient has failed to complete the project under the terms specified in awarding the grant, the authority may require remedies, including the return of all or a portion of the grant.

(6) A grantee that receives a grant from the authority under this section shall commit to using that capital capacity and program expansion project, such as the mobile crisis team, crisis stabilization unit, or crisis residential treatment program, for the duration of the expected life of the project.

(7) The authority may consult with a technical assistance entity, as described in paragraph (5) of subdivision (a) of Section 4061, for purposes of implementing this section.

(8) The authority may adopt emergency regulations relating to the grants for the capital capacity and program expansion projects described in this section, including emergency regulations that define eligible costs and determine minimum and maximum grant amounts.

(9) The authority shall provide reports to the fiscal and policy committees of the Legislature on or before May 1, 2014, and on or before May 1, 2015, on the progress of implementation, that include, but are not limited to, the following:

(A) A description of each project awarded funding.

(B) The amount of each grant issued.

(C) A description of other sources of funding for each project.

(D) The total amount of grants issued.

(E) A description of project operation and implementation, including who is being served.

(10) A recipient of a grant provided pursuant to paragraph (1) shall adhere to all applicable laws relating to scope of practice, licensure, certification, staffing, and building codes.

(e) Of the funds specified in paragraph (8) of subdivision (b), it is the intent of the Legislature to authorize the authority and the commission to administer competitive selection processes as provided in this section for capital capacity and program expansion to increase capacity for mobile crisis support, crisis intervention, crisis stabilization services, crisis residential treatment, family respite care, family supportive training and related services, and triage personnel resources for children and youth 21 years of age and under.

1 (f) Funds appropriated by the Legislature to the authority to
2 address crisis services for children and youth 21 years of age and
3 under for the purposes of this section shall be made available to
4 selected counties or counties acting jointly. The authority may, at
5 its discretion, also give consideration to private nonprofit
6 corporations and public agencies in an area or region of the state
7 if a county, or counties acting jointly, affirmatively support this
8 designation and collaboration in lieu of a county government
9 directly receiving grant funds.
10 (1) Grant awards made by the authority shall be used to expand
11 local resources for the development, capital, equipment acquisition,
12 and applicable program startup or expansion costs to increase
13 capacity for client assistance and crisis services for children and
14 youth 21 years of age and under in the following areas:
15 (A) Crisis intervention, as authorized by Sections 14021.4,
16 14680, and 14684.
17 (B) Crisis stabilization, as authorized by Sections 14021.4,
18 14680, and 14684.
19 (C) Crisis residential treatment, as authorized by Sections
20 14021.4, 14680, and 14684 and as provided at a children's crisis
21 residential program, as defined in Section 1502 of the Health and
22 Safety Code.
23 (D) Mobile crisis support teams, including the purchase of
24 equipment and vehicles.
25 (E) Family respite care.
26 (2) The authority shall develop selection criteria to expand local
27 resources, including those described in paragraph (1), and processes
28 for awarding grants after consulting with representatives and
29 interested stakeholders from the mental health community,
30 including, but not limited to, county mental health directors, service
31 providers, consumer organizations, and other appropriate interests,
32 such as health care providers and law enforcement, as determined
33 by the authority. The authority shall ensure that grants result in
34 cost-effective expansion of the number of community-based crisis
35 resources in regions and communities selected for funding. The
36 authority shall also take into account at least the following criteria
37 and factors when selecting recipients of grants and determining
38 the amount of grant awards:
39 (A) Description of need, including, at a minimum, a
40 comprehensive description of the project, community need,

1 population to be served, linkage with other public systems of health
2 and mental health care, linkage with local law enforcement, social
3 services, and related assistance, as applicable, and a description
4 of the request for funding.
5 (B) Ability to serve the target population, which includes
6 individuals eligible for Medi-Cal and individuals eligible for county
7 health and mental health services.
8 (C) Geographic areas or regions of the state to be eligible for
9 grant awards, which may include rural, suburban, and urban areas,
10 and may include use of the five regional designations utilized by
11 the California Behavioral Health Directors Association.
12 (D) Level of community engagement and commitment to project
13 completion.
14 (E) Financial support that, in addition to a grant that may be
15 awarded by the authority, will be sufficient to complete and operate
16 the project for which the grant from the authority is awarded.
17 (F) Ability to provide additional funding support to the project,
18 including public or private funding, federal tax credits and grants,
19 foundation support, and other collaborative efforts.
20 (G) Memorandum of understanding among project partners, if
21 applicable.
22 (H) Information regarding the legal status of the collaborating
23 partners, if applicable.
24 (I) Ability to measure key outcomes, including utilization of
25 services, health and mental health outcomes, and cost benefit of
26 the project.
27 (3) The authority shall determine maximum grant awards, which
28 shall take into consideration the number of projects awarded to
29 the grantee, as described in paragraph (1), and shall reflect
30 reasonable costs for the project, geographic region, and target ages.
31 The authority may allocate a grant in increments contingent upon
32 the phases of a project.
33 (4) Funds awarded by the authority pursuant to this section may
34 be used to supplement, but not to supplant, existing financial and
35 resource commitments of the grantee or any other member of a
36 collaborative effort that has been awarded a grant.
37 (5) All projects that are awarded grants by the authority shall
38 be completed within a reasonable period of time, to be determined
39 by the authority. Funds shall not be released by the authority until
40 the applicant demonstrates project readiness to the authority's

satisfaction. If the authority determines that a grant recipient has failed to complete the project under the terms specified in awarding the grant, the authority may require remedies, including the return of all, or a portion, of the grant.

(6) A grantee that receives a grant from the authority under this section shall commit to using that capital capacity and program expansion project, such as the mobile crisis team, crisis stabilization unit, family respite care, or crisis residential treatment program, for the duration of the expected life of the project.

(7) The authority may consult with a technical assistance entity, as described in paragraph (5) of subdivision (a) of Section 4061, for the purposes of implementing this section.

(8) The authority may adopt emergency regulations relating to the grants for the capital capacity and program expansion projects described in this section, including emergency regulations that define eligible costs and determine minimum and maximum grant amounts.

(9) The authority shall provide reports to the fiscal and policy committees of the Legislature on or before January 10, 2018, and annually thereafter, on the progress of implementation, that include, but are not limited to, the following:

(A) A description of each project awarded funding.

(B) The amount of each grant issued.

(C) A description of other sources of funding for each project.

(D) The total amount of grants issued.

(E) A description of project operation and implementation, including who is being served.

(10) A recipient of a grant provided pursuant to paragraph (1) shall adhere to all applicable laws relating to scope of practice, licensure, certification, staffing, and building codes.

(g) Funds appropriated by the Legislature to the commission for purposes of this section shall be allocated for triage personnel to provide intensive case management and linkage to services for individuals with mental health disorders at various points of access. These funds shall be made available to selected counties, counties acting jointly, or city mental health departments, as determined by the commission through a selection process. It is the intent of the Legislature for these funds to be allocated in an efficient manner to encourage early intervention and receipt of needed services for individuals with mental health disorders, and to assist in navigating

1 the local service sector to improve efficiencies and the delivery of
2 services.
3 (1) Triage personnel may provide targeted case management
4 services face to face, by telephone, or by telehealth with the
5 individual in need of assistance or his or her significant support
6 person, and may be provided anywhere in the community. These
7 service activities may include, but are not limited to, the following:
8 (A) Communication, coordination, and referral.
9 (B) Monitoring service delivery to ensure the individual accesses
10 and receives services.
11 (C) Monitoring the individual's progress.
12 (D) Providing placement service assistance and service plan
13 development.
14 (2) The commission shall take into account at least the following
15 criteria and factors when selecting recipients and determining the
16 amount of grant awards for triage personnel as follows:
17 (A) Description of need, including potential gaps in local service
18 connections.
19 (B) Description of funding request, including personnel and use
20 of peer support.
21 (C) Description of how triage personnel will be used to facilitate
22 linkage and access to services, including objectives and anticipated
23 outcomes.
24 (D) Ability to obtain federal Medicaid reimbursement, when
25 applicable.
26 (E) Ability to administer an effective service program and the
27 degree to which local agencies and service providers will support
28 and collaborate with the triage personnel effort.
29 (F) Geographic areas or regions of the state to be eligible for
30 grant awards, which shall include rural, suburban, and urban areas,
31 and may include use of the five regional designations utilized by
32 the County Behavioral Health Directors Association of California.
33 (3) The commission shall determine maximum grant awards,
34 and shall take into consideration the level of need, population to
35 be served, and related criteria, as described in paragraph (2), and
36 shall reflect reasonable costs.
37 (4) Funds awarded by the commission for purposes of this
38 section may be used to supplement, but not supplant, existing
39 financial and resource commitments of the county, counties acting
40 jointly, or city mental health department that received the grant.

1 (5) Notwithstanding any other law, a county, counties acting
2 jointly, or city mental health department that receives an award of
3 funds for the purpose of supporting triage personnel pursuant to
4 this subdivision is not required to provide a matching contribution
5 of local funds.
6 (6) Notwithstanding any other law, the commission, without
7 taking any further regulatory action, may implement, interpret, or
8 make specific this section by means of informational letters,
9 bulletins, or similar instructions.
10 (7) The commission shall provide a status report to the fiscal
11 and policy committees of the Legislature on the progress of
12 implementation no later than March 1, 2014.
13 (h) Funds appropriated by the Legislature to the commission
14 pursuant to paragraph (8) of subdivision (b) for the purposes of
15 addressing children's crisis services shall be allocated to support
16 triage personnel and family supportive training and related services.
17 These funds shall be made available to selected counties, counties
18 acting jointly, or city mental health departments, as determined
19 by the commission through a selection process. The commission
20 may, at its discretion, also give consideration to private nonprofit
21 corporations and public agencies in an area or region of the state
22 if a county, or counties acting jointly, affirmatively supports this
23 designation and collaboration in lieu of a county government
24 directly receiving grant funds.
25 (1) These funds may provide for a range of crisis-related services
26 for a child in need of assistance, or his or her parent, guardian, or
27 caregiver. These service activities may include, but are not limited
28 to, the following:
29 (A) Intensive coordination of care and services.
30 (B) Communication, coordination, and referral.
31 (C) Monitoring service delivery to the child or youth.
32 (D) Monitoring the child's progress.
33 (E) Providing placement service assistance and service plan
34 development.
35 (F) Crisis or safety planning.
36 (2) The commission shall take into account at least the following
37 criteria and factors when selecting recipients and determining the
38 amount of grant awards for these funds, as follows:
39 (A) Description of need, including potential gaps in local service
40 connections.

1 (B) Description of funding request, including personnel.
2 (C) Description of how personnel and other services will be
3 used to facilitate linkage and access to services, including
4 objectives and anticipated outcomes.
5 (D) Ability to obtain federal Medicaid reimbursement, when
6 applicable.
7 (E) Ability to provide a matching contribution of local funds.
8 (F) Ability to administer an effective service program and the
9 degree to which local agencies and service providers will support
10 and collaborate with the triage personnel effort.
11 (G) Geographic areas or regions of the state to be eligible for
12 grant awards, which shall include rural, suburban, and urban areas,
13 and may include use of the five regional designations utilized by
14 the County Behavioral Health Directors Association of California.
15 (3) The commission shall determine maximum grant awards,
16 and shall take into consideration the level of need, population to
17 be served, and related criteria, as described in paragraph (2), and
18 shall reflect reasonable costs.
19 (4) Funds awarded by the commission for purposes of this
20 section may be used to supplement, but not supplant, existing
21 financial and resource commitments of the county, counties acting
22 jointly, or a city mental health department that received the grant.
23 (5) Notwithstanding any other law, a county, counties acting
24 jointly, or a city mental health department that receives an award
25 of funds for the purpose of this section is not required to provide
26 a matching contribution of local funds.
27 (6) Notwithstanding any other law, the commission, without
28 taking any further regulatory action, may implement, interpret, or
29 make specific this section by means of informational letters,
30 bulletins, or similar instructions.
31 (7) The commission may waive requirements in this section for
32 counties with a population of 100,000 or less, if the commission
33 determines it is in the best interest of the state and meets the intent
34 of the law.
35 (8) The commission shall provide a status report to the fiscal
36 and policy committees of the Legislature on the progress of
37 implementation no later than January 10, 2018, and annually
38 thereafter.
39 *(i) When making funds appropriated by the Legislature available*
40 *pursuant to this section, the commission shall allocate at least*

one–half of the funds for services or programs targeted at children and youth 18 years of age and under.

SEC. 3. Part 5.5 (commencing with Section 5920) is added to Division 5 of the Welfare and Institutions Code, to read:

PART 5.5. COUNTY AND LOCAL EDUCATIONAL AGENCY PARTNERSHIPS

5920. (a) Notwithstanding any other law, a county, or a qualified provider operating as part of the county mental health plan network that provides substance use disorder services, and a local educational agency may enter into a partnership to create a program that, in addition to reflecting each school's specified culture and needs, includes all of the following:

(1) Leveraging of school and community resources to offer comprehensive multitiered interventions on a sustainable basis.

(2) An initial school climate assessment that includes information from multiple stakeholders, including school staff, pupils, and families, that is used to inform the selection of strategies and interventions that reflect the culture and goals of the school.

(3) A coordination of services team that considers referrals for services, oversees schoolwide efforts, and uses data-informed processes to identify struggling pupils who require early interventions.

(4) Whole school strategies that address school climate and universal pupil well-being, such as positive behavioral interventions and supports, as well as comprehensive professional development opportunities, that build the capacity of the entire school community to recognize and respond to the unique social-emotional, behavioral, and academic needs of pupils.

(5) Targeted interventions for pupils with identified social-emotional, behavioral, and academic needs, such as therapeutic group interventions, functional behavioral analysis and plan development, targeted skill groups, and eligible services specified by the School-Based Early Mental Health Intervention and Prevention Services Matching Grant Program pursuant to subdivision (h) of Section 4380.

(6) Intensive services, such as wraparound, behavioral intervention, or one-on-one support, that can reduce the need for

1 a pupil's referral to special education or placement in more
2 restrictive, isolated settings.
3 (7) Specific strategies and practices that ensure parent
4 engagement with the school and provide parents with access to
5 resources that support their children's educational success.
6 (8) Utilization of designated governmental funds for eligible
7 Medi-Cal Early and Periodic Screening, Diagnosis, and Treatment
8 (EPSDT) services provided to pupils enrolled in Medi-Cal for
9 mental health and substance use disorder service costs, for
10 non-Medi-Cal enrolled pupils with an individualized education
11 program (IEP) pursuant to the federal Individuals with Disabilities
12 Education Act (20 U.S.C. Sec. 1400 et seq.), and for pupils who
13 do not have an IEP if the services are provided by a provider
14 specified in paragraph (9).
15 (9) (A) An agreement between the county mental health plan,
16 or the qualified provider, and the local educational agency that
17 establishes a Medi-Cal mental health provider that is
18 county-operated or county-contracted for the provision of mental
19 health and substance use disorder services to pupils of the local
20 educational agency. The agreement may include provisions for
21 the delivery of campus-based mental health and substance use
22 disorder services through qualified providers or qualified
23 professionals to provide on-campus support to identify pupils with
24 an IEP adopted pursuant to Section 504 of the federal
25 Rehabilitation Act of 1973 (29 U.S.C. Sec. 794(a)) and pupils who
26 do not have an IEP, but who a teacher believes may require those
27 services and, with parental consent, to provide mental health or
28 substance use disorder services to those pupils.
29 (B) The local educational agency, with the permission of the
30 pupil's parent, shall provide the county mental health plan provider
31 with the information of the health insurance carrier for each pupil.
32 (C) The agreement shall address how to cover the costs of
33 mental health and substance use disorder provider services not
34 covered by funds pursuant to paragraph (8) in the event that mental
35 health and substance use disorder service costs exceed the
36 agreed-upon funding outlined in the partnership agreement between
37 the county mental health plan, or the qualified provider, and the
38 local educational agency following a yearend cost reconciliation
39 process, and in the event that the local educational agency does
40 not elect to provide the services through other means. Nothing in

1 this subparagraph shall hold the local educational agency liable
2 for any costs that exceed the agreed-upon funding outlined in the
3 partnership agreement.
4 (D) The agreement shall fulfill reporting and all other
5 requirements under state and federal Individuals with Disabilities
6 Education Act (20 U.S.C. Sec. 1400 et seq.) and Medi-Cal EPSDT
7 provisions, and measure the effect of the mental health and
8 substance use disorder intervention and how that intervention meets
9 the goals in a pupil's IEP or relevant plan for non-IEP pupils.
10 (E) The agreement shall include a process for resolving
11 disagreements between the local educational agency and county
12 mental health plan network related to any of the elements of the
13 agreement described in this paragraph.
14 (F) The agreement shall include strategies to support the
15 educational success of pupils who have repeated or prolonged
16 absences from school due to mental illness or substance abuse
17 disorders.
18 (10) A plan to establish a program described in this section in
19 at least one school within the local educational agency in the first
20 year and to expand the partnership to three additional schools
21 within three years.
22 (b) The partnership shall participate in the performance outcome
23 system established by the State Department of Health Care Services
24 pursuant to Section 14707.5 to measure results of services provided
25 under the partnership between the county mental health plan, or
26 the qualified provider, and the local educational agency.
27 (c) For purposes of this section, "local educational agency" has
28 the same meaning as that term is defined in Section 56026.3 of
29 the Education Code.
30 (d) When applicable, and to the extent mutually agreed to by a
31 school district and a plan or insurer, it is the intent of the
32 Legislature that a health care service plan or a health insurer be
33 authorized to participate in the partnerships described in this part.
34 5921. (a) (1) The Mental Health Services Oversight and
35 Accountability Commission, in consultation with the State
36 Department of Education and the State Department of Health Care
37 Services, shall develop guidelines for the use of funds appropriated
38 from the Mental Health Services Fund by a county for innovative
39 programs and prevention and early intervention programs to enter
40 into and support the partnerships described in this part.

1 (2) The guidelines shall include provisions for integration with
2 funds and services supplemented with funds from the Youth
3 Education, Prevention, Early Intervention and Treatment Account,
4 created pursuant to subdivision (f) of Section 34019 of the Revenue
5 and Taxation Code, to the extent that funds from that account are
6 appropriated for purposes of this part.
7 (b) The Mental Health Services Oversight and Accountability
8 Commission shall develop guidelines for the use of funds
9 appropriated by the Legislature for the purposes of Section 5848.5
10 by a county to enter into and support the partnerships described
11 in this part.
12 (c) The State Department of Education shall develop guidelines
13 for local educational agencies on the manner in which to enter into
14 partnerships described in this part.
15 (d) The State Department of Health Care Services shall develop
16 guidelines for county behavioral health departments on the manner
17 in which to use funds from the Mental Health Services Fund and
18 funds from the Medi-Cal program to enter into and support the
19 partnerships described in this part.
20 5922. (a) The County and Local Educational Agency
21 Partnership Fund is hereby created in the State Treasury. Moneys
22 in the fund are available, upon appropriation by the Legislature,
23 to the State Department of Education for the purpose of funding
24 the partnerships described in this part. The State Department of
25 Education shall fund partnerships described in this part through a
26 competitive grant program. Priority in funding shall be given to
27 partnerships with local educational agencies that have demonstrated
28 high levels of childhood adversity, including, but not limited to,
29 high-poverty local educational agencies and schools eligible under
30 the Community Eligibility Provision of the Healthy, Hunger-Free
31 Kids Act of 2010 (Public Law 111-296) and local educational
32 agencies and schools identified in the California Longitudinal Pupil
33 Achievement Data System as having high rates of foster youth and
34 homeless children and youth.
35 (b) (1) For the 2019–20 fiscal year and each fiscal year
36 thereafter, to the extent there is an appropriation in the annual
37 Budget Act or another act made for purposes of this part, the
38 Superintendent of Public Instruction shall allocate funds from that
39 appropriation to the County and Local Educational Agency
40 Partnership Fund.

1 (2) Other funds identified and appropriated by the Legislature
2 may also be deposited into the County and Local Educational
3 Agency Partnership Fund and used for the purposes specified in
4 subdivision (a).
5 (c) Funds made available in the annual Budget Act for the
6 purpose of providing educationally related mental health and
7 substance use disorder services, including out-of-home residential
8 services for emotionally disturbed pupils, whether required or not
9 by an individualized education program, shall be used only for
10 that purpose and shall not be deposited into the County and Local
11 Educational Agency Partnership Fund. Nothing in this subdivision
12 shall require the use of funds included in the minimum funding
13 obligation under Section 8 of Article XVI of the California
14 Constitution for the partnerships established by this part.
15 SEC. 4. It is the intent of the Legislature that, commencing
16 with the 2019–20 fiscal year, the State Department of Health Care
17 Services utilize funds from the Youth Education, Prevention, Early
18 Intervention and Treatment Account created pursuant to
19 subdivision (f) of Section 34019 of the Revenue and Taxation
20 Code to support the partnerships created pursuant to this act, and
21 to allocate a portion of those funds only to counties that also
22 provide funds from the Mental Health Services Fund and Medi-Cal
23 Early and Periodic Screening, Diagnosis, and Treatment mental
24 health and substance use disorder funds for the purposes of this
25 act.

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AGENDA ITEM 7

Information

February 22, 2018 Commission Meeting

Innovation (INN) Summit Update

Summary: The Mental Health Services Oversight and Accountability Commission (MHSOAC) will be presented with an update on the Innovation Summit held on February 2, 2018.

The MHSOAC along with several other partners, hosted California's first Innovation Summit on Mental Health. Innovate for Impact: Improving Access to High Quality Mental Health Care brought together mental health consumers, family and community members, public and private sector partners and health care leaders to strengthen our collective approach to innovation as a strategy for transformational change in our mental health system.

Presenters: Sharmil Shah, Psy.D. Chief of Program Operations; Shannon Tarter, Innovation Team Member

Enclosures: None

Handout: None

Recommended Action: Information Item Only

AGENDA ITEM 8

Action

February 22, 2018, Commission Meeting

Contract Authorization for Innovation Incubator Business Plan

Summary: The Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission) will consider authorizing the Executive Director to enter into a contract for approximately $150,000 to develop a business plan for an Innovation Incubator.

The Commission will create an Innovation Incubator to support program implementation, provide technical assistance and training and ensure that counties are fully leveraging innovation funds to improve California's mental health system. The Governor's budget included a proposal for the Commission for $2.5 million in FY 2018-19 and another $2.5 million in FY 2019-20 to set up an Innovation Incubator. The Innovation Incubator will help counties develop their innovation ideas, put them into practice, and share their learning with other counties.

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

Enclosures: None

Handouts: None

Proposed Motion: The Commission authorizes the Executive Director to enter into a contract for approximately $150,000 for the development of a business plan for an Innovation Incubator.