



WELLNESS • RECOVERY • RESILIENCE



Commission Packet

Commission Meeting
March 22, 2018

MHSOAC
1325 J Street, Suite 1700
Sacramento, CA 95814

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 Meeting Agenda

March 22, 2018
9:00 AM – 4:30 PM
MHSOAC
1325 J Street, Suite 1700
Sacramento, CA 95814

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.
Chair

AGENDA
March 22, 2018

Khatera Aslami-Tamplen
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 Meeting. Roll call will be taken.
- 9:05 AM** **Consumer Engagement**
A consumer or family member will open the Commission meeting with a story of recovery and resilience.
- 9:15 AM** **Action**
1: Approve February 8, 2018 and February 22, 2018 MHSOAC Meeting Minutes

The Commission will consider approval of the minutes from the February 8, 2018 and February 22, 2018 meetings.
- Public Comment
 - Vote
- 9:20 AM** **Information**
2: Schools and Mental Health Panels

Panel 1: The Lived Experience of Childhood Trauma and Resilience
- Emmerald Evans, Founding Member of Seneca Family of Agencies Youth Advisory Board
 - Jakaar Brandon, Transition Age Youth Advocate and Peer Counselor, Member of Seneca Family of Agencies
- 10:00 AM** Panel 2: Understanding Early Childhood Mental Health: Risks, Disparities, and Educational Outcomes
- Chandra Ghosh Ippen, Ph.D., Associate Director, Child Trauma Research Program, University of California, San Francisco
 - Gustavo Loera, Ed.D., Mental Health and Education Research Consultant, Center for Reducing Health Disparities, University of California, Davis
- 10:30 AM** Panel 3: Enhancing Opportunities for Prevention and Early Intervention
- Heather Little, M.Ed., Health Policy and Program Manager, First 5 Association of California
 - Natalie Woods Andrews, Ed.D., Director, Early Learning Department, Sacramento County Office of Education
 - Ruben Reyes, Superintendent, Robla School District
 - Ron Powell, Ph.D., Special Education Consultant, Early Childhood Mental Health Advocate

- 11:00 AM** **Panel 4: Strengthening California’s Response to Children’s Mental Health Needs**
- Curtiss Sarikey, MSW., Chief of Staff, Oakland Unified School District
 - Ted Lempert, J.D., President, Children Now

Public Comment on all of the Schools and Mental Health panels

- 11:40 AM** **General Public Comment**
Members of the public may briefly address the Commission on matters not on the agenda.

- 11:55 AM** **Lunch Break**
(Closed Session – Government Code Section 11126(a) related to personnel)

- 1:15 PM** **Report Back from Closed Session**
Chair John Boyd, Psy.D., will report back on any reportable action taken during closed session.

- 1:20 PM** **Information**
3: 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 February 22, 2018 Commission Meeting; (2) Evaluation Dashboard; (3) Calendar of Commission activities; (4) Innovation Review Outline; (5) Innovation Dashboard; and (6) Department of Health Care Services Revenue and Expenditure Reports status update.

- 1:30 PM** **Information**
4: California State Auditor’s February 2018 Report on the Mental Health Services Act
Presenter: Toby Ewing, Ph.D., Executive Director

The Commission will be presented with details regarding the State Auditor’s February 2018 Report on the Mental Health Services Act.

- Public Comment

- 2:00 PM** **Action**
5: Trinity County Innovation Plan
Presenters: Noel O’Neill, LMFT, Director; Marlinda Butler, MSW, MHSA Coordinator, Trinity County

The Commission will consider approval of \$267,000 to support a Trinity County Innovation Project.

- Public Comment
- Vote

2:30 PM

Action

6: San Francisco County Innovation Plan

Presenters: Imo Momoh, MPA, Director; Tracey Helton, MPA, CATC, Program Manager, San Francisco County; Jose Orbeta, Peer Specialist, San Francisco County

The Commission will consider approval of \$3,750,000 to support a San Francisco County Innovation Project.

- Public Comment
- Vote

3:00 PM

Action

7: Award Triage Program Grants

Presenters: Norma Pate, Deputy Director; Tom Orrock, Chief, Commission Operations and Grants; Kristal Antonicelli, Project Lead

The Commission will consider the award of the Triage Program grants in response to the Request for Applicants released by the Commission in December 2017.

- Public Comment
- Vote

3:30 PM

Action

8: 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

3:50 PM

Information

9: Stakeholder Contract Update

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

The Commission will hear an update on the progress of the advocacy, education and training, and outreach efforts of contracted stakeholders.

- Public Comment

4:10 PM

General Public Comment

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

4:30 PM

Adjourn

AGENDA ITEM 1

Action

March 22, 2018 Commission Meeting

Approve February 8, 2018 and February 22, 2018 MHSOAC Meeting Minutes

Summary: The Mental Health Services Oversight and Accountability Commission will review the minutes from the February 8, 2018 and February 22, 2018 meetings. Any edits to the minutes will be made and the minutes will be amended to reflect the changes and posted to the Commission Web site after the meeting. If an amendment is not necessary, the Commission will approve the minutes as presented.

Presenter: None.

Enclosures: (1) February 8, 2018 Teleconference Meeting Minutes and (2) February 22, 2018 Commission Meeting Minutes.

Handouts: None.

Recommended Action: Approve February 8, 2018 and February 22, 2018 Meeting Minutes.

Proposed Motion: The Commission approves the February 8, 2018 and February 22, 2018 Meeting Minutes.

State of California

**MENTAL HEALTH SERVICES
OVERSIGHT AND ACCOUNTABILITY COMMISSION**

Minutes of Meeting
February 22, 2018

MHSOAC
Darrell Steinberg Conference Room
1325 J Street, Suite 1700
Sacramento, CA 95814

866-817-6550; Code 3190377

Additional Public Locations

7775 North Palm Avenue
Fresno, CA 93711

2600 Sand Dunes Drive
Monterey, CA 93940

420 E 3rd Street
Los Angeles, CA 90013

315 N Camino Del Remedio
Santa Barbara, CA 93110

Members Participating:

John Boyd, Psy.D., Chair
Khatera Aslami-Tamplen, Vice Chair
Mayra Alvarez
Reneeta Anthony (via teleconference)
Lynne Ashbeck (via teleconference)

Keyondria Bunch, Ph.D. (via teleconference)
Mara Madrigal-Weiss
Gladys Mitchell
Larry Poaster, Ph.D. (via teleconference)
Tina Wooton (via teleconference)

Members Absent:

Senator Jim Beall
Sheriff Bill Brown
Assemblymember Wendy Carrillo

Itai Danovitch, M.D.
David Gordon

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
Tom Orrock, Chief, Commission Operations
and Grants
Sharmil Shah, Psy.D., Chief of Program
Operations

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

CONVENE AND WELCOME

Chair John Boyd called the meeting of the Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission) to order at 9:20 a.m. and welcomed everyone. Filomena Yeroshek, Chief Counsel, called the roll and confirmed the presence of a quorum.

Chair Boyd thanked staff for their work in putting together the Commission meetings. He asked attendees to give staff a round of applause.

Chair Boyd reviewed the meeting protocols.

Chair Boyd stated Chief Counsel Yeroshek will step out of the meeting and return later. Norma Pate, Deputy Director, Program, Legislation, and Technology, or Tom Orrock, Chief, Commission Operations and Grants, will handle the roll call votes during her absence.

Chair Boyd welcomed Assembly Member Wendy Carrillo to the Commission. He stated she was appointed by the Speaker last week and is currently serving on the Assembly Health Committee and the Public Safety Committee.

Chair Boyd welcomed Commissioner Alvarez to her first meeting and asked attendees to join him in giving her a round of applause.

Chair Boyd stated the California Mental Health Innovation Summit was held last month at Verily Life Sciences campus. Outcomes from the summit will be discussed later in the agenda. He stated he publicly acknowledged that, retrospectively, he wished there had been more intentional, deliberate planning around engaging young people.

Chair Boyd stated he made a two-fold commitment: to continue to work with the Governor's office in seeking support that one of the existing sixteen seats on the Commission is filled by a young person and to ensure that a young person is around the table at every Commission meeting to learn the Commission process and to be available to give their perspective on issues. He asked Audrey J., a student intern with the Commission, to introduce herself. Audrey J., California Montessori Project, stated she interned this week with the Commission, as part of her school requirements.

Chair Boyd stated Audrey J. will be available throughout the day to answer questions on what mental health looks like through the lens of a young person.

Chair Boyd stated the Commission made a commitment at the California Mental Health Innovation Summit to host a California Youth Mental Health Innovation Summit process to be led by young people. He asked Vice Chair Aslami-Tamplen to take the lead on that initiative. Executive Director Ewing is working on putting together a youth advisory group made up of approximately ten young people to help guide the process.

Chair Boyd stated that an event to discuss the Foundry, an integrated services for youth and young adults, will be held on March 7th to look at processes for young people globally that could work in California. The Foundry is in British Columbia and is based on a model called Head Space out of Australia, also known as Jigsaw, which brings everyone under one roof to support the needs of young people.

Chair Boyd stated Commissioners and staff have a commitment to public participation, planning, and predictability. The Commission has been working to hold a one- to two-day strategic planning effort. He stated Commissioner Ashbeck has done a phenomenal job in selecting the facilitator for the strategic planning effort. He asked that a contract be in place by the March meeting and that the public strategic planning effort be scheduled for over the summer.

Chair Boyd stated the Commission meetings for 2018 have been scheduled. He asked staff to look six to twelve months out to determine the locations so Commissioners and the public can better plan. The tentative list of cities will be posted by the March meeting. He summarized the current tentative meeting calendar:

- The March meeting will be held in Sacramento and will focus on schools and mental health.
- The April meeting will be held in Los Angeles. It will be a business meeting with a focus on innovations.
- The May meeting will be held in a rural county and will focus on rural mental health and suicide prevention. The name of the county will be announced at a later meeting.
- In keeping with tradition, there will be no meeting in June.
- The July meeting will be the strategic planning meeting at a location still yet to be determined but will be announced at a later meeting.
- The August meeting will be held in Sacramento. It will be a business meeting with a focus on Innovation plans.
- The September meeting will be held in Los Angeles and will focus on suicide prevention.
- The October meeting will be held in a rural county and will focus on following up on the strategic planning efforts. The name of the county will be announced at a later meeting.
- The November meeting will be held in Sacramento. It will be a business meeting with a focus on Innovations plans. It is a potential teleconference meeting.
- In keeping with tradition, there will be no meeting in December.

Chair Boyd stated there are occasionally questions from the public about the current status and activities of the Committees. He provided a brief overview of the MHSOAC Committees and named the Commissioners who are leading them.

The Client and Family Leadership Committee (CFLC) will be chaired by Commission Vice-chair, Khatera Aslami-Tamplen. The Cultural and Linguistic Competence Committee (CLCC) will be chaired by Commissioner Gladys Mitchell. The Financial Oversight Committee (FOC) will be chaired by Commissioner Lynne Ashbeck. Chair Boyd stated much of what the FOC Committee does has been addressed through the physical transparency work. He asked Commissioner Ashbeck to work with staff to assess how to best use the Committee and to explore whether it makes sense to keep

the Committee intact, given that so much information is posted online. The Evaluation Committee (EC) will be chaired by Commissioner Itai Danovitch. Chair Boyd thanked Commissioners who will be leading these Committees.

Chair Boyd stated the nation suffered another tragedy with the gun violence in Florida. He stated his comments reflect his personal perspective, which is backed by research. He reminded everyone of the reality that individuals with mental health challenges as well as mental illness are far more likely to be a victim of a crime than anyone else in society. There is a significant amount of work to do to ensure that all barriers are removed, including social prejudice and discrimination that prevent many people from seeking support. There is a significant amount of work to do to make mental health easier to access and more commonly understood.

Chair Boyd stated the Commission grieves along with everyone who has been impacted by this personally. Chair Boyd stated he was proud of the students in Florida for using this as an opportunity to step up and lead in the process, and to be on Capitol Hill and do the things that they have done this week to ensure their voices are not ignored.

Vice Chair Aslami-Tamplen appreciated Chair Boyd's acknowledging this tragedy, the pain the country is going through, the fact that individuals with mental health issues are more likely to be victims of crime than the perpetrators, and the research behind it. She stated the importance of pursuing policies that will impact the community rather than blaming mental health.

Commissioner Madrigal-Weiss shared the same sentiment and appreciated Chair Boyd's bringing the issue up. She stated schools are receiving calls daily. It is important to get information and education out there and support to the youth because youth are frightened.

Commissioner Alvarez thanked Chair Boyd for his comments and joined him in expressing pride in and inspiration from students who have stood up and demanded change and action because of the failure of the older generation. Elected officials and representatives are not representing the best interests of communities. The students have made that clear. Last night's town hall on CNN calls attention to the complexity of these issues, not only for mental health but for gun control for community safety, and youth empowerment. She stated she is excited to be on this Commission to make positive changes for youth and families.

Chair Boyd stated Commission meetings over the past several years have included thought and dialogue around how to ensure that the voices of individuals with lived experience are heard and integrated into the work. There is a meaningful aspect to the spirit behind Proposition 63, the Mental Health Services Act (MHSA). There is an opportunity to think through how to describe and define lived experience. More and more individuals are sharing their experiences with mental illness. It is part of the Commission's responsibility to champion and strengthen those voices, even if they are new and emerging. He cautioned, as those voices begin to emerge, against making any assumptions about who has lived experience and who does not because those barriers and boundaries, especially during this time, are transitioning and changing quickly. Language is important and it is important to have visible, vocal, clear leaders of

individuals with lived experience, but there also has to be room for emerging voices. He stated he intends to lead with sensitivity and to strengthen new and emerging voices of individuals who have lived experience and peer experience.

Chair Boyd asked staff, with support of Commissioners, to do a procedural shift in how meetings are opened. He asked staff to look at how to ensure at the start of every meeting that time is designated to hear from someone from California or across the nation who has lived experience or has lived experience in supporting and caring for a family member. He asked for Commissioner support in beginning every meeting with that context and with that framework.

Commissioner Mitchell applauded Chair Boyd's proposal. It is meaningful and important for Commissioners to be reminded every meeting why they are here. Commissioners should walk away knowing that they did something for someone who is living with severe mental illness.

Commissioner Madrigal-Weiss also stated support of Chair Boyd's proposal and asked that the Commission be intentional about reaching out to youth to ask them to share their experiences.

Vice Chair Aslami-Tamplen also spoke in support of Chair Boyd's proposal. She suggested inviting a second individual who is currently in the public mental health system to share their experience in peer support, especially those individuals in leadership positions. It is powerful. Consumers need that encouragement. She suggested building peer support in coming to the Commission. She stated she especially would like to hear from someone who is currently in the public mental health system and receiving services because, for so many, their voices are not heard. She stated her appreciation for Chair Boyd's vision in his proposal.

Commissioner Wooton congratulated Chair Boyd on his vision and spoke in support of the effort. To hear from more peers and family members would be beneficial for the Commission.

Commissioner Ashbeck agreed with fellow Commissioners that it is a wonderful idea. Commissioners must never forget why they do this work. She thanked Chair Boyd for his idea.

Commissioner Alvarez echoed previous Commissioners' comments. She spoke in support of Chair Boyd's proposal. She agreed with reaching out to youth and being reflective of the diverse demographics of the state of California.

Chair Boyd asked Executive Director Ewing to develop a recommendation and a process with staff about how to make this happen.

Chair Boyd thanked everyone with lived experience who regularly attends the Commission meetings, either in person or by phone. He stated the Commission has a number of contracts that are paid out through Proposition 63. Some individuals who attend the meetings are funded to do so. Under some of those contracts, they are funded to have representation throughout the state and to speak to their specific demographics or area of interest and expertise.

Chair Boyd stated he will be working with fellow Commissioners to take an assessment and a review of those contracts with staff to see what kind of activities have been supported since those contracts were funded, how they shape and influence Commission meetings, what the Commission expected in funding the contracts, and the work that is being done throughout California to change the process in the way that those public dollars were designed to do.

Chair Boyd stated there is an individual who regularly attends the Commission meetings who is never paid to attend; that individual's comments have been a consistent part of Commission meetings and have been powerful, constructive, and in the spirit of partnership. This individual makes personal sacrifices for that. Chair Boyd acknowledged this individual's efforts.

ACTION

1: Approve January 25, 2018, MHSOAC Meeting Minutes

Public Comment

Rory O'Brien, LGBTQ Program Coordinator, Mental Health America of Northern California (NorCal MHA), Project Coordinator, Out for Mental Health, thanked Chair Boyd for ensuring that youth are involved in the Commission's work. The speaker welcomed Audrey for her attendance and urged her to advocate for her position continually to acquire historical knowledge to comment even more effectively with each Commission meeting.

Rory O'Brien urged the Commission to involve all consumers in the planning process for future innovation summits as it appears that consumers generally were not engaged in the planning of the recent summit. The speaker was pleased that steps are being taken to secure a seat on the Commission for youth. The speaker reminded Chair Boyd that he agreed to wait to hear from youth about planning for a youth summit and was therefore surprised at the level of certainty that was spoken of on collaborations with IDEO when youth have not communicated that that is what they want to do.

Regarding Executive Director Ewing's youth advisory group, Rory O'Brien requested that the current youth stakeholder grantee, California Youth Connection (CYC), be involved in and funded to form and convene this advisory group to ensure that it is a youth-led and youth-oriented process.

Pete Lafollette, a recovery proponent from Ventura County, stated he has been attending Commission meetings since approximately 2012. Commissioners come and go. The speaker stated there are a lot of new faces but appreciated the Commission's receptivity of the fact that recovery and wellness proponents are engaged along the way in this process. These are most troubled times and it does not get any easier. The speaker reminded everyone to draw from their deepest beliefs the need to produce the stream of justice and goodness that reaches out and heals in these times.

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

The Commission approves the January 25, 2018, Meeting Minutes.

Motion carried 5 yes, 0 no, and 2 abstain, per roll call vote as follows:

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

The following Commissioner abstained: Commissioners Alvarez and Ashbeck.

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

Mobile Transcranial Magnetic Stimulation Innovation project

Alex Silva, Ph.D., Supervising Psychologist, Los Angeles County Department of Mental Health, stated the primary purpose of the Mobile Transcranial Magnetic Stimulation (TMS) Innovation project is to improve the quality of mental health and achieve greater outcomes by providing new and effective treatments for those individuals who are suffering from severe and chronic mental illness.

Jonathan E. Sherin, M.D., Ph.D., Director, Los Angeles County Department of Mental Health, stated the importance of looking to all opportunities to improve the lives of individuals who are suffering from medical conditions. The proposed Innovation project provides an opportunity to bring an effective intervention to the public mental health sector. This is a sensitive topic for valid reasons. The county has had robust dialogue with a variety of stakeholder groups and at the state level. The county sees this project as bringing the field of mental health up to speed with the rest of the medical field in terms of leveraging all opportunities to help individuals heal. That is the goal of this project.

Marc Heiser, M.D., Ph.D., Psychiatrist, Los Angeles County Department of Mental Health, stated depression is a common mental health condition. Approximately 35 to 40 percent of individuals with depression have refractory symptoms, meaning they do not respond to traditional treatment. The goal of the Mobile TMS Innovation project is to help raise functioning and alleviate symptoms of individuals with refractory depression who live in board and care facilities so they can live more gratifying lives.

Dr. Heiser provided an overview, with a slide presentation, of the variables, long-term efficacy and safety, other uses, and plan of the Mobile TMS Innovation project.

Commissioner Questions

Vice Chair Aslami-Tamplen stated many consumers are concerned, as represented by the letter submitted by the California Association of Mental Health Peer-Run Organizations (CAMHPRO), which was included in the meeting packet.

In response to a question from Vice Chair Aslami-Tamplen about who administers the TMS procedure, Dr. Heiser stated the project plan is to have Dr. Heiser or another psychiatrist do the initial evaluation and the initial treatment. Subsequent treatments can be delivered by the nurse or technician in communication with Dr. Heiser via telepsychiatry.

Vice Chair Aslami-Tamplen stated one of her concerns is the target population's vulnerability of being coerced into things in addition to the level of consumer protections that are needed in the target population. There is a culture of learned helplessness in that environment. Vice Chair Aslami-Tamplen asked how the county will ensure consumer protection. She stated, in her research on the subject, it looks like the majority are psychiatrists who administer the TMS procedure.

Dr. Heiser stated the Clinical TMS Society has guidelines published in 2016 that recommend that the psychiatrist must do the evaluation, prescribe the treatment, and do the initial planning of the treatment, but the subsequent treatments can be delegated to individuals who are trained, such as technicians. He stated he will not be abandoning these individuals because they will still be his patients and will have at least weekly telepsychiatry check-ins. Patients develop relationships with staff who are doing these treatments and it becomes another system of support.

Vice Chair Aslami-Tamplen expressed concern around this approach in terms of the protections of consumers in board and cares. The proposed project documentation indicated that TMS was less invasive than electroconvulsive therapy (ECT), which means there are still concerns.

Chair Boyd asked if there was an individual in attendance who had gone through the procedure who could discuss their experience.

Commissioner Mitchell stated her concern that, according to the presentation, the procedure is approved for patients with depression who have failed at least one antidepressant. She stated one is a low threshold to warrant this treatment. It would have been helpful to hear from individuals, either in person or by video, who have experienced this treatment, since Dr. Heiser stated this treatment is not typically community- or county-based. She asked about the cost of this treatment and how the county will ensure that clients in Beverly Hills are not prioritized over clients in locations such as Compton.

Chair Boyd stated he will give the county an opportunity to respond to all Commissioner questions and comments after hearing from other Commissioners.

Commissioner Alvarez stated she recognized and appreciated that TMS is completely different than ECT and that the county wants to provide a level of equity in the delivery of high-quality care to individuals engaged in the county public health system and the private system. It was encouraging to see language in the documents about soliciting peer investment by engaging individuals with lived experience in the Peer Resource Center, but in the budget, specific resources are not allocated to that investment. She asked how the county plans to engage peer patients who may have undergone this process. She asked for more information on the informed consent process so there is a greater level of understanding of what that might look like.

Commissioner Ashbeck stated this is the first Innovation project since she has been on the Commission that has a physical intervention as opposed to a program or service, which makes her nervous. She asked Executive Director Ewing if Proposition 63 envisioned this sort of innovation when that law was written.

Executive Director Ewing stated the Innovation component of the MHSA is flexible. Innovation funds can be used for research strategies, new administrative approaches, and equipment purchases. The intent of the Innovation component was to provide a resource and a mandate for counties to try things that had not been tried, particularly in areas where the existing strategies have been proven ineffective.

Executive Director Ewing stated the Commission is charged with addressing the thorny issue that innovation is in the eye of the beholder and the Commission is the beholder. There is no prohibition on how counties deploy these dollars as long as it is dedicated to mental health and intended to support an improvement in terms of access to care, quality of care, or even strengthening an existing practice. There is a broad opportunity for counties to spend these dollars.

Chair Boyd asked, in terms of the manufacturing vendor for TMS, if this is an FDA-approved vendor specific for this use. There are a few modalities of TMS globally developed that do not technically meet all the FDA requirements. Chair Boyd has his understanding that this is a treatment that prevents individuals who need more intensive intervention from ever having to have ECT. TMS can be more effective in some cases than medications. Many individuals describe the sensation as intense but not painful and, in many cases, it can be very effective.

Chair Boyd stated he does not support an approach that is not a part of integrated care and not of a broader oversight of expertise, but the application of TMS that is in the body of true coordination of care with the right oversight appears to be incredibly effective.

County Response

Dr. Sherin stated these are great and important questions to work through together and responded to Commissioner questions as follows:

- The county looks at this as an added value. It is a treatment that is important to bring to the public sector but has not been there before for barrier-type reasons.
- The treatment is voluntary. It requires informed consent. The county has a protocol in the proposal and is happy to work on that.
- The reason board and care facilities were targeted for this initial phase is because there are individuals with refractory mental health issues residing there.
- Board and cares are also where many of the most vulnerable individuals reside and the goal is to help individuals become more independent and have a greater opportunity to thrive outside of a board and care environment.
- The county is looking to improve board and care environments and improve the services generally of board and cares. This is another piece of a much larger puzzle. Dr. Sherin began working with TMS in 2008 with veterans who had

serious post-traumatic stress disorder (PTSD) symptoms and refractory depression. He was blown away by the response – not just the response to the treatment, but the simplicity of the treatment and the lack of side effects. This is a short-term treatment with a long-term effect in some cases.

- Dr. Sherin stated his commitment to ensure that psychiatrists are over-involved as a part of this effort. Dr. Heiser would take over as a primary psychiatrist for individuals in board and cares so he would see their treatment, including weekly assessments of their response.
- The county is committed to the involvement of peers and it is a core part of the mission. Dr. Sherin stated he is in the process of recruiting a chief for the county peer programming. This project is an area where peers could be very helpful as part of the team.
- The county will intentionally not offer this treatment to individuals who are conserved.
- Dr. Sherin would be happy to bring individuals to meetings or film interviews with individuals who have had experience with this treatment. He stated his team will get to work on that immediately, if that is something the Commission would like.
- Medications are biological modulators. TMS is probably a much more specific sophisticated biological modulation.
- There is no Institutional Review Board (IRB) involvement because this is not a study. This is a treatment that is approved and widely used.

Dr. Sherin stated the county would like the opportunity to try to do this project carefully and to communicate with all individuals in helping to shape how it is done. The county looks forward to moving forward and using whatever guidance the Commission can offer.

Chair Boyd agreed that TMS has been well-demonstrated and well-proven globally and throughout the United States. It is in regular use. The majority of times, unfortunately, this treatment is only offered to individuals with financial resources to pay for it and that has been the largest barrier. Many individuals could benefit who do not have the financial resources.

Chair Boyd stated there were at least three items that require additional clarity that he heard from Commissioners: the name of the vendor, clarity on the informed consent process, and socio-demographic spread throughout the county for equity of access.

Dr. Heiser stated the county is not yet working with a vendor. The vendor contract will go out for bids. All devices used for treatment of depression will be FDA approved.

Dr. Heiser stated there are standard components to informed consent in general: the individual must understand the nature of the treatment, the potential risks and benefits of the treatment, and that the treatment is consistent with their identity. The individual must be able to communicate these components back. TMS is a treatment that cannot be done unless the patient is committed to it. Some individuals try it but stop because they find they do not like it.

Dr. Sherin stated, on the socio-demographic spread, the idea would be to target board and cares. Board and cares in Los Angeles in general provide for individuals who are the most vulnerable and the project is not going into board and cares in Beverly Hills.

Commissioner Clarifying Questions

Vice Chair Aslami-Tamplen asked if the board and cares are licensed. Choice is important for consumers. One thing that is lacking in services and programs is the choice to be off medication. The presenters discussed treatment-resistant and medication-resistant consumers. The data shows that consumers in board and cares are on more than one medication. She asked if clients will have the option to be off medication.

Dr. Sherin stated the county only uses licensed board and cares. This is another option for consumers with a number of advantages. TMS for some individuals may result in a decrease in the number or dosages of medications. All of that is consumer-driven. If individuals want to take medications, they do, and if they don't want to, they don't. It is the same with the TMS treatment.

Vice Chair Aslami-Tamplen asked if the consumers could continue to live at the board and cares if they were off medications. Dr. Sherin stated being in a board and care does not require medications or any type of treatment.

In response to Commissioner Madrigal-Weiss' question, Dr. Sherin agreed that the treatment is not offered to individuals who are on conservatorship.

Commissioner Mitchell stated it would be helpful to hear from someone who has gone through the treatment. She stated she is hearing the presenters say this treatment has not been tried but then say it is used everywhere. She asked if it is in the United States. Dr. Sherin stated it is FDA approved, used around the world, and used in the United States more and more every day. It is not offered in the public mental health system because of barriers including payment.

Commissioner Mitchell asked where the data is on all the individuals who have gone through the treatment. Dr. Sherin stated he would be happy to direct Commissioners to literature on the subject. He stated many private insurance companies are paying for it because it is so effective. Medicare is paying for TMS most likely because of the frequency of refractory depression in the elderly population. It is an important treatment to offer. The county would like to build capacity to deliver it. He stated the hope that Medicaid would consider it a coverable treatment.

Commissioner Mitchell asked to see the data and some of the faces of individuals who have undergone the treatment. Dr. Sherin stated he will provide data that has been collected and will also prepare testimonials for the Commissioners.

Commissioner Alvarez asked for more detail on the peer support process. Dr. Sherin stated the county is looking to expand its peer workforce and the role of peers throughout the department, including ensuring there is a peer voice at the executive level every day. He stated his vision to assign peers to work as a part of the team with individuals who are receiving this treatment. Dr. Heiser, as the psychiatrist, would do all the preliminary work to ensure there is a good indication that it is the right treatment for

the patient. He would be involved directly, in person, for the delivery of care in the initial stages. There would be a nurse or a technician working with the individuals every day. He stated he would like to think that peers would be involved as a part of that team on an ongoing basis to provide a different perspective.

Public Comment

Sandra Marley, private advocate, spoke in opposition to the proposed Innovation project. The speaker stated the letter given out by CAMHPRO is excellent. Mayo Clinic lists several side effects of TMS. The speaker asked who is standing up for the consumers, why the psychiatrist will be the individual to get the informed consent and not a peer or someone else. This is a bad situation that shows how to use a group of people as an experiment.

Hector Ramirez, consumer and advocate, spoke in opposition to the proposed Innovation project. The speaker was excited about this new technology and its potential but was concerned. The speaker stated the same conversations were had about ECT. Even though there were great intentions with ECT, individuals' lives were stolen because of it. The speaker questioned if this project meets the threshold goals of the MHSA and was concerned how certain communities will respond to it. The project does not meet the integrated service experience involvement threshold.

Tai'Rance "Chuckii" Kelly, Sr., NorCal MHA ACCESS Ambassador, spoke in opposition to the proposed Innovation project. The speaker thanked the county for the idea of this project and the possibility that it can help. The Peer Support Specialist Full Service Partnership will begin in April. The speaker asked how to make the I-ams the I-am-nots. The speaker is a stakeholder, not the psychiatrist, but a peer support specialist who will serve in partnership. The speaker asked how to become you when the speaker is a stakeholder offender and how to make the I-ams become the I-am-nots. The disadvantages of this project outweigh the advantages.

Sally Zinman, Executive Director, CAMHPRO, spoke in opposition to the proposed Innovation project. The speaker stated this project is the same old track of somatic treatments from lobotomy to ECT without anesthesia to ECT with anesthesia to the older kinds of drugs to the newer pharmaceuticals and now to TMS. TMS is not innovative in the general sense of innovative. It is not culture changing or paradigm changing. It is invasive – it is called "less invasive." Patients are owed more than what is least harmful.

Sally Zinman stated concern about the board and care population, which is the least able to give informed consent because of the environment, the culture, the control, the institutionalization that has come before, and the disability. It may be a treatment but it is also a study. It is far more experiential than presented because it is going to a whole new population of what is termed chronic severely mentally ill. The protections must be much higher.

Stacie Hiramoto, Director, Racial and Ethnic Mental Health Disparities Coalition (REMHDCO), spoke in opposition to the proposed Innovation project. The speaker thanked the Commission for asking the questions that REMHDCO had. In general, REMHDCO would prefer nonmedical models in innovation and models that

work to reduce disparities. The community has to speak, especially for Innovations and Prevention and Early Intervention (PEI). It is hard to imagine that stakeholders in Los Angeles would prefer this treatment to some other kind of treatment for the same amount of funding. The speaker suggested paying peers to visit board and cares to take someone out to dinner and a movie five times a week. There should have been an IRB.

Adrienne Shilton, Government Affairs Director, Steinberg Institute, spoke in support of the proposed Innovation project. The speaker stated the founder of the Steinberg Institute is Darrell Steinberg and the mission is to advance sound public policy and inspire leadership on the issues of brain health. This proposal has a potential to create better outcomes from a target population that has high and chronic mental health needs. Individuals reside in board and care homes because they are unable to live independently.

Adrienne Shilton stated the Steinberg Institute sees real potential for this project that, as patients receive treatments on site, they potentially could progress to independent living without symptoms. This is a population that often has a difficult time adhering to treatment and advancing to their full recovery. For the 384 clients that Los Angeles County is intending to serve annually through this program, this has the potential to transform lives and improve their quality of life. This treatment is FDA-approved and is based on national best practices. This is not a study; it has been proven.

Kalia Mussetter, NorCal MHA ACCESS Ambassador, spoke in opposition to the proposed Innovation project. The speaker stated this project is not just treatment but also research using human subjects. A formal literature review and high protections are required because the board and care population is the most vulnerable population in specialty mental health. The speaker asked how many individuals with lived experience in public mental health are on the system leadership team in Los Angeles County. There is a huge gap between licensure and lived experience at all levels of care. The speaker suggested spending this \$2.5 million on what heals, which is human contact. It is concerning that the target population is corralled and immobilized.

Mandy Taylor, Outreach and Advocacy Coordinator, Health Access, California LGBT Health and Human Services Network, and advocate for the Out for Mental Health Project, lives with treatment-resistant depression and has worked as a social worker in board and care and so has experience on both sides of this issue. The speaker remembered, when experiencing depression at its worst, wishing treatment like TMS was affordable. The speaker researched this practice to make an informed decision on whether or not this was treatment that would be helpful. The speaker had great concerns in offering this service that does have evidence behind it to residents of board and cares, considering the type of informed consent they can give and who oftentimes cannot do that research themselves.

Mandy Taylor strongly advocated that the county ensures that the psychiatrist or treating physician is not the one sharing that information with the client initially but that the initial and ongoing contact be a peer as a support person as a part of the process – someone who can explain the process to them, someone who can sit with them through treatment, and someone who can help them articulate how it is affecting or not affecting

their life. This will help ameliorate the isolation involved in bringing a van to their board and care and will also help with the informed consent issues.

Daisy Mollinedo, Peer-to-Peer Advocate and Crisis Intervention Presenter for National Alliance on Mental Illness (NAMI) San Gabriel Valley, NAMI LACC, and NorCal MHA ACCESS Ambassador, appreciated the passion and concern for the community and almost supported the proposed project. The only hole in the presentation was stakeholder consumer testimony. Including human testimony would have alleviated the level of doubt among Commissioners and stakeholders. The speaker offered to help gather those testimonies.

Rory O'Brien echoed Stacie Hiramoto, Kalia Mussetter, and Mandy Taylor's comments regarding health equity and concerns for human protection. For counties proposing innovation today and in the future, one important purpose of innovation dollars is to discover what new practices work and therefore to evaluate those practices. The implementation and evaluation of innovative therapies and projects necessitates intentional protection of human subjects. The speaker recommended that counties speak explicitly to how they claim to protect the wellbeing, dignity, and privacy of the consumers in program implementation and evaluation. Innovation projects as pilots are research studies.

Rory O'Brien challenged the county's claim that this is not a research project and does not need an IRB. The Commission in many ways acts as an IRB. The speaker, therefore, advised counties to feature human protections, including consent processes in particular, in their proposals.

Commissioner Discussion

Chair Boyd stated research is hugely significant. U.C. Davis has been doing this for a number of years locally and is one of the pioneers and frontrunners in this field. The proposed project is not in a research phase and is completely supported by research.

Chair Boyd suggested, with Commission approval, directing staff to organize a host of experts at a future Commission meeting to walk through the levels of understanding of medical and interventional psychiatry advancements. The Commission has been focused on innovation and technology in mental health, but this proposal highlights possibly an increased desire to understand more in this field, which would help the Commission as it moves ahead.

Commissioners agreed that they were in support of a presentation from experts in this field.

Commissioner Mitchell stated it is a great idea. It is important to have the academic and intellectual knowledge in presentations to inform Commissioners but there is nothing more important than lived experience and bringing individuals who have experienced all of these mental health matters before the Commission.

Chair Boyd stated the proposed project is an evidence-based technology and support but agreed that it would have been nice to have someone with lived experience in the room that has gone through the treatments. Chair Boyd asked staff to include that as an essential component as the Commission moves forward with trying to consider these

kinds of things. If something is proven and is researched, everyone who wants access to something should have access to it and finances or resources or ability to have transportation should not be a barrier.

Commissioner Ashbeck stated what she has learned from this process as the Commission tries to refine the innovation process is that the bar for this presentation and the background on something like this feels much higher than the bar for a program or service. She stated she did not feel that enough information was presented to vote on this today. Commissioners agreed.

Dr. Sherin stated the Commission and stakeholders have had an enlightening, helpful, and healthy discussion. He asked for the opportunity to address issues brought up during the discussion and to bring back an improved presentation with more information and testimonials.

Chair Boyd asked the county to present additional details and consumer testimonials at the April Commission meeting. He thanked Los Angeles County for their hard work and commended them for their innovation stretches, and thanked Dr. Sherin for his collaboration, support, and willingness to provide the additional information requested.

Commissioner Alvarez thanked Los Angeles County for their effort and applauded their effort to ensure equity for individuals in the county system.

Update on Driving Access to Behavioral Health Care Thru Innovation: “The Technology Suite” Innovation project

Dr. Sherin stated the Los Angeles Board of Supervisors voted to support this effort last Tuesday. He shared that the county recently brought on a new program manager and is excited about the new program and new services the county is looking to bring to the system. He is also excited about the level of collaboration in terms of the process that is evolving with the Commission as well as the process that is occurring between the directors of mental health across the state. The directors must team up in order to move the system.

Bill Walker, LMFT, Director, Kern County Behavioral Health and Recovery Services, stated the county set up a vendor review system of consumers. He stated there are Consumer and Family Learning Centers 100 miles away from his office in Kern County and the volunteers, paid staff, peers, and family members meet face-to-face once a quarter. He stated next week a vanload of consumers and transition-age youth (TAY) will commute to Los Angeles to meet the consumers and TAY in Los Angeles County to begin the nucleus of the branding of what they do and do not like. The end result is consumer choice. Driving together means that discussions will be going on for the whole two hours of commute time. The county does not get feedback from consumers and then go into another room – they are driving together sharing their own joint lived experience.

Bill Walker stated people often learn from the interaction with people, from information, and from action. This project combines all of those. He honored the participation at the leadership, peer, and family levels on this project.

Karin Kalk, Senior Director, California Institute for Behavioral Health Solutions (CIBHS) and Technology Suite Project Manager, provided a truncated version of the project since the county will be given an opportunity for an in-depth discussion at the April meeting. She stated she was delighted to be partnering with the California Mental Health Services Authority (CalMHSA) and collaborating with counties on this project. It is a big and interesting project that will have many phases and should evolve into something that, each time it is presented to the Commission, will have a deeper sense of what it is, how it is serving individuals, and how it can achieve broad aims. The goal is to reach individuals who are not reached now or are not sufficiently reached and to do it in targeted and broad ways.

Karin Kalk provided an overview, with a slide presentation, of the principles and aims for collaboration, vendor selection, participation agreements, and shared learning.

Commissioner Questions

Chair Boyd echoed Dr. Sherin's comments about the leadership that is stepping up and emerging in counties and the level of collaboration and support.

Vice Chair Aslami-Tamplen stated the technology-based solution is a web-based network of peers to chat with. One of the questions that came up last time is the hope that the peers are local peers. She asked about the critical piece of engaging in person with a peer.

Bradley Cloud, Psy.D., Deputy Director, Kern County Behavioral Health and Recovery Services, stated this is one of the areas that is still in progress. The current version of peer involvement is through volunteers. The counties in California vary from populations of 1,100 to 10 million. The access to peers and the availability to pay them will differ county to county. Part of what needs to be done is to vet every type and size of county, price-point it, and then determine how the suite can or cannot be purchased because all counties cannot do the same thing in terms of peer involvement and that needs to be known up front.

Dr. Cloud stated Kern County is currently doing a price-point analysis to learn the county's involvements and what suite elements can be made available. Kern County cannot make a commitment to the level of peer involvement at this time because that will be part of the learning.

Debbie Innes-Gomberg, Ph.D., Deputy Director, Los Angeles County Department of Mental Health, stated Los Angeles County's budget, commitment, and size reflects the ability to include the peer-chatting vendor, which is component number one – hire local peers. The second thing is May, as Mental Health Month, and beyond provides an opportunity to introduce peers more broadly to the use of technology as a source of support, as an adjunct to treatment, and as an access vehicle.

Commissioner Alvarez stated one of the challenges is the sharing of data and the concerns around legal barriers to sharing data. Dr. Innes-Gomberg stated the privacy officer in the Los Angeles Department of Mental Health and the county counsel spent approximately one month going over the fine details that are not in CalMHSA's

Participation Agreement about privacy and who owns the information. The county has a thorough analysis and vetting of that, which will then form a platform for the vendors selected.

Public Comment

Flor Yousefian Tehrani, Psy.D., LMFT, Program Manager, Orange County Innovation projects, spoke on behalf of the Director in expressing support for the proposed Technology Suite Innovation project. The county is excited about the large-scale peer support and positive impact that the project will have on the community. The speaker appreciates the work Los Angeles and Kern Counties and Karen Kalk are doing to lay a foundation for this project and pave the way so other counties can join.

Sandra Marley asked about digital phenotyping using passive data and asked how the peers and transparency will be kept in the several counties involved and how an individual can access the data. The speaker suggested making the project more person-centered.

Hector Ramirez stated he was excited about this Innovation project as Los Angeles becomes the new Silicon Valley. The speaker suggested engaging stakeholders. Stakeholders who have a lot of knowledge to offer, particularly peers and family members, are not at the table. The speaker suggested including cultural competency and accessibility elements. This project provides opportunities for individuals to connect on a variety of levels and keeps them engaged, which is important in a large county such as Los Angeles. Peers and family members need to be part of the development at every level, from the discussions of data privacy and the products assigned to the way it is marketed and delivered.

ACTION

3: Mono County Innovation Plan

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

Robin K. Roberts, MFT, Director of Mono County Behavioral Health, thanked Commission staff for their work in this project. They have made themselves available to the county and are a joy to work with. She introduced the members of her team in attendance. She stated Mono County decided to formally join the Technology Suite Collaborative.

Amanda Greenberg, MPH, MHSA Coordinator, provided an overview, with a slide presentation, of the program goals, target population, value of multi-county collaboration, and funding and timeframe of the Mono County Technology Suite.

Robin Roberts continued the slide presentation and discussed the county context, demographics, and target population for the Innovation project.

Amanda Greenberg continued the slide presentation and discussed the development and implementation of the technology suite.

Commissioner Questions and Discussion

Vice Chair Aslami-Tamplen asked if the peers are local, if they are paid, and if there is a clear process in the proposal to allow human contact. Robin Roberts stated the peers are local and are paid. The county has been successful in putting on community events with food and activities and asking participants questions about needs. Individuals are willing to attend the events as long as they are not pressured with information and agency presentations. Through the process of holding events for the communities, trusting relationships are developed and attendees share who is not attending and how they can be accessed. Trust is built when community members ride along on visits to these individuals.

Commissioner Alvarez asked if members of the tribe, Latino, or senior communities are part of the Behavioral Health Advisory Board, and if individuals are given a trusted source of referral. Robin Roberts stated the county is the one-stop shop and are engaged with the Latino community. The tribal communities have been more difficult to engage. The county engages them through wraparound programs with a strength-based recovery model to develop trust and increase outreach. There are consumers and family members on the advisory committee. Transportation is an issue in the county where distances can be two hours one way. The county is looking into virtual contact such as telepsychiatry.

Executive Director Ewing stated staff visited Mono County and experienced the distance challenges firsthand. He stated he would love to facilitate opportunities for the Commission to visit the county.

Commissioner Madrigal-Weiss asked about the percentage of the population that has access to technology hardware such as smartphones and computers. The unavailability of the Internet is an issue in rural San Diego. Robin Roberts stated the county has begun surveying who has access to phone service.

Commissioner Mitchell asked about the nearest hospital. Robin Roberts stated there is one hospital in Mammoth Lakes with a community clinic attached to it. The next nearest hospital is in Inyo County. Individuals requiring specialty care go to Reno, Nevada, which is approximately three hours away, or Loma Linda, California, which is approximately six hours away.

Public Comment

Adrienne Shilton, Government Affairs Director, Steinberg Institute, spoke in support of the proposed project.

Maureen Bauman, California Behavioral Health Directors Association, spoke in support of the proposed project.

Sandra Marley spoke in support of the proposed project.

Andrea Crook, ACCESS California, Advocacy Director, NorCal MHA, stated there is a lot of fear around digital phenotyping and technology in general. The speaker stated it would be more comfortable to hear from individuals who are receiving services in the community. The speaker asked if stakeholders offered alternative programs or services to address the same goals or expressed a preference to fund other or different priorities,

and if there were other plans to address transportation barriers to create more dinner-type community events.

Susan Gallagher, Executive Director, NorCal MHA, commended the county on doing anything with \$85,000 and echoed Andrea Crook's comments about the digital phenotyping. It is new in the client community, uncomfortable, and not a community-defined solution. It may be a wonderful solution but not enough is known about it. More education on digital phenotyping and informed consent is required. It is not a replacement for human contact. The speaker asked if the county has the capacity to serve those they are outreaching to and will use local peers, and if the peers will be trained in core competencies and peer support.

Mandy Taylor echoed the comments on digital phenotyping. The speaker stated the need for local peers who are trained and valued. The California LGBT Health and Human Services Network spoke to at least one of the potential technology suites about access to technology and what became clear was that the counties get to be the gatekeepers on that.

Mandy Taylor applauded Mono County for their community engagement. Mono, Kern, and Los Angeles Counties need to put requirements on their vendor that the vendor will address the technology access issue as a part of the contract, and that they have particular competencies on an advocate for the LGBTQ community for any vendors for counties using technology suites. It needs to be built into the contract that those competencies are addressed – that individuals moderating panels have competency.

Rory O'Brien requested that the phenotyping feature only be used with clients who have been provided with in-person consent counseling and that the counseling be an opt-in process. The speaker state the technology suite should be approved in no more than three counties, as this provides a geographic spread allowing for multisite evaluation and that Mono be the last county approved for such a purpose until a full evaluation has been conducted and found to provide benefit. The speaker requested that all three counties collect data to evaluate the impact of this intervention on disenfranchised communities, impoverished individuals, individuals of color, and LGBTQ.

Pete Lafollette asked how to best utilize the human capital and the human capacity of social media. It is interactive but not transformative. In general layman's terms of teaching and sharing on that level with others, the speaker quoted from the Alternative Conference, "Education is key. I find it maddening that people with mental illness are not taught to work at their mental health. Exercise, relationships, communication skills are not taught or good nutrition is not pushed or even part of the equation. Pills are pushed and the U.S. spends more money on medicals than any other country in the world and we are not healthier for it. Money doesn't fix problems; educating people with truth to get at the root of their problem fixes problems."

Karen Stockton, Health Services Director, Modoc County, spoke in support of the proposed project. Modoc County believes in hiring local peers and supports it multiple ways, but one of the challenges of the small counties is that they do not have enough consumers with specialty areas to staff a program full-time for groups with special needs. Having the ability to use local and collaborative peers is important.

Karen Stockton stated it is also important not to close the opportunity for counties to leverage the learning of other counties joining this cooperative. It defeats the purpose of a statewide evaluation to disallow counties to participate that do not have resources to develop technology for their consumers.

Chair Boyd stated the Commission has approved similar things to the two previous counties. As this trend continues to evolve, it will be interesting to hear from a variety of young people about this. How important human contact is to young people varies depending on the situation.

Action: Commissioner Alvarez made a motion, seconded by Commissioner Madrigal-Weiss, that:

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

Program Length: Seventeen (17) Months

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

The following Commissioners voted "Yes": Commissioners Alvarez, Ashbeck, Madrigal-Weiss, Mitchell, Vice Chair Aslami-Tamplen, and Chair Boyd.

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

Bill Walker, LMFT, Director of Kern Behavioral Health and Recovery Services, summarized his background and stated individuals who are under the influence are chronically underassessed for their longer-term mental health needs. PTSD is an accepted diagnosis today, but that was not always the case. He shared a story from World War II to make it more human. He stated the humanness is that individuals in this kind of distress are put in a non-peer environment, such as a Section 5150 evaluation in a hospital emergency room, to determine if they should be hospitalized for danger to self or others, but the underlying issues are never considered. The difference between substance abuse and crisis is crisis works with individuals who are under the influence. Substance abuse works with individuals with drug problems who are not using because, if they begin using again, they are discharged. This is a program to reach the mentally ill who are under the influence.

Bradley Cloud, Psy.D., Deputy Director of Kern Behavioral Health and Recovery Services, stated the county will propose the creation of two recovery stations in Kern County – one in the city of Ridgecrest, serving the east side of Kern County, and the other in Bakersfield, serving the west side of the county. These stations will have the specific purpose of peer-provided services to help engage individuals in identifying undiagnosed mental health conditions and to help link them into services of their choosing.

Dr. Cloud provided an overview, with a slide presentation, of the problem, barriers, innovative solution, evaluation, and outcomes of the Healing Project, Kern County's proposed innovation plan.

Commissioner Questions

Commissioner Ashbeck asked about the distinction between this project and crisis stabilization units (CSUs) in Fresno County.

Chair Boyd asked Commissioner Ashbeck if the CSUs are peer-based and operated in Fresno County. Commissioner Ashbeck stated it is not primarily peer-based so that may be one distinction.

Bill Walker stated that is a great question because, when the county first began looking at this, they considered a traditional sobering center. The county traveled to other states and other cities in California to do site visits. What was uncovered was, though some had a substance abuse peer base as part of it, they generally did not have a mental health history peer base, which is an important aspect of what the county is trying to address with this project – to get to the mental health issue, not just the substance use issue.

Bill Walker stated the other point is, while it is helpful and important to help individuals sober up in a safe way, there is a lot of untreated mental illness in this population that never gets recognized and never gets addressed. The proposed project's staff will specifically be focused on the task of helping to identify that unrecognized, silent population and helping to get them mental health care, not just helping them safely sober up.

Commissioner Alvarez asked, in recognizing the value of human contact and that many of these individuals are part of a family unit, how the sobering center considers the children or parents that are left behind. She asked what the relationship of the family involvement is.

Bill Walker stated this type of center is not like a residential treatment center so it would be short-term. The county already has set up, through their PEI dollars, a circle around the facility that will continue not just the engagement with the individual but, as they leave, the engagement with the families. He stated, if the family system is not reached as part of the engagement in substance abuse, it probably will not be successful. It is doubly so with co-morbidity. A lot of intervention cannot happen at the moment that the individual is sobering up, but it needs to begin there. It is expected that family meetings will begin prior to individuals leaving the facility and continue as the connection for the aftercare.

Public Comment

Sandra Marley stated the hope that the project will be led by individuals with experience with alcohol and drugs and mental health issues. Sometimes individuals in sobering centers sober up quickly and other individuals are in a fog for possibly months, particularly if they have a mental illness. The speaker did not know how sober an individual would have to be to fill out the medical screening, which is in the form of a

questionnaire. The speaker stated the hope that the program would interface with Alcoholics Anonymous, Narcotics Anonymous, and other twelve-step programs.

Kathaleen Hefner, advocate, Access Program, state-certified substance use disorder counselor, and mental health client, spoke in support of the proposed project. The chance to get mental health services while receiving drug and alcohol recovery services changed the speaker's life. The speaker had tried many times to get clean and sober only to fall back into utilizing street drugs to self-medicate mental illness until a peer introduced the possibility of getting a mental health evaluation. Today, the speaker is seven years clean and sober because of continuing to be a mental health patient as well as a drug and alcohol person in recovery.

Tai'Rance "Chuckii" Kelly, Sr., spoke in support of the proposed project. The speaker stated the project will bring out functional individuals who are self-medicating. The speaker stated the hope that alcohol is not the only drug focused on. When focusing on the drug part and not the mental part, it does affect a person's drive to do more drugs. Separating the drugs from the mental health and focusing on the mental health is a great decision. The speaker recommended being sure that the peer leaders are not individuals who suffer only from drugs but are also consumers and clients.

Adrienne Shilton spoke in support of the proposed project. The speaker stated the barriers to care for individuals living with mental illness and substance use conditions in Kern County are significant, just considering the geography alone and the few resources for immediate access to specialized care.

Adrienne Shilton stated the Steinberg Institute is particularly impressed with this proposal's combining the elements of the sobering center with peer-led interventions and also the warm handoff and linkages to mental health services. The speaker commended county staff for their research and for doing multiple site visits. This project fills a gap in the continuum of care.

Mandy Taylor stated the California LGBT Health and Human Services Network is a network of 60-plus organizations in the state that serve the LGBT population in health and human services. Individuals who experience co-occurring disorders in crisis often come into the centers because they do not feel safe going to mainstream centers. The speaker would love to see LGBTQ training at least once a year to account for employee turnover so that individuals can feel that they can go and get affirming care that is supportive of their sexual orientation and gender identity.

Mandy Taylor suggested that the local center in Bakersfield have that training and suggested building a relationship with them so, when doing that warm handoff, the employees recognize the faces from the Bakersfield Center since the Bakersfield Center, like many LGBT Centers across the state, is peer-run. It will help connect individuals to programs. Unfortunately, this training is not always happening.

Commissioner Discussion

Commissioner Mitchell asked if the program is ready to go so it will not run into reversion issues. Bill Walker stated the county is not worried about reversion with these funds but the funds need to be put into play. Upon approval, the county will establish

locations for the project and secure a building. The project will be ready to go within a few months.

Commissioner Mitchell asked about the level of personnel in the budget. Dr. Cloud stated the plan is for approximately 12 staff in the Bakersfield Center and approximately eight staff in the Ridgecrest Center. It is a combination of licensed mental health professionals who have co-occurring disorders – a bachelor's-level nurse, recovery specialists, and substance abuse counselors.

Commissioner Mitchell asked for progress reports to the Commission on this project.

Commissioner Madrigal-Weiss read a portion of the Staff Analysis: "The county expresses that bias against individuals who have used 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 is concerning but, with the county's strong model and having peers available to work with clients, she suggested that peers go back and educate the professionals. She suggested a loop back to that where the peers share their experiences with the professionals.

Bill Walker stated this project is a step up to do something for individuals with underlying mental health needs who tend to be stigmatized because of their drinking or their drug use.

Chair Boyd asked if a report-back by letter would suffice as opposed to the county giving their report in person at a Commission meeting. Commissioner Mitchell agreed.

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

The MHSOAC approves the following Kern County's Innovation plan and requests the County provide a written status update to the Commission in six months:

Name: The Healing Project

Amount: \$14, 685, 510

Program Length: Five (5) Years

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

The following Commissioners voted "Yes": Commissioners Alvarez, Ashbeck, Madrigal-Weiss, Mitchell, Vice Chair Aslami-Tamplen, and Chair Boyd.

INFORMATION

5: Executive Director Report Out

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

Executive Director Ewing presented his report as follows:

State Audit

The Commission and the Department of Health Care Services (DHCS) have been under review by the California State Auditor. That process is being finalized and the report will be released at the end of February. Staff will work with the Chair to determine whether to put the audit on the agenda for public discussion, to invite the auditor to

present on the findings, or to invite the DHCS and other entities that may be a subject of the review to present at a future meeting.

Staff is in discussion with the Budget Committees in the Senate and Assembly. They are anticipating the audit and are expecting to hold oversight hearings in response to the audit and that the Commission will be asked to participate.

Commissioner Questions

Commissioner Madrigal-Weiss asked about the audit process. Executive Director Ewing stated the auditor gives the Commission a confidential draft, the Commission provides a confidential response, and the auditor releases a public report that includes their report, the Commission's response, and the auditor's response to the Commission's response.

Biennial Report

Staff is close to completing the Biennial Report on how Commission resources are being used. It captures all the things the Commission has done over the past two years. Staff's intent is to complete an annual report as part of the public accountability process.

Budget

The rules of procedure that the Commission adopted are clear that staff has certain expenditure authority and any expenditure above \$100,000 in the form of a contract comes to the Commission for public review and approval. It gets complicated as contract after contract come before the Commission and Commissioners do not always see the big picture.

Earlier this year, staff presented an annualized budget. Although the Commission operates under the oversight of the Legislature and the Department of Finance and follows the rules that all state agencies follow, because this is a Commission that operates publicly and is the authority for spending these dollars, staff wanted to translate the formal budget process information to a presentation that was more consumable so Commissioners could see the funding that is used and what is spent outside of the contract-by-contract approval.

This is a strategy staff is developing in order to strengthen the internal accountability. As part of that, staff will give Commissioners a periodic update.

Executive Director Ewing deferred to Deputy Director Pate to remind Commissioners of the original spending plan and where the Commission is on expenditures to date.

Deputy Director Pate summarized the Fiscal Year 2017-18 Budget Update handout, which was posted on the website:

- Triage Grants – The Request for Applications (RFA) for adult services is due on March 9th and the RFA for children's services is due on April 6th. Staff plans to ask approval to award the grants for the adult RFA at the March meeting and the children's RFA at the April meeting.
- Stakeholder Contracts – The \$365,907 balance is set aside for the TAY population. The TAY grant was issued in 2017. Staff is working with the California Youth Connection (CYC) to encumber funds for the contract for the

TAY population. The balance also includes \$25,907 for funds that were not requested in the RFP process. The Commission will need to decide how to best use those funds for the stakeholder advocacy groups.

- Children's Crisis Services – Trailer Bill language included \$3 million for children's crisis services. Those funds will be included in the Schools and Mental Health RFA to be released at the beginning of March.
- Suicide Prevention Strategic Plan – Trailer Bill language included \$100,000 for a Suicide Prevention Strategic Plan. A Work Plan was presented to the Commission last month. The first subcommittee meeting for the Suicide Prevention Strategic Plan will be on March 16th. How to best use the funds will be determined after the subcommittee meeting.
- Evaluation/Information Technology – Staff plans to ask the Commission in upcoming months for support for evaluation/information technology contracts.
- Operations – The Commission will be fully staffed by the end of the fiscal year, which will leave a remaining balance of \$696,474 to support personnel, commissioners, and day-to-day operations.

Executive Director Ewing stated most of the \$66 million are the funds that will be encumbered between now and June to support the Triage Grants that are being issued. There is a balance of approximately \$2 million that includes all the salaries, travel, and day-to-day operations with a relatively small but still substantial amount of funds left in the Research budget. The total annual budget is approximately \$45 to \$50 million. The Commission budget is in good shape. Unspent funds are left in the account for use next year.

Legislation

Last year, the Legislature signed Assembly Bill (AB) 1315, creating an early intervention program for psychosis services. It creates a fund for receipt of grant or donated dollars to allow the Commission to issue grants to counties with a required match. Consistent with the youth innovation work, staff is in the process of creating a procedure to identify members of an advisory committee. The statute is explicit in the seats that are on that advisory committee and the work that they will do.

Staff is still working with the administration on the staffing arrangement for that. The challenge is that the intent is to pay for operational activities with donated funds but there are no donated funds. The goal is to stand that up with public dollars in anticipation of receiving funds so the Commission can engage staff to support fundraising.

Last year, the governor also signed a bill giving the Commission authority to create fellowships for a Mental Health Consumer and a Mental Health Practitioner. Staff continues to explore the rules that must be adhered to for those positions because this is a relatively unusual opportunity in state government. The goal is to provide additional guidance on the rules and present a proposal on how to make that operational at the April meeting.

Project Updates

PEI and INN Regulations

When the Commission did work on the Prevention and Early Intervention (PEI) and Innovation (INN) regulations, staff sat down with the counties over the course of many months to discuss their challenges in complying with regulations and reporting requirements. Counties suggested it would be helpful for the Commission to facilitate a learning community around PEI and the goals of the regulations. On March 1st, the Commission is holding a webinar with over 80 individuals registered statewide as the first step in building out the learning community around PEI and how the Commission can provide technical assistance and support for the counties. The webinar focuses on data reporting that is essential to the understanding of how well PEI is working and for whom and is part of a broader strategy to support the success of PEI as a strategy in the MHSA.

Schools and Mental Health

Staff has met with the Department of Education to discuss collaborations on data to better understand how to monitor school outcomes and the requirement under the MHSA that Behavioral Health Funds be used to prevent negative school outcomes and support educational success.

Suicide Prevention Plan

The subcommittee will meet in Redding in March. The Redding location was chosen due to the high rate of suicide in that rural community.

Other Duties as Assigned

Consistent with AB 114, legislation signed last year that directs the Commission to write the State Suicide Prevention Plan, the Commission and the DHCS were invited to participate in a Policy Academy with the United States Department of Veterans Affairs (USDVA) and the Substance Abuse and Mental Health Services Administration (SAMHSA) regarding the veteran suicide rate. Unfortunately, the DHCS determined they did not have the capacity to participate.

The Policy Academy event will target city mayors. The city of Los Angeles and six other cities around the nation have been invited to the Policy Academy in Washington, D.C., with SAMHSA as national experts. The Commission has been asked to join the Los Angeles Policy Academy team. The team is working to get an additional seat for the State Department of Veterans Affairs to join that team with the intent of facilitating state-level coordination and support consistent with the goals of the Policy Academy. The mayor's office in Los Angeles City is the lead and Los Angeles County Mental Health is part of the team.

Strategic Planning

Staff is pushing on strategic planning work to meet the March deadline.

Youth-Focused Innovation Event

Staff is working to put a proposal together for Commissioners to consider ideally next month. The plan is to develop an application process for youth to serve as an advisory committee to ensure advisory committee members come from across the state and from various backgrounds and walks of life. The idea is to ensure that there is a group of youth that take the lead in guiding and advising this project. That would involve working with anyone who is interested as well as with existing stakeholders to ensure accessibility to youth across the state. The more partnerships created above and beyond stakeholders, the richer the experience will be.

The proposal for the innovation event will be shared with the youth advisory group to refine, improve, and enhance. Unlike the February 2nd event, which was really an exercise – a mock innovation engagement process designed to model human-centered design – the Commission would host a series of community engagements with youth to identify key challenges that they are facing. The advisory group would then refine those down to a core set of approximately six or seven key challenges. Then, working with a facilitator, they would identify potential ways to address those challenges. More community engagement with youth to do the brainstorming idea development process would then culminate in an event where the ideas would be further refined.

The goal is that youth could present those ideas to their counties as innovations that came out of a problem-identification process the Commission facilitated and the ideation process with the facilitator around innovative approaches to those. Staff will write up a sketch, present it to the Commission to consider as well as the process for identifying youth advisors, and expose that draft plan to the youth advisors for refinement.

Commissioner Questions

Chair Boyd stated it is clear that youth engagement at the county and ground levels are where that rich process can come from before it gets to the Commission. It can be formed into innovation plans and three-year plans. He asked if there is a requirement for counties to ensure that a young person is on the local county mental health board.

Executive Director Ewing stated there currently is not but there are opportunities to provide examples of how to do youth or community engagement. There are no good standards in how to deploy local boards and commissions and advisory processes. This is an area to improve. The Commission has talked informally about working with the Legislature to propose legislation that requires each local mental health board and commission to have a youth appointee. There is a long way to go in terms of formal structures and process work about how to listen.

Commission Meeting Calendar

Staff is solidifying the meeting calendar. The commitment is for at least six months in advance. It is important to align the work being done with where the Commission meets. If locations are posted on the website far in advance and then there is a change, it creates confusion for the public. Staff is trying to find a balance between predictability and surety with the flexibility for the Commission to pursue its mission.

There may need to be an unscheduled meeting in May on triage approvals. The issue is that the funding is in the budget for a period of time and it must be encumbered prior to the end of the fiscal year, which is the end of June. The RFAs are out. The questions are how quickly the applications can be returned, scored, and brought back to the Commission for approval while leaving the right window for appeals so that the funding can be encumbered in the form of a signed contract before June 30th. More time is required to determine if an additional meeting will be necessary.

GENERAL PUBLIC COMMENT

Pete Lafollette felt rushed, bewildered, and blindsided in the last two agenda items. There had been no or inadequate public notice in what had been discussed. The speaker was aware of the audit but had to research it personally. The MHSOAC website has been down for the past week and there is no summary on the Assembly Bill. The speaker stated these things are being introduced and brought to a vote the day of the meeting. The speaker asked where the preparation time is and how Commissioners can make an informed vote.

Chair Boyd stated, if Pete Lafollette's comments are directed to the Executive Director and Deputy Director's comments, there is no motion required. The Executive Director Report is a normal part of the briefing.

Chair Boyd asked staff to address Pete Lafollette's questions and concerns.

Christopher Barton spoke about the passage of AB 1134, the fellowship, and the impact Commissioner Wooton had, along with Assembly Member Todd Gloria. The speaker was a concerned adult consumer and planned on being one of the prospective applicants for the fellowship once the Commission has finalized the process. He provided a brief history of living with mental illness, overcoming numerous setbacks, being conserved and living in a licensed board and care, overcoming by doing numerous volunteer positions helping the mentally ill and homeless, serving as an alternate on the Sacramento MHSA Steering Committee, and being a prospective Sacramento County Mental Health Board Member. The speaker looked forward to being compensated in the mental health community. He thanked Commissioner Wooton for her work in passing AB 1134, giving the speaker hope to one day give back even more.

Stacie Hiramoto welcomed Commissioner Alvarez to the Commission and Andrea as the student intern and looked forward to working with them. The speaker commended Chair Boyd on his ambitious changes. REMHDCO supports the changes involving youth. She also thanked Chair Boyd for wanting to examine the community stakeholder contracts and commended the contract holders with individuals who have been testifying. They have been doing a great job. The speaker noticed that some contract holders were not present at the meetings and felt they should be. REMHDCO believes that the Commission is important in the administration and the oversight of the MHSA. That is why REMHDCO attends the meetings even though no one from REMHDCO is paid for their attendance. The speaker appreciated the work of the Commission.

Tai'Rance "Chuckii" Kelly, Sr., stated all of today's discussions are on the concerns, protections, and rights of consumers and consumers' views being heard. The speaker stated, as a trans man of color and as a consumer, individuals are not protected when it

comes to domestic things. The misunderstanding and the miseducation. People like the speaker are considered as the abuser as opposed to being a victim, which is hard. He stated there are no support groups, peers, or other individuals to help support or work with companies and/or places to come up with programs, options, or alternatives to sending individuals to jail or putting them in certain situations they do not understand. This is a big problem in the LGBTQ community of people of color. Just like there is an elderly abuse program, there needs to be a mental health abuse program for those who suffer from being abused and not only do not want to seek services from the government, but also may not want to seek services from people. That should be taken into consideration.

Sally Zinman spoke about a missing stakeholder group: older adults who experience transportation issues, dependence on others, and physical disabilities. It is hard not to feel that individuals perceive elders as no longer useful to society or in the future not being useful and therefore not deserving the same kind of investment. This Commission has discussed having an older adult stakeholder group for a long time but it has not happened. The speaker encouraged the Commission to include a stakeholder contract for older adults.

Chair Boyd stated the Commission has stakeholder groups reaching out to LGBT, consumers, and others, and this is a strong reminder that those groups strongly need to consider ensuring that the older adult population is represented. Chair Boyd thanked Sally Zinman for bringing this issue forward.

Joy Torres, NorCal MHA ACCESS Ambassador, agreed with Sally Zinman about supporting older adults. Joy Torres spoke about housing and the Shelter Care Plus Programs and how it is hard to get permanent long-term housing for consumers, especially older adults. Many older adults are being evicted because they can no longer afford the rent. Older adults do not have access to resources because the resources are used up by numerous other things. Many older adults do not know how to ask for help.

Dorinda Wiseman, LCSW, Deputy Executive Officer, California Behavioral Health Planning Council (CBHPC), thanked the Commission for speaking to the tragedy in the country. The CBHPC has talked within the leadership about how to address the shootings. It is not just about gun control. The speaker thanked the Commission for making the statement that those suffering from mental illness are often the victims and not the perpetrators because there are certain messages that need to get out there; however, coming out adds fuel to the fire. Figuring out how to work through this will be part of the solution.

Dorinda Wiseman stated the CBHPC appreciates all of the efforts and services towards the youth and various groups; however, agrees that the older adult population is being forgotten, especially when it comes to first episode breaks. Many individuals think it is only young people who are suffering from first episode breaks. There are many older adults that, because of the generation that they come from, and because of many of the medical issues that are happening, are often isolated and are not looked to in counties' PEI. The speaker implored the Commission to look at the older adult population when it comes to first episode breaks.

CLOSED SESSION

Government Code Section 11126(A) related to personnel

Chair Boyd dismissed everyone to lunch, led the Commission into Closed Session at 2:04 p.m., and resumed the proceedings in open session at 2:54 p.m.

REPORT BACK FROM CLOSED SESSION

Chair Boyd stated the Commission took no action in closed session.

ACTION

6: Legislation

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

Assembly Bill 2325 (Irwin): Mental health services: veterans

Norma Pate, Deputy Director, Program, Legislation, and Technology, stated staff has been working with Assembly Member Irwin's office on a mental health and veterans bill, Assembly Bill (AB) 2325, which is consistent with the direction that the Commission gave on improving stakeholder dollars to provide advocacy and support services for veterans with mental health needs. AB 2325 was included in the meeting packet.

Deputy Director Pate introduced Christian Berkin, who has been working with staff on this bill.

Christian Berkin, Chief Consultant, Assembly Veterans Affairs Committee, stated last year Assembly Member Jacqui Irwin introduced a bill, AB 1314, which attempted to address the problem that veterans have in the state of California that, when they are seeking mental health services, they often experience a ping-pong effect. When they go to a local provider or county agency, they are referred elsewhere or told they can go elsewhere in order to obtain those services because they are veterans. Many veterans give up, do not find anything, or do not get a referral in time. He stated, at the time, it was felt that the problem could be better documented and, over the summer, a Commission-funded case study analysis of three counties was undertaken that included a component that involved having callers call county mental health providers, identifying themselves as veterans with pressing mental health needs. In many cases, the callers found that they were unable to get a person on the line or any kind of service whatsoever. Assembly Member Irwin reintroduced AB 2325, which is a bill that is largely similar to AB 1314 but includes clearer guidance for what counties should be doing when they are contacted by a veteran in need of services.

Christian Berkin stated existing law prevents counties from denying services to veterans on the basis of their status as a veteran. That has proven to be insufficient guidance for counties. Instead, counties are referring veterans out and asking that veterans seek services from the United States Department of Veterans Affairs. The bill is drafted saying that, in the interim, counties are to provide services or referrals and not require veterans to seek services from another provider. Assembly Member Irwin asks the Commission for its support of AB 2325.

Chair Boyd stated this presentation was the first half of Agenda Item 6. He asked Commissioners if they had questions or comments on Christian Berkin's presentation.

Commissioner Questions and Discussion

Commissioner Alvarez asked if the provider must be part of the county or if it can be a community health center. Christian Berkin stated the agencies contacted did contract with the county to provide services.

Public Comment

Sandra Marley stated ATMs and electronic ordering devices remove the personal aspect, take away jobs, bring mental illness, and bring addictions. It is a cascading thing. Jobs are important. The speaker noted that Steve Leoni was not in attendance and stated he was missed.

Chair Boyd stated many in the room echo that. He thanked Sandra Marley for highlighting that.

Susan Gallagher did not see the bill on the agenda and stated the bill should be listed in the agenda to help the public determine if they want to attend the meeting. There should be a description in the agenda. The speaker stated it should be noted fully on the agenda. Last month, there were a couple of items that were voted on that also were not on the agenda. The speaker encouraged the Commission to be sure to have things properly agendized for the public so that the public can know whether or not they want to weigh in on it. Secondly, if there is not a robust discussion about it, it begs the question if there is serial communication going on because Commissioners come to meetings already ready to vote on something that no one else knows about.

Chair Boyd thanked Susan Gallagher for calling that out and ensured that anything that needs correcting will be corrected moving forward.

Chief Counsel Yeroshek pointed out that the agenda states that this agenda item will address supporting legislation related to mental health services under the MHSA. This bill specifically falls under that description.

Chair Boyd thanked Chief Counsel Yeroshek for clarifying the agenda. It is always in the Commission's strong interest to communicate clearly. There is room for improvement, and feedback given in an appropriate, positive, supportive way is always appreciated and helpful.

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

The MHSOAC supports Assembly Bill 2325 (Irwin) and authorizes the Executive Director to communicate the Commission's support.

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

The following Commissioners voted "Yes": Commissioners Alvarez, Madrigal-Weiss, Mitchell, Vice Chair Aslami-Tamplen, and Chair Boyd.

Senate Bill 1019 (Beall): Youth mental health and substance use disorder services

Executive Director Ewing referred to pages 15 and 16 of Senate Bill (SB) 1019, which was included in the meeting packet. He stated Senator Beall has introduced legislation that would create in statute the direction that the Commission adopted last year, which puts a requirement that half of the funds that are made available for SB 82 programs be dedicated towards children.

Executive Director Ewing stated, when the Commission adopted that as a policy position for RFA proposals, Senator Beall issued a letter to the Commission announcing that he wanted to make that an ongoing requirement. When the Commission first made SB 82 triage funds available to the counties, the vast majority of the funds were dedicated to programs that targeted adults. The County Behavioral Health Directors Association (CBHDA) testified that many of the programs, although they were general in design, could benefit children.

Executive Director Ewing referred to Section 5848.5(i) as follows: “When making funds appropriated by the Legislature available 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.” Executive Director Ewing stated this is the proposed change in the law. Senator Beall has asked the Commission to take a support position on SB 1019 and would like the Commission to be the sponsor of the bill.

Executive Director Ewing stated typically what it means to be a sponsor as opposed to a supporter is that the idea originated with the Commission and that the Commission will work with Senator Beall to help get the bill passed by providing background information and other supports to ensure that it becomes law. It signals a higher level of support and that this is an idea that began with the Commission. The discussion is about whether the Commission is interested in supporting SB 1019 and, if so, whether the Commission is interested in supporting to the level of being a sponsor.

Chair Boyd thanked Senator Beall and stated it is great to be moved to a space of even being considered as a sponsor. It is a great opportunity. He asked Executive Director Ewing for counsel.

Executive Director Ewing stated there are deliberations to consider. On the one hand, as evidenced by the first round of funding but also the history of mental health services in the state of California, there is a heavy bias towards programs targeting adults. The strength of the proposal is that this creates a statutory obligation for children’s programs, but the proposal removes flexibility. The trade-offs to consider are the merits of symbolically signaling that children need their “fair share” with the issue of directing the Legislation to do it this way and thereby removing flexibility.

Commissioner Questions

Chair Boyd stated, a few years ago, the Commission started the white paper on children’s crisis services, which is soon to be finalized. The reality is that child/adolescent mental health services in California are underrepresented. Far too often, even on this Commission, when individuals have made funding requests, children and adolescents have been left off the table. Chair Boyd spoke in support of this bill. If greater flexibility is required in the future, the Legislature can change it.

Executive Director Ewing suggested engaging the Senator for consideration of adjusting the age of 18 and under to 21, 23, or 25 and under because 18 is not always the right age where someone is in the lifespan.

Commissioner Mitchell stated she is a mother of a child with a severe mental illness who was diagnosed at 14 and is now 20. Mental illness has no respect for age. She stated she sees this bill as limiting and would like to see flexibility in the bill for shifts of where the need lies within the age groups.

Chair Boyd stated, independent of individual advocacy needs, it is clear that there is a significant gap in California for focus on child/adolescent/TAY services and funding. Also, this bill will likely move with or without the Commission. A motion can be made to support the Commission doing this with language built in that gives some freedom and flexibility about the age range.

Commissioner Alvarez spoke in support of this effort. She stated it is not an “either/or” issue but a “both/and” issue exploring how the Commission can support early intervention, children, and youth and consider increasing the age. California’s 9 million children mean there are 9 million opportunities to get it right and to ensure the Commission moves upstream so that the wellbeing of communities is supported from the beginning and the harder to reach population with more difficult challenges later in life can be avoided. This bill means the state of California is prioritizing the future, which is the children.

Commissioner Alvarez emphasized that mental illness, behavioral health challenges, and mental health issues are part of a broad spectrum. Many children in this day are facing a multitude of trauma, such as the immigrant, incarceration, and child welfare system. Those experiences will have life-long effects on their wellbeing. Supporting children’s development early on puts everyone in a better position to have a bright future.

Commissioner Madrigal-Weiss spoke in support of this effort. Just half the funding would be secured for children. Schools have been working diligently to break down stigma and bring understanding to educators. If the Commission is committed to prevention, this bill will allow funding to identify and provide services. She stated half of all mental health disorders begin around age 14; the funding needs to be provided. There are too many children suffering.

Vice Chair Aslami-Tamplen spoke in support of this effort. She stated she liked the flexibility around the age. TAY need specific focus. At 18, children are cut off from the children’s system and thrown into the adult system. She stated the hope that the bill supports more county systems to have a TAY system that focuses on the 18 to 24 age range.

Executive Director Ewing provided context of the options available to the Commission:

- Option 1: Flexibility around the age. There are other examples of legislation where there is even flexibility on the 50 percent. There is language in the Act that says X percent shall go towards a certain thing “until there is a determination that needs are sufficiently met,” and then there is greater flexibility on how to spend those funds. The Commission may want to leave the door open a little, but the

Senator is the author and makes decisions and the Legislature will make decisions about what the final bill will look like through the policy-making process. It has to go through the process.

- Option 2: Taking a support position or a sponsorship position, asking the Senator to be open for flexibility on the age based on consultation through that policy process, and also considering if it makes sense to have some flexibility on the 50 percent. For example, “the Commission shall allocate 50 percent unless the Commission determines that that is not the best use of public resources because...” All of that is language that can be discussed during the policy process and ultimately the Senator, as the author, decides or the Committees decide what the final product will look like.

Executive Director Ewing stated the motion could be to sponsor the bill, enthusiastically support with direction that the Commission engage the Senator around options if he is so willing, but not require, that on (a) the age flexibility, and (b) some flexibility for points in the future. The second one is a little riskier but there are models out there and there are options.

Commissioner Mitchell asked if the flexibility on the percentage means the percentage could go down. Executive Director Ewing stated it could. The bill now says “at least” 50 percent. It defers to the Commission to decide what “at least” means. A way to build in flexibility is to say “unless certain conditions are met.” The conditions typically are that the Commission, as the administering body, makes a determination that the public benefit of setting aside those funds is outweighed by the public benefit of the 50 percent determination. It is the tension between surety that the dollars will be dedicated to this population and flexibility.

Chair Boyd stated there are many options that can be considered. He suggested giving guiding principles to the author that are not intended to be exhaustive. There will be other opportunities to provide input and guidance.

Executive Director Ewing stated typically staff writes a letter actively advocating to support, if that is the Commission’s will. The question becomes at what point the legislation may evolve where it no longer reflects the legislation that the Commission supported.

Chair Boyd stated the Commission can make a motion as basic as to support in collaborating with Senator Beall’s office, to produce legislation similar to the proposed language in the meeting packet, and that the Commission would empower the Executive Director in consultation with the Chair to make appropriate language references or areas of focus that match the spirit of the Commission’s support.

Commissioner Alvarez asked if the Commission is moving to sponsor.

Chair Boyd stated the Commission will have the opportunity to make such a motion after listening to public comment.

Public Comment

Susan Gallagher spoke in support of the bill but stated there was some misinformation given out. The children system of care has already been more funded than the adult

system of care because the children system of care has SB 163 funds, formerly AB 3632 that now is AB 114, and the onus is on the schools to provide these services. The problem is they are not doing it. There needs to be more accountability around that. The speaker stated the adult system of care has only ever had Realignment and then the MHSA. There are many funding streams that children can access that are not being properly accessed.

Susan Gallagher stated, while NorCal MHA supports the bill, it would like to see those other funds being leveraged and there being pressure put on the schools to provide the required services. Individualized Education Programs (IEPs) have gone down since the transition went from county mental health departments to the schools, fewer children are receiving services, and fewer children and families are able to navigate the system. The money is out there; it is just not being used properly. There is never enough funding for children but they have had a lot of funding out there and the adults have not. The speaker stated Sally Zinman brought up a good point about older adults. Older adults need more mental health services.

Michaele Beebe, Public Policy Director, United Advocates for Children and Families (UACF), spoke in support of the bill and echoed Susan Gallagher's comments. When children turn 18, they are kicked out of the children's system of care. Continuum of care reform put foster children at age 24 or 25. The speaker stated 18 is too young. The bill should go to age 24 or 25. AB 114 was passed long ago and schools received the funding but IEPs have gone down and assessments are not being given. The onus is on the schools that received this funding to identify children and involve parents. This is not happening. Leveraging these funds with this bill to have a broader spectrum of services is good, but the funding that is already out there should not be ignored.

Chair Boyd stated the funding being discussed is linked to triage funds. He asked Executive Director Ewing to break that down.

Executive Director Ewing stated these are SB 82 funds. The language being modified is the original SB 82 language for the Mental Health Wellness Act. The SB 82 funds are one of the tools that the Commission has to incentivize changes in the system. The Commission can use these funds to leverage against other funds to incentivize collaboration.

Executive Director Ewing stated the language the Commission adopted on the current RFA includes \$30 million to incentivize stronger school/county partnerships. Senator Beall's proposed language simply states that half of the SB 82 funds must be used for children. It is an incredible incentive-based funding tool that the Commission can use to drive quality into these strategies consistent with everything that the speakers are saying.

Executive Director Ewing stated the additional piece is the issue around accountability for the funds that are already on the table. The Commission has been doing that on the MHSA funding side and are beginning to do that on the Realignment funding side and, as part of the Schools and Mental Health Project, beginning to look at other resources that are available. The comments of the speakers are consistent with what the Commission has been hearing. This bill requires the Commission, over time, to do what

it has already chosen to do and it allows the Commission to use this tool in ways that the speakers are asking the Commission to.

Maureen Bauman, CBHDA, spoke in support of the bill and the consideration of flexibility in terms of the age, and echoed the previous speakers. This bill is important and children's services are important, but adult services are also important. The proportional distribution of age is not anything like 50/50. The speaker stated the age goes up to 30 for probation grants. Young people need help for some time; other work besides triage is necessary. Legislation does not change easily once it is put in place. It is important to keep the Commission in a position to decide what is best over time.

Steve Leoni, consumer and advocate, stated the 50 percent as a baseline struck him. The flexibility is a great idea and generally the Commission should support this, but it should be based more on the proportion of children in the population or in the population of need rather than the 50 percent. The speaker suggested building flexibility on that. The speaker recommended starting with a figure that bases itself on the proportion of kids in the population, which may change and, whatever cutoff point there is, and there may be several, building in a mandate for smooth transitions to whatever follows. The TAY category was created by child advocates looking for a way to transition from children to adult.

Joanne stated there was \$2 billion that has never been explained. It disappeared back in the beginning and no one has ever answered to that. There is a lot of stuff for children and housing is a big issue. Children will be homeless as they grow up because their parents cannot get into the system or, if they do get into the system, they have a hard time getting support with Section 8 and Shelter Care Plus because no one is overseeing. The schools have funding; what happened to it? The speaker asked where all the services are that were planned for and were supposed to be in service for many years.

Commissioner Discussion

Vice Chair Aslami-Tamplen asked what the age range was in the past RFA for triage funds.

Executive Director Ewing stated the first one was TAY and adults, the second one was ages 21 and under, and the third one was school-based. The criteria the Commission adopted was that the proposals must include the younger grades. The Commission has the authority to do this now, but the Senator is trying to capture that in statute. This is \$32 million out of the \$7 billion budget. Staff has been working hard on the \$220 million Innovation funds and to leverage the Commission's authority to approve innovations so they drive quality.

Executive Director Ewing stated the motion can be less specific – to authorize staff to work with the Senator in a sponsorship role of the bill to guide this through the course of the policy process under the direction of the Chair and bring it back to the Commission as it evolves to ensure it is consistent with Commission intent.

Chair Boyd asked what percentage of funding was designated to serve children and adolescents in the first round of Triage grants before the Commission's decision that it

wanted 50 percent of unspent and current funds to go to youth. Deputy Director Pate stated the first round of grants was about 17 percent for children.

Chair Boyd stated, without the direction and support from the Commission or legislation, only 17 percent of the funding available to serve children and adolescents in crisis went to children and adolescents. He stated he does not see this as limiting, but as expansive because it is a small percentage of funding and it signals to the counties that this is important, focus on it, and plan accordingly.

Commissioner Madrigal-Weiss stated a lot of the funding towards schools is specific for the special education populations and those who are diagnosed. But, when talking about general education children who have experienced trauma that is not necessarily affecting their academics, there is no funding necessarily for that in schools. There is a host of students not being served and that is the greater majority.

Commissioner Alvarez stated it is a disservice to shared goals for the health of communities to pit populations against each other. Everyone wants their children to be healthy, their parents to age with dignity, and their families to live prosperous, healthy lives. The solution should prioritize the children for a bright future.

Vice Chair Aslami-Tamplen moved to work with the Senator to guide through policy process and consider flexibility of age through a sponsorship role of the Commission.

Chair Boyd suggested including that the Executive Director has the freedom in consultation with the Chair to work on language.

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

The MHSOAC agrees to sponsor Senate Bill 1019 (Beall) and authorizes the Executive Director to engage with Senator Beall around options to provide flexibility to the Commission regarding age and percentage of funding. The Executive Director is to work with the Chair regarding specific language and update the Commission, as needed, as the bill evolves.

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

The following Commissioners voted "Yes": Commissioners Alvarez, Madrigal-Weiss, Mitchell, Vice Chair Aslami-Tamplen, and Chair Boyd.

INFORMATION

7: Innovation Summit Update

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

Chair Boyd tabled this agenda item to the next Commission meeting.

ACTION

8: Contract Authorization for Innovation Incubator Business Plan

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

Chair Boyd stated there is a process to consider supporting a contract for consultation and facilitation services for the Innovation Center. The materials in the meeting packet

are about approving a dollar amount to empower Executive Director Ewing to work with the consultant to do some review around business planning and location for the Innovation Center.

Chair Boyd stated one decision is to be clear about it, hear public comment, and vote. Another decision is to push it to next month. Executive Director Ewing recommended voting today to avoid problems later.

Chair Boyd if Commissioners feel solid enough to hear an abbreviated discussion from Executive Director Ewing, hear public comment, and move on the motion.

Commissioners agreed to hear an abbreviated presentation.

Executive Director Ewing stated, as the Commission tried to strengthen innovation activities over the past year, it discussed the strategy of providing technical assistance to the counties around innovation in the form of sponsoring an Innovation Incubator. In discussions with the administration, the Governor included \$5 million in the budget: \$2.5 million in the 2018-19 fiscal year and an additional \$2.5 million in the 2019-20 fiscal year for a total of \$5 million to allow the Commission to launch an Innovation Incubator. The Governor asks that the Incubator focus on addressing the challenge of the backlog of individuals declared incompetent to stand trial through community-based diversion strategies.

Executive Director Ewing stated this agenda item is a proposal to authorize staff to spend up to \$150,000 for a contractor to help staff develop a business plan for an Innovation Incubator model in consultation with the Agency. These funds are linked to the work of the Department of State Hospitals in competency restoration. The Governor has asked the Commission to connect this with his broader agenda for enhancing funding for mental health services for individuals who otherwise would end up in the state hospitals.

Chair Boyd deferred to Vice Chair Aslami-Tamplen to facilitate the rest of the meeting.

Vice Chair Aslami-Tamplen asked for public comment on the contract to develop a business plan for an Innovation Incubator.

Public Comment

Mandy Taylor advocated that stakeholders be actively involved in the business planning process. There are many consumers out there with business experience. The speaker urged the Commission to require that that be part of the process.

Rory O'Brien echoed Mandy Taylor's comment that stakeholders be involved in developing the business plan for the Innovation Incubator and reminded the Commission of the comments made by Poshi Walker, Co-Director, Out for Mental Health, LGBTQ Program Director, NorCal MHA, at the Innovation Summit regarding the development of many innovative ideas and projects that could be done with LGBTQ community and innovative projects proposed in the California Reducing Disparities Projects (CRDP) that was funded through 2012. The Commission has access to all of those innovative projects and all the people involved in Phase 1 and Phase 2. They are important resources for this Innovation Incubator. The speaker urged the Commission to use them.

Stacie Hiramoto echoed Mandy Taylor and Rory O'Brien's comments about ensuring that stakeholders are involved from day one on this. The speaker reminded the Commission that the CRDP has a lot of experts and great people and programs that might be relevant to this. The speaker asked the Commission to inform the public who is representing the racial, ethnic, and other communities so they can provide them with their input.

Tai'Rance "Chuckii" Kelly, Sr., suggested members of the LGBTQIA community as well as business-oriented individuals and/or offenders be a part of this and to bridge all barriers to further things, move things around, and work with or try to make better jobs for consumers who cannot advance because of their backgrounds that should not be there due to miscommunication and misunderstanding because they suffer from disorders. The speaker suggested including peers on the Board to make business planning decisions to help alleviate problems later.

Commissioner Questions and Discussion

Vice Chair Aslami-Tamplen asked Executive Director Ewing to discuss what the stakeholder engagement would look like.

Executive Director Ewing stated the Commission has not yet entered into a contract but is asking for authorization of the funds to do that. The conversations are around finding someone with a project management background who is familiar with the different models that are out there, and then facilitating a process so that issues of governance and issues around the work can be explored and what will be relevant. The customer of the Innovation Incubator is the community with the intent of it helping to drive the decisions that the counties are making in terms of their Innovation dollars where they present their Innovation ideas before the Commission. Good representation of the voices and stakeholders who are part of that process must be ensured. There is a commitment to having robust stakeholder engagement.

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

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.

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

The following Commissioners voted "Yes": Commissioners Alvarez, Mitchell, and Vice Chair Aslami-Tamplen

NorCal MHA ACCESS Ambassador Introductions

Vice Chair Aslami-Tamplen stated Chair Boyd wanted to honor and engage the consumers and stakeholders in attendance who are representing the NorCal MHA ACCESS California program. She invited Andrea Crook to come to the podium to say a few words.

Andrea Crook invited the NorCal MHA ACCESS Ambassadors to join her at the podium.

Vice Chair Aslami-Tamplen thanked the ACCESS Ambassadors for being in attendance.

Andrea Crook thanked the Commission for the opportunity for the ACCESS Ambassadors to meet Commissioners. The speaker stated ACCESS Ambassadors are in attendance from across the state who are in the NorCal MHA Bootcamp to kick off the ACCESS California program. The speaker shared the ACCESS California program mission statement with everyone. NorCal MHA did an extensive recruitment process throughout the state and gave everyone an opportunity to be included, involved, and at the table. The speaker asked the ACCESS Ambassadors to introduce themselves and to share the region they represent and the county in which they live.

Joy Torres is the ACCESS Ambassador for the South Region and is from Orange County.

Vickie Mack is the ACCESS Ambassador for the South Region and is from San Bernardino County. The speaker is here as an ACCESS Ambassador and as Executive Director of an agency that contracts with the Office of Statewide Health Planning and Development (OSHPD) to provide Workforce, Education, and Training (WET) services. The speaker stated the issue is getting peer specialist training services to rural and frontier area consumers. There are no peer specialist training opportunities in the South Region. Additionally, current training programs use educational and background screenings to cherry pick only the highest functioning consumers, therefore effectively eliminating those who are in most need. Possible solutions include holding counties accountable for ensuring training opportunities to reach rural consumers.

Pamela Inaba, ACCESS Ambassador, NorCal MHA, and former Chair, Los Angeles Client Coalition, spoke in support of Stacie Hiramoto's comments about reducing disparities and that more representatives for peers and peer specialists of color and of all other minorities and different populations are needed, such as the physically disabled, veterans, and older adults.

Pamela Inaba was interested in more discussion on the certification training for peer specialists and suggested having those conversations sooner rather than later. In reference to Agenda Item 2, the speaker stated there is not enough outreach to stakeholders and more needs to be heard.

Karen Reynolds is an ACCESS Ambassador representing Riverside County.

Kat Wantz is an ACCESS Ambassador representing Sacramento County.

Michaele Beebe is an ACCESS Ambassador representing Sacramento County.

Kathaleen Hefner is the ACCESS Ambassador for the Central Region and is from Mariposa County.

Hollis Ellis, Jr. is the ACCESS Ambassador representing Sonoma County. The speaker was dismayed at the actions seen here today. Individuals are engaged in side conversations or on the phone while the ACCESS Ambassadors are trying to introduce themselves. He opined that it makes no difference what the Ambassadors say because no one is paying attention anyway.

Bill Floyd is the ACCESS Ambassador for the Central Region and is from Stanislaus County.

Tai'Rance "Chuckii" Kelly, Sr., is the ACCESS Ambassador for the Central Region and is from San Joaquin County.

Michael Lim is the ACCESS Ambassador for the Bay Area Region and is from San Mateo County.

Alan Cochran is the ACCESS Ambassador for the Bay Area Region and is from San Mateo County. The speaker is also on the San Mateo County NAMI Board of Directors and the only consumer on the Board presently.

Linda Crabtree, client and family advocate, Mobile Crisis Stabilization Team, Amador County, is the ACCESS Ambassador representing Amador County.

Blia Chan, Adult Family Advocate, is the ACCESS Ambassador representing Sacramento County.

Vanessa Compton, client and family advocate, is the ACCESS Ambassador representing Amador County.

Katherine Ferry represented NorCal MHA, Consumer Affairs Supervisor, Placer County Adult System of Care.

Matt Mayerson is the Client Advocate Liaison for NorCal MHA and Sacramento County's division of Behavioral Health.

Vice Chair Aslami-Tamplen thanked the NorCal MHA ACCESS Ambassadors for the work they do throughout the state and the voice they represent and the communities they represent. She welcomed their opinions and feedback.

GENERAL PUBLIC COMMENT

Joy Torres emphasize the housing issue. Grandparents and parents need to be examples for their children and they cannot be if services are unavailable. Ninety percent of consumers do not touch drugs or alcohol until they are put into sober living because of a mental health program that cannot find the right housing for clients. The speaker suggested changing the name to behavioral health because it is all about behaviors today, not about what is really going on.

Pete Lafollette thanked the Commission for their time and service and thanked everyone in the room for making this an engaged process. The speaker stated the Thomas fire in Ventura County was the largest in state history and the most destructive. The turnout from Ventura Behavioral Health to engage individuals in crisis and sort through it was unprecedented, as it was for Santa Barbara's flood. The severe weather pattern will not be going away. As a culture, individuals would do well to anticipate them and to react accordingly. The suffering and mayhem that these life-altering events cause are being seen on a regular basis. The speaker thanked the Commission for paying attention to those items.

Stacie Hiramoto was looking forward to hearing a summary report-out on the Innovation Summit and was sorry to have missed it.

Vice Chair Aslami-Tamplen stated it was tabled to the next meeting.

Stacie Hiramoto talked about potential legislation since this might be of interest to the Commission. SB 1005 by Weiner has to do with directing counties on how to spend PEI dollars. REMHDCO is scheduled to meet with the author's office and supports the bill in general because they would like to ensure that PEI funds at the county level are spent - and are spent in appropriate ways. REMHDCO agrees with that.

Stacie Hiramoto hoped the Commission will support REMHDCO and other organizations representing underserved communities. While REMHDCO supports evidence-based practices, PEI should not be limited or encouraged to provide only evidence-based practices because evidence-based practices have not been adequately tested on communities of color and the LGBT community. REMHDCO feels very strongly about that. If they are going to be doing areas of emphasis where they have to spend the money, one of the areas should be reducing disparities of special populations.

Vice Chair Aslami-Tamplen thanked Stacie Hiramoto for bringing that legislation forward. She stated Executive Director Ewing mentioned that the bill was not in print before the agenda was finalized. All MHSOAC legislation will be brought to the Commission's attention.

Andrea Crook felt emotional with a lot of anxiety. The speaker was proud of the work that ACCESS California had been able to do today and to have this opportunity to bring clients from across the state together to help empower and elevate the voice of those who have been marginalized for so long. The speaker started in October requesting from MHSOAC staff the opportunity to have some time on the agenda to bring everyone. The speaker wanted everyone to have more time to share about the work ACCESS California is doing and going to be doing.

Andrea Crook acknowledged that the Commission's time is full, but respectfully wanted to have ACCESS Ambassadors introduce themselves so Commissioners can meet some of the individuals who will be working within communities throughout the state. The speaker requested that the Commission create an objective policy on how to be put on the agenda and present it to the public at the March meeting. So often, members of the public come off as being adversarial, but they are not – they are frustrated. Members of the public want to be part of the solution and of creating the agenda.

Katherine Ferry, Consumer Affairs Supervisor, NorCal MHA, followed up on public comment on stakeholder and consumer involvement in some of the big Innovation projects heard earlier in the agenda. The speaker emphasized the importance of including clients who are currently receiving services in these conversations, and in particular to have clients with lived experience of the particular issue. Earlier this afternoon, there was discussion about clients who may have been declared incompetent to stand trial and that there was a project related to those kinds of clients. When there are planning committees related to this issue, it is important to include someone who has had that experience.

Katherine Ferry stated Placer County has a committee that is made up of clients. In those big decision-making processes, it is important to include clients who are currently

receiving services because that is who these programs are reaching out to. The speaker was pleased to hear about clients being on planning committees where it is a client and someone representing other interests. It is powerful to have a client-led committee where the focus is on client feedback. Sometimes there is only one client and everyone in the room is representing their different issue and it is hard for the client's voice to be heard.

Tairance S. Kelly, Sr., stated there is never anyone like him. The reason for that is they do not believe they can be part of this. The speaker, as a LGBTQ single father of color with an unacceptable background culture and a childhood of abuse, opens doors for others to look through different lenses through the same glass.

Vickie Mack requested increasing peer specialist training services for rural and other underserved clients. It is imperative that these consumers have access to the training opportunities because for some of them this is the only entry-level opportunity that is available to them. Solutions could include holding counties accountable for ensuring training opportunities to reach rural consumers and consumers with barriers, contracting to provide online peer service training opportunities, or establishing a peer specialist scholarship for individual consumers. The speaker asked for a mechanism to be put in place to ensure access to peer specialist training opportunities for rural and other underserved consumers.

Commissioner Alvarez stated appreciation for everyone in the room. Learning is a lifelong process and she stated she was grateful for the opportunity to learn with the public as a new member on the Commission.

Vice Chair Aslami-Tamplen asked Audrey J. if she had anything to share from a young person's perspective about her first Commission meeting. Audrey J. declined.

Vice Chair Aslami-Tamplen thanked everyone for their attendance and for providing great feedback and participating in the Commission meeting.

ADJOURN

There being no further business, the meeting was adjourned at 4:11 p.m.

State of California

**MENTAL HEALTH SERVICES
OVERSIGHT AND ACCOUNTABILITY COMMISSION**

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

Minutes of Teleconference Meeting
February 8, 2018

MHSOAC
Darrell Steinberg Conference Room
1325 J Street, Suite 1700
Sacramento, CA 95814

866-817-6550; Code 3190377

Additional Public Locations

300 N San Antonio
Santa Barbara, CA 93110

2000 Embarcadero Cove, Suite 400
Oakland, CA 94606

1033 5th Street
Clovis, CA 93612

9506 Imperial Highway
Downey, CA 90242

State Capitol, RM 2082
Sacramento, CA 95814

CONVENE

Vice-chair Khatera Aslami-Tamplen called the meeting of the Mental Health Services Oversight and Accountability Commission to order at 8:00 a.m. and welcomed everyone. Vice-chair Aslami-Tamplen requested Filomena Yeroshek, Chief Counsel to explain the process for today's agenda. Ms. Yeroshek stated that today's teleconference has only one agenda item which will be discussed in closed session. Per the Bagley-Keene Act, the teleconference is open to the public to inform everyone that the Commission would be holding a closed session to discuss its response to the confidential final draft of the state audit on the Mental Health Services Act. The Commission will go into closed session and upon completion of the closed session which is anticipated to be approximately 9:00 a.m. the teleconference will be reconvened into open session. At that time Vice-chair Aslami-Tamplen will inform the public if there was any reportable action taken in closed session.

The public was reminded that the time for the report out from closed session is an approximate time. The public teleconference phone line will remain open while the Commission is in closed session.

CLOSED SESSION

The Commission convened the closed session teleconference at approximately 8:10 a.m. to discuss the Commission's response to the confidential final draft State Audit report on the Mental Health Services Act.

REPORT OUT

Vice-chair Khatera Aslami-Tamplen reported that during the Closed Session staff was authorized to respond to the confidential final draft State Audit report consistent with Commission's direction.

ADJOURN

There being no further business, the meeting was adjourned at 9:05 a.m.

AGENDA ITEM 2

Information

March 22, 2018 Commission Meeting

Schools and Mental Health Commission Project

Summary: As part of the Schools and Mental Health Project, today's panel presentations focus on the mental health needs of children to examine how mental health and education systems can work together more effectively to recognize early warning signs and intervene appropriately, particularly in school settings. The panels will focus on effective prevention and early intervention opportunities; partnerships between school, county, and community agencies; and how successful partnerships and interventions could be adopted on a larger scale. The information shared is intended to the Commission build an action agenda to improve how, when, and where children receive culturally-competent services and supports to succeed in school.

Commissioner and Sacramento County Superintendent of Schools David Gordon will introduce the project and the need to enhance school-based mental health prevention and early intervention efforts for children.

Panel 1: The Lived Experience of Childhood Trauma and Resilience

- Emmerald Evans, Founding Member of Seneca Family of Services Youth Advisory Board
- Jakaar Brandon, TAY Advocate and Peer Counselor

Panel 2: Understanding Early Childhood Mental Health: Risks, Disparities, and Educational Outcomes

- Chandra Ghosh Ippen, Ph.D., Associate Director, Child Trauma Research Program, University of California, San Francisco
- Gustavo Loera Ed.D., Mental Health and Education Research Consultant, Center for Reducing Health Disparities, University of California, Davis

Panel 3: Enhancing Opportunities for Prevention and Early Intervention:

- Heather Little, M.Ed., Health Policy and Program Manager, First 5 Association of California
- Natalie Woods Andrews, Ed.D., Director, Early Learning Department, Sacramento County Office of Education
- Ruben Reyes, Superintendent, Robla School District
- Ron Powell, Ph.D., Special Education Consultant, Early Childhood Mental Health Advocate

Panel 4: Strengthening California's Response to Children's Mental Health Needs

- Curtiss Sarikey, M.S.W., Chief of Staff, Oakland Unified School District
- Ted Lempert, J.D., President, Children Now

Enclosures (4): (1) Panel presentations brief (2) Panelist biographies, (3) Panel invitation letters, and (4) Panelist written testimony and supporting materials.

Handouts: None.

Schools and Mental Health Project

March 22, 2018 Panel Presentations Brief

PURPOSE

This project brief provides background and rationale to support panel presentations before the Commission on March 22, 2018. These panels are designed to support the Commission's project on the mental health needs of children in school settings.

INTRODUCTION

The Prevention and Early Intervention (PEI) component of the Mental Health Services Act (MHSA) promotes strategies to reduce the negative outcomes that may result from untreated mental illness—suicide, unemployment, incarceration, homelessness, school failure or dropout, removal of children from their homes, and prolonged suffering. In 2015, the Commission prioritized several policy projects, including one on Schools and Mental Health.

The primary goal of the Schools and Mental Health project is to build a shared understanding of the barriers, challenges, and opportunities surrounding unmet or inadequately met mental health needs in California's children. An emergent focus of the project to date has been barriers and challenges to the early recognition and treatment of children's mental health needs. Through this project, the Commission will identify actionable recommendations for strategies and solutions, including those in the realm of the Commission's tools—PEI, Innovation, Triage, Plan Review, Research and Evaluation, and supporting legislation. The project final report is expected to be considered by the Commission in fall 2018.

The following sections of this document provide context for the March 22 panel presentations.

BACKGROUND

Early experiences, particularly those in the first five years of life, shape the structure and function of the developing brain and have long lasting implications for behavior, learning, and physical and mental health. Adverse early experiences, such as both trauma and longer-term, chronic stressors can impair many aspects of the developing child—the ability to self-regulate behavior and emotions, learn, trust, and develop healthy relationships with others.¹

Mental health challenges are common in young children. Approximately 1 in 5 children have a mental health need, with the most common being anxiety disorders, behavioral disorders, ADHD, and/or mood disorders.² These mental health needs often are associated with early traumatic experiences and chronic stress.³ Interventions to address these disorders are often elusive for many children and their families. Fewer than half receive needed treatment or services.^{4,5}

Untreated and/or undertreated mental health needs negatively impact a child's personal, interpersonal and academic growth. Untreated or inadequately treated mental health conditions are strongly associated with various problems at school. For example, children may be chronically absent from school and show declines in academic performance.^{6,7}

Schools and Mental Health Project

March 22, 2018 Panel Presentations Brief

School settings can be ideal environments to identify children’s mental health needs and deliver mental health services and supports. However, a range of challenges impede the efficient and effective delivery of services in school environments.

1. *Mental health risk factors and needs are not being identified early in child development.* School readiness is associated with mental health and wellness. Some children begin school ill equipped to learn and self-regulate due to emerging mental health needs, often related to adverse childhood experiences.^{8,9}
2. *Educators often find it challenging to recognize and respond appropriately to children’s mental health needs.* Educators may not receive the training, guidance, and support to identify trauma and emerging mental health needs and to support these students in the classroom.¹⁰
3. *Educators and counties often struggle to understand the needs and complexities of families in order to engage them as equal partners to support children’s mental health needs.* Stakeholder from all walks of life stated a need to improve outreach and engagement to families, particularly to families in underserved and diverse communities.
4. *Schools often lack on-campus resources to assess and address the mental health needs of young students.* As we learned from stakeholders, too often, appropriate interventions do not occur until a child is failing academically, behaviorally, or socially at school. Educators and administrators of schools that implemented multi-tiered models like Positive Behavior Interventions and Supports (PBIS) consistently stated that they struggle to provide targeted and intensive mental health services and supports on school campuses (e.g., Tiers II and III).
5. *Mental health services for children and their families often are poorly integrated across systems.* Schools alone may be unable to address the comprehensive mental health needs of the child and family. Access and linkage to services across service-delivery systems can support successful engagement. As we learned through focus groups with educators and families, a variety of barriers (e.g., parental consent, transportation, appointment wait times, fragmentation, etc.) can deter successful linkage.

Stakeholder Engagement

In this project, we have engaged a diverse group of stakeholders across the State in order to help us develop a common understanding of the barriers and challenges that children with mental health needs and their families face in receiving services, specifically in school settings. Summaries of Subcommittee Workgroup meetings, public hearings, school site visits, and focus groups can be found at <http://mhsoac.ca.gov/school-based-mental-health-services-children-early-education>.

Through these efforts, we have sought evidence, opinions, and perspectives from people in various fields and walks of life. Critically, we have invited participation and feedback from those with lived experience from diverse communities - consumers, parents, and caregivers, and those who serve them such as teachers, administrators, and mental health professionals.

Schools and Mental Health Project

March 22, 2018 Panel Presentations Brief

MARCH 22 PANEL PRESENTATIONS

The January 26, 2018 Public Hearing before the Commission on the Schools and Mental Health Project focused on the barriers and challenges to the early identification and treatment of mental health needs in young students. The March 22 panel presentations focus on potential strategies and solutions for addressing the key challenges this project has identified to date including a lack of 1) early screening and identification; 2) access to comprehensive services on school sites; 3) training and support for educators; 4) parent education and engagement; and 5) coordination across education and community mental health systems.

Panel 1. The first panel, entitled *The Lived Experience of Childhood Trauma and Resilience*, comprises two young adults – Ms. Emerald Evans and Mr. Jakaar Brandon. Each will discuss the impact that early life trauma had on their lives, what enabled them to be resilient, and what changes they see as critical to help others earlier. This panel will set the stage for all subsequent panels, privileging the consumer/advocate voice and providing an understanding from the consumer perspective on how practices and policies impact people’s lives and how we can improve upon them.

Panel 2. In Panel 2, *Understanding Early Childhood Mental Health: Risks, Disparities, and Educational Outcomes*, two presenters will embed what we heard from the opening panelists into a broader, systematic context for understanding key sources of risk and opportunities to address emergent mental health needs in young children. Dr. Chandra Ghosh Ippen will discuss how experiencing trauma in early life can have a lasting, negative impact on the developing child’s health, learning, and ability to relate to others. Dr. Gustavo Loera will help us better understand the macro-level factors (e.g., poverty, racism) that negatively impact the mental health of children and families living in our diverse communities in California. Each speaker will discuss strategies to mitigate the impact of trauma and other adversities on children to support healthy development and positive outcomes.

Panel 3. The goal of Panel 3, *Enhancing Opportunities for Prevention and Early Intervention (PEI)* is to provide an overview of the work being done in schools and communities to address the needs of children that were highlighted in Panels 1 and 2, and to explore opportunities to enhance or extend that work. Each of the four panelists – Ms. Heather Little, Dr. Natalie Woods Andrews, Mr. Ruben Reyes, and Dr. Ron Powell – will share examples of successful school- and/or community-based programs for the early recognition and treatment of trauma and mental health needs in children as they relate to efforts to ensure equity and reduce disparities. Panelists will discuss how these programs address the impact of trauma and chronic environmental stressors on children and their families, particularly for those living in underserved communities, through coalition building and leveraging resources. Speakers on this panel will discuss strategies for family engagement and provision of family-based interventions that are non-stigmatizing, linguistically and culturally appropriate, and successful in reducing disparities. Lastly, panelists will summarize the key lessons they have learned in the field and provide recommendations for enhancing PEI programs going forward.

Panel 4. The final panel, *Needs Strengthening California’s Response to Children’s Mental Health* will discuss how systemic and institutional barriers can be overcome to implement successful school- and community-based programs such as those highlighted in Panel 3, particularly in underserved communities. Panelists Mr. Ted Lempert and Mr. Curtiss Sarikey will outline a strategic policy vision for

Schools and Mental Health Project

March 22, 2018 Panel Presentations Brief

how California can ensure all young students and their families have access to mental health services and supports on school campuses.

CONSIDERATIONS

Below are some considerations for Commissioners as they listen to the panel presentations:

- How can the Commission continue to support school-county partnerships, particularly in start-up planning to integrate systems?
- Should the Commission, in collaboration with other agencies, develop a strategic statewide vision for PEI?
- How can the Commission prioritize and support innovation in the delivery of school-based mental health services?
- How can the Commission work with the California Department of Education and other State agencies to operationalize and track school failure as it relates to mental health?

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**MARCH 22, 2018 COMMISSION MEETING
SCHOOLS AND MENTAL HEALTH PROJECT
PANELIST BIOS**

EMMERALD EVANS

Emmerald Evans is a former foster youth. She is one of the co-founders of the Youth Advisory Board (YAB) for Seneca Family of Agencies who advocates, problem solves, and educates with an empowered manner to implement positive change in the foster care system. Within being a YAB member she also piloted peer mentorship in the board. She is a youth leader for the Space of Grace Youth Academy and a current student at the California State University of Sacramento. She is currently pursuing a degree of Criminal Justice and Sociology.

JAKAAR BRANDON

Jakaar Brandon is a TAY Advocate and Peer Counselor. He is a member of the Youth Advisory Board (YAB) for Seneca Family of Agencies and is also a former client. He is a passionate and dedicated advocate for youth. He currently works four jobs and is soon to become a new father.

CHANDRA GHOSH IPPEN, Ph.D.

Chandra Ghosh Ippen is the Associate Director of the Child Trauma Research Program at the University of California, San Francisco and the Director of Dissemination and Implementation for Child-Parent Psychotherapy (CPP). She specializes in working with young children who have experienced trauma and has co-authored over 20 publications on trauma and diversity-informed practice, including the manual for CPP, a randomized trial documenting the efficacy of CPP, the children's story "Once I Was Very Very Scared," and the Trinkka and Sam story series. She has over 14 years of experience conducting trainings nationally and internationally in diversity-informed practice and Child-Parent Psychotherapy. She also has a lifetime mission to bake 1000 pies and a pie in all 50 states.

GUSTAVO LOERA, Ed.D.

Gustavo Loera is a mental health educator and researcher with extensive experience in mental health workforce development and prevention and early intervention. For the past 20 years, his research has focused on merging the needs of underserved populations of low-income individuals, children, and families with mental health problems. During Dr. Loera's 17-year tenure at the Mental Health America of Los Angeles (MHALA), he was the founding Director of the Human Services Academy (HSA) model, Los Angeles' first high school career academy dedicated to Southern California's nonprofit and public human service network and its growing need for bilingual and bicultural workers to serve underserved communities. His work with schools has led to both prevention and early intervention curriculum, and workforce efforts with an outcome of establishing school-based programs that offer safe spaces for children and families to engage in dialogue about mental health treatment.

HEATHER LITTLE, M.Ed.

Heather Little joined First 5 Association of California after a 15-year career with Seneca Family of Agencies, where she served (among other roles) as Quality Assurance Assistant Director, supporting Seneca's work with families across the state. Heather is now the Health Policy and Programs Manager, overseeing the coordination efforts of Help Me Grow California and supporting the advancement of the Association's comprehensive health and development policy agenda. She has a Master's Degree in Special Education and has a deep understanding of the interplay between early learning and health systems for young children.

NATALIE WOODS ANDREWS, Ed.D.

Natalie Woods Andrews is a credentialed administrator and teacher with 30 years of experience in educational leadership, early education and public school and university instruction. She currently serves as the Director of Sacramento County Office of Education's Early Learning Department. Her role includes expanding access to high-quality early learning programs and services for children and their families, and providing leadership to expand professional learning opportunities for early learning teachers and administrators. She administers a number of local programs including Raising Quality Together - Sacramento County's Quality Rating and Improvement System and Project SOARS/Help Me Grow – Sacramento County focused on early identification and intervention services for young learners with developmental delays. She leads statewide programs such as the California Preschool Instructional Network (CPIN) and professional learning resources for transitional kindergarten. In addition, she serves on various state and local advisory councils including the California State Advisory Council on Early Learning and as co-chair for the Steering Committee on Reduction of African American Deaths.

Prior to her current position, Dr. Woods Andrews served as a principal for Title I elementary schools in the Fairfield-Suisun Unified School District; Education Specialist for Napa-Solano Head Start programs; and Program Administrator for Elk Grove Unified School District's First 5 school readiness program including Head Start, State, and Title I preschool programs. Her early professional experience began as a Coordinator of Title I elementary school services and elementary school teacher. She earned a doctor of education degree in educational leadership from the University of Southern California.

RUBEN REYES

Ruben Reyes has served the Robla School District for over twenty years, the past seven as Superintendent. He has served as a reading specialist, the Coordinator of English Learner services for the district and principal of Main Avenue School. The small elementary district on the northern edge of Sacramento serves approximately 2,500 students in preschool through grade six. All schools have very diverse student populations, with about 20 languages spoken by district families. There is also a great deal of socio-economic diversity, with over 90 percent of students qualifying for free or reduced priced meals through the federal school meal program.

RONALD J. POWELL, Ph.D.

Ronald J. Powell is the former Chief Executive Officer of the California Association of Health and Education Linked Professions, a Joint Powers Authority located in San Bernardino County, California. As CEO of the CAHELP JPA, he was the Administrator of the Desert/Mountain Special Education Local Plan Area, the Desert/Mountain Charter SELPA, and the Desert/Mountain Children's Center, a community-based mental health clinic serving over 8000 children from birth to 22 years of age annually. With over 40 years of experience as a teacher, consultant and administrator for a wide variety of innovative alternative and special education programs, Dr. Powell has been instrumental in the development of several exemplary programs for at-risk youth. Dr. Powell has served as an advisor to a number of task forces and working committees addressing the needs of at-risk youth and has made numerous conference presentations on the subject. The Association of California School Administrators has honored him as the Special Education Administrator of the Year for Region 12, and he has been the recipient of the Lifetime Advocate award by the Child Abuse Prevention Council for San Bernardino County and the Lifetime Achievement Award by the California Mental Health Advocates for Children and Youth.

CURTISS SARIKEY, M.S.W.

Curtiss Sarikey is Chief of Staff with the Oakland Unified School District (OUSD). He brings over thirty years of experience working to improve communities and schools for children and families. He was most recently at the Stuart Foundation from 2016-17 as Senior Director where he led work for the Foundation on educator leadership, labor management collaboration, and state level policy on continuous improvement and capacity building. He was also the Deputy Chief of Community Schools and Student Services department in OUSD from 2011 to 2016 where he was responsible for student and family support services and district collaborations with public and private partners. In 2016 Curtiss was awarded a Community Schools Initiative Leadership Award from the National Coalition for Community Schools. He was also adjunct faculty for University of San Francisco School Counseling Program where he taught courses in family engagement and school improvement.

His prior experience includes ten years in the San Francisco Unified School District as a supervisor for the Student and Family Services Department, executive director of Big Brothers Big Sisters of the East Bay, and social worker with the U.S. Naval Medical Center, Oakland.

TED LEMPERS, J.D.

Ted Lempert is the President of Children Now. He is also a Lecturer in the Political Science Department at UC Berkeley. Previously, Mr. Lempert was the founding CEO of EdVoice, a California education reform organization.

Mr. Lempert was a California State Assembly member for eight years representing Silicon Valley. He served as chair of the Assembly Higher Education Committee and co-chair of the Joint Committee to Develop a Master Plan for Education, and had more than 75 bills signed into

law, including major policies in the areas of education, health care, children and families, tax policy and the environment. Mr. Lempert also served on the San Mateo County Board of Supervisors, where he served on the County Hospital Board, the Health Plan of San Mateo Board, and the Mental Health Commission. He also worked for the law firm Sheppard, Mullin, Richter and Hampton.



STATE OF CALIFORNIA
EDMUND G. BROWN JR., Governor



WELLNESS · RECOVERY · RESILIENCE

JOHN BOYD, PsyD
Chair

February 12, 2018

KHATERA ASLAMI-TAMPLEN
Vice-Chair

Emerald Evans
3090 Tice Creek Way
Sacramento, CA 95833

MAYRA ALVAREZ
Commissioner

Dear Ms. Evans:

RENEETA ANTHONY
Commissioner

Thank you for agreeing to participate in the Commission's public meeting on Thursday, March 22, 2018, at the MHSOAC (1325 J Street, Steinberg Room, 17th Floor, Sacramento). During this meeting, we will hold a series of panel presentations to understand trauma and mental health needs in the birth to 3, 3 to 5 (preschool, pre-K), and 5 to 8 (early elementary school) age cohorts, and examine how the mental health and education systems can work more effectively together in recognizing early warning signs and intervening, particularly in school settings. Your participation will assist the Commission in developing an action agenda to promote wellness and resiliency in children, improve collaborative efforts to identify trauma and mental health needs early, and improve outcomes including academic success for children with mental health needs.

LYNNE ASHBECK
Commissioner

JIM BEALL
Senator
Commissioner

BILL BROWN
Sheriff
Commissioner

KEYONDRIA D. BUNCH, Ph.D.
Commissioner

Your panel is entitled *The Lived Experience of Childhood Trauma and Resilience* and is scheduled to begin at approximately 9:45 a.m. During this panel, we would like you to tell us about your early childhood challenges and experiences, what made a difference in your life to help you get to where you are today, and what could have been done better.

ITAI DANOVITCH, M.D.
Commissioner

DAVID GORDON
Commissioner

Written testimony coupled with brief summary remarks and an opportunity to engage the Commissioners in an exchange, we believe is an approach that maximizes the impact your presentation will have on the Commissioners and the public. We ask that you provide an electronic copy of any written testimony or other background materials by Monday, March 12, 2018 so that it may be included in the meeting materials. You may direct that copy to Ms. Kai LeMasson at Kai.LeMasson@mhsoc.ca.gov. Your written responses will allow those Commissioners attending the meeting the opportunity to prepare questions for you after your presentation, and will be made available to those Commissioners unable to attend the meeting.

GLADYS MITCHELL
Commissioner

MARA MADRIGAL-WEISS
Commissioner

TINA WOOTON
Commissioner

TOBY EWING
Executive Director

Please address the following questions to organize your testimony:

- How did experiencing trauma and/or a mental health need at a young age impact you and your schooling?
- What enabled you to be resilient, and why?
- From your perspective, what can schools and communities do to ensure that children who have experienced trauma and/or a mental health need succeed?

We ask that you plan on presenting summary comments in a brief presentation (8 to 10 minutes) to leave ample time for conversation with Commissioners.

We also ask that you send Ms. LeMasson a brief biography by Monday, March 12, 2018. Please note that your written responses to the items above and your biography will be shared as public documents.

Should you have any questions, I can be reached at toby.ewing@mhsaac.ca.gov or 916.445-8729.

Thank you again for your willingness to participate in this important meeting.

Respectfully,

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Toby Ewing, Ph.D.
Executive Director



STATE OF CALIFORNIA
EDMUND G. BROWN JR., Governor



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JOHN BOYD, PsyD
Chair

February 26, 2018

KHATERA ASLAMI-TAMPLEN
Vice-Chair

Jakaar Brandon
1732 Elm Street
Fairfield, Ca 94533

MAYRA ALVAREZ
Commissioner

Dear Mr. Brandon:

RENEETA ANTHONY
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STATE OF CALIFORNIA
EDMUND G. BROWN JR., Governor



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JOHN BOYD, PsyD
Chair

February 12, 2018

KHATERA ASLAMI-TAMPLEN
Vice-Chair

Chandra Ghosh Ippen, Ph.D.
Child Trauma Research Program
University of California, San Francisco
1001 Potrero Avenue Bldg 20 Suite 2100
San Francisco, CA 94110

MAYRA ALVAREZ
Commissioner

RENEETA ANTHONY
Commissioner

Dear Dr. Ghosh Ippen:

LYNNE ASHBECK
Commissioner

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BILL BROWN
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KEYONDRIA D. BUNCH, Ph.D.
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ITAI DANOVITCH, M.D.
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Your panel entitled *Understanding Early Childhood Mental Health: Risks, Disparities, and Educational Outcomes* will provide a context for understanding trauma and risk for mental health challenges in young children, particularly for those living in disadvantaged communities. This panel is scheduled to begin at approximately 10:15 a.m.

DAVID GORDON
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MARA MADRIGAL-WEISS
Commissioner

TINA WOOTON
Commissioner

TOBY EWING
Executive Director

Please address the following questions to organize your testimony:

- What is meant by trauma and how can traumas experienced early in life (birth to 3) damage child development? How, if unmitigated, do such traumas damage mental health and educational outcomes?
- Which children are at greatest risk of impeded development due to trauma, and why?
- What are the most promising or effective approaches to mitigating the negative impacts of early trauma experiences? How can schools and communities work together to support these efforts?

We ask that you plan on presenting summary comments in a brief presentation (8 to 10 minutes) to leave ample time for conversation with Commissioners.

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Executive Director



STATE OF CALIFORNIA
EDMUND G. BROWN JR., Governor



WELLNESS · RECOVERY · RESILIENCE

JOHN BOYD, PsyD
Chair

February 22, 2018

KHATERA ASLAMI-TAMPLEN
Vice-Chair

Dr. Gustavo Loera, Ed.D., Research Consultant
Center for Reducing Health Disparities, University of California, Davis,
Clinical and Translational Science Center (CTSC)
2921 Stockton Boulevard, Suite 1408
Sacramento, CA 95817

MAYRA ALVAREZ
Commissioner

RENEETA ANTHONY
Commissioner

Dear Dr. Loera:

LYNNE ASHBECK
Commissioner

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MARA MADRIGAL-WEISS
Commissioner

TINA WOOTON
Commissioner

TOBY EWING
Executive Director

Please address the following questions to organize your testimony:

- How should we understand the impact of chronic, environmental stressors (e.g., poverty, racism, discrimination) on the developmental paths and mental health needs of children and their families?
- Drawing from your expertise in grassroots community and educational capacity building, particularly in Latino communities and other communities of color, please help us better understand the disparities observed in the mental health and educational outcomes in those populations relative to the overall population of California, and why those differences persist.

-
- What are the most promising or effective approaches to mitigating the negative impacts of these stressors on the well-being of children (and their families)? How can schools and communities work together to support these efforts?

We ask that you plan on presenting summary comments in a brief presentation (8 to 10 minutes) to leave ample time for conversation with Commissioners.

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Toby Ewing, Ph.D.
Executive Director

TESTIMONY TO THE MENTAL HEALTH SERVICES OVERSIGHT &
ACCOUNTABILITY COMMISSION
SCHOOLS AND MENTAL HEALTH
MARCH 22, 2018

CHANGING THE TRAJECTORY OF A MENTAL DISORDER: THE IMPORTANCE OF
PREVENTION, EARLY DETECTION, AND TIMELY TREATMENT

Gustavo Loera, Ed.D.

Research Consultant

Center for Reducing Health Disparities

University of California, Davis

Thank you for the opportunity to speak with you about a very important topic—understanding early childhood mental health’s risks, disparities, and educational outcomes. My name is Gustavo Loera, Senior Research Consultant at the Center for Reducing Health Disparities (CRHD) at UC Davis. The core aim of the CRHD is to build on more than a decade of using community-informed knowledge and solutions to identify and address the mental health treatment gap for underserved communities in California.

Mental health is recognized as a central determinant of individual well-being, social and family relationships, and meaningful participation in community life.¹⁻³ Yet, between 50 to 90 percent of people with serious mental illness have not receive appropriate mental health care in the previous year.⁴ The onset of mental disorders usually occurs in childhood or adolescence, although treatment typically does not occur until years later.⁵ Most of the psychiatric disorders that have an onset in childhood, increase the risk for poor physical health problems in social relationships, reduced psychological well-being, and financial difficulties.⁶ Similar research has shown that developing a mental disorder at a very early age may have significant effects on educational attainment and workforce participation,⁷ interpersonal relations such as marriage and divorce,⁸ and even subsequent disabling physical conditions.⁹

The early age of disorder onset suggests the need for prevention, early detection, and timely treatment targeted to children. And, the importance of a developmental perspective in understanding trajectories of mental health and treatment for mental disorders. Early detection can change the trajectory of children’s lives and mental health disorders. That is, accurate and early detection of mental health conditions combined with continuation of mental health services for children and their families is critically important and could lead to state- and nation-wide reductions in health care costs. Furthermore, failure to work with schools on school-based mental health programs could lead to more severe conditions and the exacerbation of behavioral disorders and problems that eventually result in consignment of more children, in particular those with traumatic experiences, to the juvenile justice system, where mental health services are seriously lacking. It is estimated that 80% of children that enter the juvenile justice system have a mental disorder.¹⁰

Approximately 75% of children with emotional and behavioral problems do not receive specialty (culturally appropriate) mental health services.¹¹ For example, Latino children are 3 times more likely of having unmet mental health needs when compare to White children.¹² Underserved and marginalized populations, such as Latino immigrant families and children, have and continue to endure a host of adverse experiences, such as poor housing, acculturative stress, abuse (physical, emotional, sexual), trauma, stigma, and racism that increases their social isolation. When these adverse experiences are not adequately addressed, it increases health disparities, diminishes opportunities for children and their families to play a meaningful role in the social, economic, and cultural life of their communities, and puts children on a chronic course of mental health problems.

Social Determinants of Mental Health (Risk Factors)

Poverty including obtaining housing, health insurance, and food are often cited as major contributors to mental health problems among underserved populations in California. Underserved Latinos populations report experiencing a significant degree of anxiety related to providing food and housing for themselves and their families. That is, the burden of poverty and having the basic necessities of life has been linked to not having time and the resources to obtain mental health care, and often leads to despair, depression, and suicidal thoughts.

In the current political climate, we are seeing any possible progress toward undocumented families seeking and receiving access to mental health care for their children give in to fear, anxiety, isolation, and hopelessness. In our communities and schools, we are seeing the negative consequences of children fearing and isolating themselves from school activities out of fear of deportation and/or exposing their

parents and other undocumented family members. These negative consequences increase stigma, distrust, and expose an already vulnerable population to more trauma, racism, and other risk factors associated with mental health. This reality is especially pervasive among undocumented Latinos, who constantly fear being deported if they seek mental health services for themselves and/or their children.

The inequities that often result in challenges to access and utilization of mental health care for underserved populations, in particular Latinos are the following:

- Stigma and shame
- Lack of culturally and linguistically appropriate mental health services and providers.
- Inadequate and unreliable transportation.
- Lack of well-trained bilingual and bicultural mental health interpreters.
- Inadequate response time to requests for services resulting in long waits for appointments.
- Services during non-conventional hours, especially for rural and immigrant farm working families.
- Lack of LGBTQ-friendly services and treatment programs.
- Poor quality in consumer-provider interactions early in treatment that results in treatment drop outs.
- Frustration, fear, and distrust with the current mental health system.
- Lack of health insurance and belief that no mental health services are available for them.
- Rely on hospital emergency rooms and will only seek help when in crisis.
- Lack of family advocacy programs to increase knowledge about mental health (health literacy).
- Lack of advocacy for early detection of mental health disorders among children and assisting their families how to effectively navigate health and mental health systems.

Failing to address the psychological distress that children experience in their homes, schools, and communities eventually will lead to negative educational and mental health outcomes, including suicide. In our 2012 *Community-Defined Solutions for Latino Mental Health Care Disparities* report, we found Latino parents reporting being concerned about school educators mistaking a mental health issue for a behavioral problem and resulting in labeling their children as “at-risk” and leading to unnecessary expulsions, continuation school, and eventually prompting their children to drop out. “When schools misdiagnose our children and label them as a ‘behavioral issue’ without proper assessment for other developmental issues ... they [schools] resolve it by simply sending out children to a continuation school, where the ‘pipeline to prison’ starts,” said one Latina parent.

Failing to work with schools is a missed opportunity to integrate mental health topics into the curriculum and improve teacher knowledge and classroom instruction. While schools are not equipped with adequate school-based mental health programs, teachers play an important role as caring adults and mentors encouraging and engaging children and their families in mental health awareness activities. Mental health promotion programs in schools as early as elementary school, including early detection and prevention programs, could result in reductions in school dropouts. Researchers have found that chronic diseases are more prevalent among those with lower educational attainment.¹³

The Stories of Children on a Chronic Trajectory

It has been well documented that 75% of early onset adult mental disorders is by age 24; 50% are evident by age 14 with first symptoms occurring 2 to 4 years prior to onset. The impact of early trauma and symptoms, and onset of mental and substance use disorders are evident in the following stories of children, who were undiagnosed or misdiagnosed during their childhood years.

- 16-year-old male student. Student reported taking a bottle of prescription medication with the intention to kill himself. Student first attempted suicide in middle school. Student was physically abused by an alcoholic father and witnessed domestic violence in his home.
- 15-year-old male student uncle and aunt died by suicide a year apart. Student has history depression symptoms, suicide ideation and attempts. Student reported history of bullying by peers.
- 16-year-old female student who recently immigrated to the U.S. from Central America. Student reported her parents were murdered due to retaliation from gang members. Student fled her country with her siblings due to threats to their lives. At the U.S. border, student was separated from her siblings.
- 15-year-old female student. Student reported that she was raped by her brother and uncle between the ages of 11-12. At a very young age her father was incarcerated for murder charges, her mother died of health complications, and she started using cocaine, marijuana, crystal meth, and prescription drugs. Student was sent to drug rehabilitation but didn't complete the program due to family's lack of insurance and not being able to pay for fees. Student started using cocaine a few months after moving in with her sister.

Simply put, our school children are suffering from early trauma and other risk factors associated with mental and substance use disorders, are not receiving adequate and appropriate services and treatment to change their chronic course.¹⁴

Community-Defined Solutions

- Educating teachers about mental health topics and how to listen to the warning signs when students are asking for help.
- Academic and school-based mental health programs that focus on children and the impact of failing to adequately detect and diagnose potential mental health issues in a timely manner. Schools should represent a safe setting to educate children and their families about mental health.
- Increase county and school collaborations to identify mental health problems among children and provide interventions aimed to decrease the risk factors.
- Increase advocacy efforts and programs in schools to ensure accurate and early detection of mental disorders among children, as a strategy to change the course of a potential mental disorder as well as to avoid possible misdiagnosis that may result in mistreatment and school dropouts.
- Develop an education plan to create and integrate mental health educational standards and topics into the schools' curricula.
- Peer-to-peer strategies that involve storytelling and sharing lived experiences.
- Recognize that mental health care begins at the community level, working with schools and other community-based settings where children and families thrive, feel celebrated and accepted.
- Identify strengths of the community and recognize the unique assets and resiliency of the community and culture.

Example(s) of a Best Practice

Cal-HOSA: Future Health Professionals is a student-led organization for middle schools and high school students interested in learning more about health and mental health. In 2018, Cal-HOSA is designing and piloting a prevention and early intervention model of children and educators. This model will serve as a behavioral/mental health care framework to address the risk factors associated with health and mental health issues and suicide ideation among children of underserved populations. The aim is to develop a training model concentrating on training academic and career technical education (CTE) teachers/ educators' and students' on identifying social determinants of health earlier and addressing them using school- and student-defined strategies. This project aligns with the 2016 state law (AB 2246) that

mandates public school districts to adopt policy that address suicide prevention and early intervention among adolescents in grades 7 through 12 starting in school year 2017-18. Suicide among children and adolescents has become the second-leading cause of death.

We have anecdotal evidence suggesting that when HOSA curriculum is integrated into the school and classroom environment where students experience a sense of inclusion and belonging to a program that recognizes them as an asset to their community. Children and adolescents who are members of HOSA have reported finding a meaningful purpose in their school and community life. For example, children/youth are more: (1) invested in their schoolwork, (2) confident in their abilities to succeed in specific tasks, (3) positive in their outlook on life and committed to serving their community, (4) emotionally invested and connected to human networks and generating meaningful relationships, and (5) intrinsically motivated and find joy in serving others.

Other effective programs include the NAMI on Campus clubs, also student-led projects that: (1) raise mental health awareness, (2) educate the school community about effective prevention strategies, (3) supporting and connecting students and their parents, (4) promoting services and supports that inspire peer-to-peer dialogue, and (5) advocating for children and families. Also, mindfulness, a prevention and early intervention strategy emphasizing relaxation techniques and guided meditation that helps children reflect and become more aware of themselves in the present while acknowledging and accepting feelings, thoughts, and bodily sensations.

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COMMUNITY-DEFINED SOLUTIONS FOR LATINO MENTAL HEALTH CARE DISPARITIES

CALIFORNIA REDUCING DISPARITIES PROJECT

LATINO STRATEGIC PLANNING

WORKGROUP POPULATION REPORT





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EXECUTIVE SUMMARY

On behalf of the California Department of Mental Health (CDMH), we are pleased to present the research results of the **California Reducing Disparities Project (CRDP): Latino Strategic Planning Workgroup (SPW)**. This Executive Summary offers a brief background of the CRDP Project, followed by an overview of the research purpose, mental health status of Latinos, key findings, community-identified strategies for improving mental health treatment, and strategic directions and recommendations for reducing health disparities in Latinos.

This project examined mental health disparities for the Latino population. Our aim was to develop and implement the appropriate process for identifying community-defined, strength-based promising practices, models, resources, and approaches that may be used as strategies to reduce disparities in mental health. To accomplish this goal, we adopted a set of topics from the California Department of Mental Health (2009). We also adopted the community-based participatory research (CBPR) framework from Minkler and Wallerstein (2008) to ensure a continuum of community involvement that over time builds and strengthens partnerships to achieve greater community engagement (McCloskey et al., 2011).

Our overall findings suggest that racial and ethnic minority groups in the U.S. fare far worse than their white counterparts across a range of health indicators (Smedley, Stith, and Nelson, 2003). Non-white racial and ethnic groups now constitute more than one third of the population in the United States (Humes, Jones, and Ramirez, 2011), and as the nation's population continues to become increasingly diverse, the passing of the health care reform law (Andrulis, Siddiqui, Purtle and Duchon, 2010) becomes a critical piece of legislation in advancing health equity for racially, ethnically, and sexually diverse populations.

THE CALIFORNIA REDUCING DISPARITIES PROJECT

In order to reduce mental health disparities, improve access and quality of care, and increase positive outcomes for racial, ethnic, LGBTQ, and cultural communities in California, the California Department of Mental Health launched a statewide Prevention and Early Intervention initiative effort utilizing allocations authorized under Proposition 63, known as the Mental Health Services Act (MHSA), to fund the California Reducing Disparities Project. The project focused on five populations: (1) African Americans; (2) Asian/

Pacific Islanders; (3) Latinos; (4) Lesbian, Gay, Bisexual, Transgender, and Questioning (LGBTQ); and (5) Native Americans. As part of the project, five Strategic Planning Workgroups (SPWs), corresponding to each population, were created to provide the California Department of Mental Health with community-defined evidence and population-specific strategies for reducing disparities in behavioral health.

The Prevention and Early Intervention (PEI) initiative is key to reducing disparities and risk factors, and building protective factors and skills. The National Research Council and Institute of Medicine (NRC/IOM; 2009) defines "prevention" as programs and services that focus on "populations that do not currently have a disorder, including three levels of intervention: *universal* (for all), *selective* (for groups or individuals at greater than average risk), and *indicated* (for high-risk individuals with specific phenotypes or early symptoms of a disorder). However, it also calls on the prevention community to embrace mental health promotion as within the spectrum of mental health research" (p. 386).

The first activity of the Latino Strategic Planning Workgroup occurred in May 2009 when 15 individuals who are researchers, policy makers, public mental health leaders, consumers and advocates, community health leaders, ethnic services managers, and education professionals attended a one-day meeting. The initial meeting consisted of (1) a presentation and discussion of the overall goals of the Latino SPW; (2) a presentation of the CBPR model as a framework to guide the work of this stakeholder group; and (3) the creation of the California Latino Mental Health Concilio (see Appendix 2 for a list of the Concilio members). The Concilio is a core stakeholder group representing a range of constituencies and various age groups. The Concilio included mental health consumer advocates, ethnic services managers, mental health providers, promotoras, educators, and representatives of a variety of groups, including migrant workers, juvenile justice workers, and LGBTQ individuals. The California Department of Mental Health supplied funding that enabled the University of California, Davis, Center for Reducing Health Disparities (CRHD) to develop the Latino SPW and plan and execute the Latino SPW's objectives and activities. The UC Davis CRHD was selected because of its history in studying and addressing mental health issues among Latinos in California. Moreover, at the meeting, the Latino SPW sought to develop a long-term research and policy agenda to help sustain strength-based strategies for reducing disparities in mental health services for Latinos in California.

EXECUTIVE SUMMARY

MENTAL HEALTH STATUS OF LATINOS

Many foreign-born Latinos entered the U.S. as migrant workers and, after years of hard work, brought their families to settle permanently in this country. However, the immigration process and transition from their country of origin to the U.S. has been difficult for this segment of the Latino population. Most have become susceptible to increased pressures to acculturate and assimilate, and additionally deal with stress from hardship and poverty that often accompany these difficult transitions. As a result of immigrating to the U.S., many Latinos have endured a range of life stressors and experiences (e.g., poor housing, abuse, trauma, stigma, and discrimination) that when left unaddressed and unresolved can lead to mental health problems.

The lack of culturally and linguistically appropriate mental health services (e.g., in the preferred language of clients), compounded by mental health stigma, keeps many Latinos with mental illness from seeking services. A lack of sufficient bilingual and bicultural mental health professionals usually translates into language barriers and often results in miscommunication and misinterpretations. Language is an important factor associated with the use of mental health services and the effectiveness of treatment. Unfortunately, the number of Spanish-proficient providers remains insufficient to meet the needs of Latinos, especially monolingual immigrants. Latinos with limited English proficiency frequently do not have critically important information, such as how and where to seek mental health services. Moreover, language barriers contribute to the problems Latinos face when accessing public transportation to visit mental health clinics and to the difficulties that they encounter with completing required paperwork at clinics.

ACCESS: INDIVIDUAL, COMMUNITY, AND SOCIETAL BARRIERS TO CARE

The central focus of this study was to identify effective, community-defined practices for increasing awareness and access to mental health services and to improve prevention and intervention for Latinos in California. This portion of the report is organized into three major areas: (1) individual-level barriers, (2) community-level barriers, and (3) societal barriers.

Key Finding 1: Study and forum participants saw negative perceptions about mental health care as a significant factor contributing to limited or no access to care. Among the many concerns, stigma, culture, masculinity, exposure to violence, and lack of information and awareness were the most common.

Forum participants reported that limited or no access to mental health services was a significant factor affecting the mental health of the Latino community. The participants also cited barriers to accessing mental health services and identified many causes related to these barriers. The content analysis of the *Mesas de Trabajo* summaries and focus groups generated five major themes related to individual-level barriers: (1) stigma associated with mental health problems, (2) cultural barriers, (3) masculinity, (4) violence and trauma, and (5) lack of knowledge and awareness about the mental health system. We have outlined each barrier, and included quotations to allow the reader to understand the views of the forum participants in their own words.

Key Finding 2: A substantial proportion of the Latino participants believe that limited access and underutilization of mental health services in the Latino community are primarily due to gaps in culturally and linguistically appropriate services, in conjunction with a shortage of bilingual and bicultural mental health workers, nonexistent educational programs for Latino youth, and a system of care that is too rigid.

From the content analysis, four persistent community-level themes emerged throughout the *Mesas de Trabajo*. The themes, which are barriers that contributed to inadequate care and overall poorer mental health and outcomes, included: (1) a shortage of culturally and linguistically appropriate services, (2) a shortage of qualified mental health professionals, (3) a shortage of academic and school-based mental health programs, and (4) structural barriers to care. These four key themes were viewed as common areas of concern in addressing the causes of mental illness, and were considered barriers to accessing and utilizing mental health services.

Key Finding 3: Participants identified social and economic factors as major causes of mental illness and significant barriers to achieving and sustaining wellness among Latinos.

Social determinants of mental health were an overarching theme across all groups. Social determinants refer to the social conditions in which people grow, live, work, and age, and which have a powerful influence on people's health (Commission on Social Determinants of Health, 2007). The content analysis revealed the following three key barriers: (1) social and economic resources and living conditions, (2) inadequate transportation, and (3) social exclusion.

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STRATEGIES TO IMPROVE ACCESS TO EXISTING PROGRAMS AND SERVICES

This section of the report identifies and describes strategies that address the issues relating to reaching out and engaging the Latino community in California. Specifically, it focuses on identifying community-defined strategies to improve access, quality of care, and increase positive outcomes for Latinos in California. This portion is organized into two major areas: (1) community and cultural assets, and (2) community-identified strategies for prevention and early intervention programs.

Key Finding 4: Participants identified community assets that promoted the mental health of their communities. Our data indicated that the elements that are critically important in improving access to care consist of five community and cultural assets: (1) individual and community resiliency; (2) family involvement; (3) church and religious leaders; (4) community role models and mentors; and (5) community *Pláticas*.

Community assets and strengths can be understood as the total participation of individuals and community organizations coming together to mobilize and leverage existing community resources to improve access to existing programs. Participants believe that co-locating services is a strategy that can maximize community resources and give families and consumers a voice in their recovery. Co-location is an approach through which community-based organizations collaborate and share resources to better serve the Latino community.

Key Finding 5: Participants recommended that prevention and early intervention can best be achieved by following six strategies: (1) school-based mental health programs; (2) community-based organizations and co-location of services; (3) community media; (4) culturally and linguistically appropriate treatment; (5) workforce development to sustain a culturally and linguistically competent mental health workforce; and (6) community outreach and engagement.

Our data indicated that the practice of co-locating services may play an important role in building a mental health infrastructure that is culturally relevant and comfortable for the Latino community. The participants outlined numerous potential benefits of co-locating services for Latinos. For example, one ethnic services manager (ESM) participant remarked, “Latino families benefit when agencies collaborate and share resources within the community, as opposed to making the consumer come to our agency.”

EVALUATION AND OUTCOMES

Key Finding 6: Participants identified four major evaluation areas: (1) reliability and relevance; (2) knowledge and commitment to serving Latinos; (3) consumer and family participation; and (4) accountability panels. Participants perceived these areas as key components to measure and achieve positive outcomes in which Latinos would access mental health services based on the community-defined evidence practices, have high retention rates, and experience high-quality services.

Across all forums, participants emphasized that mental health agencies need to demonstrate commitment to serving Latino communities. In other words, their recommendations suggested that mental health programs receiving funding to serve Latinos and improve mental health disparities for Latinos should be required to produce outcomes that demonstrate increases in access to services, improved retention rates, reduced dropout rates, and increased quality care. One participant recommended linking funding with the number of Latinos served and determining the effectiveness of follow-ups according to the number of consumers who terminated treatment early.

PREVENTION AND EARLY INTERVENTION EVIDENCE-BASED COMMUNITY-IDENTIFIED STRATEGIES FOR IMPROVING MENTAL HEALTH TREATMENT

Core Strategy 1. Implement peer-to-peer strategies, such as peer support and mentoring programs, that focus on education and support services.

Core Strategy 2. Employ family psychoeducational curricula as a means to increase family and extended family involvement and promote health and wellness.

Core Strategy 3. Promote wellness and illness management, and favor community-based services that integrate mental health services with other health and social services.

Core Strategy 4. Employ community capacity-building strategies that promote the connection of community-based strengths and health to improvements in Latino behavioral health outcomes.

Core Strategy 5. Create a meaningful educational campaign that is designed to reduce stigma and exclusion and that targets individuals, families, schools,

EXECUTIVE SUMMARY

communities, and organizations and agencies at the local, regional, and statewide level.

Core Strategy 6. Include best practices in integrated services that are culturally and linguistically appropriate to strengthen treatment effectiveness.

STRATEGIC DIRECTIONS AND RECOMMENDATIONS FOR REDUCING MENTAL HEALTH DISPARITIES

Strategic Direction 1: Academic and School-Based Mental Health Programs

Focus on adolescents and the impact of failing to adequately detect and diagnose potential mental health issues in a timely manner. Schools represent a safe setting to educate families and their children about mental health. Tie mental health programs to academic achievement and performance.

Strategic Direction 2: Community-Based Organizations and Co-Locating Services

Increase collaboration among community-based organizations, schools, and other social services agencies by coordinating and maximizing community resources to achieve an increase in access to treatment among Latinos.

Strategic Direction 3: Community and Social Media

Use mainstream and Latino media to raise mental health awareness with messages that reduce stigma associated with mental health disorders and promote information and resources about early intervention.

Strategic Direction 4: Workforce Development

Develop and sustain a culturally competent mental health workforce consistent with the culture and language of Latino communities.

Strategic Direction 5: Culturally and Linguistically Appropriate Treatment

The key to providing high-quality care and treatment to Latino communities lies in instilling in mental health providers and support staff the importance of communicating with each consumer in a way that acknowledges the consumer's beliefs about mental health.

Strategic Direction 6: Community Capacity-Building and Outreach and Engagement

Provide resources for grassroots community capacity-building strategies that focus on: (1) strengthening outreach and engagement; (2) building behavioral

health leadership in the Latino community; (3) defining behavioral health outcomes at the community level and in terms that matter to Latinos; and (4) building local capacity aimed at reducing disparities and improving behavioral health outcomes. The capacity-building strategies should focus on convening and developing partnerships amongst mental health professionals and the indigenous community leaders to develop and strengthen their relationships. Through these partnerships, they should collaboratively implement strategies highlighted in this report and continue to develop ways in which they can act together to reduce disparities and improve behavioral health outcomes. In addition, resources should be allocated to create partnerships between community leaders associated with local capacity-building efforts and existing statewide leadership within the Latino behavioral health field to develop strategies to support local community capacity-building and implementation of the recommendations outlined in this report. Resources should be allocated to convene local and statewide leaders to educate them about the SPW recommendations and to disseminate them through a summit, educational campaigns, and other activities to best meet the needs of the Latino community.

Strategic Direction 7. Embedding the Recommendations from this Report into All MHSA Funded Programs

Encourage counties to adopt and implement the recommendations from this report to ensure that Latinos and other diverse underserved communities gain proportional access to MHSA programs.

Despite many commonalities across the various Latino groups, the existence of cultural, linguistic, educational, and socioeconomic differences sometimes requires classification of Latinos into sub-populations for investigative purposes. Distinguishing among Latino subgroups from different regions and examination of their demography, history, culture, and views on mental health are important for future research. Health professionals and researchers should not attempt to characterize all Latinos as one homogenous group and ignore between and within-group heterogeneity. Therefore, strategies and recommendations for providing mental health care for Latinos must not be based on a "one size fits all" recipe (Aguilar-Gaxiola, Sribney, Raingruber, Wenzel, Fields-Johnson, and Loera, 2011; Aguilar-Gaxiola and Ziegahn, 2011; Willerton, Dankoski, and Martir, 2008).

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Chapter 1

Introduction

A major challenge for today's health care system across the nation is the rapid growth in the number of individuals who are racial or ethnic minorities. Non-white racial and ethnic groups now constitute more than one third of the population in the United States (Humes, Jones, and Ramirez, 2011) and are projected to comprise 54% of the U.S. population by 2050 (U.S. Census Bureau, 2008). Racial and ethnic minority groups (i.e., African Americans, Asians, Latinos, Native Americans, and Pacific Islanders), in conjunction with sexual minority groups (i.e., lesbian, gay, bisexual, transgender, and questioning [LGBTQ]), transition-age youth, older adults, and persons with disabilities constitute a large segment of the U.S. population and are typically underserved in terms of accessing and utilizing health and mental health care services. To resolve the inability of increasing numbers of individuals from underserved populations to gain access to health care, health care workers and clinicians will have to be trained and educated so that they have an understanding of all health care consumers' cultures and life experiences (Anand and Lahiri, 2009; Dixon, Lewis-Fernandez, Goldman, Interian, Michaels, and Crawford, 2011). At present, a gap between policies and evidence-based mental health practices designed specifically for racial and ethnic minorities has resulted in a lack of innovative strategies that focus on prevention and early intervention for these groups. In response to this gap, the California Reducing Disparities project was established to provide the California Department of Mental Health with community-defined evidence and population-specific strategies for reducing disparities in behavioral health. The Latino Strategic Planning Workgroup (SPW) sought specifically to identify strategies for the Latino population in California.

Community-Defined Evidence Practices are defined as "A set of practices that communities have used and determined to yield positive results as determined by community consensus over time and which may or may not have been measured empirically but have reached a level of acceptance by the community."

—Community Defined Evidence Project Work Group, 2007

BACKGROUND ON THE LATINO POPULATION IN THE U.S. AND CALIFORNIA

The term *Latino* often is used in reference to a variety of backgrounds (e.g., people from Cuba, Mexico, Puerto Rico, South or Central America, or other Spanish culture or origin) and includes variance in immigration histories

and other factors such as generational and socioeconomic status (SES) differences. Since 2000, the nation's largest segments of the Latino population have consisted of individuals with Mexican (64%); Central and South American (14%), most notably Salvadorian, Guatemalan, and Colombian; Puerto Rican (9%); Cuban (3.5%), and Dominican (2.7%) ancestry (U.S. Census Bureau, 2010). In addition, foreign-born Latinos comprise 6% of the total U.S. population (Grieco, 2010).

California's population is the most diverse in the United States and the world, and consists of immigrants from more than 60 different countries (Public Policy Institute of California, 2007). Estimated at 14 million or more than 37.6% of the nation's population, Latinos constitute the single largest racial or ethnic group in California and are increasingly shaping the demographic makeup of the state (Pew Hispanic Center, 2010; U.S. Census Bureau, 2010). More than half (53%) of California's elementary children are now of Latino origin (California Department of Education, 2012).

By 2050, Latinos will constitute 52% of the 60 million California residents, according to estimates from the California Department of Finance (2010). Latinos are the majority of the population in nine counties in California: Imperial, Monterey, San Benito, Fresno, Madera, Merced, Kings, Tulare and Colusa (Lin, 2011). They are also the majority of the population in 16 California cities and neighborhoods: Anaheim (53%), Chula Vista (58%), Downey (70.7%), El Monte (69%), Fontana (67%), Inglewood (51%), Moreno Valley (54%), Norwalk (70%), Ontario (69%), Oxnard (73.5%), Palmdale (54%), Pomona (71%), Salinas (75%), San Bernardino (60%), Santa Ana (78.2%), and West Covina (53%) (Lin, 2011).

The overwhelming majority of Latinos in California (82%) are of Mexican descent (Grieco, 2010). Mexicans are the largest segment of the Latino population that has immigrated to California. For example, between 2000 and 2010 four million (33%) Mexican people came to the U.S. with 2.8 million (70%) coming to California (Camarena, 2011). According to Hayes-Bautista (2004), immigrants from Mexico have been migrating to California in large numbers for more than 150 years. In addition, significant numbers of Latinos from Central America, South America, and the Caribbean are immigrating to California (Pew Hispanic Center, 2010).

MENTAL HEALTH STATUS OF LATINOS

Many foreign-born Latinos entered the U.S. as migrant workers and, after years of hard work, brought their families to settle permanently in this country. However, the immigration process and transition from their country of origin to the U.S. has been difficult for this segment

of the Latino population. Most have become susceptible to increased pressures to acculturate and assimilate, and additionally deal with stress from hardship and poverty that often accompany these difficult transitions (Alegria, Canino, Rios, Vera, Calderon, and Rusch, 2002; Kouyoumdjian, Zamboanga, and Hansen, 2003). As a result of immigrating to the U.S., many Latinos have endured a range of adverse experiences (e.g., poor housing, abuse, trauma, stigma, and discrimination) that when left unaddressed and unresolved can lead to mental health problems (Kanel, 2002).

While other major mental health disorders, including schizophrenia and bipolar disorder, exist for Latinos, depression continues to be the biggest concern and a leading cause of disabilities among major ethnic and racial groups in the United States (McKenna, Michaud, Murray, and Marks, 2005), especially Latino youth. Latino youth face numerous stressors that may increase the risk of mental health problems (Centers for Disease Control and Prevention [CDC], 2004; Portes and Rumbaut, 2001). For example, Cervantes, Zarza, and Salinas (2007) found that stress among Latino youth was manifested in mental health problems that included anxiety and depression, and eventually led to substance abuse or suicide. William Vega, professor and executive director of the Edward R. Roybal Institute on Aging at the University of Southern California, makes the case for the focus on Latino youth when he says, “Examining the Latino youth, especially transition-age youth in the system, and failing to provide continuation of services, will lead to substance abuse and the exacerbation of behavioral disorders and problems, and eventually prison and higher costs in health care” (personal communication, December 16, 2011).

In a landmark study that examined lifetime prevalence of psychiatric disorders among urban and rural Mexican-origin Latinos in California (Vega, Kolody, Aguilar-Gaxiola, et al., 1998), the authors found that nativity or country of origin was associated with mental health outcomes. For Mexican immigrants, rates of mental disorders were lower than for those who were born in the U.S. (Vega et al., 1998). Their study further found that rapid assimilation to American culture was associated with negative mental health outcomes. Newly arrived immigrants have better mental health than U.S.-born persons of the same age—a phenomenon termed the “immigrant paradox.” However, as immigrants reside longer in the U.S., the protective social and cultural factors from their country of origin wear off. For Mexican immigrants, rates of mental disorders increase according to time in the U.S.; individuals living in the U.S. longer than 13 years have higher prevalence rates than those living in the U.S. less than 13 years (Vega et al., 1998). The decline in health status of immigrants over time in the U.S. is associated with higher social acculturation, including changes in lifestyle, cultural practices, increased

stress, and adoption of new social norms (Alegria, Chatterji, Wells, Cao, Chen, Takeuchi et al., 2008). Alegria and colleagues (2008) found this trend to be more evident with Mexican immigrants and less apparent in other immigrant Latino groups such as Puerto Ricans.

UTILIZATION OF MENTAL HEALTH SERVICES BY LATINOS

Current disparities in mental health care for Latinos are severe, persistent, and well documented (Alegria, Mulvaney-Day, Torres, et al., 2007; Alderete, Vega, Kolody, and Aguilar-Gaxiola, 2000; Vega, Kolody, Aguilar-Gaxiola, et al., 1999; Woodward, Dwinell, and Arons, 1995). Latinos have less access to mental health services than do whites, are less likely to receive needed care, and are more likely to receive poor quality care when treated. The reasons range from poor access and quality of care, limited insurance coverage, ineffective communication between provider and patient, patients’ lack of trust, doctors’ assumptions about the distribution of disease and their inability to perceive severity among minorities, and low minority representation in the workforce (with implications for health insurance coverage).

Research findings from the Mexican American Prevalence and Services Survey (MAPSS; Vega, Kolody, Aguilar-Gaxiola, Alderete, Catalano, and Caraveo-Anduaga, 1998) indicate that even more dramatic disparities in mental health care exist for Mexican-Americans compared to other Latino subgroups or other ethnic minorities. Only about one in four (27%) Mexican-origin adults who had one or more psychiatric disorders in the past 12-months receive any kind of service (this includes services performed by mental health providers, general medical providers, counselors and other professional providers, and informal providers such as *curanderos* [folk healers] and *sobadores* [masseurs]). This means that approximately three out of four Mexican-origin Latinos (73%) who have a diagnosable mental disorder and who need services remain untreated (also called the “treatment gap”). The problem of underutilization is even higher in Mexican immigrants. According to the MAPSS study, 85% of Mexican immigrants who needed services remained untreated (Vega, Kolody, Aguilar-Gaxiola, et al., 1999). This extreme underutilization of mental health services is even more pronounced among Mexican migrant agricultural workers (only 9% of those who need mental health counseling obtain services). Research has repeatedly shown that members of this population receive no care unless they are extremely dysfunctional or a danger to themselves or others (Vega, Kolody, and Aguilar-Gaxiola, 2001). This inequity often is a result of barriers that can best be understood as problems related to accessibility, availability, appropriateness, affordability, and advocacy, briefly describe below.

Accessibility: The physical geographic isolation and dispersion of Latino subgroups such as migrant workers often results in a lack of service opportunities. For example, farmworkers often labor far longer than the eight-hour workday, leaving little time at the end of the day to obtain health care even if badly needed. Migrant workers are reluctant to take time off work for health care because any interruption of the workday decreases their income and consequently their livelihood.

Availability: The critical shortage of mental health facilities and general practitioners and specialized providers, especially in rural (and some urban) areas, has repeatedly been identified as a major problem (Badger et al., 1999; National Advisory Committee on Rural Health, 1992, 1993; Rost, Williams, Wherry and Smith, 1995). The scarcity of professionals in rural areas creates the need for health providers to be self-contained, comprehensive, and capable of managing all the biopsychosocial problems of their patients (Bray and Rogers, 1995). Long waits for appointments with mental health specialists pose additional barriers (Lambert and Hartley, 1998). Equally, Latinos in general and migrant workers in particular need services during non-conventional hours of operation.

Appropriateness: Researchers have found that availability of culturally relevant services increased Latinos' service utilization and treatment effectiveness (Rogler, Malgady, Costantino, and Blumenthal, 1987; Curtis, 1990). To understand the appropriateness of mental health services for ethnic minorities, special concerns must be considered with regard to compatibility between the patient and therapist, mutual trust, and therapeutic efficacy. Sue (1977) suggested that the lack of mental health services responsive to the needs of ethnic minorities is one of the strongest predictors of underutilization. Providers' communication style (Sheppard, 1993) and cultural competence have been found to influence patients' retention in treatment. The quality of the patient-therapist interaction, as perceived early in treatment by patients, is a better predictor of treatment outcome than is the therapeutic strategy employed. Speaking the language of a client is a key aspect of mental health treatment; yet, many mental health professionals assume that speaking the language equates to cultural competence (Guarnaccia and Rodriguez, 1996). In a case study of miscommunication between two Spanish speakers in a mental health setting, a paranoid Hispanic client described delusions about people she thought were following her as *estaban trabajando conmigo*, which translated means "they were working with me." The therapist, who spoke Spanish but lacked cultural and linguistic competence, missed the double meaning of *trabajo*, which translated can mean work-occupation or work-spirit. He responded "En que trabajabas?" which translated means "What was

your work?" (Guarnaccia and Rodriguez, 1996). Many Latinos and especially migrant workers are reluctant to use specialty mental health services because of the stigma attached and concerns about their immigration status (Wagenfeld, Murray, Mohatt and DeBruyn, 1994; Lambert and Hartley, 1998; Badger et al., 1999; Vega et al 2001; Vega et al., 1985). Many are reluctant to recognize their problems as psychiatric and do not want treatment that focuses on psychiatric symptoms (Hauenstein and Saby, 1996). Many migrants experience discomfort in discussing mental health problems with a therapist (Vega et al., 2001). The low availability of culturally competent or ethnically matched mental health professionals compounds this problem.

Affordability: Even though mental health services are usually available to those who need them at adjustable rates or free of charge (Steffl and Prospero, 1985), cost of treatment has been found to be a significant barrier in mental care (Steffl and Prospero, 1985). Therefore, the availability of health-care coverage is a salient issue. Statistics show that Mexican-Americans are the least-insured ethnic group in the United States. However, the research is inconclusive about the relationship between insurance and mental health care. Some studies have found a positive correlation between having health insurance and the likelihood of receiving ambulatory mental health services (Cunningham, Henggeler, and Pickrel, 1996). Peifer, Hu, and Vega (2000), however, reached a contrary conclusion—that health insurance availability was not significantly related to seeking mental health services. Further research is needed to discern the effect of insurance on mental health care for Mexican-Americans. Two fifths of Fresno county residents who claim Mexican ancestry have no health insurance. Insurance coverage rates are even lower among migrant workers (Vega, et al., 2001). Migrant farmworkers have more difficulty accessing Medicaid benefits than any other population in the country (National Advisory Council on Migrant Health, 1995). Farmworkers must apply for Medicaid within the state where they reside, and benefits cannot be transferred between states. Workers often move on to another state in search of employment before eligibility can be established. Even if they have Medicaid coverage, farmworkers have difficulty locating providers who will treat them (Napolitano and Goldberg, 1998).

Advocacy: Many Mexicans and Mexican-Americans do not know where to find these services (Vega et al., 2001). Fortunately, studies have shown that knowing where to find a provider significantly increased the likelihood of using a specialty mental health service.

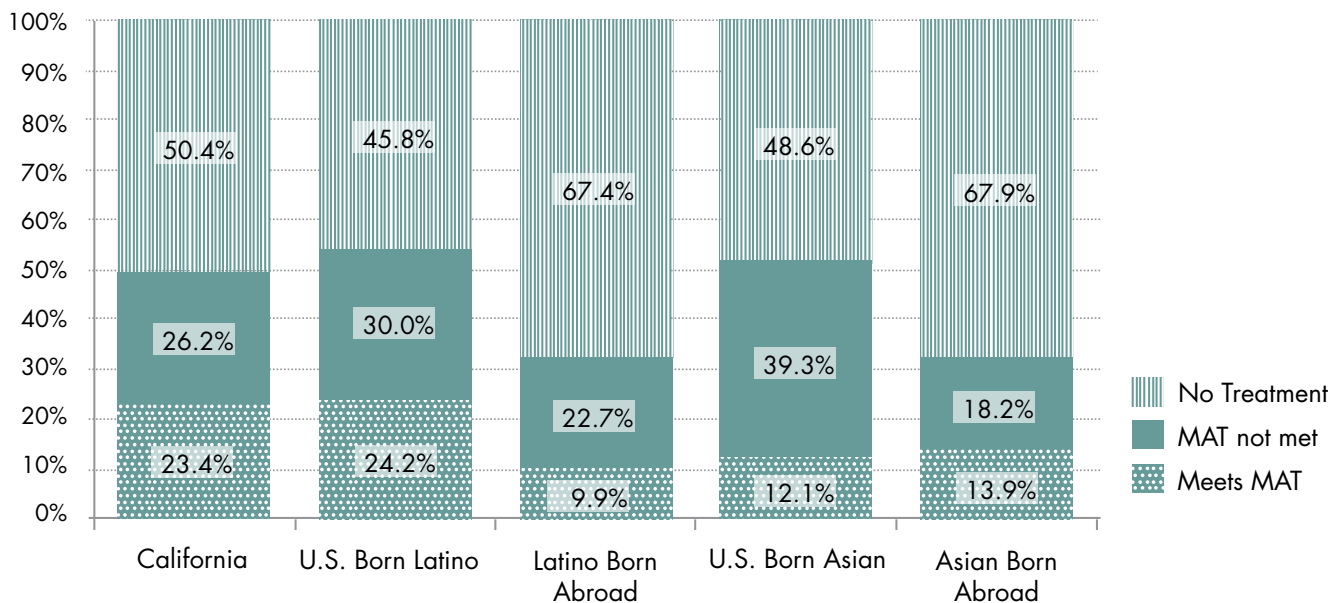
When Latinos obtain services for mental health disorders, they are significantly more likely than other clients to receive them in primary care settings rather than in

specialized settings, which is probably related to their underutilization of mental health care (Vega, Kolody, Aguilar-Gaxiola, and Catalano, 1999). The penetration rate is a frequently used measure that provides information about the amount of mental health services used by those eligible, such as those already enrolled in the Medi-Cal program. According to the California Department of Mental Health's report titled *Adult Mental Health Needs in California: Findings from the 2007 California Health Interview Survey* (CHIS; Grant, Padilla-Frausto, Aydin, Streja, Aguilar-Gaxiola, and Caldwell, 2011), utilization differs by nativity status. The authors found that approximately one quarter (24.2%) of U.S.-born Latinos received minimally adequate treatment for their mental health needs. In contrast, only 10% of Latinos born abroad, 12% of U.S.-born Asians and 14% of Asians born abroad received treatment that met the requirements for minimally adequate treatment, less than half the statewide rate (see Exhibit 1). The difference between U.S.-born Latinos and the other three groups were all statistically significant.

INTEGRATION OF MENTAL HEALTH SERVICES AND PRIMARY HEALTH CARE

The landmark U.S. Department of Health and Human Services (DHHS) report titled *Mental Health: A Report of the Surgeon General* (DHHS, 1999), followed by a 2001 report titled *Report of a Surgeon General's Working Meeting on the Integration of Mental Health Services and Primary Health Care* (DHHS, 2001), and more recently Collins (2009) all came to the same conclusion: development of partnerships among primary health care providers, local mental health practitioners, and community-based organizations as a model to appropriately move consumers across the continuum of care is critically important. Because primary care often is the initial point of contact for health problems, primary care providers play a central role in creating a system of care that prevents and treats illnesses, promote wellness, and reduces stigma associated with mental health services (Chapa, 2004; National Institute for Health Care Management [NIHCM], 2009). Findings from previous research (Katon, Lin, and Kroenke, 2007; Scott, Bruffaerts, Tsang et al., 2007) indicated that a majority of primary care consumer visits were related to mental health needs but rarely identified as mental disorders. For example, 75% of health care consumers with depression report physical complaints as a reason for seeking health care (Unützer, Schoenbaum, Druss, and Katon, 2006).

Exhibit 1: Prevalence of Minimally Adequate Treatment (MAT) by Nativity Status, Adults 18 and over, CHIS 2007



Source: California Department of Mental Health; California Health Interview Survey (CHIS), 2007.

A Robert Wood Johnson Foundation (2011) study found that 76% of physicians surveyed support a health care system that would pay for costs associated with connecting low-income health care consumers to services that address their unmet social needs (e.g., food, housing, transportation, unemployment). For Latinos, this is a relevant finding; if primary health care is their point of contact for mental health concerns, but they are unable to use primary health care because of unmet social needs, then how many low-income Latinos refrain from seeking mental health services? In other words, traditionally low-income Latino families do not have the resources, nor can they afford to take time off from work to seek treatment for their health issues. Members of these Latino families must weigh the cost of a doctor's visit with buying groceries or paying bills. Low-income Latino families commonly wait until a family member is very sick before seeking medical care. Dr. Katherine Flores, a family physician in Central California, wrote, "Many [Latino health care consumers] may never access the mental health care system, as the primary care provider either manages it, or the consumer stops seeking services beyond that—they often don't realize that they started (or ended) their mental health journey with their family physician or at the community health center's primary care provider's visit" (personal communication, February 21, 2012). She also emphasizes the importance of paying careful attention to building the skill set of primary health care providers so that they can recognize and manage care of mental illnesses and improve referrals and coordination of care with mental health care providers. Building on the notion of a continuum of integrated service model (NIHCM, 2009), co-location of mental health providers in primary care settings is an integrated approach to conduct both primary health care and mental health treatment for Latinos by providers in the same treatment location. This integrated approach offers the largest potential payoff in reduction of morbidity and mortality, and increased cost-effectiveness of care (Blount, Kathol, Thomas, et al., 2007). This integration model is aligned with the current provisions of the Affordable Care Act, which favors integrated health services delivery.

BARRIERS RELATED TO ACCESS AND UTILIZATION OF MENTAL HEALTH CARE FOR LATINOS

Numerous barriers prevent Latinos from accessing and utilizing mental health care services. One frequently studied barrier to mental health care among Latinos is stigma. Latinos fearing stigma are less likely to acknowledge their condition and more likely to avoid treatment (Vega, Rodriguez, and Ang, 2010) out of concern of being judged or victimized by discrimination. Vega and his colleagues also report that stigma is associated with lower quality of care,

especially for Latinos who suffer from depression. A study (Barrio et al., 2008) that examined the unmet mental health needs of Latino older adults found that this population was hesitant to use mental health services because of fear of being labeled as mentally ill. According to the California Department of Mental Health's 2009 report titled *California Strategic Plan on Reducing Mental Health Stigma and Discrimination*, the three major types of stigma associated with mental health that affect the lives of people and their communities are (1) public stigma, (2) institutional stigma, and (3) self-stigma. Public stigma occurs when attitudes and feelings expressed by the general public have a negative impact on people living with mental illness and their family members. Institutional stigma results from education, health care, employment, and other organizations and social systems functioning in a culture of policies and practices that reinforce negative attitudes and behaviors about mental illness. Finally, self-stigma is the effect of individuals internalizing the negative attitudes and beliefs that society, community, or groups of people perpetuate. All three types of stigma can discourage people from seeking treatment for their mental health condition.

Evidence supports the notion that the social environment in which Latinos live plays a major role in shaping their views and decisions about mental health. According to Refugio "Cuco" Rodriguez, ethnic services manager for Santa Barbara County, "Latinos are less likely to voluntarily seek help than non-Latino groups, and if they do seek help it is frequently when their condition has reached a crisis or chronic level" (personal communication, November 1, 2011). He also emphasizes that only a small percentage of Latinos who do come in contact with clinical services continue treatment for long periods of time. Although the reasons why some Latinos continue treatment have not been ascertained systematically, research shows that poor outcomes and an increased dropout rate result when Latinos feel misunderstood and experience distrust due to fear of stigma, fear of deportation, and fear of shame (Falicov, 1998, 2009). However, acknowledging and integrating cultural values or cultural family preferences in treatment can increase the motivation for engagement, retention, and collaboration of Latino consumers and result in positive outcomes (Falicov, 2009; Garza and Watts, 2010).

"Latinos are less likely to voluntarily seek help than non-Latino groups, and if they do seek help it is frequently when their condition has reached a crisis or chronic level."

—*Latino ethnic services manager*

The lack of culturally and linguistically appropriate mental health services (e.g., language skills) discourages many Latinos with mental illness from seeking services. Data from the 2005 California Health Interview Survey (CHIS; Chen, Diamant, Pourat, and Kagawa-Singer, 2005) revealed that foreign-born Latinos reported significantly lower rates of services use (18%) compared to U.S.-born Latinos (37%), and suggest that these barriers may be more prevalent for foreign-born Latinos. A shortage of bilingual and bicultural mental health professionals usually translates into language barriers, and often results in miscommunication and misinterpretations (Schwarzbaum, 2004). According to Falicov (2009), language proficiency is a crucial element by which mental health providers can establish meaningful connections with Latino consumers and avoid causing acculturative stress for families. Other studies have indicated that Latinos prefer language to ethnic matching when seeking mental health services (Folsom, Gilmer, Barrio, Moore, Bucardo, Lindamer et al., 2007; Griner and Smith, 2006). In other words, language is an important aspect associated with the use of mental health services and the effectiveness of the treatment. Unfortunately, the number of Spanish-proficient providers remains insufficient to meet the needs of Latinos, especially monolingual immigrants (Barrio et al., 2008; Falicov, 2009). Language also can be a barrier for Latinos, especially Latinos with limited English proficiency, in terms of awareness and knowledge about mental health services available to them (Benz, Espinosa, Welsh, and Fontes, 2011). Latinos with limited English proficiency frequently do not have critical information, such as how and where to seek mental health services. Moreover, language barriers contribute to the problems Latinos face when accessing public transportation to visit mental health clinics and to the difficulties that they encounter with completing required paperwork at clinics (Barrio et al., 2008; Kouyoumdjian, Zamboanga, and Hansen, 2003).

Individual and institutional practices related to the cultural deficit perspective also may constitute a barrier for Latinos seeking to access and utilize mental health services. Researchers (e.g., Gándara, 1995; Valencia, 1997) have conducted extensive work on the harm that a cultural deficit perspective has exerted on Latino youth with respect to their poor academic achievements. They argue that this perspective takes the position that Latino students and families are at fault for poor academic outcomes. Cultural deficit practices emphasize deprivation in Latino communities (Yosso, 2005). Deficit thinking is also common in mental health care. This perspective is used when interpreting the causes for why Latinos do not access or utilize mental health services. In other words, some individuals operate under the assumption that Latinos simply do not know how to access or do not want to utilize services. Henry Villanueva, the quality assurance manager

“All resources must be relevant to the Latino community to avoid making excuses for why services aren’t accessed.”

—*Latino community leader*

for the Ventura County Behavioral Health Department, argues that, “All resources must be relevant to the Latino community to avoid making excuses for why services aren’t accessed” (personal communication, November 1, 2011). Mental health care providers must challenge the cultural deficit perspective and recognize that systemic and institutional structures continue to impede improvements in access and quality of care for the Latino individual, family, and community.

SOCIAL DETERMINANTS OF MENTAL HEALTH FOR LATINOS

Social determinants refer to the social conditions in which people grow, live, work, and age, and which have a powerful influence on people’s health (Commission on Social Determinants of Health, 2007). A great deal of research has been conducted on social and economic factors, such as poverty, social exclusion, diminished social networks, discrimination, stress, accessibility to health care, and stigma, that affect individuals’ health throughout their lives (e.g., Braveman, Egerter, and Mockenhaupt, 2011; Frieden, 2010; Wilkerson and Marmot, 2003). This research indicates that good health is grounded in a strong social and economic foundation that enables people to play a meaningful role in the social, economic, and cultural life of their communities. Furthermore, health disparities tend to reflect the underlying social and economic inequalities in society. Underserved and marginalized populations, such as Latinos, tend to lack the necessary resources to participate in the social and economic fabric of society (Woodward and Kawachi, 2000). As a result, social and economic factors combined with institutional discrimination are among the most important causes of restricted access to quality mental health care for Latinos. We believe that identifying innovative strategies that utilize individual, community, and systemic approaches would encourage new ways of thinking and providing care. These innovative strategies would help counteract the social determinants of unequal access to health care and improve quality of life for Latinos in California.

FUTURE OF AGING LATINOS IN THE FACE OF SOCIAL EXCLUSION

The aging population is a major trend shaping the 21st century, due in large part to increased longevity (Fahs, Cabin, and Gallo, 2011). One manifestation of longevity is a growing demand for special care facilities; another is that diseases become long-term and chronic, resulting in higher costs for services and more time in treatment (Cohen, 2012). The longevity among Latinos in the U.S. population has increased steadily for decades. Latinos' average life expectancy exceeds that of all Americans, despite their significantly lower education and income levels (Arias, 2011, as cited in Vega and Gassoumis, 2011).

One of the factors associated with depression and suicide among older Latinos is social isolation and loneliness (Barrio et al., 2008). For example, in 2011, Yurina Melara of *La Opinión* introduced us to 64-year-old María Barrera and her experience with isolation that led to major depression and an attempt to end her life. According to María, she felt excluded from society, felt unloved, and she saw no reason to continue living. This is not unique to María, according to the National Institute of Mental Health (2012); depression and suicide rates among Latinos stand at close to 18%. In a recent study by Castillo, Lloyd, and Aguilar (2012) on older Latinos and African Americans in low- and middle-income Los Angeles communities, 11% of participants living alone reported “poor” mental health. For María, finding local solutions and playing an active role in her treatment have been fundamentally important in her ability to manage her illness. Her experience is in agreement with Vega and González (2012), who emphasized that failure to focus on finding a local solution to better serve the low-income older Latino population will result in the complete collapse of aging care. Social isolation is a major problem and potential threat for low-income older Latinos.

LATINO CULTURAL VALUES THAT IMPACT MENTAL HEALTH CARE

Researchers (Añez, Paris, Bedregal, Davidson, and Grilo, 2005; Garza and Watts, 2010) emphasized three Latino cultural values that have the greatest potential to influence the delivery of mental health services to Latinos: (1) *familismo*, (2) *respeto*, and (3) *personalismo*. Each of these three cultural values, which are explained below, should be integrated within effective prevention and early intervention models for Latinos. Recognizing cultural differences among individuals from all walks of life and transforming the service delivery culture to match the cultural perspective of the mental health consumer are critically important to the consumer's quality of care and wellness (Hughes, 2008). Cultural values also are closely related to acculturation

(Bhatia and Ram, 2001). We agree with Maldonado-Molina, Reyes, and Espinosa-Hernández (2006), who contend that acculturation levels and strategies must be examined to assess changes as individuals, families, and communities interact with the mainstream culture over time. It is essential to stress that changes in cultural values may vary as a function of acculturation.

Familismo (family) is the cultural value that focuses on the contribution of the extended family. Improvements in individuals' outlook on life and health have resulted from intervention models that account for *familismo* by focusing on family cohesion (Garza and Watts, 2010; Hill, Bush, and Roosa, 2003). A strong sense of *familismo* actually may contribute to individual and family wellness because family members have a sense of responsibility to participate in a treatment program.

In addition, *respeto* (respect) is the cultural value that refers to the mutual regard that develops between Latino consumers of mental health and their providers. Taking into account *respeto* requires mental health providers to work with an understanding of the hierarchical system within Latino families (Garza and Watts, 2010). According to Luis García, vice president of Latino Program Development for Pacific Clinics, “A relationship with a Latino family can be established and nurtured by simply respecting the gender hierarchical structure, especially the male role as the influential figure of the family” (personal communication, November 30, 2011). Failing to understand the hierarchical system can lead Latino consumers to feel disrespected and be more likely to terminate treatment. Furthermore, Latinos place a high value on respecting their elders and authority. Mental health providers who are working with Latinos and wish to ensure compliance with treatment and retention have a crucial responsibility to be aware of the value that Latinos place on respecting authority.

Finally, *personalismo* is the cultural value that relates to the importance of close personal relationships. Zayas and colleagues (1997) emphasized that providers should engage in a more personal style of relating to Latino families. Other researchers found that incorporating a person-centered approach that emphasizes empathy, warmth, and attentiveness and that uses titles of respect (e.g., *señor* and *señora*) and physical proximity—such as a hand on the shoulder to show concern—helps build strong relationships (Flores, Abreu, Schwartz, and Hill, 2000; Santiago-Rivera, Arredondo, and Gallardo-Cooper, 2002). Overall, *personalismo* must be genuine to be effective when working with Latinos. Having a sense of being understood and valued as consumers of mental health care increases Latinos' positive experiences with the mental health system and will help them achieve positive outcomes (Garza and Watts, 2010).

In sum, treatment that creates an environment in which the Latino consumer experiences all three of the aforementioned core Latino cultural values (*familismo*, *respeto*, and *personalismo*) will translate into *confianza* (trust), which is strongly associated with involvement and treatment compliance (Garza and Watts, 2010). For Latinos, trusting their therapist is of critical importance in establishing a therapeutic relationship, and in following through with and adhering to treatment. In addition, acknowledging the between- and within-subgroup heterogeneity in the Latino culture in relationship to acculturation levels is essential to gain a unique understanding of Latino subgroups' perceptions of mental health and treatment. Finally, for non-Latino mental health providers who work with the Latino community, researchers recommend treatment approaches that focus on norms, values, and beliefs that are consistent with the Latino culture (Hall, 2001; Kouyoumdjian, Zamboanga, and Hansen, 2003) or any psychotherapy that is unique to a particular culture (Hall, Hong, Zane, and Meyer, 2011). One example suggests that therapists can achieve a closer relationship with Latino consumers by sitting more closely with them (Padilla, Ruiz, and Alvarez, 1975).

LIMITATIONS OF THE EXISTING KNOWLEDGE ABOUT MENTAL HEALTH CARE FOR LATINOS

Knowledge within the mental health care field about providing care to Latinos is limited in numerous ways. One limitation of the existing literature is that few researchers have investigated Latinos' perceptions about mental health prevention or their perceptions about how to adequately measure the effects of prevention efforts on existing health disparities. Moreover, little research has been done to identify strategies to increase Latinos' access to mental health care and to improve mental health care retention rates. For example, little is known about why some service agencies exhibit higher Latino retention rates in contrast to other service agencies. Future research should be conducted to determine whether retention rates are linked to quality of care or other underlying factors.

To date, mental health preventive interventions and programs that have been designed specifically with the goal of reducing mental health disparities have been insufficient in Latino communities. Preventive interventions that focus on the value of wellness for Latinos may reduce social and economic inequalities in mental health. However, few studies have been conducted with the goal of identifying effective and culturally responsive prevention and intervention strategies that empower the individuals' and families' ability to use information to choose, use, and sustain treatment.

The current mental health service delivery system for Latinos must be reshaped to answer a central question:

How do we best serve Latinos? Modifying service delivery elements to increase engagement is particularly important. However, accounting for the characteristics of the Latino mental health consumer and other cultural factors associated with their interactions with providers is equally important. For instance, consumer-provider interactions based on cultural knowledge, trust, empathy, or perceived shared life experiences can lead consumers to feel more understood and validated (Dixon et al., 2011). Moreover, to meet the mental health needs of Latino communities, the mental health care system must allow flexibility for programs exploring practices and interventions, encouraging them to take risks in their innovations.

Strategies to increase accountability related to services are also essential in reshaping the nature of health care delivery. Behavioral health leaders (e.g., Concilio) point out the absence of financial incentives in the efforts to enhance accountability to adequately serve underserved communities, despite the potential of the Affordable Care Act's capacity to transform the health and mental health service delivery systems. Dixon and her colleagues (2011) support this claim by emphasizing that disparities will not decline unless doing so becomes financially advantageous. In other words, financial incentives to increase industry and employer accountability are viewed as important mechanisms to influence how services are delivered to underserved communities. Research indicates the crucial importance of developing strategies and identifying best practices for providing high-quality care to diverse populations using a system of care that focuses on building relationships and delivering culturally responsive services to the consumer in a respectful manner while building on strengths rather than deficits (Anand and Lahiri, 2009; Anand, 2004). Best practices, including ones recommended by the Latino SPW CDRP study, regarding strategies to increase access to health care, improve the quality of care, and reduce health inequities will have little value or impact without community participation in designing them (Shattell, Hamilton, Starr, Jenkins, and Hinderliter, 2008). We propose that community involvement in designing community-based approaches will be an important factor that will empower communities, improve care, and enhance the ability of existing resources to reduce racial and ethnic disparities.

COMMUNITY-BASED PARTICIPATORY RESEARCH

Community-based participatory research (CBPR) is one methodology that researchers can use to fill the gaps in the mental health care field's knowledge about providing care to Latinos. In CBPR, expert researchers conduct investigations collaboratively with members of a community. The researchers and community members are equally involved in the research process with "the aim

of combining knowledge with action and achieving social change to improve health outcomes and eliminate health disparities” (W. K. Kellogg Foundation, 2000). CBPR can be used to increase our understanding of mental health disparities associated with race, ethnicity, gender, LGBTQ, and SES, and to increase community engagement to achieve mental health equity and increase access to care. A large body of work has documented investigations of community engagement and participation in research (McCloskey, McDonald, Cook, Heurtin-Roberts, Updegrave et al., 2011; Minkler and Wallerstein, 2008; Wallerstein and Duran, 2006, 2010). Much of this work is based on a model of community engagement that integrates cultural and social factors related to increasing mental health equity. The major findings from this area of research have shown significant connections between community capacity and empowerment and improvements in the effectiveness of interventions (e.g., Eng, Briscoe, and Cunningham, 1990; Israel, Checkoway, Schulz, and Zimmerman, 1994; Wallerstein et al., 2008).

Innovative community-engaged research strategies have the potential to provide practitioners with community-defined approaches to better serve Latinos while reducing mental health disparities. The basis for this body of work rests on the fundamental belief that Latino communities possess the intimate knowledge of approaches that work best for them as individuals and as a community. Understanding a Latino consumer’s perspective on mental health is challenging in itself, but obtaining insight into this intimate knowledge for all Latinos in California is arguably even more complex and challenging, mainly because each Latino community is unique.

The goal for the members of the Latino SPW was to develop a workable framework that would help practitioners acquire the skills to properly explore the intimate knowledge of Latino communities in a respectful manner, and translate that knowledge into strategies to develop innovative programs and modify existing programs to better serve the Latino community. This goal is supported by Anand (2004), who contends that practitioners need to develop intercultural competencies that allow them to understand the consumer’s unique perspective, and effectively adjust their approach to maximize care to meet the needs of marginalized populations. Similarly, Dixon and her colleagues (2011) emphasize the value in translating research findings into languages that community stakeholders, such as policymakers, health providers, and consumers and their families, can understand. They go on to stress that culture and ethnicity cannot be ignored but rather must be progressively defined and measured. The work of Anand and Lahiri (2009) points out that individual health care choices and outcomes must be understood by consumers in terms of their own culture and life experiences.

Moreover, these scholars highlight the impediments that the current mental health care workforce encounters in developing intercultural competencies and increasing their knowledge of Latino mental health consumers’ culture and life experiences.

THE CALIFORNIA REDUCING DISPARITIES PROJECT

Background and Mental Health Services Act

In order to reduce mental health disparities, improve access and quality of care, and increase positive outcomes for racial, ethnic, cultural, and LGBTQ communities in California, the California Department of Mental Health launched a statewide prevention and early intervention effort utilizing allocations authorized under Proposition 63 to fund the California Reducing Disparities Project. The project focused on five populations: (1) African Americans; (2) Asian/Pacific Islanders; (3) Latinos; (4) Lesbian, Gay, Bisexual, Transgender, and Questioning (LGBTQ), and (5) Native Americans. As part of the project, five Strategic Planning Workgroups (SPWs), corresponding to each population, were created to provide the California Department of Mental Health with community-defined evidence and population-specific strategies for reducing disparities in behavioral health.

In November 2004, California voters passed Proposition 63, now known as the Mental Health Services Act (MHSA). That ballot initiative set a 1% tax on adjusted gross income above \$1 million, and earmarked those tax dollars to transform California’s mental health system into a consumer-and- family-driven, culturally competent, and recovery-oriented system (Cashin, Scheffler, Felton, Adams, and Miller, 2008; Scheffler and Adams, 2005). MHSA specifically calls for a major transformation consistent with the philosophy, principles, and practices of the recovery-oriented approach for mental health consumers. It outlines four key recovery areas: (1) promote hope, personal empowerment, respect, social connections, self-responsibility, and self-determination, which are concepts key to recovery for individuals who have mental illness; (2) endorse consumer-operated services as a way to support recovery; (3) reflect the cultural, ethnic, and racial diversity of mental health consumers; and (4) plan for each consumer’s individual needs (MHSA, 2004, as cited in Brown, Mahoney, Adams, Felton, and Pareja, 2009). As Exhibit 2 shows, MHSA funding is divided into five main funding initiatives: (1) Community Services and Supports, (2) Workforce Education and Training, (3) Capital Facilities and Information Technology Needs, (4) Innovation, and (5) Prevention and Early Intervention. These five areas furnish guidelines for expenditure of the MHSA monies.

Although California took a giant step toward transforming the state’s mental health services to support recovery for people with severe mental illness, little is known about the impact of MHSA-funded programs (e.g., Prevention and Early Intervention programs) on recovery. The Prevention and Early Intervention (PEI) initiative is key to reducing disparities and building protective factors and skills. The National Research Council and Institute of Medicine (NRC/IOM; 2009) define prevention as programs and services that focus on “populations that do not currently have a disorder, including three levels of intervention: *universal* (for all), *selective* (for groups or individuals at greater-than-average risk), and *indicated* (for high-risk individuals with specific phenotypes or early symptoms of a disorder). However, it also calls on the prevention community to embrace mental health promotion as within the spectrum of mental health research” (p. 386). The National Institute of Mental Health (NIMH, 1998) defines PEI programs and services as universal and selective prevention (occurring prior to diagnosis), and early intervention. First, *universal prevention* targets the general public or a whole population group that has not been identified on the basis of individual risks. Second, *selective prevention* targets individuals or a subgroup whose risk of developing mental illness is significantly higher than average. Finally, *early intervention* is directed toward individuals and families for whom a short duration (usually less than one year) of relatively low-intensity intervention is appropriate to measurably improve a mental health problem or concern very early in its manifestation.

The aim of *early intervention* is to avoid the need for more extensive mental health treatment or services, or to prevent a mental health problem from worsening.

LATINO STRATEGIC PLANNING WORKGROUP (SPW)

The first activity of the Latino SPW occurred in May 2009 when 15 individuals who are researchers, policy makers, public mental health leaders, consumers and advocates, community health leaders, ethnic services managers, and education professionals attended a one-day meeting. The initial meeting consisted of (1) a presentation and discussion of the overall goals of the Latino SPW; (2) a presentation of the CBPR model as a framework to guide the work of this stakeholder group; and (3) the creation of the California Latino Mental Health Concilio (see Appendix 2 for a list of the Concilio members). The Concilio is a core stakeholder group representing a range of constituencies. The Concilio included mental health consumer advocates, ethnic services managers, mental health providers, *promotoras* and *promotores*, educators, and representatives of a variety of groups, including migrant workers, juvenile justice workers, and LGBTQ individuals. The California Department of Mental Health supplied funding that enabled the University of California, Davis, Center for Reducing Health Disparities (CRHD) to develop the Latino SPW and plan and execute

Exhibit 2: The Five Initiatives of the Mental Health Services Act

INITIATIVES	DESCRIPTION AND GOALS
Community Services and Supports (CSS)	<ul style="list-style-type: none"> • Services and strategies to serve the underserved populations. • Intended to eliminate disparities in access and improve mental health outcomes for racial and ethnic populations and all underserved populations.
Workforce Education and Training (WET)	<ul style="list-style-type: none"> • Workforce development programs to build human resource capacity. • Intended to fill in the shortage of qualified and well-trained individuals to provide services for clients with severe mental illness.
Capital Facilities and Technological Needs	<ul style="list-style-type: none"> • Infrastructure to support implementation of the Community Services and Supports and other programs. • Intended to ensure funding to improve or replace the existing technology system and meet the program’s infrastructure needs.
Innovation	<ul style="list-style-type: none"> • Design and implementation of best practices specific to underserved populations. • Intended to develop and implement promising practices to increase access to and quality of services for underserved populations.
Prevention and Early Intervention (PEI)	<ul style="list-style-type: none"> • Support for the design of programs to prevent mental illnesses from becoming severe and disabling. • Intended to improve timely access to services for underserved populations.

the Latino SPW's objectives and activities. The UC Davis CRHD was selected because of its history in studying and addressing mental health issues among Latinos in California. Moreover, at the meeting, the Latino SPW sought to develop a long-term research and policy agenda to help sustain strength-based strategies for reducing disparities in mental health services for Latinos in California.

The work of the Concilio is grounded in one main goal – to reduce mental health disparities for Latinos by identifying community-defined promising practices and implementing strategies to increase capacity, access, and utilization of high-quality services, improve treatment outcomes, and enhance the quality of life for Latinos. The logic model for this goal is shown in Exhibit 3. This goal is consistent with the Affordable Care Act, which also seeks to eliminate health care disparities, strengthen public health care access, expand the health care workforce, and improve patient wellness. Similarly,

the Concilio priority reflects the Mental Health Services Act by emphasizing a recovery-oriented approach that facilitates services that are respectful of racial and ethnic, cultural, and gender differences. The Concilio inquiry calls for a deeper understanding of cultural thinking and how it influences the decisions that Latinos make about prevention and early intervention in order to stay healthy and strive to enhance and sustain wellness.

PURPOSE OF THE REPORT

The goal of the project was for the Latino SPW to develop and implement the appropriate process for identifying community-defined, strength-based promising practices, models, resources, and approaches that may be used as strategies to reduce disparities in behavioral health. The aim of this report was twofold: (1) outline the CBPR process used by the Latino SPW and (2) summarize the strategies to reduce the mental health disparities for the Latino population in California that the Latino SPW uncovered.

Exhibit 3. Logic Model of the Community-Defined Solutions for Latino Mental Health Care Disparities Project



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Chapter 2

Research Methodology

The Latino SPW CDRP study used grounded theory methods and analytic procedures as described by Corbin and Strauss (2007). Using these procedures, the research team allowed the key findings to emerge based on our review and analysis of the data collected for the study without holding preconceived notions about what the key findings would be (Patton, 2002). According to Charmaz (2000), grounded theory enables researchers to explore participants' worldviews and to richly describe the process. As such, grounded theory was the most appropriate methodology for exploring the perspectives and experiences of Latino stakeholders and for development of community-based strategies related to access and utilization of mental health services as well as prevention and early intervention.

ORGANIZATION OF THE STUDY

Structure of Worktables or “Mesas de Trabajo”

The overall goal of this report was to examine mental health disparities for the Latino population. Our aim was to develop and implement the appropriate process for identifying community-defined, strength-based promising practices, models, resources, and approaches that may be used as strategies to reduce disparities in mental health. To accomplish this goal, we adopted a set of topics from the California Department of Mental Health (2009). We also adopted the community-based participatory research (CBPR) framework from Minkler and Wallerstein (2008) to ensure a continuum of community involvement that over time builds and strengthens partnerships to achieve greater community engagement (McCloskey et al., 2011).

The forum meetings were the events where the Latino community members came to offer their perspectives on mental health services and strategies to reduce disparities among Latinos in California. At each of the forum meetings, all participants were divided into six to eight workgroups or work tables, with each work table consisting of six to 10 participants. These work tables were translated into thematic “*Mesas de Trabajo*,” which were organized around six topics (see Exhibit 4 for the strategies). Moreover, limitations on time and the number of participants per work table were considered to ensure that every participant was given the opportunity to fully describe the richness and complexity of their experiences. Furthermore, participants whose primary language was Spanish formed their own work table(s) to eliminate barriers to communication. Great efforts were taken to ensure that all materials, which included the “*Mesas de Trabajo*” workgroup instructions and the protocol of six strategies shown in Exhibit 4, were properly translated into Spanish and then read by a small pilot group of Spanish-speaking Latinos similar to those participating in the study with respect to SES, language ability, and

experiences with the mental health system. Any questions and/or text passages that might have been confusing or difficult to understand were revised until they were comprehensible to the participants.

The “*Mesas de Trabajo*” method was a unique consensus approach in which each workgroup designated one participant to lead the discussion, one participant to document the key points of the discussion, another participant to chart key recommendations that emerged from the discussions, and one participant to report the group's priorities. Each group was assigned one of the six strategies to discuss. The bulleted sentences under each of the six strategies were intended to focus the discussion on a specific theme of that strategy. The aim was to develop four priorities or key recommendations related to the strategy they discussed, but in practice the groups devised three to five key priorities. Each “*Mesa de Trabajo*” first had an open discussion for approximately 30 to 40 minutes, followed by a short 10- to 15-minute discussion on identifying key recommendations. After the discussions, all participants voted on their top priorities and the votes were tallied. Then, based on the votes, the top four priorities were selected by placing a colored dot sticker next to each recommendation; red indicated the top priority item; blue identified the second; green indicated the third; and yellow identified the fourth priority. Finally, each group was allocated 60 minutes to report their top priorities. The six specific topics that were used to elicit discussions about key practices, models, resources, and approaches to mental health access and treatment are shown in Exhibit 3.

The research team collected all typed and handwritten notes and easel paper that were used by each workgroup. The research team then reviewed all the notes and summaries from each workgroup and edited them for clarity without affecting the content or the meaning of the forum summaries. All English summaries were translated into Spanish for Spanish-speaking participants to review. Quotations that appear in this report were derived from field notes that were near-verbatim transcripts of the dialogue among forum participants.

Site Selection and Participants

The research team used a three-step approach to select the forum sites for the current study. First, we selected counties based on the California Department of Mental Health's designated four geographic regions—Bay Area (including San Francisco), Central Valley Area, Southern Area (including Los Angeles), and the Superior Area—because of the relationships and interconnections among various partners in those regions associated with the study. These partners included county ethnic services managers (ESMs), who are well grounded in their

Exhibit 4: Six Key Strategies of the “Mesas de Trabajo” for Latinos

1. Strategies for increasing treatment participation of Latinos by reducing individual and community barriers to care:

- Ideas on reducing stigma (community and individual education)
- Increasing workforce appropriate to Latinos at all levels (training and education)
- Increasing family and community support
- Suggestions on appropriate mental health programs for Latinos
- Suggestions on approaches to community outreach and engagement

2. Strategies for increasing treatment participation by improving access to existing programs and services:

- Ideas on how to increase treatment participation
- Ideas on how to improve access to existing programs
- Suggestions on programs that are proven to be successful with Latinos
- Suggestions on culturally appropriate workforce development (training and education)

3. Recommendations for new programs and modification of service delivery to increase participation:

- Ideas on new programs that should be offered to increase participation
- Ideas on modification of existing programs to increase Latino participation
- Ideas on programs that have proven to be successful in serving Latinos

4. Recommendations for new programs and modification of service delivery to increase retention in services and reduce dropout:

- Ideas on how to reduce dropout rates
- Ideas on how to modify current programs to reduce dropout rates
- Determination of new programs that should be offered to reduce dropout

5. Recommendation for new programs and modification of existing services to improve successful treatment outcomes (other than retention):

- Ideas on modifying existing programs to improve treatment outcomes
- Ideas on new programs that would improve treatment outcomes

6. Strategies for designing effective approaches to the evaluation of implemented recommendations:

- Ideas on how to evaluate individual quality of care
- Ideas on how to evaluate complementary interventions
- Ideas on how to evaluate programs serving Latinos

community and serve as liaisons between the county region and a core cultural group in their communities. The main role of an ESM is to ensure that community-based mental health services are conducted in a culturally and linguistically competent manner. Another reason for the geographic regions was to reach a variety of Latinos with different demographic, economic, political, and educational characteristics (Perna, Rowan-Kenyon, Thomas, Bell, Anderson, and Li, 2008).

Second, from these four regions, 12 cities and communities (see Exhibit 5) were purposively selected. We used purposive sampling to ensure that we obtained a diverse sample of Latinos. We achieved this by asking ESMs and Concilio members to recommend community sites that contain a large Latino population. Participants from each of the 12 communities reported to a designated site; most of these sites were either community centers, local hotels, or public services agencies. Three additional

sites included two high schools and a university, and only students enrolled in those schools participated at those sites. We used the knowledge of ESMs and Concilio members to identify community sites with which Latino groups could identify and considered safe environments for discussion of mental health issues in these regional forums. Exhibit 5 also shows the penetration rates for Latinos who were eligible for Medi-Cal in each county. According to the California External Quality Review Organization, the overall utilization rate for Latinos who were eligible Medi-Cal in 2010 was 3.7%.

Third, we used initial responses from the first three regional workgroups to make changes to the proposed sites. Based on their comments and suggestions, two of the 12 sites were dedicated to the Latino LGBTQ community. Additionally, in response to their suggestions, we purposively selected two high schools and one university from the southern region to capture Latino students' perspectives.

A total of 553 participants took part in the present study. Appendix 3 shows the demographic data for the

Exhibit 5: Forum Sites by City, Region, and County

City or Community	Geographical Region	County	Study Participants by County (N = 553)	*Latino Population % of County or School	**Latino Penetration Rates % by County
Oakland	Bay Area	Alameda	60	25.4 %	5.0%
Salinas	Bay Area	Monterey	69	75.0%	3.4%
San Jose	Bay Area	Santa Clara	35	33.2%	3.8%
Camino	Central Area	El Dorado	21	12.1%	3.2%
Fresno	Central Area	Fresno	40	50.3%	2.7%
Sacramento	Central Area	Sacramento	14	26.9%	4.0%
Stockton	Central Area	San Joaquin	52	40.3%	2.7%
Arcadia	Southern Area	Los Angeles	30	12.1%	3.6%
Carson (Cal State University)	Southern Area	Los Angeles	54	41.5%	3.6%
Cerritos (high school)	Southern Area	Los Angeles	13	15.2%	3.6%
Huntington Park (high school)	Southern Area	Los Angeles	20	98.5%	3.6%
Los Angeles	Southern Area	Los Angeles	32	48.5%	3.6%
San Diego	Southern Area	San Diego	39	28.8%	5.0%
Solvang	Southern Area	Santa Barbara	34	29.2%	3.1%
Chico	Superior Area	Butte	40	15.4%	4.8%

Sources: * U.S. Census Bureau, 2010; Los Angeles Unified School District, 2010; ABC Unified School District, Cerritos, 2010; California State University, 2010; California Department of Education, 2011;

**External Quality Review Organization, 2010

study participants. Because mental health is a sensitive subject for Latinos, measures were taken to ensure the confidentiality of participants, many of whom withheld demographic information about themselves. As a result, the demographic data reflects only the 260 participants who volunteered their information. The age mean of the 260 respondents was 37.7 (range 17–76). See Appendix 3 for additional demographic data.

Participants at County Forums

The first three forums in which Latinos participated in the “Mesas de Trabajo” were conducted in Southern California (i.e., San Diego, Arcadia, and Solvang), between December 2010 and February 2011. These initial meetings were within driving distance of the Concilio members who administered the “Mesas de Trabajo.” The responses and suggestions from these three sessions made significant contributions to the course of the project. Most notably, the research team added an overarching question: “If you could make one thing happen in mental health that would benefit Latinos, what would it be?” With this question, we were attempting to ease the participants into an already difficult discussion while, at the same time, framing the issue of disparities. Although the preliminary data that emerged from these initial sessions were rich and significant, the data collected also identified a gap in our sample—the LGBTQ population was not represented and needed to be included.

In order to gain access to hard-to-reach segments of the Latino population, such as Latinos who have been socially marginalized and LGBTQ Latinos, we used the snowball sampling technique (Faugier and Sargeant, 1997; Frank and Snijders, 1994). In short, this technique is used to identify an initial group of appropriate participants, who are asked to help identify additional appropriate participants. Also known as chain sampling, this technique helps locate information-rich key informants (Patton, 2002). It was used to identify and recruit these hidden Latino populations by working through ESMs and/or community representatives who distributed flyers to their Latino groups and encouraged them to use word-of-mouth to recruit more Latinos of interest.

The research team conducted the rest of the forums in March, April, and June 2011. Consistent with the previous three forums, the research team obtained the names, e-mail addresses, and phone numbers of interested mental health consumers, family members, “promotoras” (i.e., community health workers), service providers, and other interested individuals and/or organizations from an ESM and/or a Concilio member. Names, e-mail addresses, and phone numbers were provided to the research team. The initial invitation e-mail message consisted of a brief description of the project and

the location and agenda for the event. After the initial e-mails were distributed, one member of the research team sent subsequent e-mails reminding the participants of the upcoming forum session in their region. Also, the ESMs and/or Concilio members reinforced those messages with phone calls encouraging potential participants to attend the forums in their respective region. All e-mailed material, including the invitation, was in English and Spanish. The invitation e-mail informed participants about the opportunity to participate in a study about reducing disparities. According to ESMs and Concilio members, 100% of the participants recommended for the forums had e-mail access as well as a telephone number, and all Spanish-speaking individuals who received a phone call were addressed in Spanish. In total, 420 participants attended one of the 10 forums, not including the LGBTQ forums.

Participants at LGBTQ Forums

In the spring of 2011, the research team obtained the names, e-mail addresses, and phone numbers of interested Latino LGBTQ individuals from a community-based organization administrator who serves this population. These individuals agreed to participate after the community-based organization administrator described the study to them. After the initial invitation e-mails were distributed, one member of the research team sent supplementary e-mails reminding the participants of the April forum sessions. The staff from the community-based organization also placed phone calls encouraging prospective participants to attend the forums in Sacramento and Los Angeles. In total, 46 self-identified LGBTQ participated in one of the forums (14 participants in Sacramento and 32 in Los Angeles).

Participants at Secondary and Post-secondary School Forums

Due to the unique mental health needs of the adolescents and young adults, the research team opted to conduct focus groups with high school and university students instead of asking them to participate in the forums used for the other study participants. A total of 10 focus groups with 6 to 10 individuals per group were conducted in April and May 2011 to examine students’ opinions about mental health services in a school setting. All focus groups were between 40 to 60 minutes in duration. In order to stay consistent with the previous forums, the same topics shown in Exhibit 4 were used. However, the topics were slightly modified and organized as guiding questions (see Appendix 4). Specifically, the topics were converted into a 9-question protocol focusing on Latino students’ perceptions and participation in mental health services on a school campus. We also were looking for findings related to social and economic issues, family

and traditional responsibilities, immigrant status, and language barriers that may affect Latino students' education and mental health. Furthermore, we assessed respondents' knowledge of existing campus-based mental health programs and services that are Latino-specific, and assessed respondents' views on how to identify, invite and engage more Latino students in seeking and promoting access to care. Such knowledge would provide insight into students' ideas about essential characteristics of successful services programs. All focus groups were audiotaped and transcribed verbatim. The member of the research team who conducted the focus groups has experience working with Latino students in academic settings.

The focus groups encompassed 87 Latino student participants: 33 high school students recruited from two large high schools with sizable Latino populations, and 54 undergraduate students recruited from one public four-year university with a large proportion of Latino students. At the high schools, students were recruited by an administrator and/or school psychologist who visited selected Chicano/a studies classrooms and solicited their participation. The university students were given a flyer inviting them to attend a conference titled "The State of Mental Health Among Latino University Students: Issues Affecting Mental Health Disparities and Retention in Services" that occurred at the same time the research team had planned on conducting the focus groups. The flyer informed students about the opportunity to participate in a study following the conference. Most students who attended the conference volunteered to take part in the study.

Data Analysis

Members of the research team independently read the summaries and transcripts, and marked meanings in the text. Through numerous meetings, research team members discussed, developed and agreed upon a list of potential codes that could be used for all of the summaries and transcripts, to analyze the data, we created a database that included summaries from the community workgroups and transcriptions from the focus groups (Yin, 2009). We used ATLAS.ti software (Version 6; Scientific Software Development GmbH, 2009), a qualitative data analysis software package, to facilitate the coding and compiling of data into categories. The code book shown in Appendix 5 was created to ensure that only codes that were noted repeatedly by respondents and described across different groups, forums, and workgroups were included and consistently used by the coders. We then consolidated the codes to identify themes—points of interest or salience based on the researchers' interpretations. The themes were assigned brief titles and tied to phrases or longer sections of text.

We used several strategies to ensure the trustworthiness and credibility of the study's findings and conclusions (Yin, 2009). Most importantly, we collected information from multiple sources, including participants with different perspectives, such as health care providers and consumers, family members, administrators, LGBTQ individuals, and secondary and post-secondary students. We also produced a draft template of the findings for each of the six topics. These templates consisted of three categories: (1) statements and quotes, (2) codes, and (3) patterns and themes. Finally, we asked 22 Concilio members who are mental health experts and have extensive experience working with Latinos with mental health issues to review the templates and evaluate whether the preliminary results made sense to them based on their experiences.

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Chapter 3

Findings and Discussion

During the community forums and focus groups, the participants discussed barriers that inhibit access to mental health services for the Latino population in California. The participants also discussed strategies to reduce the mental health disparities that exist for Latinos, and they prioritized the key strategies as proposed solutions for the disparities. These barriers and proposed solutions are presented below as findings at the individual, community, and societal levels.

ACCESS: INDIVIDUAL, COMMUNITY, AND SOCIETAL BARRIERS TO CARE

The central focus of this study was to identify effective practices for increasing awareness and access to mental health services and to improve prevention and intervention for Latinos in California. This portion of the report is organized into three major areas: (1) individual-level barriers, (2) community-level barriers, and (3) societal barriers.

Individual-Level Barriers to Accessing Mental Health Care

Key Finding: Study and forum participants saw negative perceptions about mental health care as a significant factor contributing to limited or no access to care. Among the many concerns, stigma, culture, masculinity, exposure to violence, and lack of information and awareness were the most common.

Forum participants reported that limited or no access to mental health services was a significant factor affecting the mental health of the Latino community. The participants also cited barriers to accessing mental health services and identified many causes of these barriers. The content analysis of the *Mesas de Trabajo* summaries and focus groups generated five major themes related to individual-level barriers: (1) stigma associated with mental health problems, (2) cultural barriers, (3) masculinity, (4) violence and trauma, and (5) lack of knowledge and awareness about the mental health system. We have outlined each barrier, and included quotations to allow the reader to understand the views of the forum participants in their own words.

Stigma associated with mental health problems

Descriptions by most of the participants associated mental illness with being “crazy”; stigma manifested itself in the form of shame and fear of being judged. This theme was best expressed in the story shared by one participant about a family member’s bouts with depression:

I think it [stigma] is true in the Latino community. I have an aunt with a lot of problems but she doesn’t want to go ask for help. She would rather just stay at home ... suffering from depression than go out and look for help. It has to do with [her] not wanting other people to find out what she’s going through, and sometimes it has to do with not being told that you’re like crazy. It’s based on being labeled and how we are seen in other people’s eyes. We [Latinos] are scared of what other people have to say. We don’t like to be judged.

Even though lack of health insurance coverage, inadequate transportation, and lack of awareness of existing mental health services are formidable barriers to accessing mental health services, stigma continues to be a main contributing factor that deters Latinos from mental health treatment. It is possible that Latinos who do not seek mental health services feel more comfortable dealing with their mental illness on their own rather than disclosing the illness and potentially appearing weak to others. In addition, many Latinos may avoid seeking treatment because they may be in denial about their illness.

Stigma may manifest itself in the form of distrusting others. An individual may be unwilling to trust an outsider with intimate information, for example, even if that outsider is a Latino mental health professional. One Latina depicted her frustration with her mother’s resistance to trusting her therapists and, as a result, not benefiting from the treatment:

My mother is receiving mental health services and she still ... she denies it.... She sees a psychiatrist and a psychologist to deal with her anxiety and depression ... but she holds back.... I tell her ‘if you don’t say exactly how you’re feeling to that professional, then how is it really gonna be 100% effective?’ I feel like I can’t tell my mom what to do.... I think it has to do with your culture.... It’s very hard to accept that ... but at least she is making one step further from breaking the chain.

Along similar lines, Lesbian, Gay, Bisexual, Transgender, and Questioning (LGBTQ) participants described stigma as a major cause of the disconnection between LGBTQ individuals and their families, and the social isolation they experience after coming out. Stigma also stifles LGBTQ individuals’ help-seeking behaviors. Most of the participants described the detrimental effects of stigma on their self-esteem. Participants saw building an LGBTQ persons’ self-acceptance as a primary

responsibility of a provider and an essential component of any treatment in order to facilitate the coming out process. A participant noted, "...therapists need to understand how to help LGBTQ individuals become more accepting of who we are ... [and] increase our self-esteem."

"...therapists need to understand how to help LGBTQ individuals become more accepting of who we are ... [and] increase our self-esteem."

—LGBTQ participant

Another LGBTQ participant described how the use of negative labels, especially from the Spanish-language news and entertainment media, promotes homophobia and stigma at the individual level. These labels portray same-sex activities as an illness, particularly among Latino LGBTQ persons with HIV. An overarching social stigma against LGBTQ is normalizing homosexuality by challenging heteronormativity. In other words, communication media tend to portray gay characters (especially men) in a "flamboyant or stylish" manner and reinforce a stereotype that has nothing to do with one's sexual orientation. Disparaging portrayals in the media often mock gay characters and lack the educational component that can eliminate fear, stereotyping, homophobia, and hatred. One participant noted that:

Media plays a role in showing negative aspects of what it is to be LGBTQ [Latino].... Media needs to show positive aspects of being LGBTQ [normalize LGBTQ].... Gays and lesbians are your neighbors, they have homes, children, pay taxes, are doctors, nurses, lawyers.... They live amongst us and are part of the fabric of our community.

Overall, our findings are consistent with previous research showing that homophobia and the stigmatization of LGBTQ individuals and the LGBTQ community further isolates them and contributes to an LGBTQ subculture of concealment and denial (Guarnero and Flaskerud, 2008).

Consistent with the Latino adults who participated in the forums, the Latino high school students attached a stigma to mental health problems. For example, when Latino high school youth were asked, "As a Latino/a what does mental health mean to you?" the majority of the students used words like "psycho," "crazy," "schizophrenic," "bums," and "retarded" to describe a person with a mental illness. These high school youth often verbalized their fear of being perceived as weak and labeled "crazy" if they had a mental

health problem. The origins of the stigma connected with getting treatment for mental illness were rooted in Latinos' family structures and cultural values. In other words, obtaining help from a therapist equated to abandoning their family unit and cultural values. A female participant said, "the reason [we] don't seek help is because there is more to lose than there is to gain," referring to shaming her family and being disowned by her family for disclosing her depression to the public. Another student summarized it this way:

Psychology and therapists isn't the way we would go through.... It's always been like that.... It's like if you have problems, you always have to take care of it yourself [with family], you know ... like no one is gonna sit there and baby you.... But I guess in the [Latino] culture, it's more frowned upon ... like 'Oh, you're going to therapy? What kind of a person are you? Like you can't handle [it] yourself?'

Cultural barriers

Culture influences the ways in which individuals interpret psychological distress. Culture also determines the types of treatment or help sought, and may affect individuals' willingness to access services in the traditional mental health system. For example, a young Latina expressed her feelings about the traditional mental health system and her cultural beliefs and suspicions about mental health services:

I'm trying to answer some of those [barriers to treatment] questions, but I can't come up with an answer because I'm struggling with the idea that mental illness is due to one's poor luck. I've thought about it [mental health] from time to time, but I've suppressed those thoughts because it's not culturally accepted and I don't want people to think that I'm crazy.... I know I have an opinion about it [mental health], I just don't know if my cultural upbringing allows me to agree with my own opinion.... My opinions are debatable because as a young Latina who values cultural stability, I battle with my own opinions and I can't really bring myself to seeking help for stress or any form of mental health problems.

Participants suggested that Latinos' cultural beliefs (e.g., faith, spirituality, and religion) are often used to explain mental illness as fate, and may lead to their reluctance to seek mental health services. Our data revealed that a sizable percentage of Latinos hold the belief that mental illnesses are caused by God's will or by evil done by others. For

example, some Latinos believe that *mal de ojo* (evil eye) and *susto* (fright or shock) can be healed only through cleansing (*limpia*) by a folk-healer (e.g., *un curandero*). These cultural manifestations are described by the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)* as culture-specific conditions. These simple expressions of physical and mental distress lessen Latinos' beliefs in mainstream mental health services.

Masculinity

Latino young males who took part in the forums view masculinity or "machismo" as an important factor. Conversations about masculinity focused on the understood belief that Latino males need to exert themselves more to appear in control and strong. Machismo was described as a Latino man's ability to care for his family as well as work through problems on his own. Many of the youth and young adults who participated viewed machismo as a positive attribute in men in terms of having a dignified presence and being the pillar of strength of the family. The following statement from a Latino male typified these sentiments, "You're built to be a Mexican man ... a Latino man, you have to be strong." However, participants also recognized machismo as a barrier to seeking mental health services and complying with treatment. Participants suggested that males seeking mental health services often were viewed as weak individuals who are exposing their families' weaknesses. For example, one Latino male described his views about asking for help:

Coming from a Latino family it's always that traditional perspective where the male is the type of guy that has to kind of be the head of the house.... Being a kid and growing up in that certain perspective, it's normal for the male to be like, "you know what? There's no point in me looking for help. I can handle my own.... I have to maintain my head up strong because if I show weakness, then they're going to take advantage of me." I remember the man has to be the head of the household and if he has problems, he has to hold it in. He has to keep his head together because if he shows his weakness, then he shows his family's weaknesses....

Participants identified a consistent generational view on the issue of machismo. Most of the male participants, who self-identified as third and fourth generation, agreed that their beliefs were strongly influenced by first-generation Latino males. One 50-year-old male who self-identified as being a first-generation Latino did not view his perspective on masculinity as a barrier, but the younger generations felt the older generation's perspective on masculinity was a barrier. The 50-year-old stated:

It's the way men should be. I am a 50-year-old [Latino] and he [youth] is not my age and still, he's thinking the same way. We are males ... [we] were not built different. But you know, society pushes us to be different [more emotional]. And then sometimes we give in. [As a Latino] I am aware and I've been pushing and kicking [against change] and I am very happy with that.

Young female participants reinforced this cultural norm, suggesting that they also expect Latino men to be the strong ones in the family. One young Latina said, "Sometimes us women are like 'yeah, they [Latino men] are the strong ones,' so when we see that they are getting weak ... you know, [we're] looking up to you and then you're weak so it makes us weak." Although the authors of this study encourage caution when using the term "macho," it did emerge as a concern among the youth participants in which dominance and control were common in their household, and often was seen as a barrier to seeking mental health treatment.

Violence and trauma

Conversations about violence and trauma focused on exposure to violence in the home, school, and community. Participants indicated that violence or threats of violence were barriers that prevented Latinos from obtaining the mental health services that they need. Furthermore, participants suggested that violence in the home often is accompanied by limited or lack of education and limited resources regarding mental health services. One participant reported that when her brother was diagnosed with schizophrenia, he was criticized for being weak, and her father viewed physical punishment as the treatment for his son's illness. Another young participant reported that when the family urged him to obtain help for his anger and potential mental health problem, his father's anger spiraled out of control. The youth recalls his father's anger getting progressively more severe and leading to physical and emotional abuse.

In addition to exposure to violence in the home, youth reported experiencing violence in their schools. Many of the young participants suggested that being bullied and subjected to violence often contributed significantly to their feelings of anxiety and fear. Youth participants believe that schools are not equipped with appropriate counseling staff and supportive resources to help students and their families. In other words, due to the amount of violence in urban schools, the number of school psychologists and counselors available to work with youth is insufficient. For example, schools serving 4,000 students commonly have only one school psychologist on

campus. Participants indicated that schools are supposed to be safe places in which to learn in pursuit of a life better than that of their parents. However, concerns over gangs, drug use, and crime in general are significant stressors. One young Latina stated:

When I was in the ninth grade, I had all this stress ... fights, guys [in gangs] wanting to beat me up... It was a hard world.... These guys with shanks, they wanted to like shank me.... I was pretty terrified. [At school] I didn't know who to go to.

These findings are consistent with the recent work by Kataoka and her colleagues (2009) who found that Latino youth exposed to high levels of violence on their school campus were not adequately treated for these traumatic experiences. Moreover, they concluded that school educators and administrators need to do more to improve violence prevention and early intervention efforts. Many study participants shared stories about young Latinos attempting suicide because they were too stressed with school life and fed up with the psychological distress experienced in their communities and neighborhoods.

Youth participants suggested that failing to address the psychological distress that youth experience in their homes, schools, and communities eventually will lead to more severe outcomes, including suicide. This theme was particularly relevant for LGBTQ youth, who reported that rejection from their family, school, and community contributed to feelings of bereavement, hopelessness, despair, and suicidal thoughts and actions. This finding agrees with prior research (Mustanski, Garofalo, and Emerson, 2010) that has found LGBTQ youth reporting higher rates of suicide attempts. Suicides by LGBTQ individuals also can traumatize family members who rejected their LGBTQ family member. A father described his life overshadowed by sadness after his son completed suicide days after being rejected for being gay. "I live every day wanting a moment with my son to speak and reconnect with him," the father said.

One participant observed that the discussions overlooked the traumatic experiences that many Latinos have while crossing the border. This participant noted that Latino adolescents in particular become the most susceptible to post-traumatic stress disorder and other mental disorders during and after their border crossings. This claim is consistent with the work of Shattell et al. (2008), who found this particular subgroup of the Latino population to be the most vulnerable to risk factors, including acculturation stress, drug use, gang involvement, teen pregnancy, and

dropping out of school, as they struggle to form their personal identity in a new country after crossing the border.

Knowledge and awareness barriers

Most participants believe that Latinos lack information and strategies on how to access mental health services and treatment options. One participant commented that unfamiliarity with warning signs of mental illness contributes to many Latinos' lack of awareness of the problem and potential actions to address it. Responses such as, "Educate people [Latinos] on these critical points of access, so they know where to go for help, know how to obtain a referral, and be assertive in requesting a referral to a Latino provider," were commonly articulated when Latino participants discussed ways to improve access to existing programs and services. Participants also commented that Latino families, in particular immigrant groups, lack a network of people from whom to obtain information about available services. One participant suggested that educating entire households, including extended family members, might help to produce a knowledgeable network:

Sometimes the extended family does not understand what is happening and becomes suspicious and negative [toward seeking services].... The family doesn't have support from the extended family. Implement a family advocacy program so that family members interested in knowing more about mental health can do so and at the same time learn strategies to support their loved ones.... [Latino] consumers feel they don't have family support and that their family lacks an understanding about mental illness.

Many participants stated that even when services are available, individuals who need the services might not have sufficient familiarity with the mental health system to take advantage of them. In other words, making information available without supportive activity may be insufficient; empowering individuals and families to use information to examine and choose the appropriate treatment option is also necessary in order to overcome culture-based resistance to mental health services. Participants believe that increasing one's knowledge about how to use treatment options through empowerment can translate into reducing barriers to care.

In summary, the predominant concern regarding access to mental health care was the perceptions of individuals about mental health care. Participants identified numerous barriers to care that are deeply

rooted in cultural influences in conjunction with exposure to stressful conditions and limited knowledge or unawareness about navigating the mental health system. These barriers reduced Latino individuals' willingness and motivation to engage in treatment.

Community-Level Barriers To Accessing Mental Health Care

Key Finding: A substantial proportion of the Latino participants believe that limited access and underutilization of mental health services in the Latino community are primarily due to gaps in culturally and linguistically appropriate services, in conjunction with a shortage of bilingual and bicultural mental health workers, nonexistent educational programs for Latino youth, and a system of care that is too rigid.

From the content analysis, four persistent community-level themes emerged throughout the *Mesas de Trabajo*. The themes, which are barriers that contribute to inadequate care and overall poorer mental health and outcomes, included (1) a shortage of culturally and linguistically appropriate services, (2) a shortage of qualified mental health professionals, (3) a shortage of academic and school-based mental health programs, and (4) structural barriers to care. These four key themes were viewed as common areas of concern in addressing the causes of mental illness, and were considered barriers to accessing and utilizing mental health services.

Lack of culturally and linguistically appropriate services

Among the forum participants, cultural incompatibility was one of the most cited causes for low utilization of services by Latinos. "Many providers do not speak the language of the client or lack cultural competence," stated one forum participant. The ability to understand mental disorders within the context of the Latino culture and the ability to perform culturally sensitive and acceptable treatment was of great importance to the participants. Forum participants expressed frustration and described difficulties associated with seeking appropriate care from providers. Many participants spoke about the difficulties they had finding care that was aligned to their cultural values and beliefs, life experiences, and family practices. One said:

First of all, it's hard for us to go and look for help. And then, when you do look for help and that professional is not familiar with you and he opens your "Pandora's Box" then you know ... it's like "My God! I was crazy!" They [professionals] lay you out in the open while they look for a diagnosis from a book, and now I'm crazy and all alone to fend for myself! That is worse than not seeking help in the first place. It's, like, why did I go in the first place?

This challenge was critical for participants who had a hard time finding value in seeking treatment and felt disappointed with a diagnosis from a provider with whom they did not identify and perceived as lacking awareness of their culture. The failure of mental health care providers to attend to cultural issues may contribute to Latinos' reluctance to seek care. Many LGBTQ participants described past and ongoing difficulties with finding mental health services that are culturally and linguistically sensitive and compatible with their sexual orientation. Participants described experiences of homophobia, particularly from providers who were not LGBTQ or LGBTQ-sensitive. One young woman who self-identified as a Latina lesbian stated, "I've seen doctors who were not sensitive to the LGBTQ community, and most seemed uncomfortable treating me once I told them I was a lesbian." A lack of LGBTQ-appropriate services combined with providers' negative perceptions and attitudes toward LGBTQ people were perceived to be barriers to care for LGBTQ participants.

"I've seen doctors who were not sensitive to the LGBTQ community, and most seemed uncomfortable treating me once I told them I was a lesbian."

—LGBTQ Latina

Lack of qualified mental health professionals

The shortage of a bilingual and bicultural workforce available to serve Latinos was an issue that participants discussed. Many participants attributed their reluctance to seek care to the lack of well-trained care providers who are familiar with the Latino culture. A common idea that kept emerging among the participants was the shortage of bilingual and bicultural mental health providers who can deliver mental health services that are culturally and linguistically appropriate. The participants also highlighted the need to "grow our own" mental health providers. A major gap, according to the participants, is the lack of pipeline programs and curricula in the secondary and post-secondary educational system. Participants reported insufficient communication and alignment among the mental health field, education system, and Latino community to educate youth about careers in mental health, and design curriculum that focuses on culturally and linguistically competent skills.

The forum participants also viewed the lack of Spanish-language training for the current mental health professionals equally as important as the lack of cultural competence. Many participants described their unsatisfactory experiences with the interpretation

procedure, including interpreters who were not able to relate to consumers' life experiences. Bilingualism and biculturalism are not only measured in an individual's ability to speak the language proficiently, but also involve genuinely understanding the consumer's historical background and using the language to connect and communicate within that historical context (González, Tarraf, and Vega, 2010).

The lack of LGBTQ culturally competent mental health professionals and the added burden of repeated requirements to disclose their sexual identity were apparent in the LGBTQ participants' responses. The LGBTQ participants believe that a workforce of mental health providers who are able to relate to the LGBTQ participants' experiences does not exist. This theme was best expressed in the words of an LGBTQ person who self-identified as a gay man with depression:

I don't like seeking help from providers who are not educated and trained on use of language and LGBTQ terminology. They need to be better equipped to help someone like me who is a gay man with depression. There needs to be specialization in treating LGBTQ consumers. Currently, there is no system in place for Latino LGBTQ [like me] to access LGBTQ-friendly services ... or programs that convey to the LGBTQ consumer that that agency is LGBTQ-friendly. It's a terrible feeling to have to constantly fill out more forms where I have to check the category of "other" and disclose my sexual identity for the one thousandth time.

A majority of participants noted positive experiences working with *promotoras/es* or health navigators. For instance, one participant stated, "[I found] *promotoras* to be a peer support model that provided [me and my family] survival skills as well as living and socialization skills around issues of mental health." The role of *promotoras/es* is to serve as a communication broker with communities in need of increased preventive care. More must be done to increase acknowledgement of *promotoras/es*, not as substitutes to an academically trained workforce, but rather as well-respected individuals in the community who can help improve Latinos' access to care. The "Strategies" section of this report includes more information about the *promotoras/es* model as a potential approach to achieve improvements in care access and quality.

Lack of academic and school-based mental health programs

Participants expressed concern about the general level of support for school-based mental health programs. Many participants spoke about the funding difficulties that schools encountered as they worked to keep programs and services available, typified by one person who said, "Make sure funding is available to support activities leading to education and outreach ... [and] ensure that the services are for free." This concern was multilayered for participants who also mentioned the need to train parents, teachers, and educators about mental health issues, proper ways to identify signs of mental illness, and appropriate methods to provide adequate help for students. One parent who has experienced frustration working with school district administrators said, "The school district denied my son services even though they knew there was something wrong with him, but they could not diagnose or treat him." Participants emphasized that schools have an important responsibility to provide appropriate services for their children. Latino parents also expressed concern about the tendency of school personnel to mistake a mental health issue for a behavioral problem, resulting in labeling their children as "at-risk" and leading to unnecessary expulsions, continuation school, or eventually prompting affected students to drop out. "When schools misdiagnose our children and label them as a 'behavioral issue' without proper assessment for other developmental issues ... they [schools] resolve it by simply sending out children to a continuation school, where the 'pipeline to prison' starts," said one Latina parent.

The school district denied my son services even though they knew there was something wrong with him, but they could not diagnose or treat him."

—*Latina parent*

Although participants noted the difficulties of ensuring the availability and accessibility of school-based mental health programs for students experiencing mental illness, they saw great potential in the ability of schools to promote the mental health field as a viable career path for Latinos and to begin educating mental health workers. Building on the previous notion of "growing our own," participants emphasized mental health career pathways at the high school level and certification programs at the community college level for persons interested in pursuing a career in mental health.

All of the youth participants observed how the lack of classroom instruction about mental health issues may have created a barrier to their help-seeking behaviors. Participants also noted the lack of continuity in educational material about mental health topics from middle school to high school and on through post-secondary education. One youth stated:

I think there's negativity about mental health in our schools. A lot of teachers and administrators try to deny it... I think it's time, like, that teachers and administrators started paying attention to what's going on in their schools 'cause sometimes they limit the health education that teaches students about basic health and life skills to just one semester.

Many of the youth and young adults who participated believe that schools often miss an opportunity to integrate mental health topics into the curriculum and maximize youths' knowledge and interest in mental health. Others spoke of the missed opportunity to also improve teacher knowledge and classroom instruction.

Structural barriers to care

Organizational and systemic barriers. Participants expressed concern over the misalignment of the culture and context of mental health agencies with the culture and context of the Latino individual and community. Specifically, participants say that the procedures and protocol of mental health agencies and providers frequently conflict with the cultural values and beliefs of the Latino consumer. In these situations, the participants believe that mental health agencies and providers are not equipped to respond appropriately to conflict. Latinos commonly value the idea of touching one's hand or hugging to show concern and support, for example. However, this idea comes into conflict with agency guidelines and other compliance protocols prohibiting proximity between the consumer and the provider, reinforcing the perception of providers' failure to become culturally attuned to treatment needs of Latinos (Falicov, 2009). As previously mentioned, failure to consider the Latino consumer's values and beliefs and incorporate them as part of the treatment can lead to detrimental consequences and eventually to premature termination of the treatment. This finding is consistent with previous research (Anand and Lahiri, 2009) that emphasized the importance of the ability of providers to think through how they will respond in the event of a conflict between what they believe and what the patients believe.

Along similar lines, one Latino community leader suggested that listening and paying attention to Latinos'

immediate reactions to clinical environments are not the only means by which to measure stress and stigma, but also can help determine how successful the treatment will be for that individual. The majority of participants emphasized their frustrations and dissatisfaction with the current mental health system, and cited a lack of attention to Latinos' need for a sense of safety, normalcy, and dignity that is violated when they are subjected to seemingly meaningless rigid protocol that include long waiting lists and stressful settings. Describing her experience at a clinic, one participant said, "Waiting in a line outside the door, it made for a stressful situation.... It cut down on [my] privacy.... A person doesn't want the next person in line to know what you are here for."

Flexible hours of service. Mental health care providers' lack of flexible schedules or service hours emerged as a major concern, especially for participants who sought mental health services after working long hours. If something as simple as providing services around Latinos' work schedules is ignored when developing and implementing strategies for addressing poor access and utilization rates, achieving prevention effectiveness and wellness might be compromised because Latinos rarely exchange a day of work for a clinical appointment.

"Waiting in a line outside the door, it made for a stressful situation.... It cut down on [my] privacy.... A person doesn't want the next person in line to know what you are here for."

—*Latino consumer*

Societal Barriers to Accessing Mental Health Care

Key Finding: Participants identified social and economic factors as major causes of mental illness and significant barriers to sustaining wellness among Latinos.

Social determinants of mental health were an overarching theme across all groups. The content analysis revealed three key barriers: (1) social and economic resources and living conditions, (2) inadequate transportation, and (3) social exclusion.

Social and economic resources and living conditions

Participants cited difficulties related to poverty, including obtaining housing, health insurance, and food for their families simultaneously, as contributors to mental health problems. In particular, many participants reported that they experience a significant degree of anxiety related

to providing food and housing for themselves and their families. Mental health concerns linked to poverty frequently fell into two categories: (1) internalizing disorders (e.g., depression, stress, and suicide) and (2) violence or other criminal activities. Overall, participants expressed despair, depression, and suicidal thoughts related to the burden of poverty, and the responsibility of providing for family members. Because Latino families had to focus on the basic necessities of life, they frequently did not have the time or resources to obtain mental health care.

The youth and young adults who took part in the focus groups described the academic difficulties they encountered while they and their families struggled with poverty. For many youth, the necessity to miss school to watch siblings or drop out of school to work to support their families were common experiences. Many of the youth also reported that their parents saw the value of an education, but that family and the household were the priorities. After missing too many days of school, many youth indicated that motivation to finish school was difficult to achieve, which for some led to stress and depression. One student's comments exemplified these experiences:

Well, a lot of us are born at a disadvantage ... like when my dad got locked up my mom was the only one working, so I had to miss a lot of school to take care of my brother.... I was missing a lot of school ... I'd only go to school like one day [out of the week]. I wouldn't be able to do homework 'cause I had to go home and like clean and cook and watch my brother. That's how I ended up in an alternative school. I stopped doing things at school and it hurt me mentally.

Some participants identified poverty as a key contributor to violence and crime in their communities. Participants described continual frustration with the lack of opportunities for employment. They suggested that unemployment and financial instability lead individuals in their communities to resort to illegal activities to support themselves and their families. In addition to concerns related to financial stress, many participants reported living in poor housing conditions. Some participants indicated that they did not have access to running water, while others spoke of living in neighborhoods with high levels of crime and drug use.

Lack of health insurance was cited as a major barrier to Latinos' access to mental health services. Some of the participants who do not have health insurance believe that no mental health services are available for them; that

perception is especially pervasive among undocumented Latinos who constantly fear being deported if they seek help for themselves and/or family members. Statements arising from discussions about economic barriers to care concurred with that of the participant who said, "I have no way of paying for help. If you don't have means to pay for services, you have nothing [no services] because there is no way to pay for them ... [and] if my family is not legal, I don't know where to get them help because they are fearful of immigration [authorities]." This perception is consistent with previous studies that have found that Latinos have lower rates of health insurance compared to other ethnic groups (Rutledge and McLaughlin, 2008). But, even when insured, Latinos have less access to health care than other Americans (PEW Hispanic Center and Kaiser Family Foundation, 2002).

For migrant workers, in particular, poor living conditions contributed to stress and depression. Migrant workers who participated indicated that they were unable to obtain running water and lived in geographically isolated areas where access to grocery stores, water, laundry facilities, and recreation for their children was limited. Geographic isolation was a barrier to accessing mental health services.

Inadequate transportation

Participants overwhelmingly cited the inadequacy of transportation services, which contributed to isolation and limited access to mental health services. The cost of public transportation also was mentioned as a significant limiting factor. Although transportation is a simple barrier, it often is overlooked. One participant noted, "You don't have a way to go out. [If] you don't have a car ... you are nothing. You feel desperate because there is no way to get to town ... if you get sick or you need something." Another participant emphasized the importance of having reliable transportation, especially in rural areas, to ensure that follow-up services are administered and to increase the likelihood that clients complete their treatment. One participant stated:

Latinos in rural areas need transportation to and from services and appointments. If a patient has a doctor's appointment in the morning and wants to participate in other services offered in the afternoon or evening, most cannot benefit because they don't want to wait, and simply go home.... If they go home, they don't have a ride back to the facility.

Transportation is a simple yet critically important need that rarely is considered when promoting access to mental health services.

Social exclusion

Social exclusion is the process by which individuals and groups of people are wholly or partly barred from participation in social activities. In this process, some individuals, due to their background, life experiences, or circumstances, are denied access to society's resources, resulting in poor living conditions, physical and mental health problems, and other interrelated problems. Social exclusion is measured not only in an individual's or community's living conditions (i.e., poverty), but also in an individual's sense of not belonging to a community or, on a broader scale, a community not belonging to a larger society. Many participants expressed the belief that they could not access mental health services due to social exclusion.

A number of students in the focus groups said they felt excluded in their environment because they were poor. Despite their desire to obtain an education and live a healthy life, they often felt ignored by their school and community and, as a result, they did not have aspirations to seek help when they were overwhelmed with stress and eventually developed depression. An 18-year-old Latina youth described her experience of feeling disregarded and the difficulties she had in accessing mental health care in her community:

When I was 15 and depressed, I remember it [community counseling environment] wasn't welcoming.... I went to all the local places in my area because I wanted to give it [therapy] a try, I wanted to see what services they would have for me.... They made me feel out of place. Maybe it was the area, the location, the people in that place, but I felt out of place. I think like right now the scene for poor kids isn't really being focused on their health or getting help because we think there is no help out there for poor people. I focused on friends and other bad things and got kicked out of my regular high school.... I don't think the environment is good right now.

For the youth participants, feeling excluded from the larger society in general and disconnected from the Latino community was associated with increased substance abuse and other risky behaviors that can lead to mental health problems.

Along similar lines, many participants verbalized the reason for their mental health problems and poor advancement in society as "lacking information about my human and legal rights." Some participants expressed fear

and mistrust of government agencies, including agencies that offer mental health services. Participants described their fear of deportation as a social condition that kept them from seeking mental health services. Although most service systems do not inquire about legal status, many undocumented immigrant Latinos fear being reported and ultimately deported. Fear of deportation is a significant barrier that discourages Latino immigrants from seeking mental health services. One Latina participant stated, "I know families where the parents are undocumented, but their children are documented and they are afraid to ask for help because they might get deported and separated from their kids.... As a mother [I know] it's a scary thing."

STRATEGIES TO IMPROVE ACCESS TO EXISTING PROGRAMS AND SERVICES

This section of the report identifies and describes strategies by which to contact, invite, and engage the Latino community in California. Specifically, it focuses on identifying community-defined strategies to improve access, quality of care, and positive outcomes for Latinos in California. This portion is organized into two major areas: (1) community and cultural assets, and (2) community-identified strategies for prevention and early intervention programs.

Community and Cultural Assets

Key Finding: Participants identified community assets that promoted the mental health of their communities. Our data indicated that the elements that are critically important in improving access to care consist of five community and cultural assets: (1) individual and community resiliency; (2) family involvement; (3) church and religious leaders; (4) community role models and mentors; and (5) community *Pláticas*.

Individual and community resiliency

The data revealed that the most notable protective factors that strengthened community resiliency were attributable to three cultural core values: (1) the value of family (*familismo*), (2) respect (*respeto*) for community members who are perceived in authority positions, and (3) the value of personal relationships (*personalismo*) with people and institutions. (These values are described in detail in the literature review portion of this report.) Participants emphasized community resiliency as an asset developed as a result of families, friends, churches, schools, and community groups working together to strengthen individuals and communities alike. In a particularly salient account, a participant described a sense of resiliency that he experienced in his community while in treatment: "[I developed] a sense of resiliency and

persistence in treatment using [my] community resources to increase protective factors, and working closely with schools, [my] clergy and faith-based programs.” In this instance, simply feeling a sense of connectedness and tapping into the strengths of his community resulted in the increase of protective factors and persistence in the face of challenges. A Latino community leader emphasized a strategy that focuses on a community development framework. “We need to focus on strategies that empower community groups at the local level ... encouraging Latino individuals and communities to grow and change according to their needs and priorities,” said this community leader. Mental health providers who participated in the forums also highlighted the critical role of community development on building individual and community resiliency. In particular, providers believe that co-locating services to maximize community resources and integrating mental health services as part of the community helped to normalize mental health. Furthermore, providers recommended building on protective factors (e.g., *familismo*) to help Latino consumers overcome barriers in accessing care.

“We need to focus on strategies that empower community groups at the local level ... encouraging Latino individuals and communities to grow and change according to their needs and priorities.”

—Latino community leader

Family involvement

Building on the cultural core value of *familismo*, participants who actively sought mental health treatment or had a family member seeking help described the significant role that family plays in the success of individuals’ recoveries. Providers who participated in the forums also put an emphasis on integrating family as part of the consumer’s treatment, and referring to family members as essential resources when coping with mental health conditions. However, providers also highlighted the complexities that accompany disclosure of mental health illnesses to family members. In particular, participants noted the antagonism that LGBTQ individuals face when disclosing their mental illness and their sexual orientation. One provider gave this striking account:

I was working with an LGBTQ youth who was suffering from depression and contemplating suicide because he feared being rejected by his family once he came out. When he came out to his parents, his father immediately kicked him out and told him he was never to step foot in his home. The youth’s mother pleaded with her husband not to abandon their son.... The mother was also asked to leave if she continued to support their son’s sexual identity.... The youth went and jumped off a bridge in an attempt to end his life. I made several attempts to connect with the youth’s father and he refused to speak with me, cursing me out [at] every attempt I made.... When he finally took my call, he asked what I would have done if one of my sons came out to me? I responded with “my love for my son would not change just because he is gay, [and] I would love him no matter what ... This is what family does.” He invited me to his home to continue our conversation.... During our face-to-face talk, he continued expressing his difficulties with accepting his son’s sexuality.... Respecting his position, I demonstrated concern by simply placing my hand on his shoulder while we talked about the importance of family involvement.... During our conversation, we realized that we both grew up in the same town in Mexico ... [and] our conversation became more about family and no longer about his son being gay.... He finally came around and embraced his son and actively participated in his son’s treatment.

In this instance, the level of family involvement was dependent on the approachability of a community mental health provider with a common family and cultural understanding and expression of *familismo*, combined with *respeto* and *personalismo*. Latino LGBTQ participants also identified engaging extended family members as a strategy in the coming-out process. Extended family plays a key role as a support system for both the parents and the LGBTQ person. One Latino LGBTQ participant noted:

When I came out to my mom, she was devastated and could not understand. She was, like, “How can this be? You went to school, you got a master’s degree?” She thought I must have gotten it from school or my friends.... But my niece who also has a master’s degree in social work, she educated her [mother].... “grandma, this is normal, he was born this way,” so she was my resource to talk to my mom. My mom trusted my [niece], she was educated, so a new generation educated her [the mother], because she was not ready to listen to me ... and that support system helped me focus on treatment for my depression.

Prior research has shown that Latino family members are important resources and are integral parts in the successful treatment of a family member (Garza and Watts, 2010), especially children and youth (Shetgiri et al., 2009).

Participants also seemed to agree that family plays an important role in promoting resilience among young Latinos. Participants suggested one strategy to engage struggling families: to ask individuals from other families who had a striking success story conduct home visits and share their knowledge, skill, and experience in overcoming barriers. The basis for this strategy is to focus on family members rather than on the youth with mental health problems, and thereby build families' confidence in handling crises. This strategy is in line with the National Alliance on Mental Illness (NAMI) Family-to-Family Educational Program, which is designed to encourage family members to become actively involved in the treatment process by gaining the knowledge and skills needed to cope with crises more effectively. Home visits, and particularly a family-to-family approach, were described as beneficial for youth with mental health problems. One young Latina participant spoke clearly about her beneficial experience with a family-to-family approach:

I've just always been like going through stuff ... through addictions and stuff like that.... I was going through drama in life.... At the time it doesn't seem like it affects you ... but having families of youth with similar issues educate my parents on where to go for help, [and] how to obtain a referral, helped me deal with my issues, and even though I'm in an alternative school, I'm graduating and I'm doing it for my [family].

Church and religious leaders

Many participants identified churches as significant sources of strength and support in their communities. Participants also described their preference for seeking support from church priests, pastors, or other non-traditional service providers in times of emotional crisis. Overall, the participants believed that churches were in a better position than agencies to effectively disseminate mental health information to the community. One strategy envisions persuading church leaders to become involved by providing them with information and training regarding mental health illness and interventions. One Latina mother of three summarized the importance of community and mental health education through the church:

Many children in my community have mental health challenges and are often mistreated because nobody knows how to address their needs. Many of these children including my three go to catechism, and parents are in mass every Sunday... I think it is important for priests and other church leaders to be properly educated about mental health issues and available resources so that it becomes part of their sermons and catechism education.

Moreover, participants believe that their faith and religion play a major role in their healing. This revelation is consistent with the findings from other studies on faith, spirituality, and religion (Falicov, 2009). Many LGBTQ participants emphasized the need to focus on reconnecting Latino LGBTQ to their spirituality and on the importance of being connected to one's spirituality as a strategy in dealing with rejection and achieving good health. One LGBTQ participant stated:

In my perspective, a large majority of the LGBTQ people are still out there floating, they're in limbo because they want to belong to an institution [church] but feel betrayed by the institution.... We have learned that spirituality is the number one important thing for Latino LGBTQ, then comes the mother, then the self ... so they put God first and all this ties into one's validation of who they are as people. [Being connected to one's spirituality] helps an LGBTQ person accept himself and in defining how do they deal with shortcomings, how do they deal with mental health issues, how do they deal with substance abuse, and all things that put them at higher risk.

Community role models and mentors

The function of community role models and mentors emerged as an important theme across the range of forum participants. Role models and mentors were seen as particularly important in increasing individuals' and communities' knowledge and awareness of barriers to care. Many participants emphasized the importance of increasing the numbers of professional role models who are knowledgeable of the Latino culture and community as an overall strategy to enhance knowledge about mental health services and reduce stigma.

The involvement of *promotoras/es*—community health advocates, leaders, educators, and outreach workers in the Latino community—emerged as a strategy to bridge the mental health care system and Latino communities using a

peer-to-peer format. A peer-to-peer approach in the current study is defined as the involvement of people or “peers” who share similar life experiences and are able to relate and empathically connect with others in need. Participants suggested that *promotoras/es* can help compensate for the shortage of mental health workers. Many participants described the demonstrably beneficial influence of *promotoras/es* on their mental health treatment, including their impact on reducing the stigma associated with mental health treatment. As one *promotora* stated:

Promotoras/es ... connect consumers with resources, mentor, and train others to serve as promotoras/es.... These trainings focus on [preparing] people to go out into the community where they are able to relate to the community and build trust.... Promotoras/es talk to the community about [accessing] resources, while at the same time, outreaching and linking people in need of services.... The promotoras/es model builds on community strengths and [is] guided by one goal ... to [empower and] organize the community so that they know what to do during a crisis.

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Promotoras/es seemed to be a crucial vehicle to communicate with the Latino community and increase awareness and access to mental health services and reduce stigma. Another benefit of the *promotoras/es* is that they constitute a local workforce strategy. The use of *promotoras/es* aligns with one participant’s sentiments: “Service providers should be people from our culture that have more education [and training].... This will help to increase capacity of our community.”

Although participants noted that schools were not equipped with adequate school-based mental health programs, they highlighted the important role that teachers and professors have as role models and mentors in encouraging and engaging students in mental health awareness activities. One university student stated:

I think professors should be like ... encourage students.... Professors themselves have to be more knowledgeable and know about everything that’s going on in this school ... like [mental health] services ... [so] they can inform their students ... because right now, we ask them a question and it’s like, “oh, I don’t know.” Well, thank you for nothing, you know? Knowing that one [Latino] professor ... you can relate to and who is knowledgeable and ... actually does care ... you’re gonna feel comfortable talking about it [mental health].

In this example, having a knowledgeable role model from her own culture was important for the university student. The lack of school-based mental health programs seemed to be secondary to the participant relating to the professor and the professor being well informed about the services available to students.

Participants also described experiences working with mentors—specifically those who are familiar with the mental health system. In a particularly salient account, a respondent described a comfortable and humorous experience with her mentor: “You know you will feel like you’re gonna go and sit in [his talks] and feel that relaxation right away.... You’re like ... ‘Ohhh, okay ... I can be myself.’ And I think that like with [mentor] ... he’s like the same Latino culture, we can relate a lot to his jokes and to his, you know, his George Lopez personality.... I think it’s great that he has the ability to make us laugh.” The availability of role models and mentors who are able to relate to the Latino consumer and able to create a relaxing atmosphere where the consumer feels at ease communicating about mental health issues is crucially important.

Community pláticas (conversations)

Pláticas or conversations emerged as a prominent theme to promote Latino mental health. In a particularly striking account, a parent participant described the sense of helplessness she experienced in her attempt to obtain help for her son: “[My] teenage son was having a crisis and I called a mental health hotline.... They didn’t speak Spanish and [I] was told to call the police for them to arrest [my son].... I immediately hung up the phone and tried to get him under control because I couldn’t bear seeing [my son] arrested.... I wish I could talk to other parents who went through this.” Of particular importance to this parent and other participants was the notion of community *Pláticas* used in support groups composed of Spanish-speaking people with similar experiences and well-informed community leaders (e.g., *promotoras/es*). Participants also expressed the value of *Pláticas* that

incorporate the testimonials of Latino consumers with successful recovery stories as an inspiration and sign of hope. Participants demonstrated significant awareness of the extent to which community *Pláticas* enormously benefited Latino communities in addressing issues that affect various segments of the Latino community (e.g., women, men, youth, elderly). Using this format, domestic violence, drug and alcohol abuse, discrimination, mental health, stigma, and other topics of interest were discussed in a place where people felt safe sharing personal accounts.

A young Latina teacher who participated in the focus groups suggested conducting a series of *Pláticas* at schools for faculty, students, and parents on issues and topics relevant to Latinos and mental health. The Latina teacher advocates “on-site training of professionals working in schools with kids ... [in] regular community [*Pláticas*] that educate on services and programs and networks so that providers and community [educators] know where to access services and what those services provide.” Many participants emphasized the importance of using schools as a vehicle to host these community *Pláticas*, including parenting classes, faculty meetings, and visual and performing arts. Another participant suggested use of theatrical presentations directed toward children and youth in schools to teach them about mental health issues in a non-threatening manner.

Community-Identified Strategies for Prevention and Early Intervention Programs

Key Finding: Participants recommended that prevention and early intervention can best be achieved by following six strategies: (1) school-based mental health programs; (2) community-based organizations and co-location of resources; (3) community media; (4) culturally and linguistically appropriate treatment; (5) workforce development to sustain a culturally competent mental health workforce; and (6) community outreach and engagement.

School-based mental health programs

Participants emphasized the importance of building partnerships with schools and noted that schools are easily accessible and convenient for both mental health treatment and prevention programs. In particular, participants discussed the importance of mental health education in schools to improve understanding among students and their parents about mental health problems, signs and symptoms, and treatment. Participants also noted that mental health promotion programs in schools, including early detection and prevention programs, could result in reductions in school dropout rates.

Participants agreed that secondary schools, colleges, and universities are in a unique position to promote mental health education and to help increase knowledge and

awareness about mental health issues and barriers to care. When asked about strategies to increase mental health treatment participation at an individual and community level, participants overwhelmingly suggested implementing more programs on school campuses to promote mental health awareness. School-based mental health services may be essential for Latino youth, whose access to specialty mental health services has been compromised (Kataoka, Zhang, and Wells, 2002). Kataoka, Zhang, and Wells stressed early identification of adolescents who have mental health problems that have never been detected or properly diagnosed, as well as early intervention with these adolescents. Community education with a focus on early detection and intervention was recognized as an essential strategy not only for raising awareness, but also for taking swift action in reducing the severity of a disorder and the cost of care.

The participants emphasized the importance of family support and involvement in a school context as a strategy to educate Latino families and communities about mental health services. Participants recommended scheduling parenting classes on mental health, which would include core classes before their children pass through critically important school transitions (e.g., the transition from elementary to middle school). More programs are needed to strengthen families, such as parent-to-parent training sessions conducted by parents with relevant experience. Furthermore, participants advocated creation of more support groups on school campuses. Another parent participant noted:

[We] need to be positive advocates.... Our kids don't even really hear about it going to school ... [and] they don't really hear about it in their family.... I think mental health is just one of those things that we need to promote.

Adolescence is a crucial period because it coincides with the time during which many individuals begin to experience mental health problems that will persist into adulthood (Keller, Salazar, and Courtney, 2010). Acknowledging and acting on the early identification and mental health intervention of adolescents may decrease incarceration rates, drug use, and eventually severe mental illness. Early detection and community-defined best practices can change the course of young people's lives and mental health disorders. Accurate and early detection of mental health conditions for this segment of the Latino population is critically important and could lead to nationwide reductions in health care costs. Furthermore, failure to work with high schools on school-based mental health programs could result in consignment of more youth, in particular transition-age

youth, to the juvenile justice system, where mental health services are seriously lacking.

Community-based organizations and co-locating resources

Participants identified co-locating existing community resources as a potential strategy to improve the provision of mental health services, by means of innovative methods to maximize resources and engage individuals and agencies. Collaboration among all parts of a community, including homes, schools, and churches, helps Latinos establish trusting relationships that can significantly influence their decisions regarding accessing services and deciding upon treatment options. Churches, schools, community centers, and other organizations were identified as community settings where Latinos can feel safe and comfortable visiting frequently without fear of discrimination or deportation. The ability to empower a Latino community and strengthen its capacity to serve its members is of great importance to the participants.

Community assets and strengths can be understood as the total participation of individuals and community organizations consolidating to mobilize and leverage existing community resources and natural communities of support. Doing so can help enhance access to existing programs and lead to improved behavioral health outcomes for the Latino community. Participants believe that the strategy of building on assets and establishing a collaborative network could maximize community resources and give families and consumers a voice in their recovery. Also, ethnic services managers (ESMs) who participated consistently endorsed the value of nurturing and coordinating collaborative partnerships to increase access to care. One ESM described community-based organizations in collaboration as:

A strategy that builds on the strengths of Latino communities by focusing on partnerships within the community... The idea is not to make the consumer have to travel a long distance and come to us, [but] rather [to] engage the community and build services around the community by maximizing already existing resources.

Co-location is an approach that integrates mental health services into primary care as a pathway to improving access to and utilization of mental health services. This approach is in accordance with the National Institute for Health Care Management Foundation's (2009) definition of co-location as primary health care and mental health providers within the same treatment setting, including non-traditional settings (e.g., schools and community-based organizations). Co-location enables organizations

to collaborate and share resources to better serve the Latino community. As previously mentioned, a potential benefit of co-locating resources is increased likelihood that primary health care providers will be able to recognize and manage care of mental illnesses and coordinate referrals with their mental health provider counterpart (Katherine Flores, 2012). As a result, this collaboration will reduce the long waiting lines for mental health services, and increase the likelihood that Latino consumers and their families will use and adhere to their mental health treatment at their point of entry into the health system (NIHCM, 2009).

Our data indicated that the practice of co-locating services may play an important role in building a mental health infrastructure that is culturally and linguistically relevant and comfortable for the Latino community. The participants outlined numerous potential benefits of co-locating services for Latinos. For example, one ethnic services manager (ESM) participant stated, "Latino families benefit when agencies collaborate and share resources within the community, as opposed to making the consumer come to our agency." Educators emphasized the importance of co-locating mental health services and academic counseling where students could access mental health services during non-school hours. They also mentioned that AB 540 students or undocumented students would be able to benefit from co-locating services. AB 540 is a California law that enables undocumented students to attend a California public college or university and pay in-state tuition.

Another benefit of co-locating services is the ability to maintain alternative operating schedules, with services in the evenings and/or weekends. The idea of offering mental health services on different days and times and being flexible to accommodate Latinos' work schedules was a critical factor that related to the participants' ability to attend their appointments. One participant noted: "I work long hours and I can't afford to lose work to attend an appointment. Work around my work schedule if you want me to show up." The majority of participants spoke about the great importance transportation in accessing mental health services, especially for low-income families. One ESM who participated in the Solvang forum suggested establishment of pilot transportation programs with routes customized to serve consumers during their treatment (depending on their need and the recommendation of the clinician), and with monitoring and evaluation for cost

"I work long hours and I can't afford to lose work to attend an appointment. Work around my work schedule if you want me to show up."

—*Latino adult*

efficiency. Some participants also recommended mobile clinics that are dispatched to the consumer's community for treatment as a strategy. A mobile clinic is a special-purpose coach or bus in which mental health services are performed for members of underserved communities who do not have means of transportation.

Another alternative to co-locating services is the "collaborative care model" (Katon and Unützer, 2006). This evidence-based model of integrated care includes six key ingredients: (1) care management [i.e., patient education and empowerment, ongoing monitoring, and care-provider coordination]; (2) evidence-based treatments [i.e., effective medication management and/or psychotherapy]; (3) expert consultation for patients who are not improving; (4) systematic diagnosis and outcome tracking; (5) stepped care; and (6) technology support [i.e., creating and maintaining registries]. Research from Katon and Unützer shows that the collaborative care model is strongest for treating depression, anxiety, and other common mental disorders in primary care settings. Emerging evidence also indicates that the collaborative care model is effective at improving medical care for patients with severe mental illness (Katon and Unützer, 2006). The collaborative care model has been shown to reduce suicidal ideation in depressed older patients, as well as to improve the rates of diminishing pain severity and depression in patients with arthritis (Lin, Katon, Von Korff, et al., 2003).

A meta-analysis study consolidating the results from 37 randomized studies, which encompassed 12,355 patients who received treatment for depression in primary care settings utilizing the collaborative care model, found that collaborative care is more effective than standard care in improving depression outcomes, in long-term and short-term time frames (Gilbody, Bower, Fletcher, et al., 2006). The "active ingredients" in positive depression outcomes in collaborative care for depression in primary care settings included improved identification of depressed consumers, professional education of the staff, and on-site psychiatric supervision (Gilbody, Bower, Fletcher, et al., 2006). A collaborative care model adapted for cultural and social factors has been used with low-income, diabetic Latinos receiving care in safety-net clinics, and it has been found to improve depression, functional outcomes, and receipt of depression treatment (Ell, Katon, Xie, et al., 2010).

Community media

Participants attained consensus that communication media could play a critical role in educating Latinos about mental health services as well as removing barriers to care, particularly for Latino immigrants. The participants viewed this type of media approach as a way to increase community education, reach out to more Latinos, "plant

the seeds" regarding mental health care, and decrease stigma related to mental illness.

Participants reported that *fotonovelas* could be particularly important sources of information for mental health issues. A *fotonovela* is a culturally informed health literacy media tool that presents information in familiar, readable, and entertaining format. For example, in San Diego, participants credited the bilingual (Spanish and English) *fotonovelas*, a media booklet that educates Latinos about mental health issues, with increasing awareness about available resources and services. In addition, one participant emphasized doing more to "use social media, Facebook, and Twitter for the younger (Latino) population." These suggestions are consistent with the research showing that media such as film or the Internet are critical tools in promoting access and reducing disparities (Dixon et al., 2011). After examining depression *fotonovelas*, Cabassa, Molina, and Baron (2010) proclaimed *fotonovelas* as engagement tools for providers to educate consumers about depression and said they can enhance existing depression treatments in primary care and specialty care settings.

LGBTQ participants also discussed the use of community radio as an asset to educate the community about issues related to mental health and homophobic violence. A respondent suggested that *Radio Bilingüe* (Bilingual Radio; www.radiobilingue.org/), which broadcasts Spanish-language radio *novelas* (soap operas), could convey salient stories about being an LGBTQ individual, while at the same time promoting acceptance and equality. Participants understood the critical role of *novelas* as part of a strategy for addressing stigma and giving the LGBTQ community a voice. For example, a *novela* could depict a gay character living with HIV/AIDS and enjoying life with proper treatment. A key idea would be conveyance that being gay does not automatically translate into having HIV/AIDS, and having HIV/AIDS does not mean a "death sentence."

Culturally and linguistically appropriate treatment

A major theme that emerged from the discussions that occurred during the forums was the importance of understanding an individual's or a community's assumptions and perspective on mental health. The participants achieved consensus that integration of clients' cultural values and beliefs, life experiences, and family practices as part of their treatment plan is a fundamental element in working effectively with Latino individuals. This is an important finding because it differentiates between "simply being aware," such as textbook knowledge, and "putting into practice" by immersion into a patient's everyday life experiences. In other words, the forum participants advocated for culturally appropriate approaches to treatment of mental health problems.

Participants believe that a culturally appropriate approach could be achieved through quality time spent building a relationship and conducting informal but relevant conversations (Plática y conocimiento) about one's cultural values and beliefs, way of life, and family practices. The participants also cited the need to ensure that clinics and providers are specialized in the language of the community they are serving. Failure to use proper language consistent with the Latino culture could make Latino mental health consumers feel misunderstood and foster distrust toward the provider. Participants likewise noted that the terminology used when discussing mental health with Latinos often is too technical, which may contribute to potential vulnerability and stigma. For example, one participant commented:

Change the terminology or soften the language when discussing mental illness in order to promote acceptance and reduce the stigma... Mental illness should be perceived the same way as other illnesses are perceived, such as diabetes. [Providers] must know the education level of the people that they serve.... Often times this aspect is unknown when serving patients and their mental health, and they don't know how to provide literature that is at their level.

When discussing cultural and linguistic competence for the LGBTQ community, most participants emphasized LGBTQ culturally competent services and recommended creation of a specialized certificate that requires therapists and clinicians to receive training to become LGBTQ culturally competent.

Workforce development—sustaining a culturally competent mental health workforce

The majority of the participants believe that the number of qualified bilingual and bicultural mental health care workers in California is insufficient. Some participants expressed frustration with the lack of communication and collaboration among the mental health industry, schools and colleges, and the Latino community to educate youth about careers in mental health and design curricula that focus on culturally and linguistically competent skills. One overarching strategy to diversify the mental health workforce would be dissemination of information and engagement in recruiting in high schools to encourage students to consider entering social work or other mental health professions. Better and more consistent educational programs must be established to teach students how to enter the mental health field. One Latino community leader stated:

There is a lack of bilingual and bicultural mental health providers who can provide mental health and effective prevention services that are culturally responsive to the Latino community... More should be done to establish scholarship and loan forgiveness programs for Latino students interested in a career [in] mental health care ... [accompanied by] additional funding to colleges and universities to develop [a] curriculum in mental health.... Getting high school students interested in mental health is key to a strong workforce.

Along similar lines, participants noted the potential of the Fair, Accurate, Inclusive, and Respectful (FAIR) Education Act as a framework to begin aligning mental health and LGBTQ issues and classroom instruction to better educate youth, and also to promote career readiness opportunities for youth. For instance, one participant said: "Provide young Latinos who are interested in pursuing a mental health career with resources such as [a] specialized curriculum, professional mentors, and course of study to achieve their career goals." The FAIR Education Act is not only about teaching adolescents about LGBTQ issues. It also promotes classroom instruction about civil and social movements, and history of all people (e.g., people with disabilities, Latinos, and LGBTQ people) in ways that reduce social exclusion.

With regard to career pathway programs, one participant stated, "Promote positive exposure to behavioral health careers through experiential learning and education ... [and] work with schools to inform students about mental health career programs." The participants clearly recognized the need to work with schools to educate parents and families, while at the same time helping schools and educators modify their curricula and establish learning conditions that would shape perceptions about using mental health services and choosing mental health careers for Latino students. Working with schools to promote mental health careers can be a strategy that could help counteract the low academic expectations that plague many schools and the lack of school continuity beyond high school. Participants emphasized the value in

"Promote positive exposure to behavioral health careers through experiential learning and education ... [and] work with schools to inform students about mental health career programs."

—Latina university student

working with high schools on career pathway programs that could help smooth the transition into adulthood for Latino youth, reduce high expulsions, and decrease alternative school designations for Latino youth.

Moreover, participants place high priority on collaboration between colleges and universities and Latino communities to create a culturally and linguistically appropriate workforce serving Latinos. School workforce pipeline programs that include career pathway academies, associate degree and certificate programs at community colleges, as well as other educational and career-related curricula were of particular importance to many participants. One participant noted:

Develop a culturally appropriate workforce by providing students with loan forgiveness programs, state and federal grant money, free financial aid, distance learning opportunities, college credit for work or lived experience such as a certificate process for lived experience, and employee benefits once they start working.

Another participant emphasized that “more internship programs at the master’s degree and doctoral levels for [Latino students] in a mental health career track” are needed. Other forum participants suggested developing an associate of arts degree program at a community college as a strategy to enlarge the pool of bilingual and bicultural mental health workers. In short, participants believe that more should be done to define and develop the elements that help structure a successful pipeline to maximize students’ interest in health care and their understanding of the industry’s focus on prevention and early intervention as a result of the Mental Health Services Act. Ultimately, the goal of the education system should be to implement a pipeline structure with content that emphasizes activities that promote career readiness and knowledge, experiential learning, and self-efficacy related to mental health care careers.

Community outreach and engagement

Community outreach and engagement are necessary to disseminate more information about mental health issues and treatment, how and where to access services, and knowledge about existing mental health professions. Participants recognize that, for the most part, Latinos do not engage in preventive care services or seek help before or during the early onset of an illness. The resistance to preventive care or early action results in prolonged suffering for consumers and their families, and often

requires more costly treatment as the illness progresses. When asked why some Latinos continually access and use mental health services while other Latinos terminate treatment early, many participants attribute the consumer-therapist relationship and the relationship between the consumer and the agency as critical factors. This finding is consistent with the results of Lewis and Osborn’s (2004) study, which found that successful outreach and retention rates are associated with relationship-building.

Two critical questions to consider regarding mental health services for Latinos are: (1) What is the nature of the relationship between consumers and the agency or provider with which they come into contact? And (2) What about this contact encourages consumers to continue and follow through with treatment? “Leverage the culture and the community assets of the consumer so that he or she feels acknowledged and validated,” said one participant. One Latino community leader recommended establishment of pilot outreach and engagement programs focusing on comprehensive bilingual educational and co-location programs to reduce stigma and develop strong ties with the Latino community to enhance treatment participation and retention. Ruben Imperial, program manager for Stanislaus County Behavioral Health and Recovery Services, supports this notion and expands on the idea of capacity-building: “Strengthen the capacity of our local [Latino] communities by developing strategies that promote the health and well-being of individuals ... leveraging what already exists in the form of community assets and natural communities of support” (personal communication, March, 9, 2012).

“I’ve found that quality time between me and my provider where I can discuss issues without a time limit to me makes all the difference in the world to me.”

—*Latina consumer*

The majority of participants described the influence of the consumer-therapist relationship on achieving successful outcomes. “I’ve found that quality time between me and my provider where I can discuss issues without a time limit to me makes all the difference in the world to me,” said one consumer participant. Another participant noted the reciprocal learning that occurs between the consumer and the provider, with the provider learning from the consumer and the consumer learning from the provider. This participant says that viewing treatment of the conversation between the consumer and provider as an expert-to-expert dialogue is more constructive than seeing it as an expert-to-patient one-way conversation.

EVALUATION AND OUTCOMES

Strategies for Designing Effective Approaches for the Evaluation of Implemented Recommendations

Key Finding: Participants identified four major evaluation areas: (1) reliability and relevance; (2) knowledge and commitment to serving Latinos; (3) consumer and family participation; and (4) accountability panels. Participants perceived these areas as key components to measure and achieve positive outcomes in which Latinos would access mental health services based on the community-defined evidence practices, have high retention rates, and experience high-quality service.

Reliability and relevance

Several studies of both adult and youth populations suggest that Latinos are more likely than non-Hispanic whites to prematurely drop out from treatment, with as many as 60 to 75% of Latinos dropping out after just one session (McCabe, 2002). Understanding why Latinos drop out of mental health treatment after the first session continues to be a huge concern for the Latino community. Many of the forum participants suggested that irrelevance of mental health services to Latinos who seek help contribute to high rates of client withdrawal from treatment programs. Most of the participants recommended dedication of more attention to understanding the relationships between the consumers and providers, as well as to measures to ensure that treatment and interventions are the right fit or relevant to the Latino consumer. This recommendation is consistent with Lewis and Osborn's (2004) finding that relationships can engender high retention rates. In addition, as a way to achieve strong retention rates, participants asserted that mental health agencies should rethink and reorganize their evaluation strategies and interventions to include consumer criticisms and suggestions.

Knowledge and commitment to serving Latinos

Across all forums, participants emphasized that mental health agencies need to demonstrate commitment to serving Latino communities. In other words, their recommendations suggested that mental health programs receiving funding to serve Latinos and improve mental health disparities for Latinos should be required to produce outcomes that demonstrate increases in access to services, improved retention rates, reduced dropout rates, and increased quality of care. One participant recommended linking funding with the number of Latinos served and determining the effectiveness of follow-ups according to the number of consumers who

terminated treatment early. Specifically, this participant noted that, "Good evaluation methods means ensuring that [mental health] agencies are following up with clients who don't show up and following up with the other services the [social] worker has referred the client to... Determining how the funding is being disbursed is one way to evaluate an agency's commitment [to Latinos]."

Consumer and family participation

Participants recommended participation of consumers in the evaluation approach used to measure improvements in mental health conditions. Additionally, the participants suggested that providers should routinely check in with consumers to determine the effectiveness of the treatment and services. Other participants recommended an evaluation strategy that included the participation of family members. The consumer participants said that treatment and evaluation methods with greater family focus could result in reduction in consumer early treatment termination or dropouts. As one participant noted, "A well-structured evaluation is one where the consumer and family members are involved and provide feedback based on the treatment and services."

Accountability panels

The participants recommended formation of accountability panels that would monitor the effectiveness of mental health programs. Participants said these panels would review the way in which Latino programs and practices are implemented and ensure that services are relevant to Latinos. The panels also would monitor to see whether services are being administered consistently and in accordance with the needs of Latino communities and their treatment goals. The accountability panels, according to the participants, could consist of consumers; family members; legislators and other civil servants; personnel from nonprofit organizations; representatives from educational institutions and law enforcement and criminal justice systems, and general public community advocates. The general assumption was that these accountability panels would develop culturally attuned evaluation instruments that would measure the impact of the services Latinos received, and identify baselines to better gauge penetration and retention rates over time.

PREVENTION AND EARLY INTERVENTION EVIDENCE-BASED COMMUNITY-IDENTIFIED STRATEGIES FOR IMPROVING MENTAL HEALTH TREATMENT

Core Community-Identified Strategies to Improve Community Services and Treatment

These core strategies reflect the merging of participants' opinions from the various participating Latino communities in California, and were put forth and prioritized as a guide to generating a set of statewide strategic directions to promote prevention and early intervention solutions to improve community services and mental health treatment.

Core Strategy 1. Implement peer- to-peer strategies, such as peer support and mentoring programs, that focus on education and support services.

One main finding from this report was that in order to be effective in improving mental health treatment for underserved Latinos, organizations and community services and supports must adopt peer-to-peer approaches. The key goals of peer support and mentoring programs are reduction of stigma and increases in accessibility to treatment by focusing on building trust, maintaining open communication, and developing relationships. Participants regard the promotoras/es model, family-to-family programs, and other peer-to-peer strategies as effective means of reaching out and educating Latino communities about mental health. The participants also highlighted the benefits associated with positive role models who come from their communities.

Core Strategy 2. Employ family psychoeducational curricula as a means to increase family and extended family involvement and promote health and wellness.

As noted in the findings and discussion section of this report, another strategy to which participants assign prominence is education of the whole family and relatives, close friends, and other people who are in supportive roles to Latinos receiving mental health services. The desire to educate the whole family aligns with high value that Latinos place on *familismo*. The critical goals are to help families learn more about mental illness and learn ways to prevent or intervene before common stressors and other problems lead to severe mental disorders. The focus of the curriculum will be to teach families the basic information about mental illness, as well as provide resources that Latino families can use to support the recovery and wellness of their family member. Research has shown family psychoeducation to be helpful for Latino individuals with bipolar disorder and depression, as well as helpful for members of families that have

individuals with these disorders (e.g., Dixon, McFarlane, Lefley, et al., 2001).

Core Strategy 3. Promote wellness and illness management, and favor community-based services that integrate mental health services and other health and social services.

Holistic well-being at the individual, community, and societal levels—emphasizing the whole person and his or her interactions with their environment—was a recurring theme uncovered by this report. Prevention and early intervention strategies must focus on empowering individuals, families, and communities. The key goal is to develop interventions that empower Latino communities to adopt healthy behaviors, improve health status, and better manage chronic conditions. For example, the Alliance for California Traditional Arts (ACTA) is a program that emphasizes the use of traditional art forms of mental health consumers' cultures to help individuals and communities achieve wellness, spiritual and emotional connections, resilience, and an understanding of health from a holistic perspective.

Community-informed practices and programs that can be piloted and evaluated to determine their potential in serving Latino communities must be carefully identified. That process must be accompanied by assessment of whether these practices and programs generate sustainable outcomes through activities that can be identified as a best practices.

Core Strategy 4. Employ community capacity-building strategies that promote the connection of community-based strengths and health to improvements in Latino behavioral health outcomes.

Community-based assets can be understood as the total participation of individuals and community organizations collaborating to mobilize and leverage resources to improve health and mental health promotion and prevention. As this report highlights, many of the strategies suggested to improve behavioral health for Latinos are rooted in community action, participation and partnership, leveraging indigenous and cultural healing practices, and natural communities of support, with culturally and linguistically competent, accessible professional mental health services. Incorporating public health community development and principles of community engagement, strategies should focus on building the capacity of the local Latino community, including (1) political, (2) community leadership, (3) residents, and (4) family members and consumers, to define behavioral health outcomes at the community level and mobilize and align the various community partnerships and resources described in this report. Using community strategic action plans at the local level,

community-based organizations and county and local government agencies should convene local stakeholders to design mental health programs that meet local mental health needs, reduce mental health disparities, and improve results. Counties and local governments should collaborate with community groups and allow diverse local community stakeholders to agree on desirable outcomes, plan how and when to achieve them, and annually report progress. A statewide Latino behavioral health leadership initiative should be developed to focus on strengthening the capacity of local community efforts to develop strategies and actions to improve behavioral health outcomes for Latinos.

One main goal is to implement strategies that rely on community-based organizations, community leaders, and advocates to help reduce stigma. Another goal is to create an environment in which concern for others' welfare translates into a healthy community with effective crisis prevention, which could lead to lower health care costs in the future. A key finding from this report was the notion of co-locating services and the important role that doing so plays in establishing a mental health structure that is culturally and linguistically relevant and comfortable for Latino communities. Attention should be given to implementing a comprehensive system of care for Latinos that focuses on building on existing community assets and resources to improve access to care. Strategies that aim to increase consumer and family engagement also are important in prevention and early intervention planning and programs. Consistent with the methods used by the Latino Access Project (Latino Behavioral Health Institute, 2010), employing strategies that were aligned with the individual's culture and language proved to be an effective approach to engage Latino individuals and families in treatment.

Core Strategy 5. Create a meaningful educational campaign that is designed to reduce stigma and exclusion and that targets individuals, families, schools, communities, and organizations and agencies at the local, regional, and statewide level.

This report presented evidence showing an association between stigma and mental health treatment. The overall finding was that stigma manifests itself in the form of shame and fear of being judged and ultimately can deter an individual from seeking treatment. Surmounting this barrier requires design of a stigma reduction educational campaign that focuses on changing the Latino community's attitudes about mental health while increasing awareness and knowledge about mental health. The campaign would rely on a multifaceted approach incorporating numerous media methods to reach a large number of Latinos and achieve changes in attitudes and behaviors. Radio and television programs that are

entertaining and aim specifically to influence Latino communities could be used for this purpose.

Core Strategy 6. Include best practices in interated services that are culturally and linguistically competent to strengthen treatment effectiveness.

Attention should be given to integrating mental health treatment with primary care and substance abuse treatment programs. The mental health programs should be housed in existing community-based organizations serving far-reaching Latino communities. For treatment to be effective, community-defined practices and programs must embrace behaviors, attitudes, and policies that are compatible with the culture and language of the Latino consumer and his or her family. The participants were particularly interested in seeing the adoption of evidence-based practices for Latino communities that traditionally are the most difficult to engage and serve. Therefore, the focus should be on coordination of care encompassing an array of behavioral health services to create a comprehensive system of prevention and early intervention.

STRATEGIC DIRECTIONS AND RECOMMENDATIONS FOR REDUCING MENTAL HEALTH DISPARITIES

Strategic Directions and Recommended Actions

The six aforementioned core strategies provided the foundation from which these seven strategic directions were developed and prioritized. These key recommendations can serve as guiding principles to promote and enhance the ability to identify community-defined promising practices, increase access and utilization of quality services, and improve treatment outcomes and quality of life for Latinos.

Strategic direction 1: academic and school-based mental health programs

Focus on adolescents and the impact of failing to adequately screen, detect, and diagnose potential mental health problems in a timely manner. Schools constitute a safe setting in which to educate families and their children about mental health. Tie mental health programs to academic achievement and performance.

Recommended actions at the local and state level

- 1.1 Increase county collaboration with secondary schools to identify mental health problems among Latino adolescents and provide interventions aimed to decrease the risk of incarceration, drug use, and mental illness. Stress that early detection and identification translate into reductions in cost of care.

- 1.2 Increase advocacy efforts and programs in schools to ensure accurate and early detection of mental disorders among Latino youth, as a strategy to change the course of a potential mental disorder as well as to avoid possible misdiagnosis that may result in mistreatment and high dropout rates.
- 1.3 Develop a plan to create and integrate mental health educational standards and topics into the schools' curricula.
- 1.4 Develop and offer parenting classes or seminars to educate Latino parents about the school system and to increase their awareness of available free or inexpensive academic and mental health services.

Strategic direction 2: community-based organizations and co-locating resources

Increase collaboration among community-based organizations, schools, and other social services agencies by coordinating and maximizing community resources to achieve an increase in access to treatment among Latinos.

Recommended actions at the local and state level

- 2.1 Engage a consortium of faith-based organizations to develop and implement strategies to promote pathways to wellness, reduce mental health stigma, promote social inclusion, and advocate for the importance of spirituality to one's well-being.
- 2.2 Encourage expansion of Latino older adults' social and family networks, and help increase their social engagement and emotional support by focusing on the integration of health and mental health providers at the community level. Optimize their health and functioning with co-located services and an emphasis on access and a comprehensive continuum of care.
- 2.3 Develop and support networks of individuals and organizations so that more co-location of resources and services can occur. Ask networks to work together in coordination, integration, and improvement of policies and practices to produce better mental health treatment and outcomes. Network partners can consist of:
 - Mental health agencies
 - Community clinics and hospitals
 - Churches and other faith-based organizations
 - Local law enforcement agencies and units of the adult criminal justice system
 - Juvenile justice agencies
 - Child protective services
 - Foster care agencies
 - Elementary and secondary schools
 - Colleges and universities

- The business community
- Non-traditional organizations (e.g., soccer groups, cultural arts sponsors, youth development programs)

- 2.4 Following implementation of item 2.3, coordinate with network partners to develop and activate a transportation system to convey consumers to appointments and other activities related to their treatment.
- 2.5 Invest in training opportunities for primary health care and mental health providers to coordinate and manage the care of mental health illnesses, in order to reduce the wait for mental health services and increase access and retention rates of mental health treatment.
 - 2.5.1 The following recommendations were adopted and slightly modified from the Report of a Surgeon General's Working Meeting on the Integration of Mental Health Services and Primary Health Care (U.S. Department of Health and Human Services, 2001):
 - Design and incorporate a survey tool that measures skills, knowledge, and attitudes, and reflects evidence-based "best practices" and treatment management.
 - Create and implement a set of education and training standards for the integration of mental health and primary health care involving academic stakeholders and accreditation bodies.
 - Evaluate implemented programs and best practices to determine if the integration leads to reduction of health and mental health disparities, accompanied by improvements in treatment outcomes and quality of life.

Strategic direction 3: community and social media

Use media to raise mental health awareness with messages that reduce stigma associated with mental health disorders and promote information and resources about early intervention.

Recommended actions at the local and state level

- 3.1 Engage Latino news media and the entertainment industry in supporting educational programs that promote balanced and informed portrayals of mental health problems, LGBTQ issues, and mental health services.
- 3.2 Create and disseminate *fotonovelas*, which are stories told with photos and dialogue, to promote greater understanding of mental health problems and services.

- 3.3 Coordinate with Spanish radio and television stations that have large Latino audiences, and promote educational programs that can raise awareness about mental health issues. Direct many of the messages to youth audiences. Some of the Spanish radio and television stations, programs, and personalities that can be targeted include:
- Piolín por la Mañana, Mexican radio personality for KSCA, 101.9 FM in the Los Angeles area
 - Radio Bilingüe
 - *Telenovelas* (soap operas)
- 3.4 Create recordings of meaningful conversations or *Pláticas* in which Latino families with individuals who are successfully recovering from a mental illness share their stories and unique perspectives. Deliver the *Pláticas* via various mainstream and ethnic media outlets.
- 3.5 Convene youth workgroups to design thoughtful messages relevant to youth and mental health stigma, and disseminate these messages using Facebook, Twitter, YouTube, blogs, and other social media outlets.

Strategic direction 4: workforce development

Develop and sustain a culturally and linguistically competent mental health workforce consistent with the culture and language of Latino communities.

Recommended actions at the local and state level

- 4.1 At various academic levels, support career pathway activities that lead to certification programs and advanced degrees with a focus on bicultural and bilingual training and other population-specific subject matter, including courses related to geriatrics and addiction treatment.
- 4.2 Establish a certificate course of study at the community college level through which individuals interested in the mental health field can be certified as a Latino mental health specialist.
- 4.3 Following implementation of items 4.1 and 4.2, expand opportunities for promotoras/es to enroll in higher education to further their education in behavioral health, which will allow them to perform a greater range of services and assume leadership positions in their communities.
- 4.4 Increase the priority of offering loan forgiveness programs for Latinos pursuing a career in the mental health field and for current Latino and non-Latino providers looking for retraining opportunities.
- 4.5 Strengthen connections with Chicano/a or Latino studies and LGBTQ studies programs on post-

secondary campuses to increase education and training opportunities for Latinos and LGBTQ Latinos seeking careers in the mental health field.

Strategic direction 5: culturally and linguistically appropriate treatment

The key to providing high-quality care and treatment to Latino communities lies in conveying to mental health providers and support staff the importance of communicating with each consumer in a way that acknowledges the consumer's beliefs about mental health.

Recommended actions at the local and state level

- 5.1 Convene a small workgroup made up of the Latino Concilio members to develop and implement training guidelines that adequately assess the ability of the current and future workforce to effectively conduct culturally and linguistically appropriate care for Latinos.
- 5.2 Assign high priority to collaboration with community-defined evidence programs in creation of a set of key characteristics of a welcoming environment that emphasizes Latino mental health consumers' sense of comfort while accessing services.
- 5.3 Following implementation of items 5.1 and 5.2, direct the same Concilio workgroup to develop a "Latino cultural and linguistic assessment tool" to assess how well providers and support staff comply with the recommended community-defined evidence practices mentioned in this report.
- 5.4 Expand the opportunities for promotoras/es who are proficient in Spanish and other dialects (e.g., Mixteco) to receive education, training, and eventual employment to meet the needs of the Latino community.

Strategic direction 6: community capacity-building, outreach, and engagement

Provide resources for development of grassroots community capacity-building strategies that focus on: (1) strengthening outreach and engagement; (2) building behavioral health leadership in the Latino community; (3) defining behavioral health outcomes at the community level and in terms that matter to Latinos; and (4) building local capacity aimed at reducing disparities and improving behavioral health outcomes. The capacity-building strategies should focus on convening and developing partnerships amongst mental health professionals and the indigenous community leaders to develop and strengthen their relationships. Through these partnerships, they

should collaboratively implement strategies highlighted in this report and continue to develop ways in which they can act together to reduce disparities and improve behavioral health outcomes. In addition, resources should be allocated to create partnerships between community leaders associated with local capacity-building efforts and existing statewide leadership within the Latino behavioral health field to develop strategies to support local community capacity-building and implementation of the recommendations outlined in this report. Resources should be allocated to convene local and statewide leaders to educate them about the SPW recommendations, and to disseminate the recommendations through a summit, educational campaigns, and other activities to best meet the mental health needs of the Latino community.

Recommended actions at the local and state level

- 6.1 Increase the priority of identifying Latino leaders who are ready to make a commitment to play an active role in advocating and disseminating this report's strategies and recommendations.
- 6.2 In each county create and implement a Latino Concilio of leaders who will help to facilitate development of the necessary partnerships and relationships amongst Latino community leaders and the professional mental health system in implementation of promising practices, and will help shape the next steps in improving behavioral health outcomes for the Latino community.
- 6.3 Following implementation of items 6.1 and 6.2, establish specific actions for follow-up care focused on connecting with natural communities of support after a consumer drops out from treatment. Also, provide funding to these Concilios to develop local community Latino behavioral health collaboratives to sustain community capacity-building efforts, and comprehensive, bilingual outreach and education campaigns aimed at increasing awareness and understanding of: (1) how Latinos can improve their behavioral health by connecting to culture and natural communities of support; (2) mental health issues and services available; (3) how and where to access services; and (4) ways to reduce the stigma that Latinos with a mental illness may experience when using mental health services.

Strategic direction 7. Embedding the recommendations from this report into all MHSA funded programs

Encourage counties to adopt and implement the recommendations from this report to ensure that Latinos and other diverse underserved communities gain proportional access to MHSA programs.

Recommended actions at the local and state level

- 7.1 Incorporate the recommendations from this report into all MHSA funding programs and components.
- 7.2 Develop a Prevention and Early Intervention funding structure that will support the recommendations from this report and ensure that the funding is aligned to the demographic representation of the Latino population in California, in particular Latinos living below the poverty level.
- 7.3 Evaluate the influence of these seven recommendations for each of the MHSA components, in particular the inclusion of Latinos in community services and supports, full-service partnership programs, prevention and early intervention programs, workforce and education training programs, and innovation programs.

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Chapter 4

Community-Defined Evidence Programs and Practices

Participants emphasized that promising programs and practices with potential to resolve barriers to care do not operate with a “one-size-fits-all” approach. We adopted the community-defined evidence practices that the National Latino Behavioral Health Association (NLBHA) devised, along with that organization’s criteria for identifying existing programs for Latinos in California, because they compose the most comprehensive body of material on this topic.

NLBHA used the following seven-item complement of criteria to identify promising practices and programs: (1) capacity building and consciousness-raising, which focuses on building capacity to improve behavioral health or wellness; (2) raising public awareness about mental health, which emphasizes raising mental health awareness within Latino communities through media formats; (3) community outreach, which focuses on community outreach to improve access and follow-up services; (4) increasing service accessibility, which gives attention to reducing barriers and increasing access to care for Latinos; (5) innovative engagement practices, which emphasize the importance of using cultural values in engaging Latino consumers; (6) local adaptations of evidence-based practices for Latino populations, which focus on a provider-consumer relationship; and (7) interventions and treatment, which focus on interventions

or treatment developed specifically for Latinos. Using those seven criteria and the recommendation from the forum participants, the research team identified the programs shown in Exhibit 6 as community-defined evidence programs and practices that merit consideration for increased funding and use in California. Although no specific measures guarantee the effectiveness of these community-defined evidence programs and practices, the CRHD research team completed each of the following procedures: (1) conducted content analysis on the website and annual reports for each of the community-defined evidence programs and practices; (2) e-mailed to each of the organizations a short self-report instrument with the seven-criteria set, and asked each to articulate a rationale for each of the criteria that best applies to their promising practice; (3) conducted a second content analysis examining the rationale of each organization’s promising practices and rated their potential using NLBHA’s seven-item list of criteria. A symbol (✓) indicates that the program is fulfilling those criteria. An evaluation tool, to be developed as part of this project, will test each instrument for its feasibility, acceptability, and trustworthiness, as part of the process of measuring the effectiveness of the promising practices mentioned in this report.

Exhibit 6: Latino SPW Matrix of Organizations with Community-Defined Evidence Programs

COMMUNITY-DEFINED EVIDENCE PROGRAMS (CDEP)

Identified by the forum participants as promising practices for Latinos in California

Program	Brief description	California region	Criterion 1 Capacity building	Criterion 2 Awareness about mental health	Criterion 3 Community outreach	Criterion 4 Latinos' access to services	Criterion 5 Meaningful practices	Criterion 6 Local adaptations for Latinos	Criterion 7 Interventions and treatment
Bienestar – serves Latino LGBT youth, gay and bisexual men, transgender, and HIV/AIDS communities	Operates culturally and linguistically appropriate programs for the Latino community. Understands how important culture intertwines with HIV and seeks to meet the needs of each community.	Southern: Los Angeles County	✓	✓	✓	✓	✓	✓	✓
Bienvenido Program – serves Latino youth, families, and consumers	Is a prevention and intervention program that increases access to mental health services, and improves mental health and quality of life of Latino immigrants.	Central: All counties in the Central Valley	✓	✓	✓	✓	✓	✓	
Casa de La Familia – serves at-risk Latino male youth and victims of crime	Specializes in treatment of post-traumatic, anxiety, and depressive disorders of children, adolescents, adults, and elderly clients through crisis intervention and long-term individual and family therapy.	Southern: Los Angeles and Orange Counties	✓	✓	✓	✓	✓		✓
Center for Community Advocacy – provides training to farmworkers to serve and advocate for improved housing and health conditions	Provides leadership through a Mexican promotoras/es-based model. Promotoras/es are trained using a curriculum designed by the center with a focus on reaching out to rural communities.	Bay Area: Monterey County	✓	✓	✓	✓	✓	✓	

Exhibit 6: Latino SPW Matrix of Organizations with Community-Defined Evidence Programs (continued)

Program	Brief description	California region	Criterion 1 Capacity building	Criterion 2 Awareness about mental health	Criterion 3 Community outreach	Criterion 4 Latinos' access to services	Criterion 5 Meaningful practices	Criterion 6 Local adaptations for Latinos	Criterion 7 Interventions and treatment
Centro La Familia – serves Latino youth, children, families, and consumers	Conducts direct advocacy and intervention services for low-income residents. Its mission is to empower low-income people to access life-sustaining resources.	Central: Fresno County	✓	✓	✓	✓	✓	✓	
Familias Unidas – serves Latino youth, families, and consumers	Strives to integrate individual, family and community treatment to increase the wellness, empowerment, and self-sufficiency of consumers.	Bay Area: Contra Costa County	✓	✓	✓	✓	✓	✓	✓
Family Acceptance Project – serves lesbian, gay, bisexual, and transgender (LGBT) youth	Focuses on community outreach, intervention, education and policy initiative to decrease health and mental health-related risks for LGBT youth.	Bay Area: San Francisco County	✓	✓	✓	✓	✓		
Latino Community Relations, Engagements & Outcomes (CREO) – serves indigent Latinos and those in underserved and unserved areas	Strives to form partnerships with natural support systems in Latino communities through churches, schools, health clinics, and community centers to create community awareness of mental health issues and increase access to mental health treatment.	Southern: Los Angeles County	✓	✓	✓	✓		✓	✓

Exhibit 6: Latino SPW Matrix of Organizations with Community-Defined Evidence Programs (continued)

Program	Brief description	California region	Criterion 1 Capacity building	Criterion 2 Awareness about mental health	Criterion 3 Community outreach	Criterion 4 Latinos' access to services	Criterion 5 Meaningful practices	Criterion 6 Local adaptations for Latinos	Criterion 7 Interventions and treatment
Manitos – serves primarily Spanish-speaking older Latino populations.	Focuses on social and recreational activities that educate older Latinos on nutrition, exercise, health, and well-being.	Central: Sacramento County	✓	✓	✓	✓	✓	✓	
National Latino Fatherhood and Family Institute – works with fathers of all ages	Provides training services using culturally competent curricula focusing on family violence, gangs, teen pregnancy, teen fatherhood, and Latino male youth rites of passage.	Statewide: services to many counties in California	✓	✓	✓	✓	✓		✓
Northern Valley Catholic Social Service Promotores Program – serves Latino populations in rural areas	Promotes awareness about domestic violence, depression, substance abuse, and anxiety	Northern: Butte County	✓	✓	✓	✓	✓		✓
Pacific Clinics – serves Latino children, youth, adults, families, and consumers	Provides an array of services ranging from prevention and early intervention to recovery and wellness maintenance, with a major emphasis on programs for children and families.	Southern: Los Angeles, Orange, Riverside, San Bernardino, and Ventura Counties	✓	✓	✓	✓	✓	✓	✓

Exhibit 6: Latino SPW Matrix of Organizations with Community-Defined Evidence Programs (continued)

Program	Brief description	California region	Criterion 1 Capacity building	Criterion 2 Awareness about mental health	Criterion 3 Community outreach	Criterion 4 Latinos' access to services	Criterion 5 Meaningful practices	Criterion 6 Local adaptations for Latinos	Criterion 7 Interventions and treatment
Retiro de Hombres Campesinos – serves male farmworkers www.education-leadership.org	Provides training sessions to educate fathers about the role they play as a man and head of their household. Also provides advocacy training.	Central: Fresno, San Joaquin, and Tulare Counties	✓	✓	✓	✓	✓	✓	✓
The Wall-Las Memorias Project – serves Latino LGBTQ youth and adults and families: www.thewalllasmemorias.org	The agency provides a wide array of support services and community involvement opportunities for families, churches, and individuals at high risk for HIV.	Southern: Los Angeles County	✓	✓	✓	✓	✓	✓	✓
Ventanillas de Salud – serves Latino Families	Provides knowledge about lifestyles and prevention measures through education and health priorities.	Statewide: services to counties statewide	✓	✓	✓	✓			
Visión y Compromiso – serves Latino families, consumers, and uninsured and underinsured communities	Dedicated to improving socioeconomic and health outcomes of underrepresented communities through support, enhancement, and advocacy of promotoras and community health workers (CHWs).	Statewide: services to counties statewide	✓		✓	✓	✓	✓	

1. BIENESTAR

Background: Bienestar was founded in 1989 as a grassroots community-based organization to address the HIV/AIDS prevention and care needs of the Latino community in Los Angeles. Since its establishment, Bienestar has evolved into a multi-service, multi-center agency, becoming one of the leading HIV/AIDS service provider agencies in Southern California, with eight centers located throughout Los Angeles, San Bernardino and Riverside counties.

Promising Practices for Latinos in California: The organization runs several campaigns to raise awareness within the Latino community about homophobia, discrimination, mental health, sexuality, self-esteem, and stigma related to HIV/AIDS. An example of one campaign is Amor de Madre. The campaign consists of a *fotonovela* and a press conference focusing on acceptance, the LGBT community, and a mother's love. The *fotonovela* focuses on an LGBT child coming out, and how doing so affects self-esteem and the mental sense of well-being.

Community outreach – Bienestar performs outreach and education services for LGBT Latinos and individuals living with HIV/AIDS in Los Angeles County. The organization connects the target population to individual counseling, weekly support groups, skills-building intervention sessions, free rapid HIV testing, mental health services, case management, housing, STD screening, substance abuse services, community forums, and social and cultural events. Bienestar uses the peer model to connect, educate, and outreach to the identified community. The organization conducts outreach and education services at nightclubs, identified streets and intersections, health fairs, methadone clinics, needle exchange sites, and shopping centers.

Meaningful engagement practices – Bienestar conducts organizational assessments to determine the level of an agency's needs in developing culturally specific programs. Bienestar conducts training to teach the staff members of community-based organizations how to adapt and tailor their own programs and offer one-to-one peer mentoring and customized support.

Local adaptations of evidence-based practices – Bienestar has successfully adapted eight HIV effective behavioral interventions (EBIs), including empowerment for gay and bisexual Latino youth ages 14–24, “Many Men, Many Voices” for Latino gay and bisexual men, Voces (Voices) for Men Who Have Sex With Men and Women (MSMW), and SISTA for male-to-female transgender individuals.

Website: www.bienestar.org

2. BIENVENIDO PROGRAM

Background: The Bienvenido program is a strengths-based mental health promotion curriculum that focuses on building the emotional and behavioral health of Latinos and helps reduce the risk of reliance on substance abuse due to potentially living in an ongoing marginalized social status.

Promising Practices for Latinos in California: The Bienvenido program conducts sessions exclusively in Spanish primarily for individuals who have arrived in the U.S. during the past decade. It helps participants gain potentially new mental health knowledge and cope with the trauma of their immigration experiences through discussion and dialogue. A successful radio campaign (consisting of 20 Spanish-language public-service announcements) promotes good mental health and suicide prevention. The program represents an innovative step to respond to the needs of an emerging Latino community.

Community outreach – The Bienvenido program operates in multiple locations, both urban and rural, and outside of the agency itself, incorporating community members as facilitators. The organization takes steps to meet consumers on their familiar territory: restaurants, parks, soccer fields, schools, churches, health centers, youth centers, and juvenile correctional centers.

Meaningful engagement practices – One of the strengths of this program is the reliance on community networking and team building. This endorsement of the “it's our community” principle is an innovative and unique approach to responding to individuals with emotional or behavioral problems. A second distinctive characteristic of this program is the treatment of participants not as stigmatized individuals but rather as a group of people who have the choice of recognizing and using their strengths to contribute to a better community.

Local adaptations of evidence-based practices – The trained facilitator uses the Bienvenido curriculum, a Spanish language-teaching tool, at each class session. The Bienvenido program's curriculum is novel in that facilitators who deliver the material are instructing Latino immigrants on topics of acculturative stress and mental health needs, and building relationships with Latino immigrants who would not otherwise have had contact with this type of educational material. The curriculum encompasses fundamental aspects with a focus on: (1) relationship-building, (2) awareness of mental health topics, and (3) consumer engagement.

Website: www.necmh.org/body.cfm?lv11=servic&lv12=latino

3. CASA DE LA FAMILIA

Background: Casa de la Familia performs outreach, including presentations, conferences, and active participation in the community, for prevention of mental illness and promotion of mental health wellness. The organization's goals include creation of an open forum for discussion of topics such as mental illness stigma elimination and healthy communities.

Promising Practices for Latinos in California: Casa de la Familia conducts presentations using multiple sources of media, including theatrical plays, self-help material, radio, television, books, curricula for teenage empowerment, and other means of conveying ideas and information.

Community outreach – The organization uses a promotora model and has reached communities that otherwise would have no access to mental health information and services.

Meaningful engagement practices – Casa de la Familia personnel understand that the agency must have a presence in the community and do not expect community members to simply come to the organization's quarters. Casa counselors realize that trust is an essential factor and that word of mouth is invaluable in encouraging participation.

Local adaptations of evidence-based practices – Members of the Latino community know who they can and cannot trust. Being exploited by many unscrupulous people, community members have become distrustful of people who unexpectedly offer help, and they use their "feelings" to decide whom they can trust. Providers need to be genuine in their interactions, commitment and dedication.

Website: www.casadelafamilia.org

4. CENTER FOR COMMUNITY ADVOCACY (CCA)

Background: CCA was founded in 1989 as a farmworker housing advocacy organization, and since 2000 has expanded its mission to improve the health of farmworkers and their families in the Monterey Bay region.

Promising Practices for Latinos in California: CCA uses promotoras/es and community leaders' networks as advocates for their program. CCA participates with Radio Bilingüe regularly. CCA disseminates educational information through health fairs and presentations at churches, schools, and through migrant programs. Most presentations are in Spanish.

Community outreach – The organization reaches out to the community through the use of promotoras/es who have built trust over time and have a relationship with the community. CCA offers expert referral when appropriate. A program that CCA developed in collaboration with the Monterey County health department assigns a specific therapist to people that CCA refers for services.

Meaningful engagement practices – CCA representatives develop trust with community leaders, listen to community members, ask consumers about their needs and which aspects of the current models they have found helpful, and also seek their comments about changes they believe should be made. The organization engages in true partnership collaboration with other agencies. Their promotoras/es are made to feel welcome; treated well, and appreciated.

Local adaptations of evidence-based practices – The organization performs services for clients locally at a convenient time, not just from 9 a.m. to 5 p.m. Therapists are asked to be flexible with their time in their local areas. Doctors come after 6 p.m. to do presentations and to speak to clients. CCA offers food and gas money to encourage prospective clients to attend, especially because many attendees come after work. Community members are asked to come with "confianza."

Website: www.cca-viva.org

5. CENTRO LA FAMILIA ADVOCACY SERVICES, INC. (CLFA)

Background: Centro La Familia Advocacy Services (CLFA) is a community-based nonprofit organization that has served low-income families throughout Fresno County for more than 30 years.

Promising Practices for Latinos in California: CLFA recruits, trains, and monitor community health workers who ensure that individual, group, and classroom-based instruction are conducted for Latino families. Community presentations at schools, churches, and community centers stress the importance of breaking the myths and stigma associated with mental health problems and treatment. CLFA raises awareness by utilizing local Latino television station KFTV Univision channel 21, local radio outlets, and Radio Bilingüe, as well as community conferences, community forums, and presentations at local health fairs.

Community outreach – Outreach strategies enable mental health participants to reduce the number of crisis events and to maintain a personal and family commitment to wellness and recovery through: (1) “*platicas*” (a community forum-focus group); (2) one-day workshops introducing the *What to Do in a Mental Health Crisis* guide for families, friends, and law enforcement agencies, along with the 2011 *Guide to Local Mental Health Resources*, a comprehensive overview of all available mental health resources in the area; (3) community health workers in rural communities; (4) the community health workers who design and conduct longer series (4–6 weeks) of presentations on specific mental health topics—e.g., depression, stress, or anxiety.

Meaningful engagement practices – CLFA establishes trusting relationships with community members by showing a respect for culturally specific ways of accomplishing goals. The promotora-mentoring concept is rooted in the notion that intergenerational transfer of information, skills, and knowledge results in empowerment, especially within minority communities.

Local adaptations of evidence-based practices – CLFA acquaints clients with cancer awareness support groups in urban and rural Fresno with the assistance of a “*comadre*,” a term used to describe the non-biological close female kinship that exists in the Hispanic-Latino extended family. This approach lends a sense of trust and confidentiality among participants of the support groups.

Website: www.centrolafamilia.org

6. FAMILIAS UNIDAS

Background: Familias Unidas was founded in 1979 by Contra Costa County educators, civic leaders, mental health professionals, and residents. The nonprofit organization envisions a “community counseling and information center” helping people in a holistic and culturally appropriate manner.

Promising Practices for Latinos in California: Culturally and linguistically appropriate information is available over the phone, in person, or through distribution of bilingual self-help directories. Familias Unidas assists clients with language interpretation services (English-Spanish), cultural orientation, and advocacy.

Community outreach – The organization takes advantage of every opportunity to promote its services, which include participation in local health fairs, Cinco de Mayo events, and Kaiser Permanente health fairs. Familias Unidas distributes brochures and other literature. The organization has become well known in the community through word of mouth and grassroots community exposure because of its longevity and the various services it offers.

Meaningful engagement practices – Trauma-informed therapy best practices have contributed to establishment of a comfortable space that families find acceptable and welcoming. The organization has built a library of age-appropriate instructional books in English and Spanish, and bilingual and bicultural Familias Unidas representatives acknowledge every person who walks in the door. Staff members apply *personalismo* to make a difference and maintain a tightly knit group. Familias Unidas employees are interested and engaged in serving their local communities.

Local adaptations of evidence-based practices – Familias Unidas offers counseling interventions that are both innovative and culturally relevant to the Latino population and other diverse communities. The therapeutic approach integrates individual therapy, group therapy, case management, and medication services. Familias Unidas offers psychiatric services, including evaluation and medication prescriptions, to patients receiving mental health services in order to enhance their treatment and therapeutic outcomes.

Website: www.familias-unidas.org

7. FAMILY ACCEPTANCE PROJECT

Background: The Family Acceptance Project™ is a community research, intervention, education, and policy initiative that works to decrease major health threats and related risks—including suicide, substance abuse, HIV, and homelessness—for lesbian, gay, bisexual, and transgender (LGBT) youth, in the context of their families.

Promising Practices for Latinos in California: The project is being carried out in collaboration with key community groups and representatives from community organizations that work with youth in schools and health-care settings, and with families.

Community outreach – Members of the target population, providers, teachers, parents, and youth collaborate on the project by participating in a community research council and providing guidance on outreach activities, developing protocols, analyzing data, developing publications, and disseminating findings.

Meaningful engagement practices – Participatory research is a core approach. The Family Acceptance Project is committed to developing new models of participatory research, not only to inform research and planning, but also to share these approaches with other researchers and decision makers to ensure that research reflects the lives, needs, and experiences of individuals and groups in the context of their cultures and communities. One outcome of the Family Acceptance Project is a model of participatory research for prevention and health services research.

Local adaptations of evidence-based practices – The Family Acceptance Project puts research into practice through an evidence-based family model of wellness, prevention, and care to strengthen families and promote positive development and healthy futures for LGBT children and youth.

Website: familyproject.sfsu.edu

8. LATINO COMMUNITY RELATIONS, ENGAGEMENT AND OUTCOMES (CREO)

Background: Founded in 2001, CREO is a nonprofit organization that strengthens peer-to-peer opportunities for individuals and families with mental health needs. One of their successful programs is Un Paso Más which is a part of Project Return Peer Support Network. Both Un Paso Más and Project Return were created by and continue to be affiliated with Mental Health America of Los Angeles, a nonprofit organization that is nationally recognized for helping low-income individuals with serious mental illness recover to lives of wellness in their communities.

Promising Practices for Latinos in California: The cultural values of *familismo*, *respeto* and *personalismo* – elements that create *confianza* – are constants of CREO's approach. It incorporates the strength of family and faith, and the sense of community and sensitivity to personal attention, as it engages individuals, educates them about mental illness, extends service resources, and encourages development of grassroots advocates. CREO publishes instructional materials—flyers for schools and libraries and bulletin announcements for churches—in Spanish and English. The organization also administers support groups.

Community outreach – The organization identifies and develops relationships with natural support systems, including churches, schools, and community centers, and conducts its outreach and engagement activities at these natural support locations. CREO co-locates programs with El Centrito, a mental health peer-run center, and the two organizations collaboratively identify mental health needs of the community by interviewing key leaders.

Meaningful engagement practices – CREO outreach and engagement activities recognize that “one size does not fit all.” The organization's practice concentrates on the faith and family structures that traditionally are important to the culture and customs of the community it serves. CREO personnel have found that churches and schools often are considered trusted resources, and their services for Latino families may overlap with mental health issues. As another strategy for using natural support, CREO cultivates community mentors.

Local adaptations of evidence-based practices – The California Institute for Mental Health reviewed and accepted CREO as a community-defined evidence model in the Los Angeles County Department of Mental Health's PEI planning in 2010. CREO adapts evidence-based practices such as the Wellness Recovery Action Plan (WRAP) or Seeking Safety (for trauma) to the Latino community.

9. MANITOS

Background: Manitos is a large social group open to older adults who speak Spanish. The group's meetings, conducted entirely in Spanish, feature games, food, songs, exercise, and more. Educational seminars and other presentations are scheduled frequently.

Promising Practices for Latinos in California: All information presentations are printed for sharing with friends and relatives. Manitos encourages its members to participate in community health clinics and wellness events, and cultivates family awareness of activities and support. All information is presented in Spanish to surmount social, cultural, and linguistic barriers and nurture effective communication.

Community outreach – La Familia and El Hogar are two agencies through which members receive services. Senior Link has helped members obtain health services and support. Manitos seeks participation of other agencies that can offer services to members.

Meaningful engagement practices – Many agencies ignore or are unaware of the linguistic needs of members. Difficulties related to rapid transit, parking, directions, and availability of facilities are discussed during gatherings.

Local adaptations of evidence-based practices – Music activities, exercise, and information presented are evidence-based. Manitos encourages seniors to participate in physical exercise at the gym, at swimming pools, and through participation in other outdoor and indoor activities with personnel who are bilingual and bicultural.

10. NATIONAL LATINO FATHERHOOD AND FAMILY INSTITUTE (NLFFI)

Background: NLFFI, which operates under the auspices of the National Compadres Network, is a nationwide program that brings together nationally recognized leaders in the fields of Latino fatherhood, rites of passage, health, education, juvenile justice, social services, and advocacy.

Promising Practices for Latinos in California: NLFFI is working in collaboration with President Barack Obama's effort to help men better understand the positive role they play in adding protective factors to their children's lives. These activities will help build strength and resilience in children to enable them to achieve their goals and dreams. At the national level, the center conducts services for associated professionals, including consulting, seminars and conferences, on-site training and curricula, and publications.

Community outreach – NLFFI builds a strong network of organizations that will influence the direction of the initiative in order to: 1) identify existing policy gaps preventing the development of effective fatherhood and to create involvement programs and, 2) develop positive fatherhood and male involvement policies and programs that build on the strengths of fathers and other male mentors.

Meaningful engagement practices – Through research, training, and direct services, the institute helps fathers of all ages develop strong, active roles in the lives of their children, while concurrently addressing the very painful aspects of child abuse, domestic violence, gang violence, school failure, illiteracy, teen pregnancy, and other related issues.

Local adaptations of evidence-based practices – The center performs culturally sensitive social and educational services with programs designed to strengthen and preserve families, prevent teen pregnancy, influence men to become strong fathers and responsible men, and instill the importance of culturally sensitive physical and mental health services.

Website: www.nlffi.org

11. NORTHERN VALLEY CATHOLIC SOCIAL SERVICE PROMOTORES PROGRAM

Background: The Northern Valley Catholic Social Service's Promotores Program, based in Chico, was established to respond to and resolve cultural barriers as a means of increasing awareness and facilitating access to mental health services. The cultural barriers that impede access to mental health services include language, stigma, legal status, and acceptance of alternative healing practices.

Promising Practices for Latinos in California: The Promotores program participates in a Chico-area Latino radio station to offer services and raise awareness about mental health. The broadcasts are intended to increase awareness of the mental health services available in the community.

Community outreach – The Promotores program regularly conducts outreach to community agencies to explain its core services: case management, support groups, and a direct connection to mental health services. The promotores are bilingual Spanish and English speakers.

Meaningful engagement practices – Innovative ways that have been used to engage the Latino population include sponsorship of soccer teams, posadas, and offering services at the Catholic church during mass. Cultural food and music have also been utilized and proven to be successful when engaging the community.

Local adaptations of evidence-based practices – Support groups that meet weekly in areas populated by Latinos host mental health presentations in a safe and nurturing environment. Discussion topics often include sensitive issues that are seldom discussed openly among the Latino culture, including domestic violence, depression, substance abuse, and anxiety. Guest speakers, participation-focused groups, presentations, and group discussion are used to deliver information to the groups.

Website: www.nvcss.org/programs/buPromotores.aspx

12. PACIFIC CLINICS

Background: Pacific Clinics, a private, nonprofit community behavioral health-care agency, was established in 1926 as Pasadena Child Guidance Clinic. Since then, the organization has expanded its focus to encompass the mental and behavioral health concerns of families and individuals of all ages.

Promising Practices for Latinos in California: The organization has conducted mental health education and awareness programs through local churches, county and community agencies, schools, the YMCA, city programs, parks and recreation collaboration, National Association of Mental Illness (NAMI), conferences, workshops, beauty salons, PTA meetings, and other opportunities. A collaboration has been built with celebrity and high-profile people such as Congresswoman Grace Napolitano, boxer Mia St. John, actor Edward James Olmos, dancer Mark Ballas, and other prominent figures who have helped in promoting awareness among the community on a wide variety of topics about mental health. Pacific Clinics produced a Spanish-language video in 1999 about cultural factors, religious beliefs relating to mental illness, and concerns about stigma that impede access to professional care. The video details the symptoms of major illnesses, including schizophrenia, depression, and bipolar disorder. The DVD was promoted throughout Los Angeles County, as well as nationwide and internationally.

Community outreach – Pacific Clinics' Latino services incorporate a comprehensive approach that includes five key components: 1) prevention; 2) outreach; 3) community education and awareness; 4) parents' psycho-educational support groups; and 5) comprehensive mental health services.

Meaningful engagement practices – The organization builds rapport by being attentive to cultural orientations. For many families, social agencies can be intimidating and frightening depending on previous interactions with mental health providers or "the system," in which they may have experienced stigmatization or other forms of discrimination. Factors the organizations considers include 1) language, 2) ethnicity, 3) cultural aspects, 4) values, 5) beliefs, 6) religion, 7) myths, and 8) legal status.

Local adaptations of evidence-based practices – Pacific Clinics makes cultural modifications during engagement and treatment; the organization uses 1) *personalismo*, 2) *familismo*, 3) *colectivismo* and *comunidad*, 4) *respeto*, 5) *simpatia* and *amabilidad*, 6) *confianza* (trust), 7) *espiritualidad* and *religion*, 8) *marianismo* and *machismo*, and 9) *fatalismo* (fate).

Website: www.pacificclinics.org

13. RETIRO DE HOMBRES CAMPESINOS

Background: Retiro de Padres was founded in 2008 in response to the need to improve the educational environment of Latino public school students. The activities of Retiro de Hombres Campesinos, target males who are farmworker parents and are designed around their particular needs.

Promising Practices for Latinos in California: Clients learn about the program mainly by word of mouth and on a referral basis. Retiro de Hombres Campesinos has established a partnership with CSU Fresno migrant education program, which promotes the organization's activities.

Community outreach – Networks are utilized through the CSU Fresno migrant education program and through contact with migrant personnel from the local school districts. Parents are informed about the program through the school districts. Retiro de Hombres Campesinos program personnel contact parents who express interest.

Meaningful engagement practices – Workshops topics, determined by the participants, include; 1) improving your role as a father figure; 2) improving your home environment; 3) improving your relationship with your wife and your children; 4) improving your family's mental and physical health; 5) providing an academic environment at your home; and 6) accepting yourself for who you are.

Local adaptations of evidence-based practices – The services are delivered in a circle format to allow each participant to develop his or her own plan for change, and to give participants the opportunity to share their experiences with others.

* Website: ums.csufresno.edu/

* The coordinator responds to inquiries.

14. THE WALL - LAS MEMORIAS PROJECT

Background: Founded in 1993, The Wall - Las Memorias Project is dedicated to promoting wellness and preventing illness among Latino populations affected by HIV/AIDS by using the inspiration of the AIDS Monument as a catalyst for social change. During the past 14 years, The Wall - Las Memorias has built strong community support for its innovative educational programs and awareness events. The agency conducts a wide arrange of support services and community involvement opportunities for families, churches, and individuals at high risk for HIV.

Promising Practices for Latinos in California: The organization promotes awareness about stigma, bigotry, and mental health throughout all of its activities. The project hosts an annual conference on Latinos, faith culture, HIV, and mental health for more than 350 parish and congregant leaders of Los Angeles County.

Community outreach – In conducting its services, The Wall - Las Memorias Project uses a community mobilization model that encourages consumers and community members to discuss their needs and disparities. The agency also trains community members to promote public policy to create systems change as a means by which agencies can better serve community members.

Meaningful engagement practices – Because of the important contribution of religious faith to culture, mutually respectful linkages with faith communities as full partners promote wellness and have eliminated stigma among all people. Individual voices of the community are heard, and all are in agreement on the essential need for social change.

Local adaptations of evidence-based practices (EBPs) – The Wall-Las Memorias provides educational opportunities and training to consumers. It identifies specific cultural and linguistic needs and adapts evidence-based best practices to all of its current programs.

Website: <http://thewalllasmemorias.org/>

15. VENTANILLAS DE SALUD (VDS)

Background: The Mexican government, through its consulates and the Instituto de los Mexicanos en el Exterior (IME), has taken an active role in promoting the rights and welfare of Mexican people in the United States.

Promising Practices for Latinos in California:

Ventanillas de Salud (VDS) raises awareness and educates the community about health issues through workshops, referrals to health practitioners, and education about health concerns.

Community outreach – Ventanillas de Salud has a variety of outreach strategies, including services within the Mexican Consulate, mobile units, community health fairs, and organizing a binational week program each October. VDS partners with numerous local health organizations, as well as academic and social sectors.

Meaningful engagement practices – Ventanillas have been established at 10 locations in California. These ventanillas are based in the Mexican Consulate's offices in Sacramento, San Francisco, San Jose, Oxnard, Los Angeles, Fresno, Santa Ana, San Bernardino, San Diego and Calexico. In addition, each ventanilla provides periodic services in rural and remote areas through their mobile units.

Local Adaptations of Evidence-Based Practices – Not available

For more information visit the local Mexican Consulate office.

16. VISIÓN Y COMPROMISO (VyC)

Background: Visión y Compromiso (VyC) expresses its mission as *Hacia una Vida Digna y Sana/Working Towards A Healthy and Dignified Life for All*. That mission reflects the work of the organization to improve socioeconomic and health outcomes of underrepresented communities. By building promotores' capacity, VyC strengthens the ability of Latino communities to identify issues of concern, confront barriers, propose locally defined solutions, inform policies, change organizational practices, and improve individual and community health outcomes.

Promising Practices for Latinos in California: VyC, which was founded in 2000, operates with leadership committees made up of promotores, community workers, and other leaders who represent diverse groups and organizations. They meet monthly, and as a coalition, they identify local needs of the community and of the promotores, and identify the region's priorities. With that information, they develop, implement, and evaluate a yearly work plan that supports the local promotores with capacity building, work tools, and resources to strengthen their work.

Community outreach – Local promotoras conduct outreach in their community to inform residents of local health resources or community services available, and they assist clients in accessing these services.

Meaningful engagement practices – The network has five main strategies: to advocate, build capacity for promotores, collaborate with other leaders, communicate, and validate the promotores model.

Local adaptations of evidence-based practices – Promotores offer servicio de corazón (heartfelt service) and culturally relevant health prevention education to native-born and immigrant communities. They “give their time, their charisma, their passion.” Promotores are sensitive to the practical and cultural realities that increase health risks for Latinos, and they are aware of the health system barriers that limit access to preventive services. They use personal contacts, trust and respect to address sensitive topics, counter misinformation, and advocate for quality health care, acting as cultural, linguistic and socioeconomic allies to the community. Promotores have access to valuable information about what is (and is not) working in health-care systems, and can suggest realistic solutions to respond to the critical issues in their communities.

Website: www.visionycompromiso.org

CONCLUSION

Latinos comprise nearly 40% of the California population and are increasingly shaping the demographic makeup of the state. More than half of California's newborn children and those attending elementary school are of Latino origin. Latinos compose the majority of the population in nine California counties: Colusa, Fresno, Imperial, Kings, Madera, Merced, Monterey, San Benito and Tulare (Lin, 2011) as well as the majority of the population in 17 California cities and neighborhoods.

The overwhelming majority of Latinos in California (82%) are of Mexican descent. Despite many commonalities across the various Latino groups, the existence of cultural, linguistic, educational, and sociopolitical differences sometimes requires classification of Latinos into sub-populations for investigative purposes. Distinguishing among Latino subgroups from different regions and examination of their demography, history, culture, and

views on mental health are important for future research. Researchers should not attempt to characterize all Latinos as one homogenous group and ignore between and within-group heterogeneity. Therefore, strategies and recommendations for providing mental health care for Latinos must not be from a "one size fits all" recipe (Willerton, Dankoski, and Martir, 2008).

When Latinos do suffer from mental illness, they are not as likely as members of other population groups to access mental health care and services. Underutilization of mental health services is even higher in Mexican-Americans and even more pronounced among Mexican migrant agricultural workers. This report sheds some light on the nature of the gaps in mental health service utilization by Latinos. The report describes strategies and recommendations by Latino community members that must be taken into account in order to reduce disparities in access and in mental health service utilization by Latinos.

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JULY 2014

**PREVENTION and EARLY INTERVENTION – EDUCATION
(PEI – EDUCATE): CHANGING THE COURSE OF A DISORDER**

SCHOOL-BASED MENTAL HEALTH CURRICULA FOR URBAN YOUTH



WELLNESS • RECOVERY • RESILIENCE

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Executive Summary

On behalf of the California Mental Health Services Authority (CalMHSA), we are pleased to present **Prevention and Early Intervention – Education (PEI-Educate)**. PEI-Educate emerged from the 2012 report titled “*Community-Defined Solutions for Latino Mental Health Care Disparities*” in which Latino youth was identified as a critical segment of the Latino community who face numerous stressors that can increase the risk of mental health problems (Aguilar-Gaxiola et al., 2012). These researchers found that stress among Latino youth and adolescents was manifested in mental health problems that included anxiety and depression, and eventually led to school dropout rates, substance abuse and/or suicide. This Executive Summary offers a brief background of the PEI-Educate project, followed by the use of the PEI-Educate Standards Framework.

Background

Prevention and early intervention (PEI) have become increasingly important as the mental health community looks for ways to increase knowledge to respond to mental health disparities earlier and change the course of a serious mental health disorder. PEI-Educate, a school-based mental health curriculum, is centered on the Mental Health Services Act’s PEI initiative. Specifically, this curriculum is grounded in one main goal—to educate students, educators, parents, and community leaders about the importance of early identification of a mental health disorder and thereby change the course of that disorder, while at the same time increasing school engagement.

PEI-Educate is a standards curriculum that serves as a framework for teachers to collaborate with mental health partners to align mental health profession standards with academic core standards. The purpose of this curriculum is to reduce mental health disparities through education and curriculum to meet the needs of the unserved, underserved, and inappropriately served Latino youth. Although the target group for this curriculum is Latino youth in secondary schools, it can be modified and applied to all youth in secondary education. We argue that failing to examine the youth, especially Latino youth in secondary schools who are at greater risk of dropping out of school, can lead to substance abuse and the exacerbation of mental health disorders, and eventually prison. This curriculum addresses this issue by examining and organizing a set of prevention and early intervention standards that focuses on Latino youth at risk of exposure to trauma, mental health disorders, substance use, dropping out of school, stigma and discrimination, incarceration, and suicide, among other risks. Specifically, these standards will serve a twofold purpose: (1) be the foundation for the school curriculum to guide educators in integrating prevention and early intervention strategies in classroom instruction; and (2) provide educators a curriculum framework that will be the interplay among standards, classroom content, instruction delivery, and assessment. As such, the curriculum will consist of lesson plans that focus on classroom instruction that leads to growth in knowledge and eventually transmission of that knowledge to real life through experiential learning. According to a student:

“I think that the more we can talk about what mental illness is, the more we can understand and treat people with mental illness. If we just ignore it and think ‘oh, this only affects them, we can’t talk about it too much’ ... then it’s not going to help, it’s just going to keep the stigma alive ... that people with a mental illness are under the whole category of being a psychopath.... More education [is needed].”

Conversations about mental health and the many risk factors that contribute to mental health disorders are critical and should be the focus of school educators and administrators. Acknowledging and acting on the early identification and mental health intervention of youth may decrease incarceration rates, drug use, and eventually severe and persistent mental illness.

How to Use PEI-Educate

For PEI-Educate to be effective in: (1) designing new curriculum, (2) delivering curriculum in ways that engage students, and (3) assessing knowledge growth, collaboration is required between the mental health profession and the academic field. For this reason, we recommend that PEI-Educate is readily suited for high schools that are already designed as schools within schools (i.e., small schools). They have 50 to 500 students who take a sequence of academic and industry-related courses (e.g., English, social studies, and health) together. Some of the schools are charter schools, magnet schools, and middle college programs that enroll all of their students in the pathway program. A major component of these programs is articulation with an industry partner so students have the opportunity to learn about current health issues and skills needed in the industry.

The curriculum based on the PEI-Educate standards framework will emphasize the most important ideas, concepts, and strategies to: (1) build educators' capacity to teach youth about mental health issues, (2) apply concepts that raise awareness and lead to early identification of mental health issues in youth, and (3) support educators in integrating prevention and early intervention strategies in the classroom.

To ensure that all students benefit from this curriculum, the PEI-Educate Standards Framework will be aligned with English Language Arts (ELA) Common Core State Standards (ELA-CCSS). Specifically, the PEI-Educate curriculum will infuse mental health and prevention and early intervention material into the selected ELA core standards. This integration process must be performed with collaboration between the ELA teacher(s) and a mental health professional to ensure that the appropriate content is being aligned and curriculum activities developed.

Introduction

The 2012 report titled “*Community-Defined Solutions for Latino Mental Health Care Disparities*” identified Latino youth as a critical segment of the Latino community who face numerous stressors that can increase the risk of mental health problems (Aguilar-Gaxiola et al., 2012). For example, these researchers found that stress among Latino youth and adolescents was manifested in mental health problems that included anxiety and depression, and eventually led to school dropout rates, substance abuse and/or suicide. Indeed, numerous barriers prevent Latinos from accessing and utilizing mental health-care services. Problems with language, lack of knowledge about services, and poor financial resources are major barriers for Latinos in seeking and accessing care (Garza & Watts, 2010). The majority of Latinos prefer attending to all mental health issues within their family in order to avoid undesirable attention and the stigma that is often associated with seeking services.

Fear of stigma reduces the likelihood of Latinos to acknowledge their condition and typically discourages them from seeking treatment (Vega, Rodriguez, & Ang, 2010) out of concern of being judged or victimized by discrimination. This is particularly true among young Latino men, who often exert themselves more to appear in control and strong. Young men who come from a “traditional” household are more likely to adhere to the traditional male values such as being tough, self-reliant, and not showing weaknesses (Zayas & Torres, 2009). Evidence supports the notion that the social environment in which Latino youth live and study plays a major role in shaping their views and decisions about mental health (Aguilar-Gaxiola et al., 2012). McLoyd (2004) contends that true understanding of individuals’ social environment and potential risk factors requires integration of a framework based on people’s lived experiences that are associated with culture. Such a framework helps Latino youth interpret and understand their social and academic surroundings.

Along similar lines, other researchers (e.g., Gándara, 1995; Valencia, 2012) have conducted extensive work on the harm that a cultural deficit perspective has exerted on Latino youth with respect to their poor academic achievements. They argue that this perspective takes the position that Latino students and families are at fault for poor academic outcomes. Cultural deficit practices emphasize deprivation in Latino communities (Yosso, 2005). Deficit thinking is also common in mental health care. This perspective is used when interpreting the causes for the reluctance of Latinos to access or utilize mental health services in schools. Latino youth are among those at highest risk for poor educational and health outcomes (Pérez-Escamilla & Putnik, 2007; Shetgiri et al., 2009). For these young people, deficit thinking may also act as a barrier to seeking help. Focusing on a strength-based approach to youth development and resilience may result in more effective outcomes than a deficit thinking approach in responding to youth issues. Moreover, resiliency combined with learned optimism helps to combat deficit thinking. Resiliency is defined as a process of positive adaptation that helps people to cope effectively with adversity and life challenges (Kobau et al., 2011; Masten, Cutuli, Herbers & Reed, 2009; Shetgiri et al., 2009; Zolkoski & Bullock, 2012). While resilience helps people overcome the negative effects of trauma and risk exposure (Fergus & Zimmerman, 2005), optimism helps people challenge negative beliefs and avoid deficit thinking (Kobau et al., 2011). Optimism can improve resiliency in Latino youth. PEI-Educate is an example of a framework that promotes resiliency and strengthens self-efficacy among Latino youth.

A community-based program with an infrastructure that provides teachers with resources for teaching and opportunities for students to engage in meaningful structured community engagement learning activities (Levin & Rutkow, 2011) is critically important to student motivation and increasing health literacy. Michener and colleagues (2012) emphasize that establishing this infrastructure requires leadership and commitment from the top in order to

transform a rigid institutional (school) culture into one that is flexible and community-ready to engage community partners. PEI-Educate is a standards curriculum that serves as a framework for teachers to collaborate with mental health partners to align mental health profession standards with academic core standards. This infrastructure must align the goals of the mental health and school communities to not only expand the core curriculum in both the classroom and students' daily lives (Lohmeier, 2009), but also to become an effective training model in prevention and psychosocial intervention (Brooker & Brabban, 2006). That is, for PEI-Educate to be effective in: (1) designing new curriculum, (2) delivering curriculum in ways that engage students, and (3) assessing knowledge growth, collaboration is required between the mental health profession and the academic field. For this reason, we emphasize that PEI-Educate is readily suited for high schools that are already designed as schools within schools (i.e., small schools). They have 50 to 500 students who take a sequence of academic and industry-related courses (e.g., English, social studies, and health) together (Loera & Nakamoto, 2013). Some of the schools are charter schools, magnet schools, and middle college programs that enroll all of their students in the pathway program. A major component of these programs is articulation with an industry partner so students have the opportunity to learn about current health issues and skills needed in the industry.

PREVENTION AND EARLY INTERVENTION: THEORETICAL BASIS FOR PEI-EDUCATE

In November 2004, California voters passed Proposition 63, now known as the Mental Health Services Act (MHSA). That ballot initiative set a 1% tax on adjusted gross income above \$1 million, and earmarked those tax dollars to transform California's mental health system into a consumer- and family-driven, culturally competent, and recovery-oriented system (Cashin, Scheffler, Felton, Adams, & Miller, 2008). MHSA's prevention and Early Intervention (PEI) initiative is key to reducing disparities and building protective factors (e.g., resiliency to cope with challenges) and skills (e.g., knowledge about mental health disorders).

Prevention and early intervention have become increasingly important as the mental health community looks for ways to increase knowledge to respond to mental health disparities earlier and change the course of a serious mental health disorder. A great deal of research has been conducted on social and economic factors—such as poverty, social exclusion, diminished social networks, discrimination, stress, limited accessibility to health care, and stigma—that affect individuals' health throughout their lives (e.g., Braveman, Egerter, & Mockenhaupt, 2011; Frieden, 2010; Wilkerson & Marmot, 2003). PEI-Educate, a school-based mental health curriculum, is centered on MHSA's PEI initiative. Specifically, this curriculum is grounded in one main goal—to educate students, educators, parents, and community leaders about the importance of early identification of a mental health disorder and thereby change the course of that disorder, while at the same time increasing school engagement.

This school-based curriculum focuses on building capacity in secondary schools aimed at suicide prevention, reducing stigma and discrimination, and improving youth mental health outcomes. The underlying rationale is that early identification can be instrumental in averting or curtailing a potential mental health disorder. This curriculum also will help in convening and developing partnerships amongst mental health professionals and the academic community. Additionally, through this curriculum, relationships and collaboration will strengthen and lead to the implementation of strategies highlighted in the 2012 *Community-Defined Solutions for Latino Mental Health Care Disparities* report. Finally, this curriculum can be replicated with local capacity-building efforts and existing statewide leadership within the Latino behavioral health communities. Specifically, local and statewide leaders should convene to learn about ways in

which to integrate prevention and early intervention strategies in schools, and how to disseminate the curriculum through educational campaigns and teacher credentialing programs.

The purpose of this report is to offer a curriculum framework that reduces mental health disparities of the unserved, underserved, and inappropriately served Latino youth through education in schools. We are interested in Latino youth in secondary schools and mental health care disparities because Latinos, in general, have less access to mental health services than do non-Latinos and are less likely to receive needed care. Failing to examine the Latino students, especially Latino youth in secondary schools who are at greater risk of dropping out of school, can lead to substance abuse and the exacerbation of mental health disorders, and under some circumstances prison. This report addresses this issue by examining and organizing a curriculum that focuses on Latino youth at risk of exposure to trauma, mental health disorders, substance use, dropping out of school, stigma and discrimination, incarceration, and suicide, among other risks.

PEI-EDUCATE DIMENSIONS: KNOWLEDGE, EXPERIENTIAL LEARNING, AND SELF-EFFICACY

Knowledge

Anderson and Krathwohl (2001) make the distinction between types of *knowledge* that can serve as a framework for organizing the Prevention and Early Intervention Education (PEI-Educate) curriculum: (1) *Factual knowledge* refers to basic knowledge such as terminology, details, or elements that one must understand to be successful in the classroom; (2) *Conceptual knowledge* refers to the acquisition of conceptual, theoretical, and strategic knowledge, including categories, classifications, principles, and models; (3) *Procedural knowledge* refers to knowing “how to” do something that requires a specific type of skill and process; and (4) *Metacognitive knowledge* refers to self-knowledge or awareness of one’s own cognition. Metacognitive knowledge is the type of knowledge that allows one to self-monitor and self-evaluate while achieving a specific goal. Boreham (2002) argued that knowledge and skill are embodied within students and educators, and these interactions lead to opportunities for students to experience and find relevance in what they are learning. In addition, Hedin (2010) emphasized the importance of student exposure to real-life experiences and the educators’ role in enhancing that learning process.

Experiential learning

Experiential learning has become an integral and meaningful component in education in which students and educators become active learners. In this context, *experience* means that students are able to develop and apply knowledge or skill to real-life scenarios and tasks. This is accomplished not only through classroom instruction, but also through participation in mental health-related activities outside of the classroom. According to Sturko and her colleagues (2008), understanding how people construct meaning from their experiences can be helpful in designing and developing learning opportunities for them. Findings from previous research support a central proposition that possessing the knowledge and experience necessary to recognize the negative impact of a mental health disorder is critical to Latino youth full participation in school life and when making the transition into adulthood (Shetgiri et al., 2009). This research indicates that good health is grounded in a strong social and economic foundation that enables people to play a meaningful role in the social, economic, and cultural life of their communities. With regard to Latino youth gaining interest in the mental health workforce, Pulakos and colleagues (2000) add that the development of employability skills can be attained

only if students are provided with meaningful learning experiences and given frequent opportunities for them to practice and increase their knowledge and capabilities.

Self-efficacy

Positive psychology theorists (Costello & Stone, 2012; Fredrickson, 2001; Kobau et al., 2011; Seligman & Csikszentmihalyi, 2000) contend that students' self-efficacy improves when they are learning in a positive environment that promotes students' strengths and their cultural assets. Therefore, school performance can be explained by students' beliefs about how well they will do on a specific activity and the extent to which they are emotionally invested in and value the activity. In other words, students with low levels of self-efficacy may lack the knowledge and protective factors (coping skills) to be resilient in the face of risk. In contrast, students who are able to sustain their self-efficacy are likely to be more effective in managing risk factors and reaching a level of positive emotions and optimal functioning.

The PEI-Educate Standards

The PEI-Educate Standards will focus on mental health care disparities with Latino cultural considerations for prevention. In other words, the PEI-Educate Standards will consist of concise statements that define what educators must teach so that all youth know and are able to identify and reduce mental health problems. Specifically, these standards will serve a twofold purpose: (1) be the foundation for the school curriculum to guide educators in integrating prevention and early intervention strategies in classroom instruction; and (2) provide educators a curriculum framework that will be the interplay among standards, classroom content, instruction delivery, and assessment. As such, the curriculum will consist of lesson plans that focus on classroom instruction that leads to growth in knowledge and eventually transmission of that knowledge to real life through experiential learning.

BACKGROUND AND FORMATION OF PEI-EDUCATE STANDARDS

The development of these eight PEI standards consisted of a three-pronged approach. First, on March 3, 2014, a presentation titled “Mental and Behavioral Health: Linking Industry to the Classroom,” which consisted of sample PEI standards and performance indicators, was delivered to approximately 75 secondary school educators attending the Educating for Careers Conference in Sacramento, California. Working in small groups, these educators were given 35 to 40 minutes to read and critique the sample PEI Standards and suggest additional mental health or substance abuse topics and standards. Based on the responses and recommendations from these educators, sample standards and performance indicators were modified and new ones were created. The majority of the feedback was centered on standards that were tied to community and cultural aspects of students’ lives.

Second, three Ethnic Service Managers (ESMs), who are familiar with Latino mental health issues, were presented with a draft consisting of seven PEI-Educate standards and performance indicators and asked for their critiques. On one occasion, ESMs offered their reactions and guidance on framing the standards that specifically focused on: (1) Latino youth and academic issues; (2) health literacy in schools, and (3) a solid dissemination plan to reach a large number of Latino students. Their suggestions led to a new draft of the PEI-Educate standards framework. A second conversation with ESMs determined the need to simplify the language of the standards and performance indicators and revise them to coincide with the appropriate grade level. Meeting participants determined that each school that adopted the PEI-Educate standards must have a mental health industry professional working alongside teachers and co-teaching to increase teachers’ ability and confidence in teaching topics essential in responding to mental and substance use disorders. This element was emphasized as a component of critical importance in achieving the goal of this project. As a result of these suggestions, we modified the PEI-Educate standards and performance indicators, and included a section that gives emphasis to the value of involving the mental health profession inside the classroom.

Finally, 15 students (2 elementary school students, 3 middle school students, and 10 high school students) were asked to read each of the PEI-Educate Standards and performance indicators and determine if the framing of the standards with respect to language and relevance was clear and applicable to the academic (e.g., English Language Arts [ELA]) standards that they are required to learn. All students were specifically asked to read each standard and performance indicator and repeat what they thought was being asked of them to learn. Any confusing or difficult-to-understand items were revised until text was comprehensible to these

student participants. All student participants were successful in conveying what each PEI-Educate standard and performance indicator was requiring them to be knowledgeable in and able to perform. Moreover, the high school students requested addition of a standard on leadership in mental health so that students with leadership potential could discover and explore that leadership potential in the mental health field.

On June 20, the PEI-Educate Standards framework was introduced to 154 health science educators attending the 9th Annual Health Science Educators' Institute in Sacramento. These educators represented 18 health science capacity-building collaboratives (i.e., high schools, middle schools, community colleges, and the health-care industry). At this conference, educators were given an overview of the PEI-Educate Standards and asked to assess feasibility and utility of implementing these standards and performance indicators. Consensus was that the PEI-Educate Standards are not only feasible, but also extremely necessary to be taught on a school campus for all students. Educators requested that PEI-Educate Standards and additional materials be made available to them, in order to incorporate the standards and mental health topics as they prepared their new 2014–15 work plans.

Secondary school educators do not have adequate knowledge about mental health issues, and more needs to be done on prevention versus remediation (Hickman-Poloney, 2013). Also, teachers may require guidance on strategies to successfully incorporate and implement the PEI-Educate standards into their curricula. ESMs encouraged the involvement of the mental health industry in helping to shape the curriculum (personal communication, May 22, 2014). Therefore, we recommend professional development activities that will engage both the secondary school educators (i.e., ELA teachers) and a mental health industry professional as a starting point to launch this project. As part of the implementation, the ELA teachers and mental health industry professional participate in curriculum alignment and development activities in which they meet recurrently during school hours to plan and co-teach the mental health topics.

IMPLEMENTATION AND EVALUATION OF PEI-EDUCATE STANDARDS

The PEI-Educate implementation describes the activities in which educators and mental health professionals engage as part of curriculum development. Curriculum development can benefit if the mental health industry partner is helping teachers target specific learning goals and skill requirements. Ethnic service managers (ESMs) guided us as we identified the critical components of implementing PEI-Educate. During a personal communication (2014), our ESM partners emphasized the importance of establishing a collaborative between the mental health industry and teachers in the implementation of PEI-Educate.

A collaborative-pedagogical process that consists of the teachers' classroom practices and their interactions with the mental health industry professionals is essential to the success of this curriculum. That is, an important aspect of the implementation of this project is each teacher's willingness to: (1) work with a mental health professional on developing and aligning PEI standards with academic standards; (2) be mentored or coached by a mental health professional on special topics about mental health; and (3) co-teach the curricula with a mental health professional. Furthermore, the development of strong teacher and mental health professional collaborative play an important role in: (1) promoting a positive school climate and establishing a sense of community for students via smaller learning communities; (2) facilitating an awareness of mental health issues and reducing stigma; and (3) creating a program of study that increases students' interest in the mental health field.

Another vital aspect of implementation is incorporating the PEI-Educate standards with an academic course that will reach the majority of students. For this reason, we chose English

Language Arts (ELA). All students enrolled in a 7th–12th-grade program of study in California are required to study ELA among other core academic courses (e.g., math, social studies, science). We decided against focusing on one-semester courses such as health or psychology, which at first glance would appear to be the obvious choice to integrate PEI-Educate standards, because they would limit the impact and capacity of the PEI curriculum.

Evaluation also is a key component to determine the effects of PEI-Educate on increasing awareness and prevention and early-intervention practices. For the evaluation piece, participants (i.e., ELA teachers, mental health professionals, and students) will complete the pre-test survey in the fall and the post-test survey in the spring. We will design three surveys in parallel to assess the utility of the PEI-Educate standards and other critical components of the project. The three surveys will contain a number of overlapping sections and items. For instance, the ELA teachers may be asked to report on their level of knowledge about mental health topics, mental health professionals may be asked to report on their perceptions of their teacher mentees' knowledge about the same topics, and students will be asked to report on their level of awareness and readiness to engage discussions about mental health issues in the classroom and practice in their communities.

LEVELS OF INSTRUCTION AND PEI STANDARDS

Basic Level: Factual and Procedural Thinking

At the basic level, students are required to acquire rudimentary knowledge about mental health and substance use disorders and their causes. At this level, students are asked to recall facts and information about mental health and substance use disorders. Students might also be asked to describe, in writing or orally, key features of a disorder or people with a mental health disorder. For example, *knowing that schizophrenia is a type of mental health disorder, or knowing that a mental health disorder can coexist with a substance use disorder*. They also may be expected to *describe a course of a mental health disorder when undetected early in life* (see Exhibit 1). These PEI standards are more appropriate for students in 7th through 9th grades. Learning module 1 shows how these standards are put into practice.

Teaching Tip

Focus on helping students to feel safe about discussing mental health. Get a sense of students' prior knowledge about mental health and their perceptions about people with a mental health disorder. Here are potential questions to engage students in a group discussion about basic aspects of mental health using a *who, what, when, where, why and how* procedure:

- Who needs to learn about mental health?
- What is mental health? Mental illness? Substance abuse? Stigma? Suicide?
- When do people develop a mental health disorder?
- Where can people learn about mental health? Where should we promote mental health?
- Why is it important for young people to learn about mental health problems?
- How can early signs of suicide be detected? How can suicide be prevented?

Exhibit 1. Basic PEI standards and performance indicators for grades 7 through 9

PEI Standard 1.0 Be familiar with how mental health and substance use disorders affect a person’s daily living activities.
<i>Performance indicators</i> 1.1 Describe mental health disorders and substance use disorders. 1.2 Discuss how trauma may influence someone’s risk of a mental health disorder. 1.3 Use technology, including the Internet, to gain knowledge about conditions that lead to mental health disorders. 1.4 Determine the meaning of words and phrases as they are used in describing mental health issues. 1.5 Brainstorm ways in which mental health disorders are related to thoughts of suicide.
PEI Standard 2.0 Demonstrate understanding of early signs that can lead to mental illness and possible suicide.
<i>Performance indicators</i> 2.1 Gather relevant information from multiple sources about trauma, and make an argument on how it puts youth at risk of developing a mental disorder. 2.2 Analyze how and why life events and risky behaviors can lead to mental health problems. 2.3 Define and clarify the meaning of stigma, using both writing and speaking formats. 2.4 Write narratives (stories) about real experiences or events that increase or reduce stigma about mental health. 2.5 List and recognize warning signs of suicide and what causes suicidal thoughts and behaviors.

Application Level: Metacognitive Thinking

Exhibit 2 shows the set of PEI standards that require students to apply and connect new knowledge with prior knowledge. Make meaningful applications of classroom instruction to real-life situations. Students must use strategic thinking and reasoning when learning and problem solving. Having strategic knowledge allows students to think through their application of key concepts to increase prevention and early intervention—for example, *using writing and verbal abilities to create culture-specific communication tools*, or *interpreting mental health disorders using images and words that move people to act*. This level is suitable for students in 9th through 11th grades. The unpacking of these standards is shown in learning module 2.

Teaching Tip

Engage students through interactive activities that involve cultural values and mental health promotion. Help students organize information about mental health and find associations with culture. To get students started, ask them to work in small groups and act as a think tank and tackle one of these tasks:

- Create a culturally responsive and supportive school environment.
- Create a mental health promotion and suicide prevention media campaign.
- Use media to create an educational public services announcement about risk and protective factors that affect mental health.
- Design a health literacy initiative on campus to increase student and parent awareness about mental health and stigma.

Exhibit 2. Applied PEI standards and performance indicators for grades 9 through 11

<p>PEI Standard 3.0 Demonstrate understanding of health literacy and how it is used in the mental health field.</p>
<p><i>Performance indicators</i></p> <ul style="list-style-type: none"> 3.1 Define and describe health literacy. 3.2 Explain how health literacy is associated with mental health outcomes. 3.3 Build strong verbal knowledge to use language in ways that communicate healthy behaviors. 3.4 Analyze the impact of health literacy on peoples’ resiliency, discovery, strength, and self-efficacy.
<p>PEI Standard 4.0 Become culturally informed and develop a <i>fotonovela</i> or media booklet for Latino communities.</p>
<p><i>Performance indicators</i></p> <ul style="list-style-type: none"> 4.1 Explain the use of a <i>fotonovela</i> or health literacy media booklet. 4.2 Create a <i>fotonovela</i> that incorporates key words about mental health and presents information that is familiar, readable, and entertaining for Latinos. 4.3 Draw upon the cultural-specific knowledge and skills found in Latino communities, and express them as resources to increase mental health awareness. 4.4 Conduct a stigma reduction campaign project that involves developing a school-wide strategy to disseminate knowledge about preventing or managing a mental health disorder and suicidal ideation.
<p>PEI Standard 5.0 Be familiar with a strength-based or asset-based approach that increases resiliency and reduces risk in Latino communities.</p>
<p><i>Performance indicators</i></p> <ul style="list-style-type: none"> 5.1 List and describe risk factors that are associated with poor developmental outcomes. 5.2 List and describe resiliency and other cultural-related features that promote the fortitude, discovery, strength, and wellness of individuals and families. 5.3 Describe how cultural-specific aspects such as family (<i>familismo</i>), relationships (<i>personalismo</i>), and respect (<i>respeto</i>) increase resiliency in Latinos. 5.4 Identify school-related factors (e.g., school connectedness, socially and academically supportive environments) that are associated with strong developmental and educational outcomes.

Experiential Learning Level: Advanced Thinking and Performing

Transferring information from classroom to real-life experiences is described as experiential learning. The most effective way to teach and assess students’ capabilities to carry out these standards is to move from recalling and recognizing, and procedural and strategic thinking, to transferring learning into real-life scenarios. At this level, students are also analyzing, evaluating, and fine-tuning their abilities to translate theory into real-life practices—for example, *job shadowing a mental health professional for several hours, or interviewing a person living with a mental health disorder. Producing a video or public service announcement about mental health in schools* (see Exhibit 3) is another approach. This level is suitable for students in grades 11 and 12. Learning module 3 shows how these standards are put into practice.

Teaching Tip

Strengthen community engagement through experiential learning. These activities constitute an integral and meaningful component of the PEI-Educate curriculum in which students become active learners. The goal is to immerse students in real-life application of knowledge and strategies learned in the classroom. Strengthen students' experiential learning with these activities:

- Offer recovery-oriented organizations the opportunity to conduct field trips in which students can interact with professionals and people in recovery.
- Organize small groups of students to complete the following school projects:
 - Design student-defined components of a PEI program on the school campus.
 - Organize a mental health promotion day involving mental health organizations.
 - Become student leaders and advocates of mental health promotion and strengthen the message in middle schools.

Exhibit 3. Experiential PEI standards and performance indicators for grades 11 and 12

PEI Standard 6.0	Relate classroom instruction with real-life experiences at a mental health facility.
<i>Performance indicators</i>	
6.1	Engage in a one-day workplace learning activity under the guidance of a mental health professional, and connect classroom knowledge with on-the-job knowledge.
6.2	Listen and experience a day in the life of a mental health worker and a person living with a mental health disorder.
6.3	Document strategies used by the professionals and the facility to detect early signs or prevent or living with and managing a mental health disorder.
PEI Standard 7.0	Design a school prevention and early intervention program that emphasizes community engagement.
<i>Performance indicators</i>	
7.1	List and describe elements of community engagement and translate them into school principles to ensure early detection of mental health disorders and access to treatment.
7.2	Develop a plan for students and teachers to collaborate on organizing and implementing a school forum about mental health and substance use problems.
7.3	Integrate multimedia into preparing a presentation to emphasize the relationship between community engagement, schools, and the mental health profession.
7.4	Practice and demonstrate mental health advocacy skills.
PEI Standard 8.0	Develop a leadership narrative in mental health that communicates a purpose to lead, a sense of community, and urgency to act.
<i>Performance indicators</i>	
8.1	Identify an experience that led to the discovery of your leadership potential.
8.2	Develop a leadership narrative that incorporates values.
8.3	Practice telling your leadership narrative (story).
8.4	Apply your leadership approach, and take action to engage and empower a community.

The PEI-Educate Standards Framework and Learning Modules

CURRICULUM ALIGNMENT WITH PEI-EDUCATE STANDARDS

The curriculum based on the PEI-Educate standards framework will emphasize the most important ideas, concepts, and strategies to: (1) build educators' capacity to teach youth about mental health issues, (2) apply concepts that raise awareness and lead to early identification of mental health issues in youth, and (3) support educators in integrating prevention and early intervention strategies in the classroom.

To ensure that all students benefit from this curriculum, the PEI-Educate Standards Framework will be aligned with English Language Arts (ELA) Common Core State Standards (ELA-CCSS). Specifically, the PEI-Educate curriculum will infuse mental health and prevention and early intervention material into the selected ELA core standards. This integration process must be performed with collaboration between the ELA teacher(s) and a mental health professional to ensure that the appropriate content is being aligned and curriculum activities developed.

Reading standards for literature in grades 6–12 focus on ensuring that students: (1) gain adequate exposure to a range of texts and tasks; and (2) students read increasingly complex texts (California Department of Education, 2013). Sample standards include *“Determine a theme or central idea of a text and analyze its development over the course of the text, including its relationship to the characters, setting, and plot; provide an objective summary of the text”* and *“Determine the meaning of words and phrases as they are used in a text, including figurative and connotative meanings; analyze the impact of specific word choices on meaning and tone, including analogies or allusions to other texts.”*

Writing standards for literature in grades 6–12 focus on instruction to help ensure that students: (1) gain adequate mastery of a range of skills and applications; (2) demonstrate increasing sophistication in all aspects of language use, from vocabulary and syntax to the development and organization of ideas; and (3) make use of increasingly demanding content and sources (California Department of Education, 2013). Sample standards include *“Write informative/explanatory texts to examine a topic and convey ideas, concepts, and information through the selection, organization, and analysis of relevant content”* and *“Write narratives to develop real or imagined experiences or events using effective techniques, relevant descriptive details, and well-structured event sequences.”*

Listening and speaking standards for literature in grades 6–12 focus on instruction to help ensure that students gain adequate mastery of a range of skills and applications (California Department of Education, 2013). Sample standards include *“Engage effectively in a range of collaborative discussions (one-on-one, in groups, and teacher-led) with diverse partners on grade 8 topics, texts, and issues, building on others' ideas and expressing their own clearly”* and *“Analyze the purpose of information presented in diverse media and formats (e.g., visually, quantitatively, orally) and evaluate the motives (e.g., social, commercial, political) behind its presentation.”*

THE FRAMEWORK AND LEARNING MODULES

The learning modules are divided into five parts: (1) instructional units with subunits; (2) formative assessment or activities; (3) summative assessment or culminating activities; (4) curriculum standards; and (5) depth of knowledge. They are described in more detail below.

Instructional unit with subunits: This section of the module contains a specific curriculum topic or theme that defines the structure or plan that will guide the teacher in providing students with learning experiences. In other words, an instructional unit refers to a lesson plan framework that outlines a sequence of instruction, knowledge, skills, and classroom practices, or application.

Formative assessment or activities: This part of the module has to do with ongoing assessment directly linked to classroom activities. Assessment may be conducted in various ways, including quizzes, informal discussions, and journal writing.

Summative assessment or culminating activities: This portion of the module guides assessment of students' performance while they are engaged in cumulative projects. Assessment occurs at the completion of an instructional unit.

Curriculum standards (PEI and academic standards): This part of the module focuses on specific PEI standards and academic standards, and their alignment—in other words, the degree to which PEI and academic standards correspond with each other. The more closely aligned standards are to each other, the better the organization and quality of instruction and learning. The degree of alignment is determined by comparing learning objectives with assessment, learning objectives with instruction and application, and instruction and application with assessment (Anderson & Krathwohl, 2001).

Depth of knowledge (DOK): This section of the module concentrates on four main levels of knowledge. Webb (2002) summarized these key four levels of knowledge. *Level 1 Recall* requires students to recall basic facts, information, or procedures. This recall can include basic knowledge of terminology about mental health and substance abuse and knowledge of specific data and causes of mental and substance use disorders. *Level 2 Skill and concept* involves knowledge about the use and organization of information that necessitates two or more steps—that is, knowledge of how to do something. *Level 3 Strategic thinking* involves command of thought processes or reasoning. This level requires complex thinking involving cognitive tasks and developing a plan with a sequence of steps to reach multiple answers—in other words, thinking beyond the obvious. *Level 4 Extended thinking* or advanced thinking requires critical thinking skills linked to investigation, and thinking through a problem-solving process encompassing multiple conditions. Advanced thinking embodies application of concepts in real-life situations and monitoring one's thinking to acquire new knowledge and build on prior knowledge.

Module 1: Basic PEI Standards Aligned with English Language Arts (ELA)

Instructional unit with subunits	Formative assessment (activities)	Summative assessment (culminating activities)	Curriculum standards Depth of knowledge (DOK)			
			PEIS	DOK Level	ELAS	DOK Level
Instructional unit: Define mental and substance use disorders and their effects on people’s daily living activities.	Activities leading to a required set of skills and knowledge	Activities that assess students’ performance at the completion of an instructional unit	PEI (Grades 7–9)		ELA (Grades 7–9)	
Subunit 1: Describe mental health disorders and substance use disorders.	Define and describe mental health disorders and substance use disorders. Lead a short discussion on the impact that a mental and substance use disorder has on an individual and families.	Use voice appropriate to the definition of mental health and substance use conditions. Write persuasion essay arguing for a position and providing evidence.	PEI 1.1	1	CCSS Writing 1.a-c; 2.a-f; 3.a-e; 4.a-6	1
Subunit 2: Identify and translate the role that trauma has on someone at risk of a mental health disorder. Describe stigma as a cause and effect of mental health disorders.	Engage students in a short discussion about trauma and its effects. Ask students to identify behaviors in their neighborhood that can be traumatizing. Connect traumatizing events with and potential for mental health disorders.	Answer comprehension questions and work in discussion groups. Translate observations and text (e.g., Internet literature) into real experiences. Research topic (trauma and mental health) and write a short essay using words in context.	PEI 1.2, 1.3, 2.1, 2.2	2	Reading 1 – 10 Speaking & Listening 1.a – d; 4.a Language L.3.3a, L.4.1f, L.4.3a, L.6.1e, L.6.3b, L.7.3a, L.8.1d	2
Subunit 3: Determine the meaning of words and phrases as they are used in describing mental health issues. Describe the different types of stigmas. Relate these issues with thoughts of suicide.	Engage students in small-group discussions about stigma and its impact on treatment for mental health and substance use disorders, and suicide. Discuss case studies and practice detecting types of stigma. Recognize key words and phrases that increase stigma.	Interpret and paraphrase different types of stigmas (e.g., self-stigma, public or social-stigma, cultural stigma). Also, explore causes of suicide. Develop rationales for linking a type of stigma with a case study. Write essay-style paragraphs to explain reactions to stigma.	PEI 1.4, 1.5, 2.3, 2.4, 2.5	2		3

NOTE: CCSS = Common Core State Standards; ELAS = English Language Arts Standards; PEIS = Prevention and Early Intervention Standards

Teaching the PEI Standards for the Basic Level

<p>PEI standard and performance indicators</p>	<p>PEI 1.0: Be familiar with how mental health and substance use disorders affect a person’s daily living activities.</p> <ol style="list-style-type: none"> 1.1 Describe mental health disorders and substance use disorders. 1.2 Discuss how trauma may influence someone’s risk of a mental health disorder. 1.3 Use technology, including the Internet, to gain knowledge about conditions that lead to mental health disorders. 1.4 Determine the meaning of words and phrases as they are used in describing mental health issues. 1.5 Brainstorm ways in which mental health disorders are related to thoughts of suicide. <p>PEI 2.0: Demonstrate understanding of early signs that can lead to mental illness and possible suicide.</p> <ol style="list-style-type: none"> 2.1 Gather relevant information from multiple sources about trauma, and make an argument on how it puts youth at risk of developing a mental health disorder. 2.2 Analyze how and why life events and risky behaviors can lead to mental health problems. 2.3 Define and clarify the meaning of stigma, using both writing and speaking formats. 2.4 Write narratives (stories) about real experiences or events that increase or reduce stigma about mental health. 2.5 List and recognize warning signs of suicide and what causes suicidal thoughts and behaviors. 	
<p>Content knowledge level</p>	<p><input checked="" type="checkbox"/> Basic <input type="checkbox"/> Applied <input type="checkbox"/> Experiential</p>	
<p>Duration</p>	<p>The duration for this content to be taught by teachers and performed by students will be approximately three days.</p>	
<p>What do students need to know?</p>	<p><i>Define and recall</i></p> <ol style="list-style-type: none"> 1. Define mental health and substance use disorders 2. Define trauma and its features 3. Describe people’s experiences with trauma and stigma 	<p><i>Benchmarks</i></p> <ol style="list-style-type: none"> 1. Name five of the most common and severe mental health and substance use disorders. 2. Mention three different types of trauma and their effects. 3. Identify and report on the experiences of two people.
<p>What should students be able to do?</p>	<p><i>Skills and concepts</i></p> <ol style="list-style-type: none"> 1. How to acquire information and know where to go to learn about mental health and substance use disorders 2. How to ask questions about one’s life experiences 3. How to identify traumatic and stigma experiences 	<p><i>Benchmarks</i></p> <ol style="list-style-type: none"> 1. Use the Internet to find three sources that define mental health and substance use disorders. 2. Create a list of five questions to interview two people. 3. Find two volunteers who experienced trauma and stigma, and carry out the interviews.
<p>What must be taught?</p>	<ol style="list-style-type: none"> 1. Develop basic knowledge about mental health and substance use disorders. 2. Create basic inquiry questions to be used as a communication tool. 3. Connect mental health disorders with real-life experiences. 	

Module 2: Applied PEI Standards Aligned with English Language Arts (ELA)

Instructional unit with subunits	Formative assessment (activities)	Summative assessment (culminating activities)	Curriculum standards Depth of knowledge (DOK)			
			PEIS	DOK Level	ELAS	DOK Level
Instructional unit: Demonstrate the use of cultural-specific resources to promote health literacy.	Activities leading to a required set of skills and knowledge	Activities that assess students' performance at the completion of an instructional unit	PEI (Grades 9–11)		ELA (Grades 9–11)	
Subunit 1: Define and describe health literacy with details and examples.	Define and describe health literacy. Discuss health literacy with details and examples.	In a written format, define health literacy. Work in groups to illustrate health literacy's benefits.	PEI 3.1, 3.2, 3.3, 3.4	3	CCSS Writing 1.a-c; 2.a-f; 3.a-e; 4.a-6	2
Subunit 2: Support health literacy using a culture-specific media booklet (<i>fotonovela</i>). Apply this concept in reducing stigma.	Introduce the concept of a health literacy media booklet. Students identify and describe cultural values that are important to their community. Students examine the relationship between cultural values, the media booklet, and mental health.	Verbalize the purpose and significance of a media booklet. Describe the role that cultural values play in helping people manage/recover from a mental illness. Create a 5-page media booklet (<i>fotonovela</i>) with cultural values, narrative, and photos about mental health.	PEI 4.1, 4.2, 4.3	3	Reading 1 – 10 Speaking & Listening 1.a – d; 4.a Language L.3.3a, L.4.1f, L.4.3a, L.6.1e, L.6.3b, L.7.3a, L.8.1d	3
Subunit 3: Explain events linked to risk factors, and identify protective factors (i.e., resiliency) that can be used as mental health promotion strategies.	Discuss risk factors and their impact on mental health and substance use disorders. Discuss protective factors and their impact on mental health and substance use disorders, and suicide. Ask students to identify and bring to class risk and protective factors they witness in their communities. Link to trauma and suicide.	Describe the effects of risk factors on mental health and substance disorders. Describe the constructive influences of protective factors and cultural aspects on mental health outcomes. Use media to create an educational public announcement about risk and protective factors that affect mental health/wellness.	PEI 4.4, 5.1, 5.2, 5.3	3		3

NOTE: CCSS = Common Core State Standards; ELAS = English Language Arts Standards; PEIS = Prevention and Early Intervention Standards

Teaching the PEI Standards for the Applied Level

<p>PEI standard and performance indicators</p>	<p>PEI 3.0: Demonstrate understanding of health literacy and how it is used in the mental health field.</p> <p>3.1 Define and describe health literacy. 3.2 Explain how health literacy is associated with mental health outcomes. 3.3 Build strong verbal knowledge to use language in ways that communicate healthy behaviors. 3.4 Analyze the impact of health literacy on peoples' resiliency, discovery, strength, and self-efficacy.</p> <p>PEI 4.0: Become culturally informed and develop a <i>fotonovela</i> or media booklet for Latino communities.</p> <p>4.1 Explain the use of a <i>fotonovela</i> or health literacy media booklet. 4.2 Create a <i>fotonovela</i> that incorporates key words about mental health and presents information that is familiar, readable, and entertaining for Latinos. 4.3 Draw upon the cultural-specific knowledge and skills found in Latino communities, and express them as resources to increase mental health awareness. 4.4 Conduct a stigma reduction campaign project that involves developing a school-wide strategy to disseminate knowledge about preventing or managing a mental health disorder and suicidal ideation.</p> <p>PEI 5.0: Be familiar with a strength-based or asset-based approach that increases resiliency and reduces risk in Latino communities.</p> <p>5.1 List and describe risk factors that are associated with poor developmental outcomes. 5.2 List and describe resiliency and other cultural-related features that promote the fortitude, discovery, strength, and wellness of individuals and families. 5.3 Describe how cultural-specific aspects such as, family (<i>familismo</i>), relationships (<i>personalismo</i>), and respect (<i>respeto</i>) increase resiliency in Latinos. 5.4 Identify school-related factors (e.g., school connectedness, socially and academically supportive environments) that are associated with strong developmental and educational outcomes.</p>	
<p>Content knowledge level</p>	<p><input type="checkbox"/> Basic <input checked="" type="checkbox"/> Applied <input type="checkbox"/> Experiential</p>	
<p>Duration</p>	<p>The duration for this content to be taught by teachers and performed by students will be approximately one week.</p>	
<p>What do students need to know?</p>	<p><i>Strategic thinking</i></p> <ol style="list-style-type: none"> Define and apply health literacy Use cultural-specific concepts to address inequalities Apply concepts to increase resiliency, discovery, and wellness 	<p><i>Benchmarks</i></p> <ol style="list-style-type: none"> Explain the use of health literacy. Use cultural-specific knowledge and skills to raise mental health awareness. Support cultural-specific aspects with details and examples.
<p>What should students be able to do?</p>	<p><i>Skills and concepts</i></p> <ol style="list-style-type: none"> How to design a health literacy tool How to link a health literacy tool to the needs of a specific group How to identify risk and protective factors that affect mental health 	<p><i>Benchmarks</i></p> <ol style="list-style-type: none"> Use the Internet to find examples of health literacy resources. Create a media booklet (<i>fotonovela</i>). Create mental health promotion media campaign.
<p>What must be taught?</p>	<ol style="list-style-type: none"> Using health literacy resources to increase mental health and substance use awareness, and suicide prevention on a school campus. Using health literacy materials to reduce stigma on mental health treatment. Employing school resources to create a supportive and safe environment to talk about mental health without stigma. 	

Module 3: Experiential PEI Standards Aligned with English Language Arts (ELA)

Instructional unit with subunits	Formative assessment (activities)	Summative assessment (culminating activities)	Curriculum standards Depth of knowledge (DOK)			
			PEIS	DOK Level	ELAS	DOK Level
Instructional unit: Plan and carry out real-life activities linked to community engagement.	Activities leading to a required set of skills and knowledge including teaching students the concept of confidentiality and its role	Activities that assess students' performance at the completion of an instructional unit	PEI (Grades 11–12)		ELA (Grades 11–12)	
Subunit 1: Interpret and relate classroom knowledge through experience in a real-life situation.	Discuss the key characteristics and skills needed to be an effective mental health professional. Organize a field trip to a mental health facility to enable students to gain real-life experiences.	Analyze and synthesize key characteristics of a mental health professional. Apply concepts learned in class in a mental health organization under the guidance of a professional.	PEI 6.1, 6.2, 6.3	4	CCSS Writing 1.a-c; 2.a-f; 3.a-e; 4.a-6 Reading 1 – 10	2
Subunit 2: Organize a mental health promotion day involving the mental health community.	Introduce community engagement and its value to mental health. Discuss topics and strategies to promote mental health on the school campus. Network with community leaders and organizations.	Explain “community engagement” with details and examples. Design and perform specific tasks in implementing a mental health day for students. Design strategies to engage community leaders and organizations.	PEI 7.1, 7.2, 7.3	4	Speaking & Listening 1.a – d; 4.a Language L.3.3a, L.4.1f, L.4.3a, L.6.1e, L.6.3b, L.7.3a, L.8.1d	3
Subunit 3: Develop a mental health leadership narrative and action.	Identify a leadership style and connect it to mental health. Develop a leadership narrative through storytelling. Practice telling leadership stories connecting to life challenges.	Practice solving real-life problems using leadership style. Write a leadership story and practice with a partner for feedback. Fine-tune a leadership story incorporating feedback, and deliver a leadership narrative.	PEI 8.1, 8.2, 8.3	4		4

NOTE: CCSS = Common Core State Standards; ELAS = English Language Arts Standards; PEIS = Prevention and Early Intervention Standards

Teaching the PEI Standards for the Experiential Level

PEI standard and performance indicators	<p>PEI 6.0: Relate classroom instruction with real-life experiences at a mental health facility.</p> <p>6.1 Engage in a one-day workplace learning activity under the guidance of a mental health professional, and connect classroom knowledge with on-the-job knowledge.</p> <p>6.2 Listen and experience a day in the life of a mental health worker and a person living with a mental health disorder.</p> <p>6.3 Document strategies used by the professionals and the facility to detect early signs or prevent or living with and managing a mental health disorder.</p> <p>PEI 7.0: Design a school prevention and early intervention program that emphasizes community engagement.</p> <p>7.1 List and describe elements of community engagement and translate them into school principles to ensure early detection of mental health disorders and access to treatment.</p> <p>7.2 Develop a plan for students and teachers to collaborate on organizing and implementing a school forum about mental health and substance use problems.</p> <p>7.3 Integrate multimedia into preparing a presentation to emphasize the relationship between community engagement, schools and the mental health profession.</p> <p>7.4 Practice and demonstrate mental health advocacy skills.</p> <p>PEI 8.0 Develop a school prevention and early intervention program that emphasizes community engagement.</p> <p>8.1 Identify an experience that led to the discovery of your leadership potential.</p> <p>8.2 Develop a leadership narrative that incorporates values.</p> <p>8.3 Practice telling your leadership narrative (story).</p> <p>8.4 Apply your leadership approach, and take action to engage and empower a community.</p>	
Content knowledge level	<input type="checkbox"/> Basic <input type="checkbox"/> Applied <input checked="" type="checkbox"/> Experiential	
Duration	The duration for this content to be taught by teachers and performed by students will be approximately one week.	
What do students need to know?	<p><i>Advanced thinking</i></p> <ol style="list-style-type: none"> Understand the role of a mental health professional Know about community engagement Demonstrate leadership potential 	<p><i>Benchmarks</i></p> <ol style="list-style-type: none"> Complete five hours of job shadowing. Apply at least three aspects of community engagement. Develop a brief leadership narrative.
What should students be able to do?	<p><i>Skills and concepts</i></p> <ol style="list-style-type: none"> How to transfer classroom knowledge into a workplace setting How to apply elements of community engagement How to implement leadership style and through storytelling influence others 	<p><i>Benchmarks</i></p> <ol style="list-style-type: none"> Connect and advance experiential knowledge into their community. Change school culture and attitudes about mental health using a community engagement approach. Realize the value of lived experiences in leadership and raising awareness about mental health.
What must be taught?	<ol style="list-style-type: none"> Transforming classroom knowledge into experiential learning in a real-life setting. Acquiring understanding of and applying community engagement principles. Discovering and applying leadership skills to increase mental health awareness. 	

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Appendix 1: Selected Student and Educator Comments on the Utility of PEI-Educate Standards on a School Campus

What comes to mind when you think or hear about mental illness?	<p>“A disease of the brain ... people with traumas.”</p> <p>“When I think of mental illness, I always think of my family members because some of my family do have mental illness like autism and schizophrenia, so it does hit home when someone mentions mental illness.”</p>
How much do you know about mental illness?	<p>“I really don’t think I know much about mental illness.... In general, I know a bit like the autism spectrum, schizophrenia, and depression, but I wouldn’t say I’m an expert.”</p> <p>“I can’t say I know much.... I know of them, but not what is wrong with them or what happens to them.”</p>
Is it important to include people with a mental illness in our social interactions?	<p>“Yes, they feel left out because they have a mental [illness].... They shouldn’t be discriminated [against] just because of that.”</p> <p>“Yes, I think they are human beings that are afflicted with a disease ... but they are still people, unlike what others think of people with mental illness being nonhuman, psychotic, angry, or that they are just stupid.... They only hear the part of someone with mental illness breaking down and not the positive stuff.”</p> <p>“Treat them as normal.... Increase communication and get more connected with them so they can be seen as normal.”</p>
Should the subject of mental health be in our school curriculum?	<p>“Yes, absolutely.... I think that should be a topic of conversation at some point for everyone, and the classroom is the perfect place to talk about it because they [classrooms] are safe, they are academic, they are open for discussion [settings] ... they are the perfect place to have those conversations.”</p> <p>“We need to be educated about mental illness, be more transparent and not be afraid to talk about mental illness.... It’s been hidden for too long, and we need to bring it out in the open, just like cancer and diabetes.”</p>
How can we reduce mental health stigma in schools?	<p>“I would try to make friends with someone who lives with a mental illness, because all their lives they have been left out.... Yes, do something about it!”</p> <p>“I think some people should be more aware of it [mental illness], some people may not know much about it and they can hurt those who suffer from a mental illness with words that are insensitive.”</p> <p>“I’d have a discussion with my teachers about organizing a club or group to help get rid of the stigma [in our school].”</p> <p>“We can promote them ... promote the fact that they are not much different than us.... We shouldn’t discriminate [against] them, because they are people, too.”</p>
Do we [school culture] need to be more open about mental health?	<p>“Absolutely.... There is so much stigma attached to mental health.... There is a lack of awareness.... We can teach students [about] what mental conditions are and that they are treatable.”</p> <p>“I think that the more we can talk about what mental illness is, the more we can understand and treat people with mental illness. If we just ignore it and think ‘oh, this only affects them, we can’t talk about it too much’ ... then it’s not going to help, it’s just going to keep the stigma alive ... that people with a mental illness are under the whole category of being a psychopath.... More education [is needed].”</p>

**Career Technical Education (CTE) Standards and Performance Indicators
for Mental and Behavioral Health Curricula
The California Department of Education, CTE Model Curriculum Standards
Prepared by Gustavo Loera, EdD**

The Mental and Behavioral Health Pathway prepares high school students for work in entry-level positions in the mental health industry through classroom instruction and real-world experiences where they apply skills and knowledge learned in the classroom. Because the goal is to guide high school students toward an industry-designed degree or certificate, the Mental and Behavioral Health Pathway will also prepare students for college and, eventually, a career in mental health. The Mental and Behavioral Health Pathway curricula include introductory content on mental health topics with an emphasis on mental health recovery and integrated across academic disciplines such as English, social studies and science.

1. Recognize and interpret principles of community engagement.

- a. Define the psychoeducation approach and describe how it is used as a tool to help consumers and their families learn more about managing their mental illness.
- b. Use and apply community-based participatory research methods to increase community participation and resources.
- c. Develop and explore basic outreach approaches that can be successful in increasing awareness about mental health services.
- d. Research and organize community resources that promote community wellness.
- e. Advocate for community inclusion and social roles such as, supported housing, employment, education, parenting, citizenship, and anti-stigma.

2. Demonstrate the ability to build relationships through empathic communication.

- a. Define and describe active listening using a step-by step process.
- b. Demonstrate active listening by connecting new knowledge or experiences with prior knowledge and problem solving.
- c. Differentiate between giving advice and active listening by constructing real-life examples.
- d. Build strong verbal knowledge to frame language in ways that increases engagement.
- e. Build on communication by using motivational interviewing as an engagement tool.

3. Develop and employ collaboration skills that engage others and build trust.

- a. Define collaboration in a mental health context and build on prior knowledge by recalling collaborative experiences.
- b. Employ aspects of collaborative leadership that enhance decision-making and consensus building.
- c. Explore and practice collaborative methods to work with special populations to increase their community capacity.
- d. Design innovative strategies to monitor and evaluate engagement.

4. Recognize and differentiate between the stages of mental health recovery.

- a. Define the four stages of mental health recovery (hope, empowerment, self-responsibility, and meaningful roles in life) and demonstrate their impact on complex mental health problems.
- b. Demonstrate the ability to formulate goals related to each of the four stages of recovery using a multiple-step process of goal setting.
- c. Compare and contrast psychosocial rehabilitation and recovery model from the medical model of mental illness.
- d. Integrate and apply four stages of recovery by designing a recovery plan based on goals that require real-world scenarios.
- e. Assess the implementation of the recovery plan and formulate alternative approaches to reach desired outcomes.
- f. Advocate for hope and respect, and believe that all individuals have the capacity for learning and growth.
- g. Examine ways in which one's recovery from mental illness can be measured.

5. Communicate and practice leadership and accountability behaviors.

- a. Identify strategies to work under pressure and cope with stress.
- b. Develop a basic understanding of various leadership styles that promote positive change in mental health services.
- c. Compare and contrast different leadership styles and accountability in mental health.
- d. Construct multiple steps to solve complex problems using real-world scenarios in mental health services.

6. Analyze and interpret elements of positive psychology (e.g., hope, resilience, strengths, creativity, community building, and supportive spirituality).

- a. Recall the recovery model and communicate how positive psychology impacts a mental health consumer's recovery.
- b. Interpret key terms from the positive psychology perspective in relationship to holistic wellness.
- c. Assess the impact of positive psychology's elements on risk reduction and integrated primary care.
- d. Build on the discovered strengths and capabilities of individuals.

7. Formulate and implement quality care and treatment plans.

- a. Define and describe practices that help individuals improve the quality of all aspects of their lives; including social, occupational, educational, spiritual and financial.
- b. Identify an effective collaborative approach in mental health recovery that is inclusive of the individual in need.
- c. Practice promoting health and wellness, encouraging individuals to develop and use individualized wellness plans.
- d. Design a treatment plan that addresses the unique needs of individuals, consistent with their values, hopes and aspirations.

- e. Adhere to consistent documentation of implemented interventions and progress.

8. Synthesize, understand, and predict the impact of mental health disparities across consumer populations.

- a. Define mental health disparities.
- b. Organize and summarize knowledge on the impact of mental health disparities among different populations.
- c. Diagnose and analyze causes for mental health disparities using current research methods and literature.
- d. Synthesize research articles related to mental health disparities and produce a statement problem on what causes such disparities.

9. Design a practice model of a personal support network by utilizing prior knowledge of recovery concepts and using natural supports within communities.

- a. Identify community-based self-help/peer support groups.
- b. Communicate with self-help/peer support groups in the community and generate information about their specific functions and responsibilities to the community they serve.
- c. Compare and contrast self-help/peer support groups to determine strengths and gaps in service delivery.
- d. Design a practice self-help/peer support group model that fills in the identified gaps and builds on the identified strengths.
- e. Examine the role that natural supports such as religious organizations, community centers, and other community-related resources play in an individual's mental health recovery.

10. Formulate an argument and predict how electronic health records can transform quality of care and promote a green economy.

- a. Access and become familiar with basic electronic health records functions.
- b. List and describe at least five reasons electronic health records will transform quality of care.
- c. List and describe at least five ways that electronic health records will advance a green economy.
- d. Distinguish between interoperability at the local primary care level and interoperability with statewide mental health systems in using electronic health records.

11. Recognize and respect the various cultures of a community and other factors that indicate its diversity in all aspects of communication, designing and implementing patient care.

- a. Identify and understand the patterns of communication including the use of languages.
- b. Communicate and listen effectively across cultures and all levels of care.
- c. Demonstrate appropriate judgment on when and how to use trained interpreters.

- d. Research factors that define cultural differences between and among different ethnic, racial and special populations.
- e. Illustrate how to incorporate culturally appropriate community resources.
- f. Design and utilize an ethnographic approach focusing on information retrieval, observing social behavior, and managing stress and time; ask questions, explore aspects of global significance, analyze data using relevant concepts.

12. Evaluate the purpose and components of a treatment plan related to the consumer's health status.

- a. Understand the roles of a patient advocate to ensure treatment quality and resources.
- b. Explain the components of a treatment plan.
- c. Adhere to the roles and responsibilities, within their scope of practice, that contribute to the design and implementation of a treatment plan.
- d. Prioritize and organize work in accordance with the patients' treatment plans.
- e. Determine the resources available for the effective implementation of treatment plans for patients.
- f. Select appropriate equipment and instruments in accord with the treatment plan.

13. Identify and apply leadership styles in personal growth and development.

- a. Develop goal setting that leads to professional and career growth.
- b. Build and employ self-confidence to empower self and others.
- c. Refine and upgrade technical and clinical skills.
- d. Participate in student leadership and skill development activities such as Cal-HOSA.
- e. Employ self-regulation strategies that include self-monitoring and self-evaluation in approaching new and challenging tasks.
- f. Create and design a working portfolio that will be used on interviews.



STATE OF CALIFORNIA
EDMUND G. BROWN JR., Governor



WELLNESS · RECOVERY · RESILIENCE

JOHN BOYD, PsyD
Chair

February 12, 2018

KHATERA ASLAMI-TAMPLEN
Vice-Chair

Heather Little, M.Ed.
Health Policy and Program Manager
First 5 Association
1115 Atlantic Ave
Alameda, CA 94501

MAYRA ALVAREZ
Commissioner

RENEETA ANTHONY
Commissioner

Dear Ms. Little:

LYNNE ASHBECK
Commissioner

Thank you for agreeing to participate in the Commission's public meeting on Thursday, March 22, 2018, at the MHSOAC (1325 J Street, Steinberg Room, 17th Floor, Sacramento). During this meeting, we will hold a series of panel presentations to understand trauma and mental health needs in the birth to 3, 3 to 5 (preschool, pre-K), and 5 to 8 (early elementary school) age cohorts, and examine how the mental health and education systems can work more effectively together in recognizing early warning signs and intervening, particularly in school settings. Your participation will assist the Commission in developing an action agenda to promote wellness and resiliency in children, improve collaborative efforts to identify trauma and mental health needs early, and improve outcomes including academic success for children with mental health needs.

JIM BEALL
Senator
Commissioner

BILL BROWN
Sheriff
Commissioner

KEYONDRIA D. BUNCH, Ph.D.
Commissioner

ITAI DANOVITCH, M.D.
Commissioner

Your panel entitled *Enhancing Opportunities for Prevention and Early Intervention* will share examples of successful school- and/or community-based programs and partnerships for the early recognition and treatment of trauma and mental health needs in children as they relate to efforts to ensure equity and reduce disparities. This panel is scheduled to begin at approximately 10:45 a.m.

DAVID GORDON
Commissioner

GLADYS MITCHELL
Commissioner

Written testimony coupled with brief summary remarks and an opportunity to engage the Commissioners in an exchange, we believe is an approach that maximizes the impact your presentation will have on the Commissioners and the public. We ask that you provide an electronic copy of any written testimony or other background materials by Monday, March 12, 2018 so that it may be included in the meeting materials. You may direct that copy to Ms. Kai LeMasson at Kai.LeMasson@mhsoc.ca.gov. Your written responses will allow those Commissioners attending the meeting the opportunity to prepare questions for you after your presentation, and will be made available to those Commissioners unable to attend the meeting.

MARA MADRIGAL-WEISS
Commissioner

TINA WOOTON
Commissioner

TOBY EWING
Executive Director

Please address the following questions to organize your testimony:

- Please describe your programs and/or intervention strategies for identifying children's trauma and mental health risk early?
- How have you leveraged resources and partnerships in your community to support these programs?
- What lessons have you learned from your efforts?
- How can these programs be implemented on a larger scale?

We ask that you plan on presenting summary comments in a brief presentation (8 to 10 minutes) to leave ample time for conversation with Commissioners.

We also ask that you send Ms. LeMasson a brief biography by Monday, March 12, 2018. Please note that your written responses to the items above and your biography will be shared as public documents.

Should you have any questions, I can be reached at toby.ewing@mhsaac.ca.gov or 916.445-8729.

Thank you again for your willingness to participate in this important meeting.

Respectfully,

A handwritten signature in blue ink that reads "Toby Ewing". The signature is written in a cursive style with a large initial 'T' and 'E'.

Toby Ewing, Ph.D.
Executive Director



February 28, 2018

Kai LeMasson
Senior Researcher
Mental Health Services Oversight & Accountability Commission
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first5association.org

Dear Ms. LeMasson,

Please accept these responses to the questions for the upcoming MHSA Commission meeting. I have taken the liberty of exchanging the word “program” with the word “system” to better capture the heart of Help Me Grow. I welcome your feedback and any further requests you may have to help in your preparation for this day.

1. Please describe your system and/or intervention strategies for identifying children’s trauma and mental health risk early.

Based on a national model, First 5’s Help Me Grow (HMG) California is a prevention and early intervention system to detect behavioral and cognitive delays, and link families to supports and services to address identified needs. Early detection and intervention for any developmental delay, including social-emotional, are critical to ensure optimal outcomes for children— yet too often these are overlooked. HMG ensures everyone in a community—including primary care providers, educators, early care providers, community organizations, and families— has centralized access to developmental milestone information, resource and referral support, surveillance and screening promotion, care coordination, and system navigation. In short, Help Me Grow California unites a community around, and for, its children.

2. How have you leveraged resources and partnerships in your community to support this system?

HMG successfully leverages a community’s *existing* resources through effective outreach, communication, coordination, and data analysis to better identify delays and connect families to appropriate intervention. Rather than supplanting the work of early childhood agencies, organizations, or providers, HMG works to increase awareness of and demand for local supports and services to better serve and strengthen families. Comprehensive outreach connects the dots across healthcare, education, child care, community-based organizations, and families, to better coordinate care and increase the likelihood of a child achieving their greatest potential.



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first5association.org

A local example of how this works can be seen in First 5 Sacramento's choice of the Sacramento County Office of Education (SCOE) to be its lead Help Me Grow organization. This choice sends a message that the county recognizes the importance of EII before children enter the school system. SCOE is able to leverage its vast community *and* school district connections to bring Help Me Grow to scale in Sacramento.

3. What lessons have you learned from your efforts?

First 5, like other organizations, recognizes that California's early childhood landscape is complex, complicated to navigate, and filled with leaders who want to positively affect prevention and early intervention. Too often these leaders and organizations, particularly those that provide specific interventions, are siloed from one another, however. We have learned that designating a lead organization to bridge state systems and maintain a connection to the local landscape is essential. Counties and regions must be afforded the flexibility to be innovative and responsive to the unique needs and strengths of their community as they develop their system. Also, it is important to engage in conversations *across* local and statewide sectors, in order to establish an overarching network that is universally supportive of the system's growth.

4. How can this system be implemented on a larger scale?

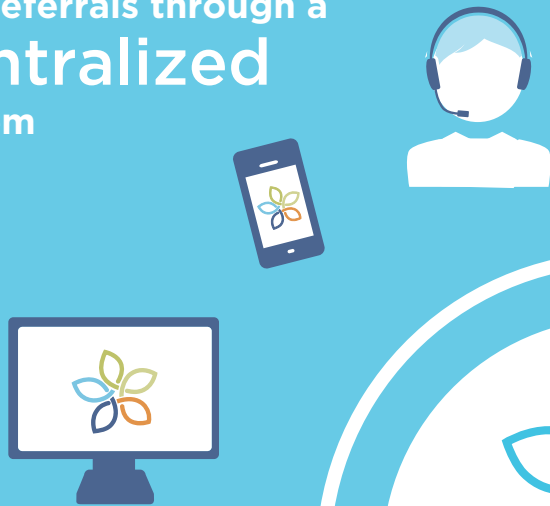
First 5's HMG is slowly expanding its reach across California, but we need statewide support, resources, and partners like MHSA to bring the system to scale.

Thank you for offering me the opportunity to share about First 5's Help Me Grow. I look forward to an engaging meeting on March 22.

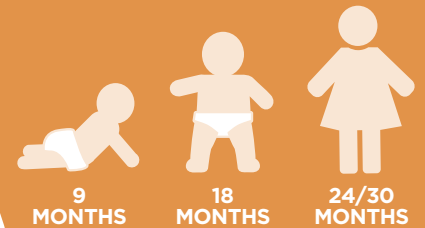
Heather Little
Health Policy and Program Manager
First 5 Association

Help Me Grow Supports Success for **All Children** by:

Helping families and professionals **navigate** resources and referrals through a **centralized** system

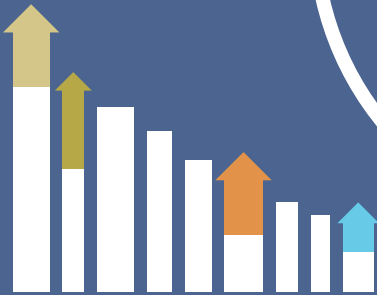


Ensuring ALL children with developmental delays are **identified** and **linked** to appropriate resources



HELP ME GROW
UNITES A COMMUNITY
AROUND ITS
CHILDREN

Collecting and **evaluating data** to improve systems that support young children and their families



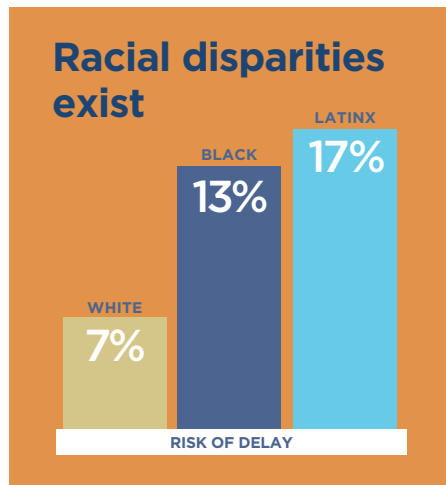
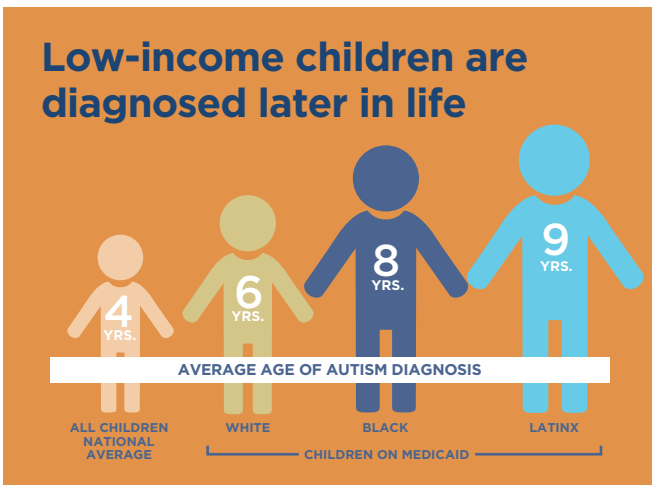
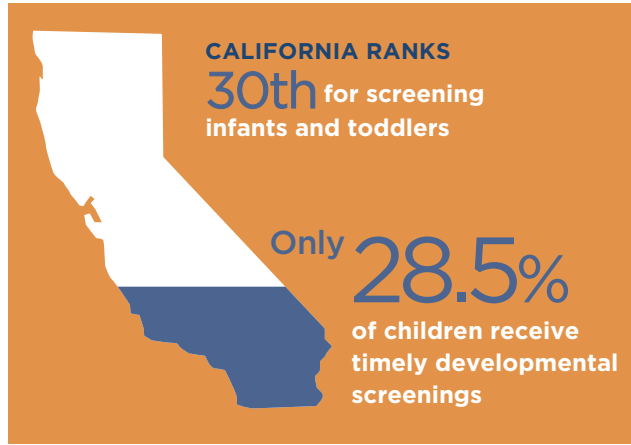
Providing **outreach** and **education** about available community resources



California must invest in **First 5's Help Me Grow** system to ensure all children reach their greatest potential.



EARLY IDENTIFICATION MATTERS



ABUSE, NEGLECT, POVERTY, HOMELESSNESS: all contribute to a child's risk of developmental delay **47%** of California's children are living in or near poverty

California's Children **deserve to succeed**

THE FORMULA FOR SUCCESS

Timely Screening
THREE SCREENINGS BEFORE THIRD BIRTHDAY

+

Early Intervention
INFORMATION, LINKAGE, REFERRAL AND SUPPORT

=

Successful Outcomes
KINDERGARTEN READY TO INDEPENDENT ADULT

CDC Grand Rounds: Addressing Health Disparities in Early Childhood

Lara R. Robinson, PhD¹; Rebecca H. Bitsko, PhD¹; Ross A. Thompson, PhD²; Paul H. Dworkin³; Mary Ann McCabe⁴; Georgina Peacock, MD¹; Phoebe G. Thorpe, MD⁵

Research suggests that many disparities in overall health and well-being are rooted in early childhood (1,2). Stressors in early childhood can disrupt neurologic, metabolic, and immunologic systems, leading to poorer developmental outcomes (1). However, consistent, responsive caregiving relationships and supportive community and health care environments promote an optimal trajectory (3,4). The first 8 years of a child's life build a foundation for future health and life success (5–7). Thus, the cumulative and lifelong impact of early experiences, both positive and negative, on a child's development can be profound. Although the health, social service, and education systems that serve young children and their families and communities provide opportunities to support responsive relationships and environments, efforts by these systems are often fragmented because of restrictions that limit the age groups they can serve and types of services they can provide. Integrating relationship-based prevention and intervention services for children early in life, when the brain is developing most rapidly, can optimize developmental trajectories (4,7). By promoting collaboration and data-driven intervention activities, public health can play a critical role in both the identification of at-risk children and the integration of systems that can support healthy development. These efforts can address disparities by reducing barriers that might prevent children from reaching their full potential.

Developmental Trajectories

Healthy child development includes not only physical developmental domains but also emotional, behavioral, cognitive,

language, and general learning competencies. The human brain undergoes rapid growth during childhood, driven in part by a child's acquisition and integration of skills across many developmental domains. Development in all domains is finely integrated across neural circuitry, allowing for more complex learning and tasks over time (8). Skill acquisition depends on children being ready to learn and can be envisioned as a developmental trajectory.

Exposure to adversity and stressors such as poverty, lack of safety and stability in the home environment, and lack of access to quality early education can negatively affect a child's development (1,2). These exposures can lead to an "at-risk or vulnerable" trajectory and in severe cases, a "delayed or disordered"

INSIDE

- 773 [The Role of Screening and Treatment in National Progress Toward Hepatitis C Elimination — Georgia, 2015–2016](#)
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This is another in a series of occasional MMWR reports titled CDC Grand Rounds. These reports are based on grand rounds presentations at CDC on high-profile issues in public health science, practice, and policy. Information about CDC Grand Rounds is available at <https://www.cdc.gov/about/grand-rounds>.

Continuing Education examination available at https://www.cdc.gov/mmwr/cme/conted_info.html#weekly.



trajectory (5). Conversely, protective factors provided in a child's home or community environment, such as consistent and responsive caregiving relationships and coordinated health care and other services, can reduce and even ameliorate the impact of adverse circumstances, allowing children to reach or return to a healthy trajectory (2,5).

Chronic stressors in early childhood, such as poverty, can have cumulative lifetime effects on learning, earnings, and health (3). Language differences associated with socioeconomic status have been documented as early as age 18 months (9). Vocabulary skills by age 3 years predict third grade reading, which in turn predicts high school graduation rates (10–12). High school graduates achieve increased earning potential and are less likely to have chronic diseases, such as diabetes, chronic pain, and symptoms of mental disorders than are non-graduates (13). High school graduates are also more likely to report good health and visit a health professional, important markers of positive health outcomes (13).

Identifying Vulnerable Children and Informing Action

Screening, early identification, and linkage to services can prevent vulnerable children (i.e., children at risk for or with a developmental delay) from progressing to levels of higher risk (14). For disadvantaged groups, early intervention can yield the greatest social and economic returns (15). For example, an economic analysis of two similar early childhood

interventions for socioeconomically disadvantaged children, Carolina Abecedarian Project and the Carolina Approach to Responsive Education, identified a 7.3 benefit/cost ratio and a 13.7% rate of return per annum when examining the long-term health, crime reduction, educational, and employment benefits of program participation (15).

Public health surveillance data characterize population-level impacts and can be used to inform public health action. For example, recent analyses identified treatment patterns for young children with attention-deficit/hyperactivity disorder that were not aligned with the American Academy of Pediatrics' (AAP) recommendations (16). These data have led to collaborations to 1) increase awareness of recommendations for behavior therapy before medication for preschool children, 2) increase available behavioral therapy options for providers and families, and 3) inform state and local decision-makers about best practices (16). Surveillance data continue to inform and monitor the impact of these collaborations and other early childhood initiatives.

Screening measures inclusive of social determinants of health provide opportunities for strengthening protective factors through family, community, and health care connections (3). Public health activities to improve early detection and referral to treatment include the Early Hearing Detection and Intervention* programs to identify hearing loss in infants; online tools developed by CDC and AAP for identifying motor delays†; and Learn the Signs. Act

* <https://www.cdc.gov/ncbddd/hearingloss/ehdi-programs.html>.

† <http://motordelay.aap.org>.

The *MMWR* series of publications is published by the Center for Surveillance, Epidemiology, and Laboratory Services, Centers for Disease Control and Prevention (CDC), U.S. Department of Health and Human Services, Atlanta, GA 30329-4027.

Suggested citation: [Author names; first three, then et al., if more than six.] [Report title]. *MMWR Morb Mortal Wkly Rep* 2017;66:[inclusive page numbers].

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Early[§] for children with or at risk for developmental disabilities. These tools leverage state, provider, and family-level actions to reduce the time to diagnosis and initiation of services.

Integrating Support Services for Vulnerable Children and Their Families

A large number of service agencies work to support optimal child development, but many have specific age requirements (e.g., early intervention, preschool, or school age), or provide specific types of services (e.g., developmental, health, social welfare, or educational). Too often, vulnerable children are identified but do not meet strict criteria for services of the agencies contacted, leaving them without needed services. An example of a program that has reduced service gaps by integrating available services for children is Help Me Grow.[¶] Help Me Grow serves as a centralized point of entry for both state- and community-based services where families of vulnerable children are matched to service agencies that offer the support they need (14). Through a single information line, vulnerable children who are likely to meet eligibility criteria are linked to one or more publicly funded early intervention services, preschool special education services, and interventions for children with special health care needs. Vulnerable children at risk because of environmental or biologic factors, but who do not meet eligibility requirements for the described services are linked to other community-based programs and services through Help Me Grow. In 2015 alone, Help Me Grow served 42,511 children and their families. Promising evaluation results have led some states to embed the Help Me Grow model within various federal initiatives, including the Health Resources and Services Administration's Maternal, Infant, and Early Childhood Home Visiting and Early Childhood Comprehensive Systems and the Substance Abuse and Mental Health Services Administration's Project LAUNCH (Linking Actions for Unmet Needs in Children's Health) program.

Integrating Behavioral and Physical Health

Behavioral health services can promote the health and development of children when high-quality services can be accessed by the children who need them (17). Nationally representative data from 2011–2012 suggest that 15% of U.S. children aged 2–8 years have a parent-reported mental, behavioral, or developmental disorder (18), and children living in small rural areas have a higher prevalence (19%) than children living in urban areas (15%) (19). In 2012, nearly \$14 billion in medical expenditures for mental disorders among children were spent across all payment types (private insurance, public insurance, out of pocket,

and other); these costs were higher than those for any other health condition (e.g., chronic obstructive pulmonary disease and asthma, trauma-related conditions, and acute respiratory infections).^{**} However, only an estimated 20% of children and youth with behavioral problems receive mental health services (17). In particular, children in rural communities often have less access to early childhood interventions and behavioral health care services highlighting the need for behavioral health care in alternative settings and coordinated care solutions (20).

Mental, behavioral, and developmental disorders in young children have been associated with potentially modifiable family, community, and health care factors (18,19). Two-generation approaches that support the health, educational achievement, economic self-sufficiency, and wellbeing of both children and their caregivers have indicated some beneficial effects on early childhood literacy and language development (3,7). Within primary care, screening and referral to appropriate services for maternal depression can support the parent-child relationship and enhance both child and maternal health (3). For children facing circumstances that put them at risk, such as poverty, enhancing these maternal-child protective factors might be particularly important for reducing the negative effects of stressors on long-term child health (3). Furthermore, pediatric primary care can expand beyond anticipatory guidance by promoting protective factors and resiliency through evidence-based interventions that address parental self-care, positive parenting strategies, and parent-child relationship building (3,7). By coordinating and integrating care across medical systems and community providers, the prevention- and patient-focused medical home (family-centered coordinated primary care) model promotes both behavioral and physical health.

Promoting Supportive Relationships Across Multiple Contexts

Early childhood objectives outlined in *Healthy People 2020*^{††} highlight the need to support parents and caregivers, create supportive communities, increase access to high-quality health care, and increase the proportion of children ready for school in all domains of healthy development. Programs that create connections across the early learning and home environments by supporting family engagement in learning have demonstrated positive impacts on young children's academic success and development (7,8). However, gaps exist in access to high quality early care and education, training, and evidence-based resources to support family engagement partnerships (7,8). A 2016 AAP policy statement aimed at ameliorating the health and developmental impacts of poverty describes the importance

[§] <https://www.cdc.gov/ncbddd/actearly/index.html>.

[¶] <https://helpmegrownational.org>.

^{**} https://meps.ahrq.gov/data_files/publications/st472/stat472.shtml.

^{††} <https://www.healthypeople.gov/node/3498/objectives#4816>.

of effective interventions and strategies focused on economic aid, access to comprehensive care coordination, early care and education, early identification of children and families in need of services, and promotion of protective factors through family support programs (3). The common thread for these approaches is the focus on both risk factors and protective factors for the entire family across multiple systems, not simply on the child with an identified condition in a single context.

Importance of Integration and Collaboration

Early childhood represents a period of growth that lays the foundation for successful learning, development, and health; disparities emerge early and widen over time (6). Intervening in early childhood can prevent the development of diseases and disorders among at-risk and vulnerable children but will require collaboration. Strategies that foster consistent and responsive caregiving relationships and supportive environments can improve outcomes for both parent and child (7). Parents and early care providers can work together to provide the responsive interactions and consistent environments that nurture the development of young children. Practitioners can screen and identify children early, promote family strengths, and refer to services before risks progress. States and communities can use surveillance data to drive action around early childhood investments. Partners within public health can use data-informed approaches to prevent health disparities by facilitating service linkages across health, social, and educational systems. Timely referral and better integrated services might help children at low or moderate risk reach their full potential by returning to healthy developmental trajectories.

Conflict of Interest

No conflicts of interest were reported.

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STATE OF CALIFORNIA
EDMUND G. BROWN JR., Governor



WELLNESS · RECOVERY · RESILIENCE

JOHN BOYD, PsyD
Chair

February 12, 2018

KHATERA ASLAMI-TAMPLEN
Vice-Chair

Natalie Woods Andrews, Ed.D., Director
Early Learning Department
Sacramento County Office of Education
P.O. Box 269003
Sacramento, CA 95826-9003

MAYRA ALVAREZ
Commissioner

RENEETA ANTHONY
Commissioner

Dear Dr. Woods Andrews:

LYNNE ASHBECK
Commissioner

Thank you for agreeing to participate in the Commission's public meeting on Thursday, March 22, 2018, at the MHSOAC (1325 J Street, Steinberg Room, 17th Floor, Sacramento). During this meeting, we will hold a series of panel presentations to understand trauma and mental health needs in the birth to 3, 3 to 5 (preschool, pre-K), and 5 to 8 (early elementary school) age cohorts, and examine how the mental health and education systems can work more effectively together in recognizing early warning signs and intervening, particularly in school settings. Your participation will assist the Commission in developing an action agenda to promote wellness and resiliency in children, improve collaborative efforts to identify trauma and mental health needs early, and improve outcomes including academic success for children with mental health needs.

JIM BEALL
Senator
Commissioner

BILL BROWN
Sheriff
Commissioner

KEYONDRIA D. BUNCH, Ph.D.
Commissioner

ITAI DANOVITCH, M.D.
Commissioner

Your panel entitled *Enhancing Opportunities for Prevention and Early Intervention* will share examples of successful school- and/or community-based programs and partnerships for the early recognition and treatment of trauma and mental health needs in children as they relate to efforts to ensure equity and reduce disparities. This panel is scheduled to begin at approximately 10:45 a.m.

DAVID GORDON
Commissioner

GLADYS MITCHELL
Commissioner

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MARA MADRIGAL-WEISS
Commissioner

TINA WOOTON
Commissioner

TOBY EWING
Executive Director

Please address the following questions to organize your testimony:

- Please describe your programs and/or intervention strategies for identifying children's trauma and mental health risk early?
- How have you leveraged resources and partnerships in your community to support these programs?
- What lessons have you learned from your efforts?
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Thank you again for your willingness to participate in this important meeting.

Respectfully,

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Toby Ewing, Ph.D.
Executive Director



STATE OF CALIFORNIA
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JOHN BOYD, PsyD
Chair

February 12, 2018

KHATERA ASLAMI-TAMPLEN
Vice-Chair

Ruben Reyes, Superintendent
Robla School District
Superintendent's Office
5248 Rose Street
Sacramento, CA 95838

MAYRA ALVAREZ
Commissioner

RENEETA ANTHONY
Commissioner

Dear Superintendent Reyes:

LYNNE ASHBECK
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JOHN BOYD, PsyD
Chair

February 12, 2018

KHATERA ASLAMI-TAMPLEN
Vice-Chair

Ron Powell, Ph.D.
Special Education Consultant, Early Childhood Mental Health Advocate
California Association of Health and Education
13478 Delaware Rd
Apple Valley, CA 92308

MAYRA ALVAREZ
Commissioner

RENEETA ANTHONY
Commissioner

Dear Dr. Powell:

LYNNE ASHBECK
Commissioner

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BILL BROWN
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JOHN BOYD, PsyD
Chair

February 12, 2018

KHATERA ASLAMI-TAMPLEN
Vice-Chair

Curtiss Sarikey, Chief of Staff
Oakland Unified School District
1000 Broadway, Suite 680
Oakland, CA 94607

MAYRA ALVAREZ
Commissioner

RENEETA ANTHONY
Commissioner

Dear Mr. Sarikey:

LYNNE ASHBECK
Commissioner

Thank you for agreeing to participate in the Commission's public meeting on Thursday, March 22, 2018, at the MHSOAC (1325 J Street, Steinberg Room, 17th Floor, Sacramento). During this meeting, we will hold a series of panel presentations to understand trauma and mental health needs in the birth to 3, 3 to 5 (preschool, pre-K), and 5 to 8 (early elementary school) age cohorts, and examine how the mental health and education systems can work more effectively together in recognizing early warning signs and intervening, particularly in school settings. Your participation will assist the Commission in developing an action agenda to promote wellness and resiliency in children, improve collaborative efforts to identify trauma and mental health needs early, and improve outcomes including academic success for children with mental health needs.

JIM BEALL
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BILL BROWN
Sheriff
Commissioner

KEYONDRIA D. BUNCH, Ph.D.
Commissioner

Your panel entitled *Strengthening California's Response to Children's Mental Health Needs* will provide local and statewide solutions for addressing the trauma and mental health needs of young children and elementary school students. Your panel is scheduled to begin at approximately 11:45 a.m.

ITAI DANOVITCH, M.D.
Commissioner

DAVID GORDON
Commissioner

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GLADYS MITCHELL
Commissioner

MARA MADRIGAL-WEISS
Commissioner

TINA WOOTON
Commissioner

TOBY EWING
Executive Director

Please address the following questions to organize your testimony:

- What are the local and/or statewide solutions to the systemic and institutional barriers that prevent schools and communities from adopting PEI programs that work?
- How can successful PEI programs be implemented on a larger scale?
- How do we incentivize schools, counties, and leaders to prioritize this work?

We ask that you plan on presenting summary comments in a brief presentation (8 to 10 minutes) to leave ample time for conversation with Commissioners.

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Toby Ewing, Ph.D.
Executive Director



STATE OF CALIFORNIA
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JOHN BOYD, PsyD
Chair

February 12, 2018

KHATERA ASLAMI-TAMPLEN
Vice-Chair

Ted Lempert, J.D., President
Children Now
1404 Franklin Street, Suite 700
Oakland, CA 94612

MAYRA ALVAREZ
Commissioner

RENEETA ANTHONY
Commissioner

Dear Mr. Lempert:

LYNNE ASHBECK
Commissioner

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BILL BROWN
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KEYONDRIA D. BUNCH, Ph.D.
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MARA MADRIGAL-WEISS
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TINA WOOTON
Commissioner

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Executive Director

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Toby Ewing, Ph.D.
Executive Director

Mental Health Services Oversight and Accountability Commission
Remarks from Ted Lempert, President, Children Now
Strengthening California's Response to Children's Mental Health
Thursday, March 22, 11:45 am
Approx. 10 minutes speaking time

- Good morning Commissioners. My name is Ted Lempert. I am the president of Children Now, a statewide non-partisan research, policy development, and advocacy organization dedicated to improving children's overall well-being. I'm also a dad and a former state Assemblymember and County Supervisor.
- I would like to thank the Commission for their hard work in putting together the today's panel and for hosting today's discussion on the importance of student mental health in state policymaking.
- I am hopeful that today's conversation will allow us to develop the support systems necessary for vibrant and effective school, county and state involvement.
- Schools are a constant in a child's life, while service systems and personnel often fluctuate.
- Children 18 and under spend a majority of their lives in school, which is why schools are a vital place to improve mental health services for youth.
- However, as important as schools are, we believe mental health services must start as early as possible in order to have well-rounded emotionally stable adults. The mental health of moms, dads, caregivers and other adults is a key part of ensuring a child's wellness. That is why we support voluntary evidence-based home visiting programs statewide. Home visiting has shown that it is an effective prevention method that aims to promote maternal health, improve child development, and strengthen families and communities.
- Once a child leaves the home to enter child school and/or pre-school, there should be culturally appropriate outreach and on-site mental health consultation, screening and evaluation at those settings. These services should continue into the elementary, middle and high-school settings. While some counties have these programs in place, they are far from widespread and many need to be re-thought on how best to provide culturally competent outreach in diverse communities.
- Our 2018 *California Children's Report Card*, gave the State a D+ in the area of mental health and building resilience. With only 35% of California children who reported needing help for emotional or mental health problems, the State has a long way to go before every kid has what they need.

- The Legislature and Administration play an important role in prioritizing the mental health of students. By mandating and funding certain programs/practices across the State, we can make a statement to counties and stakeholders that this is a priority.
- What is clear is that we need to do more as a state. Schools, mental health professionals and county behavioral health departments have developed deep expertise about what works, and in too many cases we're just ignoring their contributions to the conversation about how we can help kids.
- There are **several recommendations that the state should follow** to strengthen child wellness in state policymaking –They include:
 - Implementing home visiting across the state as home visiting will improve maternal mental health and strengthen positive parent-child interactions.
 - While we applaud the \$27 million included in the Governor's budget for home visiting, it should go beyond a pilot program and beyond its slated schedule to end in 2021.
 - Adopt widespread culturally appropriate screening, outreach and referral processes for all children.
 - The state should start by convening the advisory group (as required by AB 340) that would develop, if appropriate, tools and protocols for screening children for trauma.
 - Develop a cross-agency council that would include (but is not limited to): Department of Social Services, Department of Public Health, California Department of Education, Department of Health Care Services, Department of Justice so that the many departments and agencies that serve children can better coordinate their efforts. Children Now worked with all these players to ensure a coordinated response across agencies around the issue of chronic absence in schools. We need to do the same for mental health.
 - And finally, counties who have been successful in implementing PEI programs could educate the Legislature in an effort for the state to have a better understanding of what works and what could be scaled across county lines.
- These recommendations would take us a long way towards better utilizing the incredible expertise of schools, counties and stakeholders.
- Thank you for your time and for leading the way in including meaningful conversation about mental health services as part of our policymaking for kids in California.

2018
CALIFORNIA
CHILDREN'S
REPORT CARD

A review of
kids' well-being
& roadmap
for the future

CHILDREN NOW





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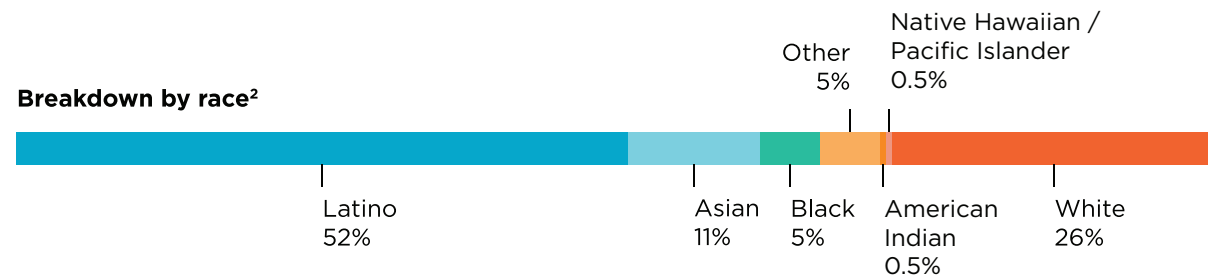
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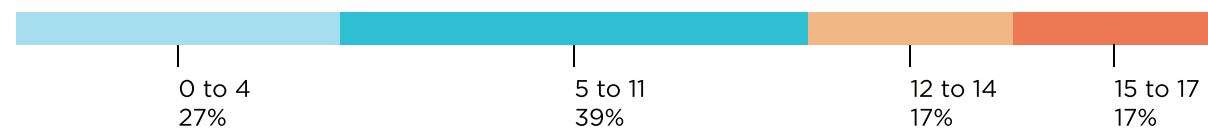
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California is home to 9,092,863 children.¹

Breakdown by race²



Breakdown by age³



43%
are low-income.⁴

20%
are in poverty.⁵

21%
are food insecure.⁶

4,367,000
are children from immigrant families.⁷

1,332,405
are English learners in TK-12 schools.⁸

5,217,677
are in Medi-Cal.⁹

55,983
are in foster care.¹⁰

9,092,863 need support.

Over the last year, our country and state have faced a number of challenges and tragedies. While the rhetoric of many leaders focuses on the importance of children to a better future, the reality is the rhetoric is too often just that.

Lack of progress for improving the lives of kids is unacceptable. All children need stability and a path to opportunity. This is true for nearly half of California's children who live in low-income families, where caregivers struggle to afford the quality support and services they need for their kids. This is also true for the approximately three-fourths of kids of color and just under half of kids growing up in immigrant families who face significant structural barriers to their stability and often highly stressful experiences that disrupt their healthy development.

As the *2018 California Children's Report Card* shows, the vast majority of our state's children face extraordinary challenges to reaching their full potential. Yet, the success of California's economy and civil society ultimately depends on policies that tear down these barriers and give all kids access to the quality support they need to succeed—from quality, affordable child care to a rigorous education to health coverage to safety. Public policy change is the fastest and most efficient way to scale innovative, high-impact programs, and secure the needed resources and reforms.

It's time to take action to improve the lives of California's kids. By connecting the thousands of organizations, businesses, and individuals who care about kids, we have the ability to be stronger than any other interest group, pushing kids to the top of the public policymaking agenda. So if you're



the leader of an organization or a business or a faith leader or a concerned resident, we're asking you and your group to join The Children's Movement (www.childrennow.org/themovement) to learn about and support children's needs. And if you're a policymaker, we're asking you to commit to prioritizing the Pro-Kid Agenda detailed in this report.

Together, we can do better to provide for our most vulnerable kids, and in turn, our state's economic and democratic future.

Sincerely,

Ted Lempert
President

Infant & Toddler Care

GRADE: D+

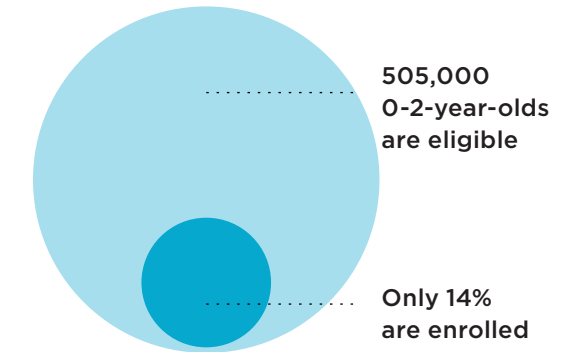
More than 1.5 million infants and toddlers live in California families. Most families struggle to find affordable, stable, quality child care. Healthy brain development and growth in the earliest years is fueled by responsive caregivers, consistent everyday interactions, and safe, enriching experiences.



California low-income families with young kids need better access to quality child care programs.

Of California's infants and toddlers, 62% are born into low-income households,⁵ yet only 14% of income-eligible infants and toddlers are enrolled in a publicly-supported child care program.

Low-Income 0- to 2-year-olds Served in Publically-Funded Early Learning Programs⁶



Licensed child care is limited throughout the state.

There are currently only enough licensed child care spaces on average in California for

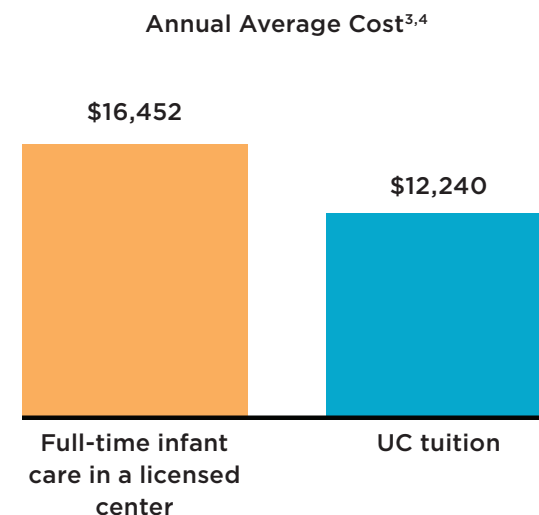
25% of children¹

Only 1 county

has enough licensed child care spaces for the majority of its children.²

The cost of child care is out of reach for many families.

The average annual cost of child care for an infant in a licensed center is more than a year of UC tuition.



Progress Report

The state has been slow to expand child care assistance for struggling families. However, recent incremental increases to rates paid to child care providers, which is important to ensure a quality workforce, may prevent further decline in available spaces. Updated eligibility guidelines will prevent low-income families from losing their subsidy because of a wage increase, and parental leave protection was recently expanded to include small businesses so that more parents can spend time with their newborns and look for child care with greater ease.

Pro-Kid[®] Agenda

California policymakers must ensure all families with infants and toddlers have access to enriching, stable, and affordable child care, including sufficient subsidies for low-income families, kids in foster care, and families experiencing circumstances of need or risk. In the near-term, investments in state-funded child care programs should be expanded so that more families with babies and toddlers have equitable opportunities from the very start.

Preschool & Transitional Kindergarten

GRADE: B

Quality early learning programs, such as preschool or transitional kindergarten, are critical to school readiness and to the long-term success of all children, especially children who may face systemic or structural inequities such as kids of color, kids from low-income families, kids in foster care, and dual language learners.



Early learning programs help kids get ready to succeed in school.

Transitional kindergarten, a publically-funded early learning option for those four-year-olds not old enough to enter kindergarten in the fall, has been found to boost language, literacy, and math skills for children.

Benefits of transitional kindergarten for participating students include:⁴

- letter+word identification
- phonological awareness
- expressive vocabulary
- math problem solving
- math concepts and symbols
- class engagement

Too few California 3- and 4-year-olds have access to preschool.

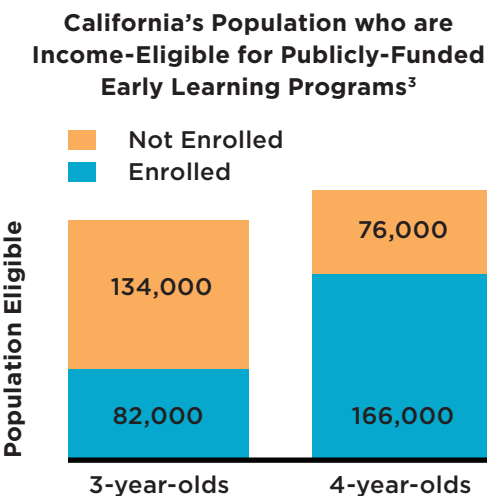
High-quality early learning programs can yield positive, long-lasting effects, yet fewer than half of California's young children attend preschool.

Many of California's poorest kids do not have access to publicly-funded programs, despite being eligible.

High-quality early learning programs have been shown to narrow the achievement gap and can be especially beneficial to low-income children.²

Only 49%

of all 3- and 4-year-olds in California attend preschool.¹



Progress Report

California has shown increased commitment to early learning by expanding investments in its State Preschool Program and establishing a transitional kindergarten program. However, transitional kindergarten is not designed to serve all four-year-olds or target services to the state's most vulnerable kids. Without significant additional resources, State Preschool and Head Start cannot fill this gap in access. Many working families and professionals seek to ensure they can provide developmentally-appropriate full-day options for their three- and four-year-olds.

Pro-Kid[®] Agenda

California policymakers must provide children with access to high-quality early learning programs and educators. In the near-term, the Governor and the Legislature must keep their commitment to continue to expand state-funded preschool and transitional kindergarten to four-year-olds, but must also begin to address the huge unmet need in early education services for three-year-olds.

Early Learning Workforce Compensation & Training

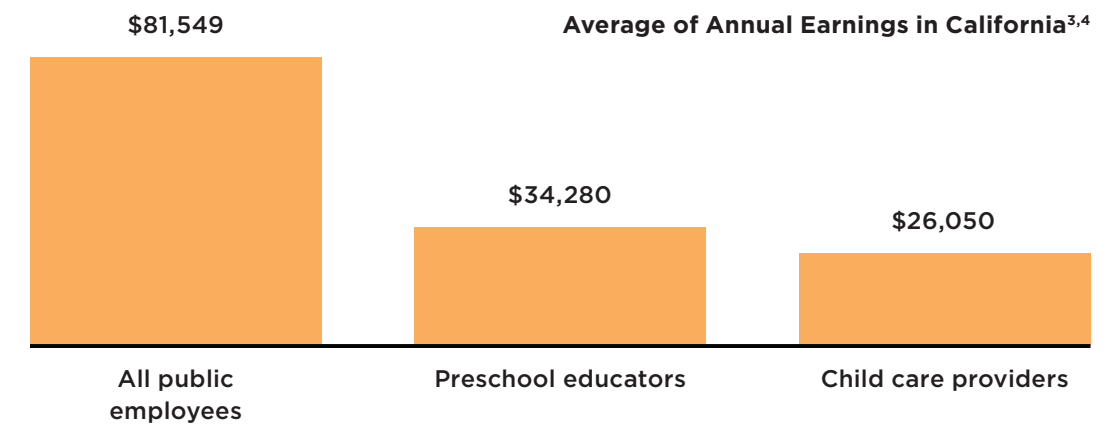
GRADE: C -

Teachers and caregivers are foundational to high-quality early care and education because young children develop and learn through enriching relationships and interactions. Still, California's workforce is highly underpaid, stretched thin, and lacks consistent professional development support.¹



Early child care providers are responsible for kids during the period of their lives with the most rapid brain development, yet they are poorly compensated.

Preschool educators and child care providers get paid well below the average salary of other public employees.



Early childhood educators are expected to be competent in a wide range of skills.

An effective early childhood educator must be knowledgeable about child development, skillful at observing and assessing learning, and intentional in planning experiences and environments to support children's learning, among other skills. **Yet, professional development requirements are inconsistent across early learning settings, and compensation is far too low for the expertise required.**²

Areas of Expertise:

-  observation, screening, assessment, & documentation
-  culture, diversity, & equity
-  health, safety, & nutrition
-  dual language development
-  relationships, interactions, & guidance
-  family & community engagement
-  learning environment & curriculum
-  special needs & inclusion

Progress Report

Recent increases to provider reimbursement rates may translate to some higher wages, however, the state has yet to address the endemic economic insecurity facing the workforce. There have been sporadic steps to improve training and education levels, including recent recommendations to the Commission on Teacher Credentialing to revise the child development permit needed for those that provide service in the care, development, and instruction of children in a child care and early learning programs. The Department of Education, state leaders, and experts also recently completed an extensive state-level plan to strengthen the state's workforce system.

Pro-Kid[®] Agenda

California must fully scale its quality improvement and workforce development initiatives that support the knowledge, skills, professional opportunities, and economic well-being of the workforce. In the short-term, policymakers should proactively support the initial implementation of the state's ambitious plan to transform the early childhood workforce over time. This includes expanding the Early Care and Education (ECE) Workforce Registry, a system designed to verify and securely store and track the employment, training, and education accomplishments of ECE teachers and providers, to gain a meaningful assessment of current challenges.

Education for Dual Language & English Learners

GRADE: D+

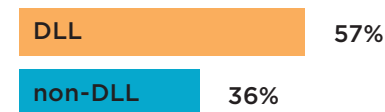
Children learning English in addition to their home language are considered dual language learners (DLL) before entering school, and designated English learners (EL) in TK-12 in California. California has the highest number of kids who are DLL (60%)¹ and EL (21%) in the country.²



Language learners are the growing majority of California's kids.

Language development is critical to overall educational success. Children who are dual language learners are more likely to be living in low-income families than children who are non-dual language learners, and consequently are less likely to have access to early learning opportunities that help with language development before school.

Percent living in low-income families by language learning status³



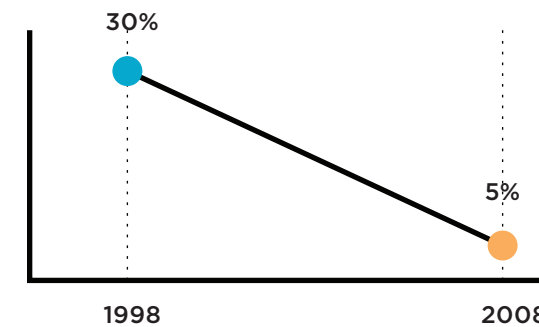
Percent enrolled in Pre-K by language learning status⁴



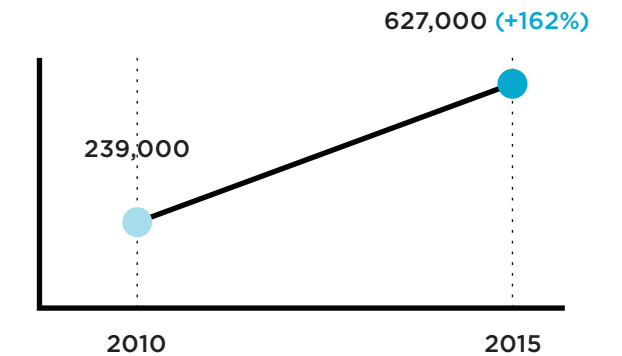
Demand for a bilingual workforce is increasing.

Students who are bilingual have an advantage in the workforce, yet fewer students are being served by bilingual programs in California.

Percent of English Learners Served by Bilingual Programs in California⁵



Number of Online Job Listings for Workers with Bilingual Skills in the US⁶



Progress Report

With the passage of Proposition 58 last year, California reversed harmful restrictions on bilingual education put in place via Proposition 227 in 1998. The state's recent adoption of the TK-12 English Learner Roadmap and the English Language Arts/English Language Development Framework provide a good start for the state—in addition to \$5 million in the budget to support the Bilingual Professional Development Program through 2019-20 - but much more needs to be done.

Pro-Kid[®] Agenda

California policymakers should ensure children who are dual language and English learners have the support needed to eliminate achievement gaps. The state should adopt a plan to ensure DLL and EL students graduate ready for college, career, and civic life. The state should also adopt a plan to promote bilingualism for all students.

TK-12 Funding

GRADE: C -

California has been underfunding its schools and shortchanging its students for decades. Without adequate funding, many districts struggle to hire qualified teachers and other trained adults and to keep class sizes small—two factors that contribute to student success.



The ratio of teachers and other trained adults to students is a prominent factor in education quality.

Yet California ranks near the bottom among the 50 states on the most important trained-staff-to-student ratios.

	CA's Staff to Student Ratios ³		
	National average	CA	CA rank
Total staff	1:8	1:11	48
Teacher	1:16	1:24	50
Librarian	1:1,128	1:7,783	50
Guidance counselor	1:482	1:760	49
Administrator	1:207	1:300	47

Despite California's high per capita income, the state lags behind the national average in school funding.

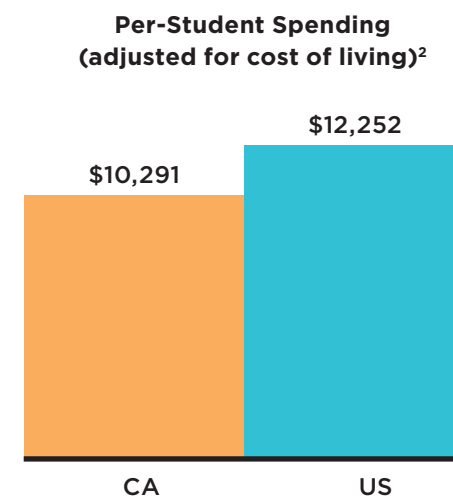
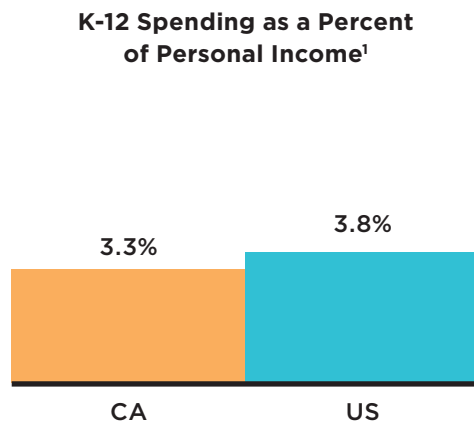
Among all states, California ranks 37th for percentage of personal income spent on education, and 41st in per-student spending.

Progress Report

The Local Control Funding Formula (LCFF), California's new school finance system, is approaching its initial funding targets which guarantee that all districts will finally receive their pre-recession level of funding. But, this doesn't account for growing cost pressures such as pension obligations, health care, and special education. Funding remains inadequate to meet schools' needs, and as a result schools have fewer teachers and other caring adults to support students, especially students who need language development support, live in poverty, or face other risk factors.

Pro-Kid® Agenda

California policymakers must create a long-term funding solution for TK-12 education to effectively address gaps in student achievement and provide every student with a high-quality education. In the near-term, policymakers should complete the initial LCFF implementation, and then grow the formula to reflect new cost pressures. Policymakers must also ensure that resources are used to improve education for low-income students, students of color, English learners, and kids in foster care, as the law intends.



Academic Outcomes

GRADE: D

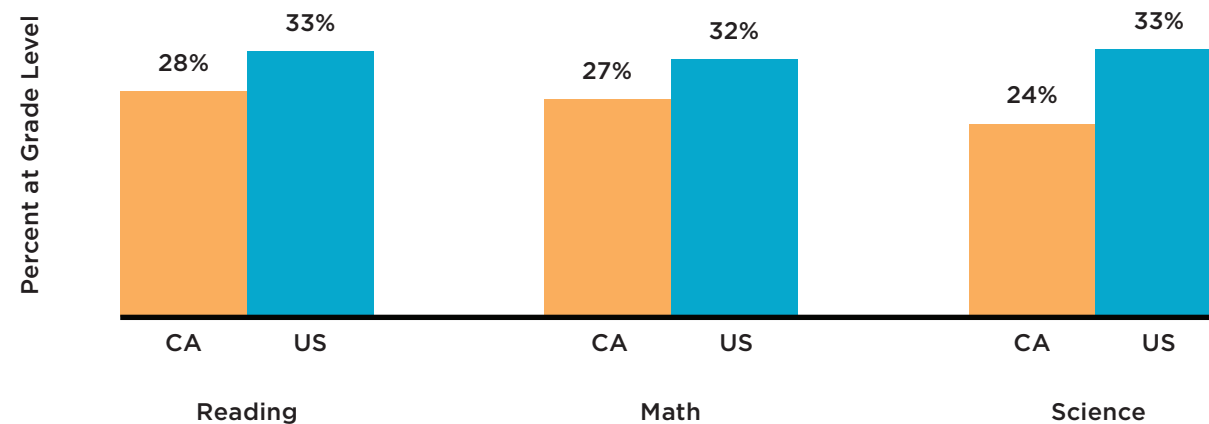
Every student needs a high-quality education, yet California lags behind the nation on academic measures. The State is accountable for ensuring that all of California's TK-12 students are graduating from high school ready for college, career, and civic life.



California ranks near the bottom nationally for performance in reading (40th), math (40th), and science (42nd).

Fewer than one-third of California students tested proficient in reading, math, and science, putting the state well below national performance.

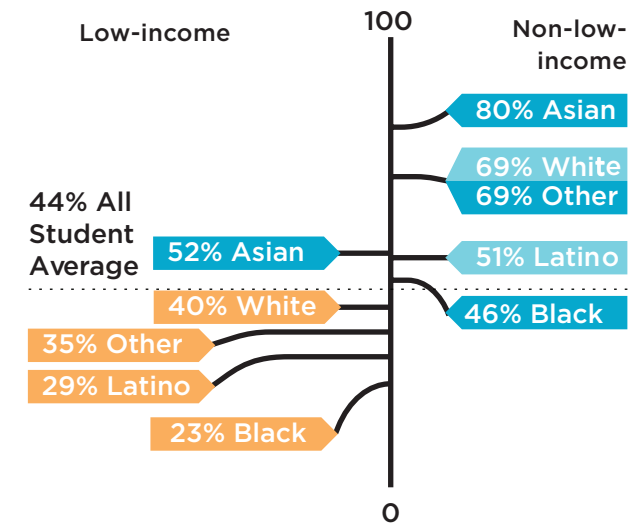
8th Grade Performance on the National Assessment of Educational Progress¹



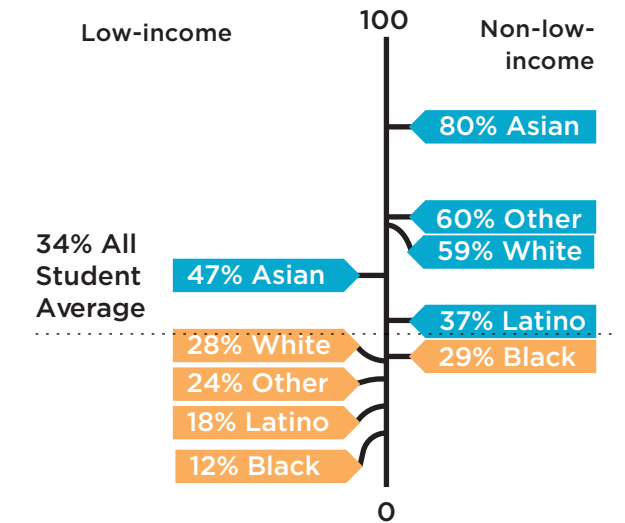
California has large disparities in academic achievement.

Achievement varies by income, and performance for children who are Black and Latino trails that of their peers who are Asian and White.

Percent of CA 3rd Graders at Grade Level in English Language Arts²



Percent of CA 5th Graders at Grade Level in Math³



Progress Report

California has created a foundation to support the success of all students. This includes adopting college- and career-aligned standards, implementing a finance system that invests in our most vulnerable kids, and launching a fledgling accountability system. While these structural pieces are important, there needs to be continued urgency to use these tools and others as intended, to ensure every California student has a high-quality education that helps close our achievement gaps.

Pro-Kid[®] Agenda

California policymakers must ensure that all K-12 students, especially the most vulnerable, graduate ready for college, career, and civic life. Our leaders should continue to use multiple measures in our state accountability system, not just achievement. This system must provide greater transparency on whether gaps in student achievement are closing or not. When improvement is needed, all schools, districts, charters, and county offices should have access to timely support to meet their unique needs.

STEM Education

GRADE: C

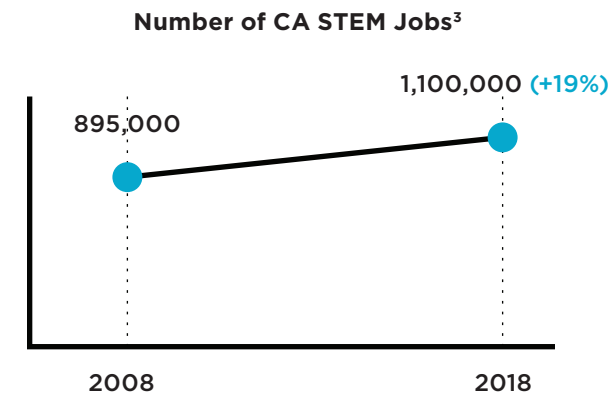
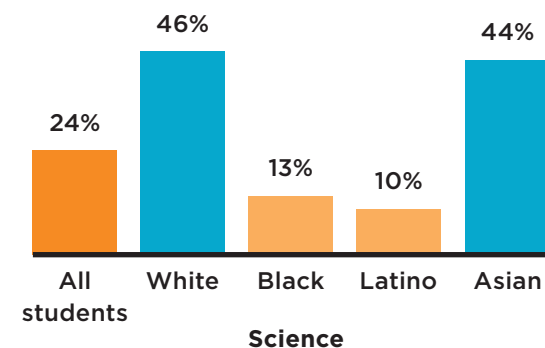
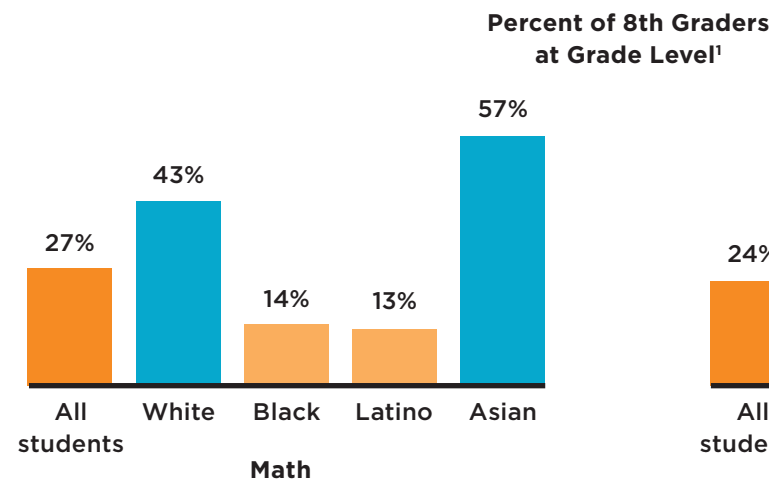
STEM (science, technology, engineering and math) education equips students with the knowledge and skills to succeed in a world that's becoming increasingly complex—from the hard skills needed to succeed in STEM-related jobs, to soft skills like asking important questions and testing multiple solutions.



As demand for STEM jobs continues to grow, California ranks 40th in student performance in math,¹ and 42nd in student performance in science.²

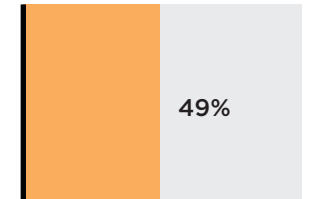
California students are not meeting grade-level expectations in math and science, and the performance gap is most pronounced for students who are Black and Latino.

Due to multiple factors, including systemic barriers and significant educational disparities, students who are Black and Latino perform well below the statewide average and below their peers who are White and Asian in math and science on the National Assessment of Educational Progress (NAEP).

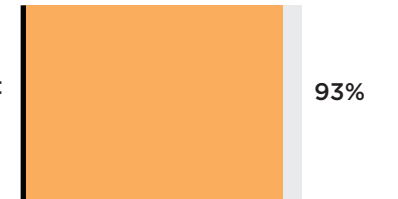


By 2018:⁴

Percent of STEM jobs in CA that will be computer occupations



Percent of STEM computer occupations that will require a post-secondary education



Progress Report

California's adoption of the Common Core State Standards and Next Generation Science Standards (NGSS) raised expectations in science and math to be consistent with the evolving world. The state is developing computer science education standards and has invested in the training and recruiting of new STEM teachers. While these developments are important, California isn't doing nearly enough. The state needs to address a severe STEM teacher shortage, and uneven and inequitable access to quality STEM learning.

Pro-Kid[®] Agenda

California policymakers should make high-quality STEM instruction a core element of every child's education, especially for kids of color and girls. In the near-term, policymakers must build the capacity to prepare and support teaching to the new math and science standards, and expedite an assessment that is aligned to the NGSS; meanwhile, district leaders must plan for, and increase, their investments in multi-year implementation of NGSS-based teaching and learning.

Teacher Pipeline, Preparation, & Placement

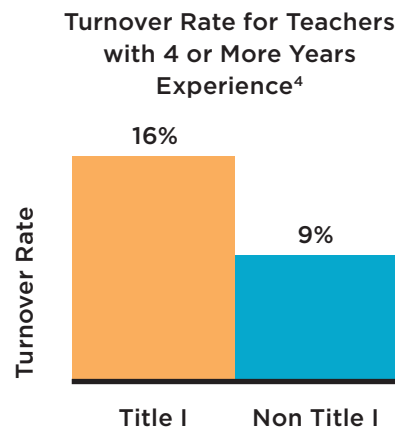
GRADE: D+

Students deserve to be taught by high-quality and well-prepared teachers. Yet recent research shows significant declines in the number of teachers entering the profession, and growing disparities in teacher preparedness, retention, and faculty diversity, negatively affecting low-income schools.^{1,2,3}



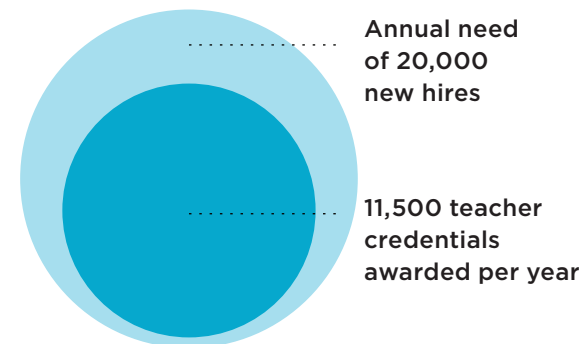
Students who are low-income are more likely to have under-prepared teachers.

Experienced teachers are nearly two times more likely to leave Title I schools, which have higher percentages of students who are low-income, than non-Title I schools.



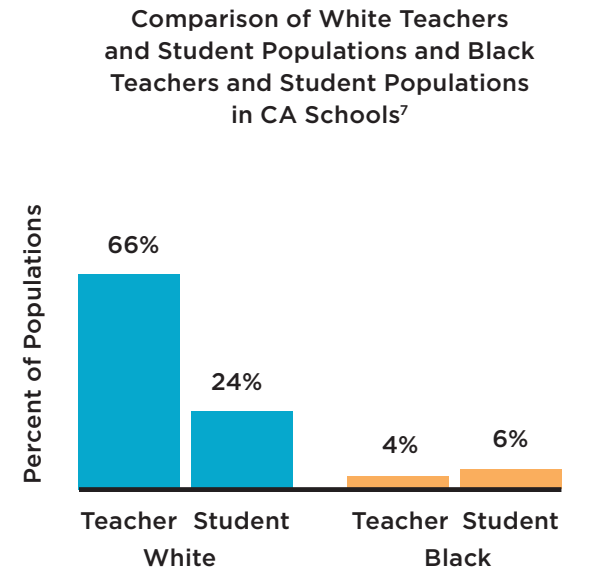
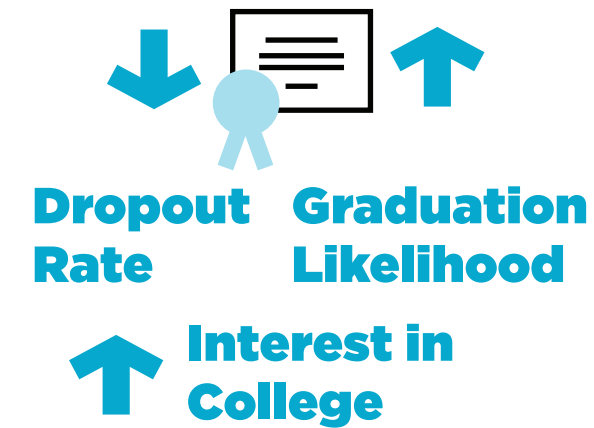
California is experiencing a severe shortage of teachers.

Fewer Teachers are Credentialed Than Meet Schools' Needs⁵



Teacher diversity matters.

Research has shown that male students who are low-income and Black who have at least one teacher who is Black in grades 3-5 have a 39% lower chance of dropping out of school and a 29% increased interest in pursuing college.⁶



Progress Report

California students deserve qualified and effective teachers in every classroom, but this is not the reality for many students. Shortages continue to inequitably impact student groups based on race and income and must be addressed—which is also required by the federal Every Student Succeeds Act provisions to ensure equitable distribution of effective, experienced and qualified educators. We must do a better job of recruiting, training, and supporting effective educators, including recruiting from a more diverse pool of candidates, as well as conducting a deep review of the laws yielding inequitable access to effective educators.

Pro-Kid[®] Agenda

California policymakers must address the diminishing pipeline of new educators, improve preparation, training, and support—including providing new teachers with meaningful and objective feedback that helps improve their teaching—and ultimately ensure that kids of color and low-income kids are not disproportionately served by ineffective, out-of-field, or inexperienced teachers. In the near-term, policymakers should increase investments in improving the pipeline and quality of new teachers, make improvements in evaluation, tenure and support, and monitor the equitable distribution of educators.

School Climate & Discipline

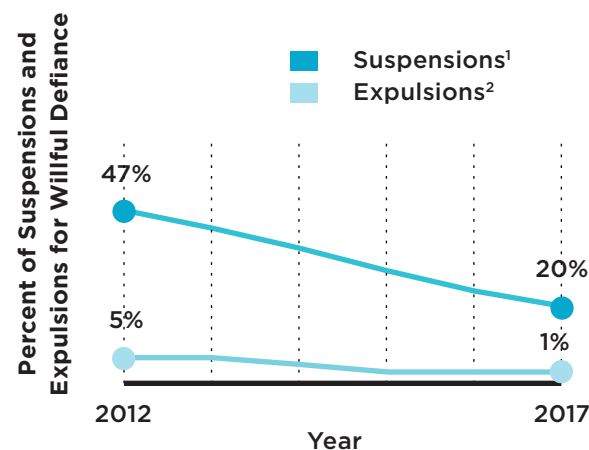
GRADE: B-

Students should feel safe at school, connected to peers and supported by caring adults. Unfair, punitive discipline policies negatively impact school climate and disproportionately affect students of color. Inclusive, student-centered, and restorative practices promote positive school climate.



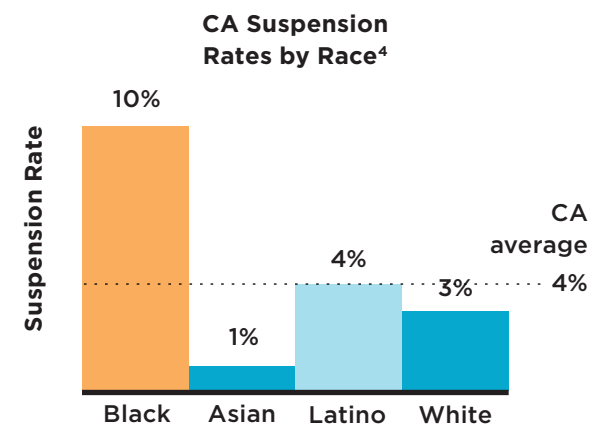
Student suspensions and expulsions in California are declining.

The decline is due in part to state law banning suspensions for willful defiance (a subjective category of overly broad and minor offenses) for kindergarteners through third-graders and expulsions for willful defiance for all students.



Suspensions disproportionately affect kids of color.

Research on implicit bias shows that teachers are more likely to associate challenging behavior with boys who are Black relative to their peers who are not Black.³ As a result, suspension rates are highest among students who are Black.



86% of teachers report needing more training on positive discipline practices.⁵

Teachers need more support to incorporate alternatives to punitive discipline policies in the classroom. These alternatives help to encourage respect, strengthen relationships, and hold students accountable.

Practices that promote positive school climate:



dismantling racism and bias



trauma-informed practices



social-emotional learning



restorative justice



positive behavior supports



culturally-responsive practices

Progress Report

State law currently bans suspensions for defiance/disruption in transitional kindergarten through third grade, and prohibits defiance/disruption expulsions in all grades. While some districts have banned willful defiance suspensions for all grades, to ensure California kids don't miss out on valuable class time for minor offenses, more training and stronger efforts to eliminate defiance/disruption suspensions in the upper grades is still needed, and surveys must monitor progress on school climate and engagement.

Pro-Kid[®] Agenda

California policymakers must make sure that preparation, training, and ongoing professional development activities for all teachers and administrators are based on restorative, trauma-informed, and culturally-responsive practices. Suspensions and expulsions for defiance/disruption should be eliminated for all students. Policymakers should also develop and require common surveys to measure school climate and student engagement, and continue to make substantial investments in research-based practices through the Multi-Tiered System of Support framework and the Proposition 47 grant program.

Chronic Absence

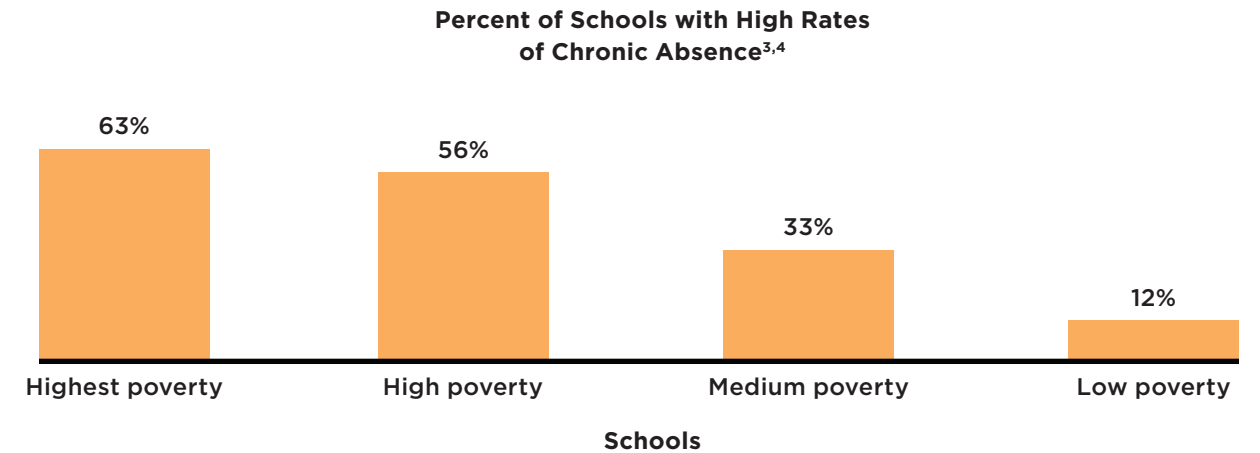
GRADE: B -

School attendance is a key predictor of students' future academic performance. When students miss ten percent or more of the school year, they are considered chronically absent. Students who are chronically absent are more likely to fall behind in school and drop out.



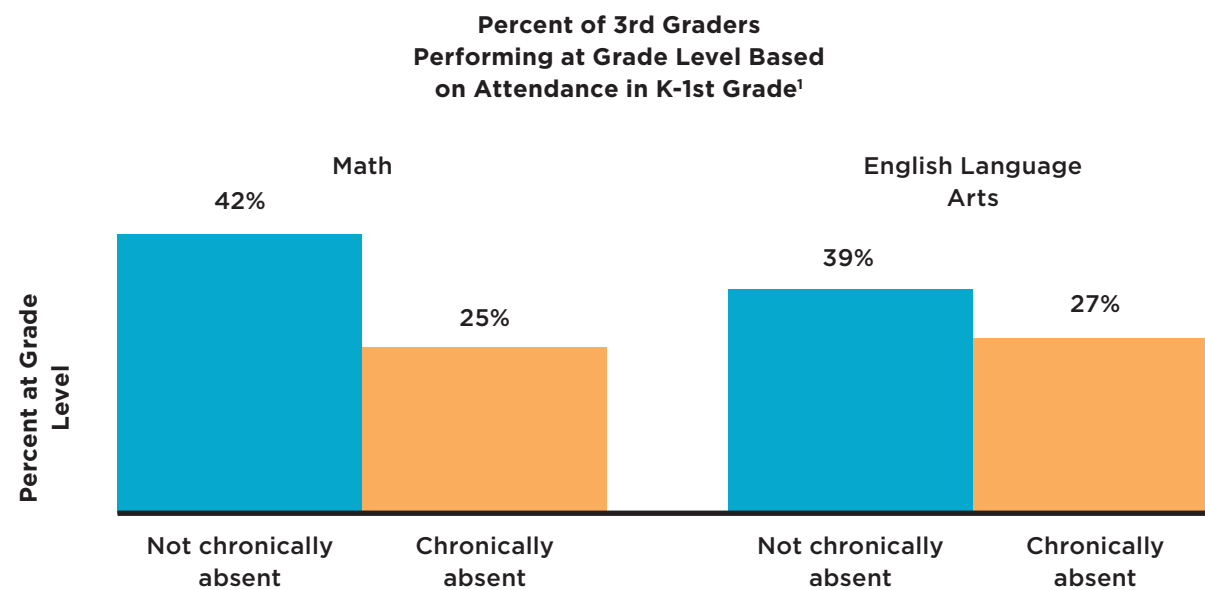
Low-income schools have higher rates of chronic absence.

Barriers such as unstable housing, lack of transportation, poor health, and greater exposure to environmental hazards can disproportionately affect low-income communities and contribute to higher rates of students who are chronically absent in high-poverty schools.²



Students who are chronically absent have a hard time catching up.

For example, only one-fourth of students who were chronically absent in kindergarten and first-grade met or exceeded state standards in third grade.



Progress Report

Seven years after the passage of SB 1357 (Steinberg), student attendance data was finally collected and released to the public for the first time in California in 2017. This was an important first step in addressing chronic absence. However, more needs to be done to help students who are chronically absent. Districts need to enable early warning systems to keep students on course for success, and the state must fully integrate chronic absence as a meaningful measure of school performance into the new state accountability system and dashboard.

Pro-Kid[®] Agenda

California policymakers and district leaders should monitor chronic absence closely at the state and local levels. Chronic absence data should be counted for accountability purposes and used by schools as an early warning sign for systemic and individual student needs. The Governor and Legislature should fund the California Department of Education's data collection, reporting, and system development to provide districts, researchers, and the public with useful, timely, transparent, and actionable information.

Afterschool & Summer Learning Programs

GRADE: B -

Afterschool and summer learning programs have been proven to help prevent the achievement gap from growing between students who are low-income and non-low-income.¹ There is a high need for these programs, yet the necessary funding to meet this need remains inadequate.



Despite recent investments, afterschool funding remains insufficient.

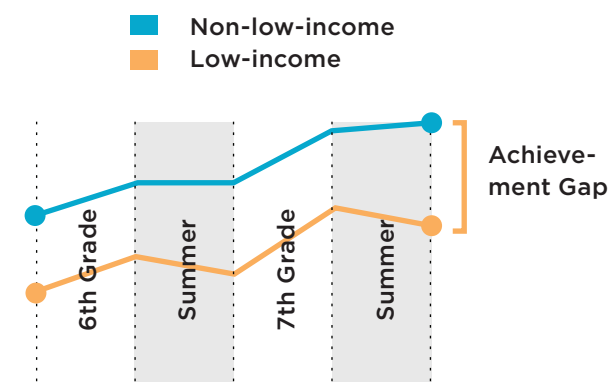
In the 2017 budget, Afterschool Education and Safety Programs (ASES) benefitted from an increased investment of \$50M dollars from the state. With increasing cost of living in California, this investment is welcomed but far below what is needed.

49%

of students who would benefit continue to lack access to state funded afterschool programs.²

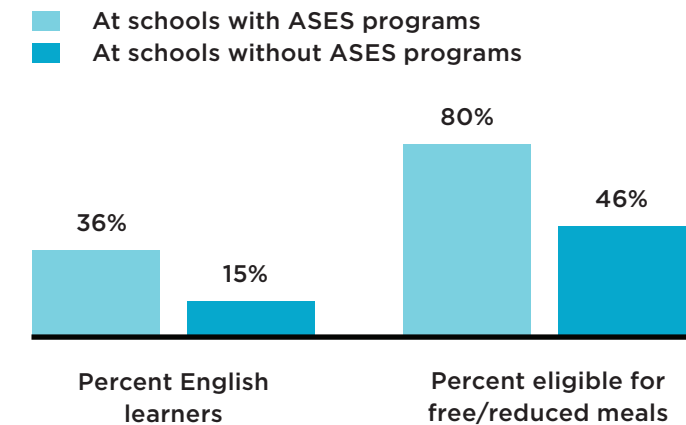
Summer learning programs stop the loss of academic gains.

Each summer, students who are low-income and lack access to quality summer learning programs have been shown to fall behind by nearly two months in reading by the time they start school in the fall.³



ASES funding is essential to supporting high-needs kids.

ASES funding, which funds California's afterschool programs, is targeted to schools with a higher number of English learners and low-income students.⁴



Progress Report

In 2017, afterschool reimbursement rates which had been stagnant for nearly a decade were increased. This increased investment was required because the already-existing gap between programs' needs and funding would only widen as a result of the rising minimum wage and cost of living pressures. California must find ways to increase investments further to ensure quality, access, and preparedness to face threats of federal cuts to funding.

Pro-Kid® Agenda

California policymakers should sustain and build on proven afterschool and summer programs so all kids, particularly those who face poverty, racism, or other systemic barriers, have access to safe environments that allow them to be active and engaged in afterschool and during the summer. In the near-term, policymakers should support quality improvement efforts to increase investments in afterschool and summer programs, and to ensure students continue to have access.

Access to Higher Education

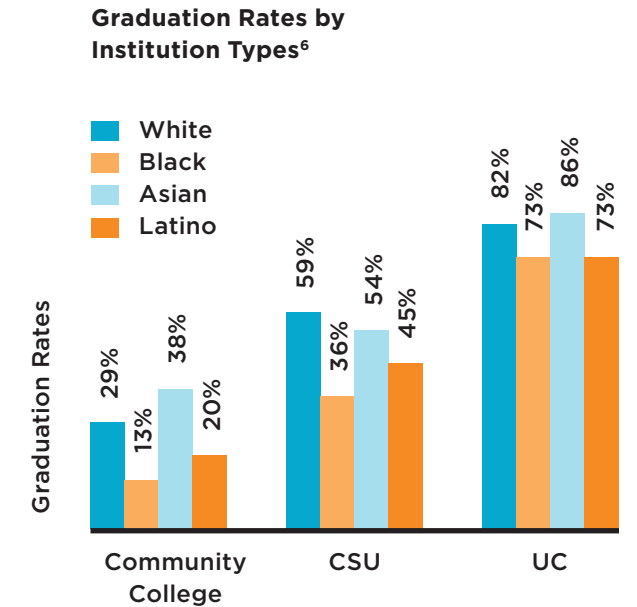
GRADE: C

While more California high school graduates are prepared for college, enrollment at the University of California and California State University has not kept pace with demand. A shortfall of 1.1 million college graduates is predicted by 2030.¹



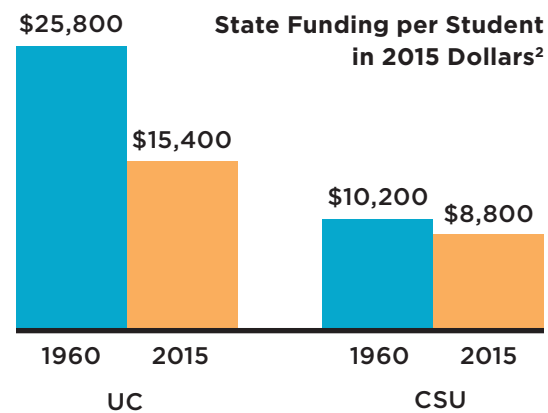
Racial disparities in postsecondary graduation rates persist.

Due to educational and other inequities, students who are White and Asian are more likely than their peers who are Black and Latino to graduate from all types of public higher education institutions.



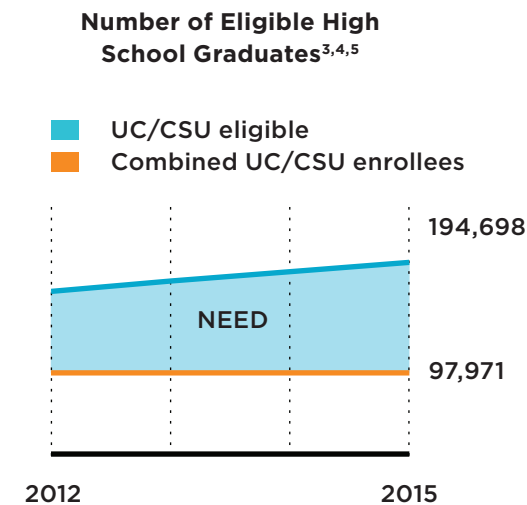
State investment in public higher education has dropped.

The lack of state support means students are paying more out-of-pocket for attending school. This burden discourages students from attending college and makes it less likely they will graduate.



California needs to expand college access for high school graduates.

California has succeeded in preparing more high school graduates for higher education, but the gap between those prepared for UC/CSU and those actually enrolled is growing.



Progress Report

While overall state funding for higher education has been declining, in recent years California has begun to reinvest in public higher education to help students defray the rising costs of attending college, and to further the expectation that higher education leaders will make their institutions accessible to all who are eligible. The transition between K-12 and higher education has improved, and more students are moving into college-level courses faster. Technology is being integrated in new ways to improve learning, and curriculums have been redesigned to create seamless pathways to degrees and credentials. Although these are significant steps forward, the state must do more to address college affordability, diversity, student readiness, and student success and completion.

Pro-Kid[®] Agenda

California policymakers must make good on the promise of an accessible and affordable system of public higher education. Our leaders need to reinvest in the UC, CSU, and community colleges, and remove the, often insurmountable, barriers of attending college, such as the high cost of tuition and housing, food insecurity, and limited access to childcare for students with children. Our state leaders should also develop long-term plans to accommodate more students, close the attainment gap, stabilize funding, increase graduation rates, and create accountability through transparency and measuring performance.

Developmental Screenings

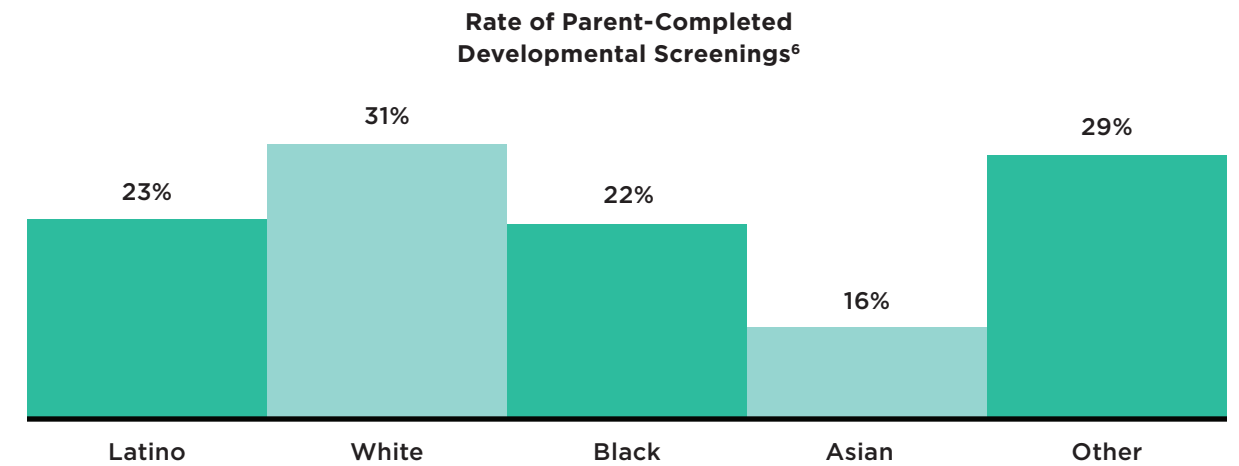
GRADE: C-

The American Academy of Pediatrics recommends that all children under the age of three be screened routinely to monitor their development and identify potential delays. Screening is the first step to connecting children with the supports they need for healthy development.



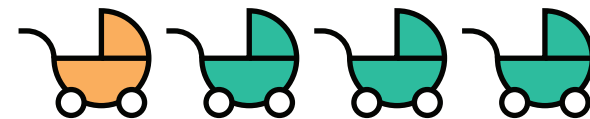
Screening rates are even worse for kids of color.

Children of color are less likely to receive developmental screenings, largely because fewer providers ask families of color about their child's development.⁵

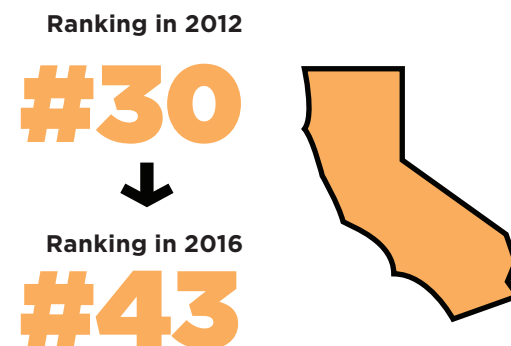


Of California's 2.5 million young kids,¹ 1 in 4 are at risk for developmental, behavioral, or social delays.²

Developmental, behavioral, or social delays can impact a child's school readiness and affect their overall well-being. The earlier children begin receiving support, the better.



CA's rank has dropped 13 places for the rate of young children who received screenings:^{3,4}



Too few California kids are receiving the health screenings they need.

Screenings can help detect delays earlier, which is essential for initiating interventions that help prevent or mitigate future challenges. Yet, California ranks near the bottom among states for the rate of young kids who receive screenings (21%), falling 13 places in recent years.

Progress Report

Due to the unacceptably low rates of developmental screenings for young California kids, the California Department of Health Care Services has begun to investigate how to increase screening rates. There are inconsistent, and often insufficient, levels of cross-sector health and early childhood collaboration, shared data, and parent and provider education and outreach to ensure that kids receive screenings and get connected to needed early intervention services.

Pro-Kid[®] Agenda

California policymakers should ensure that kids under age three receive routine developmental, behavioral, and other health screenings at the intervals recommended by the American Academy of Pediatrics, and invest in robust referral and early intervention systems to connect kids with services they may need for supporting their healthy growth and development. In the near-term, the California Department of Health Care Services should leverage all available data to improve the rate of kids receiving developmental screenings.

Home Visiting

GRADE: D+

Voluntary home visiting programs match new and expectant parents with trained professionals who provide one-on-one support and education during the critical early years. Home visiting programs reinforce parent-child relationships, equip parents to nurture children's health and learning, and can have a positive impact on families.



Home Visiting programs reach fewer than 3% of California families.^{5,6}

Despite research proving the benefits of voluntary home visiting programs, and data indicating two-thirds of families with babies and toddlers could potentially benefit from them,⁷ home visiting is not reaching enough California families with infants and toddlers.

Home visiting programs:



support health of mom & baby



help parents understand child development



promote positive parenting



help families set future goals

Many California families with very young kids face challenges that have the potential to undermine their well-being in the short- and long-term.

62%

of babies are born into low-income households.¹

Over 1 in 6

women report prolonged depression while pregnant or after their baby is born.²

41%

of parents report having one or more concerns about their young child's physical, behavioral or social development.³

Over 40,000

infants are born preterm, making them susceptible to health and learning difficulties throughout childhood.⁴

Progress Report

Home visiting works for families, communities, and taxpayers by boosting the health and well-being of both parents and children, and also preventing downstream costs related to unaddressed learning delays, child maltreatment and involvement with the juvenile justice system. Yet California is not one of the 30-plus states dedicating general funds to home visiting, nor one of the many states directing Medicaid and Temporary Assistance for Needy Families funds to home visiting. Current federal and local funding for home visiting through county First 5 Commissions, Early Head Start, and the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) grant is fragmented and falls far short of meeting the need.

Pro-Kid® Agenda

Policymakers should expand voluntary home visiting programs for new and expectant parents in California. The state must identify sustainable funding, prioritize families most in need of support, and ensure that programs are effective, high-quality and responsive to the diverse needs of families.

Health Insurance

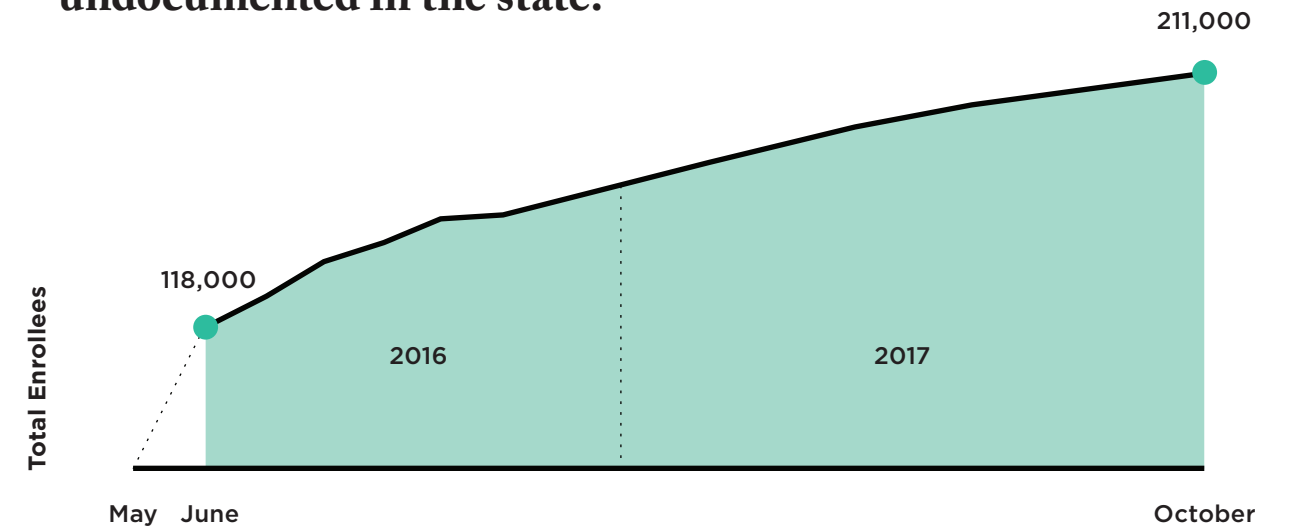
GRADE: A

Quality affordable health insurance helps kids access timely, comprehensive health care, and supports their overall well-being. All California kids are now eligible for affordable health coverage through private insurance, or through Medi-Cal, a program which is the cornerstone of kids' health coverage and must be protected against federal cuts. Medi-Cal provides health coverage to 5.2 million California kids.



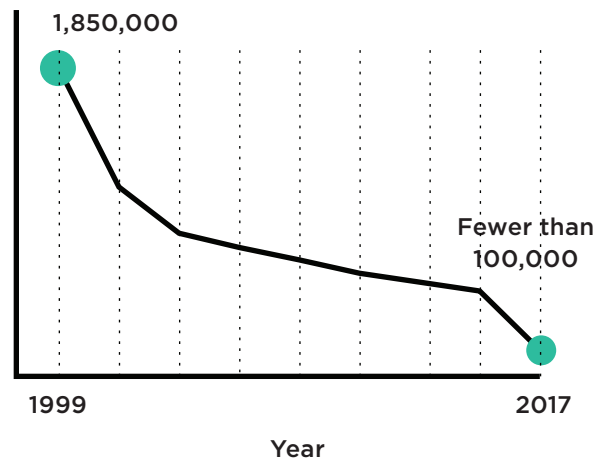
Health4AllKids expanded Medi-Cal to kids who are income-eligible and undocumented in the state.

Health4AllKids implementation has been a huge success. More than 200,000 children have enrolled since May 2016, when the law took effect.⁸



California is making steady progress toward ensuring all kids have health insurance.

Number of Uninsured Children in California^{1,2,3}



Kids covered by Medicaid experience a host of benefits.



do better in school and miss fewer days⁴



are more likely to graduate from high school and go to college⁵



have fewer emergency room & hospital visits as adults⁶



earn more money as adults⁷

Progress Report

California has made incredible progress toward ensuring affordable health coverage for every child, with nearly all California kids covered today. The successful implementation of Health4AllKids extended Medi-Cal to more than 200,000 kids who are undocumented. However, threats to federal funding for Medicaid, the Children's Health Insurance Program (CHIP), and the Covered California marketplace established by the Affordable Care Act may jeopardize the health coverage that the majority of California's kids depend upon.

Pro-Kid[®] Agenda

California policymakers should ensure that every single kid is enrolled in health coverage and is receiving comprehensive and consistent benefits across public and private insurance carriers, so that all families can access high-quality, affordable care for their kids. In the near-term, the California Department of Health Care Services should work to enroll all 100,000 eligible-but-currently-uninsured California kids in Medi-Cal. It is also critical to California kids' well-being that federal investments in Medicaid, the CHIP, and Covered California remain strong.

Health Care Access & Coordination

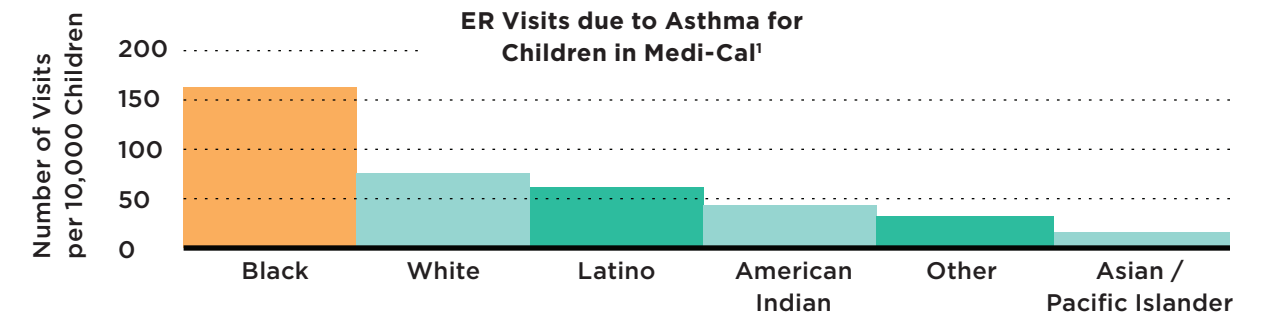
GRADE: C-

Accessible, quality health care and seamless care coordination are critical to achieving positive health outcomes for children and to promoting efficient care through prevention, early detection and disease management. Care coordination is especially critical for children with special health care needs.



Due to poor access, more kids end up in the ER for chronic health conditions, like asthma.

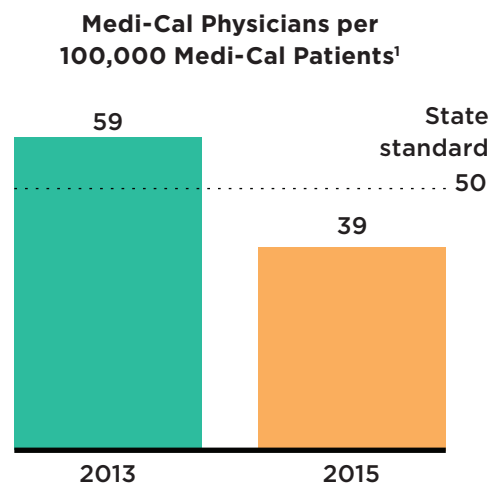
Children who lack access to quality preventive care resort to using emergency services. Large racial disparities exist in accessing healthcare.³ For example, children who are Black were eight times more likely than children who are Asian/Pacific Islander to visit the ER for asthma-related complications.



Nearly half of California kids are covered by Medi-Cal, but there aren't enough doctors to ensure everyone is getting quality preventive care, and the problem is getting worse.

There are only 39 doctors who accept Medi-Cal for every 100,000 patients, which is well below the standards set by the state.

California provider reimbursement rates are well below the national average. **California ranks among the bottom 2 states for Medicaid provider rates.**



California only reimburses providers at 66% of the national average.²



Progress Report

Though most California kids have health insurance, access to timely and coordinated care continues to be a challenge. While the California Department of Health Care Services has elevated concerns about kids' access to health care, more must be done to ensure that kids can access appointments in a timely way, preventive care and services are readily available, and health plans and providers are held accountable for delivering quality care.

Pro-Kid® Agenda

California policymakers must collect and report data on kids' access to care; increase public insurance program funding; establish robust provider network standards on serving kids; promote quality improvement of health care services delivery; and address language access, transportation, and regional provider shortages that exacerbate racial and socioeconomic disparities. In the near-term, the California Department of Health Care Services should implement state and federal regulations to increase transparency and accountability in Medicaid managed care services.

Mental Health & Building Resilience

GRADE: D+

Children need access to quality, affordable mental health care and supports that monitor and treat mental illness, help kids build positive relationships, assist kids who have experienced trauma, and give kids the ability to face typical stressors with resilience.



Traumatic events can lead to a lifetime of mental and physical health consequences.

Adverse Childhood Experiences (ACEs) are physical, emotional, or social events that are stressful or traumatic. **Of California children, 42% experience one or more ACE.**³ Proper treatment and support for these children can help build resilience.

Examples of Adverse Childhood Experiences include:



abuse



neglect



incarcerated relative

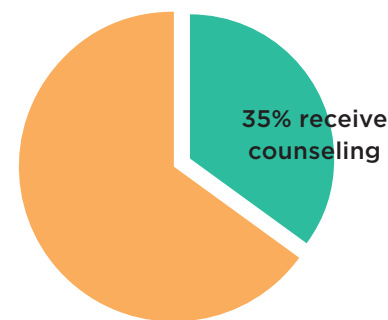


household dysfunction

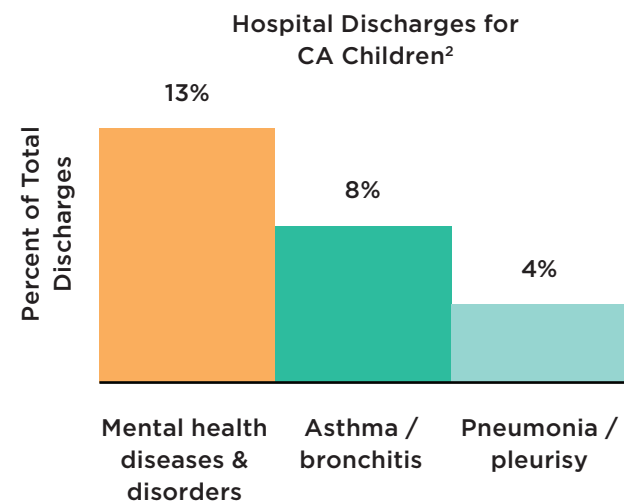
California kids aren't getting the mental health services they need.

Only 35% of California children who reported needing help for emotional or mental health problems received counseling.

All Children Who Report Needing Mental Health Care¹



Mental illness is the #1 reason California kids are hospitalized.



Progress Report

California's current patchworks of kids' mental health and trauma services are deficit-based, often built for adults, and under-resourced to address the level of need. Efforts to build awareness of childhood trauma, improve school climate and teacher training to support student wellness, and increase screening and referral for mental health and trauma services are moving California in the right direction, but more must be done to develop a system of care that meets kids' needs.

Pro-Kid[®] Agenda

California policymakers should increase access to mental and behavioral health services for all kids that need them, especially for those who have experienced trauma. Additionally, policymakers should reform the Medi-Cal mental health system, improve coordination between physical and mental health care, and expand the reach of school-based mental health services so that mental health screenings and basic services are provided at all early education and TK-12 sites.

Oral Health Care

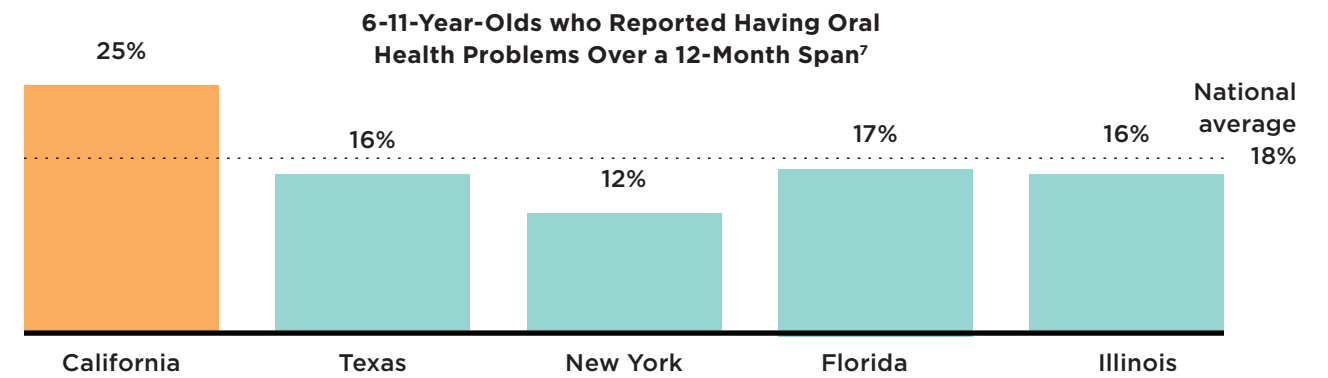
GRADE: C-

Tooth decay is the most common chronic illness among children.¹ Timely preventive dental services and treatment are essential to pregnant women's and children's overall health. Denti-Cal provides coverage for 5.2 million California children,² yet few of these children receive the services they need.



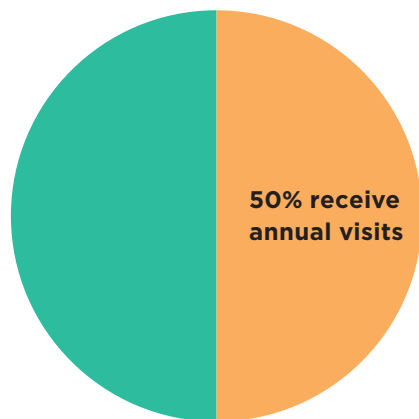
While cavities, tooth decay, and associated tooth pain are nearly 100% preventable, poor oral health is one of the leading causes of school absences.⁶

California has the second worst rate in the nation when it comes to oral health problems in elementary aged children.



Kids are not receiving the recommended annual dental visits.

All Children 0-20 on Denti-Cal^{3,4}



Oral health affects kids' overall health and academic success.

When oral health problems go untreated, children are at risk for experiencing negative academic, physical, and social-emotional consequences.⁵

- increased absences
- lower grades
- low self-esteem
- trouble sleeping
- difficulty eating
- weakened immune system

Progress Report

Little progress has been made to improve oral health outcomes for kids enrolled in Medi-Cal, who make up more than half of California's kids. The Dental Transformation Initiative, an effort by the California Department of Health Care Services, supports local pilot projects aimed at increasing access to preventive services and creating sustainable systems of care for kids in their communities. Also, a state oral health plan being implemented by local health departments includes the collection and reporting of kindergarteners' oral health status, which could help improve outcomes.

Pro-Kid[®] Agenda

California policymakers should ensure all kids have access to timely dental care and should invest in preventive services to treat kids where they are, including screenings in schools and early learning programs that can identify problems and refer kids to dental providers for treatment. Policymakers should also monitor promising local models like data-sharing agreements between a kid's doctor and dentist, using community health workers to help parents and caregivers make and keep appointments, and using virtual dental homes to bring care to areas where there is limited access.

School-Based Health Services

GRADE: D+

Children with access to school-based health services are more likely to receive health care and do better in school.¹ Services range from primary care and mental health, oral and vision screenings, to full-scale school-based health centers.



Only 2% of California schools have school-based health centers (SBHCs).^{5,6}

Children with access to SBHCs are more likely to receive critical physical and mental health services.

SBHCs offer the following services:



The American Academy of Pediatrics recommends one nurse per school, but California is far from hitting that goal.

CA Needs More Nurses for its Students^{2,3}

6,228,235

TK-12 students

10,477

schools

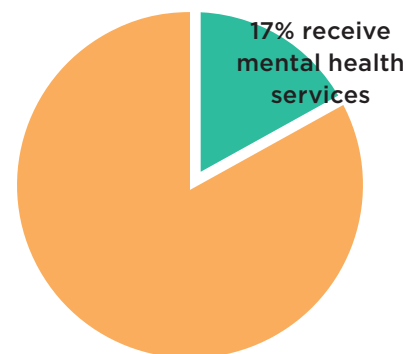
2,630

nurses

Kids are not receiving the mental health care they need as part of their Individualized Education Plans (IEPs).

About 700,000 California children have a serious mental or behavioral health need, but only approximately 17% receive therapy or counseling as part of their IEPs.

Children with Serious Mental or Behavioral Health Needs⁴



Progress Report

California has seen slow growth in school-based health services, and the state as a whole has failed to invest sufficient public resources in prioritizing care for students. Bright spots include passage of SB 379 (Atkins), which will strengthen the kindergarten oral health assessment process, and a limited (\$30 million) state budget investment in the Scale-Up Multi-Tiered System of Support Statewide Initiative, which helps local educational agencies implement comprehensive tiered systems of support to address students' mental health, academic, behavioral, and social-emotional needs. A state-funded Los Angeles County pilot program to provide Medi-Cal-enrolled students with mobile vision services at their school site is also showing promising results.

Pro-Kid[®] Agenda

California policymakers should provide more school-based health services and increase the number of school-based health centers so that more kids are able to access physical, mental, vision, and dental health services at their schools. This will improve kids' well-being, increase their access to preventive care and lighten the load for families. In the near-term, the California Departments of Education and Health Care Services should work together to streamline financing for school districts that want to provide health care services to their students.

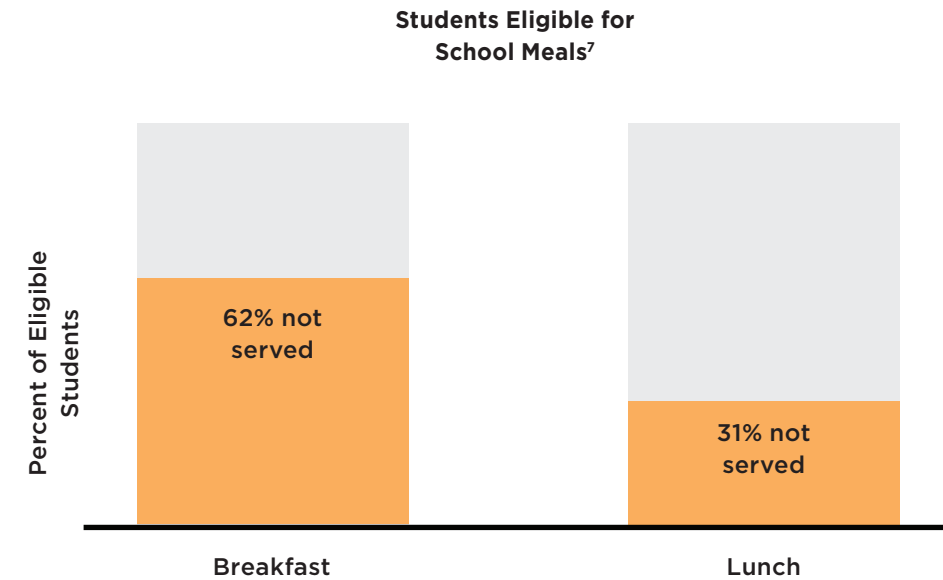
Food Security

GRADE: C-

Children who are food insecure may go to bed hungry. Food insecurity is paradoxically related to both hunger and obesity.¹ Children who are food insecure are more likely to develop serious and costly health conditions.^{2,3}



For many kids, free and reduced-price school meals provide them with the food they need to make it through each day, yet these meals aren't reaching all eligible kids.



More than 20% of California's kids are food insecure.⁴

Children who are food insecure are more likely to:⁵

repeat a grade in elementary school



experience developmental delays

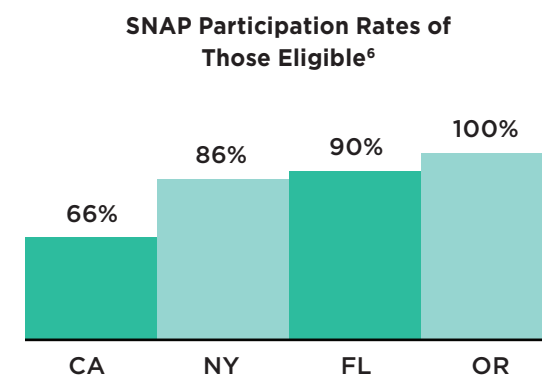


have more social and behavioral problems



California ranks among the bottom of the 50 states in federal Supplemental Nutrition Assistance Program (SNAP) participation.

CalFresh, California's SNAP, helps families afford the food they need, yet many eligible families are not enrolled.



Progress Report

California is not doing enough to ensure that kids have access to healthy food. The state has demonstrated the importance of improving school meal and CalFresh participation rates by reaching out to Medi-Cal participants and streamlining their enrollment in nutrition programs. However, participation rates are still very low, with too few kids and families served by nutrition assistance programs, federal funding left on the table, and missed opportunities to bolster kids' well-being.

Pro-Kid[®] Agenda

California's policymakers should do whatever it takes to increase our state's low participation rates in child and family nutrition support programs. Policymakers should also focus on increasing access to healthy food choices for kids in and out of school, and supporting kids' physical activity. In the near-term, policymakers should reduce the consumption of sugar-sweetened beverages by implementing a statewide soda tax.

Child Abuse & Neglect Prevention

GRADE: D

Child abuse and neglect present serious threats to children's well-being. Providing prevention services, such as home visiting, can help prevent child maltreatment.¹



Programs that support parents and caregivers can help prevent child abuse and neglect.

For example, voluntary home visiting programs match new and expectant parents with trained staff who provide one-on-one support and education during the critical early years. Home visiting programs reinforce parent-child relationships, equip parents to nurture children's health and learning, and can have a positive impact on children.

Home visiting reduces:



child maltreatment⁵



later juvenile justice involvement⁶



family violence⁷

Home visiting improves:



school readiness⁸



maternal & child health⁹



family economic self-sufficiency¹⁰

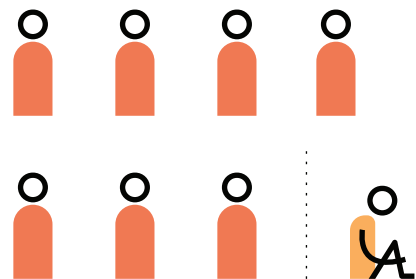
Too many kids are victims of maltreatment.

In the US, 1 in 100 children are confirmed victims of child abuse and neglect each year.²

Kids who die from abuse and neglect are overwhelmingly very young.

Child abuse and neglect can be fatal, especially for young children⁴

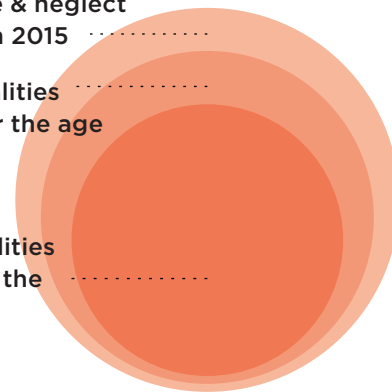
1 in 8 U.S. children will be a victim of maltreatment by age 18³



1,585 child fatalities from abuse & neglect in the US in 2015

75% of fatalities were under the age of 3

50% of fatalities were under the age of 1



Progress Report

The kids and youth of California deserve a more robust system of abuse and neglect prevention, including targeted support services for kids and families at risk of abuse and neglect. For example, home visiting programs have shown to reduce the occurrence of child maltreatment, yet fewer than three percent of kids receive home visiting services.^{11,12}

Pro-Kid[®] Agenda

California policymakers must support a statewide prevention program for kids at risk of abuse and neglect. The program should support families, promote prevention services, keep kids safe from maltreatment, expand early identification and intervention services and, when possible, work to keep kids and families together.

Placement Stability & Permanent Connections

GRADE: C

A child that has a stable placement or finds a permanent home, through reunification with parents, guardianship or adoption, is more likely to receive the services and supports they need to heal and thrive.



Placement instability has adverse consequences for kids in foster care.

Different factors can contribute to the stability or instability of a placement, including how prepared foster families are to care for children in foster care and the effectiveness of matching foster families with children and youth.³

Multiple placement changes can negatively impact:⁴



ability to form healthy relationships



mental health and brain development



academic achievement

Too many kids in foster care experience frequent placement changes, adding to their trauma.

Providing more training and supports for foster parents as well as improving children in foster care's access to services in home-based settings can improve placement stability for children.

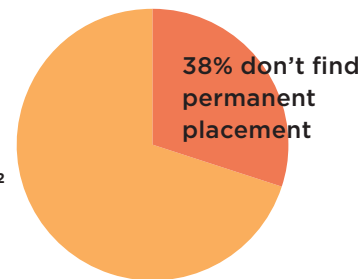
3+ Nearly 28% of children in foster care for 12 months or longer experience 3 or more placement moves.¹



Too few kids in foster care exit to a permanent home.

Caregivers need services such as child care, social support, and ongoing therapeutic assistance to make permanency possible and successful.

Percent of children in foster care who don't find permanent placement within 12 months of care.²



Progress Report

The state is implementing Continuum of Care Reform (CCR) to reduce the number of youth in institutional care and to ensure stable family placements for kids in foster care. To this end, the state is initiating many new efforts like the Emergency Child Care Bridge Program for Foster Children and Parenting Foster Youth. Included in the 2017-18 state budget, this innovative program addresses a huge barrier to stability: access to affordable child care. The state must promote more creative, targeted approaches like this in order to stabilize placements for kids in foster care, particularly for older kids, who have a more difficult time securing stable placement.

Pro-Kid[®] Agenda

California policymakers must ensure caregivers receive support and kids in foster care receive the services they need to thrive in a family setting, and should develop and implement policies to minimize both placement instability and youth institutionalization. The California Department of Social Services must carefully implement CCR to develop an improved system of supports and services and monitor outcomes for our state's kids in foster care.

Health Care for Kids in Foster Care

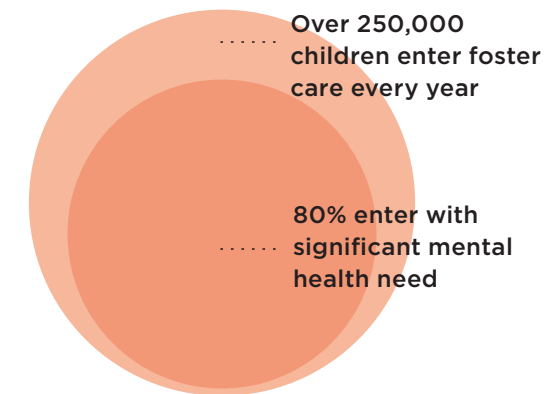
GRADE: C-

Children in foster care have experienced abuse, neglect, and other traumas, which can cause serious, ongoing physical and mental health difficulties.¹ Yet, there are barriers to accessing needed services, including lack of trauma-informed providers and limited availability.



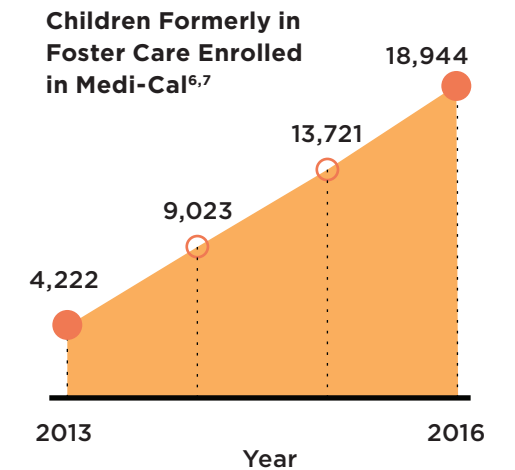
Many kids in foster care need mental health services to heal from trauma.

Percent of Children in Foster Care With a Significant Mental Health Need^{4,5}



Health coverage helps ensure critical supports for kids aging out of care.

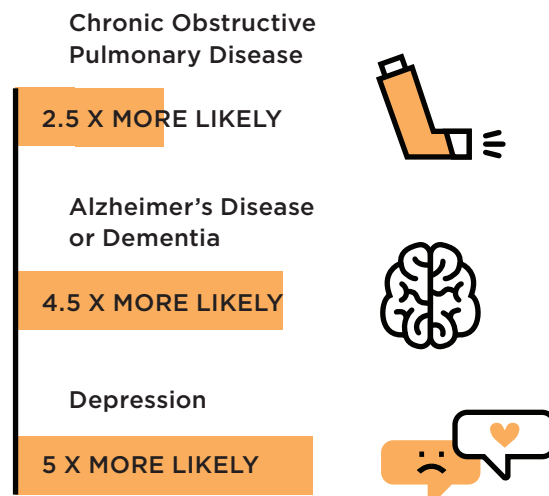
The number of children formerly in foster care covered by Medi-Cal until age 26 has more than quadrupled since the Affordable Care Act took effect.



Half of kids in foster care have endured four or more adverse childhood experiences.²

Adverse Childhood Experiences (ACEs) negatively impact the mental and physical health of youth in foster care. Children who endure multiple ACEs are more likely to develop negative health behaviors, chronic diseases, and depression in adulthood.

An adult with four or more Adverse Childhood Experiences is more likely to suffer from:³



Progress Report

Kids formerly in foster care have increased access to health care due to ACA outreach and policy implementation efforts, but more work is needed to ensure kids receive timely, coordinated services while in foster care. Continuum of Care Reform and recent changes in state law provide an opportunity to improve timely access to mental health services for kids in foster care living in family settings, including kids who move across county lines.

Pro-Kid[®] Agenda

California policymakers should ensure that kids in foster care—who may experience a myriad of health difficulties due to their past trauma—have appropriate access to comprehensive health care, including the mental health services they need to heal from trauma. In the near-term, policymakers should increase state oversight and accountability to ensure kids in foster care have timely access to the full continuum of physical, mental, and oral health services.

Education Support for Students in Foster Care

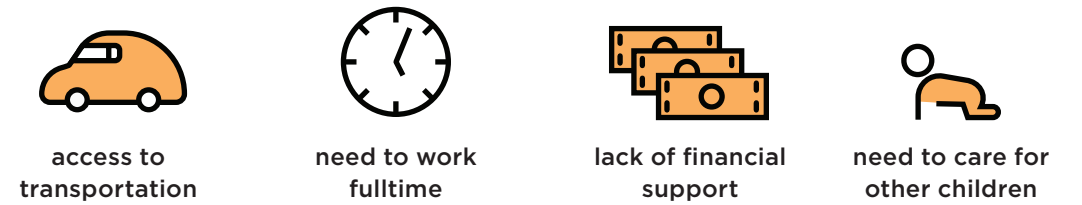
GRADE: D+

Due to multiple moves and school changes, missed school days, and trauma, youth in foster care face unique challenges to academic achievement. Targeted services and supports can help youth in care succeed in school and prepare for college and career attainment.



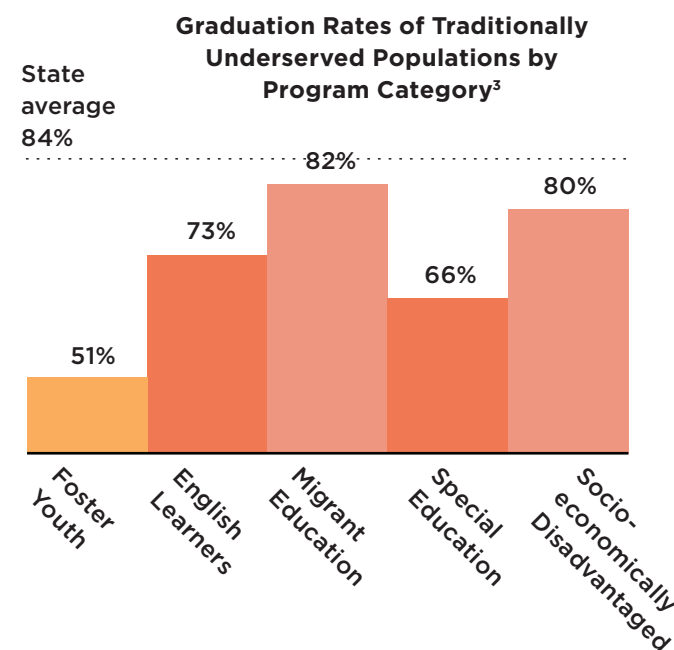
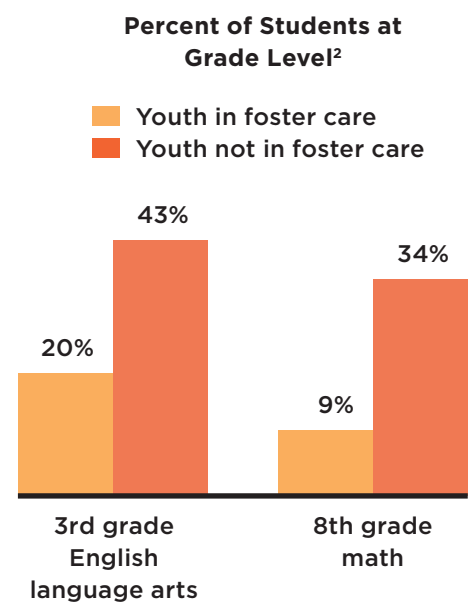
While 80% of kids in foster care want a college degree, due to many barriers, only 24% actually enroll.⁴

Top Barriers to Enrollment for Youth in Foster Care⁵



School transitions and trauma cause students in foster care to struggle to stay on track in school and graduate on time.

Students in foster care change public schools an average of 3.5 times during the first four years of high school.¹



Progress Report

The California Department of Education now releases academic achievement data for kids in foster care. This newly accessible data will ensure that the key levers of the Local Control Funding Formula (California’s new school finance system)—transparency, targeted support, and accountability—will result in more attention and support for kids in foster care, a traditionally underserved population.

Pro-Kid[®] Agenda

California policymakers must ensure that kids in foster care, who face unique educational barriers related to school instability, and trauma that can impair their ability to focus, receive the supports they need to succeed in school. In the near-term, policymakers can ensure that the new school finance system benefits students in foster care as intended, by keeping schools accountable to their success.

Youth Justice

GRADE: D

Due to systemic inequities and racial bias, there is disproportionate representation of children of color and youth with child welfare involvement in the juvenile justice system.¹ Incarceration can often retraumatize youth, further jeopardizing their health and future success.²



Juvenile justice systems must become trauma-informed to help youth improve their outcomes.

Youth who are incarcerated with unaddressed trauma can be traumatized further. Outcomes for youth in the juvenile justice system can be improved if efforts to screen, assess, treat, and prevent trauma are instituted.

Youth who are incarcerated are more likely to:⁵



suffer from depression



not further their education



have suicidal thoughts

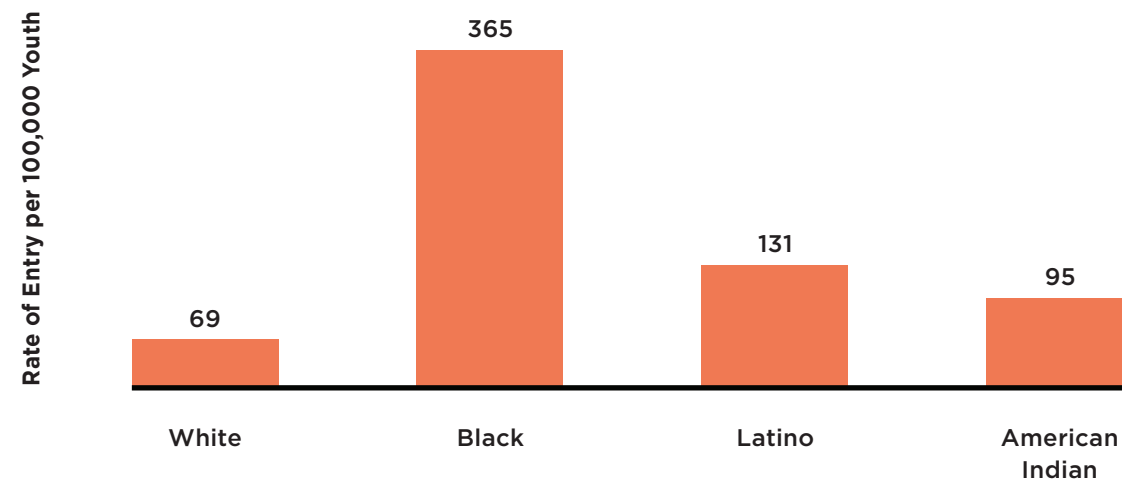


be incarcerated as adults

Youth of color are over-represented in the juvenile justice system.

Systemic racial, and other inequities persist in the juvenile justice system resulting in disproportionate treatment for children of color for the same crimes committed by children who are White, from arrest through incarceration.³

Rate of Entry into the CA Juvenile Justice System⁴



Progress Report

While California’s juvenile justice system is intended to rehabilitate youth, too often youth are only punished and retraumatized. Many youth enter the juvenile justice system having a prior history of trauma and involvement with the child welfare system; research shows that the juvenile justice system exposes them to further trauma.⁶ Later health outcomes are also impacted, with youth who were formerly incarcerated demonstrating worse physical and mental health in adulthood compared to adults with no prior juvenile justice system involvement.

Pro-Kid[®] Agenda

California policymakers should incentivize evidence-driven investments and increase oversight of juvenile justice agencies. Trauma-responsive justice systems grounded in adolescent development yield better outcomes for youth, reduce racial inequities and increase public safety more effectively than punishment alone.

Endnotes

Demographics

- 1 Kids Count Data Center (2016). Child population by age group, 2016. Retrieved on December 5, 2017, from <http://datacenter.kidscount.org>
- 2 Kids Count Data Center (2016). Child population by race, 2016. Retrieved on December 5, 2017, from <http://datacenter.kidscount.org>
- 3 Ibid, 1.
- 4 Kids Count Data Center (2016). Children below 200 percent poverty, 2016. Retrieved on December 5, 2017, from <http://datacenter.kidscount.org>
- 5 Kids Count Data Center (2016). Children in poverty (100 percent poverty), 2016. Retrieved on December 5, 2017, from <http://datacenter.kidscount.org>
- 6 Feeding America (2017). Map the Meal Gap 2017: Child Food Insecurity in California by County in 2015. Retrieved from http://www.feedingamerica.org/research/map-the-meal-gap/2015/MMG_AllCounties_CDs_CFI_2015_1/CA_AllCounties_CDs_CFI_2015.pdf
- 7 Kids Count Data Center (2015). Children in immigrant families, 2015. Retrieved on December 5, 2017, from <http://datacenter.kidscount.org>
- 8 California Department of Education (2017). Facts about English Learners in California- CalEdFacts. Retrieved from <https://www.cde.ca.gov/ds/sd/cb/cefelfacts.asp>
- 9 California Department of Health Care Services (2017). Medi-Cal Statistical Brief: Medi-Cal's Children's Health Insurance Program (CHIP) Population. Retrieved from http://www.dhcs.ca.gov/dataandstats/statistics/Pages/RASD_Statistical_Briefs.aspx
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Infant & Toddler Care

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Credits

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AGENDA ITEM 3

Information

March 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 calendar, and other matters relating to the ongoing work of the Commission.

Presenter: Toby Ewing, Executive Director

Enclosures: (1) The Motions Summary from the February 22, 2018 Commission Meeting; (2) Evaluation Dashboard; (3) Calendar of Commission activities; (4) Innovation Review Outline; (5) Innovation Dashboard; and (6) Department of Health Care Services Revenue and Expenditure Reports status update

Handout: None

Recommended Action: Information item only



Motions Summary

**Commission Meeting
February 22, 2018**

Motion #: 1

Date: February 22, 2018

Time: 10:03 AM

Proposed Motion:

The Commission approves the January 25, 2018 Meeting Minutes.

Commissioner making motion: Vice-chair Aslami-Tamplen

Commissioner seconding motion: Commissioner Mitchell

Motion carried 5 yes, 0 no, and 2 abstain, per roll call vote as follows:

Name	Yes	No	Abstain
1. Commissioner Alvarez	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Commissioner Anthony	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Commissioner Ashbeck	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Commissioner Beall	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Commissioner Brown	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Commissioner Bunch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Commissioner Carrillo	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Commissioner Danovitch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Commissioner Gordon	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Commissioner Madrigal-Weiss	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Commissioner Mitchell	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Commissioner Poaster	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Commissioner Wooton	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Vice-Chair Aslami-Tamplen	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Chair Boyd	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



Motion #: 2

Date: February 22, 2018

Time: 12:36 PM

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

Commissioner making motion: Commissioner Alvarez

Commissioner seconding motion: Commissioner Madrigal-Weiss

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

Name	Yes	No	Abstain
1. Commissioner Alvarez	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Commissioner Anthony	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Commissioner Ashbeck	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Commissioner Beall	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Commissioner Brown	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Commissioner Bunch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Commissioner Carrillo	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Commissioner Danovitch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Commissioner Gordon	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Commissioner Madrigal-Weiss	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Commissioner Mitchell	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Commissioner Poaster	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Commissioner Wooton	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Vice-Chair Aslami-Tamplen	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Chair Boyd	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



Motion #: 3

Date: February 22, 2018

Time: 1:12 PM

Proposed Motion: The MHSOAC approves the following Kern County’s Innovation plan and requests that the County provide a written status update in six months:

Name: The Healing Project
Amount: \$14,685,510
Project Length: Five (5) Years

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

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

Name	Yes	No	Abstain
1. Commissioner Alvarez	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Commissioner Anthony	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Commissioner Ashbeck	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Commissioner Beall	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Commissioner Brown	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Commissioner Bunch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Commissioner Carrillo	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Commissioner Danovitch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Commissioner Gordon	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Commissioner Madrigal-Weiss	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Commissioner Mitchell	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Commissioner Poaster	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Commissioner Wooton	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Vice-Chair Aslami-Tamplen	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Chair Boyd	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



Motion #: 4

Date: February 22, 2018

Time: 1:21 PM

Proposed Motion:

The MHSOAC supports Assembly Bill 2325 (Irwin) and authorizes the Executive Director to communicate the Commission’s support.

Commissioner making motion: Vice-chair Aslami-Tamplen

Commissioner seconding motion: Commissioner Alvarez

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

Name	Yes	No	Abstain
1. Commissioner Alvarez	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Commissioner Anthony	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Commissioner Ashbeck	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Commissioner Beall	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Commissioner Brown	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Commissioner Bunch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Commissioner Carrillo	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Commissioner Danovitch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Commissioner Gordon	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Commissioner Madrigal-Weiss	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Commissioner Mitchell	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Commissioner Poaster	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Commissioner Wooton	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Vice-Chair Aslami-Tamplen	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Chair Boyd	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



Motion #: 5

Date: February 22, 2018

Time: 3:36 PM

Proposed Motion:

The MHSOAC agrees to sponsor Senate Bill 1019 (Beall) and authorizes the Executive Director to engage with Senator Beall around options to provide flexibility to the Commission regarding age and percentage of funding. The Executive Director is to work with the Chair regarding specific language and update the Commission, as needed, as the bill evolves.

Commissioner making motion: Vice-chair Aslami-Tamplen

Commissioner seconding motion: Commissioner Alvarez

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

Name	Yes	No	Abstain
1. Commissioner Alvarez	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Commissioner Anthony	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Commissioner Ashbeck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Commissioner Beall	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Commissioner Brown	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Commissioner Bunch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Commissioner Carrillo	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Commissioner Danovitch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Commissioner Gordon	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Commissioner Madrigal-Weiss	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Commissioner Mitchell	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Commissioner Poaster	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Commissioner Wooton	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Vice-Chair Aslami-Tamplen	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Chair Boyd	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



Motion #: 6

Date: February 22, 2018

Time:

Proposed Motion:

The Commission authorizes the Executive Director to enter into a contract for \$150,000 to develop a business plan for an Innovation Incubator.

Commissioner making motion: Commissioner Alvarez

Commissioner seconding motion: Commissioner Mitchell

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

Name	Yes	No	Abstain
1. Commissioner Alvarez	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Commissioner Anthony	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Commissioner Ashbeck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Commissioner Beall	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Commissioner Brown	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Commissioner Bunch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Commissioner Carrillo	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Commissioner Danovitch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Commissioner Gordon	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Commissioner Madrigal-Weiss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Commissioner Mitchell	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Commissioner Poaster	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Commissioner Wooton	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Vice-Chair Aslami-Tamplen	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Chair Boyd	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

MHSOAC Evaluation Dashboard

Summary: The Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission) Evaluation Dashboard assists in monitoring the major evaluation efforts currently underway. The Evaluation Dashboard provides information, objectives, and the status of all current deliverables for internal and external evaluation contracts and projects. Below is a list of all changes/updates to all evaluation projects, which are highlighted in red within the Dashboard.

Changes/Updates:

External Evaluation Contracts

- **DOJ Criminal Data Linkage & Analysis** *Mental Health Data Alliance*
Update: Deliverables 3.1-4 were added with status "In Progress."
- **CSI & DCR Data Analysis & Standardize Reporting** *Mental Health Data Alliance*
Update: Deliverable 2.2-2.10 and 2.11 statuses changed to complete. The total spent is equal to total contract amount.
- **Visualization Configuration & Publication Support Services** *The iFish Group*
Update: Total spent increased.

Enclosures: MHSOAC Evaluation Dashboard

Recommended Action: None

Presenter: None

Motion: None

MHSOAC Evaluation Dashboard March 2018

(updated 3/09/18)



Current MHSOAC Evaluation Contracts & Deliverables

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

Deliverables		October 2017 – June 2018					
1	Statewide Criminal Justice Data Linkage Report	11/14/17					
2.1	County Participation Confirmation Report		11/30/17				
3.1	Evaluation Report of Longitudinal Criminal Justice Involvement among FSP Clients			06/01/18			
3.2	FSP Client Self-report Arrest Data Validation Report				06/01/18		
3.3	CSI Duplicative Client Record Study Report					06/01/18	
4	Monthly Review and Approval of Agile Deliverables						03/18-05/18

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 March 2018

(updated 3/09/18)



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: **\$149,980**

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

Deliverables		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 March 2018

(updated 3/09/18)



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

Deliverables		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 March 2018

(updated 3/09/18)



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

Deliverables		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

2018 Commission Meeting Dates

January 25th Sacramento Office of Education, Mather, CA
February 22nd MHSOAC, Sacramento, CA
March 22nd MHSOAC, Sacramento, CA
April 26th Anaheim, CA
May 24th MHSOAC, Sacramento, CA
July 26th Santa Barbara (tentative)
August 23rd Sacramento, CA (tentative)
September 27th Los Angeles, CA (tentative)
October 25th Mono County (tentative)
November 15th Sacramento, CA (tentative)



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



INNOVATION DASHBOARD
March 2018

INN Proposals to be CALENDARED:

TOTAL # of DRAFT INN PROPOSALS RECEIVED	# of COUNTIES THAT SUBMITTED	TOTAL INN AMOUNT REQUESTED
9	7	\$17,479,185

INN Concepts being DEVELOPED:

TOTAL # of INNOVATIVE CONCEPTS RECEIVED	# of COUNTIES THAT SUBMITTED	TOTAL INN AMOUNT REQUESTED
13	6	\$42,200,000

APPROVED INNOVATION PLANS-FIVE (5) FISCAL YEARS



2017-2018

- Total INN Dollars : **\$88,557,465**
- Total INN Extensions: \$5,172,606
- Total # of Projects: 21
- **# of Counties Submitted: 10**

2014-2015

- Total INN Dollars : **\$127,742,348**
- Total INN Extensions: \$1,111,054
- Total # of Projects: 26
- **# of Counties Submitted: 16**

2016-2017

- Total INN Dollars : **\$66,347,688**
- Total INN Extensions: \$2,008,608
- Total # of Projects: 27
- **# of Counties Submitted: 18**

2013-2014

- Total INN Dollars : **\$7,867,712**
- Total INN Extensions: \$0.00
- Total # of Projects: 14
- **# of Counties Submitted: 8**

2015-2016

- Total INN Dollars : **\$46,920,919**
- Total INN Extensions: \$5,587,378
- Total # of Projects: 17
- **# of Counties Submitted: 15**

Fifty-two (52) Counties have presented an INN Plan to the Commission since 2013= **88%**

*Seven (7) Counties have NOT presented an INN Plan to the Commission since 2013= **12%**

Agenda Item 3, Enclosure 8: DHCS Status Chart of County RERs Received
March 22, 2018 Commission Meeting

Attached below is a Status Report from the Department of Health Care Services regarding County MHSA Annual Revenue and Expenditure Reports received and processed by Department staff, dated March 12th, 2018.

This Status Report covers the FY 2012-13 through FY 2016-17 County RERs.

For each reporting period, the Status Report provides a date received by the Department of the County's RER and a date on which Department staff completed their "Final Review."

The Department provides MHSOAC staff with weekly status updates of County RERs received, processed, and forwarded to the MHSOAC. MHSOAC staff process data from County RERs for inclusion in the Fiscal Reporting Tool only after the Department determines that it has completed its Final Review.

The Department also publishes on its website a web page providing access to County RERs. This page includes links to individual County RERs for reporting years FY 2006-07 through FY 2015-16. This page can be accessed at <http://www.dhcs.ca.gov/services/MH/Pages/Annual-Revenue-and-Expenditure-Reports-by-County.aspx>

Counties also are required to submit RERs directly to the MHSOAC. The Commission provides access to these reports through its Fiscal Reporting Tool at <http://mhsoac.ca.gov/fiscal-reporting> and a data reporting page at http://mhsoac.ca.gov/documents?field_county_value=All&date_filter%5Bvalue%5D%5Byear%5D=&field_component_tid=46.

Department of Health Care Services

County	FY 12-13			FY 13-14			FY 14-15		
	Electronic Copy Submission Date	Return to County Date	Final Review Completion Date	Electronic Copy Submission Date	Return to County Date	Final Review Completion Date	Electronic Copy Submission Date	Return to County Date	Final Review Completion Date
Alameda	1/4/2015		1/6/2015	1/10/2017		1/5/2017	9/14/2017		9/29/2017
Alpine	9/12/2016		9/13/2016	9/12/2016		9/13/2016	6/26/2017		6/26/2017
Amador	10/30/2015		9/9/2016	9/8/2016		3/27/2017	3/27/2017		3/27/2017
Berkeley City	7/6/2015		7/17/2015	4/18/2016		5/2/2016	5/2/2016		7/26/2016
Butte	4/10/2015		4/13/2015	3/7/2016		3/7/2016	4/4/2016		6/23/2016
Calaveras	12/1/2015		12/1/2015	12/18/2015		1/19/2016	1/4/2016		1/13/2016
Colusa	3/27/2015		8/4/2015	11/16/2015		11/16/2015	1/8/2016		2/10/2016
Contra Costa	4/13/2015		4/14/2015	3/8/2016		3/14/2016	3/8/2016		3/14/2016
Del Norte	4/1/2015		4/15/2015	11/2/2015		1/4/2016	5/13/2016		5/16/2016
El Dorado	4/1/2015		4/7/2015	12/15/2015		8/29/2016	2/9/2016		2/11/2016
Fresno	3/25/2015		4/21/2015	10/30/2015		11/12/2015	12/14/2015		12/18/2015
Glenn	4/30/2015		5/1/2015	10/30/2015		11/4/2015	3/17/2016		3/24/2016
Humboldt	2/10/2015		4/8/2015	6/3/2016		6/6/2016	9/30/2016		10/3/2016
Imperial	4/1/2015		4/8/2015	10/28/2015		11/3/2015	12/31/2015		1/4/2016
Inyo	5/29/2015		6/29/2015	11/19/2015		12/5/2015	2/24/2016		2/24/2016
Kern	3/27/2015		4/2/2015	11/12/2015		11/12/2015	10/31/2016		10/31/2016
Kings	4/17/2015		6/5/2015	4/7/2016		7/26/2016	4/7/2016		5/2/2017
Lake	1/31/2018		1/31/2018	2/12/2018		2/12/2018			
Lassen	3/30/2015		7/27/2015	11/1/2015		12/16/2015	9/21/2016		9/29/2016
Los Angeles	5/6/2015		7/29/2015	10/17/2016		10/19/2016	4/20/2017		4/21/2017
Madera	4/1/2015		11/8/2016	11/13/2016		12/7/2016	12/6/2016		12/7/2016
Marin	3/11/2015		3/12/2015	9/6/2016		9/6/2016	10/21/2016		10/21/2016
Mariposa	6/26/2015		6/29/2015	9/23/2016		9/23/2016	9/23/2016		9/28/2016
Mendocino	5/1/2015		5/1/2015	10/28/2015		10/28/2015	5/31/2017		5/31/2017
Merced	5/9/2015		10/15/2015	10/20/2015		10/21/2015	3/28/2017		3/29/2017
Modoc	3/11/2015		3/12/2015	10/27/2015		11/10/2015	3/24/2016		3/25/2016
Mono	5/1/2015		6/2/2015	3/30/2016		4/4/2016	3/30/2016		4/6/2016
Monterey	4/27/2015		5/6/2015	10/20/2017		10/23/2017			
Napa	6/17/2015		8/25/2017	8/18/2017		8/25/2017	8/18/2017		8/25/2017
Nevada	4/1/2015		4/2/2015	11/3/2015		11/23/2015			
Orange	4/1/2015		4/7/2015	10/29/2015		10/5/2016	12/30/2015		12/30/2015
Placer	4/1/2015		12/16/2017	10/4/2016		10/5/2016	11/15/2016		11/17/2016
Plumas	11/3/2015		11/3/2015	4/10/2017		4/10/2017	6/8/2017		6/23/2017
Riverside	4/1/2015		4/6/2015	10/30/2015		11/2/2015	5/12/2017		5/15/2017
Sacramento	12/11/2015		12/11/2015	9/21/2016		9/21/2016	5/8/2017		5/8/2017
San Benito	4/8/2015		4/14/2015	4/18/2016		4/19/2016	10/24/2016		3/8/2016
San Bernardino	4/1/2015		4/14/2015	11/17/2015		11/17/2015	5/19/2016		5/19/2016
San Diego	4/8/2015		4/8/2015	12/2/2015		9/28/2016	12/18/2015		5/26/2017
San Francisco	4/17/2015		4/21/2014	10/30/2015		11/2/2015	3/4/2016		3/4/2016
San Joaquin	4/2/2015		4/7/2015	11/10/2016		11/10/2016	6/8/2017		6/13/2017
San Luis Obispo	4/3/2015		4/6/2015	11/6/2015		9/29/2016	1/15/2016		1/15/2016
San Mateo	3/15/2016		3/17/2016	9/28/2016		10/3/2016	5/9/2017		5/9/2017
Santa Barbara	4/2/2015		5/8/2015	5/24/2017		5/24/2017	5/24/2017		6/20/2017
Santa Clara	4/18/2017		4/20/2017	4/18/2017		4/20/2017	5/5/2017		5/11/2017
Santa Cruz	4/2/2015		4/17/2014	3/18/2016		3/23/2016			
Shasta	10/29/2015		11/2/2015	10/29/2015		9/30/2014	10/7/2016		10/7/2016
Sierra	10/9/2015		11/2/2015	10/17/2016		10/18/2016	10/17/2016		10/17/2016
Siskiyou	10/30/2015		3/24/2017	6/30/2017		7/10/2017	6/30/2017		7/10/2017
Solano	4/1/2015		4/6/2015	10/29/2015		11/3/2015	12/29/2015		12/30/2015
Sonoma	12/18/2015		11/20/2016	12/6/2016		12/6/2016	4/10/2017		4/10/2017
Stanislaus	3/19/2015		4/3/2015	10/27/2015		10/28/2015	12/22/2015		12/22/2015
Sutter-Yuba	11/19/2015		12/22/2015						
Tehama	5/29/2015		6/19/2015	3/31/2016		4/4/2016	4/29/2016		5/11/2017
Tri-City	4/3/2015		4/16/2015	10/30/2015		2/3/2016	12/30/2015		2/3/2016
Trinity	10/9/2015		10/14/2015	3/23/2016		3/23/2016	9/19/2016		9/23/2016
Tulare	3/26/2015		6/9/2015	12/3/2015		12/3/2015	3/17/2016		3/22/2016
Tuolumne	4/1/2015		4/7/2015	10/26/2015		11/2/2015	12/23/2015		12/28/2015
Ventura	6/19/2015		6/30/2015	10/29/2015		11/3/2015	12/31/2015		1/4/2016
Yolo	4/2/2015		4/7/2015	6/16/2017		6/21/2017	6/21/2017		6/21/2017
Total	59		59	58		58	54		54

Current through 03/12/18

1 DHCS has had ongoing communication with county regarding submission.

Department of Health Care Services

County	FY 15-16			FY 16-17		
	Electronic Copy Submission Date	Return to County Date	Final Review Completion Date	Electronic Copy Submission Date	Return to County Date	Final Review Completion Date
Alameda	9/29/2017		1/3/2018	1/2/2018		1/3/2018
Alpine	11/22/2017		11/27/2017			
Amador	4/7/2017		4/10/2017			
Berkeley City	4/13/2017		4/13/2017	1/25/2018		2/1/2018
Butte	4/17/2017		4/18/2017			
Calaveras	4/18/2017		4/19/2017			
Colusa	5/17/2017		5/17/2017			
Contra Costa	4/17/2017		4/18/2017	12/29/2017	1/5/2018	1/24/2018
Del Norte	4/17/2017		5/19/2017	2/23/2018		2/26/2018
El Dorado	4/17/2017		4/19/2017	12/29/2017	1/5/2018	1/24/2018
Fresno	4/17/2017		4/18/2017	12/29/2017	1/8/2018	
Glenn	7/20/2017		7/20/2017	2/22/2018		2/22/2018
Humboldt	4/13/2017		4/18/2017	12/21/2017	1/3/2018	
Imperial	4/27/2017		4/27/2017	12/28/2017		1/9/2018
Inyo	5/9/2017		5/9/2017			
Kern	5/30/2017	1/16/2018 ¹	2/7/2018	1/30/2018		2/7/2018
Kings	5/2/2017		5/24/2017	1/29/2018		1/29/2018
Lake						
Lassen	5/18/2017		5/25/2017			
Los Angeles	1/31/2018		2/1/2018			
Madera	5/12/2017	1/4/2018 ¹				
Marin	5/10/2017		5/11/2017	1/31/2018		2/1/2018
Mariposa	5/18/2017		5/19/2017			
Mendocino	8/31/2017		8/31/2017			
Merced	7/21/2017		7/21/2017	2/1/2018		2/1/2018
Modoc	4/17/2017		4/19/2017			
Mono	4/25/2017		6/20/2017			
Monterey						
Napa	11/9/2017		11/13/2017			
Nevada						
Orange	12/27/2016		4/13/2017	12/29/2017	1/17/2018	1/25/2018
Placer	4/14/2017		4/18/2017	12/22/2017		1/23/2018
Plumas						
Riverside	6/9/2017		6/12/2017	12/29/2017	1/24/2018	1/25/2018
Sacramento	6/19/2017		6/20/2017	12/29/2017	1/24/2018	1/25/2018
San Benito	9/8/2017		9/12/2017			
San Bernardino	5/1/2017		5/1/2017			
San Diego	5/26/2017		5/26/2017			
San Francisco	7/5/2017		9/18/2017			
San Joaquin	10/3/2017		10/4/2017	12/29/2017	1/24/2018	1/25/2018
San Luis Obispo	5/12/2017		5/16/2017	2/15/2018		2/16/2018
San Mateo	10/10/2017		10/18/2017			
Santa Barbara	5/24/2017		6/20/2017	12/22/2017	1/22/2018	1/25/2018
Santa Clara	12/18/2017		1/4/2018			
Santa Cruz						
Shasta	4/14/2017		4/17/2017			
Sierra	8/16/2017	1/4/17 ¹				
Siskiyou	6/30/2017		7/10/2017			
Solano	3/23/2017		4/4/2017	12/28/2017	1/23/2018	1/25/2018
Sonoma	6/26/2017		6/27/2017			
Stanislaus	4/5/2017		4/5/2017			
Sutter-Yuba						
Tehama	5/8/2017		5/16/2017			
Tri-City	4/6/2017		4/6/2017	12/29/2017	1/24/2018	2/15/2018
Trinity	7/14/2017		7/14/2017	1/4/2018	1/4/2018	
Tulare	4/12/2017		4/12/2017	12/26/2017	1/22/2018	1/25/2018
Tuolumne	4/10/2017		5/18/2017	2/16/2018		3/1/2018
Ventura	4/14/2017		4/27/2017			
Yolo	3/9/2018		3/12/2018			
Total	53		51	25		22

Current through 03/12/18

1 DHCS has had ongoing communication with county regarding submission.

AGENDA ITEM 4

Action

March 22, 2018 Commission Meeting

California State Auditor's February 2018 Report on the Mental Health Services Act

Summary: The Commission will be presented with an overview regarding the State Auditor's February 2018 report on oversight of the Mental Health Services Act.

The overview provides background on the impetus for the State Auditor's report, a summary of key findings, and recommendations.

The Auditor's report including the responses to the audit report from DHCS, the Commission, and Alameda County Behavioral Health Care Services is on the State Auditor's website:

- <https://www.bsa.ca.gov/reports/2017-117/index.html>

Background

In June 2017 the Joint Legislative Audit Committee directed the State Auditor to conduct an audit on the oversight of the Mental Health Services Act (MHSA). This audit request was initiated by Senator Beall, a member of the Joint Legislative Audit Committee and of the Mental Health Services Oversight and Accountability Commission.

The audit request was, in part, a result of the Commission work on the MHSA fiscal reversion policy. A full copy of the April 2017 Reversion Report is on the Commission's website:

- <http://www.mhsoac.ca.gov/fiscal-reversion-0>

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

Enclosures: (1) Overview of the California State Auditor February 2018 Report: *Mental Health Services Act, The State Could Better Ensure the Effective Use Of Mental Health Services Act Funding*; (2) Audit: *Mental Health Services Act, The State Could Better Ensure the Effective Use of*

Mental Health Services Act Funding

Handouts (1): PowerPoint presentation will be available at the meeting.



Overview of the California State Auditor February 2018 Report:
*Mental Health Services Act, The State Could Better Ensure the Effective Use
Of Mental Health Services Act Funding*

INTRODUCTION

On February 27, 2018 the California State Auditor released a report on the Mental Health Services Act, “The State Could Better Ensure the Effective Use of Mental Health Services Act funding”. The report focuses on the responsibilities of the Department of Health Care Services and the Mental Health Services Oversight and Accountability Commission..

This overview provides a brief background on the impetus for the State Auditor’s report, a summary of key findings and recommendations related to the California Department of Health Care Services (DHCS) and the Commission, and discusses next steps for the Commission’s consideration.

A full copy of the Auditor’s report, including the responses to the audit report from the DHCS, the Commission, and Alameda County Behavioral Health Care Services, is on the State Auditor’s website (<https://www.bsa.ca.gov/reports/2017-117/index.html>).

BACKGROUND

In June 2017 the Joint Legislative Audit Committee directed the State Auditor to audit the oversight of the Mental Health Services Act. This effort was led by Senator Beall, a member of the Joint Legislative Audit Committee and of the Mental Health Services Oversight and Accountability Commission.

The audit request was, in part, a result of the Commission work on the MHSA fiscal reversion policy. A full copy of the April 2017 Reversion Report is on the Commission’s website <http://www.mhsoac.ca.gov/fiscal-reversion-0>).

In its April 2017 fiscal reversion report, the Commission found that counties held in excess of \$100 million that, by law should have been returned to the State Mental Health Services Fund by the end of fiscal year 2015-16 The Commission’s policy report noted that, according to the Department of Health Care Services, no funds had reverted since 2008.

The Commission has to date not been able to fully document the amount of unspent MHSA funds held by the counties because the State has not received all of the required, annual Revenue and Expenditure Reports. The Commission’s report found that despite these annual reporting requirements, many

counties had not submitted their reports by the annual deadline, and in some cases had not submitted required reports within a year or more of the deadline.

In response to the Commission's work on fiscal reversion, in July 2017 the Legislature enacted Assembly Bill 114 (Chapter 38, Statutes of 2017), which allowed counties to retain funds that should have reverted in prior years. AB 114 also required DHCS to report on the funds that otherwise would have been subject to reversion and the counties are required to develop a spending plan by July 1, 2018 and spend those funds prior to July 1, 2020.

SUMMARY OF KEY FINDINGS

The Auditor lists the following three key findings:

- ✓ DHCS' ineffective oversight of local mental health agencies and the MHS Fund allowed hundreds of millions of dollars to remain unspent.
- ✓ DHCS has provided only minimal oversight of the MHSA funds that local mental health agencies received.
- ✓ The Oversight Commission is implementing processes to evaluate the effectiveness of MHSA-Funded programs.

Department of Health Care Services (DHCS)

- ❖ Due to DHCS' ineffective oversight of local mental health agencies, as of the end of fiscal year 2015-16 there was between \$469 million to \$586 million in unspent MHSA being held by the local mental health agencies. The Auditor bases this finding on the following:
 - ✓ \$231 million of unspent funds at the county level as of the end of fiscal year 2015-16 that should have been reverted to the State for reallocation to the other counties. These unspent funds held by the counties were the result of DHCS' failure to develop a process to implement the return of unspent MHSA funds.
 - ✓ The Audit report points out that the Legislature provided a one-time fix through Assembly Bill (AB) 114 that allowed counties to keep the funds subject to reversion as of July 1, 2017. AB 114 also directs DHCS to resolve the issue of funds subject to reversion after July 1, 2017.
 - ✓ \$81 million in unspent MHSA interest through fiscal year 2015-16 is held at the county level. The report finds that due to lack of guidance from DHCS, counties have been inconsistent on how they treat interest earned on MHSA funds held locally. This lack of guidance has allowed counties to accumulate millions in unspent MHSA interest without reference to a reversion period in which the funds must be spent or returned to the State fund.
 - The report cites that the three counties visited, Alameda, Riverside, and San Diego have not established policies governing how to spend interest on MHSA funds. Alameda reported \$3.9 million in unspent MHSA interest as of FY 2015-16 and treated it as fiscal reserve because it believed the interest was not subject to reversion. Riverside indicated

it had \$6.6 million in interest and it too believed it was not subject to reversion. San Diego had \$11 million in interest.

- ✓ Between \$157 million and \$274 million in excessive local prudent reserves as of end of fiscal year 2015-16. These funds are in addition to cash reserves—MHPA revenues that have not yet been expended or transferred to a local prudent reserve. Counties are required by law to maintain a local prudent reserve in their local MHPA funds, not subject to fiscal reversion, to insure that essential mental health services can be maintained when new MHPA revenues fall below recent averages, adjusted for population growth and inflation. According to the audit report, the excessive reserves are a consequence of DHCS not establishing a process for overseeing the sufficiency of local mental health MHPA fund reserves. The audit report states that these reserves totaled approximately \$535 million at the end of fiscal year 2015-16.

Current law permits counties to transfer a portion of annual Community Services and Supports (CSS) revenue into its local MHPA prudent reserve or to two other MHPA component accounts (Workforce Education and Training programs or for Capital Facilities and Technological Needs projects).

- The report states that because prudent reserve accounts are not subject to reversion, the lack of DHCS guidance has permitted counties to shelter unspent CSS funds from reversion.
 - The report recommended DHCS use historical declines in the MHPA funding for CSS to establish a reasonable level of reserves. The audit reports, that the average revenue decrease in years in which revenues declined from the prior year was 23 percent of the prior year's revenue, with a maximum decline of 33 percent from the prior year. The audit states that had DHCS required counties to maintain a maximum prudent reserve level of 23 percent, an additional \$274 million would have been available for mental health services in fiscal year 2015-16.
 - According to the audit, DHCS intends to include a standard reserve level in the regulations that it anticipates submitting in January 2019.
- ❖ DHCS has spent from \$7.9 million to \$8.6 million annually over the past four fiscal years to administer the fund and has not developed the regulations necessary to implement fiscal reversion, regulate prudent reserve levels, or manage interest earned on unspent local MHPA funds. According to the audit report, DHCS initially anticipated submitting the regulations for regulatory review in June 2018 but in its response to the audit report the department has pushed the date back to January 2019. However, AB 114 specifically authorizes DHCS to implement, interpret or make specific the MHPA-related fiscal provisions of the bill via all-county letters or similar instructions until such regulations are in place.
- ❖ DHCS has not exercised appropriate oversight of the MHPA Fund balance under its authority. Per the State Controller's accounting records, there was a MHPA Fund balance in DHCS' appropriations of \$225 million that has existed since 2012. According to the audit report, as of February 2018 the State Controller made an adjustment and removed the \$225 million fund balance. The audit report notes that DHCS will work with the State Controller to ascertain the reason for the adjustment.

- ❖ DHCS provided only minimal oversight of the MHSA Funds that local mental health agencies received.
 - ✓ DHCS has developed reporting instructions but it has made little effort to ensure counties submit their annual revenue and expenditure reports on time. This has hampered DHCS' ability to calculate MHSA reversion and properly oversee MHSA spending. State regulations requires counties to submit their annual report by December 31 following the end of the fiscal year. Most counties failed to submit their reports on time. Only 1 of the 59 counties had submitted its fiscal year 2015-16 report by the regulatory deadline.
 - ✓ DHCS has had the legal authority and the funding to establish regulations that would allow it to implement sanctions against counties that do not comply with the annual reporting requirements since 2012. DHCS anticipates developing regulations in January 2019.
- ❖ Although DHCS has taken some steps towards implementing fiscal audits, it had not completed an audit for any county as of December 2017. Specifically, in 2014 DHCS developed a process for MHSA fiscal audits and hired three permanent audit staff, and had done the fieldwork at three counties but none of these audits have been finalized.
 - ✓ The report noted that DHCS indicated that audit results will not be released until it establishes a regulatory appeals process that enable a county to challenge any of the audit findings of unallowed costs. DHCS anticipates submitting the audit appeals regulations in the spring of 2019.
 - ✓ According to the audit report DHCS' has decided to conduct MHSA fiscal audits in conjunction with its Medi-Cal cost reports, which has resulted in DHCS focusing on data and processes that are outdated because of the backlog of overdue Medi-Cal cost reports. Given the age of the information, the audit's findings and recommendations would have limited value. According to the report, DHCS acknowledged that performing fiscal audits on more recent fiscal years may be needed to ensure more relevant reviews and findings of controls over MHSA funds.
 - ✓ DHCS has not developed regulations nor has it implemented program review process to ensure MHSA projects operated by local mental health agencies comply with program requirements contained in state laws and regulations.

The Oversight Commission

- ❖ The Commission is implementing processes to provide technical assistance to and improve dialogue with the counties regarding Innovation projects.
 - ✓ Counties have struggled to spend Innovation funds within the required time frame. Even though Innovation funds are only 5 percent of the total MHSA that counties receive, they account for approximately 63 percent of the \$231 million in MHSA funds the audit report identified as subject to reversion as of the end of fiscal year 2015-16.

- ✓ The audit report references the Commission’s Innovation subcommittee’s list of the challenges that counties face when developing viable Innovation projects as factors that might have contributed to counties’ inability to spend Innovation funds in a timely manner:
 - Pressure from local stakeholders to focus on direct services that are less risky and result in easily attainable outcomes.
 - Lack of clarity as to the types of projects the commissioners consider “innovative.”
 - Not enough dissemination of lessons learned from project ideas that did not succeed and limited sharing of new project ideas among local mental health agencies.

- ✓ The report states that the actions the Commission has taken, such as establishing the subcommittee on Innovation, updating the template for use by counties in submitting their proposed Innovation projects, and the one-day Innovation event, are reasonable steps to encourage more engagement and dialogue between the counties and the Commission. The audit report notes that it is too soon to know the impact of these actions on improving the counties’ understanding of Innovation and reducing the level of unspent Innovation funds.

- ✓ The report notes that the length of the Commission’s approval process does not appear to have been a factor affecting the ability of counties to spend Innovation funds.

- ❖ The Commission is adopting a process for analyzing the local mental health agencies’ status reports for Prevention and Innovation projects.
 - ✓ The report states that the Commission is taking steps to implement its responsibility to evaluate the effectiveness of the Prevention and Innovation projects. It notes the regulations issued by the Commission in 2015 in response to a 2013 change in state law require local mental health agencies to submit detailed demographic data on the populations that are being served by the counties. The first status report was due December 2017 and the audit report suggests that the Commission has not developed internal processes to review and analyze the reports.

 - ✓ The report mentions that in August 2017, the Commission launched an online MHSA fiscal transparency tool that uses an interactive map to display the counties’ annual MHSA revenues, expenditure, and year-end balances of unspent funds.

- ❖ The Commission is developing statewide metrics to evaluate the effectiveness of MHSA-funded triage grants.
 - ✓ The first round of triage grants that the Commission awarded required the counties that receive the grants to submit progress reports on the number of triage personnel they have hired, the individuals they have served, and the encounters with individuals that have led to referrals to mental health services. The report notes that the Commission reviews these reports and conducts site visits to ensure that the grantees have attained the goals they identified in their grant applications.

- ✓ The audit report notes that the initial round of grants did not have a unified evaluation approach and the evaluations the Commission received from the grantees represented different approaches and proved too diverse for the Commission to aggregate and translate into a statewide picture. The report acknowledges that the Commission is funding a statewide evaluation for the second round of triage grants.
- ✓ The report states that the steps the Commission had taken were reasonable but questions why the Commission had not established a statewide process for evaluating triage effectiveness sooner.

Alameda, Riverside, and San Diego Counties

The audit report briefly mentions the results of its review of three local mental health agencies: Alameda, Riverside, and San Diego. The report notes that these three counties allocated MHSA funds appropriately, and generally monitored their MHSA-funded projects effectively.

AUDITOR'S RECOMMENDATIONS AND AGENCIES' RESPONSES

The audit report contains specific recommendations to address the findings. There are eight recommendations directed to DHCS, three directed to the Commission, and one directed to Alameda County.

As part of the audit process, each agency was provided a confidential draft of the findings and recommendations related to the specific agency and an opportunity to respond. As provided by the Bagley-Keene Open Meeting Act, the Commission held a closed session on February 8, 2018 to review the confidential draft and write a response.

The audit report contains a copy of the responses submitted by DHCS, the Commission and Alameda County. It also contains the Auditor's comments to DHCS' response.

Each of the recommendations and a summary of the responses are listed below. A reference to the page number where the full responses may be found is provided.

Recommendations Directed to DHCS and DHCS' Response

- ❖ To effectively monitor MHSA spending and provide guidance to the local mental health agencies, DHCS should publish its proposed regulations in the California Regulatory Notice Register by June 2018 and subsequently take the following actions:
 - ✓ Develop an MHSA reversion process to ensure the State can reallocate any MHSA funds that local mental health agencies do not spend within the statutory reversion time frames.
 - DHCS agrees with the recommendation. The DHCS' full response is on page 51 of the audit report.

- ✓ Clarify that the interest the local mental health agencies earn on unspent MHSA funds is subject to the same reversion requirements as the MHSA funds they received.
 - DHCS agrees with the recommendation. The DHCS' full response is on page 52 of the audit report.

- ✓ Establish and enforce an MHSA reserve level that will allow local mental health agencies to maintain sufficient funds to continue providing crucial mental health services in times of economic hardship, but that will not result in them holding reserves that are excessive. DHCS should also establish controls over local mental health agencies' deposits to and withdrawals from their reserves.
 - DHCS agrees with the recommendation. The DHCS' full response is on page 53 of the audit report.

- ❖ DHCS should complete its analysis of the \$225 million fund balance in the MHS Fund by May 1, 2018 to determine why this balance existed, whether there is any impact on funding to the local mental health agencies and, if so, distribute those funds accordingly. It should also establish a process to regularly scrutinize the MHS Fund to identify any excess fund balances and the reasons for such balances.
 - DHCS partially agrees with the recommendation. The DHCS' full response is on page 54 of the audit report.

- ❖ To ensure that it provides effective oversight of local mental health agencies' reporting of MHSA funds, DHCS should publish its proposed [fiscal] regulations in the California Regulatory Notice Register by June 2018. DHCS should then subsequently implement a process that will enable it to withhold MHSA funds from local mental health agencies that fail to submit their annual reports on time.
 - DHCS partially agrees with the recommendation. The DHCS' full response is on page 54 of the audit report.

- ❖ To ensure that local mental health agencies appropriately spend MHSA funds, DHCS should publish its proposed [audit appeal] regulations in the California Regulatory Notice Register by September 2018. It should then develop and implement an MHSA fiscal audit process, independent of the Medi-Cal reviews, to review revenues and expenditures for the most recent fiscal year.
 - DHCS disagrees with the recommendation. The DHCS' full response is on page 55 of the audit report.

- ❖ To ensure that local mental health agencies comply with their performance contracts and MHSA requirements, DHCS should establish a process for conducting comprehensive program reviews and begin conducting those reviews by July 2018.
 - DHCS agrees with the recommendation. The DHCS' full response is on page 56 of the audit report.

Recommendations Directed to the Commission and the Commission's Response

- ❖ To ensure that local mental health agencies are able to spend Innovation program funds in a timely manner, the Commission should continue its efforts to help local mental health agencies understand the types of Innovation projects that the commissioners believe are appropriate. These efforts should include engagement and dialogue with local mental health agencies through Innovation events and forums about the types of innovative approaches that would meet the requirements of the MHSA. The Commission should use meetings of the Innovation subcommittee or a similar mechanism to evaluate the progress of its efforts to reduce unspent Innovation funds and the need for continued engagement and dialogue with local mental health agencies.
- ❖ To ensure proper oversight and evaluation of outcomes for the Prevention and Innovation projects, the Commission should finalize its internal processes for reviewing and analyzing the program status reports no later than July 2018. Further, in order to fulfill its statutory responsibility to provide oversight and accountability of MHSA programs, the Commission should ensure that it launches all three data tools to track local mental health agencies' funding, services and outcomes as it intends.
- ❖ To ensure the MHSA-funded triage grants are effective, the Commission should require that local mental health agencies uniformly report data on their uses of triage grants. It should also establish statewide metrics to evaluate the impact of triage grants by July 2018.

Recommendations Directed to Alameda County and the County's Response

- ❖ To strengthen its monitoring of MHSA projects and ensure that it spends MHSA funds appropriately, Alameda should develop and implement MHSA program monitoring guidelines to ensure that staff appropriately perform and document their monitoring activities.
 - Alameda County agrees with the recommendation. The County's full response is on page 72 of the audit report.

NEXT STEPS

- ❖ Follow up on the \$225 million noted in the audit report that was removed from the DHCS' fund balance by the State Controller in February 2018.
 - In response to Commission staff's request, Department Finance (DOF) stated that there was no \$225 million fund balance in the MHSF and that the amount identified in the audit report was an old holdover appropriation of county funds which DOF believes is attributed to the transition from Department of Mental Health to DHCS. DOF informed staff that the appropriation did not have an impact to county MHS Fund allocation when DOF completed its monthly fund reconciliation.
 - Commission staff has reached out to the State Controller Office to get further clarification on the adjustment and will work with DHCS on this issue.
- ❖ As to the recommendations directed to the Commission:

- Staff is continuing its efforts to support local mental health agencies in their Innovation projects. As directed by the Commission at the February 2018, staff is proceeding with developing the Innovation Incubator business plan.
- Staff is analyzing the Prevention and Early Intervention (PEI) and the Innovation annual reports that were submitted by the counties. To date, there are twenty- two counties that have not yet submit the PEI report and thirteen counties that have not submitted their Innovation report. Staff is working with these counties to better understand the delay and provide assistance to ensure the reports are submitted.
- Staff is proceeding with implementing the Commission’s authorization to enter into a \$10 million contract for evaluating the second round of Triage grants.

AGENDA ITEM 5

Action

March 22, 2018 Commission Meeting

Trinity County Innovation Project

Summary: The Mental Health Services Oversight and Accountability Commission will consider approval of Trinity County's request to fund a new Innovative (INN) project: Cedar Home Peer Respite for a total of \$267,000 over twenty seven (27) months. Trinity County proposes to promote the importance of lived experience in the delivery of quality mental health services by opening Cedar Home, a peer-led respite. This project is a pilot study to determine the effectiveness of peer respite in a rural setting.

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:

- Noel O'Neill, LMFT, Director;
- Marlinda Butler, MSW, MHSA Coordinator.

Enclosures (3): (1) Biographies for Trinity County Innovation Presenters (2) Staff Innovation Summary, Cedar Home Peer Respite and (3) County Project Brief.

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

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/2018-03/trinity-county-inn-plan-description-cedar-home-peer-respite>

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

Name: Cedar Home Peer Respite

Amount: \$267,000

Project Length: Twenty Seven (27) Months



Biographies for Trinity County Presenters Cedar Home Peer Respite

Noel J. O'Neill, LMFT

Mr. O'Neill has been the Agency Director of Trinity County Behavioral Health Services since 2008. He began his career in Mental Health as a volunteer in the crisis hotline setting. Prior to Trinity he worked in various management and direct provider positions for Mendocino County for 23 years, co-chaired the Small Counties Committee for CBHDA and served on the Executive Team for six years. He is currently serving a second term as a member of the California Mental Health Planning Council. He has been a nine-year commissioner on both the Trinity County First Five and the Mendocino County Juvenile Justice Commissions.

Marlinda Butler, MSW

Ms. Butler has been the MHSA Coordinator of Trinity County Behavioral Health Services since 2009. She has been integral to Trinity County's efforts to embed peer support and wellness and recovery-oriented programming into community mental health services. Ms. Butler has been the agency's Cultural Competency Committee chair for the past 9 years; responsible for organizing relevant cultural trainings to staff, community and stakeholders. In addition, Ms. Butler is providing direct services as she works toward licensure.



STAFF ANALYSIS— TRINITY COUNTY

Name of Innovative (INN) Project:	Cedar Home Peer Respite
Total INN Funding Requested:	\$267,000
Duration of Innovative Project:	Twenty-Seven (27) Months

Review History:

Approved by the County Board of Supervisors:	January 17, 2018
County submitted INN Project:	December 7, 2017
MHSOAC consideration of INN Project:	March 22, 2018

Project Introduction:

Trinity County proposes to continue to promote the importance of lived experience in the delivery of quality mental health services by opening Cedar Home, a peer-led respite program. This project is a pilot study to determine the effectiveness of peer respite in a rural, home-based setting to see if peer respite services are a more efficient, humane and culturally competent way to support individuals through a mental health crisis.

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 MHSOAC 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: increases access to mental health services to underserved groups; increases the quality of mental health services, including measured outcomes; promotes interagency and community

collaboration related to Mental Health Services or supports or outcomes; or, increases access to mental health services.

The Need

Trinity County is a rural area with isolation and poverty contributing to the mental health needs of community members. Trinity County has a statistically higher rate of poverty (21.3 percent) than national (12.7 percent) and statewide averages (14.3 percent). Research suggests that both generational poverty and situational poverty increases the risk of individuals experiencing disruption from mental health needs (Elliott 2016; Allen, et al 2014).

The County has been working to improve the capacity of their mental health services since the implementation of the Mental Health Services Act by shifting away from the medical model and toward resiliency and recovery-oriented services. Although the County has been successful in implementing new programs, they identify that access to services during times of crisis continues to be a need throughout the rural county.

Trinity County specifically states that the primary problem facing individuals at risk of a psychiatric crisis, or who are in crisis, is lack of appropriate, local services. The current practice is to evaluate individuals at the local emergency department, if hospitalization is needed, then they are hospitalized out of county. Evaluation often happens in the hallways of the emergency room. If the crisis occurs at night, the Sherriff's Department faces a dilemma of how to provide support at the emergency department and address public safety concerns as the rural County only staffs one or two deputies at night.

The Response

To address these issues, the County is proposing to use innovation funds to create and test peer-led respite services as a way to improve access to care and outcomes for individuals at risk of hospitalization for psychiatric crises.

Live & Learn, Inc. convened a panel to develop specific criteria for defining peer respite programs. The panel defines peer respite as, "a voluntary, short-term, overnight program that provides community-based, non-clinical crisis support to help people find new understanding and ways to move forward. It operates 24 hours per day in a homelike environment" (Peer Respite, 2015).

California currently has three operating peer respite programs, two in Los Angeles County and one in Santa Cruz County (Graebner 2014).

Trinity County has demonstrated the effectiveness of peer support in both their wellness center and in the use of a respite bed at the County Board and Care facility. The County reports that the previous projects resulted in the reduction of hospital bed days, out-of-county hospitalizations, crisis evaluations at the emergency room and repeated crisis episodes.

Trinity County proposes this innovation project as the next step by conducting a pilot study to determine the effectiveness of a peer-led respite home. The County anticipates this project will further reduce the number of psychiatric crises, emergency room visits, hospital encounters with law enforcement.

The County may wish to explain how individuals will be transported to Cedar Home and indicate at which point the crisis intervention will occur.

The County readily recognizes that peer respite is not a new approach to service delivery, but asserts that the peer-led respite qualifies for innovative funding because the approach is being adopted for the resourced challenged, rural setting of Trinity County. In addition, the peer liaison will be in an administrative role further distinguishing this project from other respites that are staffed by peers but not led by peers.

Like other rural counties, Trinity County has a shortage of health care professionals. By investing in the psychiatric rehabilitation training and hiring of peers, the County is addressing the shortage of available professionals while also utilizing a therapeutic approach proven to be effective. The County is participating in the Superior Region Workforce Education and Training Collaborative which creates educational pathways for individuals working in the mental health field to further support the training of peers.

Cedar Home will be a 24 hour, peer-led respite home where any community member in need of respite space and peer support can stay for up to 2 weeks.

The respite will be run by a qualified peer staff, called the Cedar Home Peer Liaison, who will oversee the daily operations and work closely with the both Trinity County Behavioral Health Services clinical deputy director and the crisis triage manager to identify individuals who would most benefit from a stay at the home.

The County may wish to describe the referral process and how the peer liaison will work with community partners to identify individuals in need of peer respite.

Innovation funds will be primarily used to fund the Cedar Home Peer Liaison, classified as a Case Manager II. The Peer Liaison will be trained in Intentional Peer Support, a trauma-informed model that enables peer supporters to provide crisis support by building healing, trusting relationships. Services provided by the peer staff will include, intensive peer support to help de-escalate crisis situations. Peer staff will connect consumers to applicable resources in the community including the Milestones Wellness Center and will ensure seamless connection with Trinity County Behavioral Health.

Additional peer staff will be hired and funded through other sources. Cedar Home will also have an advisory group, composed of individuals who have personal experience with psychiatric diagnosis, trauma, addictions, homelessness, and other significant life challenges, and will assist in implementation and assuring that the interests of the peer are respected.

The Community Planning Process

The County reports that they engaged in an extensive Community Planning Process while developing this proposed plan for Cedar Home. They held three focus groups in varied community locations to gather input from the community and stakeholders. The focus groups were held in Weaverville, population 3500; Hayfork, population 2500; and in Southern Trinity, population of 500. Community members were encouraged to participate in the focus groups through widely-distributed flyers and a newspaper ad. The County states that input gathered from stakeholders and community members through the focus groups was affirming to the county's ongoing efforts to incorporate peer support services into existing community mental health and a continued focus on building capacity for crisis response by utilizing peer staff.

The County reports that they received feedback that the community was concerned that this new service would not be available to individuals in the outlying areas such as Hayfork and Southern Trinity.

The County responded that every effort will be made to support the residents of the county regardless of where they live. **The County may wish to explain how individuals living in the outlying areas will be supported to access the services offered by Cedar Home.**

Trinity County reports that they have an active cultural competency committee including two members with lived experience. They report that regular, culturally focused trainings are offered to staff, partner agencies, consumers, and family members. Some examples of the trainings offered are: Latino culture, Hmong culture, Native American culture, spiritual diversity, LGBTQ culture, consumer perspective and culture of poverty. The County states that members of the Native American, Hmong, Latino and LGTBQ communities all represent under-represented populations in the county and that outreach efforts to engage these groups are ongoing.

The County may wish to identify if members of these under-represented groups are part of the cultural competency committee and how the committee participated in or contributed to the development of this plan.

This Innovation Project proposal was shared with MHSOAC stakeholders beginning on February 14, 2018. No letters of opposition or support were received.

Learning Objectives and Evaluation

Trinity County has proposed opening a peer respite center that will further the County's exploration into the impact of peer support and peer interventions relative to mental health services. While the respite center will be available to any community member over the age of 18, Trinity County will target underserved populations in the county that are experiencing significant rural poverty, including: Latinos, Hmong, and Native Americans. The County estimates that they will serve 200 clients annually.

The main learning goals of the project is to determine if peer respite in a rural/frontier setting can: (1) improve quality of services, (2) improve outcomes, and to (3) develop a sustainable peer support program model for Trinity County. Specific outcomes that the County hopes to arrive at include:

- Reduction in emergency room utilization by 20 percent.
- Reduction in psychiatric response calls by law enforcement.
- Reduction in hospital bed utilization.
- Improved service experience through increased social connectedness, re-establishment of roles in the community, and an increase in overall mental health functioning.

To assess these goals, the County will track process and outcome measures to inform its program decisions and other rural/frontier communities that may be considering implementing a similar peer respite program. In order to track these measures, the County will utilize data collected from ER visit logs, sheriff contact logs, program administrative data, as well as client survey information. Specific measures will include service utilization, hospital bed utilization, client satisfaction, agency satisfaction, among others. **The County may wish to identify the baseline data that will be used to measure the primary purpose of their project.** All data will be analyzed by the Quality Assurance team who, which also will conduct the evaluation and prepare a final evaluation report.

The Budget

The Innovation portion of the proposed budget is \$267,000 over twenty-seven (27) months. The evaluation component will be partially contracted out to support the County's Quality Assurance Team. The County has allotted \$9,000 (3 percent of total budget) for evaluation of the Innovation project.

The majority of Innovation funds will cover the salary and benefits costs to hire one (1) qualified peer at the county classification level of a Case Manager II. The hired staff will utilize their lived experience, education and additional training to provide consumers with recovery and wellness focused interventions and act as a liaison between the Cedar Home and Trinity County Behavioral Health Services including Milestones Wellness Center.

The annual budget includes all \$89,000 in Innovation funds allocated to Trinity County each year. The first quarter of the project begins April 2018 and ends June 2018. During this time, the County anticipates spending \$16,000 to providing training for the Case Manager II and additional peer staff who will be hired to support the peer respite programming. The County will use \$3,000 to begin the contract for evaluation and \$6,000 will be non-recurring costs for computer equipment and office furniture. Salary and benefits are estimated at \$64,000 for one (1) Case Manager II and to partially fund a crisis manager to support start-up activities.

For both Fiscal Year 18-19 and Fiscal Year 19-20, the County anticipates spending \$86,000 on salary and benefits for one (1) Case Manager II and \$3,000 for evaluation. Salary and benefit increases for the Case Manager II position are built into the budget.

Trinity County states that the total annual cost to operate Cedar Home will be \$375,000. Innovation funds will cover \$89,000 of the expenses outlined above and \$286,000 will be drawn from other sources to fund additional peer staff and cover administration and operational expenses. Other funds will include Intergovernmental Transfer dollars, MHSA Outreach and engagement funds, Medi-Cal funds, and Realignment funding will be used to support the operation of the Cedar Home.

In addition, the County is using a \$750,000 grant from the California Health Facilities Financing Authority to establish the physical building for Cedar Home Peer Respite.

Regarding sustainability, the County and stakeholders will review the results of the evaluation to determine whether to continue the project. If successful, the County would continue funding this program through its Community Support and Service (CSS) component of the MHSA.

Additional Regulatory Requirements

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

References

US Census 2016:

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Allen, Jessica & Balfour, Reuben & Bell, Ruth & Marmot, Michael. (2014). Social Determinants of Mental Health. International Review of Psychiatry. 26. 10.3109/09540261.2014.928270.

Peer Respite Definition (2015). Retrieved from <http://www.peerrespite.net/directory#/california/>

Graebner, L (2014). Retrieved from <http://www.calhealthreport.org/2014/08/12/peer-respites-for-mental-health-consumers-prevent-hospitalizations/>

Ostrow, L., & Croft, B. (2015). Peer Respite: A Research and Practice Agenda. *Psychiatric Services* (Washington, D.C.), 66(6), 638–640.
<http://doi.org/10.1176/appi.ps.201400422>

Full project proposal can be accessed here:

<http://mhsoac.ca.gov/document/2018-03/trinity-county-inn-plan-description-cedar-home-peer-respite>

Trinity County Innovation Plan-Brief

This brief summary of Trinity County's Innovation plan underscores the main problem with which the county struggles: lack of services, specifically services for individuals experiencing or at-risk for a crisis. Although respite interventions and peer support are not new concepts in terms of mental health strategies they introduce a much-needed fresh perspective in frontier areas like Trinity County that still harbor significant mental health stigma. Peer support that engages people in mutually supportive nonmedical relationships based on respect, shared responsibility, and agreement of what is helpful is a well-researched and documented practice in more urban areas (Chinman et al., 2014; Mead, 2003). Introducing this strategy in a frontier setting is not only providing quality direct services to individuals in need who have few other options, but also working to change the macro-level system that is the community and how it perceives individuals with a mental health diagnosis and recovery from a mental health disorder (Segal, Silverman, & Temkin, 2013). Trinity County is endeavoring to make a real change to standard mental health practice in Trinity County by implementing a peer respite program in a rural setting to improve access and quality of services including better outcomes.

Historically in Trinity County, if a person is experiencing a psychiatric crisis he or she would be evaluated at the local emergency department and then hospitalized if he or she met criteria. This involves transporting the individual to a psychiatric hospital located outside of the county, sometimes hundreds of miles away and over narrow mountain roads that are often negatively impacted by weather. Travel out of the county means multiple hours in the vehicle in order to reach the nearest psychiatric facility with an available bed. In some instances, transportation to a psychiatric facility must be done via an ambulance versus a county vehicle referred to as a 'cage car'. In either case, travel to the psychiatric facility can be destabilizing to the consumer. Not only did this represent a significant cost to the county it also represented a substantial gap

in the quality of services. Individuals who were hospitalized out of county were isolated from their natural support systems and then also faced the stigma of a psychiatric hospitalization

Establishing a peer respite will add depth to the services that are available to treat mental health issues in Trinity County. The Cedar Home will house six adults that are in need of an intervention but do not meet criteria for a psychiatric hospitalization. The home will be staffed around the clock and seven days a week by Peer Specialist under the direct oversight of the Behavioral Health Crisis Team. The home will be managed by a day time coordinator (Cedar Home Peer Liaison) who will be a rehabilitation specialist with lived experience. Trinity County is allocating \$89,000 of Innovation dollars. It is the intent of the county to utilize this entire amount to fund the Cedar Home Peer Liaison Position. The timeline of the project is 27 months; beginning April of 2018 and running through June 30, 2020.

The addition of a peer respite in Trinity County not only reduces the need for out of county placements it furthers the county's efforts to demonstrate the efficacy of peer support and to further embed recovery and resiliency programming a 'cornerstone' to successful behavioral health treatment within the county system.

AGENDA ITEM 6

Action

March 22, 2018 Commission Meeting

San Francisco County Innovation Plan

Summary: The Mental Health Services Oversight and Accountability Commission will consider approval of San Francisco County's request to fund a new Innovative (INN) project: Intensive Case Management/Full-Service Partnership to Outpatient Transition Support for a total of \$3,750,000 over five (5) Years. San Francisco County proposes to implement a peer linkage team to provide wraparound services for clients transitioning from intensive case management or full-service partnerships to outpatient services. Peers will be trained and compensated to serve as step-down specialists, ensuring that clients are provided with seamless connections to resources.

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:

- Imo Momoh, MPA, MHSA Director;
- Tracey Helton, MPA, CATC;
- Jose Orbeta, Peer Specialist.

Enclosures (3): (1) Biographies for San Francisco County Innovation Presenters (2) Staff Innovation Summary, Intensive Case Management/Full-Service Partnership to Outpatient Transition Support 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/2018-03/san-francisco-county-inn-plan-description-intensive-case-management-full-service>

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

Name: Intensive Case Management/Full-Service Partnership to Outpatient Transition Support

Amount: \$3,750,000

Project Length: Five (5) Years



Biographies for San Francisco County Presenters Intensive Case Management/Full Service Partnership (ICM/OP) to Outpatient (OP) Transition Support project

Tracey Helton, MPA, CATC

Tracey Helton, MPA, CATC, is a person in recovery. After completing rehab in 1998, she dedicated her life to the care and treatment of those with similar struggles. Tracey entered school through an ex-offender's program where she earned a Bachelor's of Business Administration and Masters of Public Administration. She has been involved with peer programs for nearly 20 years, and is currently an MHSA Program Manager overseeing peer programs.

Jose Orbeta

Jose Orbeta is a peer counselor with six years of experience. He has worked in inpatient, outpatient, and community settings. He recently completed the Richmond Area Multi-Services, Inc. Advanced Peer Certificate Counseling course and is certified as a Wellness Recovery Action Plan (WRAP) facilitator.

Imo Momoh, MPA

Imo Momoh is currently the Director of the Mental Health Services Act program for the City and County of San Francisco. Imo has spent his career developing, managing, and providing leadership and innovation for programs that promote consumer empowerment, cultural humility, social justice, health equity and multicultural education. Imo once led a Bay Area Ethnic Services Managers Committee, a coalition of nine counties, charged with advocating and developing strategies towards the reduction of health disparities in the Bay Area region. With passion, Imo continues to serve local communities in an effort to increase mental health awareness, reduce stigma and increase access to care for unserved, underserved and inappropriately served communities.



STAFF ANALYSIS— SAN FRANCISCO COUNTY

Name of Innovative (INN) Project:	Intensive Case Management/Full-Service Partnership to Outpatient Transition Support
Total INN Funding Requested:	\$3,750,000
Duration of Innovative Project:	Five (5) Years

Review History:

Approved by the County Board of Supervisors:	October 17, 2017
County submitted INN Project:	February 6, 2018
MHSOAC consideration of INN Project:	March 22, 2018

Project Introduction:

San Francisco County proposes to implement a peer linkage team to provide support for clients transitioning from intensive case management or full-service partnerships to outpatient services. Peers will be trained and compensated to serve as step-down specialists, ensuring that clients are provided with seamless connections to outpatient services and related resources.

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: increases access to mental health services to underserved groups; increases the quality of mental health services, including measured outcomes; promotes interagency and community

collaboration related to Mental Health Services or supports or outcomes; or, increases access to mental health services.

The Need

The County reports that they have identified a linkage issue occurring when clients are ready to transition from Intensive Case Management/ Full-Service Partnership (ICM/FSP) to Outpatient services (OP). ICM programs are a type of intensive mental health outpatient services with low caseloads, multi-disciplinary team approach, and a rich array of wraparound services. FSP's are a subset of ICM programs and reflect an intensive and comprehensive model of case management based on a client- and family-centered philosophy of doing "whatever it takes" to assist individuals diagnosed with Severe Mental Illness or Severe Emotional Disturbance. When clients no longer need the intensive level of care and service provided by ICM and FSP programs and they are discharged, many individuals do not link successfully to medically necessary, regular outpatient services.

The County defines successful linkage to outpatient care as a client receiving 8 or more services in the OP setting within 90 days of being discharged from an ICM/FSP.

Each year, the County's ICM/FSP programs serve approximately 1500 clients and are expected to discharge 20 percent of those clients to allow room for high-need individuals to begin services.

In fiscal year 2016-17, the County reports that 227 clients were discharged from an ICM/FSP program. Only 18.9 percent of those clients received 8 or more services from outpatient services within 90 days.

In addition, the County reports that discharge data from calendar years 2013-2015 show that on average 38 percent of discharged ICM/FSP clients have no new services recorded in the electronic health system, suggesting that they have become disengaged from mental health care.

These numbers indicate that many clients who have worked hard on their wellness and recovery may be at risk for destabilization if no longer connected to mental health services. In order to fulfill the purpose of the MHSA and the principles of recovery, it is important for San Francisco County to learn how to support clients who are ready to successfully transition to a lower level of care without disrupting their stability.

In addition, San Francisco County identifies that continuing to discharge clients when they are clinically ready for a lower level of care is imperative because a 3-4 month-long waitlist has formed for ICM/FSP services. Clients waiting for these services have the most acute, severe and chronic behavioral impairments and are most in need of intensive mental health services.

The Response

To address these issues, the County is proposing the Intensive Case Management/Full-Service Partnership to Outpatient Transition Support project. This project is a

collaboration between peer navigators, Behavioral Health Services, and community-based organizations, who will work together to support clients to successfully transition from ICM/FSP to outpatient services.

The County will hire an autonomous peer linkage team to provide supportive services and a warm hand off for clients transitioning to outpatient services. The team will include five culturally and linguistically diverse peers and one clinician. Peers will serve as step-down specialists and help connect clients with resources and information, help set expectations, provide follow up, and communicate with providers.

The team will outreach to transitional clients who are preparing to leave ICM/FSP services and guide them until successful linkage to outpatient services occurs.

The County states that while peer expertise is being utilized throughout public health systems for navigation, the specific design of an autonomous peer team that works interdependently with a clinic, is a new design. Peers will be compensated by the County through a contractor and will be fully imbedded within the County mental health community.

Additionally, the County and stakeholders envision a robust support and training program for the peer team, including:

- a. Peers to be situated in a cohort with each one being able to respond to any client referred to the peer team.
- b. As part of training and orientation, the peers do a “rotation” at each ICM/FSP program to gain familiarity with the programs and their staff, and vice versa.
- c. Peers to participate in individual supervision, client case conferences, staff meetings, and clinical training (e.g., Motivational Interviewing, Cognitive Behavioral Therapy, Trauma-Informed Systems, as needed).
- d. Clinical supervision to be provided by a licensed therapist or social worker at an agency supporting the peer cohort.
- e. Regular peer cohort meetings/trainings with all peer transition team members, i.e. weekly.
- f. As an ICM/FSP client nears readiness for a referral to OP, the peer is invited to the ICM/FSP by the ICM/FSP case manager to meet the client.
- g. Peer transition team member then conducts outreach with the client to facilitate connections, introduce client to community supports, conduct an orientation to the OP site, and together with the ICM/FSP case manager, and connect the client to the new provider.
- h. Accommodation for the peer member if/when they feel challenged emotionally, re-traumatized, and/or destabilized at work.

The County identified programs utilizing peers for navigation but was unable to identify any programs specifically focused on compensating peers to support clients to successfully navigate a step down in services.

Los Angeles County established guidelines for the use of “Service Extenders” in their Field Capable Clinical Services programs. Service Extenders are described as clients in recovery or family members who, following specialized training, volunteer to serve as members of multi-disciplinary teams. One of the roles of Service Extenders is to provide support to clients who are transitioning from one level of care to another. This is similar to what San Francisco County proposes as one of the roles of their peer team. The difference is that San Francisco County will hire and train peer counselors who will be part of a compensated peer team whose function is to be a bridge for each client transitioning to outpatient care. The County envisions this team as supporting the client to feel that they are gaining a team instead of losing a service. The peer support team also will not be constrained by Medi-Cal billing and thus able to provide transition support to any client regardless of changing insurance or other circumstances.

The County may wish to indicate how they will support individuals who choose not to work with the peer linkage team during their transition from an ICM/FSP program to outpatient services.

The Community Planning Process

San Francisco County completed a robust Community Planning Process (CPP).

The County reports that throughout the CPP for this project, clients, front line staff, clinic directors, and peer staff all recommended peer linkage as a potential solution to the difficulty facing clients as they navigate the step down in their services.

San Francisco County MHSa staff hosted eleven (11) community engagement meetings, inviting participants from all eleven districts to collect community member feedback. Attendees included mental health and other service providers, consumers of mental health services and their families, representatives from local public agencies, community and faith-based organizations, residents of San Francisco, and other community stakeholders.

The County reports that printed and electronic materials were translated into Spanish, Mandarin, and other languages, and interpretation was offered at all public community meetings.

In addition to the CPP meetings, staff from the Adult and Older Adult System of Care, Quality Management, and Mental Health Services Act staff organized a series of six meetings that consisted of ICM/FSP and outpatient program directors and clinicians, consumer/peer advocacy staff, and individual consumers with lived experience in mental health services. These six meetings were designed specifically to address client and program needs when a client is transitioning from an ICM/FSP to an appointment based outpatient clinic.

Highlights from the meetings include: using data to refine the understanding of the problem, brainstorming and discussion of possible solutions. A consumer panel shared their personal experiences of transitioning from ICM/FSP to outpatient programs.

Altogether, input and feedback was provided by diverse communities including individuals identifying as from Asian, black/African American, Hispanic/Latino, American Indian/Alaskan Native, multi-lingual and LGBTQ communities.

This Innovation Project was shared with MHSOAC stakeholders beginning February 14, 2018. No letters of opposition or support were received.

Learning Objectives and Evaluation

San Francisco County has proposed implementing a peer linkage team to provide wraparound services for transitional clients. Peers in the ICM/FSP-OP program will serve as step-down specialists, ensuring that the clients served are provided with connections to resources and information as well as helping clients to communicate with providers. In addition to peers, the peer linkage team include a clinician. Peers will work interdependently with a single clinic to ensure clients are provided with a smooth transition to/from any services that are deemed necessary.

The County has identified five main program goals:

1. Support clients to live increasingly independent of mental health services, as appropriate.
2. Serve clients at the lowest intensity of services that facilitates recovery.
3. Provide seamless continuum of care to clients.
4. Facilitate client connections to outpatient (OP) services when appropriate.
5. Practice MHSOAC principles of peer-drive model of care.

Each of these main goals have accompanying strategies, as well as short, intermediate, and long term outcomes. Long term outcomes include: more clients being successfully connected to outpatient care; less wait time for eligible clients enrolling in an ICM/FSP program; more utilization and appreciation of peer employees across the system of care; mental health service delivery that is aligned with the needs of the client. The County identifies a number of suggested measurements to arrive at these outcomes, including tracking the number of client referrals from ICM/FSP to OP care; percentage of referrals to OP that result in a new episode; tracking the number of days of ICM/OP overlap; number of client services at OP w/in 90 days of ICM/FSP episode closing date; client self-report satisfaction on transition process, among others. These data will be collected from an electronic health records system as well as manual data collected by program staff.

In addition to the identified program goals, San Francisco County has identified five main learning questions:

1. How effective is a highly skilled peer transition team in helping clients from intensive wraparound services engage in appointment-based outpatient care?

2. What program elements need to be in place for a peer transition support team to be successful?
3. What factors create a resilient relationship between the client and peer transition team member?
4. Which practices best support the peer transition team member's wellbeing and professional development?
5. What programmatic elements facilitate collaboration and communication between providers at the ICM/FSP and OP programs during a referral and linkage process?

In order to measure outcomes relative to the proposed learning questions, the County will utilize data collected using a number of methods, including: interviews with peer staff, client feedback forms, focus groups, and surveys of ICM/FSP and OP staff. The final evaluation report will be completed by San Francisco Department of Public Health evaluators; the County has laid out specific expectations that the evaluators will meet in order to ensure regulatory compliance is maintained.

The Budget

The proposed budget for this Innovation Project is \$3,750,000 over five (5) years.

The annual budget is \$750,000, and includes: \$473,009 for annual personnel direct costs and \$55,000 for benefits; \$70,000 (10.7 % of total budget) for general operating, including supplies, transportation between sites, food for clients, and client incentives; \$97,951 for contractor costs, contractor to act as the fiscal intermediary for peer navigators; \$24,040 for staff training and development, including support services to prevent burnout among peer staff; and \$30,000 (4% of total budget) for evaluation costs.

The majority of the budget will be used for personnel costs, including salaries and benefits for: one (1) Senior Peer Navigator, three (3) Peer Navigators, one (1) bilingual Peer Navigator, one (1) Clinician, and a 0.5 FTE part-time Program Manager.

Regarding sustainability, the findings from evaluation objectives and outcomes will be reviewed by the MHSA team, BHS Executive Team, and the System of Care Team in order to determine whether to fund and continue operating the peer linkage team. Following the end of this project, participating clients will be able to continue accessing the services as part of their care plans.

Additional Regulatory Requirements

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

References

Field-Capable Clinical Services Guidelines (2010)

http://www.file.lacounty.gov/SDSInter/dmh/159259_FCCSGuidelinesDG.pdf

Full project proposal can be accessed here:

<http://mhsoac.ca.gov/document/2018-03/san-francisco-county-inn-plan-description-intensive-case-management-full-service>

Project Brief:

Intensive Case Management/Full Service Partnership (ICM/OP) to Outpatient (OP) Transition Support project

Primary Focus

The ICM/FSP to OP Transition Support project will focus upon transitions and the flow of clients from ICM programs, including FSP programs, to OP services within Behavioral Health Services (BHS) in the City and County of San Francisco.

Intensive Case Management (ICM) /Full Service Partnership services (FSP)

Behavioral health ICM services offer a lifeline to very vulnerable clients with acute, severe and chronic behavioral health challenges resulting in serious and persistent functional impairments. ICM programs offer intensive mental health outpatient services with low caseloads, a multi-disciplinary team approach, and a comparatively richer array of wraparound services. Full Service Partnership (FSP) programs are a subset of ICM programs that have the lowest caseloads and is based upon doing “whatever it takes” to help individuals, including providing housing.

Primary Problem

When clients no longer need the intensive level of care and service provided by ICM/FSP programs and they are discharged, many individuals do not link successfully to medically necessary, appointment-based Outpatient (OP) services, which lack many of the supports that appeal to clients (e.g., “Rep payee” services, daily medications, social groups, meals, bus tokens, and much more). Clients feel as if they are losing a great deal, often including their relationship with a long-term clinic, staff, and milieu supports.

Avatar discharge data from calendar years 2013, 2014, and 2015 show that only 16% of clients discharged from an ICM or FSP open subsequent episodes in outpatient programs within four months, and fewer than 10% of those discharges result in sustained care (a year or more) in the outpatient setting. Furthermore, 38% of discharged ICM clients have no new episodes at all, suggesting that they are most likely disengaged from mental health care, and not doing better but worse, in some cases even deceased.

Structural barriers to successful transition include:

- Huge gap between ICM and OP supports
- ICM clinicians reluctant to discharge their healthiest clients

- Some OP programs reluctant to accept ICM clients just because they are perceived as “high acuity”
- There has been no clear support pathway for clients during the transition

With better supports in place, fewer clients will be lost from our care, and more will transition safely to outpatient care to continue in their recovery, living more self-directed lives that support their wellness and connection to a community that has meaning for them.

Project Description

This project involves an autonomous peer linkage team, consisting of culturally and linguistically diverse peers and a supervising clinician. The team will:

- Provide both peer based support and a warm hand off for clients stepping down from ICM/FSP services to OP settings.
- Serve as step-down specialists and help connect clients with resources and information, help set expectations, provide follow up, and communicate with providers.
- Outreach to transitional clients in order to support them to have successful linkages to OP services. They will be available to guide the client through all the various steps from preparation to successful placement and/or discharge.

With this Innovation project, some of the major goals are to:

- Increase client engagement in OP services among those stepping down from ICM/FSPs.
- Improve the overall client experience for those in transition.
- Support and further develop a peer-driven model of care.

The total amount being requested for this project is **\$750,000 per year** for a total of five years, hence, a **total budget of \$3,750,000**. **The project timeline is: April 1, 2018 - March 31, 2023.**

Innovative Elements. *(Start date is due to change – subject to approval timeline and administrative start-up logistics).*

This Innovation project will be a change to an existing practice and increase access to mental health services to underserved groups. While linkage, peer services, and navigation exist within the system, having a cohesive, highly-skilled, clinically supervised peer transition team that works interdependently with programs and addresses the significant transition from intensive services, is a new approach. In this new vision, transitions between the ICM/FSP and OP will be tailored to the needs of the client. Instead of a brief handoff period, we envision a bridge to the new service that is not strictly time-bound. In that frame, rather than having the transition be a loss for the client, the client is instead gaining a team of peer professionals that have flexibility in addressing the needs of the client, and connecting them to community-based supports.

Peer Navigation is a well-documented, successful practice in both behavioral and physical health settings; however, its efficacy has not been demonstrated in transitions from intensive, wraparound mental health settings to outpatient settings. Data-driven research conducted within the San Francisco BHS system has shown there is a demonstrated need for assistance given the very low rate of engagement in outpatient services after clients have stepped down from the ICM/FSP level. SF BHS has peers working within clinics but there are no peers dedicated to this particular function. Through the Community Planning Process for this project, clients, front line staff, ICM and OP clinic directors, and peer staff recommended peer linkage as a critical piece that could be added to more smoothly facilitate this step down transition process.

Community Planning Process

Leadership from the Adult and Older Adult System of Care, Quality Management (QM), and MHSA staff, supported by facilitators from Learning for Action (LFA), a consulting group, organized a series of six meetings that consisted of ICM/FSP and outpatient program directors and clinicians, consumer/peer advocacy staff, and individual consumers with lived experience in mental health services. The stakeholder meetings specifically addressed client and program needs when a client is transitioning from an ICM/FSP to an appointment based outpatient clinic.

The meetings first focused upon refining our understanding of the problem as informed by data from QM, and then brainstorming and discussing possible solutions and innovative project models. A consumer panel shared their experiences of transitions from ICM/FSP to Outpatient programs and additional consumers participated in small group discussions of improvement ideas for specific

aspects of the transition. Peer advocacy CBO organizations, in addition to other peer providers, were present and shared the perspective of peers and family members in the planning process.

In addition to the six project-focused community program planning engagement, this project was discussed at eleven stakeholder meetings that were part of the development of the San Francisco MHSA 3-year Integrated Plan.

Further feedback was collected from:

- QM interviews of front line staff using an A3 structured problem solving and continuous improvement tool
- MHSA Advisory Board and subsequent consumer interview
- SF Health Commission
- Quarterly ICM/FSP Directors and Monthly FSP data meetings

Peers participating in the process included individuals from the black/African American, Hispanic/Latino, and transgender communities. The most recent MHSA Advisory Board members' demographic profile in FY 14-15 showed representation of consumers, service providers, and family members from diverse communities, such as the Asian, black/African American, Hispanic/Latino, American Indian/Alaskan Native, multi-lingual and LGBT communities. The ICM/FSP and Outpatient Clinical Directors, and the planning team reflect the ethnic demographics of the community to some degree, with leadership from the Asian American and Hispanic/Latino communities.

Learning Questions

1. **How effective is a highly skilled peer transition team** in helping clients from intensive wraparound services (e.g. ICM, FSP) engage in appointment based outpatient (OP) care?
2. **What program elements** need to be in place for a peer transition support team to be successful?
3. **What factors create a resilient relationship between the client and peer** transition team member (e.g., availability, modes of contact/communication, boundary setting)?
4. **Which practices best support the peer transition team member's wellbeing and professional development?**
5. **What programmatic elements facilitate collaboration and communication between providers at the ICM/FSP and OP programs during a referral and linkage process?**

In addition, process measures will be gathered to track the progress of the implementation of the Peer Transition Team and the effort to link clients. For example:

- Number of peer transition staff hired, trained and their lengths of work stay (administrative).
- Number of days ICM/FSP and OP episodes overlap (Electronic Health Record (HER) System).
- Number of client referrals from ICM/FSP to OP (manual data collection).
- Percentage of ICM/FSP referrals to OP that result in a new outpatient episode (manual combined with HER data).

PRESENTER BIOS

Tracey Helton, MPA, CATC, is a person in recovery. After completing rehab in 1998, she dedicated her life to the care and treatment of those with similar struggles. Tracey entered school through an ex-offender's program where she earned a Bachelor's of Business Administration and Masters of Public Administration. She has been involved with peer programs for nearly 20 years, and is currently an MHSA Program Manager overseeing peer programs.

Jose Orbeta is a peer counselor with six years of experience. He has worked in inpatient, outpatient, and community settings. He recently completed the Richmond Area Multi-Services, Inc. Advanced Peer Certificate Counseling course and is certified as a Wellness Recovery Action Plan (WRAP) facilitator.

Imo Momoh is currently the Director of the Mental Health Services Act program for the City and County of San Francisco. Imo has spent his career developing, managing, and providing leadership and innovation for programs that promote consumer empowerment, cultural humility, social justice, health equity and multicultural education. Imo once led a Bay Area Ethnic Services Managers Committee, a coalition of nine counties, charged with advocating and developing strategies towards the reduction of health disparities in the Bay Area region. With passion, Imo continues to serve local communities in an effort to increase mental health awareness, reduce stigma and increase access to care for unserved, underserved and inappropriately served communities.

AGENDA ITEM 7

Action

March 22, 2018 Commission Meeting

Award Triage Program Grants

Summary: On December 29, 2017, the Commission released the first of three Request for Applications (RFA) for triage grants. Up to \$48 million dollars was made available to fund programs that provide services for those who are in need of a mental health crisis intervention in the Adult/Transition Age Youth (TAY) population. Two other RFAs have since been released and are intended to fund programs aimed at crisis services for children and/or their parents/caregivers and are still in open procurement.

Applications for the Adult/TAY RFA were due on March 9, 2018. Applications were scored by Mental Health Services Oversight and Accountability Commission staff. An overview of the winning Applications will be provided to the Commission with a staff recommendation to approve those Applications.

Background

Senate Bill (SB) 82, (Committee on Budget and Fiscal Review, Chapter 34, statutes of 2013), enacted the Investment in Mental Health Wellness Act (Act). Through a competitive grant process, the Act afforded California the opportunity to use Mental Health Services Act (MHSA) funds to expand crisis services for individuals who were experiencing a mental health crisis by increasing the number of crisis triage personnel throughout the state. Often through collaborative relationships with community partners and entities such as hospitals and law enforcement, crisis triage personnel provide linkages for services and direct services.

The main objectives of the Act are to decrease unnecessary expenditures of law enforcement personnel, decrease the overutilization of hospital emergency departments by individuals in a mental health crisis, and to divert individuals in crisis to more appropriate levels of care.

Round One

In February 2014, the Commission funded and administered contracts to implement triage grant services for 24 counties. These counties received a total of \$32 million per year over the course of the grants, which were to run from fiscal years (FY) 2013-14 through 2016-17. Due to implementation delays, the Commission extended the time available to expend awarded triage grant dollars by one fiscal year. This extension will end on June 30, 2018 and any unspent funds will be returned to the Commission.

The first round of grants resulted in more than 70,000 instances of individuals utilizing the services provided through the triage grants. Outcomes associated with these grants include an increase in access and linkages to services and resources and in the utilization of peers in crisis intervention, a reduction in psychiatric hospitalizations and in stigma associated with mental illness, and improved consumer well-being and coordination of services.

Despite these successes, children’s advocates expressed concern that the perception among providers and counties was that Triage funds were specifically authorized to serve adults, even though the authorizing legislation is silent on that issue. As a result of those concerns and the underrepresentation of children and youth in the first round of Triage grant programs, the Legislature modified the authorizing statute to clarify that Triage funds can be used to provide services that are specific to serving children and youth in schools and other settings. SB 833 (Committee on Budget and Fiscal Review, Chapter 414, statutes of 2016) amended the Investment in Mental Health Wellness Act to specifically authorize the triage grants to provide a complete continuum of crisis intervention services and supports for children aged 21 and under and their families and caregivers.

Round Two

In mid-2016, Commission staff began the process of writing an RFA in preparation for a second round of grant funding, slated to begin in FY 2018-19. Interested parties, stakeholders, the California Hospital Association, California Sheriffs, law enforcement personnel, other collaborative partners, and Subject Matter Experts were engaged in forums, meetings, and/or presentations to garner information about the successes and challenges of the Triage Grant programs. These meetings included quarterly meetings with county Triage Grant Coordinators, on-site visits to active triage grant programs, an informational meeting with law enforcement, a forum on Triage, an informational meeting in Berkeley, and meetings with the Commission’s Client and Family Leadership Committee and the Cultural and Linguistic Competence Committee.

During this time, Commission staff utilized the lessons learned from the information gathered and made a series of recommendations to the Commission related to the next round of grants that resulted in the following actions:

July 2017	The Commission adopted the staff-recommended principals derived from the June 29, 2017, SB 82 Triage Grant Information Gathering Meeting. These principles included the following: <ul style="list-style-type: none"> o Statewide evaluation strategy o Set aside for children’s triage funding o Population based apportionment
August 2017	The Commission voted to make 50 percent of Triage funds available for children and youth ages birth to 21 years. The remaining 50 percent would be made available to transition aged youth and adults.
November 2017	The Commission authorized the Executive Director to release the SB 82 funds in a competitive manner and within that amount, no less than \$30 million be made available for county-school mental health partnerships.

Recommended Motion: The Commission awards Triage personnel grants to the recommended counties for the specified amounts listed, inclusive of FYs 2018-19 through 2020-21, and directs staff to post in the Commission office lobby and on the Commission website, before the close of business on March 22, 2018, the Notice of Intent to make the recommended awards.

Presenters: Norma Pate, Deputy Director; Tom Orrock, Chief of Commission Operations and Grants; Kristal Antonicelli, Project Lead



Enclosures (1): Triage Grant Fiscal Information Dashboard

Handouts (2): A PowerPoint will be provided at the meeting; Staff Triage Award Recommendations

SB 82 Triage Dashboard

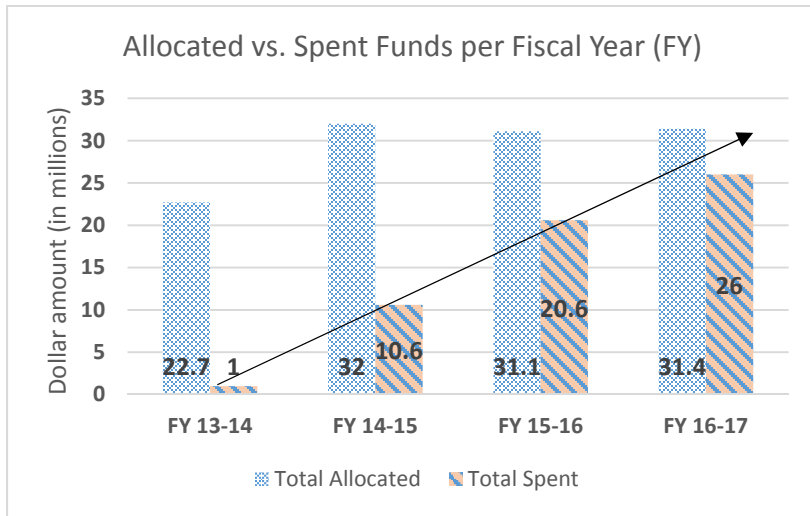
Round 1: 2014-2018

Senate Bill (SB) 82, Chapter 34 of Statutes of 2013, enacted the Investment in Mental Health Wellness Act (Act). Through a competitive grant process, the Act afforded California the opportunity to use Mental Health Services Act (MHSA) funds to expand crisis services for individuals experiencing a mental health crisis. In February of 2014, the Commission funded and administered contracts to implement Triage Grant services for 24 counties. Approximately \$32 million per year was made available to the counties over the course of the grants.

COUNTY	ALLOCATED	SPENT	TOTAL TO BE RETURNED BY 04/30/18	TOTAL TO BE DISENCUMBERED FROM CONTRACTS	TOTAL AMOUNT NEVER ENCUMBERED	TOTAL: 04/01/18 RETURN + DISENCUMBERED + NEVER ENCUMBERED
Alameda	\$2,666,797	\$567,705.90	\$489,707.10	\$804,692.00		
Butte	\$1,075,070	\$1,075,070.00				
Calaveras	\$262,686	\$147,608.50		\$41,509.50		
Fresno	\$3,073,100	\$1,250,944.00	\$24,156.00	\$899,000.00		
Lake	\$184,794	\$177,360.00	\$7,433.00	\$1.00		
Los Angeles	\$31,177,000	\$9,194,248.00	\$3,732,752.00	\$9,125,000.00		
Madera	\$1,360,596	\$884,769.62		\$79,796.38		
Marin	\$1,099,922	\$525,144.00		\$248,032		
Mariposa	\$699,428	\$610,455.89				
Merced	\$3,003,070	\$440,953.67	\$776,063.33	\$893,026.00		
Napa	\$1,323,635	\$1,041,557.83				
Nevada	\$2,477,628	\$1,353,909.40		\$358,397.60		
Orange	\$10,250,000	\$2,778,115.48	\$1,471,884.52	\$3,000,000.00		
Placer	\$2,509,346	\$1,922,810.00				
Riverside	\$7,441,142	\$4,911,106.48		\$44,717.52		
Sacramento	\$4,474,908	\$1,818,921.40	\$36,527.60	\$1,309,729.00		
San Bernardino	\$8,113,498	\$4,047,160.00		\$1,603,806.00		
San Francisco	\$14,365,009	\$9,897,600.31		\$263,014.69		
Santa Barbara	\$8,348,529	\$6,060,248.75				
Sonoma	\$3,044,363	\$2,738,219.00				
Trinity	\$497,713	\$497,713.00				
Tuolumne	\$478,713	\$414,952.00				
Ventura	\$7,573,671	\$4,994,583.68	\$1.32	\$215,043.00		
Yolo	\$1,728,234	\$1,421,892.48				
Totals	\$117,254,206	\$58,773,049.39	\$6,538,524.87 +	\$18,885,764.69 +	\$3,745,793.83	= \$29,170,083.39

In mid-2017, Triage contracts were amended to provide counties an additional year to spend their Triage funds by continuing their programs. In fiscal year (FY) 2017-18, 21 counties have been authorized a total of \$33,798,649.72.

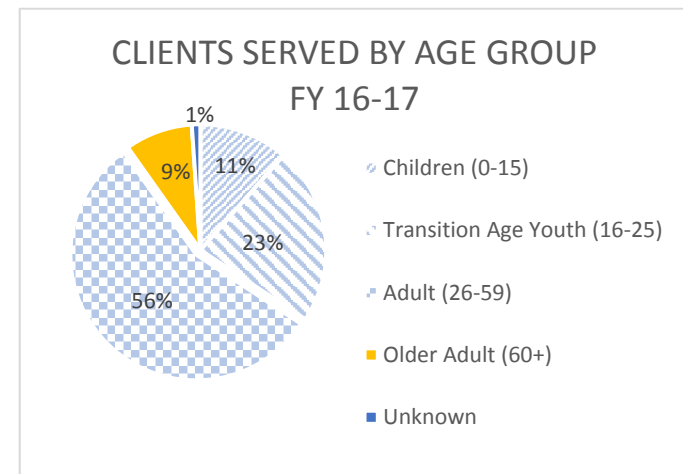
In FY 2013-14, the MHSOAC redirected \$7 million for the Golden Gate Bridge Highway and Transportation District Suicide Prevention efforts.



In the first round of Triage grants implementation was a challenge and caused service delays across the state. Of the 24 counties that received Triage Grants, the start of services delivery ranged from seven days to 88 weeks, with half of the participating counties taking more than 30 weeks to serve their first client in crisis. This delay reflects the time span between the contract execution date and the estimated program start date according to the Evaluation of Program Effectiveness reports submitted by the counties. As a result of this challenge, the Round 2 Triage Request for Applications included a requirement for counties to provide a Program Implementation Plan.

Fifty applications for Triage Grant funds were received by the Commission in 2013 upon the release of the first RFA. Six of these proposed programs were specific to youth and only three met or exceeded the minimum threshold score for funding. The Grantees with youth-centric programs received just over 17% of the total Triage funds available.

Encounter data from FY 2016-17 found that approximately 22% of Triage encounters involved youth ages 0-18. In August of 2017 the Commission directed that at least 50% of the Triage funding would be dedicated to children and youth ages 0-21.



AGENDA ITEM 8

Action

March 22, 2018 Commission Meeting

Legislation

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

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

- **Senate Bill 1004 (Wiener and Moorlach): Mental Health Services Act: prevention and early diagnosis:** This bill, as introduced, amends the Mental Health Services Act by requiring counties to expend MHSA Prevention and Early Intervention funds on specified interventions, including early psychosis, college mental health outreach, childhood trauma and other areas.

Staff from Senator Wiener's office will provide the Commission with updates on amendments which are not yet available.

Presenters:

- Toby Ewing Ph.D., Executive Director
- Norma Pate, Deputy Director
- Angela Hill, Fellow, Senator Wiener's office
- Adrienne Shilton, Government Affairs Director, Steinberg Institute

Enclosures: None

Handout (1): Senate Bill 1004 (Wiener and Moorlach) as amended.

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

AGENDA ITEM 9

Information

March 22, 2018 Commission Meeting

Stakeholder Contract Update

Summary: The Commission will hear an update on the activities and progress of the stakeholder advocacy contracts.

The Commission oversees the activities of statewide stakeholder advocacy contracts focused on supporting the mental health needs of consumers, family members, children and youth, LGBTQ, diverse racial and ethnic communities, transition aged youth, and veterans through education, advocacy, and outreach efforts.

The fiscal year (FY) 2015-2016 and FY 2016-2017 Budget Acts increased funds in the Commission's budget to support mental health advocacy to be awarded through a competitive process. Each contract is for \$670,000 per year, for a three year total of \$2,010,000.

As directed by the Legislature, the Commission conducted a competitive process and awarded \$14 million for stakeholder advocacy contracts to the following organizations:

- Clients/Consumers: awarded to Mental Health America of Northern California (NorCalMHA)
- Diverse Racial and Ethnic Communities: awarded to NAMI California
- Families of clients/consumers: awarded to NAMI California
- LGBTQ Communities: awarded to Health Access Foundation
- Parent/Caregivers of children/youth (under 18 years): awarded to United Parents
- Transition Age Youth (ages 16-25 years): awarded to California Youth Connection (CYC)
- Veterans: awarded to California Association of Veteran Service Agencies (CAVSA)

Presenters:

- Tom Orrock, Chief of Commission Operations and Grants
- Angela Brand, Stakeholder Contracts Lead

Enclosures: None

Handouts: None