Commission Packet

Commission Meeting
May 24, 2018

MHSOAC
1325 J Street, Suite 1700
Sacramento, CA 95814

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

Mental Health Services
Oversight & Accountability Commission

WELLNESS • RECOVERY • RESILIENCE

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

1325 J Street, Suite 1700
Sacramento, California 95814

Commission Meeting Agenda

May 24, 2018
9:00 AM – 4:45 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 the Commission at (916) 445-8696 or email at mhsoac@mhsoac.ca.gov.

Approximate Times

9:00 AM **Convene and Welcome**
Chair John Boyd, Psy.D., will convene the Mental Health Services Oversight and Accountability Commission meeting and will introduce the Transition Age Youth representative, Julia Ransom. Roll call will be taken.

9:05 AM **Announcements**

9:10 AM **Consumer/Family Voice**
Courtney Ransom will open the Commission meeting with a story of recovery and resilience.

9:20 AM **Action**
1: Approve April 26, 2018 MHSOAC Meeting Minutes

The Commission will consider approval of the minutes from the April 26, 2018 meeting.

- Public Comment
- Vote

9:25 AM **Information**
2: Suicide Prevention Project

Subject matter experts and stakeholders have been invited to participate in the three panels to support the Commission's understanding of opportunities to prevent suicide and improve outcomes for suicide attempt survivors and their families.

Panel I: Survivors of Suicide Loss and Attempt
Invited panelists will share with the Commission their experience with suicide and suicide loss, identify needs and gaps, and explore how services can be improved to prevent suicide.

Panelists:

- John Black, B.A., L.E., CEO of Peer Recovery Art Project Inc., and loss survivor
- Kelechi Ubozoh, Senior Program Associate, Resource Development Associates, and attempt survivor

Panel II: Challenges and Opportunities for Prevention Across the Lifespan
Invited panelists will present risk factors, including how specific experiences can increase risk, and highlight opportunities for prevention of suicide and suicide attempt across the lifespan.

Panelists:

- Sharon Birman, Psy.D., Center for Deployment Psychology, West Los Angeles Veterans Affairs Medical Center
- Caitlin Ryan, Ph.D., ACSW, Director, Family Acceptance Project, San Francisco State University
- Carolyn Stead, Psy.D., Senior Director, Integrated Behavioral Heath, Institute on Aging

Panel III: Preventing Suicide and Suicide Attempt Statewide
Invited panelists will present challenges and opportunities for preventing suicide and suicide attempt statewide, including an overview of California's current approach to preventing suicide.

Panelists:

- Brenda Grealish, Acting Deputy Director, Mental Health and Substance Use Disorder Services, Department of Health Care Services
- Rajeev Ramchand, Ph.D., Senior Behavioral Scientist, RAND Corporation
- Karen Smith, M.D., MPH, Director and State Public Health Officer, California Department of Public Health

Public Comment on All Panels

12:45 PM **General Public Comment**
Members of the public may briefly address the Commission on matters not on the agenda

1:00 PM **Lunch Break**

1:45 PM **Information**
3: Governor's May Budget Revise Update 2018
Presenters:

- Kris Cook, Department of Finance
- Elena Humphreys, Department of Finance

The Commission will be presented with information regarding the impact of the Governor's May Revision on the Mental Health Services Act and community mental health.

- Public Comment

2:05 PM **Information**

4: 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 April 26, 2018 Commission Meeting; (2) Evaluation Dashboard; (3) Calendar of Commission activities; (4) Innovation Review Outline; (5) Innovation Dashboard; (6) Department of Health Care Services Revenue and Expenditure Reports status update; (7) Youth Innovation Workplan; (8) MHSOAC Financial Oversight Report May 2018

- Public Comment

2:25 PM **Action**

5: Butte County Innovation Plan

Presenters:

- Dorian Kittrell, MFT, Director, Behavioral Health
- Danelle Campbell, Program Manager, Behavioral Health
- Sesha Zinn, Psy.D., Systems Performance Manager;
- Phillip R. Filbrandt, M.D., Butte-Glenn Medical Society
- Holli Drobny, Community Services Program Manager

The Commission will consider approval of $767,900 to support the Butte County Physician's Committed Innovation Plan.

- Public Comment
- Vote

2:55 PM **Action**

6: Sacramento County Innovation Plan

Presenters:

- Supervisor Patrick Kennedy, Sacramento County Board of Supervisors
- Uma K. Zykofsky, LCSW, Mental Health Director,
- Rosemary Younts, Senior Director, Behavioral Health, Dignity Health
- Tara Niendam, Ph.D., Associate Professor in Psychiatry, Executive Director, University of California, Davis Early Psychosis Programs
- Amy R. Ellis, MFT, Mental Health Administrator, Drug and Alcohol Administrator, Placer County
- Leslie Napper, Consumer Representative

The Commission will consider approval of $18,781,381 to support the Sacramento County Behavioral Health Crisis Services Collaborative Innovation Project.

- Public Comment
- Vote

3:25 PM **Action**

7: Legislation

Presenters:

- Toby Ewing, Ph.D., Executive Director
- Norma Pate, Deputy Director

The Commission will consider legislative and budget priorities for the current legislative session. In addition, the Commission has been asked by the authors to consider supporting the following bills: Senate Bill 1101 (Pan), Assembly Bill 2287 (Kiley), and Assembly Bill 2843 (Gloria). There are several other bills that relate to mental health under the Mental Health Services Act the Commission may wish to review. A list of those bills is included in the meeting materials.

- Public Comment
- Vote

4:00 PM **Information**

8: Stakeholder Contract Update: California Youth Connection (CYC)

Presenters:

- Joy Anderson, Policy Coordinator, California Youth Connection
- "No Stigma, No Barriers" Youth Advisory Board Representatives

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

- Public Comment

4:30 PM **General Public Comment**

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

4:45 PM **Adjourn**

AGENDA ITEM 1

Action

May 24, 2018 Commission Meeting

Approve April 26, 2018 MHSOAC Meeting Minutes

Summary: The Mental Health Services Oversight and Accountability Commission will review the minutes from the April 26, 2018 meeting. 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) April 26, 2018 Commission Meeting Minutes.

Handouts: None.

Recommended Action: Approve April 26, 2018 Meeting Minutes.

Proposed Motion: The Commission approves the April 26, 2018 Meeting Minutes.

State of California

MENTAL HEALTH SERVICES
OVERSIGHT AND ACCOUNTABILITY COMMISSION

Minutes of Meeting
April 26, 2018

Hilton Anaheim
Grand Ballroom B
777 W. Convention Way
Anaheim, CA 92802

866-817-6550; Code 3190377

Members Participating:

John Boyd, Psy.D., Chair
Khatera Aslami-Tamplen, Vice Chair
Mayra Alvarez
Reneeta Anthony
Keyondria Bunch, Ph.D.
Itai Danovitch, M.D.
David Gordon
Gladys Mitchell
Tina Wooton

Members Absent:

Lynne Ashbeck
Senator Jim Beall
Sheriff Bill Brown
Assemblymember Wendy Carrillo
Mara Madrigal-Weiss
Larry Poaster, Ph.D.

Staff Present:

Toby Ewing, Ph.D., Executive Director
Filomena Yeroshek, Chief Counsel
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

CONVENE AND WELCOME

Chair John Boyd called the meeting of the Mental Health Services Oversight and Accountability Commission to order at 9:17 a.m. and welcomed everyone. Filomena Yeroshek, Chief Counsel, called the roll and confirmed the presence of a quorum.

Youth Participation

Chair Boyd stated the Commission made a commitment to include a young person around the table at every Commission meeting to learn the Commission process and to give their perspective on issues. He asked Kimberly Coronel to introduce herself.

Kimberly Coronel, a freshman at California State University, San Bernardino, shared her story of growing up in the foster care system and becoming a foster youth advocate. She stated she is part of the California Youth Connection and is on the local Mental Health Board.

Consumer Engagement

Chair Boyd stated, since February, the Commission has begun each Commission meeting with the testimony of an individual with lived experience. The Commission invited Elyn Saks to share her story of recovery and resilience.

Elyn Saks, Ph.D., Associate Dean and Professor of Law, Psychology, and Psychiatry and Behavioral Sciences at the University of Southern California, Gould School of Law, an expert in mental health law and a MacArthur Foundation Fellowship winner, told her story of living with chronic schizophrenia. Dr. Saks told of her experience of being in denial that she had a mental illness, and spent hundreds of days in psychiatric hospitals during a period of her life. She has been free of hospitals for the past 30 years. She read excerpts from her book, *The Center Cannot Hold: My Journey Through Madness*, and described her experience of having psychotic episodes. She stated everything about her illness says she should not be here, but she is, and she is for three reasons: excellent treatment, family and friend support, and a supportive workplace. She stated occupying her mind with complex ideas has been one of her most potent and reliable defenses against her mental illness. Dr. Saks stated, the humanity we all share is stronger than the mental illness we do not share.

ACTION

1: Approve March 22, 2018, MHSOAC Meeting Minutes

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

The Commission approves the March 22, 2018, Meeting Minutes.

Motion carried 7 yes, 0 no, and 1 abstain, per roll call vote as follows:

The following Commissioners voted “Yes”: Commissioners Alvarez, Bunch, Danovitch, Gordon, and Mitchell, Vice Chair Aslami-Tamplen, and Chair Boyd.

The following Commissioner abstained: Commissioner Anthony.

ACTION

2: Los Angeles County Innovation Plans

Presenters:

- Jonathan Sherin, M.D., Ph.D., Los Angeles County Director
- Debbie Innes-Gomberg, Ph.D., Los Angeles County Deputy Director
- Marc Heiser, M.D., Los Angeles Psychiatry Specialist

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

Mobile Transcranial Magnetic Stimulation Program

Jonathan Sherin, M.D., Director, Los Angeles County Department of Mental Health, stated transcranial magnetic stimulation (TMS) is a method that is proven, FDA-approved,

reimbursable through Medicare, effective in refractory depression in the elderly population, and is showing efficacy more broadly across populations and across diagnoses. He stated this project seeks to correct the issue of parity by allowing the public mental health system to have access to this care through leveraging the Mental Health Services Act (MHSA) as part of transforming mental health care in California.

Dr. Sherin provided an overview, with a slide presentation, of the changes made to the proposed Innovation project in response to Commissioners' concerns raised at the February 22, 2018 meeting. The overview addressed the following changes:

- Modified the strategy to one that is broader and not constrained to environments where there were concerns that individuals may be coerced to use TMS
- Reviewed the commitment to leveraging peers as honest, mutual brokers in the conversation around the interest to receive care
- Recognized the lack of demonstration of the broad set of stakeholder involvement at the last presentation
- Recognized that the technology had not been articulated in a way that was easily digestible

Dr. Sherin stated three individuals who have had the treatment using private pay or private insurance are in attendance, and another person who has had the treatment will tell of their experience with TMS.

Nicole and Sophie Sela

Nicole Sela stated TMS saved her daughter Sophie's life. She shared the story of Sophie's experiences of battling with depression, many medication trials, inpatient care, hospitalization, and attempted suicide. Sophie's psychiatrist determined that she was the most profoundly depressed patient he had ever seen in his 20 years of practice and that he could no longer see her unless she agreed to undergo either electric shock therapy or TMS. He thought TMS was the best option. Sophie spent four months at the clinic where she received treatment five days per week. During this time, Sophie slowly emerged. Nicole stated drained her life savings to pay for this treatment because insurance would not cover it. The treatment worked. Sophie spoke at her high school graduation in 2017 about her experiences and stated "TMS gave me my life."

Vice Chair Aslami-Tamplen asked how long it has been since Sophie has undergone TMS. Sophie Sela stated she had a tune-up last fall. She stated there were large changes when she first began the treatment and now she goes in for one-month tune-ups when she feels she is going down to help her stay "here." She stated TMS helps her to feel stable. Although she does not feel wonderful every day, TMS gives her the tools where, if she is feeling down, she knows the rest of the day does not have to be bad. She stated she used to have down spells that would last half a year, but now they only last approximately three days, and her downs are less severe.

Vice Chair Aslami-Tamplen asked about Sophie's other support during her episodes. Sophie stated she takes medication that helps her stay "here," and TMS gave her the skills to know how to make herself happy rather than relying on medication. She stated TMS made her more motivated. She is now excited about attending college and becoming a zoologist whereas before she was excited if she made it to next week without being so down. She stated she has goals and feels she can reach for things now that were not necessarily there before.

Clara Barron

Clara Barron shared her story of living with chronic clinical depression from the age of five, never telling anyone, being undiagnosed, getting a master's degree in engineering, thinking she

was strong but all the while greatly suffering and not wanting to go on. She never knew what "normal" was until now. She read an excerpt from her journal of the day she started TMS.

Ms. Barron stated, as she was going through the TMS treatment, she began to feel something different. She read an excerpt from her journal in the middle of her TMS treatment.

Ms. Barron stated she had a life-changing experience a few years ago that sent her spiraling down. She stated her psychiatrist offered TMS for years. She finally agreed to try it for ten weeks, five days per week. The first treatment felt foreign but noninvasive. There was no pain except slight tenderness from the tapping. After a couple of treatments, it became routine. A Patient Health Questionnaire (PHQ-9) was administered weekly and her doctor visited weekly during the treatment. The score fluctuated a bit in the beginning, but, after four weeks, it consistently stayed close to zero.

Ms. Barron stated it has been a few months since the treatment. One of her medications has been removed and she is stable today. In the past, anything could and would easily trigger a downward spiral that would absorb her back into the dark vacuum. She now has coping mechanisms to deal with daily life without mood alterations or so much pain. TMS has made a big change in her. It improved her interaction with others.

Ms. Barron stated she does not openly share about her battles because of personal shame brought on by fear and a lack of understanding that most individuals have of mental illness. She stated she has always suffered quietly and alone, but today she risked coming forward for the first time to give others hope. Living with depression is not living. She stated she knows this because she is now healthy, normal, happy, and connected.

Gabriella Rosales

Gabriella Rosales stated she has been in the United States for five years and enjoys the access to the health system. She stated, if she were still in Mexico, she would not be here; she might be dead. She stated she is now functional, is beginning a career as a voice-over actor, volunteers at an organization that helps the Latino community, and is a mother of two children. She shared her story of experiencing depression at a very young age, trying her first antidepressant in 2007, and realizing that she experienced life in black and white while everyone else looked at life with colors in high definition and 3-D. She thought she was cured when she came to that realization, but her next episodes were even more difficult, lasting three to four months plus another month or two to come out of them. She stated she tried seven to eight medications. She learned about TMS after entering the United States and has been in psychotherapy for four years.

Ms. Rosales stated her first TMS treatment was in 2014 and was for six weeks. Her last treatment was in 2016. She stated she has had four six-week treatments with no side effects. She stated they all work for her but her depression would return. Her worst episode was two years ago when she separated from her then-husband and she had to provide for her children alone. Her psychiatrist raised the dose on her medication, which, until then, was working without side effects. Changing the dose created side effects, which caused her to change medications multiple times. This, in turn, caused multiple side effects and she became suicidal. Her family took turns coming from Mexico to take care of her children. The only thing that helped and did not have side effects was TMS. She stated it helped her through that difficult time.

Commissioner Questions

Commissioner Mitchell stated personal viewpoints are important, especially for consumers and family members, because they remove the clinical words and make individuals visible.

Commissioner Wooton referred to the side effects listed in the draft consent form in the materials. She asked if the practitioner obtaining consent does so from the client only or if

another person can consent on their behalf if they are incapable of consenting. Marc Heiser, M.D., Los Angeles County Psychiatry Specialist, stated the treatment will only have individuals who are capable of consenting.

Commissioner Wooton asked to change “patient” signature to “client” unless it is a medical procedure.

Commissioner Danovitch referred to the barriers to bringing the intervention to participants without a favorable payer mix. One of the barriers is stigma, and one of the ways of overcoming stigma is through stories. Regarding psychiatric treatments, stigma can be external or internal. He stated the hope that, as this proposal is evaluated, attention will be focused on the proposal as a whole.

Commissioner Wooton referred to the length of time the treatment will take and expressed concern over transportation issues. She encouraged the county to support transportation aid. Dr. Sherin stated the interest in having a vehicle with equipment is to make it possible to visit people, which was the initial interest in board and cares. Transportation would be provided if the treatment is clinic-based.

Chair Boyd asked if peers will be trained on the whole experience being offered. Dr. Sherin stated the county plans to invest significant resources as part of this pilot to reach not only peers but psychiatrists delivering the care.

Vice Chair Aslami-Tamplen asked if the psychiatrists will work full-time for this project and if they will continue full-time after the project ends. Dr. Sherin stated the psychiatrists will work full-time. The idea is to employ psychiatrists who are currently on staff and backfill their other roles.

Commissioner Wooton asked about the hourly wage for the peers. Debbie Innes-Gomberg, Ph.D., Los Angeles County Deputy Director, stated salary and employee benefits for a community worker are $59,597 per year.

Commissioner Mitchell asked to consider diversity in the hiring of peers. Dr. Sherin stated the issue of diversity is critical and will be incorporated in the hiring of hundreds of peers for the department.

Peer Support Specialist Full Service Partnership Teams (FSP)

Dr. Innes-Gomberg provided an overview, with a slide presentation, of the need, Innovation, learning questions, and evaluation of the Peer Support Specialist Full Service Partnership Teams project. She introduced Linette Morgan and Debra Gatlin.

Linette Morgan

Linette Morgan, a community worker at Long Beach Asian Pacific Islander Family Mental Health Clinic, shared her employment journey and how being a Peer Specialist FSP can help other peers get better and find stability in their lives. She shared her story of losing her job, becoming suicidal and depressed, and finding help at Long Beach Asian Pacific Islander Family Mental Health Clinic.

Debra Gatlin

Debra Gatlin, mental health advocate for the Los Angeles County Department of Mental Health, stated she came to the Department as a consumer. She stated she did not want anyone to know she was receiving mental health services because of the fear of being shunned or ridiculed. Over the course of receiving treatment, she learned that everyone goes through something, and she learned to cope with her mental stressors and became a wellness outreach

worker volunteer for the Department. After two years, she received a position as an employee of the Department to assist peers as part of the Mental Wellness Treatment team.

Commissioner Questions

Commissioner Danovitch asked about the change in the FSP model that will be evaluated. Dr. Innes-Gomberg stated the two teams do everything that an FSP does now. The key difference is the five Peer Support Specialists. There are two new teams that would replace the multidisciplinary team. The proposed project will test the removal of the Marriage and Family Therapist (MFT) and the psychologist by increasing the Peer Support Specialists to five.

Commissioner Danovitch asked what skills and training will be required to be effective and if the evaluation will include the change in the team members. Dr. Innes-Gomberg stated the evaluation will compare the outcomes of these teams with the adult FSP programs that serve a similar population. There are three levels of training for the teams.

In response to a question, Dr. Innes-Gomberg stated the two teams will focus on individuals 18 years of age and above and individuals who are involved in the criminal justice system.

Commissioner Alvarez asked how the lessons learned from this project may apply to other FSPs that serve the juvenile system. Dr. Innes-Gomberg stated the ways in which peers can engage clients in these FSP programs and help clients stay engaged in the programs. She added that the way they collect outcomes and provide the array of services will apply to other FSP programs about best practices and expand peer FSP programs.

Commissioner Gordon stated the Innovation here in terms of trying to raise the population and to create a career ladder is important but modest. He suggested that the county drive a major Innovation around building career ladders for peers and young people in the high schools, community colleges, and universities. He stated the way to do that is through paid internships and figuring out a way to pay them in the further training that will be required. All those costs will pay off in the long run because those individuals are needed in the future. A major effort with major dollars behind it will show the way to do this on major scale.

Commissioner Mitchell echoed Commissioner Gordon's comments. She stated it is great to have the Peer Support Specialist but it would be even greater to create career paths – transforming the entire picture of mental health, reducing stigma, and educating the public by bringing peers in and providing them with the right opportunities to recover, to live, and to move up. She suggested creating a path of opportunity with good salaries and showing the diversity that this affects everyone.

Vice Chair Aslami-Tamplen asked about the flex funds and legal services being a one-time cost. Dr. Innes-Gomberg stated it is meant to be an ongoing program cost over each of the four years of the project.

Commissioner Alvarez asked about the professionalization of peer specialists and other similar roles and functions in public health. There has been a large amount of research documenting the effectiveness of the model globally, yet they are not reimbursed by Medicaid. She asked whether a professionalization of this model is a long-term sustainability strategy. Dr. Innes-Gomberg stated the county thinks it is. The peer certification legislation that will hopefully pass will create a platform for reimbursement and bring on peer specialists at all different levels so there is a career ladder with supervisors. Legislation will help that tremendously.

Public Comment

Richard Krzyzanowski, member of the MHSOAC Client and Family Leadership Committee, representing the California Association of Mental Health Peer-Run Organizations (CAMHPRO), spoke in opposition to the proposed TMS project. It is a worthwhile project but is not appropriate to be funded with Innovation dollars. CAMHPRO has concerns about the quality of the process

to get truly informed consent from the residents this will be taken to, especially in the board and cares.

Adrienne Shilton, Government Affairs Director, Steinberg Institute, spoke in support of both proposed projects.

Robb Layne, Director of Communications and External Affairs, County Behavioral Health Directors Association (CBHDA), spoke in support of both proposed projects.

Karen Stockton, Mental Health Director, Modoc County Health Services, spoke as a family member. The speaker spoke in support of the proposed TMS project.

Monique Black, a previous and current TMS patient, spoke in support of the proposed TMS project. The speaker testified that TMS was very effective in her case. The speaker has been in the TMS industry for five years to raise the awareness of TMS. TMS is small enough that it does not have the backing of pharmaceutical dollars and advertising when arguably the results are more robust for treatment-resistant depression.

Walter Dunn, M.D., Ph.D., Assistant Clinical Professor of Psychiatry, University of California, Los Angeles, and Director, Mood Disorders Clinic, West Los Angeles Veterans Administration Medical Center, spoke in support of the proposed TMS project.

Gabriella Rosales spoke in support of the proposed TMS project.

Joel Crohn, Ph.D., Psychologist, spoke in support of the proposed TMS project.

Mandy Taylor, Outreach and Advocacy Coordinator, Health Access, California LGBT Health and Human Services Network, the Out for Mental Health project, spoke in support of the proposed TMS project.

Joy Torres, Mental Health America of Northern California (NorCal MHA), spoke in support of the proposed TMS project.

Steve Leoni, consumer and advocate, stated the need for right and full consent for TMS treatment. The Village model was much more than a biomedical solution. This is not built into this project.

Dave Nufer, Facilitator and Group Leader with the Pasadena Chapter of Depression and Bipolar Support Alliance (DBSA), spoke in support of the proposed Peer Support Specialist FSP project.

Pam Aiko Inaba, consumer, spoke in support of the proposed Peer Support Specialist FSP project.

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

The MHSOAC approves Los Angeles County's Innovation Project as follows.

Name: Mobile Transcranial Magnetic Stimulation

Amount: $2,499,102

Project Length: Three (3) Years

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

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

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

The MHSOAC approves Los Angeles County's Innovation Project as follows.

Name: Peer Support Specialist Full Service Partnership

Amount: $9,874,886

Project Length: Four (4) Years

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

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

Commissioner Bunch rejoined the Commissioners at the dais.

ACTION

3: Orange County and Modoc County Innovation Plans

Presenters:

- Jeffrey A. Nagel, Ph.D., Orange County Director
- Sharon Ishikawa, Ph.D., Orange County MHSA Coordinator
- Flor Yousefian Tehrani, Psy.D., LMFT, Orange County Program Manager
- Karen Stockton, Ph.D., Modoc County Director
- Rhonda Bandy, Ph.D., Modoc County MHSA Program Manager
- Guillermo Diaz, MBA, Modoc County Peer Specialist
- Adelaida B. Moore, Executive Director, Sunray's of Hope, Inc.
- Ronald Gilbert, Operations Manager, Sunray's of Hope, Inc.
- Karin Kalk, MA, Director, California Institute for Behavioral Health Solutions

Jeffrey A. Nagel, Ph.D., Director of Operations, Orange County Behavioral Health Services, introduced Andrew Do.

Andrew Do, Chairman of the Orange County Board of Supervisors, spoke in support of the proposed Mental Health Technology Solutions (Technology Suite) program. He stated Orange County is working in collaboration with Los Angeles and Kern Counties in starting this Innovation program. He discussed why the Board of Supervisors feels the proposed project is appropriate for Orange County. There is a sizeable portion of the population that struggles to access services. The lack of access and the choice not to access mental health services are much heightened in ethnic communities. Access issues and stigma work in conjunction to lower the penetration rate for mental health services. The Technology Suite allows the county to provide different levels of service that are comfortable and individualized.

Modoc County Innovation Plan

Karin Kalk, Director, California Institute for Behavioral Health Solutions, and Project Manager for the Technology Suite, provided an overview, with a slide presentation, of the shared goals, target populations, current collaborative activities, and evaluation of the proposed Technology Suite program.

Adelaida Moore, Executive Director, Sunray's of Hope, Inc., continued the slide presentation and discussed the demographics of Modoc County, primary problem, stakeholder process, and target population of the proposed Technology Suite program.

Ronald Gilbert, Operations Manager, Sunray's of Hope, Inc., continued the slide presentation and discussed the implementation and unique contribution of the proposed Technology Suite program in Modoc County.

Guillermo Diaz, MBA, Modoc County Peer Specialist, continued the slide presentation and discussed how the proposed Technology Suite program meets Modoc County's needs.

Commissioner Alvarez asked for clarification on how the trained peer mentor will be assisted by artificial intelligence (AI). Ms. Moore stated they would potentially be assisted by AI or other kinds of feedback. It has yet to be rolled out.

Ms. Moore stated older adults are not accessing services because of stigma. The Therapy Avatar component helps to reduce the stigma and can deliver evidence-based interaction.

Rhonda Bandy, Ph.D., Modoc County MHSA Program Manager, continued the slide presentation and discussed the budget of the proposed Technology Suite program.

Commissioner Questions

Commissioner Danovitch asked about the measure of evaluation. Ms. Kalk stated a series of evaluations will link back to goals such as improving access and identifying individuals with symptoms earlier. Modoc County is in the process of developing an Evaluation Plan and bringing in an evaluator to identify how to evaluate each application.

Commissioner Alvarez asked if there is an opportunity to gather information from counties that have already implemented a Technology Suite. Ms. Kalk stated the county will be taking advantage of lessons learned from those that have deployed the applications. The infrastructure is currently being built to deploy the applications in Orange County.

Commissioner Anthony asked if the county has considered incorporating guides to help individuals find locations where services occur. Dr. Stockton stated Modoc County is small and the main location is on the main street. There is signage there.

Commissioner Anthony asked if Modoc County will shortly develop proposed timeframes with dates of deliverables. Ms. Kalk stated the implementation will be incremental. The first group of counties – Los Angeles, Kern, Mono, Modoc, and Orange – will roll out only two applications this summer to ensure that security safeguards are in place, that vendor agreements are in place to ensure fair pricing, that appropriate engagement supports and peer readiness are in place to start well, and an evaluator in place to gather data.

Commissioner Bunch asked how to know who is most appropriate for this technology. Dr. Stockton stated the language refers to first break psychosis and identification.

Commissioner Bunch stated first-break psychosis clients are the group she is most concerned about. Those clients are already paranoid. This technology could potentially exacerbate their symptoms. Ms. Kalk stated the program will include a set of applications that an individual will elect to use all, some, or none of and there are individuals for whom the Wellness Coach digital phenotyping is not appropriate. Before the consent process, they will have the opportunity to decide for themselves if they want to be a part of the program.

<u>Orange County Innovation Plan</u>

Dr. Nagel provided an overview, with a slide presentation, of the demographics of Orange County. He stated the proposed Technology Suite will help to reduce stigma and increase access.

Flor Yousefian Tehrani, Psy.D., LMFT, Orange County Program Manager, continued the slide presentation and discussed the community planning process that began before the program was approved in October of 2017 for Los Angeles and Kern Counties. Dr. Tehrani presented Orange County's participation, target population, and budget for the proposed Mental Health Technology Solutions program. Through this process, a list of all the questions gathered from stakeholders is being compiled and will be posted on the website to help inform individuals who may not be familiar with the proposed program.

Sharon Ishikawa, Ph.D., Orange County MHSA Coordinator, continued the slide presentation and discussed the evaluation plan for the proposed Technology Suite program.

Commissioner Questions

Commissioner Bunch asked if the county has reached out to the Veterans Administration to discuss incorporating them and partnering this way. Dr. Yousefian stated the county has not reached out yet but has had preliminary discussion with a subject matter expert about how this will work and if it will be effective.

Commissioner Gordon asked how the proposed Technology Suite program will address the low Educational Benchmarking, Inc. (EBI) results in the county. Dr. Yousefian stated the county is working with the Garden Grove Unified School District to get feedback from students about the project and how it can be used to help the county consider apps that can be added into the suite.

Commissioner Danovitch questioned some of the technical solutions to meeting the lofty goals of the proposed project, such as whether vendors are ready to deliver the services, whether they are ready to deliver them at the scale required for this project, and how to coordinate across the suite of interventions to meet all the requirements and standards. The Innovation mechanism is strongly linked to the evaluation mechanism. He stated the need to include a way to evaluate the performance of potential vendors, the ability to coordinate across vendors, and the services that they perform. Los Angeles's plan was lofty and aspirational. He stated his concern that Orange County is disseminating and scaling the plan before it has been shown that it is possible because it has yet to be piloted.

Ms. Kalk agreed that each of the elements needs to be evaluated. The evaluator will build the evaluation as the program progresses for each application. Orange County is hoping to shape the development of these innovative, emerging applications. The evaluation will evolve as the applications are evolved with the vendors.

Commissioner Mitchell stated she, too, is concerned about the vendors. She asked about the process to ensure that vendors do what needs to be done. She emphasized the need for the program to include diverse populations including African Americans.

Commissioner Alvarez asked how many times Orange County has talked to Los Angeles County and brainstormed about the plan and the two-application idea. Dr. Ishikawa stated Orange County has been in frequent communication with Los Angeles and Kern Counties.

Commissioner Alvarez suggested an interim progress report from Los Angeles County so, as more counties come onboard and want to utilize the promise that technology holds, the Commission can be better informed.

Public Comment

Paula Shahinian, Peer Specialist, Orange County, spoke in support of the proposed project.

Joe Garcia, Peer Support Specialist, Orange County, spoke in support of the proposed project.

Linda Smith, MHSA Steering Committee, spoke in support of the proposed project.

Steve McNally spoke in support of the proposed project.

Adrienne Shilton spoke in support of both of the proposed projects.

Robb Layne spoke in support of both of the proposed projects.

David Gould spoke in support of the proposed project.

Helen Cameron, MHSA Steering Committee and family member, spoke in support of the proposed project.

Mandy Taylor spoke in opposition to the proposed project. The Commission originally approved a project for Los Angeles County that is now becoming a collaborative of several counties. If it is going to be a statewide project, there needs to be transparency and honesty around that. The California LGBT Health and Human Services Network has been doing town halls and roundtables statewide asking what participants need and not once have they stated they need technology. This has turned into a statewide plan to spend down reversion funds but does not include statewide input.

Joy Torres spoke in opposition to the proposed project.

Kimberly Coronel agreed with the previous speakers about youth and technology. It should be implemented in all counties. The process and implementation will not be the same for every county but all counties should work together as a whole.

Amelia Northcliff, Peer Specialist, spoke in support of the proposed project.

Denise Penn, Clinical Social Worker, spoke in opposition to the proposed project. The speaker stated concern that this project has not included all underserved, unserved, and marginalized minority groups in the needs assessment process and going forward. This may work in other counties, but Orange County is currently in a sociopolitical crisis that may impact the ability of this project to reach communities.

Poshi Walker, LGBTQ Program Director, Mental Health America of Northern California (NorCal MHA), Co-Director, Out for Mental Health, and California LGBT Health and Human Services Network, echoed Mandy Taylor's comments and spoke in opposition to the proposed project. Nothing in the project benefits the LGBTQ community. There are already innovative community-defined practices that can improve services and engagement for LGBTQ individuals and people of color. These should be funded and evaluated rather than duplicating the efforts that are already being done in three other counties. There is also concern about privacy.

John Leyerle, President, National Alliance on Mental Illness (NAMI), Orange County, spoke in support of the proposed project.

Linh Dang, Clinician, spoke in support of the proposed project.

Tony Ortuno, Youth Program Coordinator, LGBTQ Center of Orange County, spoke in opposition to the proposed project. The presentation did not reflect explicit inclusivity and acceptance.

Andi spoke in opposition to the proposed project. It does not serve the needs of queer individuals with disabilities because of physical, cognitive, and socioeconomic barriers. This project is not innovative. The stakeholder feedback seemed to be more from professionals and less from consumers.

Rory O'Brien, LGBTQ Program Coordinator, NorCal MHA, Project Coordinator, Out for Mental Health Stakeholder Project, spoke in opposition to the proposed project. This intervention has already been approved for three counties. This proposal is not innovative and is a waste of Orange County's funding.

Aaron McCall, LGBT Activist, Costa Mesa California, spoke in opposition to the proposed project. The privacy issue needs to be addressed and the technology suite needs to be designed by people of color and the LGBT individuals.

Andrea Crook, Advocacy Director, ACCESS California, NorCal MHA, spoke in opposition to the proposed project. The regulations contain the general standards for the community planning process and the client-driven process. It sounds like the county got robust input from stakeholders after the plan was made – it was not born from their wishes. The speaker

suggested waiting to see outcomes from the other counties before putting more funding toward this project.

Rick Boyce spoke against the proposed project and asked the Commission to look carefully at the budget. Only 35 percent of the funding is left to go to treatment and content development after the marketing costs. In the tech world, that should be reversed.

Presenter Response

Chair Boyd asked the presenters to comment.

Ms. Kalk responded to the comments about how the project will be deployed across multiple counties. The original three counties are developing a foundation, selecting applicants, and vetting them with end-users and stakeholders to understand customization. As new counties join, they inherit that infrastructure. The lead time for them to benefit from the applications is shorter and they have the opportunity to seek new applications. The early counties are creating the pathway for other counties to follow.

Ms. Moore stated time did not permit discussion of the diverse groups the county reached out to and the plans for additional groups. The county wants to represent all the voices in the community.

Dr. Bandy stated the stakeholders and peers have told the county that they have been listened to and that they have been a part of the planning process.

Ms. Coronel stated the transition-age youth (TAY) made it very clear that they did not feel represented in this process. She stated she did not hear that foster youth were being represented in the project. She suggested not reinventing the wheel but trying to be progressive in other ways.

Dr. Nagel stated not all stakeholder groups were mentioned. The county did reach out to the LGBTQ, Asian-Pacific Islander, TAY, Iranian, Korean, and veteran communities and to peer specialists. There were more stakeholder groups than were mentioned in the presentation. The effort is ongoing. The project approach was adopted based on stakeholder input.

Executive Director Ewing stated the Commission has been trying to encourage counties to collaborate around shared challenges to effect a largescale transformational change. The Commission has already approved three counties to work in this space. To date, there are approximately 20 counties that are interested in collaborating in the Technology Suite proposal. There is value to that because it allows the Commission to support the collaborative investment. Some of the challenges are associated with the newness of this idea.

Executive Director Ewing stated Assembly Bill (AB) 114 Innovation funds are approximately $139 million that should have reverted to the state but the Governor and Legislature allowed counites to keep the funds on the condition that they be spent relatively quickly. There is approximately $100 million annually going to Innovation across the state. Typically, the Commission authorizes counties to use that fund across five fiscal years. In addition to the $139 million, there is $500 million for Innovation in a potential pool.

Executive Director Ewing stated the Commission has approved three counties to do this, and questions have been raised about the appropriateness of adding more funding and more counties into the project at a time when Los Angeles, Kern, and Mono Counites are beginning to launch their projects. There are several options:

- Table this because of uncertainty.
- Support this with the kinds of conditions the Commission has raised in the past around enhancing evaluation or reporting back.

- Determine that the three counties already approved is enough and that they need to mature and move forward before investing additional funds, or, in recognition of the work that has been presented today, perhaps five counties is the right threshold. At some point, the Commission needs to come to a decision around a threshold of how much investment and how many counties partnering in Innovation is enough to learn the lesson of an Innovation in ways that this component was designed.
- Recognize that other counties can join following the evaluation phase.

Executive Director Ewing stated there are strong reasons to support this but significant concerns have been raised.

Commissioner Discussion

Commissioner Danovitch stated he liked the idea of supporting with conditions. The question is what conditions would support the goals. He suggested asking the questions about vendor procurement that were asked of Los Angeles County, evaluation, and the mechanism to coordinate the multicounty aspect of this initiative.

Commissioner Danovitch stated the Commission does not have enough information to make a decision on the number of counties. Typically, multisite activities or studies include information in the proposal about the value of every partner site to the whole. That information would help the Commission determine whether additional investments would further the goals of the project. This is missing here because multicounty proposals are new. He suggested adding it in as a guidance on the type of information required.

Commissioner Anthony suggested having someone on the tech side to coordinate community groups at the peer level and addressing cultural competency issues that have been raised.

Commissioner Gordon stated conditions are helpful up to a point. Monitoring procurements across the board for five to six counties is beyond the Commission's scope. He suggested supporting the Modoc County proposal because it fits with the three previously-approved counties and Modoc County currently does not have many options available to them.

Commissioner Gordon stated the Orange County proposal is a disappointment because technology does not equal Innovation. Innovation is connected to the local circumstance and what is needed. The survey showed that 60 percent of the children in the county have disorders that would impede their getting service. He stated the Innovation he would rush toward is what to do in the preschool space. Parents may not drive to services but they bring their children to school every day. Point of service is a powerful Innovation. He stated he would consider a modest investment into the consortium but not at the level of $24 million.

Commissioner Alvarez stated she agreed with the parameters that need to be put into place but, even before that, it is not one size fits all. A technology suite that works for one county may not work for another and the process to put it in place will not be the same. The proposal is not as welcome as the county had hoped, based on comments today. Counties cannot operate in a silo and knowing that puts an onus on the county to reach out to marginalized communities to ensure buy-in to make it successful once it is implemented.

Chair Boyd stated he agreed with Commissioner Danovitch in terms of the parameters. He asked if the Commission would like to approve the Modoc County proposal with conditions outlined by Commissioner Danovitch, with help from staff.

Chair Boyd suggested asking Orange County to come back next month with Los Angeles County to answer Commissioners' questions about implementing the project in Orange County.

Commissioner Mitchell asked if Modoc County can implement this apart from Orange County. Dr. Stockton stated the county has legal requirements of how to submit proposals and the

stakeholder process. To develop technology beyond what the county already has takes a significant investment. She asked if the Commission is overreaching to require micromanagement of these projects when the county has complied and shown the project to be innovative. Modoc County has been working on this project for five years and is ready to go. She stated Modoc County is not just trying to spend money, but it is trying to innovate.

Commissioner Danovitch stated there are two processes and conversations around these proposals. One has to do with what is important, which is highly subjective, but the experts on that are the county and stakeholders. The other piece is how to ensure what is proposed can actually get done. That is a large part of the Commission's oversight function, which is supportive although it can be a painful process. The Commission must consider how to support proposals being developed and implemented in a way that enables them to meet their objectives. This unquestionably meets the standard of Innovation. He stated what he wants to see is the Commission supporting the county's ability to evaluate this incredibly complex thing and implement it in a way that is effective.

Commissioner Mitchell stated she speaks for consumers who are living with mental illness. It is difficult work for everyone and one person's work effort is not more important than anyone else's. She stated she seeks to understand and takes these dollars very seriously. The Commission is in a unique position to help the people in this state. She stated she does not apologize for doing the work of the people who need to have their voices heard from this Commission. She stated, if she is unclear or does not agree, as an earnest person who takes this position more seriously than anything she has ever done, she will question it. She stated it is the Commissioners' responsibility to ensure clarity and inclusion.

Commissioner Danovitch stated the three previously-approved counties included guidance for the evaluation and procurement. Chief Counsel Yeroshek stated the motion approved for Los Angeles County required the county to provide information on their evaluation and their progress every three to six months beginning with implementation.

Commissioner Anthony requested that Chair Boyd work with Executive Director Ewing and the Commission on clarification and guidelines before the Commission hears from other counties regarding the Technology Suite. Chair Boyd stated he will work with Commissioner Danovitch on this issue.

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

The MHSOAC approves Modoc County's Innovation plan with the condition that the Commission will be provided information on the vendor procurement process, the evaluation, and the coordination of the multicounty aspect of this this project.

Name: Increasing Access to Mental Health Services and Supports Utilizing a Suite of Technology-Based Mental Health Solutions
Amount: $270,000
Program Length: Three (3) Years

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

The following Commissioners voted "Yes": Commissioners Alvarez, Anthony, Bunch, Danovitch, Gordon, Mitchell, and Wooton, and Chair Boyd.

The following Commissioner abstained: Commissioner Aslami-Tamplen.

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

The MHSOAC approves Orange County's Innovation plan with the condition that the Commission will be provided information on the vendor procurement process, the evaluation, and the coordination of the multicounty aspect of this this project.

Name: Mental Health Technology Solutions
Amount: $24,000,000
Program Length: Four (4) Years

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

The following Commissioners voted "Yes": Commissioners Anthony, Bunch, Danovitch, Mitchell, and Wooton, and Chair Boyd.

The following Commissioners voted "No": Commissioners Alvarez, Gordon, and Vice Chair Aslami-Tamplen.

Vice Chair Aslami-Tamplen stated there were serious and relevant issues that were brought up, particularly about privacy and stakeholder involvement. Stakeholders should be asked what they think is innovative and what they want. She stated she remains uncomfortable with the Technology Suite.

INFORMATION

4: Executive Director Report Out

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

This agenda item was tabled.

INFORMATION

5: California State Auditor's February 2018 Report on the Mental Health Services Act

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

This agenda item was tabled.

ACTION

6: Award Senate Bill 82 Children's Triage Program Grants

Presenters:

- Tom Orrock, Chief of Commission Operations and Grants
- Kristal Antonicelli, Health Program Specialist and Project Lead

Tom Orrock, Chief of Commission Operations and Grants, provided an overview, with a slide presentation, of the background and objectives of the Senate Bill (SB) 82 Children's Triage Program Grants. He stated these grant awards include the SB 833 expansion of these programs to private nonprofit corporations, school districts, and county offices of education programs. He stated the SB 82 grant awards for school and county partnership will be presented in May.

Kristal Antonicelli, Project Lead, continued the slide presentation and discussed the Request for Applications (RFA) eligibility criteria, application requirements, collaboration, timeline, and peer positions. 17 applications were received and passed the administrative review process for this grant and all were scored as a result. The applications being recommended for funding today represent over 150 collaborations throughout the state of California. Approximately 150 positions are proposed in these programs and 23 percent of those are peer positions. The total proposed

positions between the two RFAs are almost 460. The counties recommended to receive an award represent the highest scores in each of the apportionment categories. They are listed in alphabetical order on the motion slide.

Ms. Antonicelli stated the recommendation is to award the Children and Youth ages 0 to 21 Triage Personnel Grants to the counties with the highest scoring applicantions:

Butte County	Calaveras County	Humboldt County
Los Angeles County	Placer County	Riverside County
Sacramento County	San Luis Obispo County	Santa Barbara County
Stanislaus County	Yolo County	

Commissioner Questions

Commissioner Anthony asked who was on the review committee for the proposals.
Ms. Antonicelli stated MHSOAC staff reviewed and scored those applications.

Commissioner Anthony asked if peers were included in the evaluation. Ms. Antonicelli stated all levels of staff worked on this.

Public Comment

No members of the public addressed the Commission on this issue.

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

- *The MHSOAC awards the 0-21 Triage Personnel Grants to the following counties that received the highest scores for the specified amounts listed and directs the Executive Director to issue a Notice of Intent to make the following awards:*

Butte County	$333,263	Sacramento County	$2,386,811
Calaveras County	$492,291	San Luis Obispo County	$525,989
Humboldt County	$726,446	Santa Barbara County	$1,250,266
Los Angeles County	$19,489,116	Stanislaus County	$598,099
Placer County	$1,468,049	Yolo County	$294,597
Riverside County	$2,035,073		

- *The MHSOAC establishes May 10, 2018 as the deadline for unsuccessful applicants to submit an Appeal consistent with the ten working days standard set forth in the Request for Applicants.*
- *The MHSOAC directs the Executive Director to notify the Commission Chair and Vice Chair of any appeals within two working days of the submission and to adjudicate the appeals consistent with the procedure provided in the Request for Applications.*
- *The MHSOAC directs the Executive Director to execute the contracts upon expiration of the appeal period or consideration of the appeals, whichever comes first.*
- *The MHSOAC directs any additional funds that may become available for the 0-21 triage grants to be allocated first to applicants who are partially funded due to lack of funding and then to the next highest scoring counties that were not funded until all funds are allocated.*

- *The MHSOAC authorizes the Executive Director to negotiate with partially funded counties including, but not limited to, terms such as delayed implementation while awaiting possible additional funds.*

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

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

GENERAL PUBLIC COMMENT

Mandy Taylor suggested that advocates meet with the counties and provide as much policy input as possible to ensure the technology is inclusive and accessible to support personal connections since other counties will be coming on at some point. It is prohibitive of the public process when stakeholders must remain engaged in the meeting without the ability to leave the room to purchase food. The speaker suggested putting working lunch breaks on the agenda so the public can plan ahead.

Joy Torres spoke about older adults who are becoming homeless without family to care for them and asked if an Innovation project could make initiatives where there are gaps in services so that counties could bid on projects rather than devise their own plans. There are no homes for seriously mentally ill elders.

Stacie Hiramoto, Director, Racial and Ethnic Mental Health Disparities Coalition (REMHDCO), recommended placing information-only agenda items, except the Executive Director's report, at the end of the meeting after the action items and creating a legislative committee to track the bills in the legislative section that are not allotted enough time to discuss or receive public input. The speaker printed out the PEI foundational document for Commissioners and stated the public wants the Commission to stick to this document while voting. The speaker pointed out that SB 1004 is noted as support.

Susan Gallagher, Executive Director, NorCal MHA, stated the NorCal MHA letter is not in the meeting packet. The letter was strongly-worded but, as the oldest consumer advocacy organization in California, NorCal MHA felt the need to speak that way in the spirit of collaboration and partnership. NorCal MHA hoped the Commission would heed the recommendations, particularly regarding legislative items, which should be moved earlier in the agenda so that the public can weigh in on legislative priorities and which should be listed including the bill numbers. The speaker commended Modoc County for bringing peers to the table. The speaker asked if the system has enough capacity for people identified by digital phenotyping.

Poshi Walker was the director of the California LGBTQ Reducing Disparities Project, which published a report titled "First Do No Harm." The comments today underlined that local voices have not been heard. The speaker noted the claim that LGBTQ individuals were consulted but pointed out that Orange County has only one LGBTQ center and nobody there was consulted. The speaker expressed concern that the Technology Suite may be harmful to many groups of people and asked to limit how much money is spent on this type of innovation. The California Reducing Disparities Project (CRDP) Phase Two has 35 Innovative community-based practices that counties should look at first.

Steve Leoni stated many clients come to meetings all day and are forced to choose to go hungry or miss part of the meetings while purchasing food. Many consumers are diabetic. The speaker asked that the Commission consider the effect on the members of the public. The Commission does important work but needs to respect its partners. The speaker also requested moving the timeclock to where public commenters can see it and asked the Commission to consider holding meetings over multiple days.

Chair Boyd stated staff will announce working lunches in the future and will work to ensure that future agendas will not be overcrowded.

[Note: Agenda items 7, 8, and 9 were taken out of order. These minutes reflect these Agenda items as listed on the agenda and not as taken in chronological order.]

ACTION

7: Evaluation Contracts Approval

Presenters:

- Toby Ewing, Ph.D., Executive Director
- Brian Sala, Ph.D., Deputy Director

Executive Director Ewing stated the question is whether the Commission wants to authorize staff to enter into contracts for the balance of research funds in the account. He gave an overview of the context for the need to encumber those funds by June 30th. He stated one of the options is to not spend the funds which means they would go back into the mental health services fund to be distributed the next fiscal year.

Commissioner Mitchell asked how funds could be encumbered without being spent. Executive Director Ewing stated, if funds are encumbered, they are reserved for a few years. If they are not encumbered, the Department of Finance (DOF) recognizes they are still in the account and they will be made available through the regular budget process.

Brian Sala, Ph.D., Deputy Director, stated these are concepts. One challenge in contracting with an entity, such as the University of California, is that there is time sensitivity. Approval must be granted at this stage in order to get a draft contract in place in time. He provided an overview, with a slide presentation, of the background, database population, and preliminary design concepts of the next phase of the online transparency tool. Dr. Sala presented preliminary results of data linkage research done by staff. He discussed design concepts for future tools; the intent is to have monthly product releases and engage with the stakeholder community. One of the goals is to empower community members by allowing them to explore program options; another is to provide counties with a complete, downloadable data set.

Commissioner Questions

Commissioner Alvarez asked what data is collected from the counties.

Executive Director Ewing stated that data is not collected directly from the counties. The data is administrative data the counties are required to submit to the state. In the beginning, there was a 50 percent reporting rate; it has increased to 98 percent. It would be useful to have funding to hire a consultant with a strong understanding of data systems. The intent is to work with Commissioner Danovitch and with other Commissioners depending on Commission direction.

Vice Chair Aslami-Tamplen asked if the funds that need to be encumbered are unused from evaluation. Executive Director Ewing stated these funds are specific to research and evaluation. The budget will not be overspent, so the actual numbers are approximate.

Commissioner Danovitch emphasized the importance of this work moving forward.

Commissioner Gordon stated it is not research or evaluation but is refining the databases or refining the sources of data. Executive Director Ewing stated it is in part. He stated mental health data and participation in FSPs linked to criminal justice arrest rate data is preliminary but the data shows that participating in an FSP reduces criminal justice involvement, which is a goal of the MHSA. This is done as a one-point-in-time data match with the Department of Justice (DOJ).

Staff is developing a relationship with the DOJ to hopefully provide a quarterly link or once per year to track annualized trends on a county-by-county basis. It is not just strengthening the data but is understanding and accessing the data, building the analytic tools, testing the math, and running it by experts.

Commissioner Gordon stated his point was to mine the data that is already there. He stated he would be interested in bringing someone in to mine the education database in preparation of some of the upcoming Commission work but not to the exclusion of other areas. He asked if there would be room to mine multiple areas simultaneously. Executive Director Ewing stated the preference to authorize the use of these funds to secure a consultant to strengthen the process. Only a handful of research projects do this kind of data linking, so the request is to generally authorize with flexibility to do project-specific work.

Ms. Coronel thanked the Commission for allowing her to engage in the meeting process and stated appreciation for Commissioners' passion. She applauded Commissioner Gordon in particular for considering different perspectives.

Vice Chair Aslami-Tamplen acknowledged Kimberley's courage and contributions throughout the day.

Public Comment

Steve Leoni stated the need to ensure robust stakeholder participation in the contracts while creating new outcomes to be dealt with. The speaker suggested adding consumers, family members, veterans, LGBTQ, and older adults – all the communities that usually get left out of the conversation. The individuals who have lived it are the individuals who need to be there to discuss the outcomes. The speaker asked that all contracts signed include this language.

Joy Torres agreed that stakeholders need to be a part of developing and implementing statewide strategies for evaluations. The speaker suggested that Statewide Ambassadors assist the Executive Director in doing some of these evaluations and that the surveys that Orange County has done can be part of what the Statewide Ambassadors do to assist the Executive Director to save him travel expenses.

Robb Layne stated the CBHDA eagerly supports a statewide evaluation of the MHSA, but the amount of funding that the Commission is looking for may not be enough to complete the goals. Between 7 and 10 percent is a good measure to pay for a contractor as well as Commissioner Alvarez's concerns about county data collection.

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

The MHSOAC authorizes the Executive Director to enter into one or more contracts, not to exceed $1,400,000, to support the development and implementation of a statewide strategy for MHSA evaluation, including establishing statewide outcomes goals, outcomes tracking, component evaluation, and ongoing evaluation with the understanding that staff will report on the rationale and decision by June 30th.

Motion carried 4 yes, 0 no, and 0 abstain, per roll call vote as follows:

The following Commissioners voted "Yes": Commissioners Alvarez, Danovitch, and Wooton, and Vice Chair Aslami-Tamplen.

ACTION

8: Approval of Innovation Funds for Community Planning of Innovation Projects

Presenter:

- Toby Ewing, Ph.D., Executive Director

Executive Director Ewing reviewed a letter received from the County of San Diego, which was included in the meeting packet. The Commission held a human-centered design workshop with Verily to introduce the concept of human-centered design as a strategy to strengthen the community planning process around Innovations. San Diego County has asked the Commission for permission to spend up to $100,000 of Innovation funds to undertake a human-centered design Innovations with ideation process in their county. Executive Director Ewing stated it would be helpful to do this across all counties rather than have each county ask separately.

Executive Director Ewing stated staff is working hard to track the Innovation funds authorized and what was spent. Because of the way county budgeting is done, counties do not always gain Commission approval for using some of their funding, not because they are trying to hide something, but because of the way administrative costs are issued. The challenge is not only with Innovation. The financial reports submitted to the Commission by counties do not always agree with the summaries posted on the Department of Health Care Services (DHCS) website. Staff is working with the county and with the DHCS to understand why there is a discrepancy and to eliminate it so confusion is not created as to which figure is accurate.

Public Comment

Rory O'Brien spoke in support of the proposal. The speaker asked if the vendor will be the same vendor for the Innovation Summit at the Verily Campus and suggested looking toward the design methods of community-based participatory research being done at research institutions.

Poshi Walker echoed the comments of the previous speaker. The methods used or the IDEO-type vendor seen at the Verily Campus does not resonate with the majority of individuals who live in this state. If those types of voices are privileged, programs will only serve a small minority of White, Western, straight, cisgender individuals, which is not what the MHSA is for. That type of brainstorming process does not educate counties on how to do true community engagement or how to be Innovative in designing the types of projects hoped for. The speaker suggested looking at community-based participatory research methods for ensuring that the process is one that brings forth marginalized voices and Innovative projects to serve the individuals the Commission is supposed to be serving.

Andrea Crook was confused about asking for $100,000 through Innovation because that is no more than 5 percent of the annual county allocation for the community planning process for all counties and does not need to go through the Commission. The speaker asked why San Diego County is asking for this through Innovation.

Executive Director Ewing stated there is a provision in the law that ensures there is a funding stream to pay for the community-planning process. There are concerns around the robustness of the community-planning process. The goal of the Verily Innovation workshop was to highlight an opportunity to begin with a human-centered design conversation.

Susan Gallagher echoed Andrea Crook's comments. NorCal MHA found that counties are not using their 5 percent off the top of their MHSA allocation to invest in community-planning processes. The speaker questioned giving the county more funding out of Innovations if they are not using the 5 percent that is set aside for that purpose. The speaker suggested checking with counties that are using their 5 percent because that is what all counties should be doing.

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

The MHSOAC approves San Diego County's request to spend $100,000 of Innovation funds to support a Human-Centered Design strategy to develop its next Innovation Project. The Commission directs staff to develop and present to the Commission a strategy for approving use of Innovation funds to support counties' planning for Innovation projects.

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

The following Commissioners voted "Yes": Commissioners Alvarez, Anthony, Bunch, Danovitch, Gordon, and Mitchell, Vice Chair Aslami-Tamplen, and Chair Boyd.

The following Commissioner voted "No": Commissioner Wooton.

INFORMATION

9: <u>Draft Business Plan for Innovation Incubator</u>

Presenters:

- Toby Ewing, Ph.D., Executive Director
- David Smith, Consultant, X-SECTOR LAB

Executive Director Ewing stated the Commission put together a proposal to strengthen four aspects of Innovation work: county collaboration, technical assistance, evaluation, and communication. The Governor's Budget included $5 million for the Commission to launch an Innovation Incubator focused on Innovation proposals that would reduce criminal justice involvement. The Commission has asked the Governor for an additional $5 million to expand the focus of the Innovation Incubator. He stated the hope that counties will come together to help explore issues to strengthen the evaluation strategy.

Executive Director Ewing stated the Commission asked X-SECTOR LAB to help staff put together a business plan for the Innovation Incubator through a series of engagements. The primary audience is the counties; the counties are the client. The $5 or $10 million will fund the Incubator for three to five years. There are soft commitments from foundations to support that. The Commission has asked X-SECTOR LAB to discuss other models that bring together experts, stakeholders, and counties to develop a practical business plan. The first meeting to orient partners and allies on the overall strategy is Friday, May 4th.

David Smith provided an overview of the goals, key questions and dates, and challenges and opportunities listed in the "Building an Incubator for Mental Health Innovation in California" document, which was included in the meeting packet. He stated he will present his early findings at the May Commission meeting and the draft business plan at the July meeting. The Design Labs are meant to be smaller and will dig into the core work to understand the barriers, desired services, journey map, and stakeholder engagements.

Commissioner Questions

Commissioner Wooton requested phone capability for the orientation meeting and asked about focus meetings with clients to get input and ideas on the business plan. Executive Director Ewing stated phone capability is possible. He stated the Design Labs will consist of a balance of consumers and family members, providers, and county representatives because the design needs to serve each community, but the other component of the meetings is subject matter experts regarding launching these kinds of entities. The intent of the draft business plan is to anticipate the funding being made available.

Commissioner Danovitch asked if the business plan will include a landscape analysis that highlights existing models and entities. Mr. Smith stated X-SECTOR LAB is looking at existing

models in different topic areas. It is not a comprehensive landscape analysis, but it will look at analogous models to highlight pros and cons, which will be included in the business plan.

Commissioner Danovitch stated the questions are which model will be most effective and whether it should be a joint effort. The analysis will be helpful for both decisions. Mr. Smith stated the dialogue over the next few meetings will highlight whether the Commission is looking for one complete option or several in-progress options that it can continue to discuss.

Chair Boyd stated appreciation for the landscape analysis. A robust, global landscape analysis with public and private sector models and options would be ideal. He stated having only one option sounds less than favorable, preferring to see the entire landscape of best practices.

Commissioner Alvarez asked if the meeting dates are public, if people have been invited to attend, and how this opportunity will modernize government and educate other departments. Executive Director Ewing stated the issue of inclusion was challenging for the February meeting on innovation. In focusing on exploring functional issues, staff recognized the need to bring in people with practical experiences. The Design Labs are small workshops so they will include open discussion. The intent is to create touch points for a diverse audience to participate and understand while ensuring there is focused opportunity for people with practical experience to share their input. Staff is engaging partners in other state agencies and building recognition among county agencies. The hope is to shape investment opportunities in other sectors as a foundational investment in transforming areas outside of mental health.

Mr. Smith stated the potential to apply this across levels and topic areas of government is exciting. X-SECTOR LAB has worked with the Office of Personnel Management (OPM) on the federal level to create a design school for government. One of the examples that will be highlighted in the landscape review is the lab at OPM, which provides technical assistance to organizations trying to change how they engage stakeholders and does case studies on incubator topics. There is great work to build on.

Public Comment

Robb Layne stated this exciting proposal is person-centered, is innovative, and has the opportunity to give all counties access to the process. The speaker spoke in support of the policy. The CBHDA is working with staff to address how it will augment the approval process for Innovation projects without creating additional barriers.

Poshi Walker expressed concern that the process may use the lens of white, Western, straight, cisgender, socioeconomically privileged individuals, which is not indicative of California’s population. The speaker encouraged focusing on plans and innovations that will build capacity for communities and agencies that already provide innovative services in order to support what is already happening.

Mandy Taylor worked as a clinician with many young Black girls who were survivors of sex trafficking, who knew best what their peers would respond to. Innovation must uphold MHSA values, use a lens of equity, and prioritize the most marginalized populations. The speaker cautioned that people who are not white, straight, cisgender, middle-class, etc. do not respond well to what that perspective treats as best. The voices that are most likely to be quiet are the voices that most need to be listened to.

Rick Boyce stated a well-organized incubator with good mentors and good public and private sector support is effective at sourcing and polishing good ideas. The speaker spoke in support of the incubator process.

ACTION

10: Legislation

Presenters:

- Toby Ewing, Ph.D., Executive Director
- Norma Pate, Deputy Director

This agenda item was tabled.

GENERAL PUBLIC COMMENT

Stacie Hiramoto reiterated her suggestion that there be a legislative committee to run the bills through since the Commission is taking positions. If not, there should be public comment on each bill the Commission takes a position on, not two minutes at the end of a 12-bill presentation. The speaker disseminated letters to Commissioners on REMHDCO's comments on the bills and named organizations for multicultural counseling and education services in Alameda, Butte, Los Angeles, San Diego, San Francisco, and Stanislaus Counties. REMHDCO represents individuals at the local level.

Jim Gilmer took the day off and drove here at his own expense to speak on Agenda Item 10, Legislation, and it was tabled to another meeting. Legislation is important to the community, particularly communities of color. Many cities statewide are seeing increased homelessness, particularly around people of color. Robust discussions are needed when thinking about prioritizing populations. The speaker stated the hope that the Commission will follow the agendas more carefully in the future.

Joy Torres stated Los Angeles County has many peers including homeless peers who would like employment but lack the education and framework. The speaker suggested an educational piece to help peers get better jobs.

ADJOURN

Vice Chair Aslami-Tamplen stated next month is Mental Health Awareness month and May 23rd is Mental Health Matters Day in Sacramento. She encouraged everyone to be involved in the many available activities during the month.

There being no further business, the meeting was adjourned at 4:26 p.m.

AGENDA ITEM 2

Information

May 24, 2018 Commission Meeting

Suicide Prevention Project

Summary: The Commission is leading an effort to develop a strategic, statewide suicide prevention plan informed by best practice and in collaboration with community members on the basis of shared understandings of the challenges and opportunities to reduce suicide, suicide attempts, and suicidal self-harm, and to improve outcomes for suicide attempt and loss survivors.

The effort is led by the Suicide Prevention Subcommittee, a subcommittee of Commissioners appointed by Chair John Boyd, Psy.D.:

- Commissioner Wooton (Chair)
- Commissioner Aslami-Tamplen
- Commissioner Madrigal-Weiss

Subject matter experts have been invited to participate in the Commission's first public hearing on suicide prevention during the May 24th Commission Meeting. Panel presentations are designed to support the Commission's understanding of challenges and opportunities for preventing suicide–at the person, population, and systems levels–and improve outcomes for suicide attempt survivors and survivors of suicide loss.

Panel 1: Survivors of Suicide Loss and Attempt

- John Black, B.A., L.E., CEO of Peer Recovery Art Project Inc., loss survivor
- Kelechi Ubozoh, Senior Program Associate, Resource Development Associates, and attempt survivor

Panel 2: Challenges and Opportunities for Prevention across the Lifespan

- Sharon Birman, Psy.D., Center for Deployment Psychology, West Los Angeles Veterans Affairs Medical Center
- Caitlin Ryan, Ph.D., ACSW, Director, Family Acceptance Project, San Francisco State University
- Carolyn Stead, Psy.D., Senior Director, Integrated Behavioral Heath, Institute on Aging

Panel 3: Preventing Suicide and Suicide Attempt Statewide

- Brenda Grealish, Acting Deputy Director, Mental Health and Substance Use Disorder Services, Department of Health Care Services
- Rajeev Ramchand, Ph.D., Senior Behavioral Scientist, RAND Corporation
- Karen Smith, M.D., MPH, Director and State Public Health Officer, California Department of Public Health

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

Handouts (1): Additional panelist biographies or written testimony.

Suicide Prevention Project

May 24, 2018 Public Hearing Brief

PURPOSE

The purpose of this document is to provide background and rationale for the public hearing on suicide prevention during the Mental Health Services Oversight and Accountability Commission's May 24, 2018 meeting. Panel presentations were organized to support the Commission's effort to develop a statewide strategic plan for suicide prevention.

INTRODUCTION

The Commission is charged with overseeing the implementation of California's Mental Health Services Act (also known as Prop 63) and the transformation of California's mental health system. The 16-member Commission is composed of one Senator, one Assemblymember, the State Attorney General, the State Superintendent of Public Instruction, and 12 public members appointed by the Governor that represent different sectors of society including people with mental health needs, their family members, law enforcement, education, labor, business, and the mental health profession.

In collaboration with stakeholders, the Commission provides vision and leadership to expand awareness and understanding of issues facing community mental health. The Commission conducts projects to examine critical issues and make informed decisions on how to improve services and provide better care to consumers.

Through the more than $2 billion generated every year by Prop 63, some $350 million is earmarked annually for prevention and early intervention (PEI) services and another $100 million is designated for innovations. Most of those funds are distributed directly to counties to provide services with a range of goals, including reducing suicide. Assembly Bill 114 (Chapter 38, Statutes of 2017) authorized the Commission to develop a new, statewide strategic plan for suicide prevention.

BACKGROUND

Suicide and suicide attempts affect every demographic group in California. More than twice as many Californians die annually by suicide as from homicide.[i] Rates vary in significant ways, however. Some three-quarters of Californians who die by suicide each year are male.[ii] Adults aged 20-59 account for more than 70 percent of suicides in the state, while the highest suicide death rates are among middle aged and older adults.[iii] The largest numbers of suicides occur in southern California, with Los Angeles County accounting for about 20 percent of statewide suicide deaths annually. In contrast, suicide death rates are highest in rural northern California, with rates in the Superior region close to twice the national average. Additional at-risk populations include people involved with the criminal justice system, people experiencing homelessness, immigrants and refugees, veterans and military personnel, and LGBTQ – particularly transition aged youth.[iv] As is true nationally, Californians are most likely to die by suicide using firearms (42 percent) compared to other means, such as suffocation (27 percent) and poisoning (19 percent).[v]

In addition to the devastating human impacts on survivors of suicide loss, suicides and suicide attempts also significantly affect the economy. The American Foundation for Suicide Prevention reports that in 2010 suicides cost California over $4 billion in combined medical expenses and lost productivity.[vi] Another report suggests that suicide and suicide attempts nationally cost anywhere between $58 billion and $94 billion in 2013.[vii]

The purpose of Commission's Suicide Prevention Project is to develop a suicide prevention plan informed by best practice and in collaboration with community members on the basis of shared understandings of the challenges and opportunities to reduce suicide, suicide attempts, and suicidal self-harm, and to improve outcomes for survivors of suicide attempts and survivors of suicide loss. The Commission will develop this plan with stakeholders and will leverage previous efforts, including California's current suicide prevention plan drafted in 2008 by the former Department of Mental Health and the 2012 National Strategy for Suicide Prevention, developed by the U.S. Surgeon General and the National Action Alliance for Suicide Prevention.[viii]

The Commission is organizing a series of public hearings and meetings, community forums, site visits, and small group discussions to understand challenges and opportunities for the prevention of suicide. The project is led by the Suicide Prevention Subcommittee, a subcommittee of Commissioners appointed by MHSOAC Chair John Boyd, Psy.D., including Commissioners Tina Wooton (Chair), Khatera Aslami-Tamplen, and Mara Madrigal-Weiss.

The first meeting of the Commission's Suicide Prevention Subcommittee was held in Redding, California. The overarching goals of the meeting were to share the project goals and objectives, and to explore with meeting attendees the potential causes of high suicide rates, barriers to reducing rates, and what could be done to reduce suicide, suicide attempts, and associated harm. The subcommittee organized a series of site visits prior to the meeting to support the understanding of several key concerns, including comprehensive suicide prevention planning, issues impacting Northern California Tribal communities, and care for people in or at-risk of a suicidal crisis. The public discussion focused largely on disconnection as a barrier to suicide prevention – disconnection between people and community, but also disconnection or gaps in the system. A summary of the site visits and subcommittee meeting is attached to this brief.

The Suicide Prevention Subcommittee will hold two additional meetings, in Sacramento, California on May 23, 2018 and San Diego, California on June 13, 2018.

PUBLIC HEARING ON SUICIDE PREVENTION

The first public hearing on suicide prevention will focus on barriers and challenges to preventing suicide and suicide attempt. Panel presentations are designed to support the Commission's understanding of opportunities for preventing suicide and suicide attempt at various levels--person, population, and system.

Panel 1: Survivors of Suicide Loss and Attempt

Stigma remains a major barrier to preventing suicide, and can often keep people with lived experience from feeling safe to share their stories of survival, hope, and resilience – perpetuating isolation and reinforcing suicide as "taboo." Experts with lived experience have been asked to begin the Commission's public hearing on suicide prevention to elevate the voices of survivors of suicide loss and attempt.

Mr. John Black will share his experience as a suicide loss survivor after the death of his wife, Linda. His presentation will include the type of support that was helpful for him and his suggestions for helping people with chronic suicidal thoughts or attempts. Ms. Kelechi Ubozoh will present her experience as a woman of color and survivor of multiple suicide attempts. Her presentation also will include how suicide and suicide attempts are experienced in communities of color – communities that may be underreported in suicide data – and implications for improving policy and practice.

Panel 2: Challenges and Opportunities for Prevention across the Lifespan

The Substance Abuse and Mental Health Services Administration's guidance to states developing suicide prevention plans is to strategically address suicide prevention across the lifespan and to incorporate a population-based public health approach.[ix] Other research recommends that plans should include intersectional approaches, emphasizing strategies for populations at increased risk, such as LGBT youth, adult veterans, and older adults, often with chronic or emerging physical health conditions.[x]

Dr. Caitlin Ryan's presentation will highlight what she has found through decades of research to be the major gap in prevention and care for LGBT youth--the family – which may be missed with traditional models of intervention. Dr. Sharon Birman will present factors that increase suicide risk in middle-aged adults, particularly veterans. She also will provide an overview of the *Mayor's Challenge to Prevent Suicide among Service Members, Veterans, and their Families*, and how the City of Los Angeles is participating in that effort. Dr. Carolyn Stead will share with the Commission factors that increase suicide risk for older adults, and the Institute on Aging, including the Center for Elderly Suicide Prevention, is working to address suicide and suicide attempt in older adult populations.

All presentations will include how panelists believe the state could support local efforts to prevent suicide and suicide attempt and improve mental health outcomes for communities at high suicide risk.

Panel 3: Preventing Suicide and Suicide Attempt Statewide

Suicide is preventable, but will require a dynamic strategy that addresses a wide range of risk and protective factors. The Center for Disease Control and Prevention--and others--suggests that states developing a strategic suicide prevention plan should address a wide range of factors

related to suicidal behavior, including social support, mental illness, substance abuse, economic factors, and community and personal risk and resiliency.[xi] The final panel of the Commission's public hearing on suicide prevention will address suicide prevention broadly, and will provide an overview of California's current strategy for preventing suicide.

Dr. Rajeev Ramchand has been invited to present an overview of the challenges to identifying people at risk of suicide, and intervening effectively statewide, and what could be done collectively to create systems that prevent suicide and intervene during suicidal crisis. Most state resources for suicide prevention fall under the authority of the California Health and Human Services Agency, which includes the Department of Health Care Services and the Department of Public Health. Ms. Brenda Grealish will provide an overview of California's current strategy to prevent suicide, including suicide prevention activities conducted by the Department of Health Care Services. Dr. Karen Smith will present on the mission and activities of the Safe and Active Communities Branch within the Department of Public Health, and will provide an overview of the department's *Violence Prevention Initiative*, including potential implications of that initiative for understanding opportunities for suicide prevention within a public health framework.

CONSIDERATIONS

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

- Should the Commission support a statewide effort to create safer conversations around suicide to breakdown stigma? Should the Commission support the development, sustainability, and investment of safer environments for suicidal people to feel comfortable so they will more likely seek help?
- How can policies and practices be more responsive to early warning signs that someone may be at risk for suicide or self-harm, and more aware of and responsive to cultural differences?
- How can California's health care and behavioral health care delivery systems be better aligned to support identification of suicidal people and intervene more effectively and efficiently?
- How can California prevent suicide using a public health approach across the lifespan? Who are the appropriate public and private partners necessary to implement and sustain momentum over time? How could the Commission support public-private partnerships and create sustainable funding streams to support suicide prevention?
- The Commission directly administers a $100 million grant program to support crisis triage personnel. Should the prevention of suicide, suicide attempt, and self-harm be prioritized as a key outcome of this investment? Should evaluation of this investment include suicide outcomes?
- The Commission approves a $100 million annual investment in innovations. How could the Commission encourage innovation in suicide prevention with this investment?

- The Commission regulates a $350 million annual state investment in prevention and early intervention, which includes the goal of reducing suicide among people with mental health needs. Currently, counties may use PEI to fund suicide prevention programs, including public and targeted information campaigns, suicide prevention networks, capacity building programs, culturally specific approaches, survivor-informed models, screening programs, suicide prevention hotlines or web-based suicide prevention resources, and training and education.[xii] Should the Commission use its regulatory authority to strengthen suicide prevention using this investment?

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[i] American Foundation for Suicide Prevention. Suicide: California 2017 Facts & Figures. Accessed January 12, 2018 at http://chapterland.org/wp-content/uploads/sites/10/2016/03/California-Facts-2017.pdf.
[ii] Ramchand, Rajeev and Amariah Becker. *Suicide Rates in California: Trends and Implications for Prevention and Early Intervention Programs*. Santa Monica, CA: RAND Corporation, 2014. Accessed on January 12, 2018 at https://www.rand.org/pubs/research_briefs/RB9737.html.
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[iv] U.S. Department of Health and Human Services, Office of the Surgeon General and National Action Alliance for Suicide Prevention. *2012 National Strategy for Suicide Prevention: Goals and Objectives for Action*. 2012. Accessed on January 11, 2018 at https://www.surgeongeneral.gov/library/reports/national-strategy-suicide-prevention/full-report.pdf.
[v] National Center for Injury Prevention and Control, CDC. Data Source: NCHS Vital Statistics System for numbers of deaths. *WISQARS: Web-based Injury Statistics Query and Reporting System*. (1999-2014). Accessed January 12, 2018 at https://webappa.cdc.gov.
[vi] American Foundation for Suicide Prevention. *Suicide: California 2017 Facts & Figures*. Accessed January 12, 2018 at http://chapterland.org/wp-content/uploads/sites/10/2016/03/California-Facts-2017.pdf.
[vii] Shepard, D. S., Gurewich, D., Lwin, A. K., Reed, G. A. and Silverman, M. M. (2016). *Suicide and Suicidal Attempts in the United States: Costs and Policy Implications. Suicide Life Threat Behav, 46*: 352–362. doi:10.1111/sltb.12225
[viii] Office of the Surgeon General and National Action Alliance for Suicide Prevention (2012). *National Strategy for Suicide Prevention: Goals and objectives for action*. Washington, DC: US Department of Health & Human Services.
[ix] *Guidance for State Suicide Prevention Leadership and Plans*, SAMHSA
[x] Wong, Y.J., Maffini, C.S., & Minkyeong, S. (2013). The Racial-Cultural Framework: A Framework for Addressing Suicide-Related Outcomes in Communities of Color, *The Counseling Psychologist, 42*, 13 – 54.
[xi] For the full report, please visit https://www.cdc.gov/violenceprevention/pdf/state-suicide-prevention-planning-brief.pdf
[xii] California Code of Regulations, Title 9, Section 3730. Suicide Prevention Programs.

Suicide Prevention Project
Panelist Biographies
May 24, 2018

JOHN BLACK, B.A., L.E., CEO of Peer Recovery Art Project Incorporated

Over 30 years ago my ambitions, hopes and dreams faded. At that time I slowly found myself imprisoned inside my mind as the onset of my first psychotic break introduced me to a world riddled with mental illness that destroyed my life. The episodes were horrific as family members, friends and business associates watched the disease take its course. For years I felt like I had failed my family friends and that my life was over. Even so I began to access care at a Stanislaus County Regional outpatient facility.

Recovery Happens: Peer Support

My world changed as I listened and learned from others who seemed to have risen above their destructive and humiliating past. I began my first step into service work as I helped to provide coffee and warm space at a local drop-in center. The volunteer tasks were minimal yet I began to feel a sense of belonging and really felt the unity amongst my peers. My service benefits were twofold. Not only was I helping others in their quest for sobriety but also for the first time I too remained sober. Now educated on the facts about sobriety my life took on new meaning. This service work, backed by a strong conviction to follow my psychiatrist's direction, proved very beneficial in opening the gates to freedom. Armed with a vision of hope and a reluctance to remain on Social Security, I chose to volunteer. My first mental health volunteer job was during the development of a new conceptual Stanislaus county mental health program, Wellness Recovery Center. We answered calls for peers and facilitated recovery support groups at a variety of locations including inpatient psychiatric hospital settings. I soon achieved purpose as a peer mentor. The position raised my self-esteem and fired my imagination. My career expanded into a position with Stanislaus County as the Behavioral Health and Recovery Service Peer Advocate with assignment as coordinator of Wellness Recovery Center. In 2017 I retired from Stanislaus County

Reintegration: Community

I set high goals for my education and received full scholarships at the junior college level. I served as a teacher's aide and received recognition as a goodwill ambassador to the college due to my efforts to enroll others. In 2010 I finished my studies at California State University at Stanislaus, participating in a leadership development program, and my bachelor degree in Social Sciences with Phi Kappa Phi honors. The long road of reconstruction filled with heartache and feelings of uselessness has now subsided. I have become through my life's experiences a better man. My example of strong recovery and perseverance has set the tone for others who may struggle on their respective paths to freedom. My life was (is) full of passion. I was "Gifted" in so many ways, that in 2004 I fell in love and married July 2007. As we returned from our honeymoon my lovely bride was diagnosed and sent to UCSF neurological center for brain aneurysm clipping. . In 2007 we founded and I continue to serve as CEO of Peer Recovery Art Project, a community service through arts as well as an emotional health and wellness organization. So much joy and intolerable pain ensued. My Love Linda was just too fragile for this world. On Valentine's Day

2015 she took her life. Little did I know that my journey was just beginning and life was to take on a whole new meaning. Even with all the education and life's experiences at 64 years of age I must work even harder on my recovery to try to be a model for others. I believe in recovery from mental illness, I live it and I share it.

KELECHI UBOZOH, Senior Program Associate, Resource Development Associates

Kelechi Ubozoh is a Nigerian-American writer and mental health advocate. A former journalist, Kelechi was the first undergraduate ever published in *The New York Times.* Kelechi is featured in the Substance Abuse and Mental Health Services Administration (SAMSHA) Voice Award-Winning documentary, *The S Word*, which follows the lives of suicide attempt survivors to end the stigma and silence around suicide. Previously, Kelechi supervised stigma discrimination reduction programs at a mental health non-profit organization, PEERS, where she partnered with Dr. Patrick Corrigan on a California Mental Health Services Authority (CALMHSA) Statewide project to provide mental health recovery story-telling trainings across 41 California counties. Her work also included overseeing a stigma reduction research project in the Chinese community with Dr. Larry Yang and Columbia University. Currently, Kelechi works as a consultant and conducts community-based participatory research and facilitation spanning the fields of mental health, child welfare, criminal justice, and education. Her poetry was recently published in an Anthology of San Francisco Area Writers & Artists of Color, called *Endangered Species, Enduring Values*.

CAITLIN RYAN, Ph.D., ACSW, Director, Family Acceptance Project, San Francisco State University

Caitlin Ryan is the Director of the Family Acceptance Project®. Dr. Ryan is a clinical social worker who has worked on lesbian, gay, bisexual, and transgender (LGBT) health and mental health for nearly 40 years. She received her clinical training with children and adolescents at Smith College School for Social Work. Dr. Ryan pioneered community-based acquired immune deficiency syndrome (AIDS) services at the beginning of the epidemic; initiated the first major study to identify lesbian health needs in the early 1980s; and has worked to implement quality care for LGBT youth since the early 1990s. She started the Family Acceptance Project with Dr. Rafael Diaz in 2002 to help diverse families to decrease rejection and prevent related health risks for their LGBT children - including suicide, homelessness and human immunodeficiency virus (HIV) - and to promote family acceptance and positive outcomes including permanency.

Dr. Ryan and her team have been developing a wide range of research-based materials and assessment tools to help families and caregivers to support their LGBT children, including a series of short documentary films that show the journey from struggle to support of ethnically and religiously diverse families with LGBT children. Her work has been acknowledged by many groups, including the American Psychiatric Association, the National Association of Social Workers, the American Psychological Association, Division 44 that gave her the Distinguished Scientific Contribution Award for groundbreaking research on LGBT youth and families, and many other groups. She has served on many national advisory groups including the Committee on

LGBT Health for the Institute of Medicine, National Academy of Sciences and the LGBT Suicide Prevention Task Force of the National Action Alliance for Suicide Prevention. Dr. Ryan is collaborating with institutions, agencies, faith communities and advocates to develop an international movement of family acceptance to promote wellness and healthy futures for LGBT children, youth and young adults.

SHARON BIRMAN, Psy.D., **Center for Deployment Psychology, West Los Angeles Veterans Affairs Medical Center**

Sharon Birman, Psy.D., is a clinical psychologist working at the Department of Veteran's Affairs. She has been dedicated to serving homeless Veterans, who have typically fallen between the cracks of our system, devoted to 'upstreaming' patient care. She is also a CBT trainer working with the Military Training Programs at the Center for Deployment Psychology (CDP) at the Uniformed Services University of the Health Sciences in Bethesda, Maryland, with whom she has traveled widely across the United States and OCONUS providing training in Evidence-Based Practices with military connected individuals. She joined the CDP in 2014 after completing her postdoctoral fellowship at Harbor-UCLA Medical Center, where she was actively involved in CBT and DBT intervention, supervision and education. She completed her pre-doctoral internship at Didi Hirsch Mental Health Center, focusing her training suicide prevention and evidence-based interventions for the treatment of individuals with severe, chronic mental illness. Dr. Birman received her bachelor's degree in psychology from the University of Southern California and her master's and doctorate degrees in clinical psychology from Pepperdine University.

CAROLYN STEAD, Psy.D., Senior Director, Integrated Behavioral Health, Institute on Aging

Dr. Stead currently serves as Senior Director of Integrated Behavioral Health at the Institute on Aging in San Francisco. Dr. Stead is a licensed clinical psychologist specializing in geriatrics. She completed her doctorate at William James College in Boston, MA, and fellowship in geropsychology at the Boston VA Healthcare System. Prior to moving to California, Dr. Stead served as a staff psychologist at the Boston VA, where she held an affiliated academic appointment at Harvard Medical School in the Department of Psychiatry. In 2017, Dr. Stead was selected to participate in the two-year California Health Care Foundation Health Care Leadership Program. Led by national experts in health care and leadership development from the Healthforce Center at UCSF, the program addresses health care issues from the perspectives of business management and public policy.

RAJEEV RAMCHAND, Ph.D., Senior Behavioral Scientist, RAND Corporation

Rajeev Ramchand, Ph.D. is Senior Behavioral Scientist with RAND Corporation. He studies the prevalence, prevention, and treatment of mental health and substance use disorders in adolescents, service members and veterans, and minority populations. He has conducted many studies on suicide and suicide prevention including environmental scans of suicide prevention programs, epidemiologic studies on risk factors for suicide, evaluations of suicide prevention

programs, and has developed tools to help organizations to evaluate their own programs. He has testified on suicide prevention before the United States Senate and California State Senate. Other current areas of research include military and veteran caregivers (he has testified before the U.S. House of Representatives on military caregivers), the role of firearm availability, storage, and policies on suicide, the impact of disasters on community health, and violent extremism. He received his B.A. in economics from the University of Chicago and his Ph.D. in psychiatric epidemiology from the Johns Hopkins Bloomberg School of Public Health.

BRENDA GREALISH, Acting Deputy Director, Mental Health and Substance Use Disorder Services, Department of Health Care Services

Brenda Grealish is currently the Acting Deputy Director for Mental Health and Substance Use Disorder Services. She was appointed Assistant Deputy Director for Mental Health and Substance Use Disorder Services within the California Department of Health Care Services (DHCS) in November 2014. As Acting Deputy Director, Ms. Grealish is responsible for all of the DHCS mental health and substance use disorder divisions. Ms. Grealish began her state career with the Office of Statewide Health Planning and Development. She then worked at the Department of Mental Health for almost ten years in increasingly responsible positions. She has four years of management experience with the Department of Corrections and Rehabilitation during which she advanced from a Research Manager II to a Research Manager III, then to Deputy Director. Prior to her appointment as Assistant Deputy Director, Ms. Grealish was the Chief of the DHCS Mental Health Services Division. Ms. Grealish has a Bachelor's and Master's Degree in Psychology.

KAREN SMITH, M.D., MPH, Director and State Public Health Officer, California Department of Public Health

On March 23, 2015, Karen Smith, MD, MPH, was sworn in as director of the California Department of Public Health and state public health officer. Dr. Smith is a physician specializing in infectious disease and public health. Prior to her appointment, Dr. Smith served as public health officer and deputy director at the Napa County Health and Human Services Agency beginning in 2004.

Dr. Smith completed her medical training and infectious diseases fellowship at Stanford University after having obtained a Master of Public Health degree at Johns Hopkins School of Hygiene and Public health. She served as clinical faculty at the Santa Clara County Valley Medical Center Division of Infectious Diseases from 1997 to 2004 and was a faculty consultant for the Francis J. Curry International Tuberculosis Center at the University of California, San Francisco from 1997. Smith also served as TB Controller and Deputy Health Officer for Santa Clara County from 1997 to 2004.

STATE OF CALIFORNIA
EDMUND G. BROWN JR., Governor

MHSOAC
Mental Health Services
Oversight & Accountability Commission

April 20, 2018

John Black, L.E.
Delivered via email

Dear Mr. Black:

Thank you for agreeing to participate in the Commission's public hearing on suicide prevention on Thursday, May 24, 2018 in our board room located at 1325 J Street, 17th Floor, Sacramento, California. The public hearing portion of the Commission's meeting will include three panels to support the Commission's understanding of opportunities to prevent suicide and suicide attempt, and support the Commission's efforts to develop a strategic statewide suicide prevention plan, as authorized by the California Legislature.

Your panel will highlight perspectives of survivors of suicide loss and attempt, and is scheduled to begin at approximately 9:30 a.m. Please plan to present for 10 to 15 minutes to leave time for conversation with Commissioners. Please organize your testimony to respond to the following:

- Your experience as a suicide loss survivor
- Resources you received - or would have liked to have received - after the death of your loved one, including what was helpful and what was harmful
- Challenges and opportunities for preventing suicide, especially for people with chronic suicidal thoughts or multiple attempts

Please send a brief biography and written response or background materials to the items above by Wednesday, May 9, 2018 to Ashley Mills at ashley.mills@mhsoac.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 available for those Commissioners unable to attend the meeting. Please note that your written responses and biography will be shared as public documents.

Should you have any questions, I can be reached at toby.ewing@mhsoac.ca.gov or 916.445-8729. Thank you again for your willingness to participate in this important meeting.

Respectfully,

Toby Ewing

Toby Ewing, Ph.D.
Executive Director

Experience: Incident

The neighbor called me home. The immense terror I felt upon arrival there were fire-trucks, police cars and my wife's best friend standing, there tears flowing. The officers would not let me in. Few minutes later we were let in, she lie on the floor covered by sheet. As I weep her friend pulled back the cover and kissed her forehead.

I screamed, ran to the side of home and cried. That started the journey of up down unidentifiable emotions while I immersed myself with peer support and community.

That week at the board meeting for Peer Recovery Art Project my team asked what direction I would take. I said business as usual, let's move forward. They confirmed and unanimously agreed they would prompt me up but I am and should continue to be the front man.

The first few months seemed ok, with purchase of a new home, host of parties, some travel, staying very busy. There were also hours of crying alone in my new home, but those tears seemed normal. I thought her death was more a sacrifice to help me because her struggles were so intense, or " right to die" incident. Not sure when but it was close to year before it hit, it was in fact suicide.

In addition to peer and community support I enlisted a health coach and I continue to follow his direction. My primary care doctor was very supportive and I took advantage of services from caring therapist as well.

Then on the anniversary of her death my brother I went to Cabo San Lucas. We had spent many vacations there in fact my wife were married there on the beach.

The trip triggered to a higher level of mania and delusions. Even though I knew my mental illness was flaring I was convinced I could manage it. The next year I opted for disability benefits from both PRAP and Stanislaus County Behavioral Health. June 10th 2017 I chose retirement after very successful career.

I was supported with bi-weekly therapy, primary care provider closely following me. In fact my primary care doc of over 20yrs commented " we cannot lose you now ". But still I found myself over the threshold of reality and listen up people I am strong recovery.

Finally after 20 yrs plus of stability and my primary referred to a psychiatrist of my choice. At first I resisted when he suggested medication for mania. At first few weeks meds were great, I slept good ate well, slept during the day and at night. Now I am well rested and 20 lbs heavier (UGH). I have adjusted my meds twice, gone back to work at Peer Recovery Art Project. Life is to be lived so that's the plan.


MAXIS

April 16, 2018

Kelechi Ubozoh
Senior Program Associate
Resource Development Associates
2333 Harrison Street
Oakland, CA 94612

Dear Ms. Ubozoh:

Thank you for agreeing to participate in the Commission's public hearing on suicide prevention on Thursday, May 24, 2018 in our board room located at 1325 J Street, 17th Floor, Sacramento, California. The public hearing portion of the Commission's meeting will include three panels to support the Commission's understanding of opportunities to prevent suicide and suicide attempt, and support the Commission's efforts to develop a strategic statewide suicide prevention plan, as authorized by the California Legislature.

Your panel will highlight perspectives of survivors of suicide loss and attempt, and is scheduled to begin at approximately 9:30 a.m. Please plan to present for 10 to 15 minutes to leave time for conversation with Commissioners. Please organize your testimony to respond to the following:

- Your experience as a survivor of multiple suicide attempts
- How suicide and suicide attempts are experienced in communities of color, including some of the reasons why suicides may be underreported for people of color
- Culturally relevant strategies for prevention and intervention that may more effectively address suicide and suicide attempt in diverse communities

Please send a brief biography and written response or background materials to the items above by Wednesday, May 9, 2018 to Ashley Mills at ashley.mills@mhsoac.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 available for those Commissioners unable to attend the meeting. Please note that your written responses and biography will be shared as public documents.

Should you have any questions, I can be reached at toby.ewing@mhsoac.ca.gov or 916.445-8729. Thank you again for your willingness to participate in this important meeting.

Respectfully,

Toby Ewing

Toby Ewing, Ph.D.
Executive Director

Biography

Kelechi Ubozoh is a Nigerian-American writer and mental health advocate. A former journalist, Kelechi was the first undergraduate ever published in *The New York Times.* Kelechi is featured in the SAMSHA Voice Award-Winning documentary, *The S Word*, which follows the lives of suicide attempt survivors to end the stigma and silence around suicide. Previously, Kelechi supervised stigma discrimination reduction programs at a mental health non-profit organization, PEERS, where she partnered with Dr. Patrick Corrigan on a CALMHSA Statewide project to provide mental health recovery story-telling trainings across 41 California counties. Her work also included overseeing a stigma reduction research project in the Chinese community with Dr. Larry Yang and Columbia University. Currently, Kelechi works as a consultant and conducts community-based participatory research and facilitation spanning the fields of mental health, child welfare, criminal justice, and education. Her poetry was recently published in an Anthology of San Francisco Area Writers & Artists of Color, called *Endangered Species, Enduring Values*.

Written Statement

Thank you for the invitation to present before the Commission on suicide prevention. I believe that just like people, systems can get better, healthier, stronger, and smarter. Over the past twenty years, the role of mental health consumers in the mental health service system has grown. However, suicide is still a topic that is taboo even within our mental health advocacy community. I am a suicide attempt survivor who wants to shatter the silence around suicide, because if my black community doesn't start talking about it we'll continue to lose more people to the 10th leading cause of death. I am someone who has been fired for disclosing having a mental health diagnosis at work and experienced discrimination in seeking help and receiving help in hospitals. These experiences drive my personal crusade to end the stigma of suicide and mental health through story. I am *honored* for the invitation to share my experience to support your suicide prevention work.

The intersection of mental health, communities of color, and suicide

- *MHSOAC Question: How are suicide/ suicide attempts experienced in communities of color? What is are some reasons suicide is underreported for people of color?*

*In this response, I will discuss my own personal experiences and work I've done in black communities.

There is a widespread misconception amongst many mental health professionals and researchers, that suicide is not a problem in black communities. However, this is **not true.** Recent studies show that nationwide, suicides among black children under 18 are up 71 percent in the past decade, rising from 86 in 2006 to 147 in 2016, the latest year such data is available from the Centers for Disease Control and Prevention.[1]

[1] http://www.chicagotribune.com/lifestyles/health/ct-black-childrens-suicide-20180308-story.html

The truth is, we are not having the right conversations about suicide in the black community. When I was struggling as a teenager with suicidal ideations and eventually attempted, I heard many problematic messages from my community. *Black people don't have mental health issues. We don't try to kill ourselves. Get over yourself. Stop being so dramatic. Pull yourself up by your bootstraps. Pray it away. Take it to Jesus. Mental illness is a "white problem".* None of these messages was helpful, eventually I started pretending that everything was okay so that I would not disappoint anyone or receive judgment from my community. There is a huge myth that the mere mention of suicide, plants the idea of suicide in someone's head. This is one of the many reasons people avoid the conversation. People are also afraid of saying the wrong thing. However, I know that because of the silence around suicide many people suffer in isolation. **We must create resources and venues for communities of color to safely have these important conversations.**

Blue Suicide

Most of the time black people are missing in the data around suicide, and "traditional research" does not always accurately capture our stories. During my work as a researcher and peer advocate, I interviewed black communities in San Bernardino County about suicide and mental health recovery. Young black men told me stories of losing their friends to *blue suicide*. They explained that because they grew up in the church, and that faith-based communities warn of the "spiritual consequences" of suicide (e.g. eternal damnation) that instead friends and family members who were struggling with thoughts of self-harm opted to intentionally antagonize police offers as a means to dying. This is called *blue suicide*. This concept came up across many interviews, because this neighborhood had lost several black community members (mainly young black men) to *blue suicide*. Community members shared that someone on the outside looking in would categorize these deaths as homicides, which demonstrates one of the ways that suicide in the black community goes underreported. **We have to get more culturally responsive approaches to data collection for communities of color to accurately reflect what is really going on.**

Trauma and the Label of Strong Black Women

For many black women, like myself, there is a disbelief that we are struggling because we are "so strong". According to a recent *New York Times* article, black women are more likely than white women to have experienced post-traumatic stress disorder resulting from childhood maltreatment and sexual and physical violence, and are more likely to have stress related to family, employment, finances, discrimination and or racism. Yet fewer than 50 percent of black adults with mental health needs receive treatment. Barriers include mental health stigma and shame, and black women also prefer black mental health care providers, and there are not enough[2]. Many of us suffer silently, because we have to take care of our families, hold it down at work, and show up for our communities. Even though many of my black sisters have

[2] https://www.nytimes.com/2018/04/25/opinion/strong-stressed-black-woman.html?smprod=nytcore-iphone&smid=nytcore-iphone-share

experienced trauma, discrimination and racism, many of us don't prioritize our own self-care. If we could shift the paradigm that asking for help is a strength not weakness, we might be able to reduce suicide attempts. **However, when we are ready to reach out for help, the help needs to be the ready for us.** When I was struggling with suicidal thoughts after a traumatic experience, I sought help at psychiatric hospital. Unfortunately, the staff thought because I was able to articulate my suicidal thoughts and depression that I couldn't be struggling. They were "culturally irresponsible". They ignored my mental health crisis, because I didn't look or act like some cast member of a Lifetime Movie. I, like many black women, "present well" and look put together. This means my pain often goes unseen. Shortly after being dismissed from needing care for being too "high-functioning", I was sent back to this very hospital after a suicide attempt. The very thing, I was trying to prevent.

<u>How communities of color present in a crisis</u>

For many communities of color, mental health and crisis present differently. What someone may view as "angry" or "aggressive" might actually be trauma. There is a high correlation/connection between trauma and suicide attempt and deaths by suicide (youth and adults). There is also a high correlation between experiencing racism and traumatic stress. Because of a myriad of reasons, (e.g. implicit bias) if communities of color cannot access mental health services because they aren't presenting in a way that is recognized by providers, they are at risk for receiving mental health services in emergency room settings or in the criminal justice system. **Trauma-informed approaches across the life span can address the issues driving suicidality.** Additionally, supported decision-making and collaborative approaches to care are important. Trauma-specific treatments such as EMDR and Somatic Experiencing Intentional peer support teaches a trauma-informed relational approach. I've personally benefited from trauma-informed therapy. I used to think recovery meant not every being in a dark place again. I was wrong. Recovery, for me, is about the choices you make when you are in those spaces. For me, healing was developing boundaries, being involved in the consumer recovery movement, removing toxic people from my life, poetry, and singing. I have created a safety net to catch myself, and I want to help build a community safety net for all of us.

- *MHSOAC Question:* What are culturally relevant strategies for prevention and intervention that may more effectively address suicide and suicide attempt in diverse communities?

As a mental health advocate who has benefitted from connecting with mental health advocates statewide, I thought it would only be appropriate to include them in this conversation about suicide prevention. Thank you to all of the peers, therapists, crisis intervention service providers, suicide prevention hotline workers, suicide attempt survivors, and suicide loss survivors who contributed to this response.

Culturally Relevant Strategies for Suicide Prevention

- **Consider employing culturally specific-mental health ambassadors to support suicide prevention planning.** While there are many things that communities of color share, each of these communities have a unique way of dealing with mental health and trauma. Include people from these diverse communities as mental health ambassadors and connecters to learn more about what works for them (e.g. art and healing, cultural specific practices).
- **Involve the voices of suicide attempt survivors and suicide loss survivors.** Each county should have consumers and family members representative of their "isolated and underserved" communities involved in the suicide prevention planning. It is important in communities of color to also authentically engage suicide attempt survivors of color (e.g. clear roles and responsibilities) to mitigate the experience of "tokenization".
- **Develop culturally-specific suicide prevention outreach tools that feature communities of color.** Suicide prevention needs faces of color and messages that will speak to these diverse communities. PSAs, Social Media, Billboards, Radio Ads can help normalize the conversation and let people know that suicidal ideation is something that many people experience. Include messaging that says they are not the only one or not alone and resources for help, and ensure these messages are available in many languages.
- **Create opportunities for POC with lived experience or survivors to connect and share their experiences** in safe spaces like support groups. This may help decrease stigma and isolation, increase knowledge of wellness tools, and normalize the conversation around suicide in diverse communities.
- **Alternatives to 911.** For many communities of color, calling police can escalate situations and many may avoid seeking help through this venue. Can the suicide prevention plan build networks of mutual aid and crisis-supports from the community? This should include outreach materials that provide information on alternatives to 911.
- **Strengthen discourse and 5150 Education for Law Enforcement.** A careful assessment is needed when writing a 5150. Sometimes an individual may appear to be a harm to themselves or others because they are intoxicated lead to a 5150. While in the more serious cases, of silence and hopelessness and possible rapid cycling (individuals in and out of psychiatric hospitals), nothing is done and the individual is not given the support they need. Oftentimes putting people on 5150's and placing them in a locked psych unit often exacerbates the issues. What can we learn as a community around this topic?
- **Recognize that "outcome-based/evidence based practices" are not always responsive to what consumers need in the moment.** Develop culturally responsive research that includes what is working right now and what consumers need [from people on the front line, e.g. crisis workers, warm line & hotline workers]. Involve consumers in how they measure their own success.
- **Increase overall capacity for County Crisis Support Services.** Statewide, crisis support services like warm lines, hotlines, crisis text, and crisis clinical services are seeing a severe increase in both need and calls (e.g. Alameda Crisis Support Services had 457 calls in January, and in March of 2018 had 832 calls). In order to meet the needs of these services (many who are volunteer run) these groups need more human resources,

funding and sustainability approaches to attract and maintain staff. Additionally, these groups need bilingual and bicultural staff to respond to the linguistic needs of diverse communities to provide a better option than tele-interpreters.

- **Strengthen data collection on suicide deaths by incentivizing partnerships with Coroner's offices.** Currently, there is no venue for systematic data collection from coroner's offices to support the conversation around data trends in suicide. This data could help inform outreach and crisis support needs.
- **Financially incentivize and hire more peers that are diverse and other behavioral health providers.** This also includes members from the LGBT+ communities.
- **Collaborate with primary care doctors and faith-based congregations/leaders** on how to recognize early warning signs and connect their members with mental health support. Learn from existing national models.
- **Create clinical support training for first responders like EMS/EMT and ER Nurses** who often interface with mental health consumers after a suicide attempt, but do not have training on how to triage or support them.
- **Provide information and resources to family/friends helping someone that is suicidal.** Providing support to the loved ones of those who are suffering is important. We need to educate and be supportive of family members, caregivers and friends who are supporting the individual who is at risk for suicide. Include wellness and self-care resources for the families that may be experiencing secondary trauma.
- **Develop several options for suicide prevention trainings.** Provide options from brief training on suicide prevention, "what to say to someone who is suicidal" to more intensive training like "assessment tools". Ensure trainings are free to the community, and host suicide prevention trainings for adult and youth of color.
- **Establish Statewide Peer Respite Centers**. Many mental health consumers are traumatized by their experiences in hospital settings. Peer respite centers can offer a home like environment that can be an alternative to crisis. Consider investing in crisis respite programs to divert from the Emergency Rooms.
- **Integrate the Zero Suicide** model in all inpatient hospital programs.
- **Partner with clinical programs to integrate mandatory intensive and robust suicide prevention training** into the curriculum for all providers interfacing with mental health consumers, including clinical interns. Trainings should include the intersectionality between systematic oppression (classism, racism, sexism, historical trauma) as risk factors for suicide. Provide ongoing support for their professional development.
- **Provide more education and training on assessment for suicide risk and ensure it includes cultural considerations**. Individuals at risk for suicidal ideation, intention and/or completing suicide look differently. There are cultural differences in relation to religious beliefs about dying and worldviews related to individual's racial identity. More educational support around assessment for suicide risk is need to aid clinicians in providing more thorough assessments as well as other service providers and officials who may come into contact with an individual who is at risk. Suicide is preventable and we can do so by starting with how we assess for suicide risk.

Trauma-Informed Suicide Prevention: An Idea Whose Time Has Come

Leah Harris, M.A.
Trauma Informed Care Specialist/Coordinator of Consumer Affairs
National Association of State Mental Health Program Directors

Trainer, National Center for Trauma Informed Care
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Twitter: @leahida

SAMHSA

What is Trauma?

Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.

Things to Remember

Underlying question =	"What happened to you?"
Symptoms =	Adaptations to traumatic events
Healing happens	In relationships

Video: ***Power of Empathy***

SAMHSA

What is the Adverse Childhood Experiences Study?

- **Decade long. 17,000 people involved.**
- **Looked at effects of adverse childhood experiences over the lifespan.**
- **Largest study ever done on this subject.**
- **Has been replicated in 28 states.**

Adverse Childhood Experience* Categories	Impact of Trauma and Health Risk Behaviors to Ease the Pain	Long-Term Consequences of Unaddressed Trauma (ACEs)
Abuse of Child ■ Recurrent Severe Emotional abuse ■ Recurrent Physical abuse ■ Contact Sexual abuse *Trauma in Child's Household Environment* ■ Substance abuse ■ Parental separation or divorce - ■ Chronically depressed, emotionally disturbed or suicidal household member ■ Mother treated violently ■ Imprisoned household member ■ Loss of parent – (by death, by suicide, - or by abandonment) *Neglect of Child* ■ Abandonment ■ Child's basic physical and/or emotional needs unmet * Above types of ACEs are the "heavy end" of abuse.	*Neurobiologic Effects of Trauma* ■ Disrupted neuro-development ■ Difficulty controlling anger-rage ■ Hallucinations ■ Depression ■ Panic reactions ■ Anxiety ■ Multiple (6+) somatic problems ■ Sleep problems ■ Impaired memory ■ Flashbacks ■ Dissociation *Health Risk Behaviors* ■ Smoking ■ Severe obesity ■ Physical inactivity ■ Suicide attempts ■ Alcoholism ■ Drug abuse ■ 50+ sex partners ■ Repetition of original trauma ■ Self Injury ■ Eating disorders ■ Perpetrate interpersonal violence	*Disease and Disability* ■ Ischemic heart disease ■ Cancer ■ Chronic lung disease ■ Chronic emphysema ■ Asthma ■ Liver disease ■ Skeletal fractures ■ Poor self rated health ■ Sexually transmitted disease ■ HIV/AIDS *Serious Social Problems* ■ Homelessness ■ Sex work ■ Delinquency, violence, criminal behavior ■ Inability to sustain employment ■ Re-victimization: rape, DV ■ compromised ability to parent ■ Intergenerational transmission of abuse ■ Long-term use of health, behavioral health, correctional, and social services

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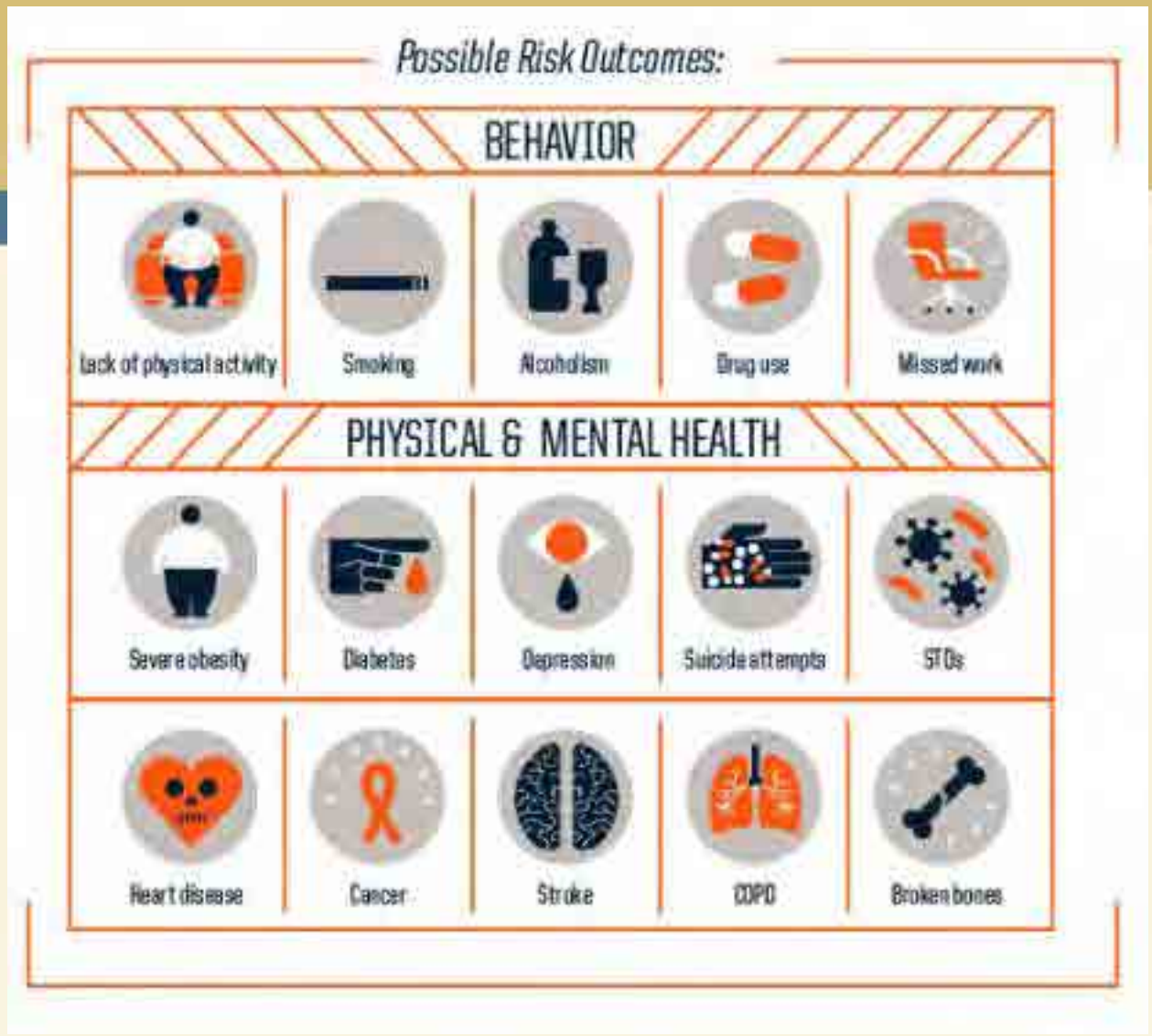
The higher the ACE Score, the greater the likelihood of…

- Severe and persistent emotional problems
- Health risk behaviors
- Serious social problems
- Adult disease and disability
- High health and mental health care costs
- Poor life expectancy
- Dose-response relationship consistently seen across domains



Source: rwjf.org/aces

SAMHSA

Trauma Prevalence in Children

71%

Number of children who are exposed to violence each year

(Finklehor, et al, 2013)

3 million

Number of children maltreated or neglected each year

(Child Welfare Info. Gateway, 2013)

3.5-10 million

Children witness violence against their mother each year

(Child Witness to Violence Project, 2013)

1 in 4 girls & 1 in 6 boys

Number who are sexually abused before adulthood

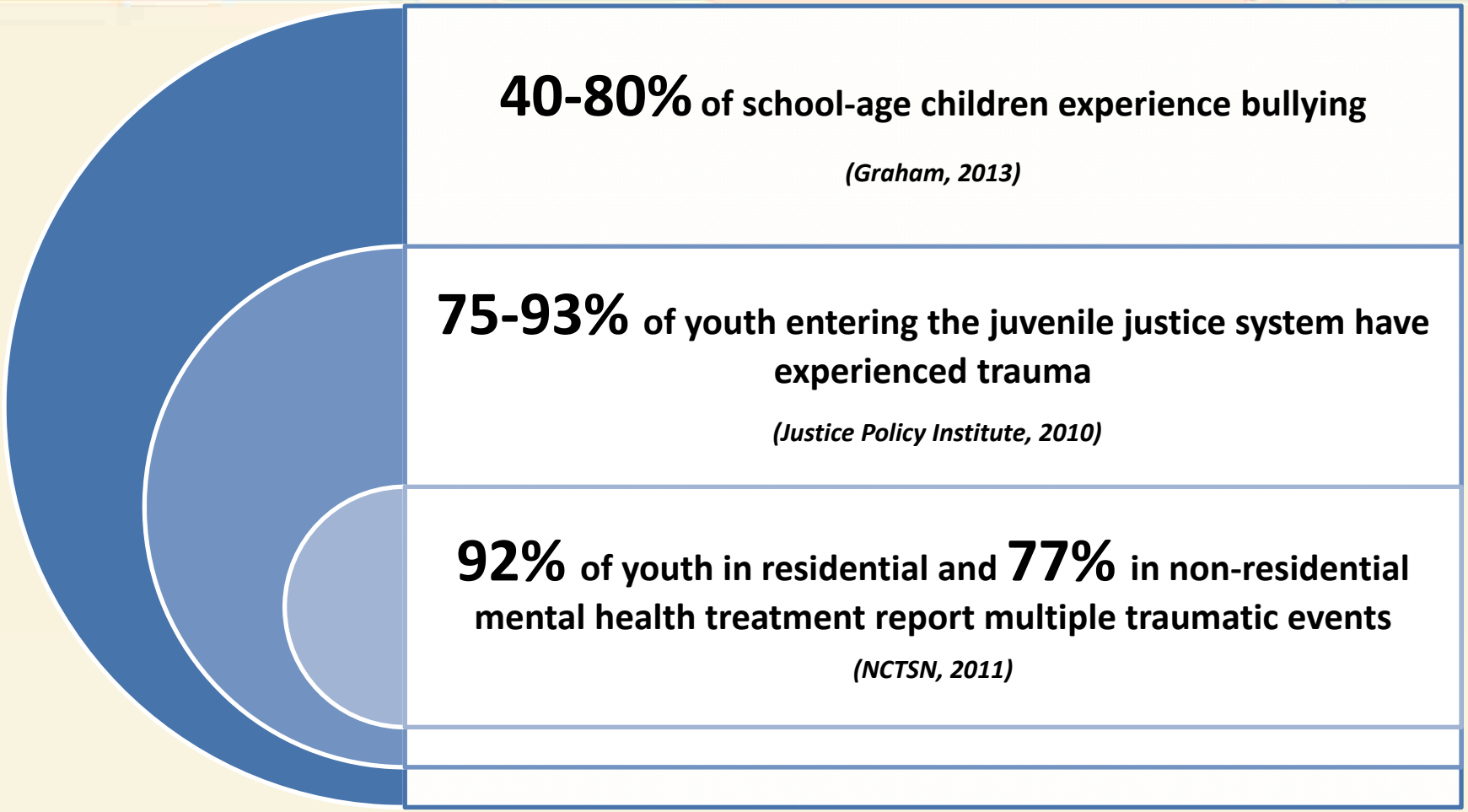
(NCTSN Fact Sheet, 2009)

94%

Percentage of children in a study of juvenile justice settings who have experienced trauma

(Rosenberg, et al, 2014)

Prevalence (Children), cont.



Trauma in Adults: Mental Health

84%+

Adult mental health clients with histories of trauma

(Meuser et al, 2004)

50% of female & 25% of male clients

Experienced sexual assault in adulthood

(Read et al, 2008)

Trauma in Adults: Mental Health, cont.

Clients with histories of childhood abuse

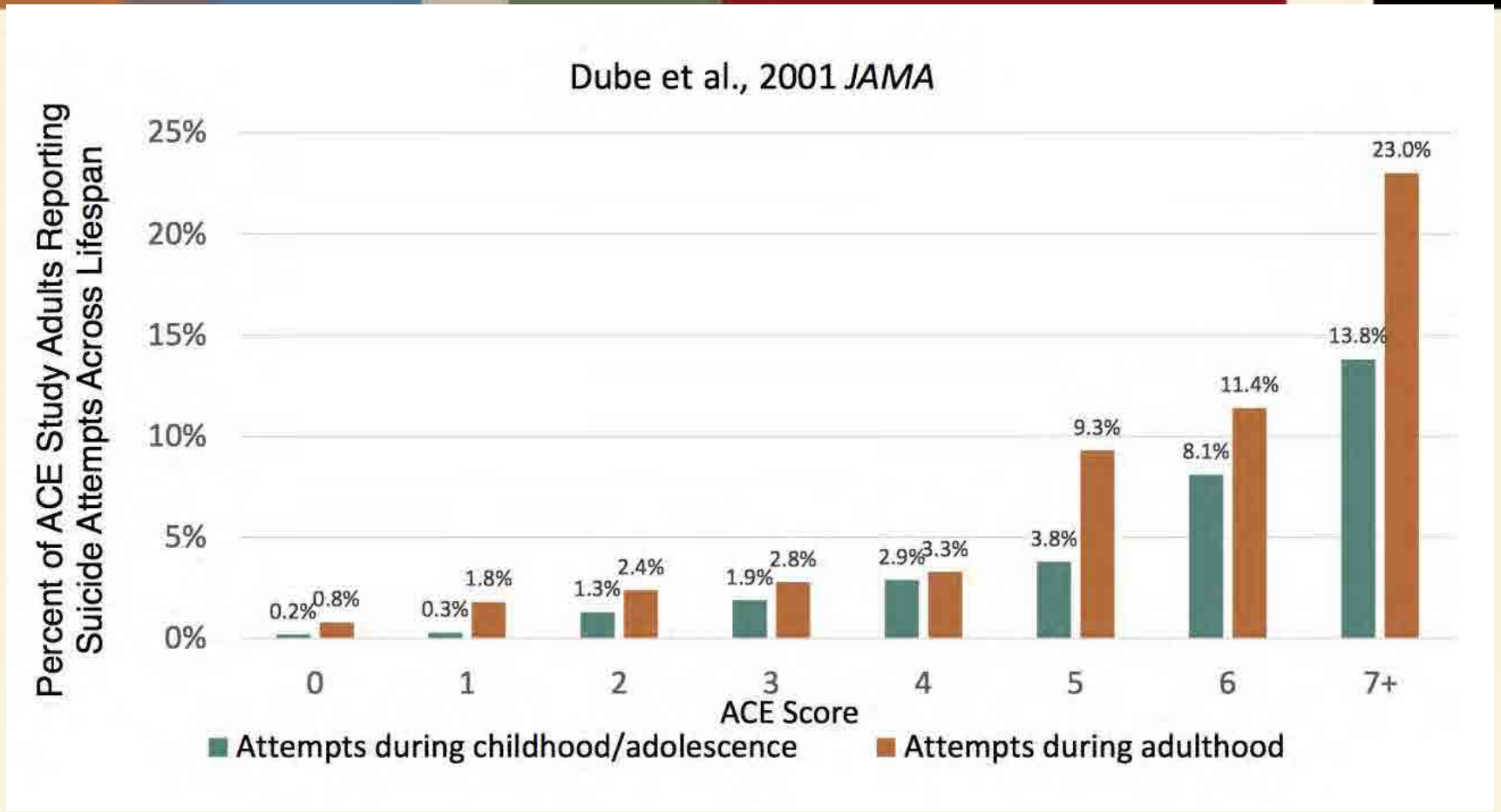
- Earlier first admissions
- More frequent and longer hospital stays
- More time in seclusion or restraint
- Greater likelihood of self-injury or suicide attempt
- More medication use
- More severe symptoms
  (Read et al, 2005)

ACEs and Suicide

- ACEs have a strong, graded relationship to suicide attempts during childhood/adolescent and adulthood.
- An ACE score of 7 or more increased the risk of suicide attempts **51-fold** among children/adolescents and **30-fold** among adults (Dube et al, 2001).
- Nearly two-thirds (64%) of suicide attempts among adults were attributable to ACEs and 80% of suicide attempts during childhood/adolescence were attributed to ACEs.

SAMHSA

ACES and Suicide



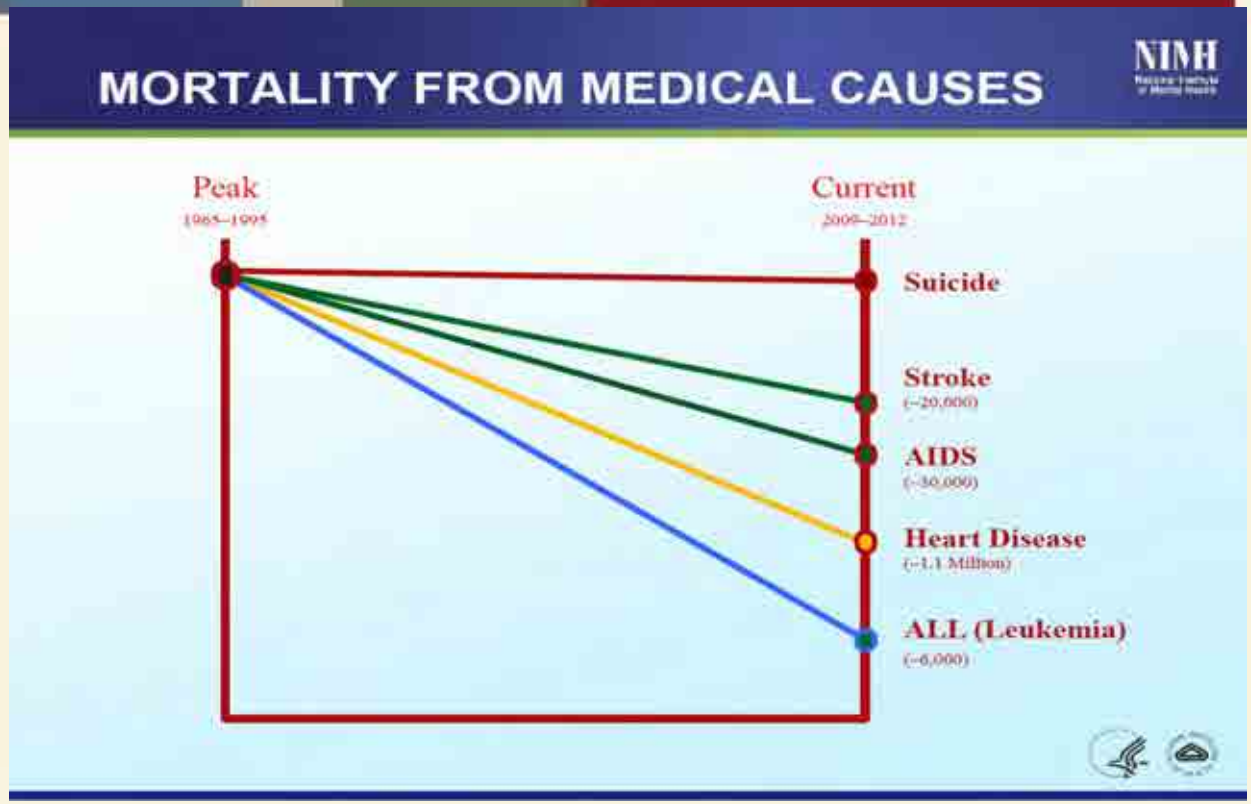
My Childhood in a Nutshell

My Story

- History of several documented adverse childhood experiences
- ACE Score: 7
- First thoughts of suicide: age 7
- Early trauma never addressed in mental health care
- Suicidality well established by teen years
- Multiple suicide attempts during adolescence
- Re-traumatized in mental health settings
- Did not receive trauma-specific treatment (EMDR, Center for Mind-Body Medicine) until my 30s

SAMHSA

We Must Shift the Paradigm!



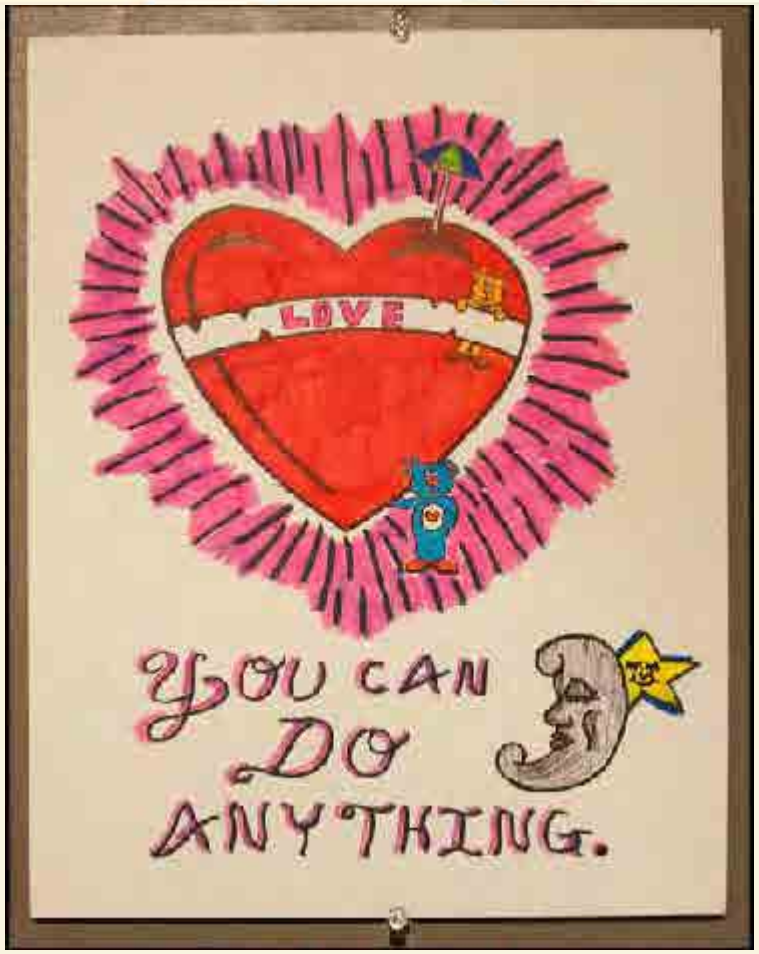
"We have failed to bend the curve when it comes to suicide prevention" -- Thomas Insel, director, NIMH

SAMHSA

Trauma Informed Approaches

- SAMHSA's Concept and Guidance for a Trauma Informed Approach
- Created in consultation with trauma survivors who had been recipients of care in multiple service system; practitioners from an array of fields, who had experience in trauma treatment; researchers whose work focused on trauma and the development of trauma-specific interventions; and policymakers in the field of behavioral health.
- MOST downloaded document on SAMHSA website!

Principle 1: Safety



Throughout the organization, staff and the people they serve, whether children or adults, feel physically and psychologically safe.

Who Defines Safety?

For people who use services:

- "Safety" generally means maximizing control over their own lives

For providers:

- "Safety" generally means maximizing control over the service environment and minimizing risk

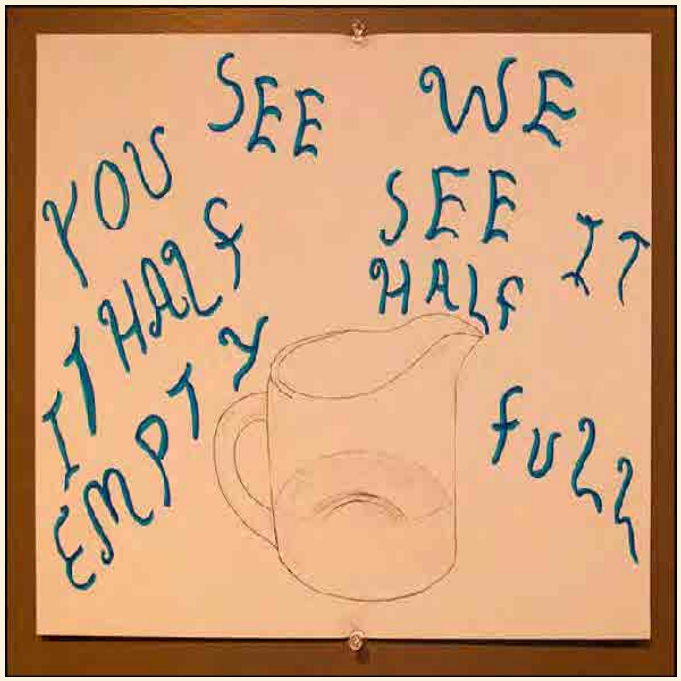
Discussion


Do staff feel safe in your organization?
Why or why not?
Do the people served feel safe?
How do you know?
What changes could be made to address safety concerns?

Principle 2: Trustworthiness and Transparency

Organizational operations and decisions are conducted with transparency and the goal of building and maintaining trust among clients, family members, staff, and others involved with the organization.

Examples of Trustworthiness



- **Making sure people really understand their options**
- **Being authentic**
- **Directly addressing limits to confidentiality**

Discussion

How can we promote trust throughout the organization?

Do the people served trust staff? How do you know?

What changes could be made to address trust concerns?

Principle 3: Peer Support

Peer support and mutual self-help are key vehicles for establishing safety and hope, building trust, enhancing collaboration, serving as models of recovery and healing, and maximizing a sense of empowerment.

Peer Support, cont.

Peer support = A flexible approach to building mutual, healing relationships among equals, based on core values and principles:

- *Voluntary*
- *Non-judgmental*
- *Respectful*
- *Reciprocal*
- *Empathetic*

Peer Roles

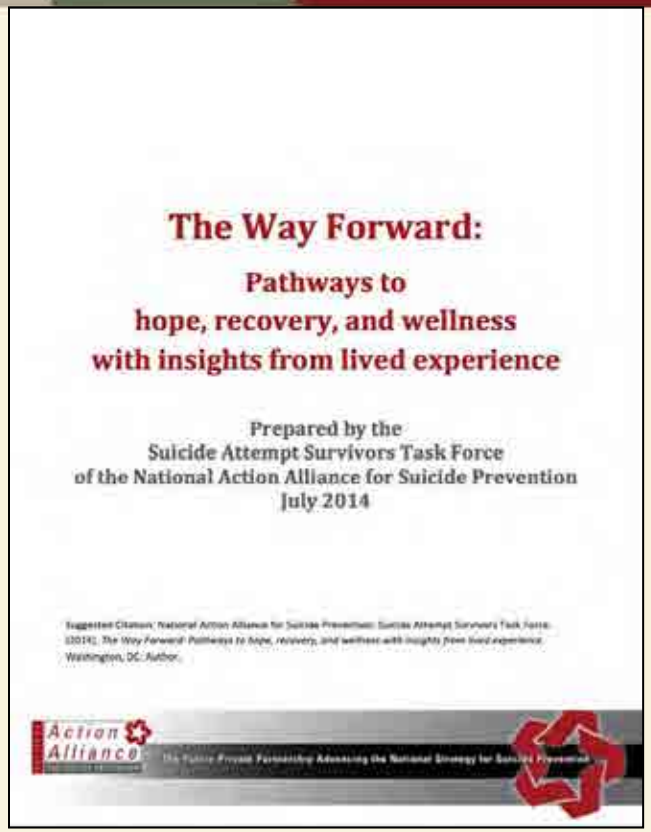
- Developing screening and assessment instruments
- Outreach and engagement
- Emergency departments
- Mobile crisis teams
- Treatment teams
- Safety planning
- Peer to peer support groups and networks
- Follow up care/facilitating connections to services, natural community supports and resources
- Research and evaluation

Peer to Peer Support Groups

- While there are many support groups for behavioral health conditions, there are few specifically designed for and led by suicide attempt survivors

- Groups in existence report positive outcomes including: improvements in mood, thinking, impulsivity, connectedness/belonging, and hope; increased connectedness, decreased suicidal desire, and improved safety planning

Resource: The Way Forward



Access at: http://bit.ly/1k2nGvy

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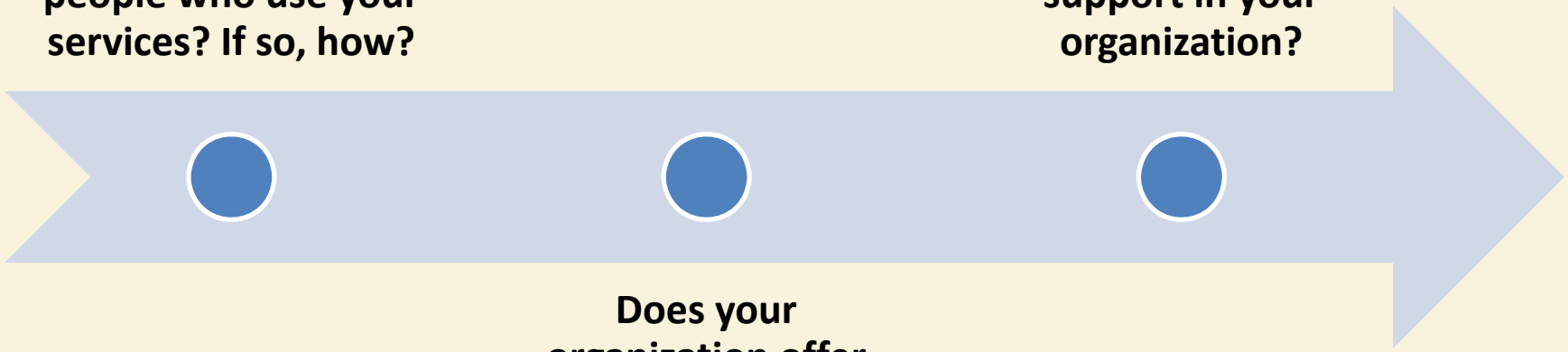
Questions to Consider

Does your organization offer access to peer support for the people who use your services? If so, how?

Does your organization offer peer support for staff?

What barriers are there to implementing peer support in your organization?



Principle 4: Collaboration and Mutuality

Partnering and leveling of power differences between staff and clients and among organizational staff from direct care to administrators; demonstrates that healing happens in relationships, and in the meaningful sharing of power and decision-making.

Everyone has a role to play; one does not have to be a therapist to be therapeutic.

Examples of Collaboration

"There are no static roles of 'helper' and 'helpee'—reciprocity is the key to building natural community connections."—*Shery Mead*

Hospital abolished special parking privileges and opened the "Doctor's Only" lounge to others

Models of self-directed recovery where professionals facilitate but do not direct

Direct care staff and residents in a forensic facility are involved in *every* task force and committee and are recognized for their valuable input

Principle 5: Empowerment, Voice, and Choice

Individuals' strengths and experiences are recognized and built upon; the experience of having a voice and choice is validated and new skills developed.

The organization fosters a belief in resilience.

Clients are supported in developing self-advocacy skills and self-empowerment

Examples

- Treatment activities designed and led by hospital residents
- Murals on walls painted by staff and residents
- Turning "problems" into strengths

Discussion

- Can you think of examples from your work setting of empowerment, voice and choice for people served?
- What about for staff?
- Can you think of policies or practices that do the opposite—that take voice, choice, and decision-making away? Could any of these things be changed?

Principle 6: Cultural, Historical, and Gender Issues

The organization actively moves past cultural stereotypes and biases, offers gender-responsive services, leverages the healing value of traditional cultural connections, and recognizes and addresses historical trauma.

Cultural Considerations

Self Identity

- Race
- Ethnicity
- Age
- Gender
- Sexual orientation
- Language
- Family
- Beliefs about capabilities
- History
- Country where born

TRAUMA

Belonging and Participation

- Spirituality
- Education
- literacy
- Incarceration
- Military
- Employment/Income
- Where you live
- Immigration status
- Illness/wellness
- Parenting

SAMHSA


We don't see things as they are,
we see things as we are.
– Anais Nin

Suicide Prevention and Trauma Informed Care Get Hitched!

- Screen for ACEs and current trauma as part of assessment process
- Utilize collaborative approaches to assessment and screening (CAMS)
- Train staff in trauma informed approaches
- Incorporate peer support and lived experience in meaningful ways
- Seek to build trusting, respectful relationships as a cornerstone of care
- Self care strategies for staff and persons served

SAMHSA

Shameless Plug

- If your agency or organization is looking to become more trauma informed, you can get free and low-cost support and technical assistance!
- Zero Suicide: http://zerosuicide.sprc.org
- National Center for Trauma Informed Care http://www.samhsa.gov/nctic

"If you think you're too small to make a difference, try sleeping in a room with a mosquito."

African Proverb

Additional Resources

- The ACE Study: www.acestudy.org
- AN EARLY PATHWAY TO PREVENTING SUICIDE: THE ROLE OF ADVERSE CHILDHOOD EXPERIENCES http://www.scattergoodfoundation.org/activity/general/linda-chamberlain-scholar#.ViaQvNasCFs
- Dube SR, Anda RF, Felitti FJ et al. Childhood abuse, household dysfunction, and the risk of attempted suicide throughout the lifespan: Findings from the Adverse Childhood Experiences Study. JAMA, 2001; 286:3089-3095.
- SAMHSA's Concept and Guidance for a Trauma Informed Approachhttp://store.samhsa.gov/shin/content/SMA14-4884/SMA14-4884.pdf
- Alternatives to Suicide Peer-to-peer Support Groups:http://www.westernmassrlc.org/alternatives-to-suicide
- Manual for Support Groups for Suicide Attempt Survivorshttp://www.sprc.org/bpr/section-III/manual-support-groups-suicide-attempt-survivors
- The Way Forward: Pathways to hope, recovery, and wellness with insights from lived experience http://bit.ly/1k2nGvy
- Zero Suicide and Trauma Informed Care: webinarhttp://zerosuicide.sprc.org/webinar/zero-suicide-and-trauma-informed-care

SAMHSA

FROM PUNISHMENT TO HEALING:

BREAKING THE CYCLE OF CRIMINALIZATION OF MENTAL HEALTH

Leah Harris, MA

Shifa Consulting, Inc

TODAY'S WORKSHOP

- How racism intersects with mentalism
- Ways "treatment" can re-traumatize/punish
- The trauma to prison pipeline
- Police violence against people with mental health conditions
- Innovative approaches for healing

TWIN BIAS RUNNING THROUGH SYSTEMS

- Racism + Mentalism (similar to ableism)
- Mentalism: defined as **discrimination** and **violence** against people of all races who are perceived as unstable or "mentally ill."
- Runs through the educational, mental health, juvenile justice and criminal justice systems
- All of our systems actually!

HISTORY OF RACIAL BIAS IN MENTAL HEALTH: SCIENTIFIC RACISM

- Benjamin Rush, MD, father of modern psychiatry described Negroes as suffering from an affliction called Negritude, which was thought to be a mild form of leprosy. The only cure for the disorder was to become white.
- Drapetomania: a conjectural mental illness that, in 1851, American physician Samuel A. Cartwright hypothesized as the cause of "black slaves fleeing captivity."
- In the late 1960s, Vernon Mark, William Sweet and Frank Ervin suggested that urban violence, which most African-Americans perceived as a reaction to oppression, poverty and state-sponsored economic and physical violence, was actually due to "brain dysfunction," and recommended the use of psychosurgery to prevent outbreaks of violence.

In Our Own Voice – African-American Stories of Oppression, Survival and Recovery in Mental Health Systems by Vanessa Jackson https://power2u.org/wp-content/uploads/2017/01/InOurOwnVoiceVanessaJackson.pdf

THE ENDURING LEGACY

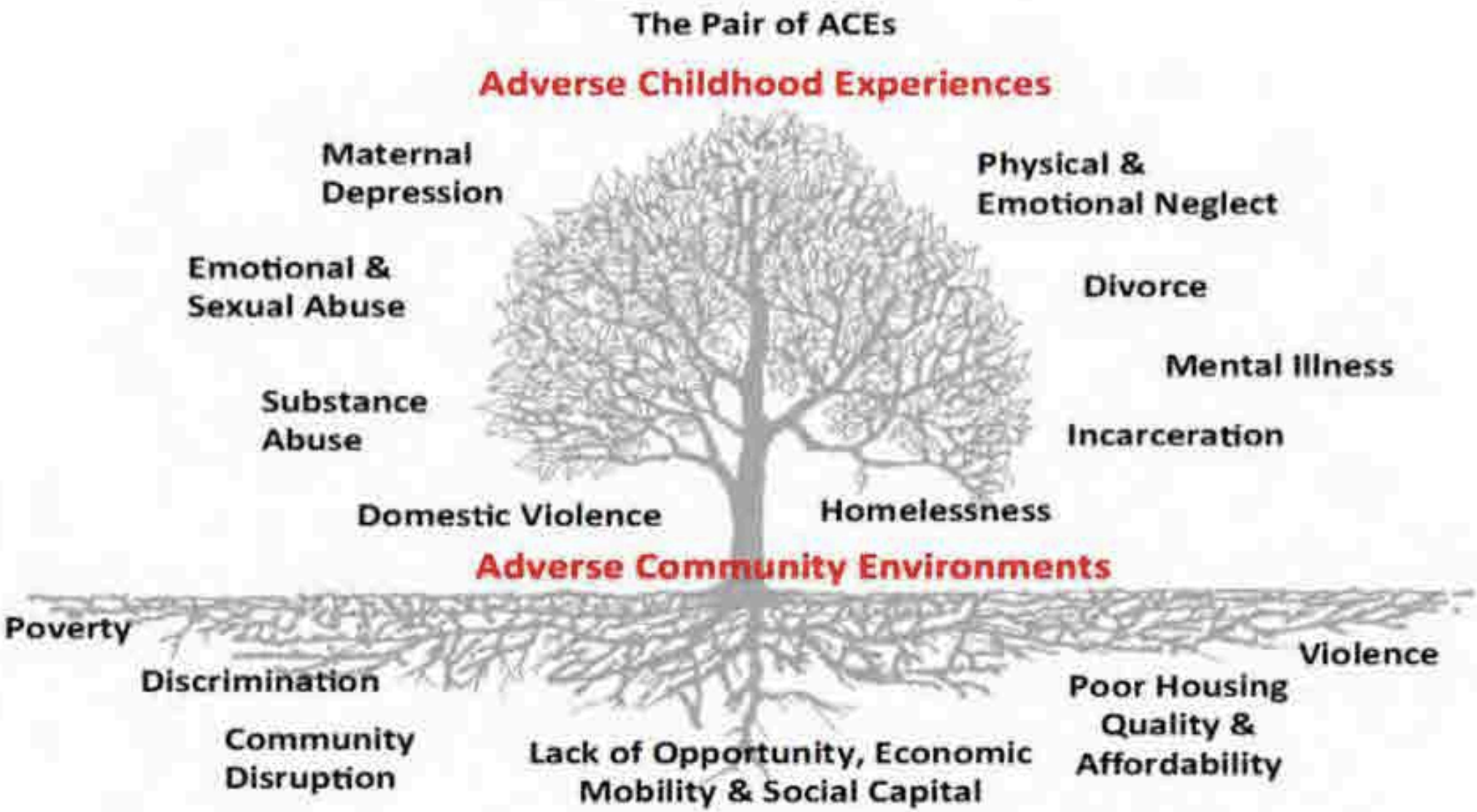
- Today: when PoC CAN access mental health care, they are more likely to have their behaviors diagnosed as "schizophrenia" than whites.
- Within the mental health system: PoC are more likely to be subjected to coercive mental health treatment, which include forced inpatient and outpatient hospitalization, and restraint and seclusion (solitary confinement).
- In the State of Colorado, the most recent yearly report for FY 2013 documents consistently that African Americans are disproportionately subjected to a wide range of coercive and restrictive measures, including 72-hour holds, certifications, instances of seclusion and restraint, extended seclusion and restraint, and involuntary medication. While African Americans are only 4% of Colorado's population, they represent 8% of these measures overall, 11% of seclusion and restraint, and over 11% of extended seclusion, extended restraint and involuntary medication.
- A study of a New York City forensic psychiatric institution (psychiatric commitment resulting from criminal proceedings) found that African Americans comprised 56% of the inmates and represented 65% of the seclusion (solitary confinement) episodes, although they make up only 25% of the city's population.

Jonathan Metzl, *The Protest Psychosis: How Schizophrenia Became a Black Disease*

CRIMINALIZATION OF TRAUMA AND MENTAL HEALTH

- *"The social conditions that affect a person's likelihood of going to prison also increase the likelihood that this person will have had numerous traumatic experiences that affect them in ways that psychiatry classifies as mental illness. In effect, trauma, poverty and race are both criminalized and psychiatrized."*

Source: Report on Forced Psychiatry and Psychiatric Abuse Against African-Americans as Intersectional Discrimination Based on Race and Disability: http://tbinternet.ohchr.org/Treaties/CERD/Shared%20Documents/USA/INT_CERD_NGO_USA_17741_E.pdf



Ellis, W., Dietz, W. (2017) A New Framework for Addressing Adverse Childhood and Community Experiences: The Building Community Resilience (BCR) Model. Academic Pediatrics. 17 (2017) pp. S86-S93. DOI information: 10.1016/j.acap.2016.12.011

RACISM IS TRAUMATIC

- Black Americans' psychological responses to racism are very similar to common responses to trauma:
- Somatization, which is psychological distress expressed as physical pain; interpersonal sensitivity; and anxiety,
- Individuals who said they experienced more and very stressful racism were more likely to report mental distress
- African Americans constitute only 2 percent of the nation's psychologists and psychiatrists

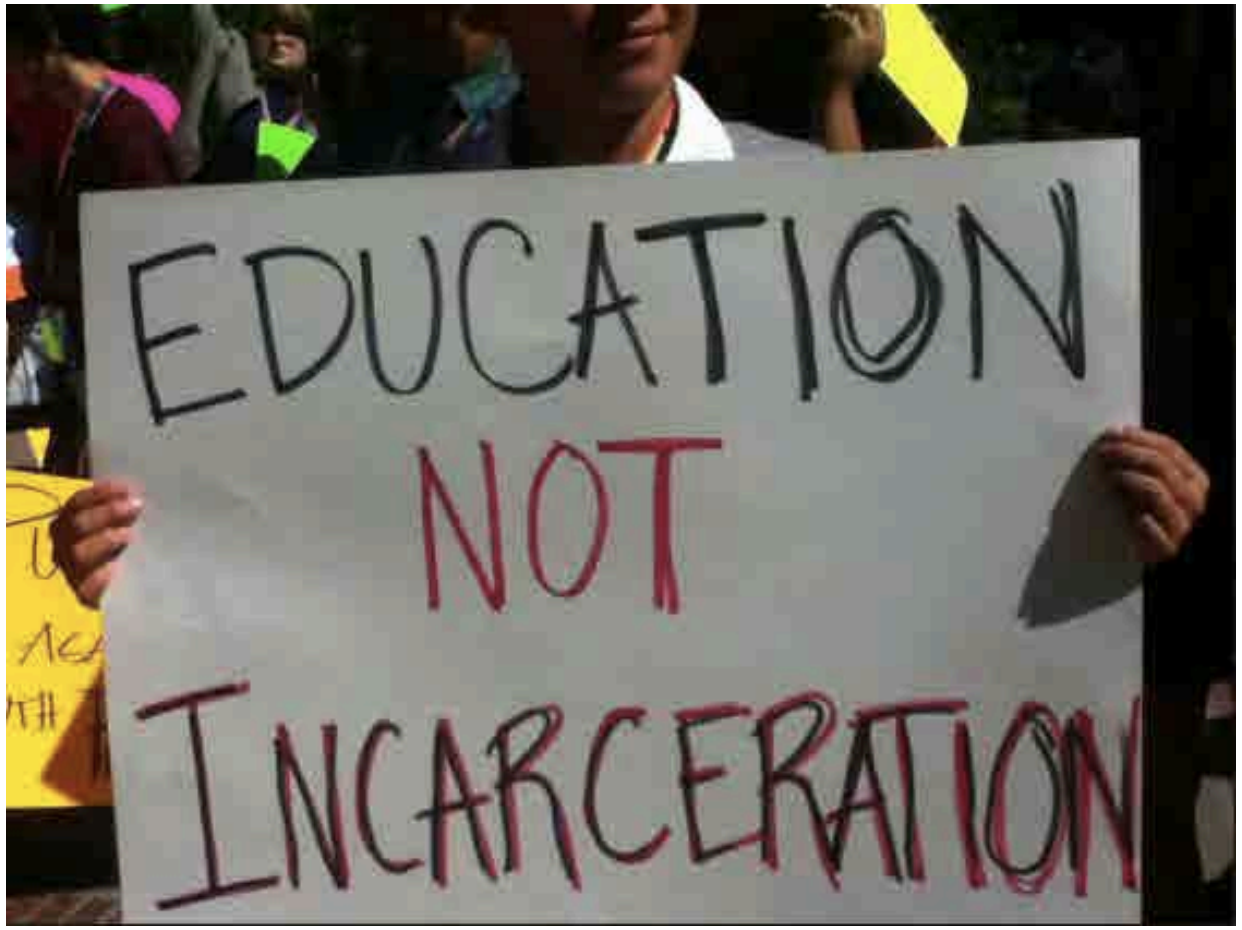
"Perceived Racism and Mental Health Among Black American Adults: A Meta-Analytic Review," Alex L. Pieterse, PhD, University at Albany, State University of New York; Nathan R. Todd, PhD, DePaul University; Helen A. Neville, PhD, University of Illinois at Urbana-Champaign; and Robert T. Carter, PhD, Teachers College, Columbia University; *Journal of Counseling Psychology*, Vol. 59, No. 1.

QUESTION THE MASTER NARRATIVE

- Certain groups, rightly condemning the criminalization of mental health, advocate for decarceration and "treatment" instead
- But what forms will this "treatment" take?
- Beware the "treatment-industrial complex" – same old corporations profiting in new ways from trauma/oppression

Source: https://www.bravenewfilms.org/treatmentcomplex

SCHOOL TO PRISON PIPELINE



Source: https://www.aclu.org/issues/juvenile-justice/school-prison-pipeline/school-prison-pipeline-infographic

Disproportionately impacted:

- Students of color are more likely to be labeled with "emotional disturbance"/disability
- Black students 3x more likely to be suspended or expelled than white students
- Students expelled or suspended 3x more likely to be in contact with the JJ system
- Second language learners

TRAUMA TO PRISON PIPELINE

- Students of color are disproportionately disciplined for subjective offenses, such as "disrespect", compared with white students.
- However, **the rates at which African-American and white students "act out" are essentially equal**.
- Root of the problematic disciplinary behavior is often not addressed. What's triggering the behavior: anxiety? Hunger? Problems at home? Trauma?
- Harsh disciplinary reactions to youth who are seeking attention and "acting out" may escalate and worsen the situation, creating a cycle of greater student distress and harsher and harsher disciplinary actions.

Source: "Suspended Progress", JustChildren Program Legal Aid Justice Center, May 2016. https://www.justice4all.org/wp-content/uploads/2016/05/Suspended-Progress-Report.pdf

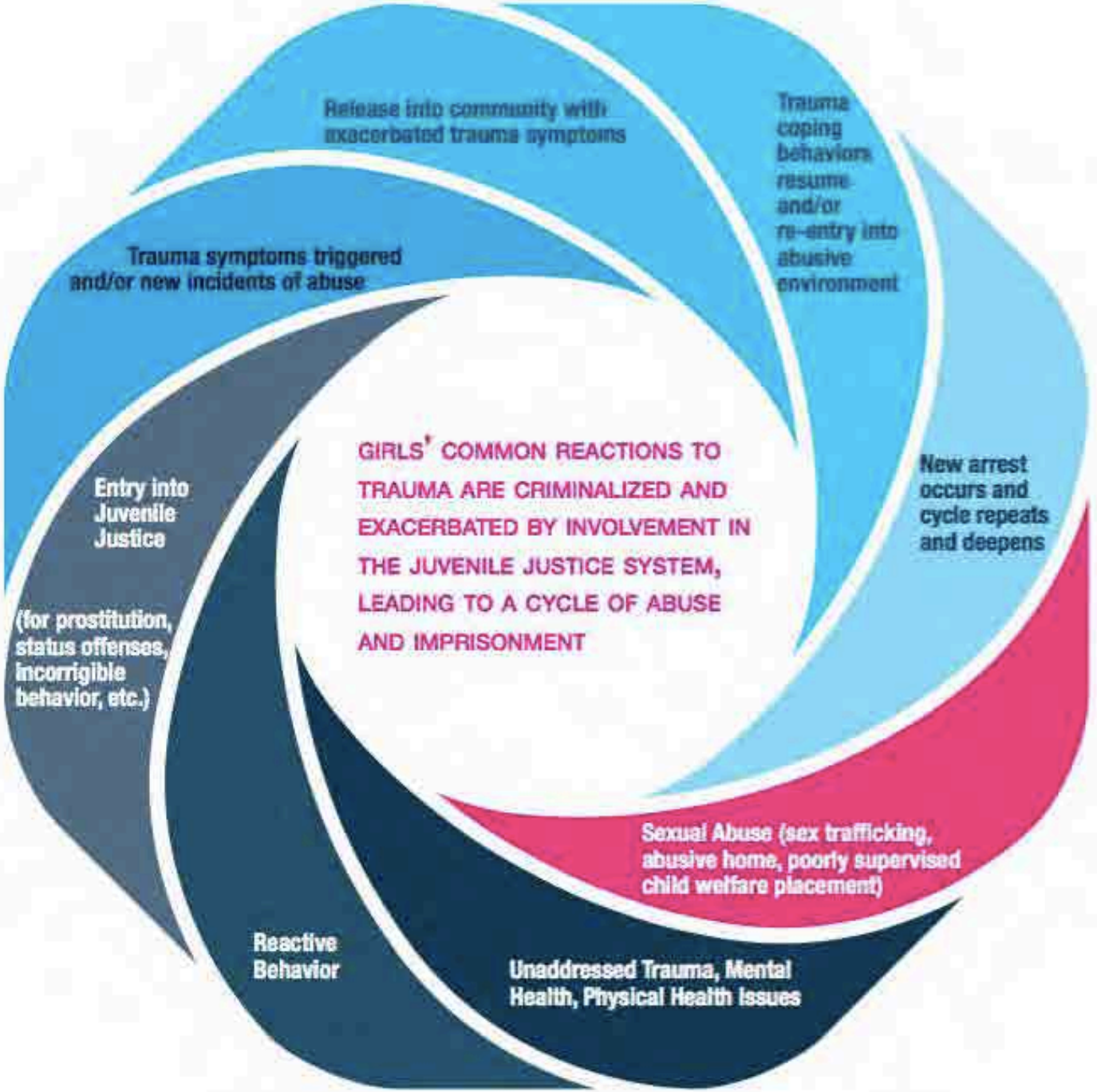
SEXUAL ABUSE TO PRISON PIPELINE

Source: Michael T. Baglivio et al., US Dep't of Justice, Office of Justice Programs, Office of Juvenile Justice & Delinquency Prevention, *The Prevalence of Adverse Childhood Experiences (ACE) in the Lives of Juvenile Offenders*, 3 JOURNAL OF JUV. JUSTICE 1, 9 (Spring 2014), *available at* http://www.journalofjuvjustice.org/JOJJ0302/JOJJ0302.pdf.

GIRLS OF COLOR AND THE PIPELINE

- Youth of color account for 45 percent of the general youth population, but girls of color — who are approximately half of all youth of color — comprise approximately two-thirds of girls who are incarcerated.
- African-Americans constitute 14 percent of the general youth population nationally, but one-third of incarcerated girls.
- Native Americans are one percent of the general youth population, but Native American girls are up to four percent of girls incarcerated.
- Latina girls are con ned at a rate of 47 per 100,000, compared to 37 per 100,000 of non-Hispanic white girls.

SOURCE: http://rights4girls.org/wp-content/uploads/r4g/2015/02/2015_COP_sexual-abuse_report_final.pdf


Release into community with exacerbated trauma symptoms
Trauma coping behaviors resume and/or re-entry into abusive environment
Trauma symptoms triggered and/or new incidents of abuse
New arrest occurs and cycle repeats and deepens
GIRLS' COMMON REACTIONS TO TRAUMA ARE CRIMINALIZED AND EXACERBATED BY INVOLVEMENT IN THE JUVENILE JUSTICE SYSTEM, LEADING TO A CYCLE OF ABUSE AND IMPRISONMENT
Entry into Juvenile Justice
(for prostitution, status offenses, incorrigible behavior, etc.)
Sexual Abuse (sex trafficking, abusive home, poorly supervised child welfare placement)
Reactive Behavior
Unaddressed Trauma, Mental Health, Physical Health Issues

POLICE VIOLENCE

- According to The Washington Post, half of the hundreds of people who are killed by police each year are people with psychiatric disabilities.
- The Portland Press Herald found that 42 percent of those shot by the police in Maine were also "mentally ill."
- However, a report from the New Mexico Public Defender Department found that 75 percent of police shootings "involved a mental health context."

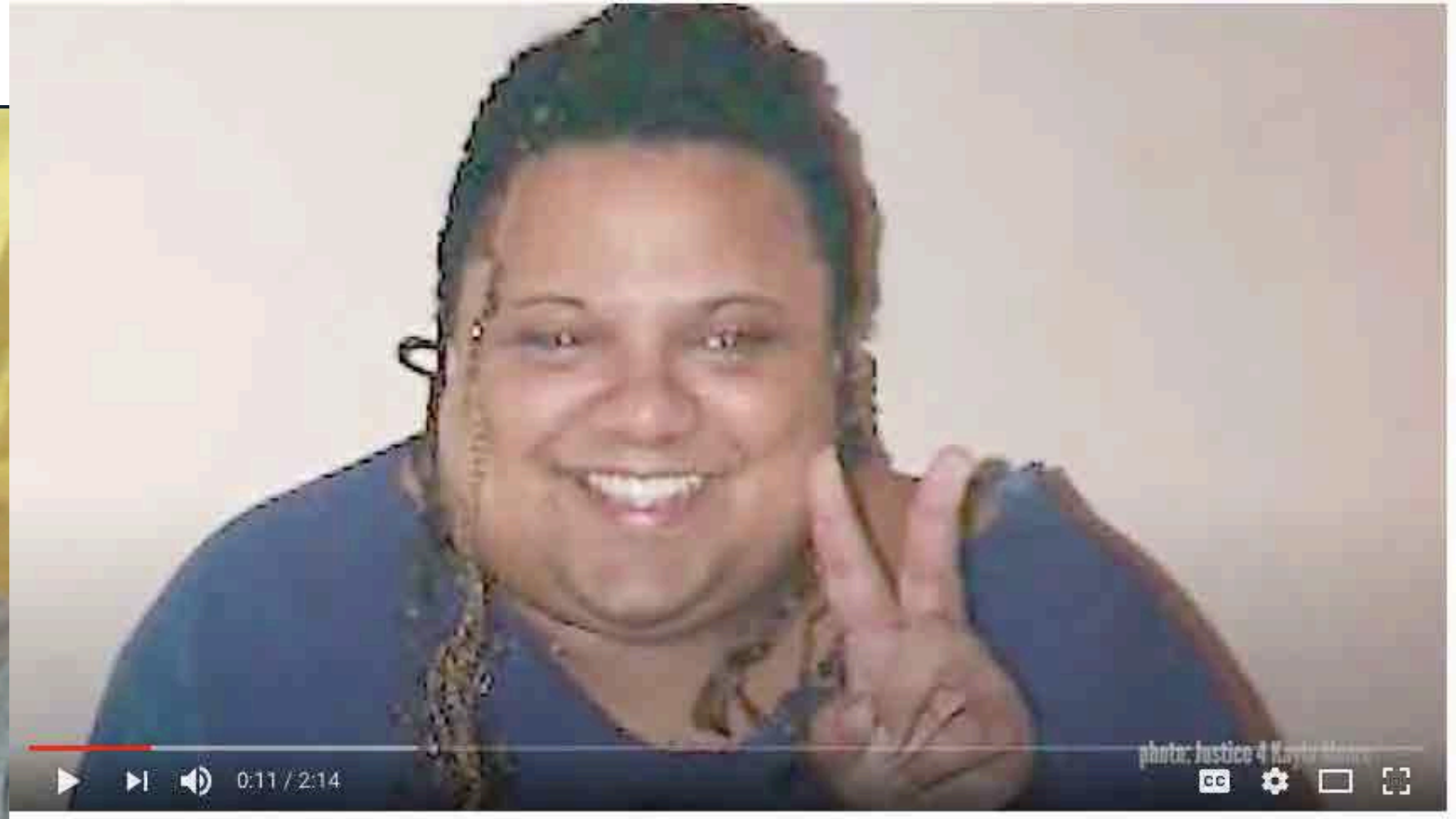
Tanisha Anderson

Sandra Bland

Dontre Hamilton

POLICE VIOLENCE AGAINST TRANSGENDER AND GENDER NONCONFORMING PEOPLE

Scout Schultz, killed by police at Georgia Tech



Justice 4 Kayla Moore: #sayhername

POLICE VIOLENCE AND THE "CULT OF COMPLIANCE"

"In many cases, people who die at the hands of the police don't obey commands, and the police initiate violence despite there being no imminent threat to their safety."

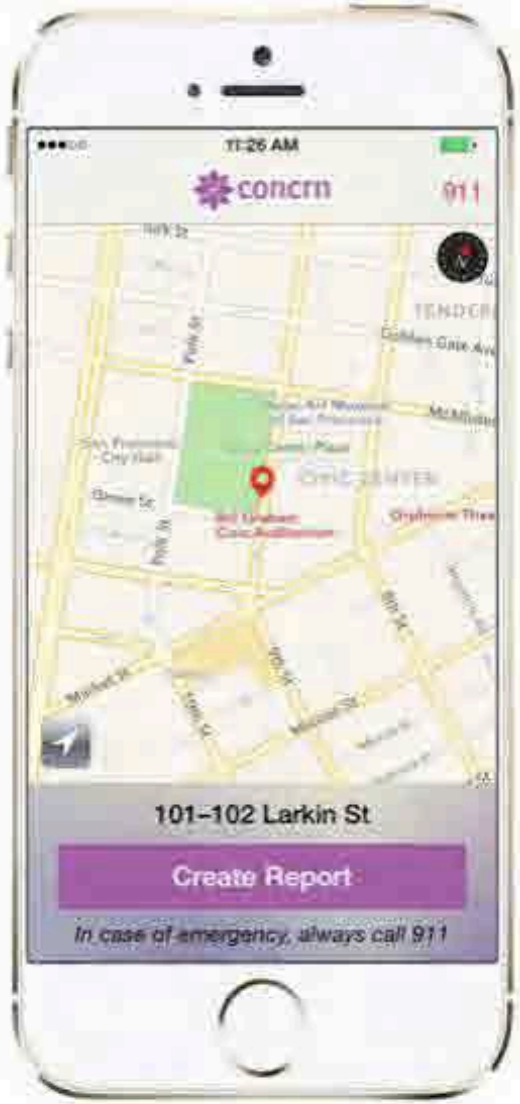
"In cases that seem very different, separated by factors such as age, race, gender, sexuality, geography, class and ability, police explain away their actions by citing noncompliance. They do it because it works. They do it because according to their beliefs, **any sign of noncompliance is an invitation to strike."**

THINK BEFORE YOU CALL 911

"Calling the police often escalates situations, puts people at risk, and leads to violence. Anytime you seek help from the police, you're inviting them into your community and putting people who may already be vulnerable into dangerous situations. Sometimes people feel that calling the police is the only way to deal with problems. But we can build trusted networks of mutual aid that allow us to better handle conflicts ourselves and move toward forms of transformative justice, while keeping police away from our neighborhoods."

Source: https://www.sproutdistro.com/catalog/zines/organizing/12-things-instead-calling-cops/

concrn

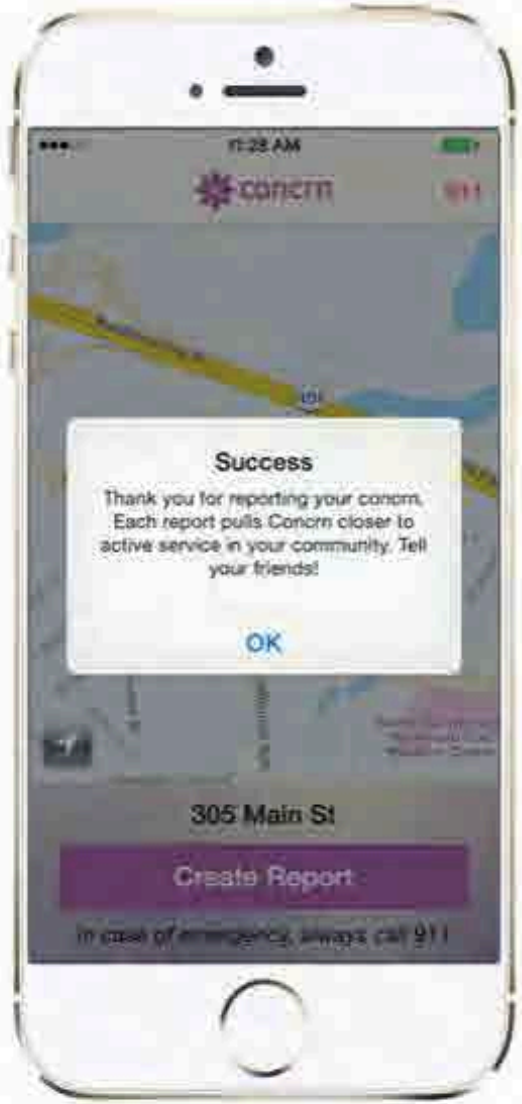


Identify

When you see a neighbor in emotional or behavioral health crises in the Tenderloin, you now have an alternative to calling emergency services.

Report

Use the Concrn App or text 415-881-8278 to request a Compassionate Responder in the Tenderloin.



Response

Trained Concrn Responders will arrive to mediate or provide assistance. Concrn Responders connect our neighbors to shelters & services as needed.

MIND-BODY SKILLS FOR COPING AND HEALING

Yoga practice can restore neurological pathways in a region of the brain that processes emotion awareness, and decreases in size among female trauma survivors.

Trauma-informed yoga can help girls overcome a feeling of disconnection to their body that is common among survivors of sexual violence.

Reported greater levels of self-esteem, self-respect and general wellbeing.

Showed declines in anger, depression, flashbacks, nightmares and anxiety.

Improved their ability to identify negative behavior patterns and resolve conflicts.

Used breathing techniques to avoid aggressive responses to provocations by peers and to manage the stress of appearing in court.

Reported past incidents of sexual violence to staff.

Holistic Life Foundation

Yoga, Self-Control and Social Transformation

TOWARDS SOLUTIONS

- Policy and practice, social, economic, political sources of trauma
- Policies that address the roots of oppression and traumatic stress for PoC and other historically marginalized communities
- Support Black Lives Matter Movement https://policy.m4bl.org
- Restorative justice approaches
- Support jail diversion and non-police response to mental health calls
- Trauma-sensitive and trauma-informed approaches across systems
- Trauma sensitive schools
- We must break down the silos! People who have experienced trauma, including racial trauma, often "touch" multiple systems
- Encourage and support community-level healing initiatives

CONTACT AND RESOURCES

leahharris10@gmail.com to receive a copy of this presentation

- Movement for Black Lives: https://policy.m4bl.org
- Showing Up For Racial Justice: http://www.showingupforracialjustice.org
- Breaking the Chains: The School to Prison Pipeline, Implicit Bias, and Racial Trauma https://equaljusticesociety.org/breakingthechains/
- Holistic Life Foundation: http://hlfinc.org
- Niroga Institute: http://www.niroga.org
- Rights For Girls: http://rights4girls.org
- Sexual Abuse to Prison Pipeline Report: https://rights4girls.org/wp-content/uploads/r4g/2015/02/2015_COP_sexual-abuse_layout_web-1.pdf
- Adverse Childhood Experiences (ACE) Study: acestudy.org
- How Childhood Trauma Affects Health Across a Lifetime (TED Talk) https://www.ted.com/talks/nadine_burke_harris_how_childhood_trauma_affects_health_across_a_lifetime
- ACEs too High: https://acestoohigh.com
- Engaging Women in Trauma-Informed Peer Support: https://www.nasmhpd.org/content/engaging-women-trauma-informed-peer-support-guidebook

STATE OF CALIFORNIA
EDMUND G. BROWN JR., Governor

MHSOAC
Mental Health Services
Oversight & Accountability Commission

April 16, 2018

Caitlin Ryan, Ph.D., ACSW
Family Acceptance Project
San Francisco State University
1600 Holloway Avenue
San Francisco, CA 94132

Dear Dr. Ryan:

Thank you for agreeing to participate in the Commission's public hearing on suicide prevention on Thursday, May 24, 2018 in our board room located at 1325 J Street, 17th Floor, Sacramento, California. The public hearing portion of the Commission's meeting will include three panels to support the Commission's understanding of opportunities to prevent suicide and suicide attempt, and support the Commission's efforts to develop a strategic statewide suicide prevention plan, as authorized by the California Legislature.

Your panel will highlight suicide prevention opportunities across the lifespan, and is scheduled to begin at approximately 10:30 a.m. Please plan to present for 10 to 15 minutes to leave time for conversation with Commissioners. Please organize your testimony to respond to the following:

- Factors that increase and protect against suicide risk in children and transition-aged youth (TAY), and opportunities for preventing suicide and suicide attempt
- The mission of the Family Acceptance Project, and how the research conducted by the project could help inform policies and practices to prevent suicide and suicide attempt
- How the state could support local efforts to prevent suicide and suicide attempt and improve mental health outcomes for children and TAY, particularly children and TAY identifying as LGBT or gender diverse

Please send a brief biography and written response or background materials to the items above by Wednesday, May 9, 2018 to Ashley Mills at ashley.mills@mhsoac.ca.gov. Your written responses will allow Commissioners attending the meeting the opportunity to prepare questions for you after your presentation, and will be available for Commissioners unable to attend the meeting. Please note that your written responses and biography will be shared as public documents.

Should you have any questions, I can be reached at toby.ewing@mhsoac.ca.gov or 916.445-8729. Thank you again for your willingness to participate in this important meeting.

Respectfully,

Toby Ewing

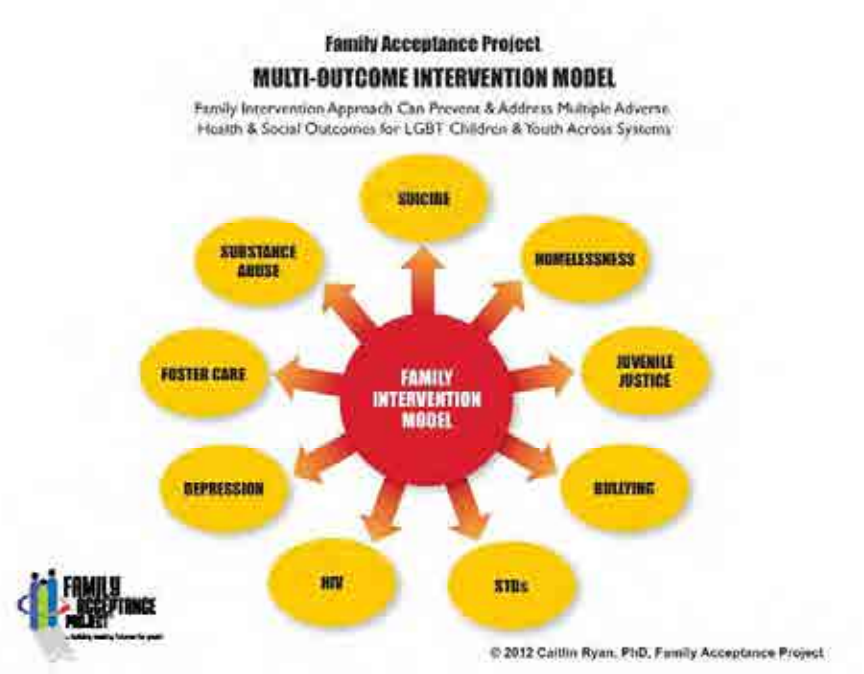
Toby Ewing, Ph.D.
Executive Director

Ryan, C. (2014). Generating a revolution in prevention, wellness & care for LGBT children & youth, *Temple Political & Civil Rights Law Review*, 23(2):331-344.

GENERATING A REVOLUTION IN PREVENTION, WELLNESS & CARE FOR LGBT CHILDREN & YOUTH

CAITLIN RYAN[1]

I want to start by reimagining the future for LGBT youth. Let's start with what we know and what programs, policies and services continue to reinforce at the individual and systems level. We know a *great deal* about very negative health and social outcomes that LGBT young people face and have faced for decades. These include a range of serious negative outcomes that affect individuals, their families, and society, in general, through the health and social costs of stigma, restricted life chances and lost lives.



Then I want to talk about where we need to go. We have a framework through the work of the Family Acceptance Project (FAP) and the emergence of family-based services to change this for *so* many LGBT young people who have been separated

1. PhD, ACSW, Director, Family Acceptance Project, SF State University.

from their families, their cultures and their communities. The Family Acceptance Project is a research, intervention, education, and policy initiative that was founded to help diverse families to support their LGBT children. Our research has shown that families do, indeed, have a compelling impact on their LGBT children's health, mental health, and well-being. Not just negatively, but also positively. That is a critical part of reimagining the future for LGBT children and adolescents. Society has focused for so long on the negatives. We must start thinking about the positives and start aligning public and private services and systems of care to promote the health and well-being of LGBT children and youth. This requires normalizing inclusion of the families of LGBT children and adolescents in education, services, care and support for their LGBT children as they are for children and adolescents, in general.

I. CHANGING THE DISCOURSE

Our team at the Family Acceptance Project has worked with very diverse families and foster families with LGBT children through our research and family intervention work for nearly fourteen years.[2] This includes working with very socially and religiously conservative families who believe that homosexuality is wrong and that gender diversity undermines their deeply held values and beliefs. We have found that families can learn to support their LGBT children when information is presented in ways that resonate with their values and beliefs—to protect their children and to help them have a good life, to strengthen and keep their families together. In essence, what we have done is to give families a different way of thinking about their LGBT children by shifting the discourse on homosexuality from morality to health and well-being, which had not happened prior to the work of the Family Acceptance Project. We have used our foundational research to develop a new evidence-based wellness, prevention and intervention model to change the way that LGBT youth are served by engaging in a family-oriented framework for prevention, services, and care that focuses on wellness as the outcome. This goes far beyond just protecting LGBT young people from harm, which has become the standard for serving LGBT youth in public settings.

Historically, most research on LGBT adolescents concentrated on schools and focused primarily on protecting LGBT youth from harm which was urgently needed. Research surprisingly ignored the other two key institutions (in addition to schools) that socialize children and adolescents: families and faith communities. These institutions were left out, not only in research, but also in programs and community services. It may seem startling, but when we initiated the first comprehensive study of what happens in families when LGBT young people come out, are forced out, or found to be LGBT during adolescence, research had only taken place from the perspective of the adolescent and not from the perspective of both LGBT youth and their families.

2. *See* FAMILY ACCEPTANCE PROJECT, http://familyproject.sfsu.edu/overview (last visited Apr. 19, 2014).

A. Lack of Family-Oriented Research & Accurate Information

When we started the Family Acceptance Project, research related to LGB adolescents and families was extremely limited, and the concept of transgender identity was still emerging. Only one or two studies had asked LGB youth about their family experiences and almost all of those studies used closed-ended survey questions that gave a few multiple choice answers to describe interactions and experiences with their parents.[3]

Research, at the time, did little to inform or change the prevailing perception among LGBT youth, adults, and providers that families were unsupportive at best and toxic at worst, and that families were unable to support their LGBT children. Perceptions of family reactions drove the way that services developed and evolved within LGBT youth support programs and mainstream health and mental health services. Providers saw part of their role in rendering services and care as protecting LGBT youth from harm, which included protecting them from their parents and families. Few providers asked LGBT youth about family support, and the primary means of helping LGBT adolescents was referring them to peer support groups that may or may not have been available in their communities.

Historically, across a range of domains—from mental health to primary care—HIV and cancer support, quality care, and culturally competent services for LGBT people emerged first within the LGBT community. But across mainstream and LGBT services, the lack of research on other key aspects of LGBT adolescents' lives beyond school settings led to a lack of family-oriented services, family approaches to care, and even limited understanding of how to talk with diverse parents and caregivers about their children's sexual orientation and gender identity.

As a social worker who has worked on LGBT health and mental health for 40 years, including with LGBT young people living with HIV/AIDS and their families, I knew that family dynamics and reactions to LGBT youth were far more varied and complex. I also knew that research with adolescents, in general, had shown that family support was protective against major health risks. And I saw that some LGB adolescents, even during the 1980s, had accepting parents, while many parents were ambivalent—so not all were rejecting.

I saw these developments in the field, and my team documented them empirically over time. In addition, every three years, starting in 2003, we conducted a statewide telephone survey of all of the LGBT-related services in California, as part of the impact evaluation for our work. When we started this work, we found no services, or even outreach activities among LGBT programs or support groups to help provide education and support to help parents and caregivers to support their LGBT children. By 2007, when we routinely provided training on our research findings and our family support strategies, the perception from one of oldest and

3. See, e.g., Anthony R. D'Augelli et al., *Lesbian, Gay, and Bisexual Youth and Their Families: Disclosure of Sexual Orientation and its Consequences, 68(3). Am. J. Orthopsychiatry 362 (1998).*

largest LGBT youth programs in the country was to not talk about families at the program. Agency staff believed that families were too painful for the youth to discuss.

The silence around these issues has had serious consequences because families are seen as adversaries by many providers and advocates who work with LGBT youth. We have to change that frame for a number of reasons. The most powerful of these is the young age of awareness and coming out among LGBT youth. We have known beginning with research in the late 1980s that, on average, young people report awareness of sexual attraction at about age ten.[4] We have seen in key studies of LGB youth since the early 1990s that, on average, young people were self-identifying as lesbian, gay or bisexual between ages fourteen and sixteen,[5] and, through our research with FAP we found that the average age of self-identifying as lesbian gay or bisexual was a little over age thirteen.[6] Our understanding of gender identity has been evolving, in research and practice, to inform how we guide families in supporting their gender diverse children. Children usually develop a sense of gender identity by about age three, and express this in a variety of ways.[7] For example, very young children express gender through their preferences for clothes, colors, hairstyles and toys. They have a personal sense of gender, even though the people around them may not understand that, and may try to push or force them in a different direction.[8] We have seen, not only through our research but also through the family intervention work we have done for the past ten years with LGBT children, youth and families that young people have a deep sense of who they are from very early ages. Increasingly, we have seen children identify as gay between ages seven and twelve.[9] Yet so many adults, including parents, families, providers

4. *See, e.g.*, ANDREW BOXER, CHILDREN OF HORIZONS: HOW GAY AND LESBIAN TEENS ARE LEADING A NEW WAY OUT OF THE CLOSET (1993); *See* D'Augelli et al., *supra* note 3, at 363 (reporting that awareness of sexual attraction typically occurred at age ten); Ryan et al., *Family Acceptance in Adolescence and the Health of LGBT Young Adults*, 23 J. CHILD & ADOLESCENT PSYCHIATRIC NURSING 205, 212 (2010) [hereinafter Ryan et al., *Family Acceptance*] (stating that researchers have observed that the average age of sexual attraction is about age 10 for heterosexual and homosexually identified youth).

5. *See* Caitlin Ryan, *LGBT Youth: Health Concerns, Services and Care.* CLINICAL RESEARCH AND REGULATORY AFFAIRS, 20, 141, (2003).

6. *See* CAITLIN RYAN ET AL., FAMILY ACCEPTANCE PROJECT, SAN FRANCISCO STATE UNIVERSITY, SUPPORTIVE FAMILIES, HEALTHY CHILDREN: HELPING FAMILIES WITH LESBIAN, GAY, BISEXUAL & TRANSGENDER CHILDREN 1 (2009), *available at* http://familyproject.sfsu.edu/publications [hereinafter RYAN ET AL., SUPPORTIVE FAMILIES] (finding "that the average age that youth realized they were gay was a little over age 13").

7. *See* Scott F. Leibowitz & Norman P. Spack, *The Development of a Gender Identity Psychosocial Clinic: Treatment Issues, Logistical Considerations, Interdisciplinary Cooperation, and Future Initiatives*, 20 CHILD & ADOLESCENT PSYCHIATRIC CLINICS N. AM., 701, 702 (indicating that gender identity generally usually develops by age three).

8. *Id*. at 712.

9. *See* RYAN ET AL., SUPPORTIVE FAMILIES at 1.

and religious leaders have a misperception that sexual orientation is only about sex and is not consolidated until late teens, or adulthood. However, *sexual orientation* is about human relationships and connectedness, including social and emotional relatedness. Moreover, young people know who they are at much younger ages than prior generations of LGBT adults largely as a result of widespread access to information, more accurate and positive images of LGBT people in the media and public life and knowing others who are LGBT. In addition, as social stigma continues to decrease, we are starting to see – for the first time – normative development of sexual orientation and gender identity which means that families, and institutions, including schools, faith communities, health and social service systems and policymakers, urgently need accurate information about these core aspects of human development.

In particular, parents and caregivers need accurate information and guidance to parent, nurture and care for their LGBT children. Without education, *accurate* information and support for families from all backgrounds, how will they learn to help their children? And how can families ask providers for accurate information and guidance when providers do not understand this either? This key knowledge and service gap becomes more serious every day since few services are currently available to help diverse families to support their LGBT children and adolescents.

B. Family-Based Research, Interventions and Policy

These developments led my colleague, Rafael Diaz, and I to start planning the Family Acceptance Project years ago to begin to lay a rigorous empirical foundation to understand the family dynamics of multicultural families with LGBT children. This project was initiated to develop a new family intervention approach for prevention, wellness, and care across disciplines and systems of care to decrease risk and promote well-being for LGBT children and adolescents.

Our findings show for the first time that the way that parents, foster parents, caregivers and families react to their LGBT children has a powerful relationship to their LGBT children's health, mental health and well-being as a young adult.[10] As Shannon Minter, Legal Director for the National Center for Lesbian Rights has noted, our findings call for a paradigm shift and a "revolution in public policy" for LGBT children and youth.[11] Implementing FAP's new approach to educate, guide, and engage diverse families with LGBT children and adolescents as allies—not

10. *See* Caitlin Ryan et al., *Family Rejection as a Predictor of Negative Health Outcomes in White and Latino Lesbian, Gay, and Bisexual Young Adults*, 123 PEDIATRICS 346-52 (2009), [hereinafter Ryan et al., *Family Rejection*] (indicating that parents and caregivers play a significant role in the health and wellbeing of adolescents); see also Caitlin Ryan et al., *Family Acceptance*.

11. Shannon Minter & Jeff Krehely, *Families Matter: New Research Calls for a Revolution in Public Policy for LGBT Children and Youth*, CENTER FOR AMERICAN PROGRESS (Feb. 07, 2011), http://www.americanprogress.org/issues/lgbt/report/2011/02/07/9117/families-matter/ ("[The findings of FAP] have profound implications for virtually every public policy issue affecting LGBT youth and their families, and call for a revolution in the way public and private agencies serve this population.").

enemies—to support their LGBT children has major implications for public policy. These implications include reinforcing the rationale to fund and support programs and interventions that go "upstream" to prevent so many debilitating, life constricting, and tragic outcomes that disproportionately affect a very vulnerable population of children and adolescents and to promote health and wellness. This means providing education and intervening at multiple points, including educating parents as part of well-baby care, early childhood development, and after LGBT young people end up out-of-home. It also means helping families, foster families, guardians, and caregivers understand how to nurture, support, and promote their LGBT child's well-being, not just protect them from harm.

II. EVIDENCE-BASED APPROACH TO WELLNESS, PREVENTION, AND CARE

In undertaking our research with LGBT youth and families, we wanted to understand not just the dynamics of how families respond, adjust, and adapt to their LGBT children, but the actual specifics of how they interact with their LGBT children. In other words, we wanted to document and measure how families, foster families, caregivers, and guardians express acceptance and rejection of LGBT adolescents, and how those specific accepting and rejecting behaviors relate to their LGBT child's health and well-being in young adulthood. Having these findings has ultimately enabled us to empirically unpack *acceptance* and *rejection*, to create a new language—a behavioral language—to show families how their reactions affect their LGBT children. This helps families change the way they interact with their LGBT children and helps them understand how to nurture and support their LGBT children—even in rejecting and ambivalent families.

We started this research the way practitioners approach their work; by understanding the lived experiences of LGBT young people and their families. We did this research all over California; in urban, rural, suburban, in farmworker, and coastal communities.[12] We wanted to go deep into their lives and experiences. When we started, I wanted to study LGBT youth and families from all ethnic groups and many languages. Even though I have been able to raise considerable funding to do this work over time, we did not have the funds to study every ethnic group. So our plan was to start bilingually and biculturally with Latino and Anglo LGBT youth and families, and to expand our focus as we went along.

We started with in-depth individual interviews ranging from two to four hours each with LGBT youth and key family members who were accepting, ambivalent, and rejecting of their adolescents' LGBT identities. Our research explored family, school and peer experiences, gender expression and related experiences, cultural and religious values and experiences related to the adolescent's sexual orientation and

12. Ryan et al., *Family Rejection* at 347 (describing the qualitative study conducted on LGBT adolescents and families throughout California); *see also* Caitlin Ryan, *Engaging Families to Support Lesbian, Gay, Bisexual and Transgender (LGBT) Youth: The Family Acceptance Project*, 17 THE PREVENTION RESEARCHER, 11, 12 (2010).

gender identity, the development of their LGBT identity, specific family reactions to their LGBT identity, victimization, social support, and future hopes and dreams. We ended up with thousands of pages of transcripts of these amazing journeys. These narratives included moving and hopeful family journeys where families responded to try to care for their LGBT children, even without resources, accurate information, or support in creative and heartfelt ways. And we saw many poignant and painful experiences of families who struggled and would have done things differently, had they only known how to help their LGBT children and themselves.

This research included LGBT young people who had been thrown out of their homes and who ran away from home, as well as those who had been removed from their homes and placed in custodial care. What we found, despite what many people believed, was that so many of these families wanted to have a relationship with their child, and wished they did things differently but did not know what to do.

Because her story was so poignant, I often think of a mother who fully rejected her lesbian daughter. She was devoutly religious and believed that being gay was deeply morally wrong. When she found out that her teenage daughter was a lesbian she reacted out of anger, threw her daughter out of the house, and has had no contact with her since. During our interview she said, "You know, when I put my head on the pillow at night I think of my daughter. I don't know where she is in the world. But I hope she's safe. I wish I didn't do that. I just didn't know what to do. I wish it could be different." Many people, including providers and advocates, perceive that parents and families who reject their LGBT children want to hurt them, do not want their children back, and do not want to have anything to do with them. But what we learned was that families can change over time and can grow and learn to support their LGBT children when information and guidance are provided to help them care for their LGBT children in ways that resonate for them, in the context of their culture, values, and beliefs.

III. MEASURING ACCEPTANCE & REJECTION

In our study of LGBT youth and families, we identified more than 100 specific behaviors that parents, foster parents, caregivers, and guardians use to express acceptance and rejection of their LGBT adolescents.[13] These include rejecting behaviors—like trying to change the adolescent's sexual orientation or gender identity or preventing them from having an LGBT friend—versus advocating for them when others mistreat them because of their LGBT identity, requiring respect for them within the family, and helping their congregation become more welcoming of LGBT people to keep their child connected with their faith.[14] We found that there was a compelling relationship between experiences of family acceptance and rejection during adolescence and the LGBT adolescent's health status and adjustment

13. See Ryan et al., *Family Acceptance* at 207; Ryan et al., *Family Rejection* at 347.

14. See Ryan et al., *Family Acceptance* at 211; Ryan et al., *Family Rejection* at 347; see also Ryan et al., SUPPORTIVE FAMILIES at 8, 9.

as a young adult.[15] Not surprisingly, we found that higher levels of acceptance and rejection were related to higher levels of well-being and risk.[16] For example, LGBT youth who were highly rejected by their families and caregivers were:

> (1) More than eight times as likely to have attempted suicide;
> (2) Nearly six times as likely to report high levels of depression;
> (3) More than three times as likely to use illegal drugs; and
> (4) More than three times as likely to be at high risk for HIV and sexually transmitted diseases.[17]

We also found that high levels of parental pressure to try to change an adolescent's gender expression to enforce gender conformity is related to high levels of depression, a nearly four times greater likelihood of attempted suicide and illegal drug use, and being more than twice as likely to put oneself at high risk for HIV. Parents and caregivers don't understand how their LGBT children experience family reactions to their LGBT identity. Many are shocked to learn that behaviors they thought were helping their LGBT children—that are motivated by care and concern, and trying to help their children have a "good life" and be accepted by others—are instead related to high levels of serious and life threatening health problems.

We also identified and measured common behaviors that are not thought of as rejection, such as not talking about or discouraging an adolescent from talking about their LGBT identity or denying and minimizing an adolescent's LGBT identity. These behaviors are commonly expressed by reactions such as, "It's just a phase," "he'll grow out of it," "how could he possibly know?," or "he's just confused."[18] These reactions are experienced as rejection by LGBT adolescents, and are related, as our research indicates, to health and mental health problems, including depression, illegal drug use, suicidality and sexually transmitted diseases.

Our research also identified and measured more than fifty supportive behaviors such as supporting a child's gender expression, welcoming their LGBT friends and partners to family events and activities and finding a positive role model to show them options for the future.[19] Our research indicates that family acceptance helps protect against suicidal behavior, depression, and substance abuse and helps promote self-esteem, well-being, and overall health for LGBT young people.[20]

IV. FAP FAMILY INTERVENTION APPROACH

We shared our findings in briefing sessions with many ethnically and religiously diverse families with LGBT children, with LGBT youth and with diverse providers

15. *Id*.
16. *See* Ryan et al., *Family Rejection* at 350. See Ryan et al., *Family Acceptance* at 208.
17. *See* Ryan et al., *Family Rejection* at 350.
18. *Id*.
19. Ryan et al., *Family Acceptance* at 211; see also Ryan et al., SUPPORTIVE FAMILIES at 9.
20. *Id*; see also Ryan et al., *Family Acceptance* at 205, 210.

who serve them to learn how these findings impact behavior and effective ways to present this information to diverse populations. We asked them to teach us what our research meant to them, how to frame it and message it, and how to share this information with people from their cultural backgrounds. We did this part of our research in three major languages. All of this work has informed the family interventions that we have developed.

A couple of core messages from this work are particularly useful in engaging and helping families to support their LGBT children. The first is that a little change in how families respond to their LGBT children can make a difference in their child's health, mental health, and well-being – so their responses don't have to be all or nothing and they don't have to choose between their child or their faith. The second is that families and caregivers' words, actions, and behaviors have a physical and emotional impact on their LGBT children. A little change opens the door for many things, including greater connectedness, and hope. Hope is in short supply for many LGBT young people who get very negative messages about their families not only from the media, but also from people around them who have told them that their families will not support them and won't be there for them.

What our research shows, for the first time, is that family rejection is linked with serious health and mental health problems, and that family acceptance is an important protective factor that helps promote well-being. [21] We also found that nearly half of LGBT out-of-home youth ended up out of home because of family rejection. For these adolescents, this has led to placement in foster care, juvenile justice facilities, and living on the streets.

A cornerstone of our work is meeting families "where they are." We have more research to publish, including protocols on specific family intervention strategies. All of this information needs to be integrated into practice across disciplines and systems of care so that providers can engage and work with families early on to do "upstream prevention," skill building, and education during early childhood, and to respond directly with families and their LGBT children at any point when crisis occurs. Nearly every family in our study has said that "We needed to know this information when our child was little." Or… "Why didn't the nurse tell me this could happen in our family when I took my baby home from the hospital?" I think of a Chinese dad who was monolingual Mandarin-speaking who said, "Why doesn't every Chinese newspaper have this information? Why don't they tell us how to help our gay children? We need to know this information before we know who our children will become."

Early intervention can make a profound difference. In addition, intervention is important at *any* point, including when crisis occurs and after families are fractured and LGBT youth have been ejected from their homes. Intervening early when conflict starts to occur enables us to help families to build healthy futures, and to change the life course for LGBT young people who have been left largely to fend for themselves. But this requires a conceptual shift in our framework, in how we think of families. We cannot approach families in a range of settings with resistance or as

21. *See* Ryan et al., *Family Rejection* at 350*;* see Ryan et al., *Family Acceptance* at 208, 209, 210.

an adversary. This continues to happen today. Many providers have written families off, have made assumptions or judgments: "They don't really want to know," or, "They're not willing to support that child," or, "They're not capable of understanding."

We found that family rejecting behaviors are actually motivated by care and concern. The reactions of families who respond negatively or say hurtful things to their child are often mediated by fear and anxiety and exacerbated by misinformation: "What's going to happen to my child in the world? How do I deal with this in my own family? How do I reconcile conflicting beliefs?" We saw in our work that families want, in essence, the best for their child, but they did not know what to do. We need to think of them as potential allies rather than as adversaries in engaging and involving them, and change the way we interact with them across systems of care.

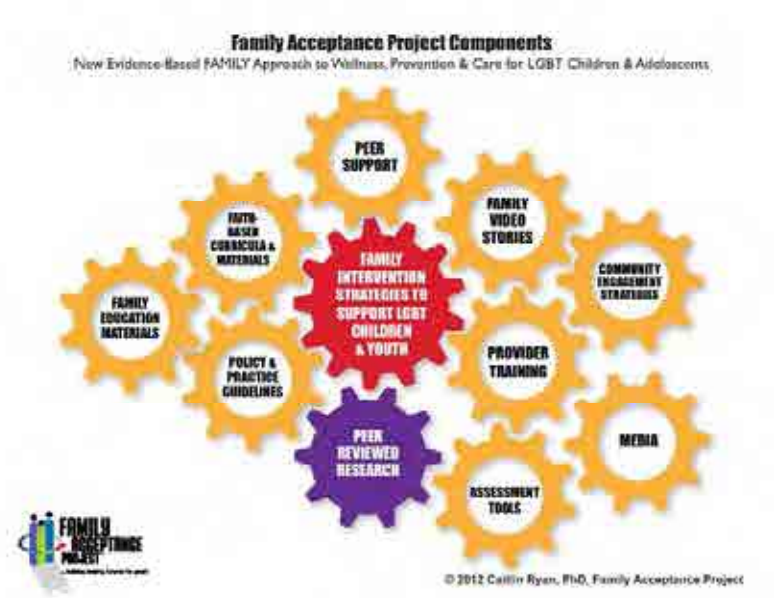
We have done a lot of work in communities across the U.S., and even outside the U.S., to help providers understand that families can be a resource and how to change the framework for the way they think about and integrate families and caregivers into services, even at a basic level. For example, LGBT youth programs that do not currently provide a way for families to interact with or learn to support their LGBT children can start by inviting families to participate in recreational activities. These interactions can change the way that youth and agency staff perceive families and give LGBT youth a sense of hope for a better relationship with their own families.

V. RESEARCH-BASED RESOURCES

Doing this work requires developing new resources, tools, materials, and a completely different approach than currently exists. We have been applying our findings to develop these resources with the help of the families and caregivers with LGBT children, LGBT youth, religious leaders and the providers who serve them. Undergirding all of our work is an empirical foundation that guides and directs the way that we have approached our interventions. We have developed a series of intervention strategies to help families to support their LGBT children that can be used across disciplines by a wide range of providers. We have been developing a range of family education materials; for example, our family education booklets that are available in several languages, faith-based family education materials, assessment tools, extensive provider training, and family education videos.[22] We found that it is essential for families to see other parents and families, like themselves, who come from their background, speak their language, and share their values.

22. *Publications*, FAMILY ACCEPTANCE PROJECT, http://familyproject.sfsu.edu/publications (last visited Apr. 30, 2014); *Family Videos*, FAMILY ACCEPTANCE PROJECT, http://familyproject.sfsu.edu/family-videos (last visited Apr. 30, 2014).

This helps them understand what it means to support their LGBT child, to show how families move from struggle to support, even when their values and beliefs are in conflict with having an LGBT child.



Our family education booklets are the first "best practice" resources for suicide prevention for LGBT young people in the Best Practices Registry for Suicide Prevention.[23] We have been developing lower literacy materials, and a faith-based series, starting with a version for Mormon families with LGBT children.[24] Faith is a culture as well as a belief system. People of deep faith live their lives grounded by their religious beliefs and need to understand how they can support their LGBT child in the context of their deeply-held values. An important aspect of our work is helping parents and families understand that they can support their LGBT child even if they believe that being gay or transgender is wrong. They don't have to accept that a child is LGBT to stop or decrease rejecting behaviors that significantly increase their child's risk for suicide. They can respond with supportive behaviors that our research

23. *See generally* RYAN ET AL., SUPPORTIVE FAMILIES; *see also* Theresa Nolan, *Family Acceptance: Groundbreaking 'Best Practice' for Reducing Suicide Risk for LGBT Youth*, HUFFINGTON POST (May, 17, 2012, 12:04PM), http://www.huffingtonpost.com/theresa-nolan/family-acceptance-lgbt-youth-suicide-risk_b_1518197.html (explaining that "the Suicide Prevention Resource Center has designated [FAP's Supportive Families report] its Best Practices designation" making the document "the first of its kind . . . suicide-prevention tool aimed specifically at LGBT youth.").

24. CAITLIN RYAN & ROBERT REES, FAMILY ACCEPTANCE PROJECT, SAN FRANCISCO STATE U., SUPPORTIVE FAMILIES, HEALTHY CHILDREN: HELPING LATTER-DAY SAINT FAMILIES WITH LESBIAN, GAY, BISEXUAL & TRANSGENDER CHILDREN 1 (2012) *available at* http://familyproject.sfsu.edu/family-education-booklet-lds.

shows help protect against risk, such as requiring that other family members respect their LGBT child even if they disagree, and standing up for their LGBT child when others mistreat them because of who they are. This gives LGBT youth hope, increases parent-child connectedness and builds that child's sense of self-worth, helping them understand that, "even if my family disagrees with me, they still care about me; they're going to help me and they're not going to abandon me."

We have also developed a risk assessment screener that has enabled us to quickly identify LGBT adolescents in diverse settings who are experiencing family rejecting behaviors that are highly predictive of serious health risks and to guide immediate referrals and interventions.[25] Our hands-on training for using the screener provides guidance on asking adolescents about their sexual orientation and gender identity, and on developing a brief family intervention plan and follow up care to prevent many negative outcomes, including homelessness and placement in custodial care.[26] Many providers do not know how to talk about sexual orientation and gender identity with young people. They are surprised to learn that in 1994 the American Medical Association published guidelines for adolescent preventive services that called for all physicians to ask adolescents about their sexual orientation.[27] Is that being done by all physicians today? No. Is it routinely being done by providers from other disciplines? No, because the perception is, "Why do we need that information? That's inappropriate. Clients and patients will be offended if I ask."

VI. FROM PREVENTING HARM TO PROMOTING WELL-BEING

Many providers and institutional administrators are still uncomfortable with non-heterosexual and gender diverse identities and see this as something that is shameful, or should be prevented and certainly not encouraged in adolescents. So, even though they may protect LGBT youth from victimization or harm—since that has increasingly become required by law and standards of care—they will not go further to promote their well-being. Yet, our research provides a roadmap for how families, caregivers, schools, health, and mental health and custodial care programs should foster the well-being of LGBT children and adolescents. Why do we tolerate a two-class system of care for LGBT children and adolescents? Why is the best that we can do for LGBT children and youth to protect them from harm while we promote the well-being of children and youth, in general? We must promote the well-being of *all* of our children and adolescents—especially those who are more vulnerable as a result of rejection and social stigma. *All* families—not just those that are rejecting—need to learn how to promote their LGBT children's well-being.

25. C. RYAN & E. MONASTERIO, SAN FRANCISCO STATE U., PROVIDER'S GUIDE FOR USING THE FAPRISK SCREENER FOR FAMILY REJECTION & RELATED HEALTH RISKS IN LGBT YOUTH (2011).

26. *Id*.

27. Arthur B. Elster & Naomi J. Kuznets, AMA GUIDELINES FOR ADOLESCENT PREVENTIVE SERVICES: RECOMMENDATIONS AND RATIONALE 70-71 (1994) (recommending that physicians ask questions about adolescent patient's sexual orientation).

Not surprisingly, we have found that many parents and caregivers who don't know about FAP's research and family intervention work see themselves as supportive and accepting. But if you ask their adolescent about whether their parents and caregivers are accepting they would say, "Well, I think they care about me, but we never talk about who I am. They never ask me to bring any of my LGBT friends to family events, and they never ask me about my work on LGBT events at school and the community." Our research shows that moderate levels of rejection still confer risk and also constrict family relationships, and decrease intimacy and connectedness.[28]

The family intervention strategies that we have developed through FAP shift the frame from focusing on preventing harm to promoting well-being, full inclusion, and positive development of LGBT adolescents in the context of their families, cultures and faith traditions. This includes teaching parents, caregivers, guardians, and all adults who work with children, youth and families what acceptance and rejection mean for LGBT youth, and how they and others can express support for their LGBT children, even if they believe that being gay or transgender is wrong.[29] Our approach is low cost, low tech, culturally-based, and rooted in the lives of LGBT young people and their families. It offers a systems approach for change at the family level by helping strengthen families, and it increases community engagement as families learn many new ways to support their LGBT children that include helping create safer, more welcoming environments in schools, congregations, and communities.

Promoting family support as a critical modality for prevention, wellness, and care for LGBT children and youth will have a significant impact beyond individuals and families. If we revisit the many negative outcomes we discussed at the beginning of this presentation and we think about what we could do if we change how we interact with LGBT young people across all the disciplines and systems of care, including faith communities, how we educate and inform providers in every service delivery arena, including educators, to think of families as resources; of interaction as an opportunity for education, for information, and for building communication skills and connectedness—we can change the future for LGBT children, youth, and families.

One of the most important things we are learning about suicide prevention is the critical role of connectedness. Connectedness helps these young people understand that they are valued, that someone cares about them, and that they are not alone. I want us to consider for a moment the opportunity costs of assuming that family rejection is the norm and writing families off. For LGBT young people, this has meant losing an innate family buffer to help protect them from stigma, victimization, and bias-related health risks. Families have different strengths; but, in

28. Ryan et al., *Supportive Families* at 6-8.
29. *See* Ryan et al., *Family Acceptance* at 211-12 (Providing information for nurses on educating parents and family of LGBT youth about the impact of acceptance and rejection on youth).

general, family connectedness helps protect children and adolescents from major health risks.[30] One of the outcomes of failure to provide informed family support for LGBT youth has been disproportionately, unacceptably, and untenably high levels of health disparities, including suicidal behavior, HIV, substance abuse, homelessness, and removal and ejection from the home.[31] As the age of coming out continues to drop to normative ages of sexual orientation and gender identity development—primarily due to widespread access to information about LGBT lives—the human cost will mount.

The Family Acceptance Project has provided a road map to navigate a seemingly intractable terrain. We know what helps parents and families to modify rejecting behaviors that our research shows are related to serious health risks for their LGBT children. We know what helps promote well-being. And we know how to create alliances with socially and religiously conservative families to help them learn to support their LGBT children. The cost of family rejection to individuals, families and society is enormous. But the cost of failing to systematically integrate family-oriented services to provide accurate information, guidance and support to families and caregivers with LGBT children is far greater.

30. *Id*. at 211 (citing Eisenberg, M. E., & Resnick, M. D., "Suicidality among gay, lesbian and bisexual youth: The role of protective factors." *Journal of Adolescent Health*, 39, 662–668 (2006).

31. RYAN ET AL., *Supportive Families*.

STATE OF CALIFORNIA
EDMUND G. BROWN JR., Governor

MHSOAC
Mental Health Services
Oversight & Accountability Commission

April 16, 2018

Sharon Birman, Psy.D.
Center for Deployment Psychology
West Los Angeles VA Medical Center
11301 Wilshire Blvd.
Los Angeles, CA. 90073-1003

Dear Dr. Birman:

Thank you for agreeing to participate in the Commission's public hearing on suicide prevention on Thursday, May 24, 2018 in our board room located at 1325 J Street, 17th Floor, Sacramento, California. The public hearing portion of the Commission's meeting will include three panels to support the Commission's understanding of opportunities to prevent suicide and suicide attempt, and support the Commission's efforts to develop a strategic statewide suicide prevention plan, as authorized by the California Legislature.

Your panel will highlight suicide prevention opportunities across the lifespan, and is scheduled to begin at approximately 10:30 a.m. Please plan to present for 10 to 15 minutes to leave time for conversation with Commissioners. Please organize your testimony to respond to the following:

- Factors that increase suicide risk in middle-aged adults, and opportunities for improving access and availability of services to prevent suicide and identifying people at risk of suicide, particularly veterans
- An overview of the *Mayor's Challenge to Prevent Suicide Among Service Members, Veterans, and their Families*, and how the City of Los Angeles is participating in that effort
- How the state could support local efforts to prevent suicide and suicide attempt and improve mental health outcomes for adults, particularly veterans

Please send a brief biography and written response or background materials to the items above by Wednesday, May 9, 2018 to Ashley Mills at ashley.mills@mhsoac.ca.gov. Your written responses will allow Commissioners attending the meeting the opportunity to prepare questions for you after your presentation, and will be available for Commissioners unable to attend the meeting. Please note that your written responses and biography will be shared as public documents.

Should you have any questions, I can be reached at toby.ewing@mhsoac.ca.gov or 916.445-8729. Thank you again for your willingness to participate in this important meeting.

Respectfully,

Toby Ewing

Toby Ewing, Ph.D.
Executive Director

NATIONAL SUICIDE RATES: FACTS & FIGURES

Suicide is a preventable public health problem and a leading cause of death in the United States. More investment in suicide prevention, education and research will prevent the untimely deaths of thousands of Americans each year.

Sharon Birman, Psy.D.

BASIC FACTS

- An American dies by suicide every 11.89 minutes
- Americans attempt suicide an estimated 1.3 MILLION times annually
- For every suicide, there is an estimated 25 attempts
- Suicide rates have increase 24% from 1999-2014
- More than 1.6 MILLION years of life are lost annually to suicide

CONTACT

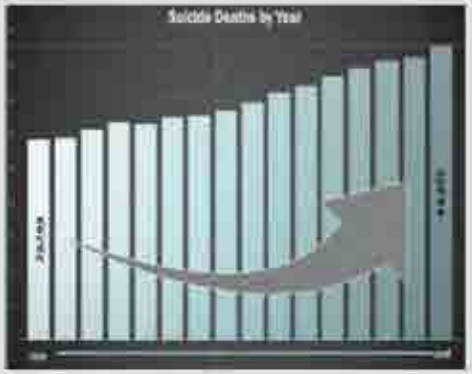
Sharon Birman
VA Medical Center, Greater Los Angeles
Sharon.Birman@va.gov
213-604-1755

NATIONAL SUICIDE RATES

More than **44,000** Americans die by suicide every year. Suicide is the **10th leading cause of death** in the United States

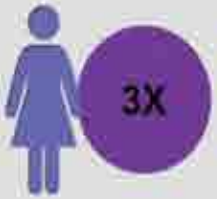
- **2nd** leading cause of death for ages 1-44
- **5th** leading cause of death for ages 45-59
- The annual age-adjusted suicide rate is **13.42 per 100,000** individuals.

Suicide rates increased from 1999 through 2014



GENDER DIFFERENCES

Males are three and a half times more likely to die by suicide

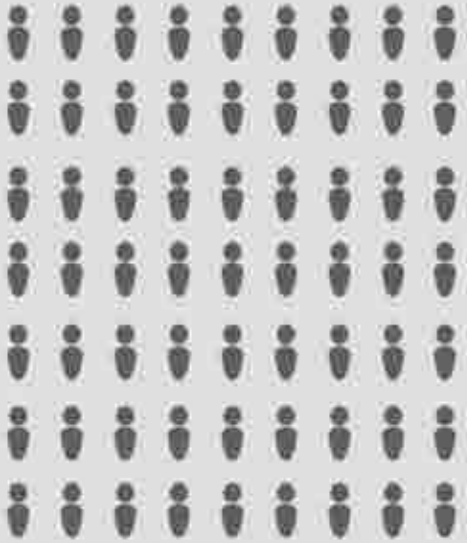


Females attempt suicide three times more often

- 10th Leading Cause of Death in the U.S
- Firearms account for 51% of suicide deaths
- Every day, 121 people die by suicide
- 90% of those who make suicide attempts do NOT go on to die by suicide

LETHAL MEANS

EVERY DAY, 63 AMERICANS



KILL THEMSELVES WITH A GUN

$ The Cost of Suicide $

$69 BILLION

The combined annual medical and work loss costs in the United States

STATE OF CALIFORNIA
EDMUND G. BROWN JR., Governor

MHSOAC
Mental Health Services
Oversight & Accountability Commission

April 16, 2018

Carolyn Stead, Psy.D.
Senior Director, Integrated Behavioral Health
Institute on Aging
3575 Geary Blvd.
San Francisco, CA 94118

Dear Dr. Stead:

Thank you for agreeing to participate in the Commission's public hearing on suicide prevention on Thursday, May 24, 2018 in our board room located at 1325 J Street, 17th Floor, Sacramento, California. The public hearing portion of the Commission's meeting will include three panels to support the Commission's understanding of opportunities to prevent suicide and suicide attempt, and support the Commission's efforts to develop a strategic statewide suicide prevention plan, as authorized by the California Legislature.

Your panel will highlight suicide prevention opportunities across the lifespan, and is scheduled to begin at approximately 10:30 a.m. Please plan to present for 10 to 15 minutes to leave time for conversation with Commissioners. Please organize your testimony to respond to the following:

- The mission of the Institute on Aging, including the Center for Elderly Suicide Prevention, and programs and services offered to reduce suicide and suicide attempt
- Factors that increase suicide risk for older adults, and opportunities for improving access and availability of services for older adults to prevent suicide, and identify older adults at risk of suicide
- How the state could support local efforts to prevent suicide and suicide attempt and improve mental health outcomes for older adults

Please send a brief biography and written response or background materials to the items above by Wednesday, May 9, 2018 to Ashley Mills at ashley.mills@mhsoac.ca.gov. Your written responses will allow Commissioners attending the meeting the opportunity to prepare questions for you after your presentation, and will be available for Commissioners unable to attend the meeting. Please note that your written responses and biography will be shared as public documents.

Should you have any questions, I can be reached at toby.ewing@mhsoac.ca.gov or 916.445-8729. Thank you again for your willingness to participate in this important meeting.

Respectfully,

Toby Ewing

Toby Ewing, Ph.D.
Executive Director

Carolyn Stead, Psy.D.
Senior Director, Integrated Behavioral Health
Institute on Aging
Dr. Stead currently serves as Senior Director of Integrated Behavioral Health at the Institute on Aging in San Francisco. Dr. Stead is a licensed clinical psychologist specializing in geriatrics. She completed her doctorate at William James College in Boston, MA, and fellowship in geropsychology at the Boston VA Healthcare System. Prior to moving to California, Dr. Stead served as a staff psychologist at the Boston VA, where she held an affiliated academic appointment at Harvard Medical School in the Department of Psychiatry. In 2017, Dr. Stead was selected to participate in the two-year California Health Care Foundation Health Care Leadership Program. Led by national experts in health care and leadership development from the Healthforce Center at UCSF, the program addresses health care issues from the perspectives of business management and public policy.

Mission of the Institute on Aging, including the Center for Elderly Suicide Prevention, and programs and services that offered to reduce suicide and suicide attempt.
The mission of the Institute on Aging is to enhance the quality of life for adults as they age by enabling them to maintain their health, well-being, independence and participation in the community.

The Center for Elderly Suicide Prevention (CESP) is a program of the Institute on Aging that provides 24/7 crisis phone support, individual and group grief counseling, outreach, and education to older adults, adults with disabilities, caregivers, and providers. CESP also offers both undergraduate and graduate internships for counseling, psychology, gerontology, and social work students aspiring to work with older adults.

The Friendship Line is the largest service in CESP and has been in existence for the last 45 years. The Friendship Line is the only fully accredited crisis hotline in the country that targets older adults and adults with disabilities. The toll free line operates around the clock, every day of the year, including holidays when it often sees the heaviest call volume. Last year the Friendship Line fielded 148,000 calls. The line is primarily staffed by volunteers, many of whom are older adults themselves. One of the unique aspects of the Friendship Line is that in addition to receiving calls, volunteers place calls out to older adults that are socially isolated and at risk of loneliness and depression, which can lead to suicide. The program takes a unique approach to suicide prevention, believing that building connections through regular scheduled outreach calls can help bind older adults to life.

CESP also provides outreach and education on risk factors, assessment, and prevention of suicide and loneliness in older adults. Last year the program provided training to almost 1,400 individuals. Many of those that received training were clinicians and providers who interface and work with older adults.

Factors that increase suicide risk for older adults, and opportunities for improving access and availability of services for older adults to prevent suicide, and identify older adults at risk of suicide.

Statistics:

- Older white men are the highest risk group for suicide.
- Older adults are twice as likely to commit suicide as teenagers, and six times more likely to succeed in a suicide attempt.
- Older adults may be less ambivalent about the decision and tend to use more lethal means.
- Depression is frequently missed by physicians because older adults are more likely to seek treatment for other physical ailments than they are to seek treatment for depression.
- 20 percent of older adults visit a doctor the day they die, 40 percent within the week, and 70 percent the month. (NAMI, 2009)
- Older adults may be more likely to commit suicide through self-neglect or poor medical care. This may not be acknowledged by others as a suicide.

Factors that increase risk of suicide in older adults:

- Social Isolation and Loneliness
- Recent Losses Including Family, Friends, and Pets
- Chronic Pain and Serious Illness
- Changes in Mobility and Loss of Independence
- Recent Hospitalization
- Substance Abuse
- Hopelessness and Depression
- Cohort Effects, Difficulty Asking for Help

Identification and access to prevention services:

- Provide training to caregivers and professionals on the risk factors and warning signs of suicide, as well as the actions that can be taken to help prevent suicide.
- Train medical professionals on how to identify risk factors and how to assess for suicide.
- Offer services that can be accessed from home, such as by telephone.
- Provide more access to in-home care, in-home medical services, and friendly visitor programs.
- Reduce barriers such as mobility, socioeconomic status, and access to technology.

How the state could support local efforts to prevent suicide and suicide attempt and improve mental health outcomes for older adults.

- Identify, champion, and expand existing programs that prevent suicide in older adults.
- Support broad screening for depression and loneliness in primary care.
- Provide widespread education on risk factors, warning signs, and suicide prevention in older adults.
- Support studies that help demonstrate the most effective programs and services that prevent suicide in older adults.

April 16, 2018

Rajeev Ramchand, Ph.D.
Senior Behavioral Scientist
RAND Corporation
1200 South Hayes Street
Arlington, VA 22202-5050

Dear Dr. Ramchand:

Thank you for agreeing to participate in the Commission's public hearing on suicide prevention on Thursday, May 24, 2018 in our board room located at 1325 J Street, 17th Floor, Sacramento, California. The public hearing portion of the Commission's meeting will include three panels to support the Commission's understanding of opportunities to prevent suicide and suicide attempt, and support the Commission's efforts to develop a strategic statewide suicide prevention plan, as authorized by the California Legislature.

Your panel will highlight a systems-level perspective, and is scheduled to begin at approximately 11:30 a.m. Please plan to present for 10 to 15 minutes to leave time for conversation with Commissioners. Please organize your testimony to respond to the following:

- An overview of the challenges to identifying people at risk of suicide, and intervening effectively statewide
- The strengths and challenges of California's current approach to preventing suicide and suicide attempts
- Collective strategies the state, counties, and communities should pursue to improve suicide prevention, intervention, and postvention efforts

Please send a brief biography and written response or background materials to the items above by Wednesday, May 9, 2018 to Ashley Mills at ashley.mills@mhsoac.ca.gov. Your written responses will allow Commissioners attending the meeting the opportunity to prepare questions for you after your presentation, and will be available for Commissioners unable to attend the meeting. Please note that your written responses and biography will be shared as public documents.

Should you have any questions, I can be reached at toby.ewing@mhsoac.ca.gov or 916.445-8729. Thank you again for your willingness to participate in this important meeting.

Respectfully,

Toby Ewing

Toby Ewing, Ph.D.
Executive Director

Testimony

Suicide Prevention in California: Three Goals for Developing a Statewide Plan

Rajeev Ramchand

CT-494
Testimony presented before the California Mental Health Services Oversight and Accountability Commission on May 24, 2018.

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Suicide Prevention in California: Three Goals for Developing a Statewide Plan

Testimony of Rajeev Ramchand[1]
The RAND Corporation[2]

Before the California Mental Health Services Oversight and Accountability Commission

May 24, 2018

My name is Rajeev Ramchand. I am a psychiatric epidemiologist and Senior Behavioral Scientist at the RAND Corporation. For the past decade, I have been conducting research to help policymakers and practitioners better address and prevent suicide in their communities. This includes work for the Department of Defense, the military service branches, the Department of Veterans Affairs, the National Institute of Mental Health, and the National Institute of Justice. Beginning in 2011, I led RAND's evaluation of California's suicide prevention and early intervention initiatives funded under Proposition 63, the Mental Health Services Act, and administered by the California Mental Health Services Authority, or CalMHSA. That evaluation documented the benefits of the Know the Signs campaign,[3] variability in the services provided by California suicide crisis lines,[4] and the potential economic and life-saving benefits of sustained training in a suicide prevention course, ASIST, throughout the state.[5]

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[1] The opinions and conclusions expressed in this testimony are the author's alone and should not be interpreted as representing those of the RAND Corporation or any of the sponsors of its research.

[2] The RAND Corporation is a research organization that develops solutions to public policy challenges to help make communities throughout the world safer and more secure, healthier and more prosperous. RAND is nonprofit, nonpartisan, and committed to the public interest.

[3] J. Acosta, R. Ramchand, and A. Becker, "Best Practices for Suicide Prevention Messaging and Evaluating California's 'Know the Signs' Media Campaign," *Crisis*, Vol. 38, No. 5, February 23, 2017, pp. 1–13.

[4] R. Ramchand, L. Jaycox, P. Ebener, M. L. Gilbert, D. Barnes-Proby, and P. Goutam, "Characteristics and Proximal Outcomes of Calls Made to Suicide Crisis Hotlines in California," *Crisis*, Vol. 38, No. 1, January 2017, pp. 26–35.

[5] J. S. Ashwood, B. Briscombe, R. Ramchand, E. May, and M. A. Burnam, "Analysis of the Benefits and Costs of CalMHSA's Investment in Applied Suicide Intervention Skills Training (ASIST)," *RAND Health Quarterly*, Vol. 5, No. 2, November 30, 2015, p. 9; K. C. Osilla, D. Barnes-Proby, M. L. Gilbert, and R. Ramchand, "A Case Study Evaluating the Fidelity of Suicide Prevention Workshops in California," *RAND Health Quarterly*, Vol. 4, No. 3, December 30, 2014, p. 11.

The Mental Health Services Oversight and Accountability Commission (MHSOAC) is charged with developing a statewide suicide prevention plan. In my testimony today, I would like to highlight three goals that MHSOAC should consider when designing this plan to support local communities and stakeholders in preventing suicide across the state. The first goal is to provide better care to individuals we know are at risk for suicide and support their families. The second goal is to identify people who may be at risk of suicide but who might not yet be benefiting from support services. The third goal is to create environments that are designed to prevent death from suicide, but to do so in a way that is fair and balanced.

Treating People at Risk for Suicide, and Supporting Their Families

The relationship between mental health disorders and suicide is well-established. Suicide rates are elevated among people with schizophrenia, depression, borderline personality disorder, bipolar disorder, anorexia and bulimia, personality disorders, and anxiety disorders, including post-traumatic stress disorder.[6] It is also elevated among those with substance use disorders, most notably opioid use disorders.[7] But while most people who die by suicide have a mental health disorder, an individual with a mental health disorder's risk of suicide is actually still quite low.[8] In other words, although many suicide deaths may have the presence of a mental health disorder, most people with a mental health disorder are not at acute risk of dying by suicide and will never attempt to take their lives.

What few people recognize is that not only are mental health problems common among those who die by suicide, many of those who die are already receiving mental health care from either a primary care provider or from a mental health professional. Nearly a quarter of the insured population who died by suicide had a mental health care visit in the month before their death, and almost half had a mental health care visit in the year before their death.[9] This suggests that we need to improve the care that individuals engaged in mental health care are receiving.

There are four empirically supported ways to achieve this goal: promote the use of evidence-based care for those at risk of suicide; invest in developing new treatments for suicidality; use

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[6] E. Chesney, G. M. Goodwin, and S. Fazel, "Risks of All-Cause and Suicide Mortality in Mental Disorders: A Meta-Review," *World Psychiatry: Official Journal of the World Psychiatric Association*, Vol. 13, No. 2, June 2014, pp. 153–160.

[7] Chesney, Goodwin, and Fazel, 2014; H. C. Wilcox, K. R. Conner, and E. D. Caine, "Association of Alcohol and Drug Use Disorders and Completed Suicide: An Empirical Review of Cohort Studies," *Drug and Alcohol Dependence*, Vol. 76, Suppl., December 7, 2004, pp. S11–19.

[8] J. T. Cavanagh, A. J. Carson, M. Sharpe, and S. M. Lawrie, "Psychological Autopsy Studies of Suicide: A Systematic Review," *Psychological Medicine*, Vol. 33, No. 3, April 2003, pp. 395–405; J. C. Franklin, J. D. Ribeiro, K. R. Fox, K. H. Bentley, E. M. Kleiman, X. Huang, K. M. Musacchio, A. C. Jaroszewski, B. P. Chang, and M. K. Nock, "Risk Factors for Suicidal Thoughts and Behaviors: A Meta-Analysis of 50 Years of Research," *Psychological Bulletin*, Vol. 143, No. 2, February 2017, pp. 187–232.

[9] B. K. Ahmedani, G. E. Simon, C. Stewart, A. Beck, B. Waitzfelder, R. Rossom, F. Lynch, A. Owen-Smith, E. M. Hunkeler, U. Whiteside, B. H. Operskalski, M. J. Coffey, and L. I. Solberg, "Health Care Contacts in the Year Before Suicide Death," *Journal of General Internal Medicine*, Vol. 29, No. 6, June 2014, pp. 870–877.

collaborative care for those at risk of suicide; and support the families of those who have attempted or are at risk of suicide.

Promoting Use of Evidence-Based Care for Those at Risk of Suicide

The first way to improve care for those at risk of suicide is to implement care strategies that we know work. Certain psychotherapies, like Dialectical Behavioral Therapy, that focus on not only the symptoms of mental illness but also specifically on the patient's desire to die have led to reductions in suicidal behaviors.[10] There is also emerging evidence about the benefits of safety planning, a component in many evidence-based treatments that may also work as a stand-alone intervention. When constructing safety plans, patients at risk for suicide identify available supports and coping skills that they can access during periods when they are thinking about suicide.[11] Those who work with suicidal patients, and those studying to work with suicidal patients, should be aware of these clinical practices and how to implement them. Health systems can promote safety planning by prompting providers to record the plans in electronic medical record systems and by making plans accessible to patients via commonly used patient portals.[12] Finally, there is emerging evidence that offering follow-up phone calls, letters, text messages, and postcards can prevent acts of self-harm among those at risk of suicide.[13] These follow-ups are feasible, easy-to-implement suicide prevention strategies that most health care agencies can adopt today.

Invest in Developing New Treatments for Suicidality

Even with increased awareness and use of evidence-based treatments and safety plans, there are only a few therapies known to treat suicidality. For this reason, it is equally important to invest in research on new treatments for preventing suicide. One of the most exciting treatments currently under investigation is ketamine. Emerging evidence suggests that for people in suicidal crises, a single, subanesthetic dose of ketamine can lower their suicidal thoughts in as quickly as

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[10] G. K. Brown, T. Ten Have, G. R. Henriques, S. X. Xie, J. E. Hollander, and A. T. Beck, "Cognitive Therapy for the Prevention of Suicide Attempts: A Randomized Controlled Trial," *Journal of the American Medical Association*, Vol. 294, No. 5, August 3, 2005, pp. 563–570; M. M. Linehan, K. A. Comtois, A. M. Murray, M. Z. Brown, R. J. Gallop, H. L. Heard, K. E. Korslund, D. A. Tutek, S. K. Reynolds, and N. Lindenboim, "Two-Year Randomized Controlled Trial and Follow-Up of Dialectical Behavior Therapy Versus Therapy by Experts for Suicidal Behaviors and Borderline Personality Disorder," *Archives of General Psychiatry*, Vol. 63, No. 7, July 2006, pp. 757–766; M. D. Rudd, C. J. Bryan, E. G. Wertenberger, A. L. Peterson, S. Young-McCaughan, J. Mintz, S. R. Williams, K. A. Arne, J. Breitbach, K. Delano, E. Wilkinson, and T. O. Bruce, "Brief Cognitive-Behavioral Therapy Effects on Post-Treatment Suicide Attempts in a Military Sample: Results of a Randomized Clinical Trial with 2-Year Follow-Up," *The American Journal of Psychiatry*, Vol. 172, No. 5, May 2015, pp. 441–449.

[11] B. Stanley and G. K. Brown, "Safety Planning Intervention: A Brief Intervention to Mitigate Suicide Risk," *Cognitive and Behavioral Practice*, Vol. 19, 2012, pp. 256–264.

[12] V. Little, J. Neufeld, and A. R. Cole, "Integrating Safety Plans for Suicidal Patients Into Patient Portals: Challenges and Opportunities," *Psychiatric Services*, March 1, 2018.

[13] A. J. Milner, G. Carter, J. Pirkis, J. Robinson, and M. J. Spittal, "Letters, Green Cards, Telephone Calls and Postcards: Systematic and Meta-Analytic Review of Brief Contact Interventions for Reducing Self-Harm, Suicide Attempts and Suicide," *British Journal of Psychiatry*, Vol. 206, No. 3, March 2015, pp. 184–190.

one hour, and the effects can persist up to seven days.[14] The science on therapies like ketamine is still limited and will benefit from further research, including research with sample sizes large enough to detect potential changes in suicide attempts and deaths.

Collaborative Care for Those at Risk of Suicide

People at risk for suicide can benefit not only from specific therapies, but also from specific ways of administering care. Collaborative care is a specific primary care approach for treating behavioral health issues, including suicide risk, that has the potential to save lives. Under the collaborative care model, traditional primary care is extended to include a team consisting of a care coordinator and a specialty behavioral health care provider, who typically provides case consultation to the primary care team. This team collaborates to create a holistic plan for the patient based on evidence-supported treatments, sets patient goals, and monitors whether goals are achieved, making adaptations when patients are not making adequate process. Collaborative care has been tested in over 80 randomized control trials, and while it has not been specifically shown to reduce suicide deaths, meta-analyses have confirmed its benefits for patients with depression and anxiety.[15] Since January 2018, collaborative care has had a designated Current Procedural Terminology code, and Medicare and health care plans like Kaiser Permanente cover it. Other health care systems in California, including MediCal, should be incentivized to implement collaborative care within their systems.

Support the Families of Those Who Have Attempted or Are at Risk of Suicide

Part of the benefit of collaborative care lies in its holistic approach of treating the person, not just their disorder. Patients who may be at risk of suicide have family members and friends who often serve as caregivers. These parents, spouses, siblings, children, and friends ensure their loved ones adhere to prescription regimens, take them to medical appointments, and help manage symptoms and behaviors stemming from the underlying mental health disorder. In fact, as is the case with most medical treatments, many of the available treatments for mental health disorders are most effective when caregivers understand and support their loved one through them. However, the care provided to suicidal people often ignores caregivers and the fundamental role they play in preventing suicide.

Health care providers and health systems need to be more inclusive with caregivers. They need to make sure caregivers are aware of the treatments their loved ones are receiving and the implications for suicide risk, always doing so in a way that respects the patients' privacy. But adequately supporting caregivers must extend beyond improving caregiving tasks to supporting caregivers themselves. Our research has shown that caregiving for people with mental health symptoms can be all-encompassing and stressful. In fact, caregivers to people with mental

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[14] S. T. Wilkinson, E. D. Ballard, M. H. Bloch, S. J. Murrough, A. Feder, P. Sos, G. Wang, C. A. Zarate Jr., and G. Sanacora, "The Effect of a Single Dose of Intravenous Ketamine on Suicidal Ideation: A Systematic Review and Individual Participant Data Meta-Analysis," *The American Journal of Psychiatry*, Vol. 175, No. 2, February 1, 2018, pp. 150–158.

[15] J. Archer, P. Bower, S. Gilbody, K. Lovell, D. Richards, L. Gask, C. Dickens, and P. Coventry, "Collaborative Care for Depression and Anxiety Problems," *Cochrane Database of Systematic Reviews.* October 17, 2012.

illnesses are at increased risk for depression themselves.[16] If a caregiver is depressed, the care they are providing to their loved one likely suffers, increasing suicide risk for the person they are providing care for and possibly themselves.

There are examples of support to caregivers. The National Alliance of Mental Illness offers Family-to-Family, a 12-session educational program for family members of people with mental illness that reduces caregiver burden and improves family members' feelings of empowerment.[17] Perry Hoffman and Alan Fruzzetti have developed a similar program, called Family Connections, for families of people with borderline personality disorder.[18] However, these programs are few and far between. Few health care providers know about them, and there is a lack of resources to implement them. Supporting families of those at risk of suicide is a huge gap in our efforts to prevent suicide, and one that the state can certainly help fill.

Detecting More People at Risk for Suicide

As I have just discussed, there are specific suicide prevention strategies for people receiving mental health care. However, not all of those who could benefit from this care are currently receiving it. Although it is arguably the strongest risk factor for suicide, only one-third of those with a mental health disorder are receiving mental health treatment.[19] Among the 4 percent of Americans who have serious thoughts of taking their own lives each year, only one-third are in mental health treatment.[20] Of those not receiving mental health care, one-quarter felt that they needed mental health services.[21] How can we find these people who are not in mental health treatment and get them into care that might help prevent suicide?

Emergency departments are a good place to start. Forthcoming research from the national Mental Health Research Network finds that in a sample of insured people who died by suicide, 48 percent had had an emergency department visit in the past year, and 20 percent had visited an emergency department in the past month. [22] Moreover, 60 percent of those who make a nonfatal

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[16] R. Ramchand, T. Tanielian, M. P. Fisher, C. A. Vaughn, T. E. Trail, C. Batka, P. Voorhies, M. Robbins, E. Robinson, and B. Ghosh-Dastidar, *Hidden Heroes: America's Military Caregivers.* Santa Monica, Calif.: RAND Corporation, RR-499-TEDF, 2014.

[17] L. Dixon, A. Lucksted, B. Stewart, J. Burland, C. H. Brown, L. Postrado, C. McGuire, and M. Hoffman, "Outcomes of the Peer-Taught 12-Week Family-to-Family Education Program for Severe Mental Illness," *Acta Psychiatrica Scandinavica,* Vol. 109, No. 3, March 2004, pp. 207–215.

[18] P. D. Hoffman, A. E. Fruzzetti, E. Buteau, D. Penney, M. L. Bruce, F. Hellman, and E. Struening, "Family Connections: A Program for Relatives of People with Borderline Personality Disorder," *Family Process*, Vol. 44, No. 2, June 2005, pp. 217–225.

[19] R. C. Kessler, O. Demler, R. G. Frank, M. Olfson, H. A. Pincus, E. E. Walters, P. Wang, K. B. Wells, and A.M. Zaslavsky, "Prevalence and Treatment of Mental Disorders, 1990 to 2003.," *New England Journal of Medicine*, Vol. 352, No. 16, 2005; pp. 2515–2523.

[20] K. Piscopo, R. N. Lipari, J. Cooney, and C. Glasheen, *Suicidal Thoughts and Behavior Among Adults: Results from the 2015 National Survey on Drug Use and Health*, Rockville, Md.: Substance Abuse and Mental Health Services Administration, 2016.

[21] Piscopo et al., 2016.

[22] Ahmedani BK. Personal Communication. March 18, 2018.

suicide attempt seek medical care for their attempt, and many of them may receive this care in an emergency room.[23]

What promise do emergency departments hold in preventing suicide? First, they can implement screening to identify populations that may be at risk. In 2015, Parkland Hospital in Dallas, Texas began screening every patient for suicide risk during every emergency department encounter; 6 percent screened positive for further assessment.[24] In fact, implementing universal screening in emergency departments doubles the number of people identified as needing treatment for suicide risk.[25] Once these people are identified, hospital staff can provide acute crisis care. In a recent multisite clinical trial, emergency department patients who screened positive for suicide risk were provided with further screening, a safety plan intervention, and a series of supportive phone calls upon discharge. Those who received this intervention had 5 percent fewer suicide attempts in the following year.[26]

Policymakers and emergency departments may need to be convinced that the extra effort of screening for suicide risk and counseling is worth it. Fortunately, that evidence exists. Follow-up postcards or text messages appear to be so cheap that they ultimately *reduce* total healthcare costs, and more-intensive interventions also have very high value.[27] With strategic partnerships, emergency departments can shift some of these responsibilities to other agencies. For example, in California, the Santa Clara County crisis hotline has a partnership with the county's emergency department and arranges for telephone follow-up with patients at risk of suicide. RAND recommends crisis hotlines pursue such partnerships, both to prevent suicides locally and to help financially sustain crisis lines.[28]

Still, some people who die by suicide have not seen any health care provider within a month, or even a year, of their death. This includes students, employees, and inmates in prisons and jails. Many of these institutions are already engaged in efforts to prevent suicide, and many others

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[23] Piscopo et al., 2016.

[24] K. Roaten, C. Johnson, R. Genzel, F. Khan, C. S. North, "Development and Implementation of a Universal Suicide Risk Screening Program in a Safety-Net Hospital System," *Joint Commission Journal on Quality and Patient Safety*, Vol. 44, No. 1, January 2018, p. 4–11.

[25] E. D. Boudreaux, C. A. Camargo, Jr., S. A. Arias, A. F. Sullivan, M. H. Allen, A. B. Goldstein, A. P. Manton, J. A. Espinola, and I. W. Miller, "Improving Suicide Risk Screening and Detection in the Emergency Department," *American Journal of Preventive Medicine*. Vol. 50, No. 4, April 2016, pp. 445–453.

[26] I. W. Miller, C. A. Camargo, Jr., S. A. Arias, A. F. Sullivan, M. H. Allen, A. B. Goldstein, A. P. Manton, J. A. Espinola, R. Jones, K. Hasegawa, E. D. Boudreaux, and the ED-SAFE Investigators, "Suicide Prevention in an Emergency Department Population: The ED-SAFE Study," *JAMA Psychiatry*, Vol. 74, No. 6, June 1, 2017, pp. 563–570.

[27] P. Denchev, J. L. Pearson, M. H. Allen, C. A. Claassen, G. W. Currier, D. F. Zatzick, and M. Schoenbaum, "Modeling the Cost-Effectiveness of Interventions to Reduce Suicide Risk Among Hospital Emergency Department Patients," *Psychiatric Services*, Vol. 69, No. 1, January 1, 2018, pp. 23–31.

[28] R. Ramchand, L. H. Jaycox, and P. A. Ebener, "Suicide Prevention Hotlines in California: Diversity in Services, Structure, and Organization and the Potential Challenges Ahead," *RAND Health Quarterly*, Vol. 6, No. 3, June 2017, p. 8.

want to know what they can do. Unfortunately, the science does not yet provide very specific answers about effective strategies these organizations can pursue.[29]

For this reason, evaluations of suicide prevention initiatives, like the evaluation CalMHSA funded RAND to conduct, are critical for broadening the evidence base. But rather than leave a vacuum of evidence, we can use available science and scientific methods to offer some suggestions.

I recently received funding from the National Institute of Justice to examine the types of suicide prevention strategies law enforcement agencies were engaged in across the United States and to identify gaps and potential solutions. Through this research, my colleague Jessica Saunders and I identified four pillars of support that law enforcement agencies can offer to prevent suicide among their officers. These pillars may be useful for other institutions to use to guide their suicide prevention efforts.

Pillar 1: Reduce Stress

Organizations should make attempts to reduce and respond to any unwarranted stress among their workforce. For example, a law enforcement agency may not be able to change the stress inherent in police work, but it could consider different shift schedules if sleep challenges are a cause of stress among its officers. However, stressors will be unique across organizations; for example, what's stressful to deputies in the Los Angeles County Sheriff Department may not be the same as what's stressful for members of the Los Angeles Police Department. Routine surveillance of stressors among populations is useful so that organizations can tailor interventions and policies to address the specific needs of their populations.

Pillar 2: Offer Support

Organizations should support their workforces' capacity to deal with stress. This can be done by promoting a culture of health that encourages positive ways to strengthen overall health and wellness. For example, some agencies offer yoga and mindfulness classes. Others offer restorative sleep rooms for officers to take naps, particularly during periods of high operational tempo.

Pillar 3: Identify People at Risk of Suicide

Third, organizations may have policies or programs that identify people in need of additional support and encourage them to seek help. This may include efforts like marketing campaigns that

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[29] R. J. Cramer, H. J. Wechsler, S. L. Miller, and E. Yenne, "Suicide Prevention in Correctional Settings: Current Standards and Recommendations for Research, Prevention, and Training," *Journal of Correctional Health Care: The Official Journal of the National Commission on Correctional Health Care*, Vol. 23, No. 3, July 2017, pp. 313–328; C. Katz, S. L. Bolton, L. Y. Katz, C. Isaak, T. Tilston-Jones, J. Sareen, and the Swampy Cree Suicide Prevention Team, "A Systematic Review of School-Based Suicide Prevention Programs," *Depression and Anxiety*, Vol. 30, No. 10, October 2013, pp. 1030–1045; A. Milner, K. Page, S. Spencer-Thomas, and A. D. Lamotagne, "Workplace Suicide Prevention: A Systematic Review of Published and Unpublished Activities," *Health Promotion International*, Vol. 30, No. 1, March 2015, pp. 29–37; K. Witt, A. Milner, A. Allisey, L. Davenport, and A. D. LaMontagne, "Effectiveness of Suicide Prevention Programs for Emergency and Protective Services Employees: A Systematic Review and Meta-Analysis," Am J Ind Med. Vol. 60, No. 4, April 2017, pp. 394–407.

promote available resources, so that people at risk of suicide know that help is available and where to turn. It could also include strategies that teach supervisors or peers to identify and intervene with people exhibiting signs of distress—interventions that are common but that lack strong empirical support.[30]

Organizations might also consider screening for suicide risk, although such screening needs to be considered carefully when performed outside of health care settings. At schools, for example, standardized screening performs better than teacher observation, but schools may be unprepared for an influx of students who screen positive.[31] Law enforcement and similar agencies are creating computer dashboards that flag officers after reaching a prespecified threshold of infractions; however, we do not know whether or how this information is used to support (as opposed to punish) officers.[32] In both schools and workplaces, a high proportion of false positives creates the risk of potential unintended consequences that need to be considered carefully and prior to implementation.

Pillar 4: Facilitate Access to Care

Finally, organizations need to reduce barriers and facilitate access to care for those in need. Many in law enforcement believe that receiving mental health services will harm their career; agencies need to revise policies that may reinforce this perception and, if accurate, assure officers that such discrimination will not occur.[33] Students may not know how to access help, which is why many advocate for parents to store the number of the National Suicide Prevention Lifeline or Crisis Text Line into their and their children's mobile phones. But facilitating access to care also means that organizations like schools, workplaces, and prisons that offer in-house mental health care services, or that contract with employee assistance programs to do so, assure that these entities use evidence-based approaches to screen for suicide risk, provide short-term care, and make appropriate referrals.

There is one additional setting in which we may be able to reach people at risk of suicide who are not engaged in the health care system, and that is through social media. Social media has the potential to reach many more people with suicide prevention messages than traditional social marketing methods, and it is particularly effective at connecting with hard-to-reach groups, such

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[30] C. Burnette, R. Ramchand, and L. Ayer, *Gatekeeper Training for Suicide Prevention: A Theoretical Model and Review of the Empirical Literature*, Santa Monica, Calif.: RAND Corporation, RR-1002-OSD, 2015.

[31] M. A. Scott, H. C. Wilcox, I. S. Schonfeld, M. Davies, R. C. Hicks, J. B. Turner, and D. Shaffer, "School-Based Screening to Identify At-Risk Students Not Already Known to School Professionals: The Columbia Suicide Screen," *American Journal of Public Health*, Vol. 99, No. 2, February 2009, pp. 334–339; D. Hallfors, P. H. Brodish, S. Khatapoush, V. Sanchez, H. Cho, and A. Steckler, "Feasibility of Screening Adolescents for Suicide Risk in 'Real-World' High School Settings," *American Journal f Public Health*, Vol, 96, No. 2, February 2006, pp. 282–287.

[32] R. Ramchand, J. Saunders, K. C. Osilla, V. Kotzias, E. Thorton, L. Strang, and M. Cahill, "Suicide Prevention in U.S. Law Enforcement Agencies: A National Survey of Current Practices," *Journal of Police and Criminal Psychology*, 2018.

[33] Ramchand et al., 2018.

as LGBTQ youth.[34] Social media provides opportunities for a person's online network to learn about and intervene with people who express suicidal thoughts, and as of last year Facebook is bypassing the person's network altogether and using artificial intelligence to detect suicidal posts and intervene in such cases.[35] Learning more about the success of these approaches, and adapting them as new social media platforms increase in popularity, is a promising area for the future of suicide prevention.

Creating Safer Environments

The third goal MHSOAC should consider in its suicide prevention strategy focuses not on a patient's desire to take their own life, but rather on the means they use to do so. Specifically, policy, research, and practice can directly address guns, which each year take more lives in California by suicide than they do by homicide. In 2016, California lost 4,294 lives to suicide. 1595 of these suicides, or roughly one third, were caused by firearms. Of the 159 children under 18 who took their lives, 41 used a firearm to do so.[36]

California has some of the most restrictive gun laws in the country. This includes a Child Access Prevention law, which makes gun owners criminally liable if a loaded firearm or unloaded handgun is stored in a way that allows a child under 18 to access it.[37] The state's Child Access Prevention law is important. In RAND's recent review of the effects of 13 gun policies, these laws have the strongest evidence that they reduce suicides, especially youth suicide.[38] Continued enforcement of this policy will remain an important component of California's suicide prevention strategy.

As the state enacts new gun laws or considers expanding existing laws, such as expanding the criteria of who can request a temporary firearm restraining order, it is important to consider evaluating these laws' effects.[39] There is a dearth of research on the effects of gun policies, largely because the federal government has not funded such research at levels comparable to

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[34] V. M. Silenzio, P. R. Duberstein, W. Tang, N. Lu, X. Tu, and C. M. Homan, "Connecting the Invisible Dots: Reaching Lesbian, Gay, and Bisexual Adolescents and Young Adults at Risk for Suicide Through Online Social Networks," *Social Science and Medicine*, Vol. 69, No. 3, August 2009, 1982, pp. 469–474.

[35] J. Robinson, G. Cox, E. Bailey, S. Hetrick, M. Rodrigues, S. Fisher, and H. Herrman, "Social Media and Suicide Prevention: A Systematic Review," *Early Intervention in Psychiatry*, Vol. 10, No. 2, April 2016, pp. 103–121; J. Novet, "Facebook Is Using A.I. to Help Predict When Users May Be Suicidal," *CNBC*, 2018.

[36] Centers for Disease Control and Prevention, "Web-Based Injury Statistics Query and Reporting System (WISQARS): Fatal Injury Data," webpage, undated.

[37] Giffords Law Center to Prevent Gun Violence, "Child Access Prevention in California," webpage, last updated October 31, 2017.

[38] A. R. Morral, R. Ramchand, R. Smart, C. R. Gresenz, S. Cherney, N. Nicosia, C. C. Price, S. B. Holliday, E. L. Petrun Sayers, T. L. Schell, E. Apaydin, J. L. Traub, L. Xenakis, J. S. Meyers, R. I. Karimov, B. Ewing, and B. A. Griffin, *The Science of Gun Policy: A Critical Synthesis of Research Evidence on the Effects of Gun Policies in the United States*, Santa Monica, Calif.: RAND Corporation, RR-2088-RC, 2018.

[39] R. J. Foley and D. Thompson, "Few States Let Courts Take Guns from People Deemed a Threat," Associated Press, February 18, 2018.

causes of death of similar magnitudes.[40] In this small pool of evidence, some of the best comes from Dr. Garen Wintemute at the University of California at Davis. The state recently invested $5 million in Dr. Wintemute and his team at the University's Firearm Violence Prevention Research Center to continue this line of research. Given the limited federal funding for studying firearms and suicide, California's investment is critical and should be applauded and sustained.

Policy is not the only way to ensure safe environments that have the potential to prevent suicides. Within healthcare settings, providers working with kids should ask parents how they store their guns at home, while those working with suicidal patients should know how to talk about guns and encourage those thinking about suicide to voluntarily, and temporarily, remove guns from their immediate environments.[41] To do so effectively, providers need to know legal options for the temporary transfer and storage of firearms. In California, a person with a valid firearm safety certificate can hold a gun temporarily for an immediate family member at risk of suicide without having to undergo a background check through a licensed firearm retailer, which is required for most other private transfers.[42] However, family members may not have safety certificates when a suicidal crisis occurs, so if a person in crisis is willing to temporarily part with their weapons, it may be worth designing easy, rapid mechanisms to allow this to occur legally.

Guns are not the only way people take their lives—in 2016, 1,382 people in California took their lives by suffocating to death. A small, but significant, fraction of these occurred in psychiatric hospitals or inpatient psychiatric units, locations where patients may be acutely suicidal and where they may easily have access to rope, cords, or fabric that can be used to strangle themselves. Because of this risk, last year the Joint Commission—the body that accredits hospitals in the United States—established recommendations that psychiatric hospitals and hospital units that work with suicidal patients prevent ligature risks. This means that there should not be points within the patient rooms, bathrooms, corridors, or common areas where a patient could loop or tie material for the purpose of taking their life.[43]

As a community committed to suicide prevention, we should always balance policy requirements with practicality. The president of the American Psychiatric Association expressed concern last November that the resources required by facilities to meet these ligature risk standards can be excessive and ultimately threaten the availability of psychiatric hospital beds.[44]

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[40] D. E. Stark and N. H. Shah, "Research on Gun Violence Versus Other Causes of Death," *Journal of the American Medical Association*, Vol. 317, No. 13, April 4, 2017, p. 1379.

[41] Council on Injury, Violence, and Poison Prevention Executive Committee, "Firearm-Related Injuries Affecting the Pediatric Population," *Pediatrics*, Vol. 130, No. 5, November 2012, pp. e1416-1423; G. J. Wintemute, M. E. Betz, and M. L. Ranney, "Yes, You Can: Physicians, Patients, and Firearms," *Annals of Internal Medicine*, Vol. 165, No. 3, August 2, 2016, pp. 205–213.

[42] A. D. McCourt, J. S. Vernick, M. E. Betz, S. Brandspigel, and C. W. Runyan, "Temporary Transfer of Firearms from the Home to Prevent Suicide: Legal Obstacles and Recommendations," *JAMA Internal Medicine*, Vol. 177, No. 1, January 1, 2017, pp. 96–101.

[43] The Joint Commission, "November 2017 Perspectives Preview: Special Report: Suicide Prevention in Health Care Settings," webpage, October 25, 2017.

[44] M. Moran, "Joint Commission Standards on Ligature Risks Cause Concern," *Psychiatric News*, 2017.

This is an example of a well-meaning requirement that might jeopardize other suicide prevention strategies; no one would argue that ligature-resistant facilities should be pursued at the cost of an inpatient psychiatric bed. The state should monitor the Joint Commission's ligature-resistant standards, support facilities to become ligature resistant, and evaluate the potential impact of these requirements on the availability of mental health services in the state—especially for smaller agencies and those in areas with limited resources.

Conclusion

In preparing my remarks today, I reflected on how much California already has done to prevent suicide. From the initiatives funded under Proposition 63 to the state's commitment to research and evaluation, California should be applauded for its recent efforts to combat suicide. But while the suicide rate has not escalated as dramatically in California as it has in the country overall, it still has risen, claiming 4,294 lives in 2016 relative to 3,077 in 1999—a rate increase from nine per 100,000 to 11 per 100,000. We must adopt the attitude that the time to end suicide is now. This will require first stabilizing the increasing trend in suicide deaths, then reversing it.

Today I have identified the strategies with the strongest evidence base for preventing suicide. As the MHSOAC develops the state's suicide prevention strategy, it should keep three goals in mind. First, provide better care to people we know are at risk for suicide, and support their families. Second, identify people who may be at risk of taking their lives but who might not yet be benefiting from the services available to support them. And third, create safe environments in a fair and balanced way.

Thank you.

STATE OF CALIFORNIA
EDMUND G. BROWN JR., Governor

MHSOAC
Mental Health Services
Oversight & Accountability Commission

May 11, 2018

Brenda Grealish, Acting Deputy Director
Mental Health & Substance Use Disorder Services
1501 Capitol Avenue, MS 4000
Sacramento, CA 95899-7413

Dear Ms. Grealish:

Thank you for agreeing to present on behalf of the Department of Health Care Services during the Commission's public hearing on suicide prevention on Thursday, May 24, 2018 in our board room located at 1325 J Street, 17th Floor, Sacramento, California. The public hearing portion of the Commission's meeting will include three panels to support the Commission's understanding of opportunities to prevent suicide and suicide attempt, and support the Commission's efforts to develop a strategic statewide suicide prevention plan, as authorized by the California Legislature.

Your panel will highlight a systems-level perspective, and is scheduled to begin at approximately 11:30 a.m. Please plan to present for 10 to 15 minutes to leave time for conversation with Commissioners. Please organize your testimony to respond to the following:

- An overview of California's strategy to preventing suicide, including activities to implement the *California Strategic Plan on Suicide Prevention (2008)*
- Current suicide prevention activities conducted by the Department of Health Care Services, and the resources allocated to those efforts, including dedicated personnel
- The strengths and challenges of California's current approach to preventing suicide and suicide attempts

Please send a brief biography and written response or background materials to the items above to Ashley Mills at ashley.mills@mhsoac.ca.gov. Your written responses will allow Commissioners attending the meeting the opportunity to prepare questions for you after your presentation, and will be available for Commissioners unable to attend the meeting. Please note that your written responses and biography will be shared as public documents.

Should you have any questions, I can be reached at toby.ewing@mhsoac.ca.gov or 916.445-8729. Thank you again for your willingness to participate in this important meeting.

Respectfully,

Toby Ewing

Toby Ewing, Ph.D.
Executive Director

STATE OF CALIFORNIA
EDMUND G. BROWN JR., Governor

MHSOAC
Mental Health Services
Oversight & Accountability Commission

April 16, 2018

Karen Smith, M.D., MPH
Director and State Public Health Officer
California Department of Public Health
PO Box 997377, MS 0500
Sacramento, CA 95899-7377

Dear Dr. Smith:

The Commission invites you to participate in the Commission's public hearing on suicide prevention on Thursday, May 24, 2018 in our board room located at 1325 J Street, 17th Floor, Sacramento, California. The public hearing portion of the Commission's meeting will include three panels to support the Commission's understanding of opportunities to prevent suicide and suicide attempt, and support the Commission's efforts to develop a strategic statewide suicide prevention plan, as authorized by the California Legislature.

Your panel will highlight a systems-level perspective, and is scheduled to begin at approximately 11:30 a.m. Please plan to present for 10 to 15 minutes to leave time for conversation with Commissioners. Please organize your testimony to respond to the following:

- The mission and activities of the Safe and Active Communities Branch within the Department of Public Health, including data collection and reporting and program activities related to violence and suicide prevention
- An overview of the department's *Violence Prevention Initiative*, including potential implications of that initiative for understanding opportunities for suicide prevention within a public health framework
- The strengths and challenges of California's current approach to preventing suicide and suicide attempts

Please send a brief biography and written response or background materials to the items above by Wednesday, May 9, 2018 to Ashley Mills at ashley.mills@mhsoac.ca.gov. Your written responses will allow Commissioners attending the meeting the opportunity to prepare questions for you after your presentation, and will be available for Commissioners unable to attend the meeting. Please note that your written responses and biography will be shared as public documents.

Should you have any questions, I can be reached at toby.ewing@mhsoac.ca.gov or 916.445-8729. Thank you again for your willingness to participate in this important meeting.

Respectfully,

Toby Ewing

Toby Ewing, Ph.D.
Executive Director

May 2017

Preventing Violence in California

Volume 1: The Role of Public Health

"Violence is a public health concern. Together with its state and local partners the California Department of Public Health can play a leadership role in bringing people together to have a meaningful dialogue about violence and how it can be prevented."

- Karen L. Smith, M.D., M.P.H.

Director and State Public Health Officer,
California Department of Public Health

California Department of PublicHealth

California Department of Public Health
Violence Prevention Initiative

Preventing Violence in California

Volume 1: The Role of Public Health

In 2015, the California Department of Public Health (CDPH) launched the Violence Prevention Initiative by linking efforts of many programs to elevate violence prevention as a departmental priority. This initiative has been facilitated by the Fusion Center for Strategic Development and External Relations in its role to inform, explore, and advance the future of public health.

This report is the initial issue of a planned series on the public health role in violence prevention that is intended to serve as a resource for local health jurisdictions and other stakeholders. This issue has focused on a broad overview of the complex topic of violence prevention. Following issues will delve further into specific topics, including data on forms of violence and prevention strategies. Based on input from local health jurisdictions the following three topics have been prioritized:

- **Child Maltreatment**
- **Intimate Partner Violence**
- **Gun Violence**

Acknowledgements

We acknowledge and appreciate the efforts of the Violence Prevention Initiative team and the many partners who contributed to the development of this report.

Feedback

If you have feedback or questions, please contact:

violenceprevention@cdph.ca.gov

Suggested Citation

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California Department of PublicHealth

California Department of Public Health
Violence Prevention Initiative

Preventing Violence in California
Volume 1: The Role of Public health

Topics Covered

1 Problem: The Impact of Violence on Californians

- Interconnected forms of violence
- A leading cause of death
- Health outcomes
- Trauma and toxic stress
- Lifelong effects
- Disparities
- Impact on communities
- Social determinants of health

2 Solutions: Violence is Preventable

- Public health role
- Primary prevention approach
- National public health perspective
- Public health programs
- Local efforts and priorities
- Multi-sector collaboration

3 What's Next: Engage and Mobilize

- Elevating violence-prevention
- Alignment to action
- Violence prevention resource series
- Maximizing violence prevention efforts

1 Problem:
The Impact of Violence on Californians

Violence is a leading cause of injury, disability, and death

Violence is a leading cause of injury, disability, and death. It impacts the health and well-being of all Californians – our families, neighbors, coworkers, schools, and communities. The consequences of violence are costly, and influence nearly all health and mental health outcomes throughout life. In 2014, there were over 6,000 violent deaths, over 27,000 hospitalizations, and 154,000 emergency department visits for violent injuries in California, with an estimated annual cost of over $11 billion in medical costs and lost productivity.[1, 2] Although these data represent the best available estimates, violence is often underreported, which means that the full magnitude and consequences of violence are far more substantial than reflected in these figures.

There are many different forms of violence that negatively impact individuals, relationships, communities and society. There are unique characteristics and different approaches for addressing each category of violence. These forms are also interconnected and share many of the same root causes, such as harmful social norms, substance abuse, social isolation, and poverty and income inequality.[3, 4, 5]

Forms of violence

- Child maltreatment
- Intimate partner violence
- Teen dating violence
- Sexual violence
- Bullying/harassment
- Youth violence
- Elder maltreatment
- Suicide
- Workplace violence
- Community violence and trauma
- Gang violence
- Gun violence
- Police-involved violence
- Crime (assault, robbery)
- Hate crimes
- Terrorism

What is violence?

The World Health Organization defines violence as "the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment, or deprivation."[6]

1 Problem:
The Impact of Violence on Californians

Violence across all ages

In both number and relative ranking, violent deaths significantly contribute to mortality across the life course. Violent deaths (homicide and suicide) are among the top six leading causes of death across all age groups in California, with the exception of infants and adults 55 and over.[7] The greatest number of homicides occur among adolescents and young adults ages 15-24.[7] The greatest number of suicides occur among adults ages 45-54.[7]

	Age <1	1–4	5–9	10–14	15–24	25–34	35–44	45–54	55–64	65+
#1	Congenital Anomalies **545**	Unintentional Injury **92**	Unintentional Injury **53**	Unintentional Injury **73**	Unintentional Injury **1,187**	Unintentional Injury **1,603**	Unintentional Injury **1,423**	Cancer **4,279**	Cancer **10,939**	Heart Disease **50,185**
#2	Short Gestation **337**	Congenital Anomalies **57**	Cancer **49**	Cancer **55**	**Homicide 556**	**Suicide 625**	Cancer **1,277**	Heart Disease **2,988**	Heart Disease **6,805**	Cancer **42,268**
#3	Maternal Complications **204**	Cancer **40**	Congenital Anomalies **16**	**Suicide 23**	**Suicide 483**	**Homicide 532**	Heart Disease **870**	Unintentional Injury **2,046**	Unintentional Injury **2,167**	Alzheimer's Disease **14,926**
#4	SIDS **118**	**Homicide 20**	**Homicide 12**	**Homicide 17**	Cancer **216**	Cancer **499**	**Suicide 609**	Liver Disease **1,228**	Liver Disease **1,801**	Cerebro-vascular **12,930**
#5	Placenta Cord Membranes **90**	Heart Disease **11**	Heart Disease **11**	Congenital Anomalies **14**	Heart Disease **86**	Heart Disease **298**	Liver Disease **429**	**Suicide 768**	Diabetes Mellitus **1,493**	Chronic Lower Respiratory Disease **11,975**
#6	Unintentional Injury **65**	Influenza & Pneumonia ---	Chronic Lower Respiratory Disease ---	Heart Disease **11**	Congenital Anomalies **49**	Liver Disease **117**	**Homicide 325**	Diabetes Mellitus **654**	Cerebro-vascular **1,269**	Diabetes Mellitus **6,399**

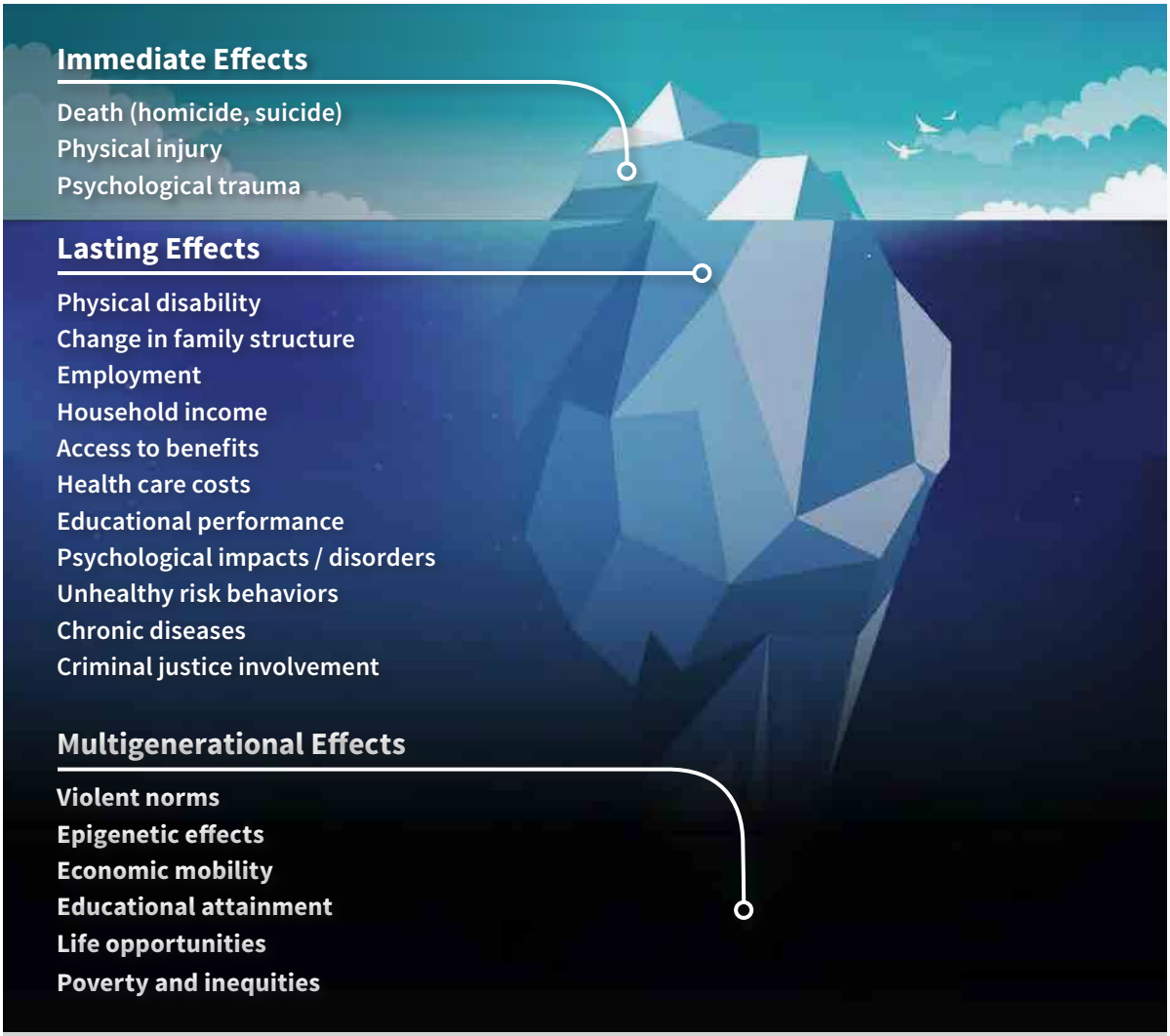
Leading Causes of Death, California 2015

Note: Includes all races, both sexes. For leading cause categories in this state-level chart, counts of less than ten deaths have been suppressed. **Produced by:** California Department of Public Health
Data Source: National Center for Health Statistics (NCHS), National Vital Statistics System (WISQARS™)

1 Problem:
The Impact of Violence on Californians

Deaths are only the "tip of the iceberg"

Deaths and injuries due to violence are only the "tip of the iceberg" of harm to individuals, families, and communities.



The immediate, lasting, and multigenerational effects of violence ultimately influence society as a whole. As a result of violence, medical and criminal justice costs increase, economic investments decrease, and employment and educational opportunities are lost.[8,9] In addition, communities of color are disproportionately impacted; concentrated, segregated areas of poverty grow; and community resilience and trust is diminished resulting in persistent inequities.[8]

1 Problem:
The Impact of Violence on Californians

Violence contributes to negative health outcomes

Exposure to violence has a negative impact on many individual health outcomes. Witnessing or experiencing violence increases the risk of mental health issues (e.g., hopelessness, depression, post-traumatic stress disorder, attachment disorder, anxiety, sleep and eating disorders, and suicide attempts) and chronic diseases (e.g., cardiovascular disease, lung disease, and diabetes).[10] In addition to mental health issues and chronic diseases, violence is associated with infectious diseases (e.g., HIV, other sexually transmitted infections).[10] Violence contributes to these negative health outcomes through trauma and toxic stress. It is also associated with an increase in unhealthy risk behaviors, including alcohol and substance abuse, tobacco use, physical inactivity, early initiation of sexual activity and multiple partners, aggression, revenge seeking behavior, and gang involvement.[10]

Impact on communities

Trauma extends beyond the individuals who are exposed to violence.[8] In addition to individual impacts, there are serious social and economic consequences of violence for families and communities. Increased crime can lead to reduced business investment, lack of job opportunities, and other economic impacts.[9] When violence becomes a common occurrence, entire communities can also experience trauma on a collective level. Violence is experienced not only as injury but as psychic trauma to individuals and communities and can lead to a breakdown of social networks, social relationships, and positive social norms across the community.[8] Violence and the fear of violence hinder access to basic human needs such as food, shelter, education, and employment.[8]

Key concepts

Trauma results from an event, series of events, or set of circumstances that may have long lasting and harmful effects on a person's physical, social, and emotional well-being.[11, 12]

Toxic stress results from adverse experiences that are severely traumatic, sustained for a long period of time, or cumulative. Prolonged activation of the stress response system floods the brain and body with stress hormones, which can disrupt early brain development, compromise the functioning of important biological systems, and lead to long-term health problems.[13, 14]

Resilience is the ability to adapt well, recover, and thrive despite being confronted with adversity, trauma, tragedy, threats, or significant sources of stress. Resilience enables individuals, families and communities to overcome exposure to violence and trauma.[15, 16]

1 Problem:
The Impact of Violence on Californians

Disparities

Though violence affects all Californians, the occurrence and impact is not equally distributed. There are significant disparities and inequities in the burden of and exposure to violence across socioeconomic and population demographics and across communities.[16]

1 in 3 women (31.5 percent) have experienced violence in an intimate partner relationship in their lifetime.[17]

Young black men (ages 15-29), compared to other racial groups, are nearly six times more likely to die from gun violence.[18]

Homicide is the second leading cause of injury death for infants, behind unintentional suffocation.[18]

Youth ages 10-14 are more likely to die from suicide than motor vehicle crashes.[18]

Hate crime events increased 10 percent in 2015, with notable increases in crimes involving anti-Hispanic and anti-Islamic bias.[19]

Older white men living in rural counties have the highest rates of suicide (37/100,000).[18]

1 Problem:
The Impact of Violence on Californians

Lifelong consequences of early exposure

Early childhood exposure to violence (child abuse, intimate partner violence) and chronic stress (poverty, neglect, and emotional abuse) can result in injury, disease, and premature death.[20, 21] A growing body of research on adverse childhood experiences has demonstrated that toxic, chronic stress harms brain development and leads to lifelong effects on learning, behavior, and health.[22, 23, 24, 25]

Additionally, there is a strong likelihood that adverse childhood experiences can contribute to a continuing cycle of violence throughout the individual's lifespan, and even for the next generation.[26, 27] In other words, the impacts of violence can be intergenerational. For example, several studies reveal that children who witness violence are more likely to become either victims or perpetrators of violence as adults.[28]

Breaking the Cycle of Violence

Used with permission from Together for Girls. Developed by the U.S. Centers for Disease Control and Prevention, *Ending Violence Against Children: Six Strategies for Action*, and by UNICEF and the United States Government Action Plan on Children in Adversity.

1 Problem:
The Impact of Violence on Californians

Violence and the social determinants of health

There is growing recognition that the social, economic, and physical environments in which people live, work, learn, and play have a measurable effect on quality and length of life, a concept often referred to as social determinants of health.[10] The social determinants of physical and mental health (e.g., education, income, and environment) can contribute to positive or negative health outcomes.

Violence itself is a social determinant of health, but may also be a result of the environments in which people live and children grow. For example, those who grow up and live in environments with limited social, educational, and economic opportunities and where violence, racism, and community and domestic instability are daily stressors are at increased risk of multiple forms of violence. Therefore, in order to prevent violence, the underlying social determinants of health need to be addressed, including root causes of inequity and social disadvantage.[10, 29]

2 Solutions:
Violence is Preventable

The public health approach to preventing violence

Public health has a long-standing mission to prevent negative health outcomes, promote healthy communities, and resilient individuals, and protect the health of entire populations.

Public health recognizes that **violence is preventable** and takes a primary prevention approach, working "upstream" to address underlying causes to prevent violence from happening in the first place. Public health works to: promote safe, stable, nurturing, healthy relationships and environments; address individual, interpersonal, community, and societal risk and protective factors; decrease structural violence; and, build individual and community resilience.

The field of public health approaches violence as it does many other issues by using data to understand and describe the problem; implementing and evaluating strategies; and, ensuring widespread adoption of evidence-informed strategies.

By addressing the multiple forms of violence and their shared risk and protective factors, we can also address overall health. Promoting safe communities, non-violent behavior as social norms, access to services, social support, housing, and economic stability. This not only creates conditions that prevent violence, but also contributes to other public health goals like increasing physical activity, reducing chronic disease and obesity, promoting healthy eating, and reducing depression.

Read more about the History of Violence as a Public Health issue and the CDC Strategic Vision for Preventing Multiple Forms of Violence.

Role for public health agencies

The Safe States Alliance released recommended roles for national, state, and local public health departments in violence prevention. CDPH has adopted this framework at the state level.

- Develop a statewide agenda for preventing violence
- Develop and implement policy approaches
- Collect, analyze and disseminate data and information
- Build local capacity
- Contribute to national efforts
- Conduct needs assessment and strategic planning
- Maximize existing resources and identify new funding streams
- Translate research into practice

2 Solutions:
Violence is Preventable

Public health as convener

Public health serves an important role as a catalyst and convener to help bring together stakeholders to pursue a "multilevel and multifaceted approach, promoting policies and programs that encourage collaboration, increased government efficiency, and a focus on equity."[5] Public health is a direct partner in violence prevention working alongside contributors in many sectors, from the criminal justice system to education to healthcare.

National recognition of public health role

There has been growing national recognition of the significance of violence as a public health problem. Mass shootings, high profile domestic and sexual violence cases, rising rates of suicide, and other violent incidents have elevated the public's concern. Many organizations including the Centers for Disease Control and Prevention,[30] American Medical Association,[31] American Public Health Association,[32] and the former U.S. Surgeon General[33] have issued statements highlighting the importance of addressing violence from a public health perspective.

> "Violence is a serious public health problem. From infants to the elderly, it affects people in all stages of life. Many more survive violence and suffer physical, mental, and or emotional health problems throughout the rest of their lives. CDC is committed to stopping violence before it begins."[34]
>
> ***-Centers for Disease Control and Prevention***

2 Solutions:
Violence is Preventable

What are governmental public health agencies doing?

At the state level, the California Department of Public Health (CDPH) collects and analyzes data to better understand the causes of and factors contributing to violence and implements many programs that address multiple forms of violence through a variety of strategies, including promoting positive social norms, community mobilization, and strengthening parent-child relationships. CDPH also facilitates collaboration among multisector partners to promote effective interventions and support policies that build and sustain healthy communities.

In order to elevate violence prevention as a departmental priority and work towards a more integrated internal approach, CDPH staff members across programs have collaborated in a department-wide Violence Prevention Initiative. Through this initiative, CDPH will continue to take a leadership role to elevate and frame the public health state government role in addressing violence and further efforts to support violence prevention work in California.

CDPH implements programs, policy initiatives, and surveillance activities to address violence at the state and local levels:

Programs and policy

- Rape Prevention and Education Program
- Domestic Violence Training and Education Program
- Essentials for Childhood Initiative
- California Home Visiting Program
- Health in All Policies Task Force: Action Plan to Promote Violence-Free and Resilient Communities

Data and surveillance

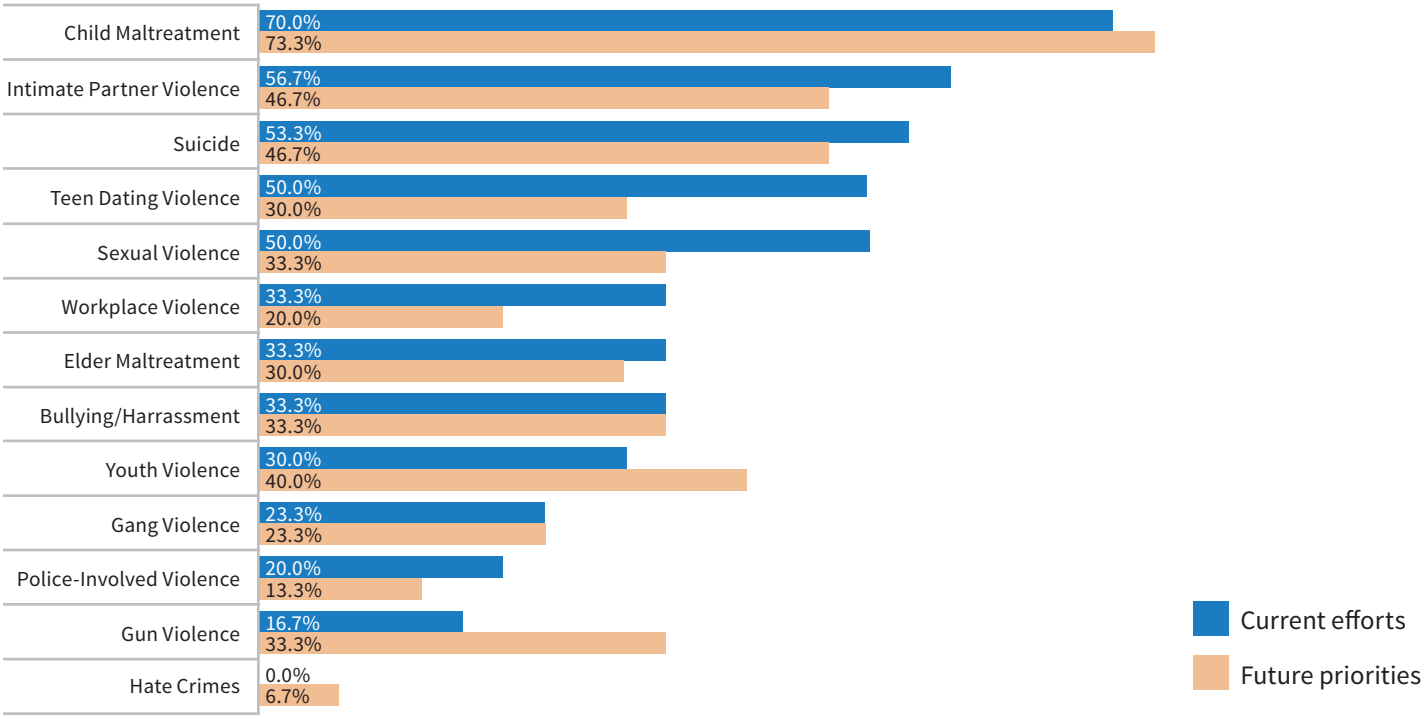
- California Electronic Violent Death Reporting System
- EpiCenter – California Injury Data Online
- Vital Statistics
- Open Data Portal
- Let's Get Healthy California
- Healthy Community Indicators Project
- Maternal and Infant Health Assessment

2 Solutions:
Violence is Preventable

Local health jurisdiction violence prevention efforts

The CDPH Violence Prevention Initiative conducted a survey of local health jurisdictions (LHJs) to better understand the scope of local violence prevention activities, and identify barriers, needs, and opportunities for collaboration. The most common focus areas at the local level are child maltreatment and intimate partner violence. LHJs have noted additional future priorities around suicide and youth violence prevention; one of the greatest changes in priority concerns gun violence, with 33 percent of LHJs interested in addressing prevention in the future compared to 17 percent that are currently addressing this issue.

Additionally, LHJs reported building coalitions and partnerships, enhancing public awareness, and implementing evidence-based policies and programs as their most frequent activities. CDPH will use these survey findings to support local efforts by providing data, actionable information, and shared messaging that will generate new opportunities for state and local governmental public health to work together to prevent violence in California.



Local Health Jurisdiction Survey Results

Blue bars reflect current LHJ violence prevention efforts. LHJs were also asked to identify up to five priority areas for future violence prevention activities. The orange bars reflect these priority areas of focus for future efforts.

2 Solutions:
Violence is Preventable

Public health driven multi-sector collaborations

Violence is a cross-sectoral issue involving significant partners such as criminal justice, land use planning, education, housing, social services, transportation, and more that are essential in addressing the underlying determinants of violence. Non-governmental entities including community based organizations, private institutions, health systems, and foundations also have an important role to play. Through collaborative efforts we can more effectively recognize and address the connections among the forms of violence.

CDPH will continue to align violence prevention activities across sectors through California Health and Human Services Agency initiatives and other state-level collaborative efforts such as the California Campaign to Counter Childhood Adversity, ACEs Connection, Let's Get Healthy California, and Health in All Policies.

3 What's Next?
Engage and Mobilize

Collaboration as a foundation

Through the Violence Prevention Initiative, CDPH staff from across programs have strengthened internal collaboration, working to share data, identify opportunities and challenges, and elevate the role of CDPH in violence prevention. CDPH is committed to taking a leadership role in highlighting and framing the role of public health in addressing interpersonal and community violence. Two key aspects of this role are providing actionable data and serving as convener to facilitate engagement across sectors, systems, and initiatives.

From alignment to action

CDPH is taking additional steps to advance prevention and intervention efforts to reduce violence across California, including:

- Developing a common language and issue framework for understanding violence as a public health issue, particularly in the context of social determinants of health;
- Providing informational reports for state and local partners on the current status of violence prevention in California;
- Using both supportive state legislation and funding from CDC, building a Violent Death Reporting System to enhance data collection and provide more actionable information on violence in California;
- Identifying effective, evidence-based strategies and best practices used by other states and national initiatives;
- Expanding dialogue with local and interdepartmental stakeholders to develop strategies to address key priorities;
- Leveraging statewide survey feedback from LHJs in California to more effectively align violence prevention efforts and resources across California; and,
- Continuing to align violence prevention activities across projects and link with statewide initiatives, including Let's Get Healthy California, and Health in All Policies.

3 What's Next?
Engage and Mobilize

Tangible success as the goal

Although many effective public policy, community-based, and programmatic solutions have been developed throughout California, the full range of available resources must be mobilized to address multiple forms of violence. By joining together in the interest of statewide public health, California can maximize violence prevention efforts for greater impact.

Through the Violence Prevention Initiative, CDPH will promote a collaborative vision for addressing violence prevention, track population-based indicators, and provide technical assistance to local partners on evidence-informed or evidence-based public health strategies through future reports and collaborative activities. CDPH is dedicated to achieving tangible and measurable success in addressing violence from a public health perspective using public health approaches to reduce violence and create safer, healthier communities across California.

Preventing Violence in California - Report Series

The development of this series provides an opportunity for collaboration. Feedback on potential topics and content is welcome. Interested partners may contact violenceprevention@cdph.ca.gov to provide feedback, sign-up for updates, or find out more about participating in this collective effort.

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35. Photo credit: iStockphoto.com

California Department of PublicHealth

Preventing Violence in California

Vol 1: The Role of Public Health

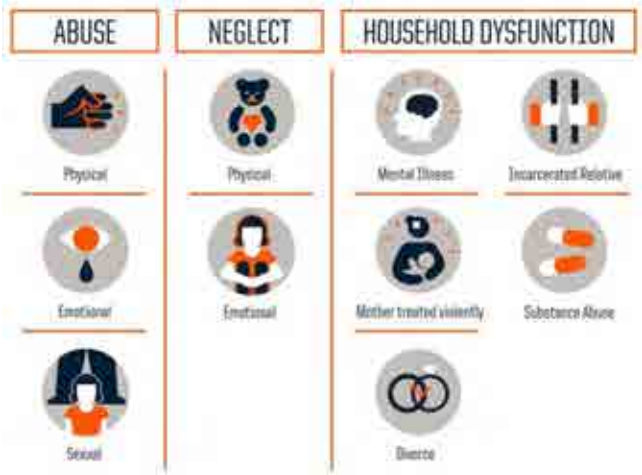
Adverse Childhood Experiences (ACEs): California Update, 2011-2013 Data

What are ACEs?

Adverse Childhood Experiences (ACEs) is a term used to describe a range of traumatic experiences that may occur during a person's first 17 years of life, including child abuse, neglect, and other household dysfunctions. The Centers for Disease Control and Prevention (CDC) and Kaiser Permanente collaborated on the original ACE study from 1995 to 1997 which examined the association between these traumatic experiences and lifelong health and well-being.[i]

Types of ACEs

Based on the original ACE study, there are ten individual ACEs items which fall under the categories of abuse, neglect, and household dysfunction.



Credit: Robert Wood Johnson Foundation

There are other ways of measuring early childhood adversity including recent work that expands the range of traumatic experiences to include community level stressors. The California Maternal Infant Health Assessment (MIHA) includes measures of childhood hardship such as family food insecurity and problems paying rent.[ii] The National Survey of Children's Health includes measures of neighborhood violence and experienced racial/ethnic discrimination.[iii]

This fact sheet uses data from the CDC Behavioral Risk Factor Surveillance System (BRFSS) ACE Module which uses the traditional ACEs categories.

How do ACEs affect health?

The original ACE study found a strong relationship between exposure to ACEs and subsequent negative health behaviors and outcomes later as adults. Since the original ACE study, a growing body of scientific evidence has consistently confirmed this negative relationship between ACEs and diminished health outcomes.[iv] Additionally this relationship displays a graded dose-response; the more ACEs an individual is exposed to, the higher the risk for adverse health outcomes.[v]

Credit: Robert Wood Johnson Foundation

Findings suggest that ACEs are a risk factor for a wide range of diseases and premature death. ACEs have been associated with multiple risky behaviors, health conditions and diseases including: smoking unintended pregnancies, alcoholism, illicit drug use, depression, suicide attempts, chronic obstructive pulmonary disease (COPD), ischemic heart disease and liver disease.[vi]

Credit: Robert Wood Johnson Foundation

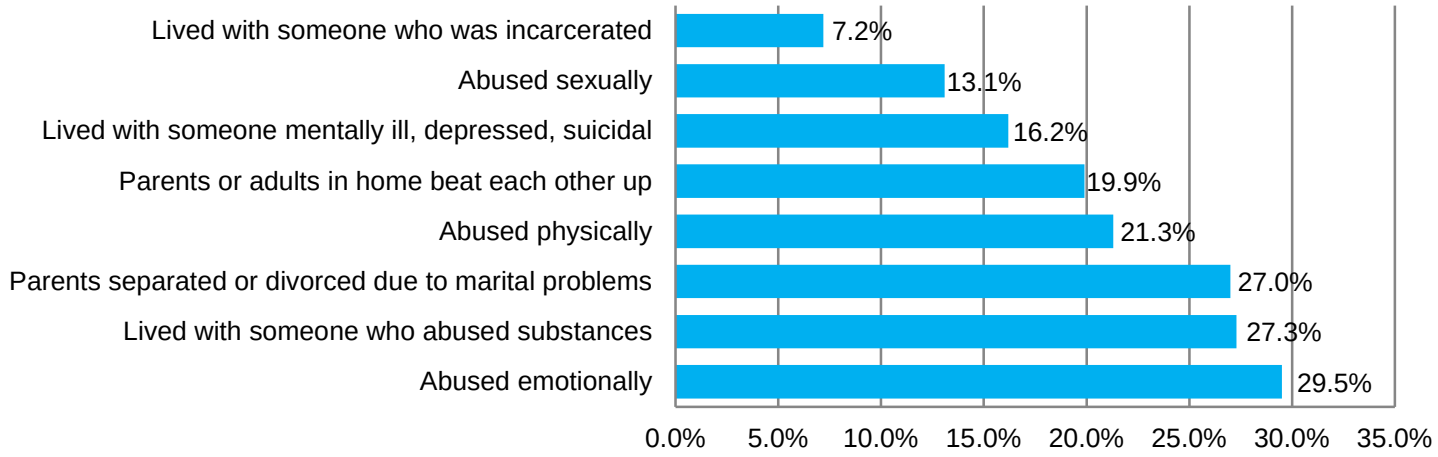
What does this fact sheet add?

The Behavioral Risk Factor Surveillance System (BRFSS) is a health-related telephone survey that collects state data about United States (U.S.) residents. Survey participants answer questions about health-related risk behaviors, chronic health conditions, and use of preventive services. California is among 32 states that collect ACEs data via the ACE module on BRFSS. This fact sheet combines data from the years 2011 and 2013 as the data from these two years are based on the same ACE module questions.[vii]

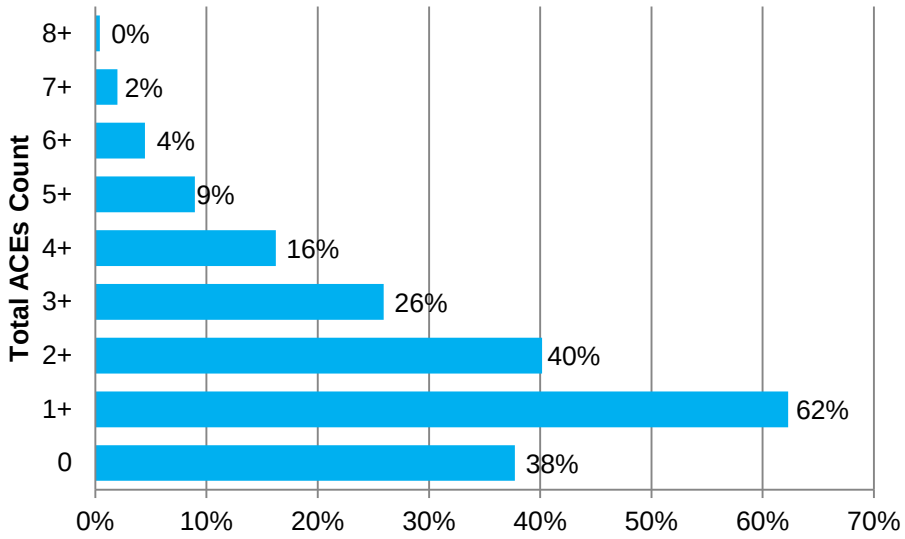
The total ACEs score used in this analysis ranges from zero to eight. The BRFSS ACE module includes 12 questions with three questions on sexual abuse and separate questions on alcohol and illicit drug use. The three questions about sexual abuse have been combined in this analysis. The questions about alcohol and illicit drug use have also been combined. Neglect was not used to calculate the ACEs score as the neglect question was only included on the ACE module in 2013.

Update on California ACEs Status – 2011-2013

Prevalence of Individual ACE Items



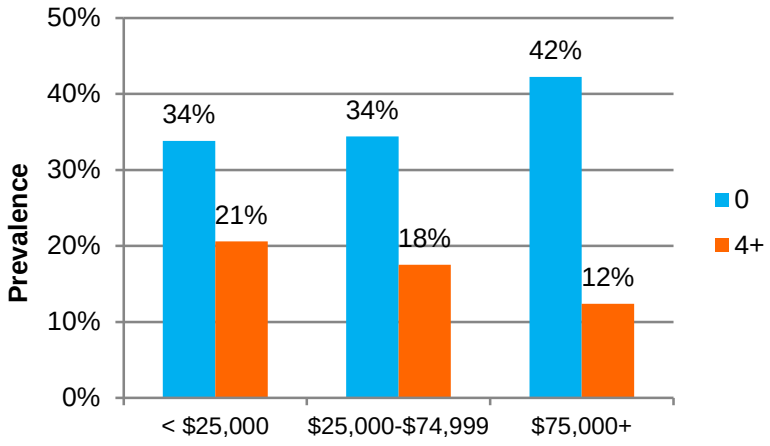
Distribution of Total ACEs Score



ACEs are very common in California, as they are across the U.S. The prevalence of individual ACEs ranges from 7% for people who had a family member incarcerated to nearly 30% for people who experienced some form of verbal or emotional abuse during childhood.

Over 60% of Californians report experiencing at least one ACE before age 18. Approximately one in four Californians reported having three or more ACEs.

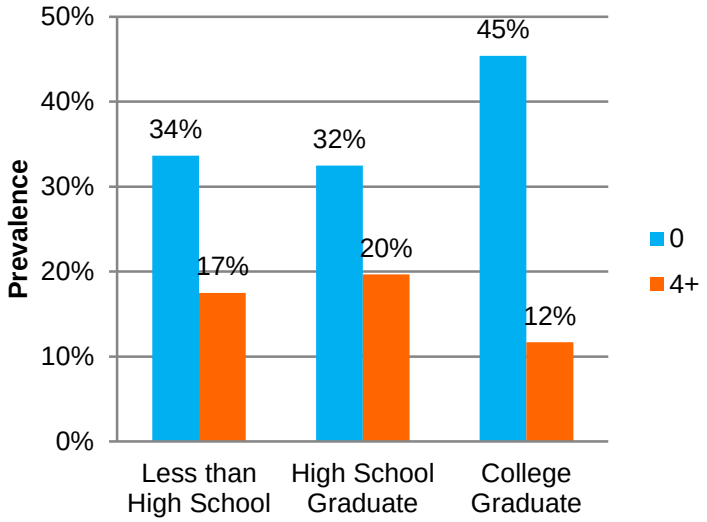
Distribution of Total ACEs Score by Income



ACEs are not evenly distributed across the population. There are significant disparities in prevalence of ACEs across different socioeconomic groups.

Respondents with a higher number of ACEs are more likely to be in lower versus higher adult income groups.[1]

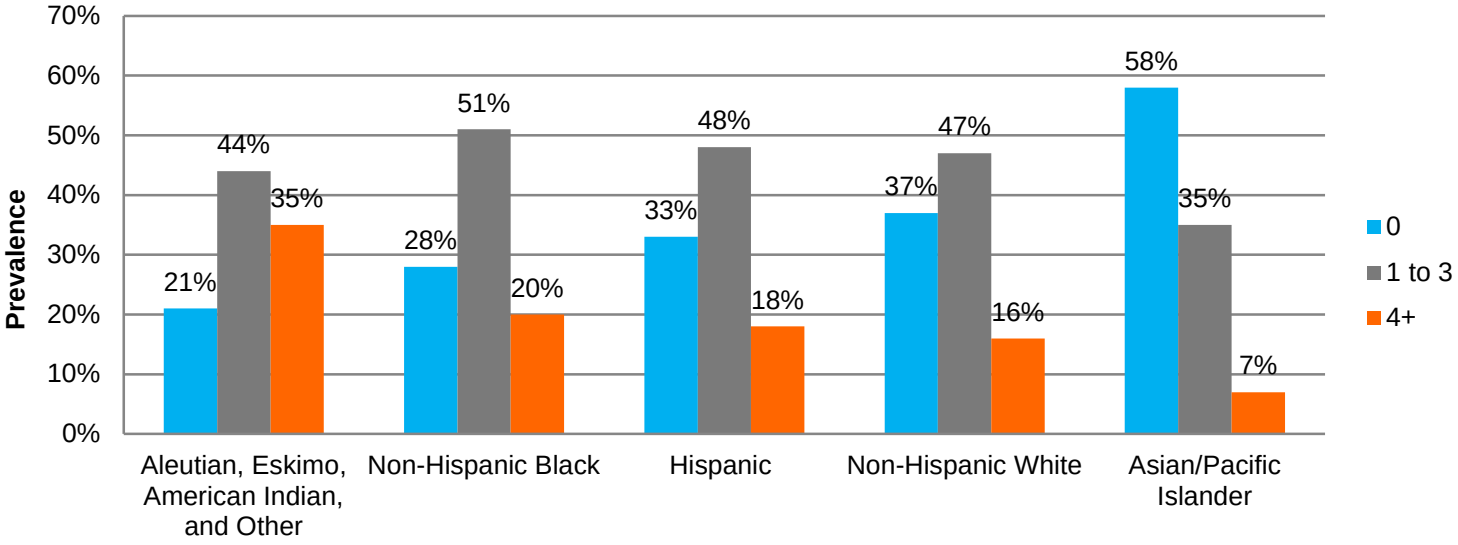
Distribution of Total ACEs Score by Education



The distribution of ACEs score by education shows a similar trend to the distribution by income. Individuals with four or more ACEs tended to have less education.[1]

There were also significant differences between racial/ethnic groups in California in how ACEs are distributed. The Aleutian, Eskimo, and American Indian subgroup had the highest prevalence of four or more ACEs while the Asian/Pacific Islander subgroup reported the lowest number of ACEs.[1]

Distribution of Total ACE Score by Race/Ethnicity



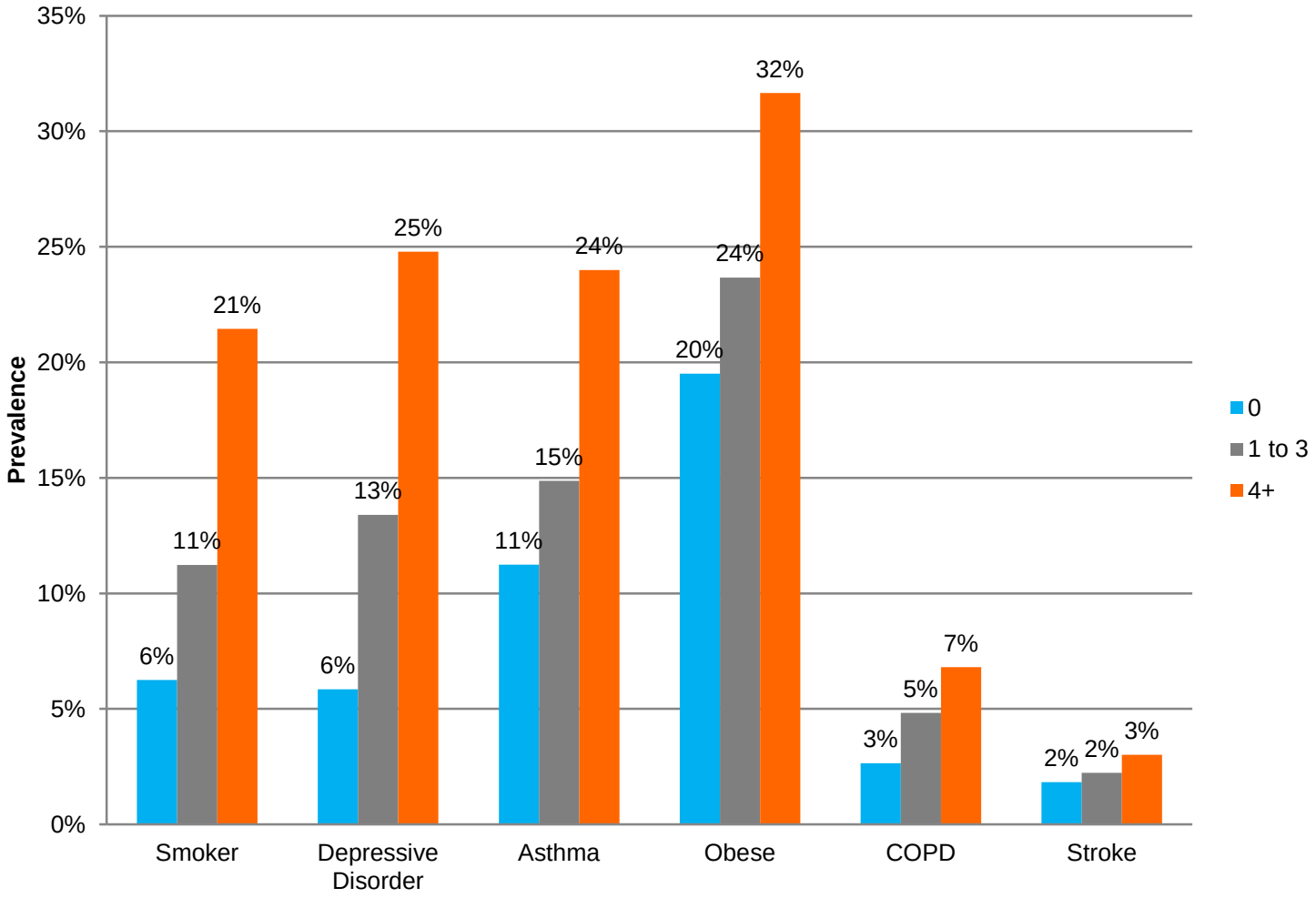
[1] Differences in income, education, and race by total ACE score are significant at 0.05 level.

Not only are ACEs differentially distributed, the cumulative impact of multiple early childhood traumas has been shown to have a life-long and direct impact on both behavior and disease. There is consistent dose response relationship between number of ACEs and risky health behaviors, mental health disorders, health conditions, and disease.

The graph below highlights several of these behavioral, emotional and health consequences, which are much more common among Californians with ACEs. Adjusting for race, sex, and gender, individuals with four or more ACEs are:

3x more likely to be current smokers
4x more likely to have a depressive disorder
2x more likely to have asthma
2x more likely to be obese
4x more likely to have COPD
3x more likely to have a stroke

Prevalence of Health Behaviors, Health Conditions, and Disease by Total ACEs Score



This BRFSS survey shows how the cumulative experiences of child trauma often lead to life-long behavioral, emotional, and health consequences. If risk factors in a child's early years are eliminated or reduced and additional protective factors are introduced, a child's mental and physical development can be redirected in a more positive direction. There are many innovative and effective statewide activities working to create safe, stable, nurturing relationships and environments for California's children and families:

- Let's Get Healthy – California (Healthy Beginnings)
  Let's Get Healthy California is a Task Force of the California Health and Human Services Agency with the vision to make California the healthiest state in the nation by focusing on health across the lifespan as well as pathways to health. "Healthy Beginnings" is one of the six project goals of Let's Get Healthy. Healthy Beginnings aims to lay the foundation for health and well-being for a person's entire life by tracking indicators of the health of Californian children as well as pregnant women to ensure children have the opportunity to thrive and reach their full potential.[viii]
  https://letsgethealthy.ca.gov/
- California Home Visiting Program (CHVP)
  The CHVP is a positive parenting program to help vulnerable families independently raise their children. CHVP was created as a result of the Patient Protection and Affordable Care Act of 2010. The program provides comprehensive, coordinated in-home services to support positive parenting, and to improve outcomes for families residing in identified at-risk communities. Currently 26 sites are funded to provide services using one of two nationally recognized home visiting models, Healthy Families America and Nurse-Family Partnership. CHVP seeks to improve maternal and child health, prevent child injuries, child abuse and maltreatment, and reduce emergency department visits, improve school readiness and achievement, reduce crime and domestic violence, improve family economic self-sufficiency, and improve the coordination and referrals for other community resources and supports.[ix]
  http://www.cdph.ca.gov/programs/mcah/Pages/HVP-HomePage.aspx
- California Essentials for Childhood Initiative
  The California Essentials for Childhood Initiative addresses child maltreatment as a public health issue. The CDC awarded a five-year grant to the California Department of Public Health to collaborate with the California Department of Social Services to support a collective impact approach to build upon, align, enhance, and collaborate with existing efforts to promote safe, stable, nurturing relationships and environments, prevent child maltreatment, and assure that children reach their full potential.[x]
  http://www.cdph.ca.gov/programs/Pages/ChildMaltreatmentPrevention.aspx
- First 5 California and County First 5 Commissions
  First 5 California, also known as the California Children and Families Commission, is dedicated to improving the lives of California's young children and their families through a comprehensive system of education, health services, childcare, and other crucial programs. First 5 California distributes funds from Proposition 10 (a 50-cent tax to each pack of cigarettes) to local communities through the state's 58 individual counties, all of which have created their own local First 5 County Commissions to implement local policies and programs to support the specific needs of local children and families and improve the well-being of families and children. Since 1998, First 5 has invested millions of dollars to design comprehensive programs that address the needs of children ages 0 to 5 and their families. Currently programs are centered on the child, parent, and teacher to improve early childhood outcomes in the areas of health, nutrition, early literacy, language development, quality child care, and smoking cessation.[xi]
  http://www.ccfc.ca.gov/ and http://first5association.org/
- ACEs Connection
  ACEs Connection is a social network that accelerates the global movement toward recognizing the impact of adverse childhood experiences in shaping adult behavior and health. The network aims to create a safe place and trusted source where members can share information, explore resources, and access tools that help them work together to create resilient families, systems, and communities.[xii]
  http://www.acesconnection.com/home and https://acestoohigh.com/

- California Department of Justice's Defending Childhood Initiative
  Led by the U.S. Bureau of Children's Justice, the Defending Childhood Initiative is a federal initiative based on the Attorney General's National Task Force on Children Exposed to Violence Report (2012).[xiii] California's Defending Childhood Initiative aims to align, integrate, and mobilize multi-sectoral resources to equitably prevent, identify, and heal the impacts of violence and trauma on children and youth. It intends to establish cross-sector teams of state agency leaders dedicated to crafting a common agenda to prevent and address children's exposure to violence and identify policy recommendations and actions to more effectively prevent and address the damage caused by children's exposure to violence and trauma.[xiv]
  http://www.defendingchildhood.org/
- The Center for Youth Wellness (CYW)
  The CYW is a health organization within a pediatric home that serves children and families in the Bayview Hunters Point neighborhood of San Francisco. The CYW aims to revolutionize pediatric medicine and transform the way society responds to kids exposed to significant ACEs and toxic stress by screening for ACEs, leading pilots for treatments for toxic stress, and raising awareness among groups ranging from parents and pediatricians to policy makers.[xv]
  http://www.centerforyouthwellness.org/adverse-childhood-experiences-aces/

Additional Resources

Centers for Disease Control and Prevention
http://www.cdc.gov/violenceprevention/acestudy/index.html

Harvard University Center on the Developing Child
http://developingchild.harvard.edu/

Acknowledgements

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- Fatal Child Abuse and Neglect Surveillance Program, Health and Human Services Agency, Maternal Child Health Title V Block Grant #B04MC29335

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California Essentials for Childhood Initiative

New Childhood Adversity and Resilience Data Topic on Kidsdata.org

Innovation Abstract

The California Essentials for Childhood Initiative, in partnership with the Lucile Packard Foundation for Children's Health, launched a new set of child adversity and resilience data indicators on the Kidsdata.org website. This is the first new data topic to be added to their website in six years. This new data resource represents a substantive accomplishment for the Essentials for Childhood Initiative because it brings together related sources of data on child adversity and resilience in order to present adverse experiences through a broader social determinants framework.

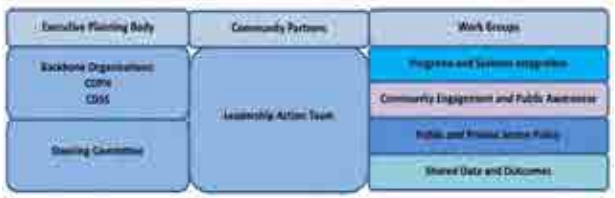
Background on Essentials

The Essentials for Childhood Initiative is a Centers for Disease Control and Prevention (CDC) funded child maltreatment prevention initiative that promotes safe, stable, nurturing relationships and environments. The grant funds the California Department of Public Health (CDPH), Safe and Active Communities Branch, and the California Department of Social Services (CDSS), Office of Child Abuse Prevention, to support a collective impact approach that builds upon existing efforts that promote safe, stable, nurturing relationships and environments for all children and families.

Vision: All California children, youth and their families thrive in safe, stable, nurturing relationships and environments.

Mission: To develop a common agenda across multiple agencies and stakeholders to align activities, programs, policies, and funding so that all California children, youth, and their families have safe, stable, nurturing relationships and environments.

Governance Structure



Essentials Focus on Child Adversity & Resilience

- **Child adversity,** such as child abuse, exposure to violence, and poverty, has a negative long-term impact on the health and well-being of the population.
- Early experiences, both positive and negative, affect brain architecture, which provides the foundation for learning, emotional development, behavior, and health.
- Toxic stress can disrupt healthy development and lead to serious health issues in adulthood such as chronic diseases, obesity, and substance abuse.
- **Resilience** is an adaptive response to hardship, that involves internal and external factors, and can mitigate the effects of adverse childhood experiences.
- Resilience is created and strengthened by safe, stable, nurturing relationships, and environments within and outside of the family.

Project Purpose & Goals

Purpose: The creation of the new Childhood Adversity and Resilience data topic was advanced through the Essentials Shared Data and Outcomes Workgroup, and aligns with the CDC goal for the Initiative of using data and best practices to inform solutions.

Goals: Increase access to child adversity and resilience data. Broaden the notion of Adverse Childhood Experiences (ACEs) to include social determinant-level causes of trauma, and provide county-level breakdowns for the data to meet the needs of our local partners.

Innovation Development

The Shared Data and Outcomes Workgroup, with direction and assistance from the CDPH team, worked with the Lucile Packard Foundation's Kidsdata staff to add three sources of ACEs data onto their website, creating a new data topic:

- Behavioral Risk Factor Surveillance System (BRFSS).
- Maternal and Infant Health Assessment (MIHA).
- National Survey of Children's Health (NSCH).

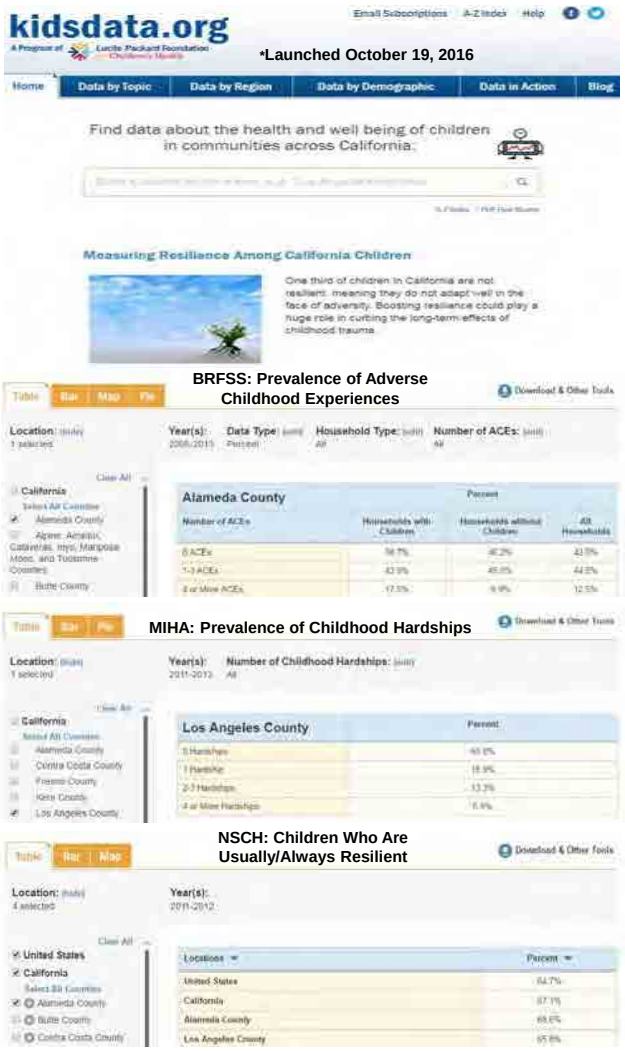
The BRFSS, MIHA, and NSCH, together, provide a framework for understanding and addressing child adversity across the lifespan. Among these three data sources, the NSCH indicators are the most contemporary because they tap into parents' views of their children's current experiences. MIHA adds an intergenerational perspective by providing information about the childhood hardships experienced by mothers of newborns. BRFSS provides a well-established standard measure of adult retrospective reports of ACEs. Each source provides a unique, but conceptually-related perspective on childhood adversity.

Adverse Experiences	NSCH	MIHA	BRFSS
Socioeconomic Hardship/Basic Needs Unmet	X	X	X
Hunger		X	
Housing Instability		X	
Neighborhood Violence	X		
Foster Care Placement		X	
Treated Unfairly Because of Race/Ethnicity	X		
Verbal, Physical, Sexual Abuse			X
Domestic Violence	X		X
Parent Divorce/Separation	X	X	X
Parent Death	X		
Incarceration of Household Member	X	X	X
Mental Illness of Household Member	X		X
Drug or Alcohol Abuse in Household	X	X	X

Collaboration and Target Population

The Essentials for Childhood Initiative utilizes a collective impact approach to engage multiple partners across the state. Representatives of the Shared Data and Outcomes Workgroup include: CDPH's Maternal Child and Adolescent Health, First 5 California, ACEs Connection, Public Policy Institute of California, USC Children's Data Network, Parents Anonymous, and Children Now, among others. The co-chairs of the Data Workgroup played a critical role in helping to shape the website narrative about child adversity. Furthermore, this data activity was cultivated under the shared vision of increasing accessibility to data in order to inform best practices and solutions that address child maltreatment.

The target population includes community coalitions and organizations, local health departments, non-profits, or others engaging in work to address child adversity and promote resilience-building at the local level.



Outcome Metrics

Measure	October 19, 2016 – February 1, 2017
Page views: Childhood Adversity and Resilience	18,209
Kidsdata news: Four advisories	4,200 average
Tweet impressions: Top five about adversity/resilience	6,048
Kidsdata Facebook posts	369

Next Steps

- Continue to promote data topic through presentations and conferences.
- Co-hosting webinar with Kidsdata on March 29, 2017.
- Working with the Kidsdata team to create state-level and county-level dashboards with 19 existing data indicators of child and family well-being.
- Working to identify gaps in existing data for Kidsdata.org website.
- Working to identify missing data indicators that need to be collected (resilience).

State of California—Health and Human Services Agency
California Department of Public Health

KAREN L. SMITH, MD, MPH
Director and State Health Officer

EDMUND G. BROWN JR.
Governor

Safe and Active Communities Branch (SACB)

The mission of SACB is to ensure all Californians have safe places in which to live, work, play, and fully participate in all activities of daily life free of violence or injury. SACB is the focal point for CDPH efforts in injury and violence prevention and surveillance. The State and Local Injury Control Section oversees program implementation and conducts planning, policy development, granting activities, and technical consultation. The Injury Surveillance and Epidemiology Section uses multiple large databases to monitor and track the magnitude and impact of injury and violence and helps guide program and policy efforts by identifying population groups most at risk, and monitoring changes and impacts of programs and policies over time.

SACB violence prevention programs and surveillance activities include:

Rape Prevention and Education Program: Supports rape crisis centers to conduct community-based strategies such as bystander intervention, community mobilization, and school-based education to prevent first-time perpetration and victimization of sexual violence.

Domestic Violence Training and Education Program: Promotes safe, healthy, and equitable relationships, to prevent domestic violence and teen dating violence, through youth leadership and community mobilization activities conducted by domestic violence services organizations.

Essentials for Childhood Initiative: Addresses child maltreatment and other adverse traumas by utilizing the Collective Impact framework to promote safe stable nurturing relationships and environments for children, families and communities.

California Electronic Violent Death Reporting System: Collects detailed information on the circumstances surrounding violent deaths (i.e., homicides, suicides) from multiple data sources (Medical Examiners/Coroners and law enforcement) to inform policy and program.

EpiCenter: California Injury Data Online: A data query system that allows access to the most versatile and comprehensive source of California injury data. It includes all types of injuries that result in death, hospitalization, or an emergency department visit.

California Reducing Disparities Project Phase II

California Department of PublicHealth

Office of Health Equity, Community Development and Engagement Unit

BACKGROUND

The California Reducing Disparities Project (CRDP), launched in 2009, is a $60,000,000 project funded by the Mental Health Services Act of 2004. It seeks to answer former U.S. Surgeon General David Satcher's call for national action to reduce mental health disparities.

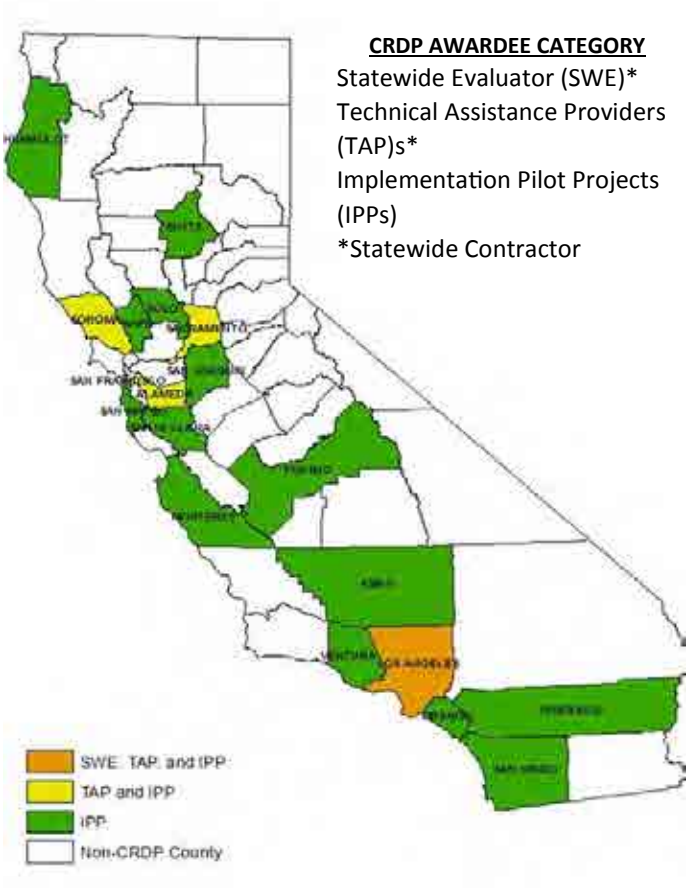
The five target populations included in CRDP are ***African American***; ***Asian and Pacific Islander***; ***Lesbian, Gay, Bisexual, Transgender, and Queer, Questioning (LGBTQ)***; ***Latino***; and ***Native American***. To date, the CRDP consists of two phases.

Phase I, projected to be completed in 2016, focuses on the development of a statewide strategic plan to reduce mental health disparities, while Phase II, to be completed in 2022, focuses on implementation of the CRDP Strategic Plan.

PHASE II GOALS

CRDP Phase II is designed to build on and implement strategies developed in Phase I. They include:

- Demonstrate through a rigorous, community-participatory evaluation process that selected Community-Defined Evidence Practices (CDEPs)* are effective in preventing or reducing the severity of mental illness.
- Increase funding of validated CDEPs by other, non-CRDP sources, including county mental health agencies.
- Support changes in statewide and local mental health delivery systems and policies that will reduce mental health disparities among unserved, underserved and inappropriately served populations.



CRDP AWARDEE CATEGORY

Statewide Evaluator (SWE)*
Technical Assistance Providers (TAP)s*
Implementation Pilot Projects (IPPs)
*Statewide Contractor

CRDP COMPONENTS

♦ *Evaluation*

The purpose of evaluation is to demonstrate the effectiveness of Community-Defined Evidence Practices (CDEPs) in reducing mental health disparities in the target populations using community based participatory research (CBPR) methods. This is a partnership approach to research that equitably involves community members, organizational representatives, and researchers in all aspects of the research process.

♦ *Technical Assistance*

Five population-specific Technical Assistance Providers (TAPs) will work with Pilot Projects to develop their administrative, programmatic and evaluation capacities. They will also help Pilot Projects improve operations, identify and secure additional resources and build strategic partnerships to better serve communities.

♦ *Pilot Projects*

Pilot Projects are CDEPs which provide culturally and linguistically competent prevention and early intervention services to members of CRDP target populations. Efforts in Phase II will expand CDEPs for effective evaluation. There are two types of Pilot Projects, Capacity Building and Implementation. CBPPs will begin six months before IPPs to allow for additional technical assistance.

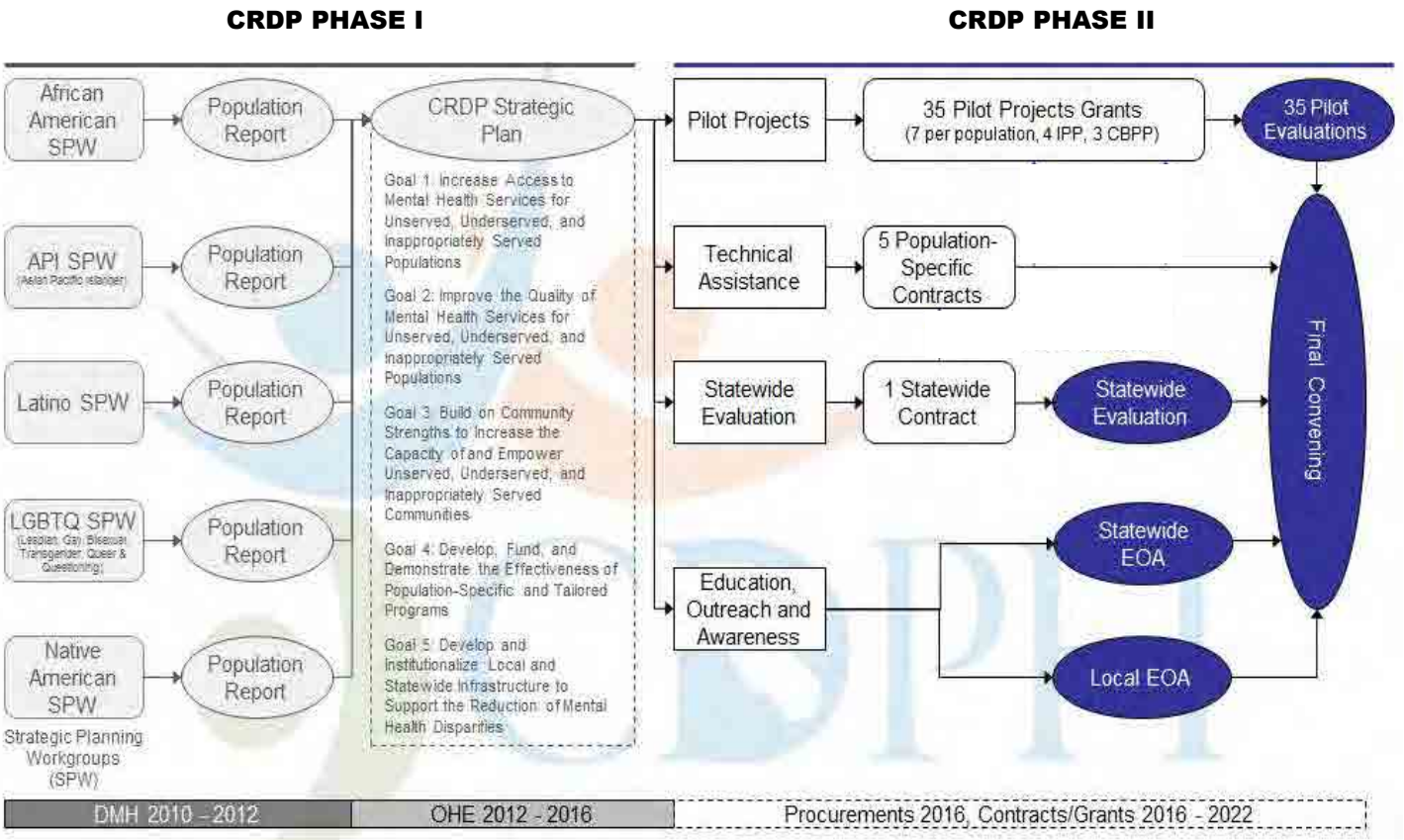
♦ *Local Education, Outreach and Awareness*

The Education, Outreach and Awareness solicitation will be issued in Fall of 2016. This will be the final solicitation under the CRDP umbrella. The focus of this solicitation is to create an improved mental health system that is culturally and linguistically focused and accessible to all populations including underserved and vulnerable communities.

*A CDEP is a set of practices used by communities and determined to yield positive result that may not have empirical evidence of effectiveness.

California Reducing Disparities Project Phase II

CRDP SCHEMATIC



GUIDING PRINCIPLES

- ***Do business differently***

Doing business differently has been a focus of CRDP from the start. Doing business differently involves attentive listening and genuine consideration of community and CRDP partner input in order to be responsive to community needs.

- ***Build community capacity***

To sustain efforts to reduce mental health disparities beyond the period of CRDP Phase II funding, it is necessary to invest in creating community capacity and supporting community-based organizations.

- ***Fairness***

A program designed to reduce disparities must not perpetuate disparities. Contracts should be awarded based on merit and only after all interested parties have been invited to apply and if needed, provided with tools and services to support their application.

- ***Systems change***

CRDP does not exist in a vacuum. If the effort to reduce disparities begun with CRDP Phases I and II is to be sustained beyond the period of funding, then Phase II needs to address the context and bigger picture within which CRDP exists. This will allow smoother integration of Phase II funded programs into the larger mental health care delivery system.

Office of Health Equity
Community Development and Engagement Unit
PO Box 997377, MS 0022
Sacramento, CA 95899-7377

Phone: 916-445-4139
Fax: 916-552-9861
Web: http://www.cdph.ca.gov/programs/Pages/OHECaliforniaReducingDisparitiesProjectPhaseII.aspx

California Reducing Disparities Project Contractors and Grantees

Statewide Evaluator

Loyola Marymount University

Technical Assistance Providers

African American
ONTRACK Program Resources
Asian and Pacific Islander
Special Service for Groups
Latino
University of California, Davis—Center for Reducing Health Disparities
Lesbian, Gay, Bisexual, Transgender, Queer and Questioning (LGBTQ)
Center for Applied Research Solutions
Native American
Pacific Institute for Research and Evaluation

Implementation Pilot Projects

African American
1. California Black Women's Health Project—Los Angeles County
2. Catholic Charities of the East Bay—Alameda County
3. Healthy Heritage Movement—Riverside County
4. Safe Passages—Alameda County
5. The Village Project, Inc.—Monterey County
6. West Fresno Health Care Coalition—Fresno County
7. Whole Systems Learning—Riverside County

Asian and Pacific Islander
1. Cambodian Association of America—Los Angeles County
2. East Bay Asian Youth Center—Alameda County
3. Fresno Center for New Americans—Fresno County
4. HealthRIGHT 360—San Mateo County
5. Hmong Cultural Center of Butte County—Butte County
6. Korean Community Services—Orange County
7. Muslim American Society: Social Services Foundation—Sacramento County

Latino
1. Health Education Council—Yolo County
2. Humanidad Therapy and Education Services—Sonoma County
3. Integral Community Solutions Institute—Fresno County
4. La Clínica de la Raza, Inc.—Alameda County
5. La Familia Counseling Center, Inc.—Sacramento County
6. Latino Service Providers—Sonoma County
7. Mixteco/Indígena Community Organizing Project—Ventura County

LGBTQ
1. Asian and Pacific Islander Wellness Center—City and County of San Francisco
2. Gay and Lesbian Center of Bakersfield—Kern County
3. Gender Health Center—Sacramento County
4. Gender Spectrum—Alameda County
5. On the Move—Napa County
6. Openhouse—City and County of San Francisco
7. San Joaquin Pride Center—San Joaquin County

Native American
1. Friendship House Association of American Indians, Inc.—City and County of San Francisco
2. Indian Health Center of Santa Clara Valley—Santa Clara County
3. Indian Health Council, Inc.—San Diego County
4. Native American Health Center—Alameda County
5. Sonoma County Indian Health Project—Sonoma County
6. Two Feathers Native American Family Services—Humboldt County
7. United America Indian Involvement, Inc.—Los Angeles County

CDPH
California Department of
PublicHealth

PORTRAIT OF PROMISE:

The California Statewide Plan to Promote Health and Mental Health Equity

Report to the Legislature and the People of California
by the Office of Health Equity,
California Department of Public Health,
August 2015

Office of Health Equity
California Department of Public Health
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Portrait of Promise: The California Statewide Plan to Promote Health and Mental Health Equity. A Report to the Legislature and the People of California by the Office of Health Equity. Sacramento, CA: California Department of Public Health, Office of Health Equity; August 2015.

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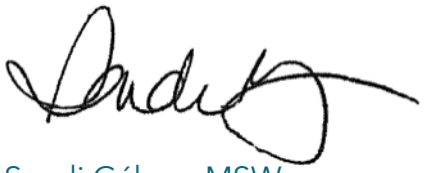
MESSAGE FROM THE CHAIR
OFFICE OF HEALTH EQUITY ADVISORY COMMITTEE

Widespread, systemic inequities take a toll on the mental and physical health of our state's residents. Those who suffer disproportionately from the stress of discrimination or the constraints of poverty also suffer disproportionately from heart disease, asthma, arthritis, and cancer.

As such, the health conditions of our most vulnerable populations will only improve as we address the source of those conditions. We have a responsibility and an obligation to understand the barriers that impede all of California's residents from achieving their greatest health potential – and to work together to remove those barriers.

It has taken hundreds of years of unjust social policies and practices to create the degree and magnitude of health inequities detailed in this report. Each resident, tribe, community, coalition, organization, institution, corporation, and philanthropy has inherited this legacy – and each has an important part to play as the tide is turned through a concerted, comprehensive, and sustained response. We welcome you to join us.

Sincerely,



Sandi Gálvez, MSW
Chair, Office of Health Equity Advisory Committee

ACKNOWLEDGMENTS

The California Statewide Plan to Promote Health and Mental Health Equity ("Plan") has been developed through a truly collaborative effort. Numerous individuals, agencies, and organizations have generously given of their time, knowledge, and expertise. The Office of Health Equity Advisory Committee (OHE-AC), the Health in All Policies Task Force, and the other state departments that participated in the development and review of this document ensured the process was a success.

Appreciation is extended to the following:

- Diana Dooley, Secretary of the California Health and Human Services Agency, and Dr. Ron Chapman, former State Health Officer and Director of the California Department of Public Health, for their leadership and steadfast support for the new Office of Health Equity (OHE) and this first report and strategic plan.

- Sandi Gálvez and Dr. Rocco Cheng, for serving as chair and vice chair, respectively, of the inaugural OHE Advisory Committee, and for providing leadership and guidance for the new OHE Advisory Committee (see the Office of Health Equity Advisory Committee page for a full list of Advisory Committee members).

- All the OHE staff, for their development and review of Plan documents, with special thanks to health research staff members Dr. Mallika Rajapaksa and Thi Mai for coalescing the data for the disparities report, as well as Senior Project Manager Dr. Tamu Nolfo, who helped manage the planning and collating of ideas into the strategic plan.

- Dr. Neil Kohatsu, California Department of Health Care Services (DHCS) Medical Director; Dr. Linette Scott, Chief Information Medical Officer at DHCS; and members of the DHCS-California Department of Public Health (CDPH)/OHE data work group for their input and guidance on the disparities report.

- Jon Stewart, a technical writer who turned data into a story that everyone can understand, in the form of the disparities report.

- The Blanket Marketing Group, a design firm that had the graphic design magic necessary to make the words come alive, and TSI Consulting Partners, which facilitated the initial Advisory Committee deliberations.

- Sierra Health Foundation, California HealthCare Foundation, and Sutter Health, which provided financial and meeting support and which have been and continue to be dedicated to advancing health equity in California.

- Finally and most important, the public, for their input and contributions at OHE Advisory Committee meetings; during webinars; and through surveys, letters, and other discussions. The quality of authentic public engagement that shaped this document is to be commended.

Without the dedication and commitment of all those involved, this Plan would not have been possible. The collaboration and synergy from this diverse spectrum of talented individuals, agencies, and organizations provide great hope for what can be accomplished to achieve health and mental health equity.

OFFICE OF HEALTH EQUITY ADVISORY COMMITTEE

The Office of Health Equity Advisory Committee (OHE-AC) is integral to advancing the goals of the office and advises on the development and implementation of The California Statewide Plan to Promote Health and Mental Health Equity. The OHE-AC comprises representatives from applicable state agencies and departments, local health departments, community-based organizations, and service providers working to promote health and mental health equity for vulnerable communities.

The OHE-AC consists of a broad range of experts, advocates, health clinicians, public health professionals, and consumers who understand the importance of the health and mental health disparities and inequities of historically vulnerable, marginalized, underserved, and underrepresented communities.

The OHE-AC works to provide a forum to identify and address the complexities of health and mental health inequities and to identify interrelated and multisectoral strategies. Additionally, the OHE-AC consults regularly with the Office of Health Equity for input and updates on policy recommendations, strategic plans, and the status of cross-sectoral work.

Advisory Committee members are:

CHAIR

Sandi Gálvez, MSW, is Executive Director of the Bay Area Regional Health Inequities Initiative (BARHII).

VICE CHAIR

Rocco Cheng, PhD, is Corporate Director of Prevention and Early Intervention Services at Pacific Clinics.

MEMBERS

Sergio Aguilar-Gaxiola, MD, PhD, is Professor of Clinical Internal Medicine and Founding Director of the University of California (UC), Davis, Center for Reducing Health Disparities; Director of the Community Engagement Program of the UC Davis Clinical Translational Science Center; and Co-Director of the National Institute on Aging's Latino Aging Research and Resource Center.

Paula Braveman, MD, MPH, is Professor of Family and Community Medicine and Director of the Center on Social Disparities in Health at the University of California, San Francisco.

Delphine Brody formerly served as Program Director for the Mental Health Services Act (MHSA) at the California Network of Mental Health Clients and is currently a member of the National Association for Rights Protection and Advocacy and of the Mental Health Services Oversight and

Accountability Commission Cultural and Linguistic Competence Committee. She also serves on the California Behavioral Health Directors Association Cultural Competence, Equity and Social Justice Advisory Committee.

Jeremy Cantor, MPH, is a Senior Consultant with John Snow, Inc., in San Francisco, California.

Yvonna Cázares is Director of Next-Level Engagement at California State PTA.

Kathleen Derby is a peer and family advocate with over 25 years of lived experience in mental health.

Aaron Fox, MPM, is Director of State Health Equity and Policy at the Los Angeles LGBT Center.

Alvaro Garza, MD, MPH, is Health Officer at San Joaquin County Public Health Services.

Cynthia A. Gómez, PhD, is Founding Director of the Health Equity Institute at San Francisco State University.

Willie Graham, MS, MTh, is pastor of Christian Body Life Fellowship Church in Vacaville, California.

General Jeff is a community activist for the underserved and unserved residents in Skid Row in Downtown Los Angeles and founder of the organization Issues and Solutions.

Carrie Johnson, PhD, is a member of the Dakota Sioux tribe and is a licensed clinical psychologist and Director of the Seven Generations Child and Family Counseling Center at United American Indian Involvement in Los Angeles.

Neil Kohatsu, MD, MPH, was appointed in March 2011 as the first Medical Director for the California Department of Health Care Services.

Dexter Louie, MD, JD, MPA, is a founding member and Chair of the Board of the National Council of Asian Pacific Islander Physicians.

Francis G. Lu, MD, is Luke and Grace Kim Professor in Cultural Psychiatry, Emeritus, University of California, Davis.

Gail Newel, MD, MPH, is an obstetrician-gynecologist who serves the Fresno County Department of Public Health as Medical Director of Maternal, Child and Adolescent Health.

Teresa Ogan, MSW, is Supervising Care Manager for the California Health Collaborative Multipurpose Senior Service Program.

José Oseguera, MPA, is Chief of Plan Review and Committee Operations for the Mental Health Services Oversight and Accountability Commission.

Hermia Parks, MA, RN, PHN, is Director of Public Health Nursing/Maternal, Child, and Adolescent Health for Riverside County.

Diana E. Ramos, MD, MPH, is the Director for Reproductive Health, Los Angeles County Public Health Department, and a practicing obstetrician-gynecologist and adjunct Assistant Clinical Professor at the Keck University of Southern California School of Medicine.

Patricia Ryan, MPA, is serving as a consultant to the California Mental Health Directors Association, having recently retired after 12 years as its Executive Director.

Linda Wheaton is Assistant Director for Intergovernmental Affairs for the California Department of Housing and Community Development and a member of the California Health in All Policies Task Force.

Ellen Wu, MPH, is Executive Director of Urban Habitat.

EXECUTIVE SUMMARY

Almost one in four children in California lives in poverty,[1] which is often associated with factors that negatively affect their health, such as substandard housing, hunger, and poor air and water quality. In California, poverty is higher among women than men and highest among Latinas and single mothers.[2] Compare the salaries of women with those of men: Women go to work on average three months per year without pay,[3] resulting in lower incomes that severely limit health-related options like sleep, nutrition, and exercise. Exacerbating these hardships, one in five women in California has experienced physical or sexual violence by her partner.[4] Through our gender lens we are also now seeing a trend that boys and young men in California are less likely to both read at grade level early on and enroll in undergraduate education through the University of California and California State Universities than are girls and young women,[5,6] and they are disproportionately impacted by school discipline, arrest, and unemployment.[7,8] Additional data demonstrates different health and mental health outcomes among people of different races, ethnicities, and sexual orientations. For example, African American families are twice as likely as their White counterparts to suffer the grievous loss of an infant,[9] due in part to the pervasive and detrimental impacts of a lifetime of discrimination on the mother's physical and mental health.[10] Such racial discrimination appears to undercut the protective benefits of educational attainment, mother's age, and marital status.[11] Lesbian, Gay, Bisexual, Transgender, Queer, and Questioning (LGBTQQ) youths experience suicidal ideation, suicide attempts, and suicide completion more often than do their straight peers.[12]

Health and mental health *disparities* are the differences in health and mental health status among distinct segments of the population, including differences that occur by gender, age, race or ethnicity, sexual orientation, gender identity, education or income, disability or functional impairment, or geographic location, or the combination of any of these factors.[7]

Are the disparities described above inevitable—or preventable?

Disparities in health or mental health, or in the factors that shape health, that are systemic and avoidable and, therefore, considered unjust or unfair are defined as **health and mental health *inequities*.**[7]

In this document, the California Statewide Plan to Promote Health and Mental Health Equity ("Plan"), we present background and evidence on the root causes and consequences of health inequities in California. We explore and illustrate how a broad range of socioeconomic forces, including income security, education and child development, housing, transportation, health care access, environmental quality, and other factors, shape the health of entire communities—especially vulnerable and underserved communities—resulting in preventable health inequities for specific populations. With a better, data-based understanding of the causes and consequences of health inequities, Californians will be better prepared to take the steps necessary for promoting health across California's diverse communities and building on the great strengths that our diverse population brings.

In 2012, as authorized by Section 131019.5 of the California Health and Safety Code, the Office of Health Equity (OHE) was established within the California Department of Public Health. One of the key duties of the OHE outlined in the code is the development of a report with

demographic analyses on health and mental health disparities and inequities, highlighting the underlying conditions that contribute to health and well-being, accompanied by a comprehensive, cross-sectoral strategic plan to eliminate health and mental health disparities.

The timely creation of the Office of Health Equity (OHE) within the California Department of Public Health (CDPH) represents an opportunity, via the Plan presented here, to lessen inequities and pursue a path that leads to health, wellness, and well-being for every member of the great and diverse family of California residents.

The Plan is intended to illuminate the scope of the health equity challenge with compelling data and narrative. It makes the case that health is a basic human right, that health inequity is a moral and financial issue, and that health equity is in everyone's best interest. It also provides a brief summary of the most pervasive social determinants of health, and it offers examples of programs, policies, and practices that have begun to make a difference in the state's most vulnerable communities.

The Plan points to what California can do to capitalize on current windows of opportunity and minimize foreseeable threats. Momentum for health and mental health equity has been building in recent years, setting the stage for this important work. For example, the U.S. Department of Health and Human Services' Action Plan to Reduce Racial and Ethnic Health Disparities: *A Nation Free of Disparities in Health and Health Care*, was released in April 2011; the state's *Let's Get Healthy California Task Force Final Report* appeared in December 2012; and the state's California Wellness Plan was launched in February 2014 – each providing intersections and synergistic opportunities for moving forward with determination and focus. In addition to state and federal plans that address health and mental health inequities, nonprofit organizations have also published reports that reflect the views of stakeholders, such as *The Landscape of Opportunity: Cultivating Health Equity in California*, authored by the California Pan-Ethnic Health Network and released in June 2012.

While the OHE facilitated the process for creating this document, the outcome reflects the thoughtful participation of hundreds of stakeholders. Those who invested the most time were the 25 members of the OHE Advisory Committee, who worked alongside the public and OHE staff over the course of

three two-day meetings and for countless hours before and between those meetings. These members were chosen from 112 applications received by CDPH, a sign of both the enthusiasm and the expertise brought to bear on this endeavor.

The Advisory Committee members have been strong advocates for paying due attention to mental health in the Plan. Mental health is one aspect of overall health and, as such, should be assumed within all references to "health." However, because mental health has historically been excluded – and in many circumstances continues to be excluded – from our society's overall approach to health, it is called out explicitly throughout this document.

The Office of Health Equity staff, working with the Advisory Committee and other stakeholders, have established a vision, a mission, and a central challenge to guide the development of strategies.

Vision: Everyone in California has equal opportunities for optimal health, mental health, and well-being.

Mission: Promote equitable social, economic, and environmental conditions to achieve optimal health, mental health, and well-being for all.

Central Challenge: Mobilize understanding and sustained commitment to eliminate health inequity and improve the health, mental health, and well-being of all.

The following are the Plan's five-year strategic priorities:

Through **assessment**, yield knowledge of the problems and the possibilities.

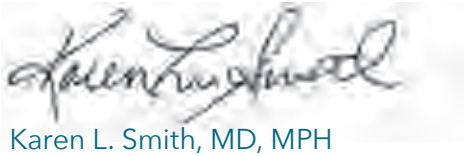
Through **communication**, foster shared understanding.

Through **infrastructure** development, empower residents and their institutions to act effectively.

Goals for each of the strategic priorities were crafted for California overall as well as within the health field, among potential health partners, and within local communities for Stage 1 (2015-2018) and Stage 2 (2018-2020) of the Plan. In this inaugural effort, the OHE also recognized the critical need to create goals aimed at building capacity for implementation of the strategic priorities.

We have the honor of introducing the inaugural California Statewide Plan to Promote Health and Mental Health Equity, which provides both a context for why this work is of utmost importance (the report) and a road map for how to achieve it (the strategic plan). This planning process has been a truly collaborative effort. We are grateful for the insightful and broad thinking of the OHE Advisory Committee, stakeholders, and staff. Their dedication, thoughtfulness, and contributions were crucial components in the creation of this Plan.

Sincerely,



Karen L. Smith, MD, MPH
Director & State Health Officer
California Department of Public Health

Wm. Jahmal Miller, MHA
Deputy Director, Office of Health Equity
California Department of Public Health

INTRODUCTION AND BACKGROUND

This report on the California Statewide Plan to Promote Health and Mental Health Equity is the first biennial report of the new Office of Health Equity (OHE), established in 2012 under the California Health and Safety Code Section 131019.5 ("Code"). The OHE, operating within the California Department of Public Health (CDPH), is tasked, first and foremost, with aligning state resources, decision making, and programs to achieve the highest level of health and mental health for all people, with special attention focused on those who have experienced socioeconomic disadvantages and historical injustice. The overriding objective of the Plan, included in this report, is to improve the health status of all populations and places, with a priority on eliminating health and mental health disparities and inequities.

The Code instructed the OHE to seek input from the public on the Plan through an inclusive public stakeholder process and to develop the Plan in collaboration with the Health in All Policies Task Force. This was accomplished through several means, including meetings, webinars, surveys, and other correspondence. The Advisory Committee was established with a membership of 25 health experts, advocates, clinicians, and consumers representing diverse vulnerable communities and vulnerable places

across multiple fields and sectors. The Health in All Policies Task Force was represented on the committee as well. The Advisory Committee held its first meeting in September 2013. All meetings have adhered to the Bagley-Keene Open Meeting Act ("Act"), set forth in Government Code Sections 11120-111321, which covers all state boards and commissions. Generally, it requires these bodies to publicly notice their meetings, prepare agendas, accept public testimony, and conduct their meetings in public unless specifically authorized by the Act to meet in closed session.

The Advisory Committee meetings held in January, March, and May 2014 were largely dedicated to providing input into the development of the Plan. At these meetings there were presentations; full committee discussions; small group discussions involving Advisory Committee members, OHE staff, and the public; and formal public comments. Members of the public who were not able to participate on-site were able to participate via conference call.

In April and May 2014, statewide webinars were held to introduce initial drafts of the Plan, answer questions, receive comments, and allow for polling to establish priorities and partnership interests. A 61-item survey was also made available during that time for more in-depth feedback opportunities. The input from over 120 surveys and several letters was considered in the further development of the Plan.

Engagement with the public consisted of hundreds of meet-and-greets in person and occurred by phone with OHE staff, primarily with the Deputy Director, Jahmal Miller. These meetings additionally informed the Plan.

Definition of Terms

Determinants of Equity: The social, economic, geographic, political, and physical environmental conditions that lead to the creation of a fair and just society.

Health Equity: Efforts to ensure that all people have full and equal access to opportunities that enable them to lead healthy lives.

Health and Mental Health Disparities: Differences in health and mental health status among distinct segments of the population, including differences that occur by gender, age, race or ethnicity, sexual orientation, gender identity, education or income, disability or functional impairment, or geographic location, or the combination of any of these factors.

Health and Mental Health Inequities: Disparities in health or mental health, or the factors that shape health, that are systemic and avoidable and, therefore, considered unjust or unfair.

Vulnerable Communities: Vulnerable communities include, but are not limited to, women, racial or ethnic groups, low-income individuals and families, individuals who are incarcerated and those who have been incarcerated, individuals with disabilities, individuals with mental health conditions, children, youth and young adults, seniors, immigrants and refugees, individuals who are limited-English proficient (LEP), and Lesbian, Gay, Bisexual, Transgender, Queer, and Questioning (LGBTQQ) communities, or combinations of these populations.

Vulnerable Places: Places or communities with inequities in the social, economic, educational, or physical environment or environmental health and that have insufficient resources or capacity to protect and promote the health and well-being of their residents.

Source: Health and Safety Code Section 131019.5.

California's Human Diversity: **Opportunities**

California's population is the most diverse in the continental United States[1] and one of the most diverse in the entire world. The Latino population is the state's largest ethnic plurality, at about 38 percent of the population, and is predicted to approach majority status by 2060 *(see Figure 1)*. That makes California only the second state in the nation, behind New Mexico, in which Whites are not the majority and where Latinos are the plurality. The state's non-Hispanic White population in mid-2014 is estimated to be a fraction of a percent smaller than the Latino population, at 38.8 percent, down from 57.4 percent in 1990. Whites are trailed by the Asian/Pacific Islander population, at 13 percent (up from 9.2 percent in 1990); African Americans, at 5.8 percent (down from 7.1 in 1990); and Native Americans, at less than 1 percent.[2]

California's human diversity goes beyond race and ethnicity. It also includes large shares of other subpopulations relative to other states, including the Lesbian, Gay, Bisexual, Transgender, Queer, and Questioning (LGBTQQ) community; persons with disabilities; undocumented immigrants; and many others. For instance, according to the 2010 census, California has one of the highest percentages in the nation of married couples of mixed race or ethnicity and is among the leading states in the number of same-sex households.[3] More than 42 percent of the state's population over the age of five speaks one of several hundred languages other than English at home, with more than two-thirds of those also speaking English well or very well, while about 10 percent do not speak English at all.[4]

Diversity's Many Benefits...

California's diversity has been a source of great strength for the state's economy and cultural life, enriching California's schools, universities, communities, and industries with a kaleidoscope of skills and knowledge and with a determination to succeed. Approximately one in three small business owners in California is an immigrant,[5] and according to the Small Business Association, close to half of all small businesses in Los Angeles are owned by immigrants, who make up about 34 percent of the city's population. Statewide, almost one-third of the state's 3.4 million small businesses are owned by people of color.[6] At the national level, Latinos alone accounted for an estimated $1.2 trillion in consumer purchasing power in 2012, a market larger than the entire economies of all but 13 countries.[7]

Foreign-born individuals also make up 38.3 percent of all science, technology, engineering, and math graduates at the state's most research-intensive universities and account for 56.5 percent of the state's engineering PhDs.[8] A recent study from the University of California,

LATINOS ARE PROJECTED TO BECOME THE LARGEST RACIAL/ETHNIC GROUP AND WILL ACCOUNT FOR NEARLY HALF OF ALL CALIFORNIANS BY 2060

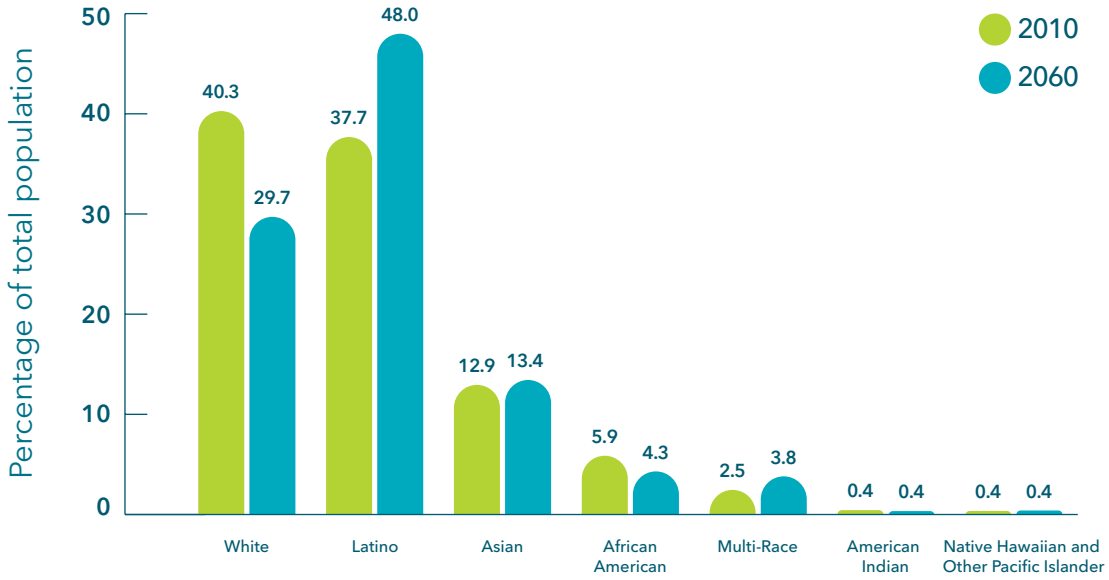


FIGURE 1: Percentage of California's population and projected population, by race/ethnicity, 2010 and projected 2060.

Source: California Department of Finance, Report P-1 (Race): State and County Population Projections by Race/Ethnicity, 2010-2060. Sacramento, California, January 2013.

Irvine, of Orange, Los Angeles, Riverside, San Bernardino, and Ventura counties looked at interrelationships among changing community factors such as racial and ethnic demographics, employment and economic welfare, housing density, crime and public safety, and land use. It found positive signs of change along all dimensions, especially rising property values in formerly homogeneous neighborhoods that have become ethnically mixed due to recent Latino and Asian immigration, reversing the trend of declining property values in the 1980s and 1990s.[9]

While immigration has already brought about powerful impacts in California, the future holds the promise of even greater change. The state's baby boomer population, which numbered 10 million in 1990, is aging into retirement over the next two decades, resulting in a steadily decreasing White share of the working age population and a rising share of workers who are Latino or Asian. The potential for the future growth of the labor force and the state's economy will increasingly depend on these younger, more diverse cohorts. The California Department of Finance projects that by 2030, the state's over-65 White population will be significantly larger than the under-25 White population, which will be only about half the size of the under-25 Latino population. Adding working-age Asians and other minority populations to the mix further illustrates the potential impact of people of color on the state's future labor force.[10]

...And Many Challenges

Despite these strengths, the great advantages of California's demographic diversity continue to be undermined by persistent, unjustifiable inequities in various social, economic, and environmental conditions that result in gaping disparities in the health of vulnerable populations, especially low-income (below 200 percent of the federal poverty level) families and neighborhoods; communities of color; the very young and the very old; and those who have experienced discriminatory practices based on gender, race/ethnicity, or sexual orientation.

These disparities in health status are a matter of life and death, shown by differences in death rates and life expectancy among the state's major racial and ethnic groups. Although the state's death rates have been steadily declining for almost all racial and ethnic groups, major gaps persist for African Americans relative to Asians and other populations as of 2010 (see Figure 2). Similarly, the state's average life expectancy of 80.8 years in 2010 masked a more than 11-year gap between Asian Americans, at 86.3 years, and African Americans, at 75.1 years.[11]

Further, life expectancy is tied to the social and environmental conditions of place – where we live, work, learn, and play. For example, residents of high-income San Francisco outlive those in the lower-income Riverside-San Bernardino area by three years: 81 to 78, respectively.[12] These neighborhood differences are particularly striking when looking within communities. In Oakland, an African American child in the low-income flatlands will, on average, die 15 years earlier than a White child who lives in the affluent hills.[12]

Similar gaps among population groups exist for numerous chronic health conditions that drive the disparities in death rates. Although death rates from stroke have declined in almost all racial and ethnic groups, the rate among African Americans remains about 50 percent higher than among some other racial or ethnic groups, mirroring similar disparities in related risks for high blood pressure, high cholesterol, tobacco use, and obesity.[12] Prevalence of diabetes is two and a half times as high among Hawaiian/Pacific Islanders as among Whites, and more than twice as high among those with a family income below 200 percent of the federal poverty level as among those with family incomes of at least 300 percent above the poverty level.[12]

While data showing the difference between aggregated populations can be useful, important disparities in health risks may be missed when looking only at this aggregated data for populations designated by large geographic areas of origin, such as Latinos and Asian/Pacific Islanders. For instance, significant gaps in rates of colorectal cancer exist among Japanese, Korean, Vietnamese, Chinese, Filipino, and South Asian Californians,[12] and so looking at only rates of colorectal cancer for Asians can be misleading and can result in missed opportunities for prevention. *(See Appendix D for information on data limitations.)*

ALTHOUGH DEATH RATES IN CALIFORNIA HAVE DECLINED, DISPARITIES PERSIST, WITH AFRICAN AMERICANS HAVING HIGHER DEATH RATES THAN OTHER RACIAL/ETHNIC GROUPS

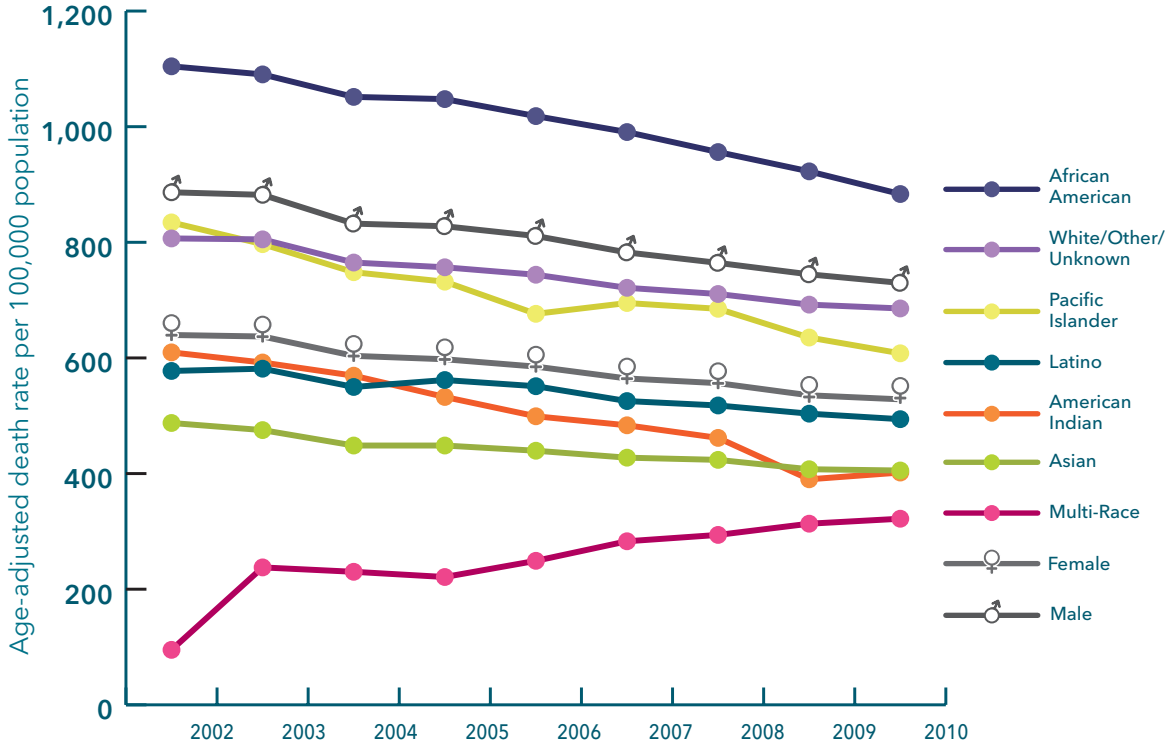


FIGURE 2: Death rates, by race/ethnicity and gender, California, 2002 to 2010.

Sources: California Department of Public Health, Death Records; and California Department of Finance, Race and Ethnic Population with Age and Sex Detail, 2000-2050. Sacramento, California, July 2007.

Note: Age-adjusted rates are calculated using year 2000 U.S. standard population.

What Drives **Health Disparities?**

One way of identifying the causes of health disparities is to examine the factors that produce and maintain healthy individuals, communities, and places. Many people assume that health is mostly a function of individuals' seeing the doctor regularly for good medical care and avoiding unhealthy behaviors, such as smoking and inactivity. However, most public health experts have adopted an upstream/downstream model of the causal factors that produce health, illness, and health disparities. In this model, factors such as medical care to maintain health or treat an illness or injury are viewed as the immediate, or "downstream," determinants of health outcomes. These downstream factors are causally related to "midstream" health determinants, such as people's genetic and biological makeup, and individual health behaviors, such as smoking, unhealthy eating, or lack of physical exercise. Further "upstream" are a host of environmental, social, and economic factors that even more powerfully influence health outcomes for entire populations. The World Health Organization (WHO) has defined these upstream factors as "the conditions in which people are born, grow, live, work, and age. These circumstances," declared WHO, "are shaped by the distribution of money, power and resources" within every level of society,[13] resulting in significant upstream health inequities and downstream health disparities that disproportionately impact low-income populations, communities of color, and other groups that are subject to racism and discrimination.

While public health researchers have differed on the relative importance of these various upstream and downstream health determinants, it is estimated that medical care, healthy behaviors, and genes and biology altogether account for only about half of a society's overall health outcomes,[14] even though downstream determinants attract the majority of health funding and expenditures.

The Social Determinants of Health

What constitutes the other 50 percent of the determinants of health and well-being is a complex interplay of environmental conditions, such as air and water quality, the quality of the built environment (e.g., housing quality; land use; transportation access and availability; street, park, and playground safety; workplace safety; etc.), and a whole host of socioeconomic factors. These latter factors include opportunities for employment, income, early childhood development and education, access to healthy foods, health insurance coverage and access to health care services, safety from crime and violence, culturally and linguistically

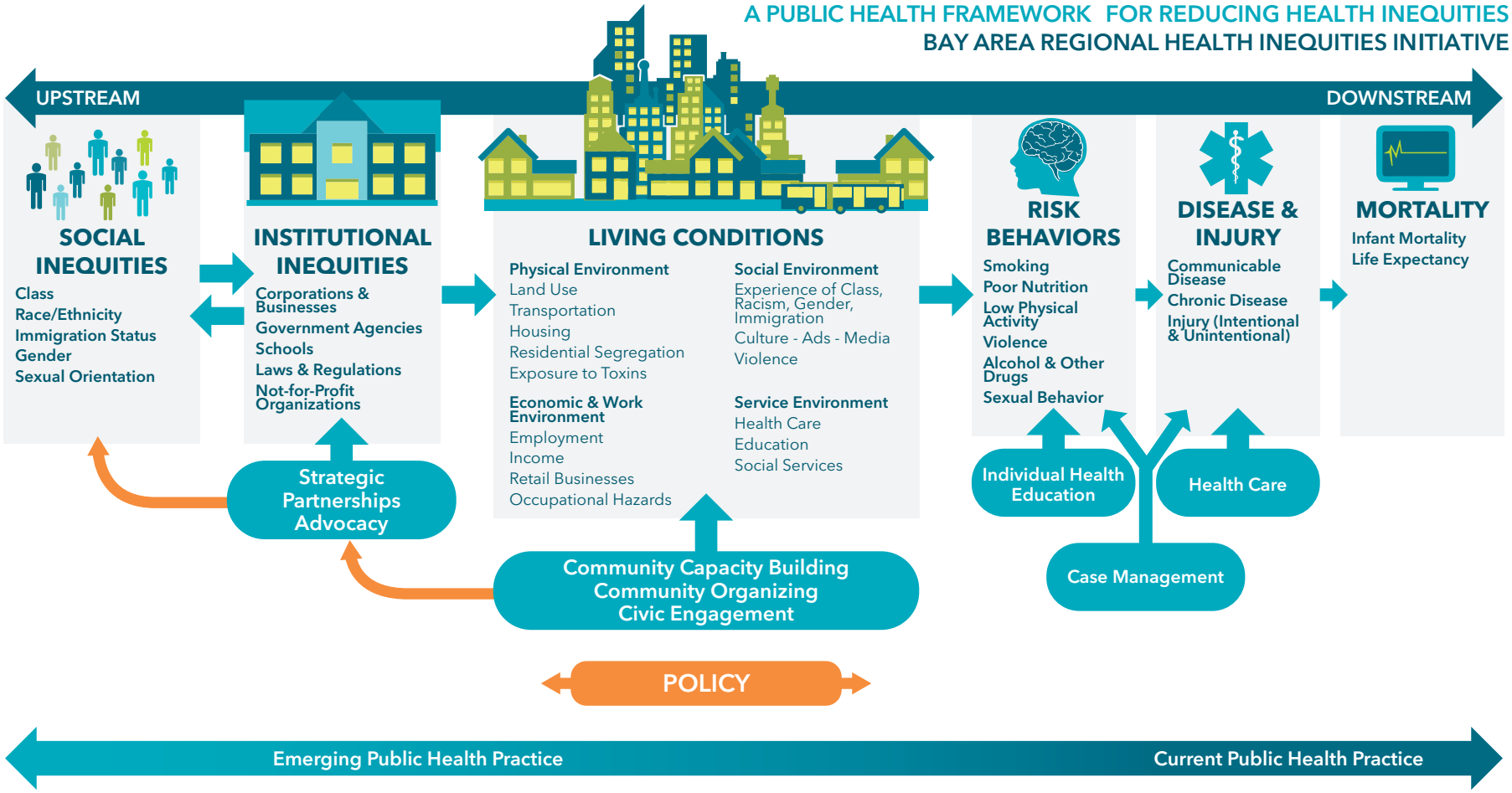


FIGURE 3: Bay Area Regional Health Inequities Initiative (BARHII) Conceptual Framework, 2006.

appropriate services in all sectors, protection against institutionalized forms of racism and discrimination, and public and private policies and programs that prioritize individual and community health in all actions.

Significantly, in contrast to the individual-level downstream determinants, these environmental and socioeconomic determinants have population-level impacts. Understanding this is vital when designing and implementing health interventions, such as economic development programs in low-income communities, which can be targeted to specific subpopulations, communities, and neighborhoods, thus affecting thousands or tens of thousands of people rather than one individual at a time.

When a society's principles and policies work to optimize these interrelated social determinants of health on the basis of justice and equity for everyone, health is created at the levels of the individual, the community, the environment, and society at large *(see Figure 4)*. When any combination of these drivers is lacking, the

engine that powers total health can break down, resulting in significant health inequities and disparities in health outcomes. Understanding what creates or limits the opportunity for health is essential to understanding what creates disparate health outcomes and what needs to be done to prevent them. Among other things, the solutions need to involve changes at the policy level by a broad set of public and private partners representing sectors that impact public health but may not have health at the center of their decision making, such as transportation, economic development, chambers of commerce, city planning, and others.

FIGURE 4: Achieving Health & Mental Health Equity At Every Level

Source: California Department of Public Health, Office of Health Equity, as inspired by World Health Organization, Robert Wood Johnson Foundation, and many others.

The Deep Roots of Health Inequities

While there are many indicators of health, income and wealth play especially important roles in determining health outcomes. Income and wealth are discussed in depth in this section because of their tremendous impact on health, and the inequities in how they are distributed among California's population.

While America's constitutional principles emphasize the importance of justice and equity, its policies and practices have historically allowed some population groups disproportionately greater opportunities for building household wealth. As the poet Ralph Waldo Emerson wrote, "The first wealth is health." That saying has recently been revised to make the point that "wealth equals health," a point forcefully driven home in the *2006 Handbook for Action: Tackling Health Inequities Through Public Health Practice*. This handbook closely examined how U.S. household wealth (meaning the value of all financial and nonfinancial assets, such as real estate owned by a household, minus any debts) serves as the major determinant of health and health inequities, influencing and influenced by virtually all other upstream environmental and socioeconomic factors, including income, education, employment, housing, bank lending policies, child care, recreational opportunities, food supply, health care access, neighborhood safety, and environmental quality.[15]

If health is wealth, it follows that efforts to understand and reverse the drivers of health inequities need to begin by looking at how the policies and actions of private institutions and governments have contributed to the large gaps in wealth that mirror the gaps between the healthy and the unhealthy.

Behind the Gaps in Wealth and Health

Historically, the United States' long eras of slavery and discriminatory policies in housing, education, transportation, and economic development largely excluded people of color and other minorities from the formal economy, up until the latter half of the 20th century and the passage of major civil rights legislation. Although many of those policies, such as lending institution redlining, have been prohibited by law in recent decades, their harmful legacies persist in numerous, less obvious ways, both officially and unofficially.

For instance, it is widely recognized today that private and public bank lending policies that enabled the subprime mortgage practices during the housing boom contributed significantly to the 2007-2009 housing bust, which wiped out vast shares of homeowners' household wealth. The bust affected all but the richest few percent of the population, having much greater negative impacts on low-income households, especially communities of color. This is the result of the fact that wealth accumulation among African American and

Latino families, among other disadvantaged groups, is more recent and more concentrated in home values than for most White families, whose much greater wealth is more broadly distributed over many kinds of assets other than housing, such as stocks and bonds.[16]

A recent analysis of national annual income surveys by the U.S. Census Bureau revealed that in 2011 – two years into the so-called recovery period from the Great Recession – average African American and Latino households owned only six and seven cents, respectively, for every dollar in wealth held by the average White family. In 2011, the median net worth of households of color had fallen from 2005 levels – before the recession – by 58 percent for Latinos, 48 percent for Asians, and 45 percent for African Americans, but by only 21 percent for Whites. The same study found that the average liquid wealth – meaning cash on hand or assets easily converted to cash – of White families was 100 times that of African Americans and more than 65 times that held by Latinos.[17] This type of wealth is key to maintaining a sense of security and stability when unexpected crises occur, such as serious illness or loss of a job, as well as to being able to act on unexpected opportunities, such as building or expanding a business in response to changed circumstances. Wealth serves as both a cushion against hard times and a potential launching pad for economic growth.

The study, from Brandeis University, also examined the significant growth of the wealth gap for African American families over a 25-year period (1984-2009) and concluded that it could be largely explained by five factors: years of homeownership, household income, unemployment, education, and inheritance, all of which are deeply influenced by local, state, and federal policies that create either opportunities or barriers to wealth and health.[16]

California's wealth gaps are shown in Figure 5. White families, which accounted for just over half of total households in 2010, held two-thirds of total wealth. African American families, with 6 percent of total households, held just 2 percent of total wealth, and Latinos, with 27 percent of households, held just 16 percent of total wealth.

Public policies and private practices affecting the economy, housing, the environment, education, and other sectors are a major factor in the persistence and growth of a widening American wealth gap, which is a key driver of health inequities among low-income families, communities of color, women, children, and other vulnerable populations. Fortunately, policies are not carved in stone. They can be reshaped to address inequities and promote greater access for all people to both wealth and health. Through policy choices, government can play an important role in slowing and even reducing the growing wealth gap, thereby helping slow and ideally reduce California's growing health inequities.

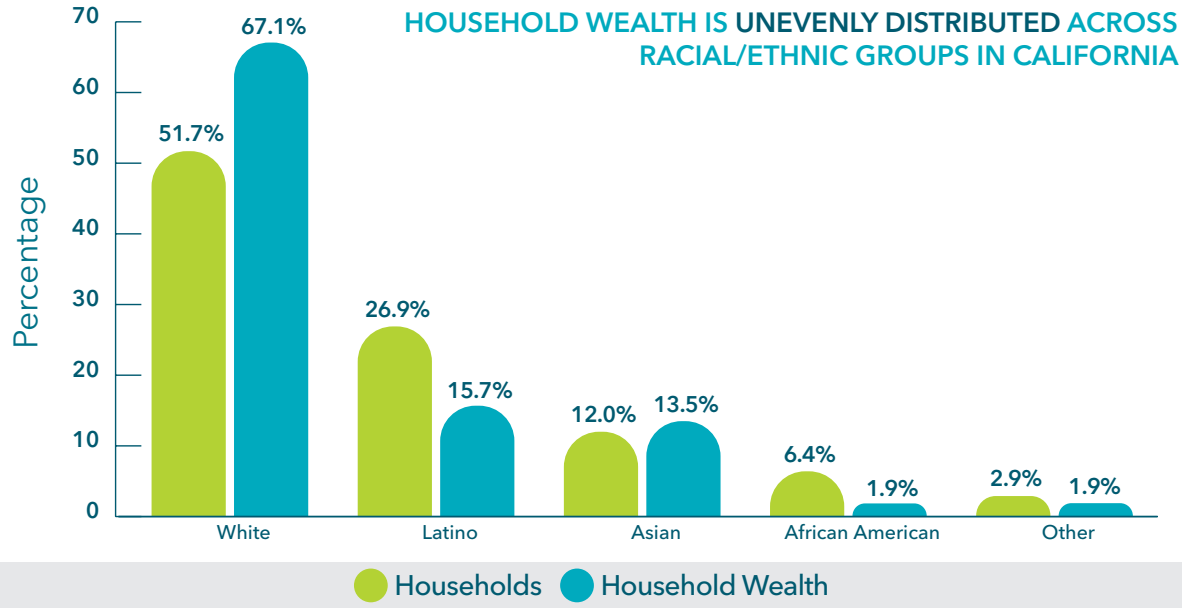


FIGURE 5: Percentage of California's households and household wealth (net worth), by race/ethnicity, California, 2010.

Sources: U.S. Census Bureau, Census 2010, Summary File 2; and Survey of Income and Program Participation (Panel 2008, Wave 7).

Health in **All Policies**

Health in All Policies is a cutting-edge approach to shaping effective public and private policies for the promotion of health and health equity. The American Public Health Association describes Health in All Policies as "a collaborative approach to improving the health of all people by incorporating health considerations into decision making across sectors and policy areas."[18]

Health in All Policies is based on the recognition that the greatest health challenges – including the health inequities described in this report – are highly complex and often interrelated. Because public health and health care institutions do not have authority over many of the policy and program areas that impact health, solutions to these complex and urgent problems require working collaboratively across many sectors to address the social determinants of health, such as transportation, housing, and economic policy.

Health in All Policies builds on public health's long and successful tradition of collaboration among government sectors, as demonstrated in such initiatives as implementing fluoridated tap water policies, reducing occupational and residential lead exposure, restricting tobacco use in workplaces and public spaces, improving sanitation, and requiring use of seatbelts and child car seats. Health in All Policies takes the idea of cross-sector collaboration further by formalizing ways to systematically incorporate a health, equity, and sustainability lens across the entire government apparatus. A Health in All Policies approach also supports collaboration across multiple sectors, ensures that policy decisions benefit multiple partners, engages stakeholders, and works to create positive structural and process change.[19]

For these reasons, a Health in All Policies approach has been embraced by the World Health Organization, the American Public Health Association, the Association of State and Territorial Health Officers, the National Association of County and City Health Officers, and other professional public health organizations. It is being implemented in a variety of ways across the United States, including by California's state government through the Health in All Policies Task Force *(see below and Appendix B for more information)*.

The Case for Addressing **Health Inequities**

Almost 70 years ago, both the then-new World Health Organization (WHO) and the United Nations (UN) broadly defined health as a basic human right. The WHO Constitution defines the right to health as "the enjoyment of the highest attainable standard of health," including the right to healthy child development; equitable dissemination of medical knowledge and its benefits; and government-provided social measures to ensure adequate health.[20] The UN's Universal Declaration of Human Rights in 1948 declared in Article 25 that "*[e]veryone has the right to a standard of living adequate for the health and well-being of himself [sic] and of his family, including food, clothing, housing, and medical care and necessary social services.*"[21] More recently, the focus on health disparities received a boost in 1998 when the federal government launched the Racial and Ethnic Health Disparities Initiative.[22] Subsequently, the Healthy People 2010 and 2020 initiatives moved beyond the traditional research paradigm of merely documenting the health inequities of vulnerable populations, by incorporating a commitment to actually "achieve health equity, eliminate disparities, and improve the health of all groups" as one of its four overarching goals.[23]

The case for viewing health and mental health equity as an issue of basic social justice has grown ever stronger as researchers and policy experts have learned more about the social and economic impacts of historic and continuing health disparities on the nation's large and growing vulnerable populations.

The Costs of Health Inequities

The moral case for addressing health inequities is buttressed by a strong economic argument, as reducing health inequities will yield savings in health care costs. Health spending accounted for 17.7 percent of gross domestic product (GDP) in the United States in 2011, by far the highest share in comparison with the 34 developed nations of the Organization for Economic Cooperation and Development (OECD) and more than 8 percentage points higher than the OECD average of 9.3 percent. The United States spent $8,508 per capita on health in 2011, two and a half times more than the OECD average of $3,339, while lagging most developed nations in key measures of health outcomes.[24]

What share of that excess U.S. spending is attributable to the cost of health disparities is a complex issue, but one widely reported study in 2011 estimated that more than 30 percent of direct medical costs faced by African Americans, Hispanics, and Asian Americans were excess costs due to health inequities – more than $230 billion over a three-year period, plus indirect costs of $1 trillion in lower workplace productivity due

to associated illness and premature death.[25] That three-year total of "excess costs" due to health disparities is equal to approximately half the total of all U.S. health care spending in 2012. Meanwhile, total spending in 2012 on public health and health prevention accounts for only 2.7 percent of total health care spending.[26]

These numbers, dramatic as they may be, fail to convey the actual human costs of health disparities – lives lost prematurely and lives stunted and scarred by debilitating ill health, both physical and mental. It may be impossible to objectively assess the full dimensions of the human tragedy of health inequities and disparities, but the cost in mortalities alone is revealing. According to a National Institutes of Health 2011 study in the *American Journal of Public Health*,[27] nearly three-quarters of a million U.S. adult deaths in 2000 were attributable to just five of the leading social determinants of health:

Low education accounted for 245,000 deaths,

Racial segregation accounted for 176,000,

Low social supports accounted for 162,000,

Income inequality accounted for 119,000,

and Area-level poverty accounted for 39,000.

In addition to moral arguments that health inequities are unjust, there are strong economic and social arguments that these health inequities impose avoidable costs.On an individual level, these inequities negatively impact the health and well-being of the populations that constitute the majority of Californians and that will increasingly represent over half of the nation's workforce and its taxpayers. In short, the elimination of health disparities and the creation of health security for all are vital to creating the kind of future we all want for our children and grandchildren.

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Creating Health Equity in California: **The Office of Health Equity**

The Office of Health Equity (OHE), operating within the California Department of Public Health (CDPH), was created in 2012. The office continues California's multifaceted efforts to reduce or eliminate health and mental health disparities among California's vulnerable communities.

The OHE was created both to build upon the existing network of public and private sector partnerships in all economic, social, and environmental sectors that influence health and mental health and to align all state resources, decision making, and programs to accomplish the following objectives:

- Achieve the highest level of health and mental health for all people, with special attention focused on those who have experienced socioeconomic disadvantage and historical injustice;
- Work collaboratively with the Health in All Policies Task Force to promote work to prevent injury and illness through improved social and environmental factors that promote health and mental health;
- Advise and assist other state departments in their mission to increase access to, and the quality of, culturally and linguistically competent health and mental health care and services; and
- Improve the health status of all populations and places, with a priority on eliminating health and mental health disparities and achieving health equity.[28]

To carry out its work, the OHE has been organized into three operational units:

- Community Development and Engagement Unit
- Policy Unit
- Health Research and Statistics Unit

Community Development and Engagement Unit

The Community Development and Engagement Unit's (CDEU's) current focus is to strengthen the CDPH's ability to advise and assist other state departments in their work to increase access to, and the quality of, culturally and linguistically competent mental health care and services.

The primary responsibility of the CDEU is to carry on the ambitious work of the **California Reducing Disparities Project (CRDP)**, launched in 2009 to improve and increase access to care, quality of care, and positive mental health outcomes for racial, ethnic, and cultural communities. Since its creation, CRDP has provided funding for the development of

five population-specific reports for identifying and reducing mental health disparities among five target populations: African Americans; Asian/Pacific Islanders; Latinos; Lesbian, Gay, Bisexual, Transgender, Queer, and Questioning individuals; and Native Americans.

The implementation and evaluation of local-level interventions recommended in these population reports is serving in the development of a single comprehensive strategic plan, authored by stakeholders, that brings together the community-identified lessons and successful strategies of each of the population-specific plans, identifying any similarities among them. This multiyear project aims to provide the state's mental health system with community-identified strategies and interventions that will result in meaningful culturally and linguistically competent services and programs that meet the unique needs of the five target populations.

Also part of the CRDP is the **California Mental Health Services Act Multicultural Coalition (CMMC)**, whose primary goal is to integrate cultural and linguistic competence throughout the public mental health system. The CMMC is a CRDP contractor and provides a new platform for racial, ethnic, cultural, and LGBTQQ communities to come together to address historical system and community barriers and collaboratively seek solutions that will eliminate barriers and mental health disparities. The coalition, launched in 2010, is made up of 30 members representing diverse multicultural perspectives on mental health, including those that have not been adequately represented in other efforts. CMMC members have provided extensive input into the comprehensive CRDP strategic plan.

Finally, CDEU also supports ongoing implementation of the Bilingual Services Act of 1973, which requires state agencies to provide translated materials in "threshold languages" or those languages identified by Medi-Cal as the primary language of 3,000 beneficiaries or 5 percent of the beneficiary population, whichever is less, in an identified geographic area.

Policy Unit

The work of the Policy Unit includes staff facilitation for the California **Health in All Policies (HiAP) Task Force**, which is made up of 22 state agencies, departments, and offices and is charged with identifying priority programs, policies, and strategies to improve the health of Californians while advancing the goals of the Strategic Growth Council (SGC). Executive Order S-04-10 created the HiAP Task Force in 2010, placed it under the auspices of the SGC, and called for the California Department of Public Health (CDPH) to provide facilitation. CDPH facilitates the HiAP Task Force through a private/public partnership with the Public Health Institute and several nongovernment funders. While CDPH facilitates the HiAP Task Force, the member agencies and departments contribute staff time for meetings and ongoing collaborative projects. CDPH engages HiAP Task Force members in an intensely collaborative and creative process to promote innovative strategies to improve health, equity, and sustainability. Because local governments play a major role in shaping communities and community health, the HiAP Task Force has focused on the unique role that state agencies play in supporting local action. The successes of the HiAP Task Force include incorporating health and equity principles in state guidance documents, increasing public input into key state processes, and growing collaboration across government sectors and among communities and decision-makers throughout California. *For more detailed information about the work of the HiAP Task Force, see Appendix B.*

The **Healthy Places Team** in the Policy Unit is building the Healthy Communities Data and Indicators Project (HCI). The goal of the HCI is to enhance public health by providing data, a standardized set of statistical measures, and tools that a broad array of sectors can use for planning healthy communities and by evaluating the impact of plans, projects, policies, and environmental changes on community health. With funding from the Strategic Growth Council, the HCI is a two-year collaboration of the California Department of Public Health and the University of California, San Francisco (UCSF), to pilot the creation and dissemination of indicators linked to the HiAP Task Force's Healthy Communities Framework.

The Policy Unit's Climate and Health Team leads CDPH's efforts to address the health aspects of the state's efforts to reduce California's greenhouse gas emissions by 80 percent by 2050, prepare for the climate change impacts that are already occurring and plan for future impacts. The staff participate in the state's Climate Action Team (CAT), a cross-sector group of 20 agencies and departments working to develop and coordinate overall state climate change efforts. The Climate and Health team leads the CAT's Public Health Workgroup, where public health, state agency partners and diverse stakeholder groups meet to review critical climate and public health issues and work to ensure that public health and health equity are recognized and incorporated in state climate change planning efforts.

Health Research and Statistics Unit

The Health Research and Statistics Unit (HRSU) is the technical backbone of the OHE, providing and sharing research and data for OHE reports as well as baseline information for programs aimed at eliminating health and mental health inequities in California.

The unit inventories and organizes the abundant information regularly collected by other CDPH programs, state agencies, research organizations, and community-based organizations on the demographics and geography of vulnerable populations and on inequities in health and mental health outcomes, health services, and social determinants of health. It also collects existing information on interventions to reduce health and mental health inequities, allowing stakeholders to rapidly access such information.

The unit is also responsible for synthesizing and analyzing data to provide this report and subsequent biennial statistical profiles of health and mental health inequity in California, thereby providing a baseline against which progress can be measured. In addition, the unit analyzes and tracks Healthy People 2020 targets in order to monitor the state's progress toward eliminating health and mental health disparities and achieving health equity for all Californians.

DEMOGRAPHIC REPORT ON HEALTH AND MENTAL HEALTH EQUITY IN CALIFORNIA

The Social Determinants
Shaping the Health of California's People and Places

As noted in the introduction to this report, the physical and mental health of individuals and entire communities is shaped, to a great extent, by the social, economic, and environmental circumstances in which people live, work, play, and learn. As explained by the World Health Organization, these same circumstances, or social determinants of health, are also "mostly responsible for health inequities – the unfair and avoidable differences in health status seen within and between countries."[1]

In preparing the California Statewide Plan to Promote Health and Mental Health Equity, the Office of Health Equity, working in close collaboration with other public and private agencies and advocacy organizations, has collected and analyzed a wealth of primary and secondary demographic and health data concerning the major underlying social, economic, and environmental conditions that contribute to the health and health inequities of the state's residents and their communities. This data and analysis represent an initial benchmark to inform the current plan for addressing health inequities and disparities, as well as for measuring future progress toward the goal of reducing and eliminating these inequities and disparities.

In the following pages, we present highlights of the data and analysis relative to each of these key social determinants of health.

Income Security: The High Cost of Low Incomes

For many years, the relationship between socioeconomic status (SES), usually measured by income, education, or occupation, and health and mental health has been known. As individuals move up the SES ladder, their health improves, they live longer lives, and they have fewer health problems. Socioeconomic status is important because it provides access to needed resources that help people avoid risks, promote healthy behaviors, and protect health, such as "money, knowledge, power, prestige, and beneficial social connections."[1]

Several recent studies of the economic impact of poverty in the United States reveal that the nation as a whole pays the equivalent of $500 billion a year, or roughly 4 percent of U.S. gross domestic product (GDP), for the lost productivity and excess costs of health and other services associated with child poverty.[2] These studies confirm that children growing up in poverty receive less and lower-quality education, earn less as adults, are more likely to receive public assistance, and have lower-quality health and higher health costs over their lifetimes.

California Wealth and Income Disparities

Although the Great Recession of 2007-2009 hit the pocketbooks of families across the entire socioeconomic spectrum, the hardest hit included those who were already on the lower ranks of the income ladder. California families at the lowest income level (10th percentile) saw incomes fall more than 21 percent, while those at the 25th and 50th percentiles saw theirs fall about 10 percent. On the other hand, individuals in the 90th percentile experienced only a 5 percent decline, resulting in a new record level of income inequality in the state.[3]

Under the official federal poverty measure, California ranks 14th among the 50 states. However, California has the highest poverty rate in the nation when calculated according to an alternate (although unofficial) measure, known as the Supplemental Poverty Measure (SPM), which was developed by an Interagency Technical Working Group commissioned by the Office of Management and Budget's Chief Statistician to better reflect contemporary social and economic realities and government policy. The SPM factors in the cost of housing; taxes; noncash benefits; and day-to-day costs such as childcare, work-related expenses, utilities, clothing, and medical costs. This alternate method adds nearly 3 million more people to the official poverty rate, meaning that nearly one in four Californians would be considered poor.[4]

Single-Mother Households and Children Bear the Brunt of Poverty

Extreme income inequality is especially acute among California families headed by a single mother, one in three of which has an income below the poverty level. The disparity is even higher for families led by Latino, American Indian/Alaska Native, and African American single mothers *(see Figure 6)*. This suggests that the persistent (if improving) inequity in wages between men and women, with women being paid 75 percent of comparable wages paid to men,[5] is not simply a women's issue but also a serious family issue that contributes to additional inequities in quality of life for children. Almost half of the state's 2 million children age 3 or under live in low-income families.[6]

The Health Impact of Poverty

One of the highest costs of poverty is paid in the high rates of poorer health and lower life expectancy among vulnerable populations.[7] Evidence has shown a strong correlation between poverty-level income and cardiovascular disease, low birth weight, hypertension, arthritis, and diabetes.[8] One-third of deaths in the United States can be linked to income inequality, and it is estimated from data from 2007 that 883,914 deaths could have been prevented that year had the level of income inequality been lowered.[9] In addition, income-based inequities emerge in cognitive development among infants as young as 9 months and widen as they age, leading to educational achievement gaps between higher- and lower-income peers in later years.[10] The prevalence of psychiatric disorders, including neurotic disorders, functional psychoses, and alcohol and drug dependence, is consistently more common among lower-income people.[11]

In short, one of the most beneficial prescriptions for improving people's health and closing the gaping disparities in health outcomes is to

Incubating Latino-Owned Startups In San Francisco's Mission District

In San Francisco, business incubators are normally associated with financial and technical assistance for high-tech startups looking to become the next Google. But since 2010, at a SparkPoint Center sponsored by United Way of the Bay Area, El Mercadito has helped nurture nine new microenterprises for Latino entrepreneurs impacted by economic circumstances. The center provides technical assistance, retail space, and financing opportunities from the Mission Economic Development Agency's Business Development Program and the Mission Asset Fund's Lending Circle program. Once the startups achieve sustainability, they can move into their own storefronts. El Mercadito merchants have also formed a small community of their own through a merchants association, assisting and relying on each other to achieve business success. Current businesses include Simmi's Boutique, Express Beauty and Warehouse, the Peruvian restaurant Cholo Soy, and Gallardo's Printing and Engraving, among others.

Recommended further reading from the Health Atlas for the City of Los Angeles: http://cityplanning.lacity.org/Cwd/framwk/healthwellness/text/HealthAtlas.pdf.

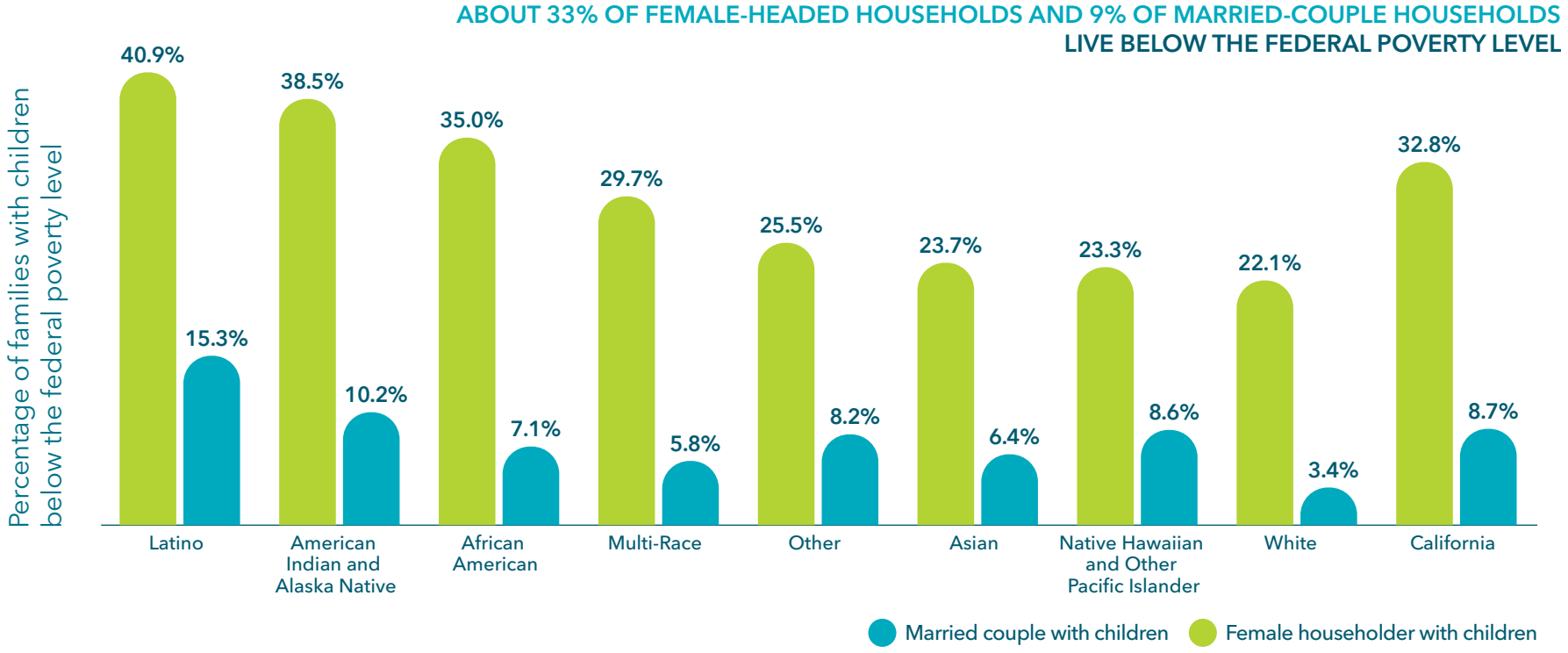

FIGURE 6: Percentage of families whose income in the past 12 months was below poverty level, by race/ethnicity, California, 2006-2010.

Source: U.S. Census Bureau, American Community Survey, 5-Year Estimates (2006-2010).

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Food Security **and Nutrition**

Food security, defined as stable access to affordable, sufficient food for an active, healthy life, is a basic human right.[1] Yet here in California, the nation's food-rich "breadbasket," many people experience periods when they cannot afford to put sufficient food on the table or they have to forgo other basic needs to do so. The food insecurity of California households with children ages 0 to 17 increased from 11.7 percent in 2000-2002 to 15.6 percent in 2010-2012.[2]

Chronic Food Insecurity Means More Than a Missed Meal

Adults who are food insecure have poorer health and are at risk of major depression as well as chronic diseases such as heart disease, diabetes, and hypertension:[3]

- Food-insecure expectant mothers may experience long-term physical health problems,[4] experience birth complications,[5] and be at greater risk of depression[6] and other mental health problems.[7]
- Food-insecure children have increased rates of developmental and mental health problems. They may also have problems with cognitive development and stunted growth, leading to detrimental impacts on their behavioral, social, and educational development.[6,8-14]
- Women living in food-insecure households are more likely to be overweight or obese. One possible explanation for this paradoxical correlation is that these women tend to overcompensate for periods when food is scarce by overeating when food is available.[15]

Communities of Color and Children Bear the Brunt

The pain of hunger and food insecurity impacts virtually all racial and ethnic groups and geographic regions of the state. However, low-income Latinos, African Americans, and American Indians/Alaska Natives have been disproportionately impacted by hunger and food insecurity *(see Figure 7)*. More than 40 percent of these individuals experience food insecurity, as do more than 26 percent of all California children. Ironically, many of California's most food-insecure communities are located in the very heart of the state's agriculturally rich – and increasingly Latino – San Joaquin Valley. For example, the percentage of children in Fresno County who are food insecure is almost double that of food-insecure children in San Mateo County *(see Figure 8)*.

Food Deserts in a Fertile Landscape

Marginalized, vulnerable communities experiencing high rates of food insecurity are not limited to the state's agricultural regions;

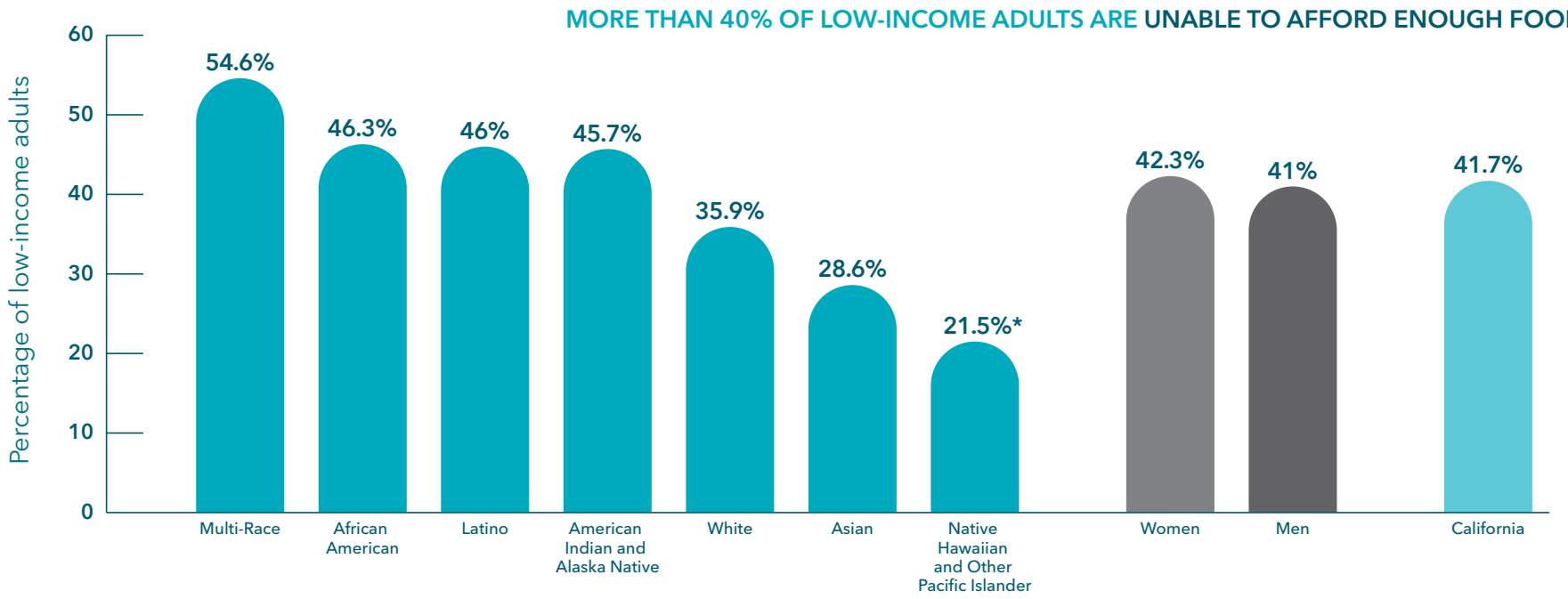


FIGURE 7: Percentage of adults whose income is less than 200% of the federal poverty level and who reported having food insecurity, by race/ethnicity and gender, California, 2011-2012.

Source: University of California, Los Angeles, California Health Interview Survey, 2011-2012.

** Statistically unreliable data.*

they are also common throughout California's cities and suburban areas. Nationally, in 2010, nearly 30 million Americans (9.7 percent of the population) lived in low-income areas more than a mile from a supermarket.[16] These areas are often defined as virtual "food deserts," where fewer than 12 percent of local food retailers offer healthier food options, such as fresh fruits and vegetables, and where residents have limited means of travel to more distant full-service grocery stores.

One study found that residents with no supermarkets near their homes were 25 to 46 percent less likely to have a healthy diet.[17]

Summer Food Service Program for Low-Income Kids

The Summer Food Service Program is a federally funded program that reimburses public and private schools, nonprofit agencies, and local governments for providing free, nutritious meals to children (18 and younger) in low-income communities through the summer months when school is not in session. Participating organizations, which are reimbursed for their costs, can serve two meals or a meal and a snack each day, or up to three meals in residential camps and migrant farm worker sites. The U.S. Department of Agriculture, which sponsors the program, is working with California Department of Education officials to expand the program in California to at least 600 sites throughout the state. Nationally, about 7.5 million meals were served on a typical summer day in 2013.

Learn more at http://www.cde.ca.gov/fg/aa/nt/sfsp.asp.

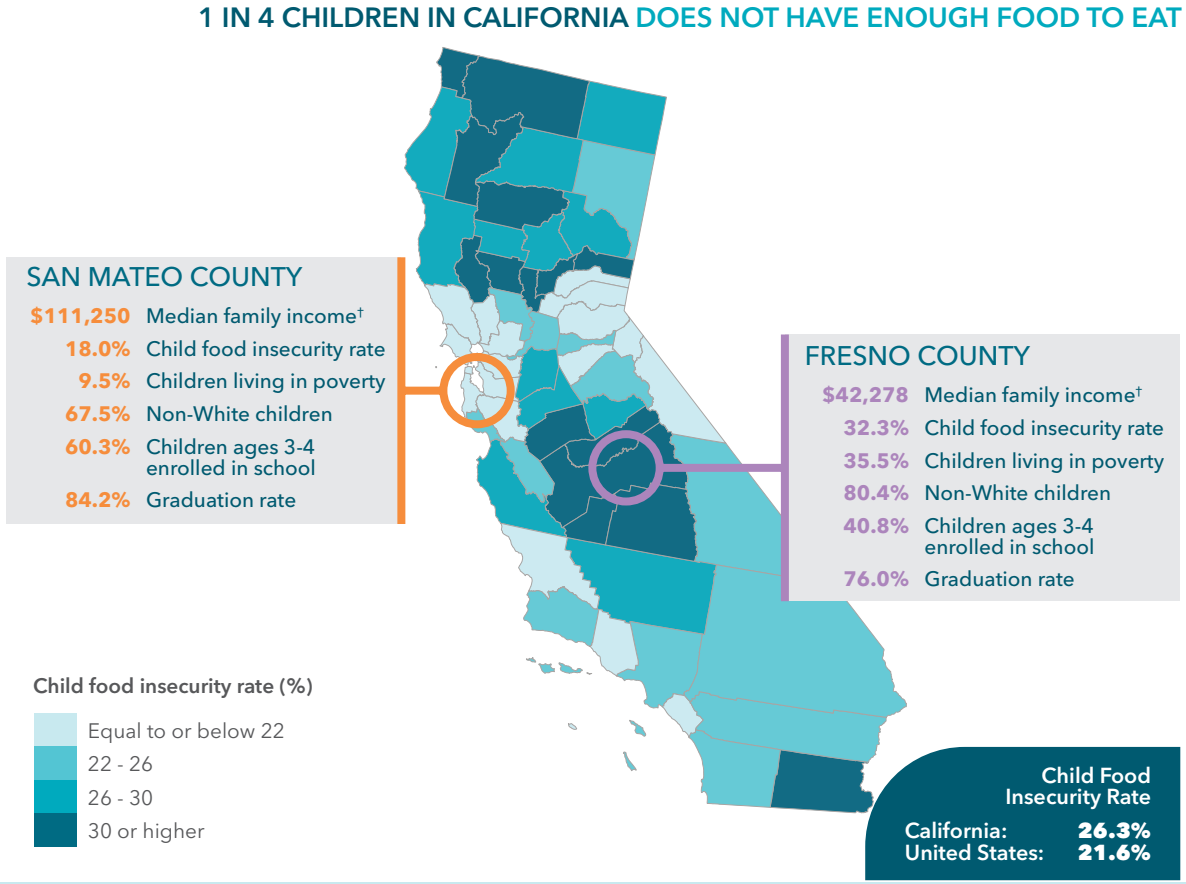


FIGURE 8: Child food insecurity rate: percentage of children under 18 years old who are food insecure, California, 2012.

Sources: Feeding America, Map the Meal Gap, 2012; U.S. Census Bureau, American Community Survey, 3-Year Estimates (2009-2011) and 5-Year Estimates (2008-2012); and California Department of Education, Graduation Data, 2011-2012.
†Median family income with own children under 18 years.

A 2005 study focused on California found that for the state as a whole there were more than four times as many fast-food restaurants and convenience stores as supermarkets and produce vendors. This ratio of unhealthy to healthy food options varied substantially among counties and cities, with two counties (San Bernardino and Sacramento) and two cities (Bakersfield and Fresno) having nearly six times as many fast-food restaurants and convenience stores as supermarkets and produce vendors.[18] The communities with high concentrations of fast-food outlets and relatively high-priced convenience stores have been shown to be characterized by disproportionately high rates of obesity and diabetes, which are precursors of other chronic diseases, such as cardiovascular disease, stroke, and arthritis.

Food Councils Tackle Food Insecurity

Food councils and local, food-centered community groups have emerged as leaders of a movement to solve food insecurity and food quality concerns across California. They do this by promoting policies and education at the state and local levels that encourage and support sustainable urban and regional foodsheds, including community and home-scale gardening efforts, farmers markets, and urban agriculture. The California Food Policy Council is bringing together the food councils from the smallest counties, such as Plumas County and Sierra County, with the largest, Los Angeles County, to ensure that California's food system reflects the needs of all its communities.

Food councils address food security through policy changes that increase access to subsidized foods, like CalFresh, WIC, senior nutrition programs, and food banks. They also promote home- and community-grown food efforts; encourage economic development; and advocate for sustainable farming and fair labor practices by large-scale food producers, retailers, and the food-service industry.

Food councils are changing the foodscape of California through local ingenuity combined with community resourcefulness and resilience.

Learn more at http://www.rootsofchange.org/content/activities-2/california-food-policy-council.

Child Development and Education:
Addressing Lifelong Disparities in Early Childhood

Many of the basic foundations for lifelong health, prosperity, and well-being are formed in early and middle childhood. That observation, increasingly recognized in policy, research, and clinical practice,[1] means that, as a society, we can minimize many of the health inequities featured in this report by focusing attention and resources on ensuring that our children – all our children – are provided with the strongest possible foundations for future success.

Getting a Head Start

In purely financial terms, early investment in childhood education is a winner. The rate of return on a $1 investment is 7 to 10 percent annually "through better outcomes in education, health, sociability, [and] economic productivity and [through] reduced crime," according to University of Chicago economist and Nobel laureate James Heckman. Over a lifetime, the return on that $1 adds up to $60

MORE THAN HALF OF THE CHILDREN IN CALIFORNIA AGES 3 TO 4 DO NOT ATTEND PRESCHOOL

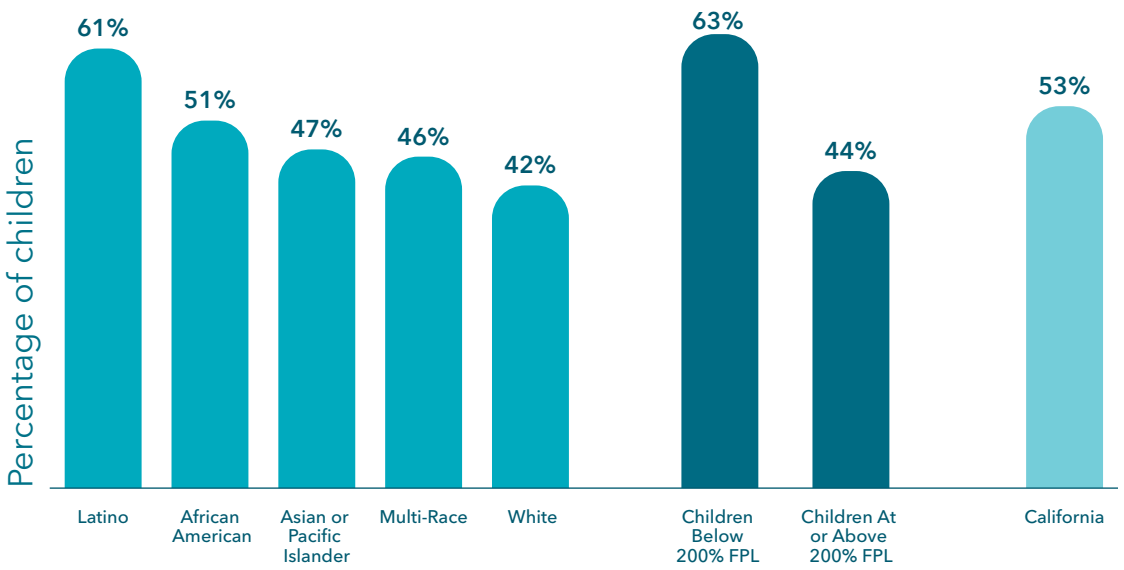


FIGURE 9: Percentage of children in California ages 3 to 4 who are not attending preschool, by race/ethnicity and federal poverty level (FPL), 2009-2011.

Source: U.S. Census Bureau, American Community Survey, 3-Year Estimates (2009-2011). Analysis by the Annie E. Casey Foundation, KIDS COUNT Data Center.

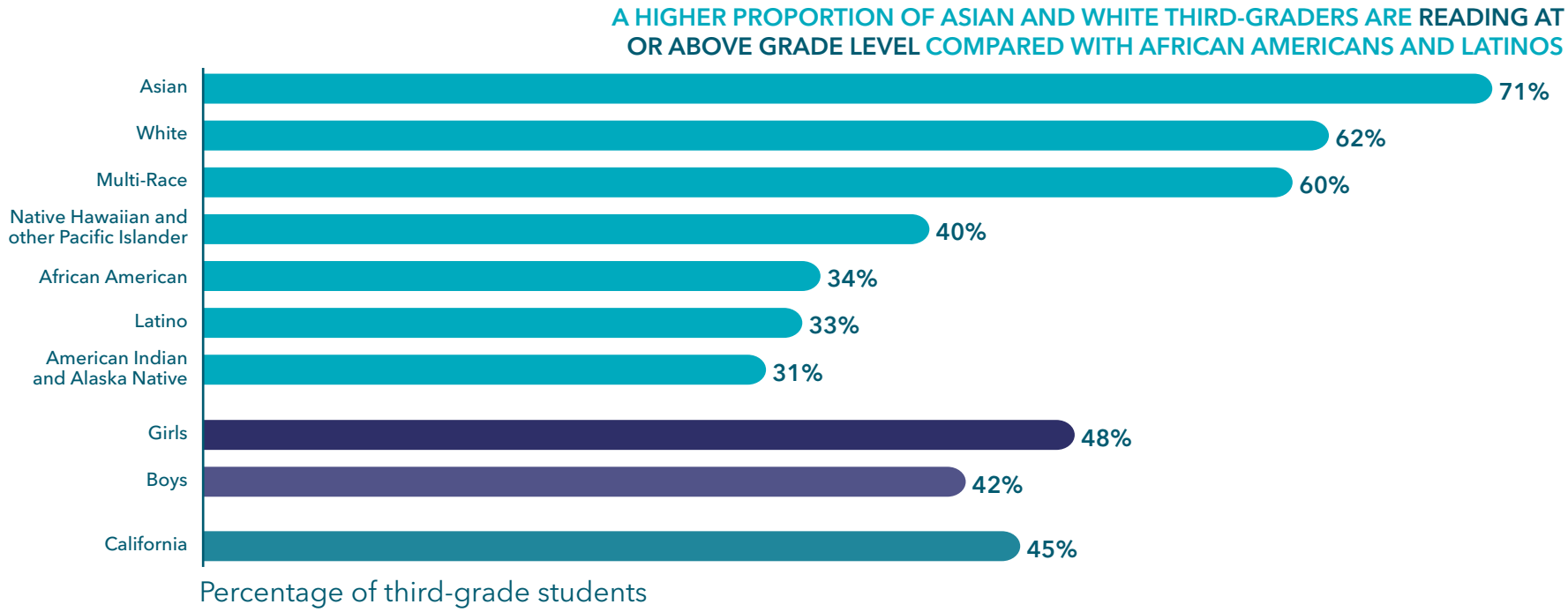


FIGURE 10: Percentage of third-grade students scoring proficient or higher on English Language Arts California Standards Test (CST), by race/ethnicity and gender, California, 2013.

Source: California Department of Education, Standardized Testing and Reporting (STAR) Results, 2013. Analysis by www.kidsdata.org, a program of the Lucile Packard Foundation for Children's Health.

to $300.[2]

One of the most successful ways of supporting healthy early childhood development is through high-quality infant and toddler care, whether provided by parent(s) who feel prepared and supported, or by family or outside day care providers, Head Start, or preschool programs.[3] Getting ready to learn is especially important for the nearly half of all California children who live in low-income families (less than 200 percent of the federal poverty level),[4] a disproportionately large share of whom are non-White. Despite the evidence demonstrating the importance of early childhood care and enrichment, only 6 percent of income-eligible children under age 3 are served by any publicly supported program.[5] Some reasons proposed for this are transportation barriers, especially for rural areas; cultural, language, or literacy barriers; lack of awareness; and staffing or facilities issues. As shown in Figure 9, about three in five low-income children ages 3 to 4 are not attending preschool, including three out of five Latinos and more than half of African Americans.

Third-Grade Reading Proficiency as a Predictor of Future Performance

When children do not participate in early developmental and educational opportunities, the impact is seen in later educational performance. In a hopeful trend, the latest data shows that the percentage of reading-proficient California third-graders increased between 2003 and 2013 for all subgroups. However, despite this overall improvement, significant gaps remain between English learners; economically disadvantaged children (those eligible for reduced-price lunch programs); boys and girls; and some of the largest racial or ethnic subgroups, including American Indians/Alaska Natives, Latinos, and African

MALE UNDERGRADUATE STUDENTS ARE UNDERREPRESENTED IN CALIFORNIA PUBLIC HIGHER EDUCATION

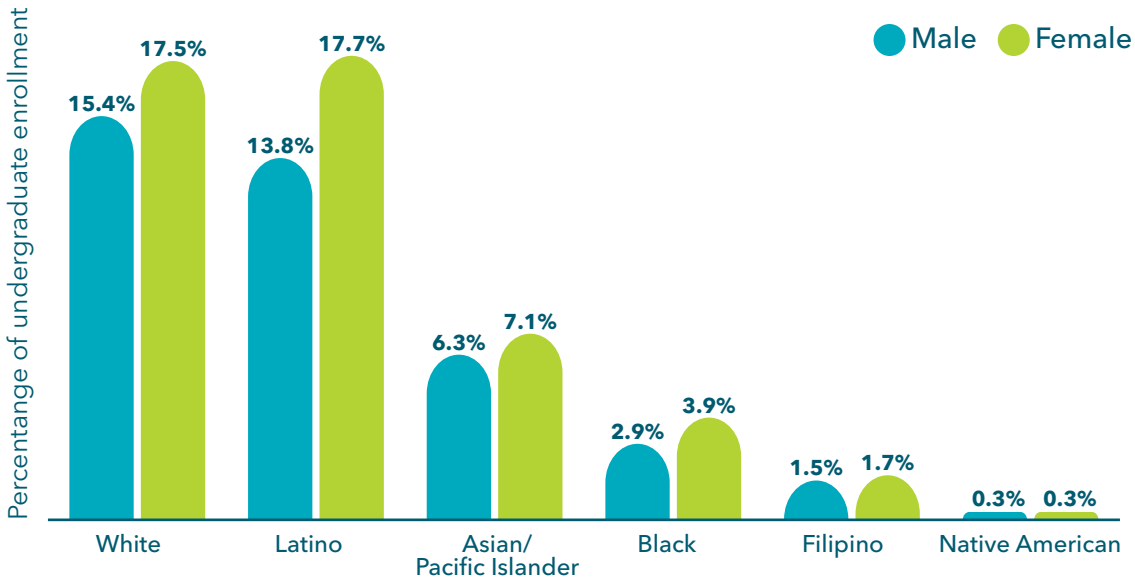


FIGURE 11: Percentage of undergraduate enrollment, by race/ethnicity and gender, California Public Higher Education, 2010.

Source: California Postsecondary Education Commission.
Note: Unknown percentage is not included in the table.

A Green Education for a Green Economy

The East Bay Green Corridor's Energy and Technology (GET) Academies were founded in 2008 to create high-quality jobs in green manufacturing and clean energy research among East Bay communities. The GET Academies, with support from the Institute for Sustainable Economic, Educational and Environmental Design, are located in nine East Bay high schools, where they are pioneering an educational curriculum in green science, technology, engineering, and math to help students graduate with the 21st-century skills and knowledge they will need to succeed in the clean energy economy. The program is designed to support the development of multiple pathways by which California's students can graduate high school, complete postsecondary education, attain industry-recognized credentials, and embark on a long and lasting career in a fulfilling, high-paying job.

Learn more at http://iseeed.org/programs/east-bay-green-corridor/.

Strong Public Support for Universal Preschool

Reflecting a growing public focus on preschool since President Obama proposed universal access to high-quality preschool for all low- and middle-income 4-year-olds, an April 2014 survey by the California Field Poll, a nonpartisan public opinion news service, registered strong voter support for extending California's transitional kindergarten to include all 4-year-olds at an estimated cost of $1.4 billion. The poll found that 56 percent of those without young children, and 57 percent of people overall, support the idea. Latinos registered the greatest support (75 percent), followed by African Americans, at 72 percent. The 2014-15 Budget Act allocates funding to support the expansion of California State Preschool Program for 3- and 4-year old children from low income families.

Sources: The President's 2015 Budget Proposal for Education. U.S. Department of Education Website. http://www.ed.gov/budget15. Accessed July 2014.

DiCamillo M, Field M. Majority of California Voters supports expanding pre-school to all four-year-olds despite its additional costs and regardless of parents' incomes. San Francisco, CA: The Field Poll; April 2014.

California State Budget 2014-2015. California State Budget Website. http://www.ebudget.ca.gov/2014-15/pdf/Enacted/BudgetSummary/FullBudgetSummary.pdf. Accessed November 2014.

Americans, compared with higher-income, White, and Asian students *(see Figure 10)*. For example, only 33 percent of economically disadvantaged third-graders in 2013 were reading at proficiency levels, compared with 67 percent of higher-income students.[6] These educational inequities start early and have long-lasting implications *(see Figure 11)*.

Similar disparities exist in terms of high school dropout and graduation rates, although here, too, there has been notable improvement in recent years. In 2012, more than 65,000 California students who started high school in 2008 dropped out – about one of every eight students. However, dropout rates vary widely by school district and among racial/ethnic groups. Generally, African American, American Indian/Alaska Native, Latino, and Native Hawaiian/Pacific Islander students have significantly higher dropout rates than Asian American and White students.[7] Research has shown that young people who do not complete high school are more likely than those with higher education levels to be unemployed, live in poverty, be dependent on welfare benefits, have poor physical and mental health, and engage in more criminal activity.[8] One national study estimated that if those who dropped out of high school in 2011 had graduated instead, the nation's economy would benefit by about $154 billion over their lifetimes.[9]

Implications for Lifelong Health

More than any other developmental period, early childhood development sets the stage for acquiring skills that directly affect children's physical and mental health – health literacy, self-discipline, the ability to make good decisions about risky situations, eating habits, and conflict negotiation.[1] These same skills influence children's health and mental health throughout adolescence, contributing to important public health and social problems, including increases in school violence, teen sexuality, and eating disorders, as well as the onset of many psychological disorders.[10]

The Mission Neighborhood Promise of Cradle-to-Career Education

Despite high and rapidly rising housing costs, San Francisco's Mission District remains one of the poorest in the city, with a high teen birthrate, a high dropout rate, and more than three out of four of its 12,000 mostly Latino children living in low-income housing, according to the Mission Economic Development Agency (MEDA). But big changes are coming to the neighborhood, thanks to a five-year, $30 million U.S. Department of Education grant recently awarded to MEDA to implement the Mission Promise Neighborhood (MPN). The MPN is a citywide partnership of local agencies, the school district, colleges and universities, and 26 nonprofit service providers to integrate a host of cradle-to-college-to-career services that improve academic achievement and build family wealth for the families of children at four participating Mission District schools. The MPN integrated service model builds on the success of the Harlem Children's Zone, which provides children and families with high-quality, coordinated educational, health, social, and community supports from cradle to career.

Learn more at www.missionpromise.org.

Housing:
A Leading Social Determinant of Public Health

Housing plays a fundamental role impacting public health, from locational attributes to housing quality and affordability.[1] Stable housing (adequate, safe, and affordable) is a foundation for healthy family growth and for thriving communities.

An Unaffordable House Is Not a Healthy Home

Healthy and stable housing is one of the most basic requirements for a sense of personal security, sustainable communities, family stability, and the health of every individual. It is essential for meeting our physical needs for shelter against environmental hazards, our psychological and emotional needs for personal space and privacy, and our social needs for a gathering place for family and friends.

When Housing Becomes Unaffordable...

Cost of shelter is the largest non-negotiable expense for most families. When the cost is excessive, families fall behind on rent or mortgage payments and have little or no disposable income, often going without food, utilities, or health care.[2] For a growing share of lower- and even middle-income Californians, lack of affordable and adequate housing has made this issue a contributor to mental stress and physical illness rather than a source of health and well-being. The rising cost of housing over several decades (a trend that reversed temporarily during the Great Recession) has put even the lowest-priced 25 percent of homes in any given area out of reach for approximately half of all American families, up from 40 percent in the mid-1980s.[3] In California, the housing "affordability index" – the percentage of households that can afford to purchase a median-priced home without exceeding 30 percent of the household income, as recommended by lending institutions – has fallen rapidly, as housing prices have rebounded since 2012. For example, in 2014, only 33 percent of California households could afford to purchase a median-priced single-family home, while 44 percent could afford to purchase a condominium or a town house. Nationally, 59 percent of households could afford to purchase a home of either type.[4] Rents are rising rapidly and rental vacancy rates are in decline, impacting lower-income households in particular, of which a third are households headed by an elderly person or a person with disabilities, and a third are families with children. The latest American Community Survey shows that almost 60 percent of all renters and 78 percent of the lower-income renters (earning 80 percent or less than the median income)

AFRICAN AMERICANS AND LATINOS ARE MORE LIKELY TO SPEND MORE THAN 30% OF THEIR INCOME ON HOUSING THAN OTHER RACIAL/ETHNIC GROUPS

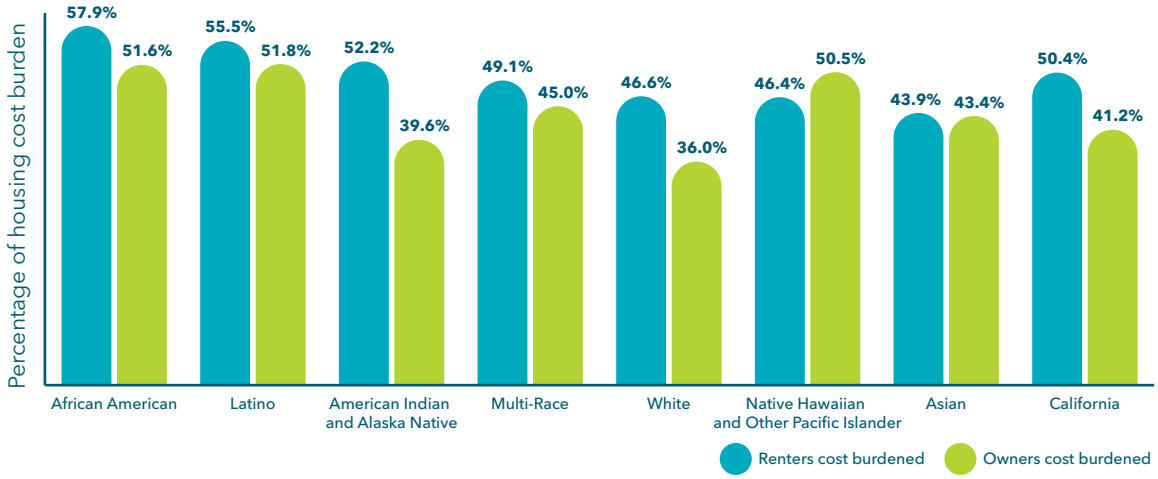


FIGURE 12: Percentage of housing cost burden, by tenure and race/ethnicity, California, 2006-2010.

Source: U.S. Department of Housing and Urban Development, Comprehensive Housing Affordability Strategy, 2006-2010. Analysis by CDPH-Office of Health Equity and UCSF, Healthy Communities and Data and Indicators Project.
Cost burdened is defined as households spending more than 30% of monthly household income on housing costs.
Housing costs include monthly, gross rent (rent and utilities) or selected, housing costs (mortgage, utilities, property tax, insurance and, if applicable, home association fees).

pay in excess of 30 percent of their income for rent.[5] Households with high housing cost burdens (over 30 percent of annual income) are often referred to as "shelter poor" because they have less to spend on other essentials, such as food, clothing, and health care, and are more likely to report that their children have only fair or poor health.[6] In California, African American and Latino households are shouldering a slightly heavier burden of housing cost, with more than 50 percent of these renters and owners spending more than 30 percent of their monthly household income on housing *(see Figure 12)*.

The Color of the Housing Crisis

The affordability crisis is particularly acute in California, and it has disproportionately affected low-income and other vulnerable populations throughout the state. Home ownership rates among Latinos and African Americans are significantly below the state average and about 31 to 43 percent lower than the rate of White families *(see Figure 13)*. In addition, African American and Latino families who were recent borrowers experienced foreclosure rates during the recession that were double the rate of White families.[7] Foreclosures and rapidly rising rents have also contributed to high rates of housing disruption for economically disadvantaged families and communities of color: African Americans and American Indians/Alaska Natives are roughly one-third more likely than the California average to experience a disruptive change of residence during a given year *(see Figure 14)*. Such unplanned changes are a source of harmful stress and disruption in families' access to health care services, education, social networks, and employment opportunities. These families will be more likely to also feel the delayed "spin-off" effects of recession, such as poor credit affecting employment and renting, or declining neighborhoods with increased crime and poverty.[8]

The barriers to healthy, stable, and affordable housing resulted in the ultimate plight of the housing crisis: homelessness.[9] With 12 percent of the U.S. population, California was home to more than 22 percent of the nation's homeless in 2013, an increase of 5,928 people from the previous year. On a single night in January 2013, 136,826 Californians were homeless. Almost seven in 10 homeless individuals in California live unsheltered (meaning they do not use shelters and are typically found on the streets, in abandoned buildings, or in other places not meant for human habitation) on any given night – the highest rate for unsheltered homeless in the nation.

Beyond Affordable Housing: Healthy Communities

A healthy home is more than an affordable house. Ultimately it must also meet at least minimum community safety and

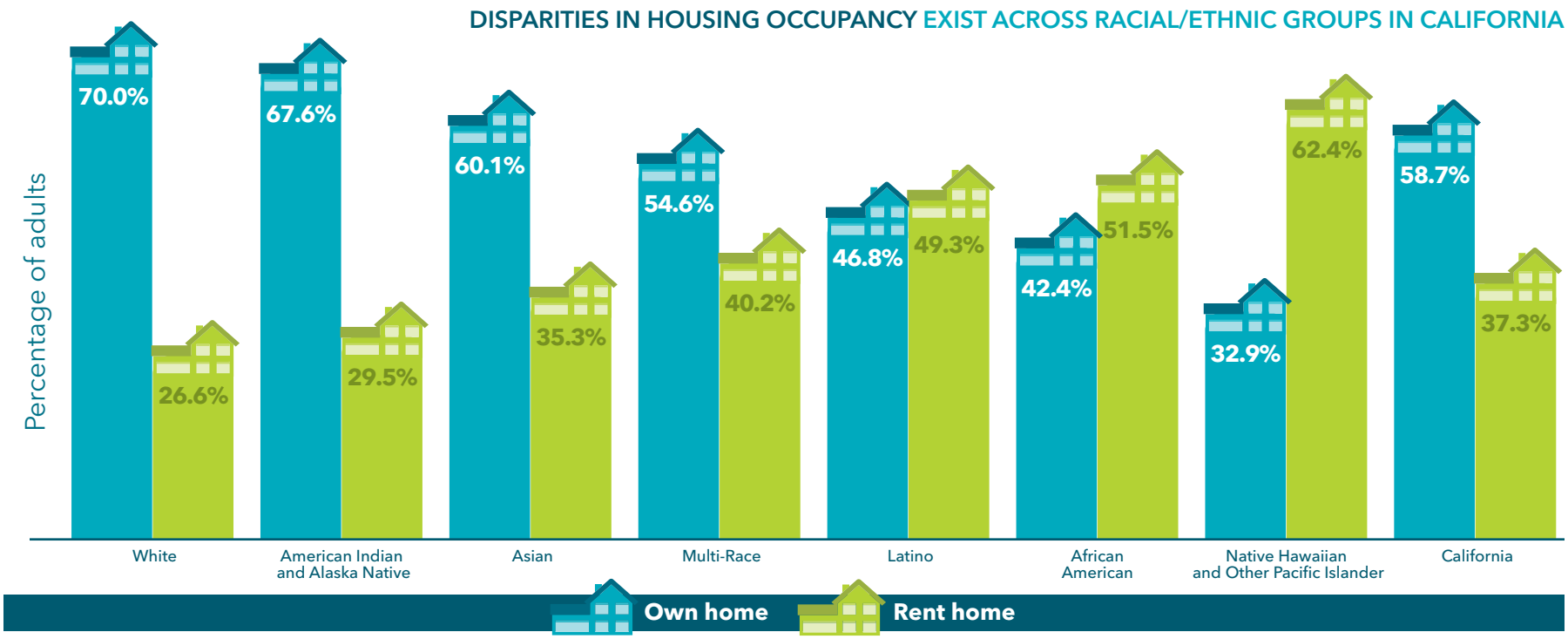


FIGURE 13: Percentage of adults who own or rent their homes, by race/ethnicity, California, 2011-2012.

Source: University of California Los Angeles, California Health Interview Survey, 2011-2012.
Note: Within each race/ethnic group, variable "have other arrangement" is not included, and the percentages may not add up to 100.

Building Housing and Wealth in East L.A.

The East L.A. Community Corporation (ELACC) is focused on developing housing and providing financial education for the low-income and mostly Latino residents of Boyle Heights and unincorporated East Los Angeles. ELACC's approach has four components: increasing the supply of quality, affordable housing; providing financial education for first-time home-buying and foreclosure prevention; providing related tenant services, including affordable childcare and English language tutoring; and community organizing for neighborhood cohesion and empowerment.

ELACC serves more than 2,000 residents every year and has leveraged more than $135 million of investment to the Eastside while completing more than 550 housing units serving more than 1,000 residents, with more than 300 units in various stages of development. It has mobilized a community organizing base of over 1,300 members annually and has helped over 3,000 families purchase their first homes, avoid foreclosure, establish savings, and build and sustain wealth.

Learn more at http://www.elacc.org/.

AFRICAN AMERICANS AND AMERICAN INDIANS/ALASKA NATIVES ARE MORE LIKELY TO EXPERIENCE THE DISRUPTION OF A RESIDENTIAL MOVE THAN ARE OTHER RACE/ETHNICITIES

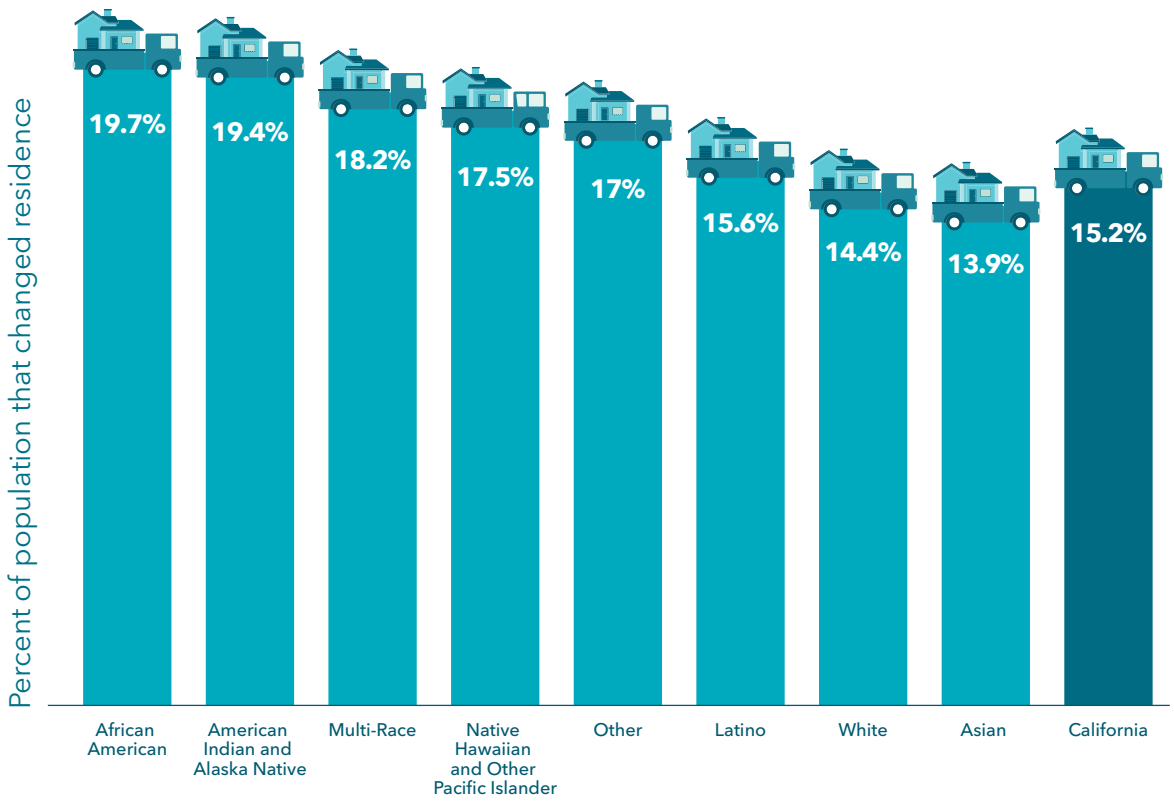


FIGURE 13: Percentage of population age 1 year and over who changed their residence (different house in the U.S.) from last year to current year, by race/ethnicity, California, 2006-2010.

Source: U.S. Census Bureau, American Community Survey, 5-year Estimate (2006-2010).

health standards and be part of a healthy neighborhood. That means being part of a community with parks and sidewalks and bike paths; with clean air and clean soil and clean water; with full-service grocery stores that stock affordable, healthy, fresh fruits and produce; with high-quality childcare, preschools, and K-12 schools that graduate all children; with reliable, affordable public transit for getting to work; and with decent-paying local jobs at healthy workplaces. That's the kind of healthy home we all deserve.

New Resource on Low-Income Housing from the California Housing Partnership Corporation

The California Housing Partnership Corporation (CHPC), a nonprofit organization created by the state legislature to monitor, protect, and augment the supply of affordable homes to lower-income Californians, has assisted more than 200 nonprofit and local government housing organizations in leveraging more than $5 billion in private and public financing to create and preserve 20,000 affordable homes. In February 2014, CHPC published *California's Housing Market Is Failing to Meet the Needs of Low-Income Families.* The comprehensive report includes an analysis of the enormous shortfall of homes affordable to low-income families in California, the impact of state and federal disinvestment in affordable housing, and recommendations for policy makers.

Learn more at http://www.chpc.net/policy/index.html.

Environmental Quality:
The Inequities of an Unhealthy Environment

The environment – the air we breathe; the water we consume; the soil that nourishes the food we eat; and all the natural and human-made conditions of the places we live, work, learn, and play – has a profound impact on the health of every one of us. Yet low-income families, communities of color, and certain other vulnerable populations, especially children, are disproportionately subjected to environmental perils that have been causally linked to epidemic rates of various respiratory problems, including bronchitis, emphysema, asthma, and other diseases, disabilities, and chronic health conditions.[1] Figure 14 illustrates that the pollution burden tends to be high in California's Central Valley, where Latinos and non-Whites make up a large proportion of the population.

Despite having achieved impressive improvements in overall air pollution quality in recent decades, California is still home to the top five cities in the nation for both ozone pollution and year-round and short-term particle pollution, the two sources of the most negative health effects of polluted air.[2] The state's smoggiest cities are also the cities with the highest densities of people of color and low-income residents who lack health insurance.[3]

Climate Change Threatens Even Greater Disparities

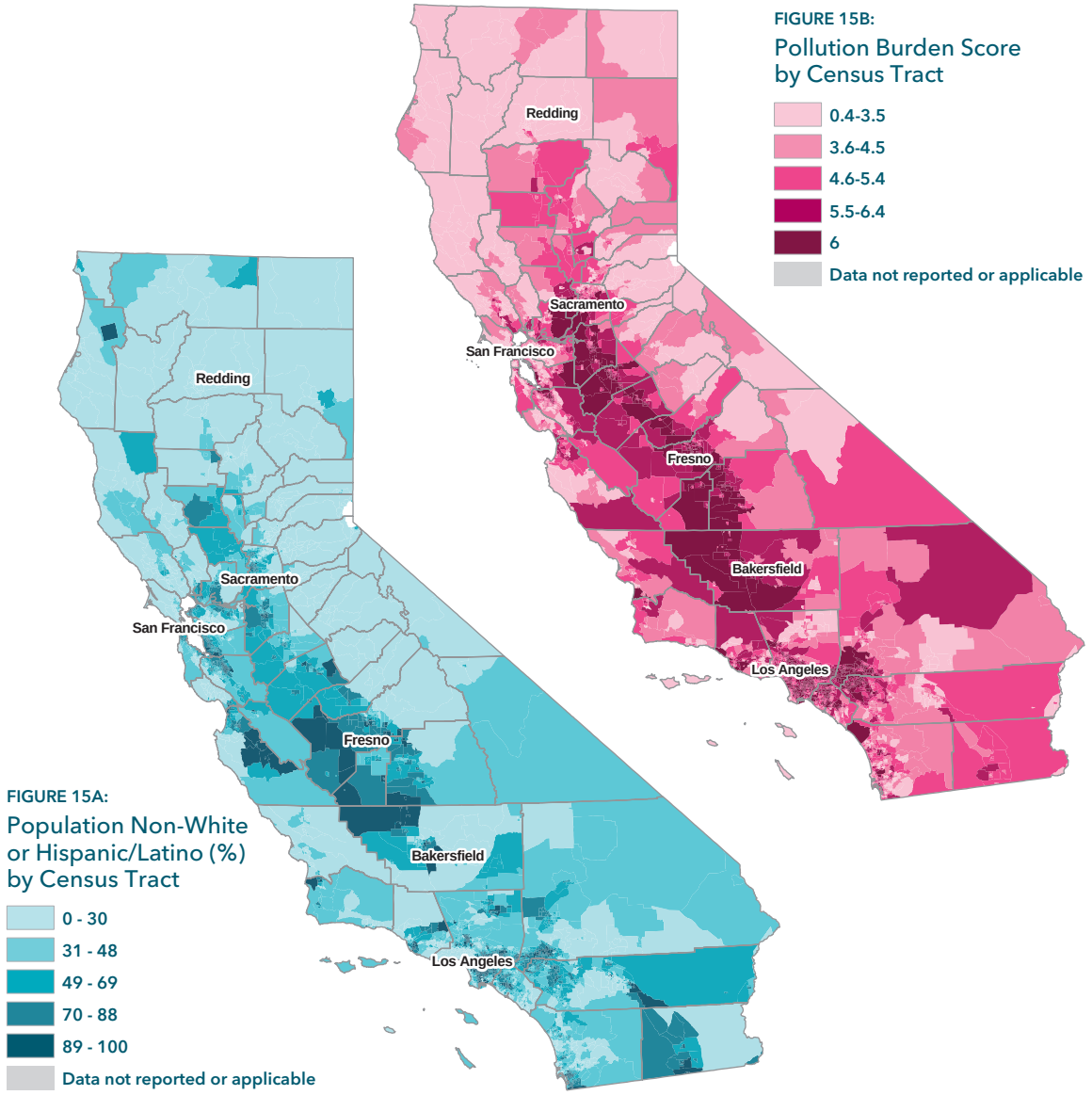
Climate change poses significant risks to the health and well-being of all Californians today and for generations to come, according to *The Third National Climate Assessment*, released in May 2014.[4] A 2009 report from the California Climate Change Center warned that current and anticipated impacts of climate change will likely create especially heavy burdens on low-income and other vulnerable populations: "Without proactive policies to address these equity concerns, climate change will likely reinforce and amplify current as well as future socioeconomic disparities, leaving low-income, minority, and politically marginalized groups with fewer economic opportunities and more environmental and health burdens." The report emphasized that some of the greatest economic impacts of climate change are expected to hit the state's agricultural sector, whose half million workers are predominantly Latino, and tourism-related industries, in which people of color make up a majority of the workforce.[3]

Responding to climate change through public health prevention and preparedness measures can help reduce existing health disparities and create opportunities to improve health and well-being across multiple sectors, including agriculture, transportation, and energy.[3]

Low-Income Children Are Uniquely Vulnerable

It is well established that children are more susceptible to environmental pollutants than are adults because their nervous, immune, digestive, and other bodily systems are still developing. Moreover, children eat more food, drink more fluids, and breathe more air in relation to their body weights compared with adults.[5] Exposure to high levels of air pollutants, including indoor air pollutants and secondhand smoke, increases the risk of premature death, respiratory infections, heart disease, and asthma.[6] Children living in low-income neighborhoods near heavy, energy-intensive industry; rail yards; and heavily trafficked freeways and streets in urban areas are at special risk of chronic respiratory conditions. African American children are four times more likely to be hospitalized for asthma compared with White children, and urban African American and Latino children are two to six times more likely to die from asthma than are White children.[7] Of the more than 600,000 Californians who experience frequent symptoms of uncontrolled asthma, nearly 240,000 cases are in families earning less than 200 percent of the federal poverty level, compared with 120,000 cases from families with income of 400 percent of the federal poverty level or higher.[8]

LATINO OR NON-WHITE POPULATIONS ARE MORE LIKELY TO LIVE IN AREAS WITH A HIGH BURDEN OF POLLUTION



Source: California Environmental Protection Agency (Cal/EPA) and the Office of Environmental Health Hazard Assessment (OEHHA), California Communities Environmental Health Screening Tool, Version 2.0 (CalEnviroScreen 2.0), 2014.

Built Environment:
Healthy Neighborhoods, Healthy People

The built environment refers to human-designed and constructed surroundings, including everything from transportation networks (e.g., streets, freeways, sidewalks) to buildings (e.g., stores, hospitals, factories, houses, schools, office buildings) to various recreational amenities (e.g., parks, playgrounds). How we design the built environment profoundly impacts every aspect of our quality of life, especially as it relates to our physical, mental, and social health.

Influence on Access to Healthy Foods and Physical Activity

The built environment influences many aspects of a community, such as whether healthy food can be accessed and where children can safely play. An analysis of data from the California Health Interview Survey has shown that people in neighborhoods with a low number of full-service grocery stores have higher rates of obesity, and neighborhoods with fewer grocery stores tend to have more poor non-White residents than do neighborhoods with easy access to fresh fruits and vegetables.[1] The dietary link to obesity is further exacerbated because many of these same neighborhoods that lack healthy food outlets also lack safe places to be active, including walkable streets, bike paths, parks, and other recreational amenities.

Land Use, Transportation, and Health

Transportation systems and land use policies can support health and equity by influencing an individual's social connections, physical activity, and level of access to jobs, medical care, healthy food, educational opportunities, parks, and other necessities. In addition, promoting safe, active transportation (e.g., walking, biking, rolling, or public transportation) is an important strategy for promoting health and equity while also reducing greenhouse gas emissions. California's state leadership has identified healthy, sustainable transportation as a priority, and in 2014 the California Department of Transportation adopted a new goal to "promote health through active transportation and reduced pollution in communities."[2]

In California and throughout the nation, the health consequences of traffic-intensive development and transport patterns include higher rates of air pollutants, which are associated with higher incidence and severity of respiratory symptoms, and stress-related health problems and other physical ailments (e.g., back pain) associated with commuting.[3] In a car-based transportation region, people are less likely to bike, walk, or skate to school or the grocery store, thus contributing to higher rates of cardiovascular disease, diabetes, and obesity. For example, school siting and transportation planning significantly impact

how children get to school; despite the health and environmental benefits of walking and biking, the percentage of children walking or biking to school in the U.S. has dropped from 40 percent in 1969 to just 5 to 13 percent in 2009.[4] Additionally, families living in these car-based transportation regions tend to spend a higher proportion of their income on transportation costs *(see Figure 16)*, and the high burden of transportation costs can put a strain on other essential expenses such as health care, education, and food.

THE BURDEN OF TRANSPORTATION COST RELATIVE TO INCOME IS HIGHER IN RURAL REGIONS AND COUNTIES OF CALIFORNIA

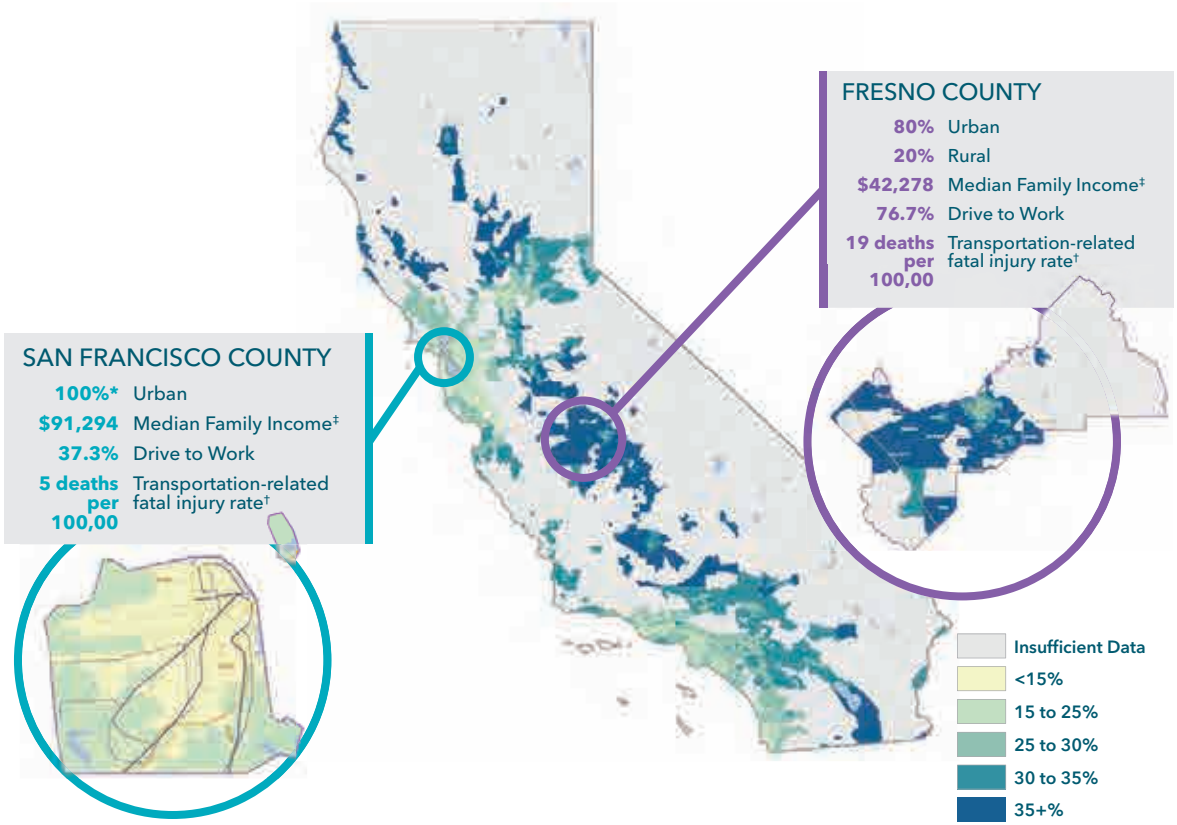


FIGURE 16: Transportation costs as a percentage of income, California, 2009.

Sources: Center for Neighborhood Technology, Housing and Transportation (H+T) Affordability Index, 2009; U.S. Census Bureau, American Community Survey, 5-Year Estimate (2008-2012); Centers for Disease Control and Prevention, National Centers for Injury Prevention and Control, Web-Based Injury Statistics Query and Reporting System (WISQARS), 2004-2010; and University of California Los Angeles, California Health Interview Survey, 2011-2012.

†Age-adjusted death rate.

**Statistically unreliable data.*

‡Median family income with own children under 18 years.

Clean Trucks, Healthier Neighborhoods

The ports of Los Angeles and Long Beach handle 70 percent of U.S. Pacific Coast cargo, and thousands of trucks spewing diesel fuel exhaust routinely passed through the low-income, immigrant neighborhoods of southwest Los Angeles each day from the port, raising cancer and asthma risks and causing injuries and traffic problems. Thanks to campaigns by a coalition of environmental, public health, and environmental justice groups, the Air Resources Board adopted a statewide regulation in 2007 and the ports adopted a Clean Truck Program in 2008; both set more stringent emission standards for port trucks. Nearly $200 million in state and local incentives aided the transition to cleaner trucks. In less than three years, these programs were responsible for cleaning up the nation's busiest drayage truck fleet and cut related air pollution in local communities by 90 percent.

Sources: Clean trucks. Port of Long Beach Website. http://www.polb.com/environment/cleantrucks/default.asp. Posted January 11, 2011. Fighting the cycle of poverty and pollution at the ports of Los Angeles and Long Beach. Coalition for Clean and Safe Ports Website. http://cleanandsafeports.org/los-angeleslong-beach/#sthash.kfSBbdib.dpuf. Accessed May 2014.

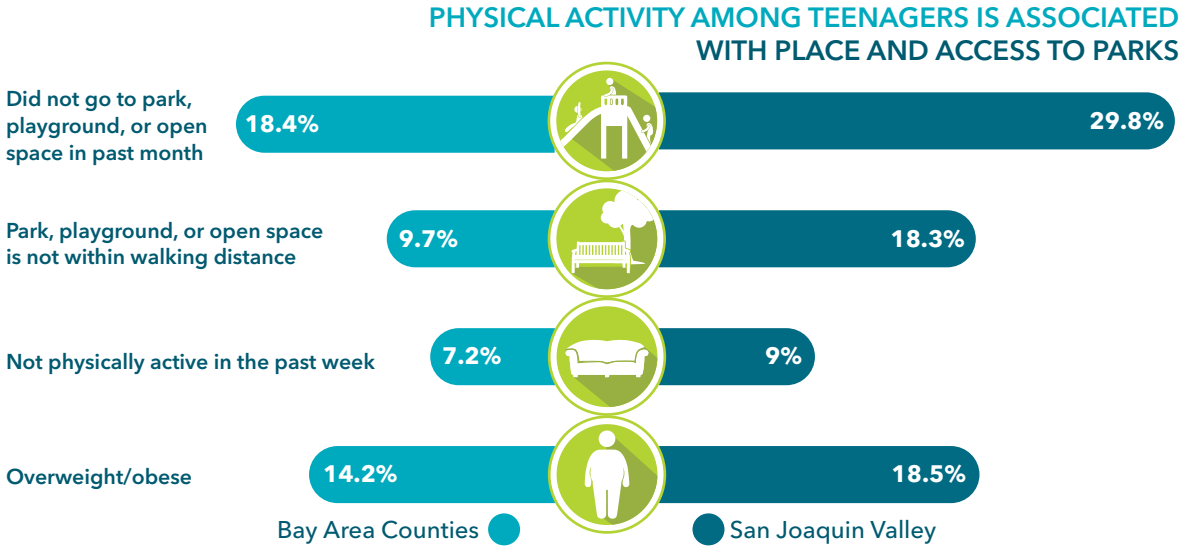


FIGURE 17: Percentage of teenagers from the Bay Area counties and San Joaquin Valley who reported not having access to parks, playgrounds, or open spaces; not being physically active; and being overweight or obese, California, 2011-2012.

Source: University of California Los Angeles, California Health Interview Survey, 2011-2012.

In addition to reducing transportation costs and the associated inequities, a focus on California's land use and transit systems can address important health inequities. People who live in highly walkable, safe, mixed-use communities with easy access to green space and public transit options have higher levels of physical activity and lower body mass indices[5,6], contributing to greater overall health *(see Figure 17)*. Strong evidence suggests that active transportation is positively associated with better cardiovascular health, lower risk of diabetes, and lower risk of hypertension. For example, the Integrated Transport and Health Impacts Model (I-THIM), developed by the California Department of Public Health, found that in the San Francisco Bay Area an increase in daily walking and biking per capita from four to 22 minutes would reduce cardiovascular disease and diabetes by 14 percent, and would decrease greenhouse gas emissions by 14 percent. The downside of this increased activity, however, would be a 39 percent increase in traffic injuries.[7] Traffic-related injuries and deaths disproportionately impact vulnerable populations such as older adults, children, communities of color, and low-income communities.[8] Investing in a range of land use and safety improvements that support active transportation could help reduce these inequities. Well-designed, well-built, safe neighborhoods and streets are essential to people's well-being, and are important strategies for promoting health and mental health throughout California.

Jobs and Healthy Food for South Los Angeles

For the 455,000 residents of South Los Angeles, the April 2014 opening of the Northgate Gonzales Market was a cause for celebration. The market, the latest addition of a local, Mexican American-owned grocery chain, gives local area residents unaccustomed access to healthy food options that have eluded this fast-food-dense area for years. It also provides 130 "living wage," permanent jobs for local people in a region with high unemployment and a large share of Mexican and Central American immigrants.

The grocery chain worked with Homeboy Industries to source and train applicants for supermarket jobs. More than 70 percent of initial hires are local residents, and more than 20 percent are African American. Eight employees were direct referrals from incarcerated youth reentry programs at either Homeboy Industries or Los Angeles County Probation.

The market's lead investor was the California FreshWorks Fund, backed by The California Endowment and other partners to finance new and upgraded grocery stores and other healthy food distribution and retail outlets in California's underserved communities.

Source: Alejandrez L. FreshWorks funded Northgate Gonzalez Marketplace brings healthy foods to South Los Angeles. The California Endowment Website. http://tcenews.calendow.org/blog/freshworks-funded-northgate-gonzalez-marketplace-brings-healthy-foods-to-south-los-angeles. Published April 15, 2014.

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Health Care Access and Quality of Care: **Narrowing the Gaps**

Access to high-quality health care services ranks as one of the most important overall health indicators of the federal government's Healthy People 2020 initiative. However, as late as 2011, nearly 23 percent of Americans did not have a regular primary care provider (a doctor or health center) whom they could visit when they were sick or needed preventive care or advice. As of 2012, about 17 percent of Americans under age 65 did not have any form of health insurance, a rate virtually unchanged since 2008.[1] For both measures, the national rates were higher for various ethnic or racial groups, especially Latinos.[2] In California, the uninsured rate among Latinos in 2011-2012, 28 percent, was almost double that among the White population *(see Figure 18)*. From year to year, the largest disparities in access to care and quality of care nationally are for Spanish-speaking Latinos,[3] a fact that points to the critical importance of access to health insurance and linguistically and culturally appropriate care.

LATINOS HAVE THE HIGHEST RATES OF BEING UNINSURED FOR HEALTH INSURANCE OF ANY RACIAL/ETHNIC GROUP IN CALIFORNIA

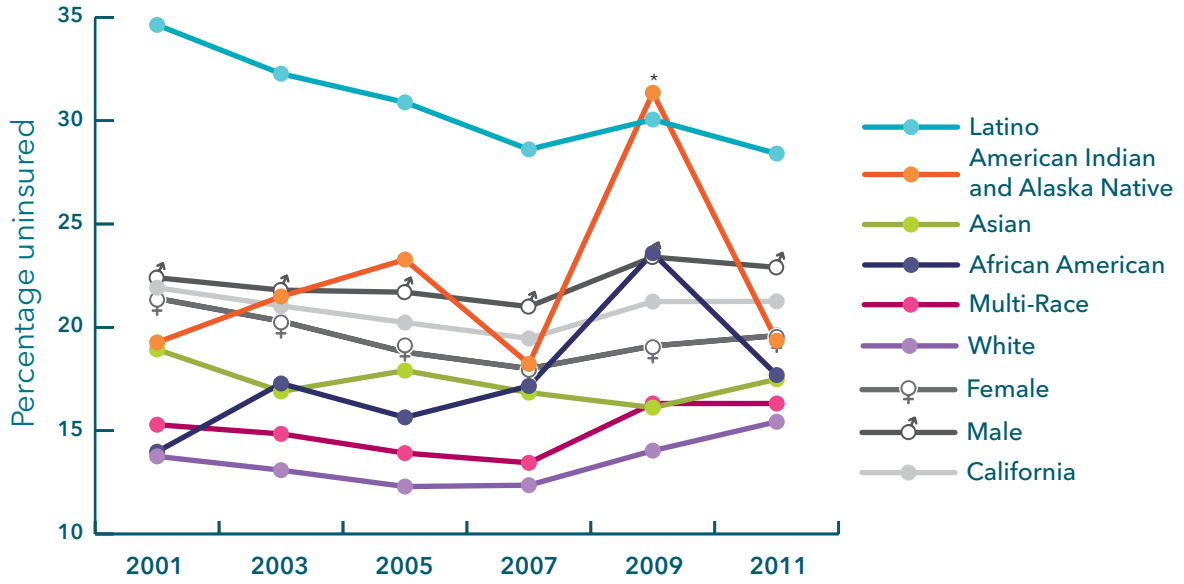


FIGURE 18: Percentage of people ages 0-64 without health insurance† during the past 12 months, by race/ethnicity, California, 2001 to 2011.

Source: University of California Los Angeles, California Health Interview Survey, 2001-2011.
Note: "Asian" includes Native Hawaiian and other Pacific Islander.
† Had no insurance the entire year or had insurance only part of the past year.
** Statistically unreliable data*

Implementation of the federal Affordable Care Act (ACA) is providing expanded access to health insurance for most people. Undocumented residents are an exception to this access, aside from those who qualify for some emergency services. In California, of the 1.4 million covered California enrollees as of February 2015, Latinos accounted for 37 percent of new enrollees, up from 31 percent during the last open enrollment period.[4] This level of enrollment represents important progress, because data on the national level has shown that having insurance coverage positively affects people's ability to obtain a usual source of care and thus increases their use of preventive, urgent, or chronic health care services.[5] However, significant racial and ethnic disparities in insurance coverage in California are likely to persist, though at lower levels, due in part to observed cultural and linguistic barriers to expanded access to insurance, and in part to ineligibility under federal law (an estimated 1.1 million uninsured, undocumented California residents are ineligible).[6]

The ACA provides a number of avenues to address the health disparities linked to cultural and linguistic barriers. For example, the ACA has expanded research on health and health care disparities and created the Patient-Centered Outcomes Research Institute to oversee studies that examine differences in patient outcomes among racial and ethnic minorities. The ACA also expands grant programs to attract and retain health professionals from diverse backgrounds and directs funding to encourage service in underserved areas. The ACA provides support for the development and dissemination of curricula to promote cultural competency and supports a variety of culturally appropriate prevention and education initiatives.

Equal Access Is One Piece of Health Equity

Although insurance provides access to care, it does not ensure that everyone receives appropriate or high-quality care at the right time; nor does it fully address the remaining financial barriers to access for low-income people with insurance.[6,7] An examination over an eight-year period of 16 "prevention quality indicators" – conditions such as pediatric asthma, hypertension, and low birth weight, for which quality outpatient care, as in a doctor's office, can often prevent the need for hospitalization – concluded that African Americans consistently had the highest hospitalization rates for 14 measures. In some cases, the rates were two to three times higher than for Whites. For example, the average hospitalization rate for short-term complications of diabetes was 134 per 100,000 for African Americans, compared with 44 for Latinos, 42 for Whites, and just 14 for Asian/Pacific Islanders.[8]

California's Wide Dental Gap

Oral health, a critical though often neglected aspect of overall health, is believed to be the single greatest unmet need for health services among children. In California, the disparity in oral health between low-income and affluent children is the second worst in the nation, exceeded only in Nevada, according to a 2014 study by the Lucile Packard Foundation for Children's Health.

The report cites data from a 2011-2012 National Survey of Children's Health based on parent reports that found that 69.7 percent of California children ages 1-17 with public insurance had a preventive dental care visit during the previous year. In comparison, 83.4 percent of children with private insurance and 46.4 percent of uninsured children had a preventive visit during that time frame.

The disparity in access to dental care should narrow somewhat beginning in 2015, when dental insurance will become available as part of health insurance plans purchased through the state's new health insurance marketplace.

This survey is based on parent responses, not on claims data. These types of surveys tend to over-report utilization, partly because of faulty recall of events that may have happened a year ago.

Source: Schor E. Dental Care Access for Children in California: Institutionalized Inequality (Issue Brief). Palo Alto, CA: Lucile Packard Foundation for Children's Health; 2014.

Major disparities in quality of care also exist across the nation among cities, regions, and states. A 2013 study of quality of care received by low-income Americans found that if every state could have achieved the high-quality levels achieved by the top-performing states, an estimated 86,000 premature deaths would have been avoided, 750,000 low-income Medicare beneficiaries would not have been unnecessarily prescribed high-risk medication, and tens of millions of adults and children would have received timely preventive care.[7] California ranked 20th among all states for overall quality of care for low-income patients but was among the lower third quartile of states for prevention and treatment.

School-Based Health Centers Boost Access to Care for Underserved Families

School-based health centers (SBHCs), which bring vital primary care services into the heart of low-income neighborhoods, have more than doubled in California over the past decade, numbering more than 226 as of 2013. Serving nearly a quarter million K-12 students and their families, the clinics, financed by a variety of public and private sources, have sprung up in schools from Del Norte County to San Diego County, with large concentrations in Los Angeles and the Bay Area.

Most SBHCs are located in schools with low-income Latino and African American students—ethnic groups that are more likely to suffer health disparities due to higher rates of violent injury, poor nutrition, physical inactivity, substance abuse, and sexually risky behavior. They also have lower rates of health insurance and less access to health and mental health services.

California schools received $30 million, almost a third of the $95 million provided under the health care reform law, for creation of school-based health clinics in 2011 to 2013.

Learn more at http://www.schoolhealthcenters.org.

Clinical and Community Prevention Strategies: **The Power of Prevention**

Prevention in health is a broad concept. It can occur in health care in a range of settings and in various ways, including public health strategies to prevent the occurrence of a disease (such as antismoking campaigns), clinical strategies or treatments to detect the early stages of a disease (such as cancer screening), or clinical interventions to prevent complications of an existing disease (such as care management plans for diabetes). Prevention also includes public health activities, such as health education about risky or positive personal behavior, and changes to the larger environmental or social conditions that have an impact on health. In all these ways, prevention has long been recognized as an essential public health strategy for creating better health and promoting health and mental health equity throughout society.

Unfortunately, prevention strategies are not fully utilized in California or elsewhere in the United States. The result has been the avoidable loss of thousands of lives annually in the United States, unnecessarily high levels of poor mental and physical health, the persistence of health disparities among vulnerable populations, and inefficient use of health care dollars. For instance, a national study from the Partnership for Prevention states that a 90 percent utilization rate for just five widely recommended and cost-effective preventive services – daily aspirin use to prevent heart attacks, antismoking advice by health professionals, periodic colorectal cancer screening, annual influenza immunization for adults over age 50, and biennial breast cancer screening for women over age 40 – would save more than 100,000 lives each year in the United States. Among the 12 preventive services examined in the Partnership for Prevention study, seven are being used by about half or less of the people who should be using them. Racial and ethnic minorities are getting even less preventive care than the general U.S. population. Latinos, for instance, have lower utilization of 10 preventive services than do non-Hispanic Whites and African Americans, and Asian adults age 50 and older are 40 percent less likely to be up to date on colorectal screening than are White adults.[1] In a number of important areas, use of preventive mental and physical health strategies among disadvantaged populations significantly lags behind use among more advantaged population groups.[2]

Disparities in Clinical Prevention: Mammograms and Childhood Immunization

In California, very low-income women are more than twice as likely as high-income women in the same age bracket to not receive timely mammograms, and almost twice as likely to not receive timely Pap tests *(see Figure 19)*.

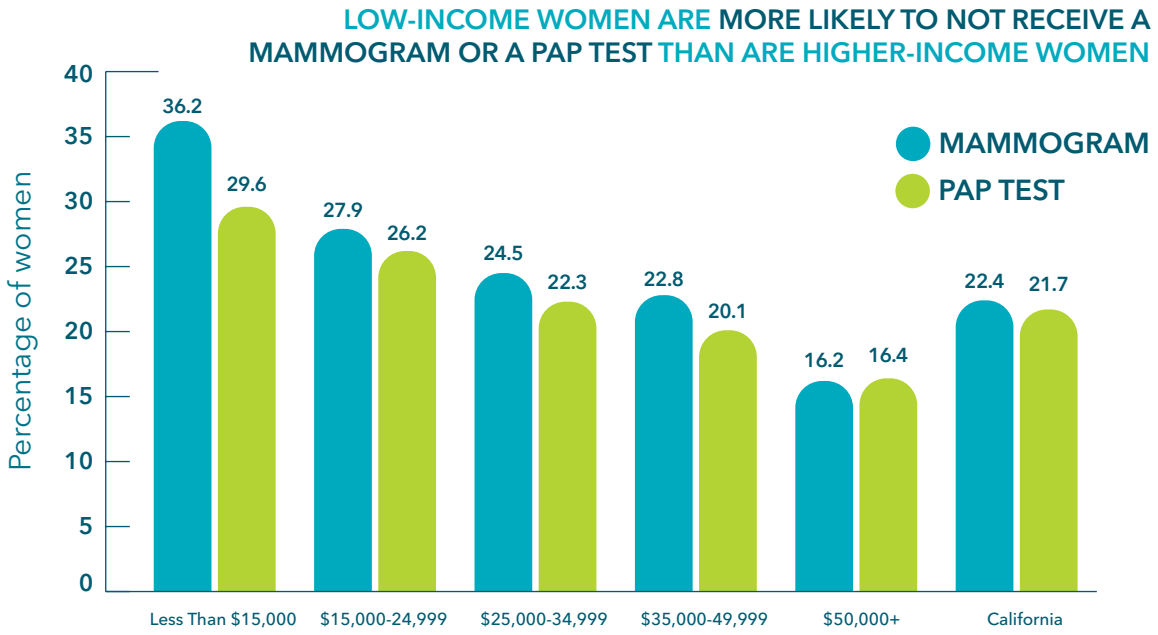


FIGURE 19: Percentage of women who have not had a mammogram or a Pap test, by annual income level, California, 2012.

Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2012.
Note: Mammogram screening among women age 40 years or over within the past two years, and Pap smear screening among women age 18 years or over within the past three years.

This is especially important for African American women, who in 2010 had the highest breast cancer death rates of all racial and ethnic groups, at 33 per 100,000, compared with 24 per 100,000 for White women, though White women are actually more likely to be diagnosed with breast cancer.[3]

Another core component of preventive medicine is the recommended childhood immunization regimen. Immunizations are estimated to save, for every United States birth cohort, 33,000 lives; prevent 14 million cases of disease; and avoid more than $43 billion in direct and indirect costs. Despite progress in immunization rates, however, approximately 42,000 adults and 300 children in the United States die each year from vaccine-preventable diseases.[4] In California, students entering kindergarten must show proof of immunizations for DTaP, polio, MMR, Hep B, and varicella.[5] The dosages required for these vaccines can be taken within the first 24 months of life.[6] As shown in Figure 20, African American kindergarteners continue to significantly lag all other racial or ethnic groups in immunization rates.

Behavior-Level Prevention: Breastfeeding

Like immunization, breastfeeding has multiple health benefits for infants and children as well

AFRICAN AMERICAN KINDERGARTNERS ARE REPORTED TO HAVE THE LOWEST IMMUNIZATION RATE AT EACH AGE CHECKPOINT FOR RECOMMENDED VACCINATION

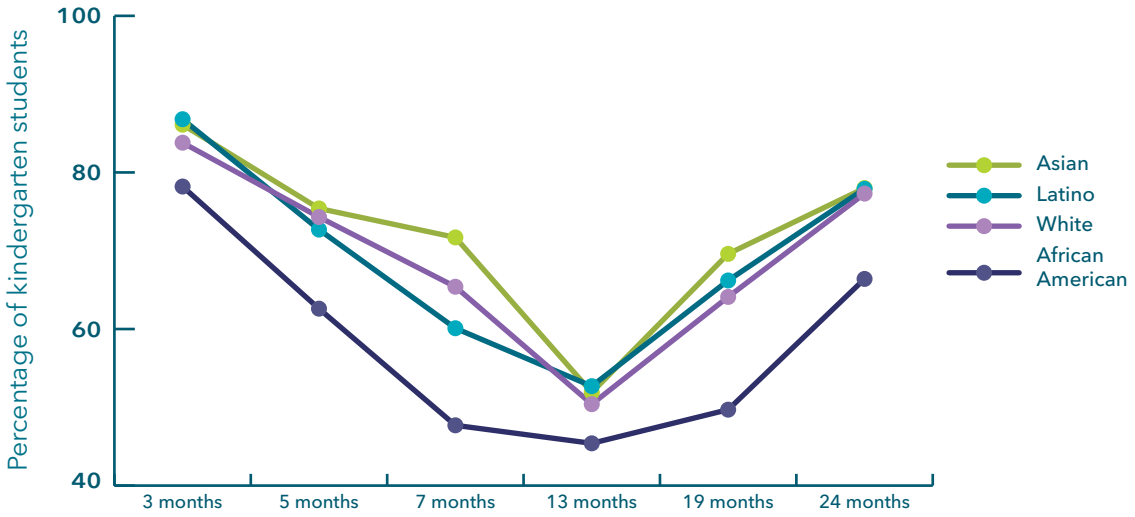


FIGURE 20: Percentage of immunization coverage among kindergarten students, by age checkpoint and race/ethnicity, California, 2010-2011.
Source: California Department of Public Health, Immunization Branch, Kindergarten Retrospective Survey Results, 2010-2011.

as mothers. It reduces the likelihood of many common infections and is associated with reduced risk of atopic dermatitis (eczema).[7] Studies estimate that 27 percent of monthly pediatric hospitalizations for lower respiratory tract infections and 53 percent of monthly pediatric hospitalizations for diarrhea could be prevented by exclusive breastfeeding.[8] Yet rates of breastfeeding beyond the first week following birth fall off sharply among California women at the lowest levels of family income, partly because low-income women are more likely than their higher-income counterparts to return to work earlier and to be engaged in jobs that make it challenging for them to continue breastfeeding.[9,10] There is a range of policy and health education strategies that can be taken to improve the rates of breastfeeding among new mothers.

Preventing Upstream Health Inequities

As this report indicates throughout, a growing body of evidence shows that many of the downstream health disparities that occur among vulnerable populations can be effectively reduced or eliminated by addressing the related upstream socioeconomic and environmental inequities.[11] Clean air and safe playgrounds, for instance, may be as effective for reducing levels of childhood asthma in low-income communities as a shot in the arm is for preventing measles. As another example, transportation systems, which are generally not thought of as part of the health care system, can indirectly impact health by influencing physical activity opportunities. Active transportation (walking, biking, and wheeling to destinations) can help prevent obesity and improve both mental and physical health.[12,13]

Improving Childhood Immunization Rates

A 2004 study involving more than 200 randomly selected English- and Spanish-speaking families with young children in Bakersfield identified the following key barriers facing any program to improve childhood immunization rates in ethnically diverse rural communities: lack of transportation, child illness, parental forgetfulness, and fear of side effects. Among providers, the key barriers were lack of an opening for an appointment, limited clinic hours, and long lines at clinics. The report concluded that effective strategies must include reminder calls, increased transportation options, weekend clinics, and improved communication with parents.

Source: Thomas M, Kohli V, King D. Barriers to childhood immunization: findings from a needs assessment study. Home Health Care Serv Q; 2004;23(2):19-39.

Experiences of **Discrimination and Health**

The United States has made progress in creating a more tolerant society, yet discrimination and inequality persist today. Discrimination, whether experienced as individual acts or at an institutional level, makes people sick.[1] Although many of the most blatant forms of discrimination have been greatly reduced since passage of the Civil Rights Act of 1964 and subsequent civil rights laws, which prohibit discrimination in workplaces, schools, public facilities, and state and local government, many groups continue to be vulnerable to both subtle and overt forms of discrimination in other social and economic sectors.[2] Numerous studies have documented the harmful mental and physical health effects of discrimination, including depression, stress, anxiety, hypertension, self-reported poor health, breast cancer, obesity, high blood pressure, and substance abuse.[3,4]

MORE THAN 40% OF AFRICAN AMERICAN WOMEN REPORTED EXPERIENCING RACIAL DISCRIMINATION, COMPARED WITH 9% OF WHITE WOMEN

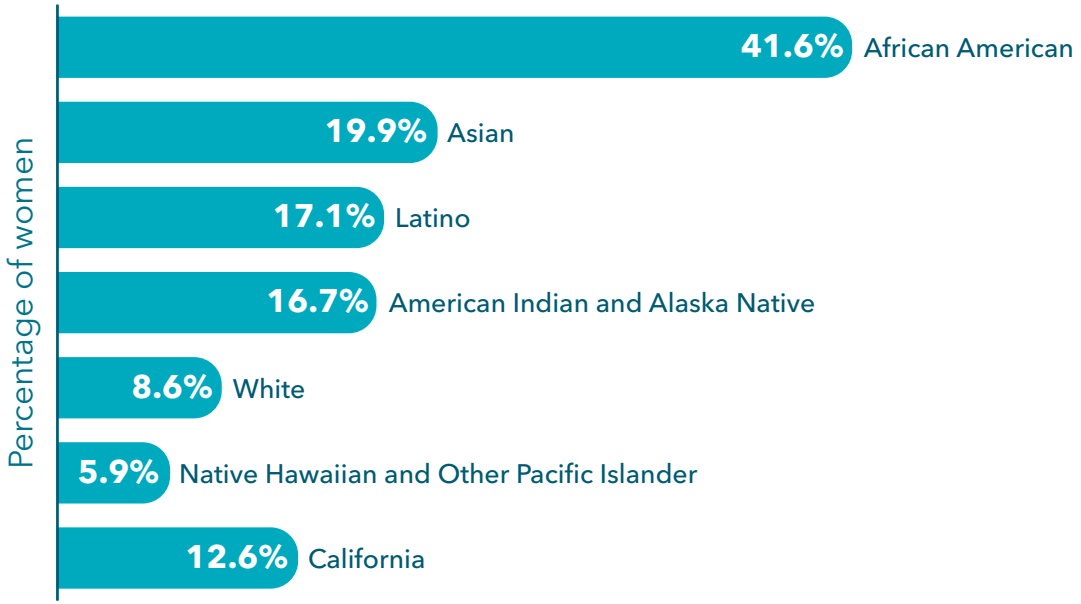


FIGURE 21: Percentage of women who reported experiencing discrimination because of their race/ethnicity, California, 2012.
Source: California Department of Public Health, California Women's Health Survey, 2012.

Prejudice and acts of discrimination are experienced by members of racial and ethnic groups, and Figure 21 details how California women experience discrimination across these groups. In addition, discrimination is experienced by individuals and groups defined by age, gender, gender identification, sexual orientation, religion, and other social or personal characteristics. Individuals who are members of two or more disadvantaged groups (such as a member of a racial minority who is also disabled) are the most likely to report acts of discrimination and to experience stress and poor mental or physical health as a result.[5]

Discrimination is complex, rooted in historical racist and sexist social policy, and compounds the disproportionate burden of poor health outcomes that marginalized groups experience directly and indirectly. Therefore, efforts to

ARRESTS FOR MARIJUANA POSSESSION DISPROPORTIONATELY AFFECT AFRICAN AMERICAN TEENAGERS

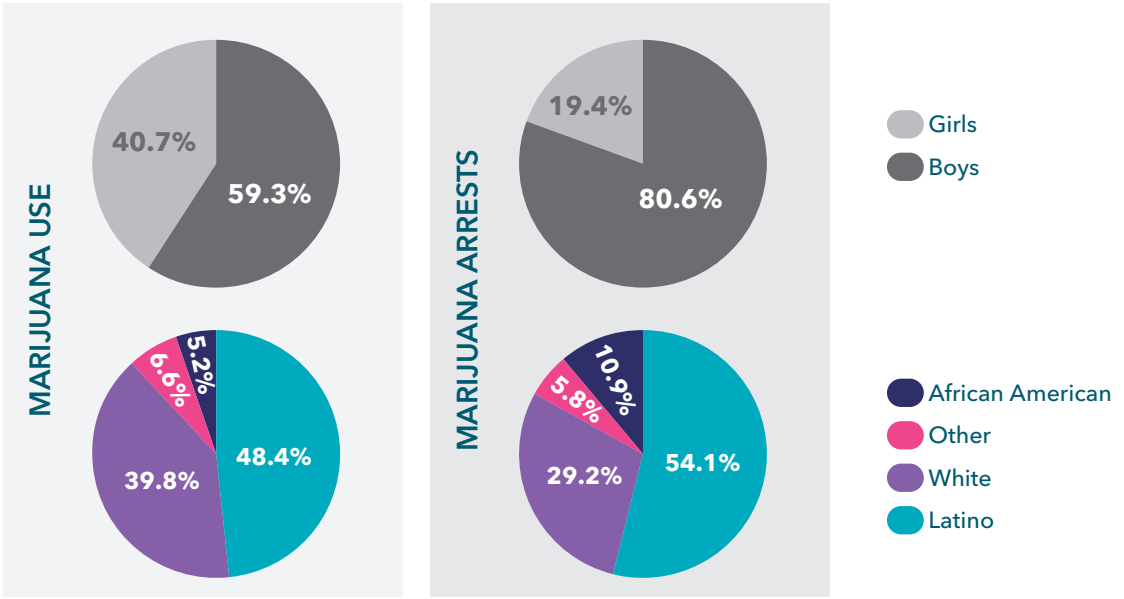


FIGURE 22: Percentage of marijuana use and misdemeanor arrests among teenagers ages 10 to 17, by race/ethnicity and gender, California, 2011-2012.

Sources: University of California Los Angeles, California Health Interview Survey, 2011-2012; and California Department of Justice, Criminal Justice Statistics Center, 2011-2012.
Note: Under California Health and Safety Code 11357b, possession of one ounce or less of marijuana for personal use is considered a misdemeanor.

Let Her Work Campaign Scores a Win

The Let Her Work campaign by Equal Rights Advocates (ERA), a statewide organization working for legal protection and policy change on behalf of the civil rights of women and girls, is focused on enabling the rising number of California's incarcerated women (most of whom are mothers) to resume their caregiving responsibilities following release. However, like men, these women face tremendous obstacles in seeking employment following their release. Many employers refuse outright to consider the application of a person with even a minor criminal record.

In partnership with the National Center for Lesbian Rights, ERA launched the Breaking Barriers: Let Her Work project to train women with criminal histories about their employment rights and promote policy changes to remove barriers to their employment. An early win for the campaign was the passage in 2013 of AB 218, which prohibits government agency employers from asking a potential new hire to disclose his or her previous criminal convictions on a preliminary employment application.

Learn more at http://www.equalrights.org/legislative-update-ban-the-box-and-let-her-work/.

Expanding Rights of Transgender Students

California became the first state in the nation in 2013 to pass groundbreaking legislation expanding antidiscrimination protections for transgender students in public elementary and secondary schools. Education Code Section 221.5 mandates that schools respect the gender identity of transgender students by allowing them equal access to the sports teams, programs, and facilities associated with their gender.

Learn more at http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201320140AB1266.

achieve health equity must also include efforts to identify and correct the discrimination that persists.

How Discrimination Gets Under Our Skin

Discrimination is not just something that we cognitively or emotionally feel. Discrimination gets under our skin and causes negative physiological changes in the body. Researchers are able to measure the body's stress response to discrimination by assessing changes in blood pressure,[6,7] stress hormone levels,[8] protein markers associated with heart disease,[9,10] and more. Over time, the resulting physiological and psychological effects of discrimination start to wear down

MORE THAN HALF OF ALL HATE CRIMES ARE MOTIVATED BY RACE/ETHNICITY, FOLLOWED BY THOSE MOTIVATED BY SEXUAL ORIENTATION AND BY RELIGION OF THE VICTIM

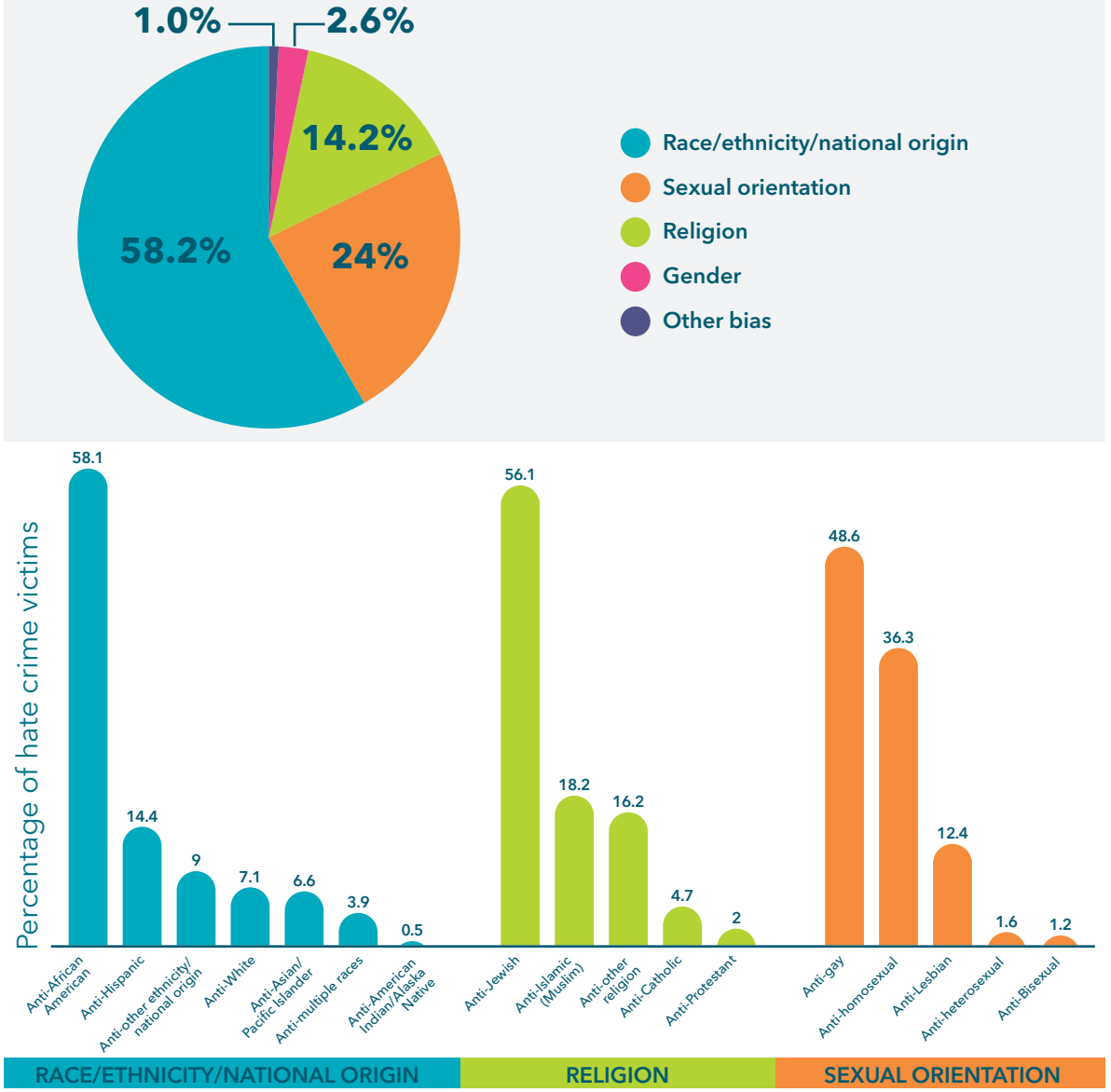


FIGURE 23: Percentage of hate crimes victims motivated by the victim's race/ethnicity/national origin, religion, and sexual orientation, California, 2012.

Source: California Department of Justice, Hate Crime in California Report, 2013.

the body. This wearing, or "weathering," effect from repeated exposure to discrimination contributes to a number of health disparities, such as the disproportionate prevalence of cardiovascular disease and low-weight births in African Americans compared with Whites.[11,13,14] Studies have shown that when comparing women with the same levels of income and education, job status, and health insurance status, African American mothers in the U.S. have lower-weight babies compared with their African-born and White counterparts, suggesting that genetic ancestry is not a strong determinant of birth weight.[12] Although this is a complex area of research, the lower-weight babies born to African American mothers can be explained in part by the stress caused by the mothers' lifelong experiences of discrimination.[13,14] This is particularly problematic because low birth weight is a strong indicator of long-term health consequences. Furthermore, according to the Institute of Medicine report *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, non-White patients tend to experience discrimination at the patient-provider level and to receive a quality of care inferior to that received by their White counterparts, even when controlling for access-related factors such as income and insurance status.[15] Given the impact of discrimination, it must be addressed as rigorously as the other social determinants of health.

The Indirect Health Effects of Discrimination

Beyond the direct health effects of discrimination, complex social and political sources of discrimination have serious health consequences. These discriminatory practices include pay inequality between women and men, bank redlining practices targeted toward lower-income individuals, disproportionate arrest rates for boys and men of color *(see Figure 22)*, and lack of job opportunities and protection for those with physical and mental disabilities, among many others. In limiting an individual's or a group of individuals' ability to make a fair and decent wage, buy a home, access high-quality education at all levels, and marry and support the person of their choice, society is directly or indirectly impacting their health and overall quality of life.

Hate Crimes Declining but Still Pervasive

One way of discussing different groups' experience of discrimination is the number of hate crimes inflicted on individuals that are motivated by the victim's race, ethnicity, or other personal characteristics *(see Figure 23)*. In California, the number of victims who experience hate crimes overall has decreased 42.4 percent in recent years, from 1,815 in 2003 to 1,045 in 2013.[16,17] In 2013, hate crimes involving race, ethnicity, or national origin were the most frequent in absolute (but not population-adjusted) terms, accounting for 609 victims (mostly anti-Black, 354 victims). Sexual orientation bias accounted for 251 victims (mostly for anti-gay bias, 122 victims), and religious bias accounted for 148 victims (mostly anti-Jewish bias, 83 victims).[17]

Neighborhood Safety and Collective Efficacy

Across the country, when you ask people what they want their neighborhood to look like, the answers are fairly consistent. People want neighbors who care enough about the neighborhood to work together to create and maintain a healthy and safe environment, with convenient access to cultural and economic opportunities, and where their children can play, learn, and thrive in an atmosphere of trust and security.[1] In other words, they want neighborhoods that ensure access to basic goods, that are socially cohesive, that are designed to promote good physical and psychological well-being, and that are protective of the natural environment. Such characteristics are essential to community mental and physical health and health equity.[2]

Trust as a Foundation for Health

An analysis of the literature on neighborhood-level social determinants of health shows that, among other factors, the collective health of neighborhoods is highly subject to the social relationships among residents, including the degree of mutual trust and feelings of connectedness among neighbors. For instance, residents of close-knit neighborhoods work together to create and maintain clean and safe playgrounds, parks, and schools. They exchange information on childcare, employment, and health access, and they cooperate to discourage crime and other negative behaviors, such as domestic violence, child abuse, substance abuse, and gang involvement, which can directly or indirectly influence health. Conversely, less close-knit neighborhoods and greater degrees of social disorder have been related to anxiety and depression.[3]

Unfortunately, California has many low-income neighborhoods, both rural and urban, where the opportunities or traditions for engagement in community service are lacking. While opportunities for social engagement benefit people across the socioeconomic spectrum, lower-income adults in California are less likely to have participated in a board, council, or organization or to have worked informally to address a community problem, when compared with higher-income California adults *(see Figure 24)*.

Unsafe Neighborhoods Produce Sick Children

Low levels of neighborhood trust and cohesion may also be related to higher rates of criminal activity in disadvantaged neighborhoods. A 2010 study from the U.S. Department of Justice found a high correlation between low household income levels and rates of property crime, such as burglary.[5] A similar relationship holds true for violent crime, as seen in Figure 25, where low-income, disadvantaged neighborhoods in the Bay Area and in South

Partying for Safe Neighborhoods

When neighbors are organized, their neighborhoods are safer. That's the concept of National Night Out (NNO). In 2013, Oakland residents hosted 670 block parties on August 6 – one of the largest NNO events in the country. When the event started about nine years ago, Oakland had only 35 parties. Each year, Oakland's mayor's office seeks to grow the number of neighborhood events and to encourage residents to take the next step and become a neighborhood watch group. The first step is simply for neighbors to get to know one another.

Central Los Angeles have the highest crime rates. The combination of high crime rates and other social factors associated with low-income neighborhoods creates barriers to healthful behaviors, such as walking and playground use; puts children at risk for poor educational, emotional, and health outcomes; and makes children more likely to become victims or perpetrators of violent crime.[5,6] Community-level crime interventions, such as well-lit, secure playgrounds; neighborhood watch organizations; and development of well-resourced teen centers to reduce neighborhood gang activity, are important components in many community-based neighborhood improvement initiatives.[7]

LOWER-INCOME ADULTS ARE LESS LIKELY TO ENGAGE IN VOLUNTEER WORK OR GET TOGETHER WITH OTHERS TO DEAL WITH COMMUNITY PROBLEMS

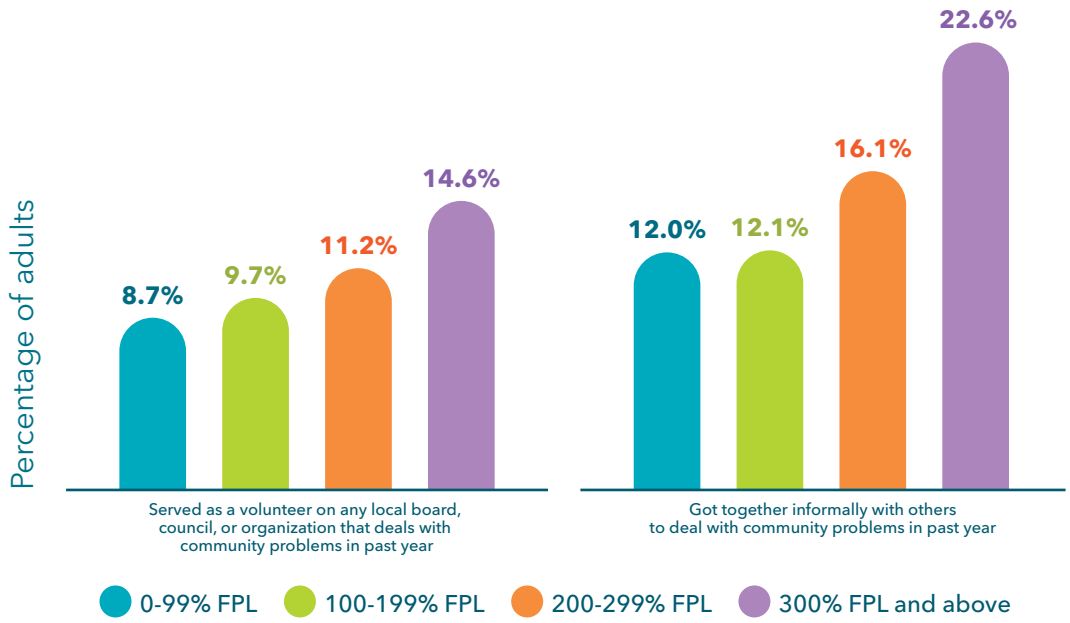


FIGURE 24: Percentage of adults who participated in community service, by federal poverty level (FPL), California, 2011-2012.

Source: University of California Los Angeles, California Health Interview Survey, 2011-2012.

Operation Ceasefire/Safe Community Partnership

Operation Ceasefire is an evidence-based strategy designed to reduce gang- and group-related homicides and nonfatal shootings. Localized versions of the Operation Ceasefire model of neighborhood gang and gun violence suppression are making headlines in 10 California cities that have seen rising rates of gun violence in recent years. In Stockton, the initiative, which operates under the name Safe Community Partnership, has been credited with helping reduce the number of homicides from 71 in 2012 to 32 in 2013. In Richmond, the city's homicide rate in 2013 was the lowest in 33 years and total crimes were more than 40 percent lower than the 2003 total. Other cities that have implemented the model in select neighborhoods include Los Angeles, Modesto, Oakland, Salinas, Oxnard, Union City, East Palo Alto, and Sacramento.

Learn more at http://www.nnscommunities.org/index.php.

THE RISK OF CRIME CAN BE HIGHLY DISPARATE FOR NEIGHBORING CALIFORNIA CITIES AND TOWNS

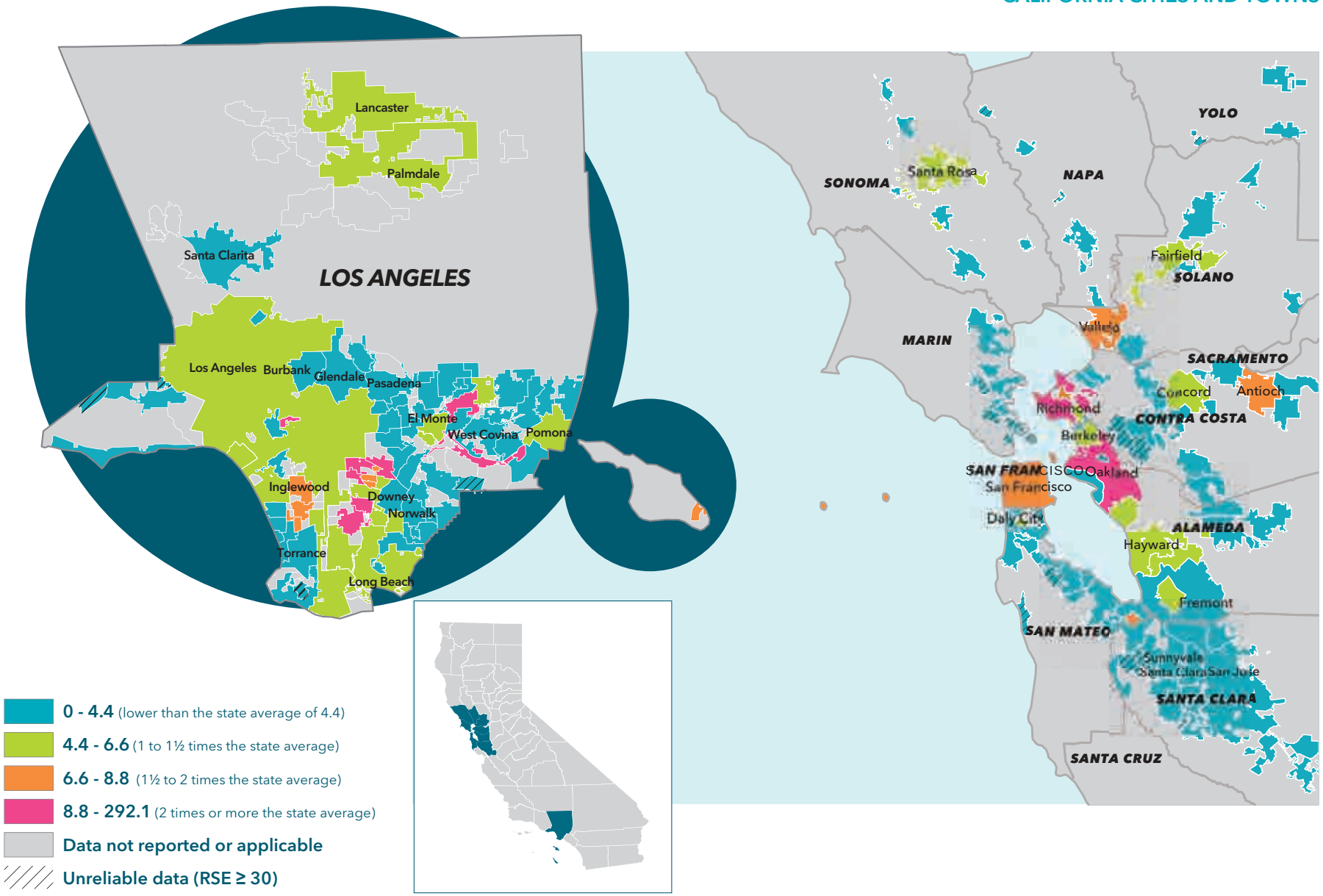


FIGURE 25: Number of violent crimes per 1,000 population, by cities and towns, Los Angeles County and Bay Area, California, 2010.

Source: Federal Bureau of Investigation, Uniform Crime Reports, 2010. Analysis by CDPH-Office of Health Equity and UCSF, Healthy Communities Data and Indicators Project.

Cultural and Linguistic Competence: **Why It Matters**

The ability of health and mental health care providers to effectively communicate with service recipients and to understand and respond to their cultural beliefs and values regarding health, illness, and wellness is essential for providing high-quality care to every person and for reducing health disparities among all social groups.[1,2,3]

California's vast and growing population diversity represents a special challenge for the state's primary and behavioral health care providers and organizations. The state is home to more than 200 languages, with more than 40 percent of the population speaking languages other than English at home, and 20 percent, or almost 7 million Californians, considered limited English proficient (LEP) – meaning they do not speak English "very well."[4,5]

The state's physician workforce in 2012 was disproportionately White and Asian.

AFRICAN AMERICAN AND LATINO PHYSICIANS ARE UNDERREPRESENTED IN CALIFORNIA

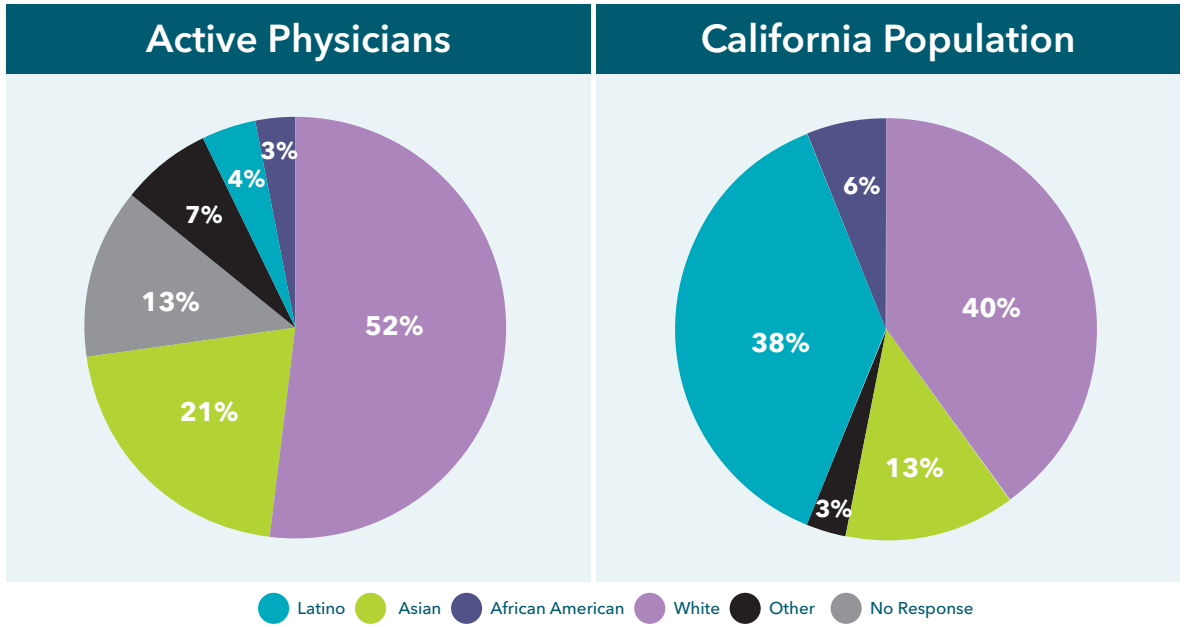


FIGURE 26: Percentage of California's population and active physicians, by race/ethnicity, California, 2012.

Sources: Medical Board of California, Cultural Background Survey Statistics, 2012; and U.S. Census Bureau, Population Division, Annual Estimates of the Resident Population by Sex, Age, Race, and Hispanic Origin for the United States: 2010-2012. Analysis by California HealthCare Foundation, California Health Care Almanac, California Physicians: Surplus or Scarcity, 2014.
Note: Data includes active medical doctors (MDs).

ALTHOUGH MEDICAL SCHOOL GRADUATES OF BOTH GENDERS WERE ABOUT EVEN, WOMEN ARE UNDERREPRESENTED IN MEDICAL PRACTICE

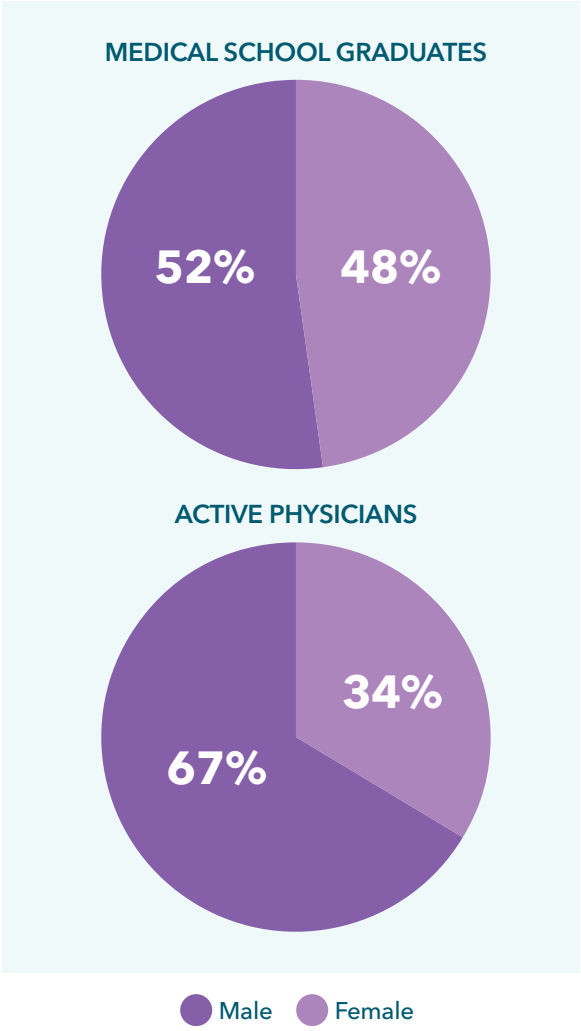


FIGURE 27: Percentage of California's medical school graduates and active physicians, by gender, California, 2012.

Source: Association of American Medical College, State Physician Workforce Data Book, 2013. Analysis by California HealthCare Foundation, California Health Care Almanac, California Physicians: Surplus or Scarcity, 2014.
Note: Data includes active medical doctors (MDs) and doctors of osteopathic medicine (DOs).

While White and Asian people made up 53 percent of the population in California, they accounted for 73 percent of the active physicians *(see Figure 26)*; women are also underrepresented *(see Figure 27)*. While Latinos constituted 38 percent of the population (and close to 50 percent in many regions), Latino physicians made up only 4 percent of the physician workforce, including those in Los Angeles and the San Joaquin Valley, where Latinos are a near majority. African Americans, who make up about 6 percent of the state's population, account for just 3 percent of physicians. It is estimated that roughly nine out of 10 physicians, dentists, and pharmacists in California are either White or Asian.[6]

Impacts on Quality of Care

Although as many as 20 percent of the state's non-Hispanic White physicians are relatively fluent in Spanish,[7] significant cultural and linguistic barriers remain for many patients,

ADULTS WITH LIMITED ENGLISH PROFICIENCY (LEP) GENERALLY HAVE POORER HEALTH COMPARED WITH THOSE WHO SPEAK FLUENT ENGLISH

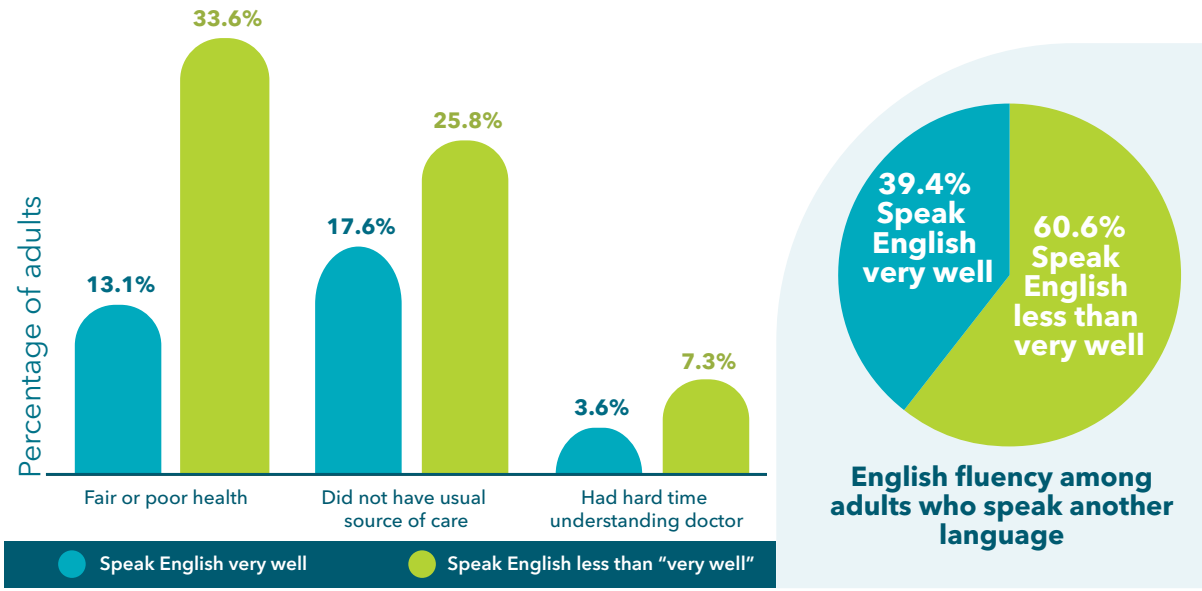


FIGURE 28: Percentage of English fluency levels among adults ages 18 years and older who speak a language other than English at home, by selected characteristics, California, 2011-2012.

Source: University of California Los Angeles, California Health Interview Survey, 2011-2012.
Note: Adults who reported speaking English less than "very well" includes those who reported speaking English well, not well, or not at all.

and these barriers are associated with multiple forms of reduced quality of care and decreased access to primary and preventive care.[8,9,10] The Institute of Medicine report *Unequal Treatment* indicates that U.S. racial and ethnic minorities are less likely to receive routine medical procedures and more likely to experience a lower quality of health services.[11] Racial/ethnic minorities and individuals with low household incomes are more likely than their non-Hispanic White and higher-income counterparts to experience culturally insensitive health care and dissatisfaction with health care – health care experiences that have been linked to poorer health outcomes.[12]

The persistent racial, cultural, and linguistic gaps in the health care workforce are reflected in significant health disparities between population groups with limited English proficiency and those that speak English very well *(see Figure 28)*. In order to achieve cultural and linguistic competency in California's public and private health care institutions, we must look beyond the issue of language alone and grapple with a larger challenge – that of developing a primary and behavioral health care workforce capable of providing services that are responsive to the health beliefs, health practices, and cultural and linguistic needs of California's diverse population.

Priming the Medical School Pipeline

The University of California, Riverside, School of Medicine obtained $3 million in private grant funding in 2013 to expand its existing medical school pipeline programs, aimed at broadening and diversifying the pool of students in inland Southern California applying to medical school. The program, Imagining Your Future in Medicine, will link students as young as the middle school level with pipeline initiatives at the high school, community college, and university levels. For middle school students it includes a one-week residential summer camp called Medical Leaders of Tomorrow, in which 40 to 50 educationally and socioeconomically disadvantaged students in the Inland Empire have access to presentations on science and health care topics; study skills, workshops, and training; leadership and team-building activities; laboratory and clinic tours; and college admissions information. Once students enter the pipeline, they are provided a continuous path for academic preparation and enrichment, hopefully leading to entry into medical training, particularly in primary care and short-supply specialties.

Source: UC Riverside Today, April 3, 2013.

Sharing Trained Health Care Interpreters

The Health Care Interpreter Network (HCIN), funded in 2005, by California HealthCare Foundation and others, is a national network of more than 40 hospitals and provider organizations that share more than 100 trained health care interpreters in 16 languages through an automated video/voice call center. Videoconferencing devices and all forms of telephones throughout each hospital and clinic connect within seconds to an interpreter on the HCIN system, either at their own hospital and clinic or at another participating hospital and clinic.

In California HCIN membership is offered to:

- Public, district, or University of California hospitals
- Community hospitals that are not members of hospital systems larger than three distinct acute care facilities
- Community clinics that serve the Medi-Cal population
- Health plans that serve the Medi-Cal population

Learn more at http://www.hcin.org/.

Mental Health Services: **'No Health Without Mental Health'**

The World Health Organization (WHO) defines mental health as "a state of well-being in which the individual realizes his or her own abilities, can cope with normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community." WHO adds, "Mental health is an integral part of health; indeed, there is no health without mental health,"[1] since physical health impacts mental health and vice versa.

Mental disorders, characterized by alterations in thinking, mood, and/or behaviors that are associated with distress and/or impaired functioning, contribute to a host of physical and emotional problems, including disability, pain, or death. In fact, mental health disorders are the leading cause of disability in the United States, accounting for 25 percent of all years of life lost to disability and premature mortality.[2] In California, suicide, which is a direct outcome of mental distress, is the third leading cause of death among individuals ages 15 to 34.[3]

Unequal Burdens

The prevalence of mental illness and problems of availability, affordability, and access to mental health treatment and preventive services are areas of striking disparities on the basis of race, ethnicity, gender, income, age, and sexual preference. Various racial, ethnic, and other minority groups and low-income individuals of all races experience higher rates of mental illness than do Whites and more affluent individuals. Further compounding the problem, these individuals are less likely to access mental health care services, and when they do, these services are more likely to be of poor quality.[4] In California, almost one in six adults has a mental health need, and about one in 20 (and one in 13 children) suffers from a serious mental illness (SMI), according to a recent study by California HealthCare Foundation.[5] The study found that nearly half of adults and two-thirds of adolescents with mental health needs did not get recommended treatment. Other findings included significant racial and ethnic disparities for incidence of SMI, with Native Americans, multiracial individuals, African Americans, and Latinos all experiencing rates above the state average.

A notable exception to the link between race/ethnicity and mental illness is the suicide rate, which is highest among White men.[5] This is an area that could benefit from additional understanding, as White men do not report having seriously thought about committing suicide any more than their multiracial and American Indian and Alaska Native counterparts do (the data on

RATES OF SUICIDAL THOUGHTS ARE HIGHER AMONG BISEXUAL, GAY, AND LESBIAN ADULTS

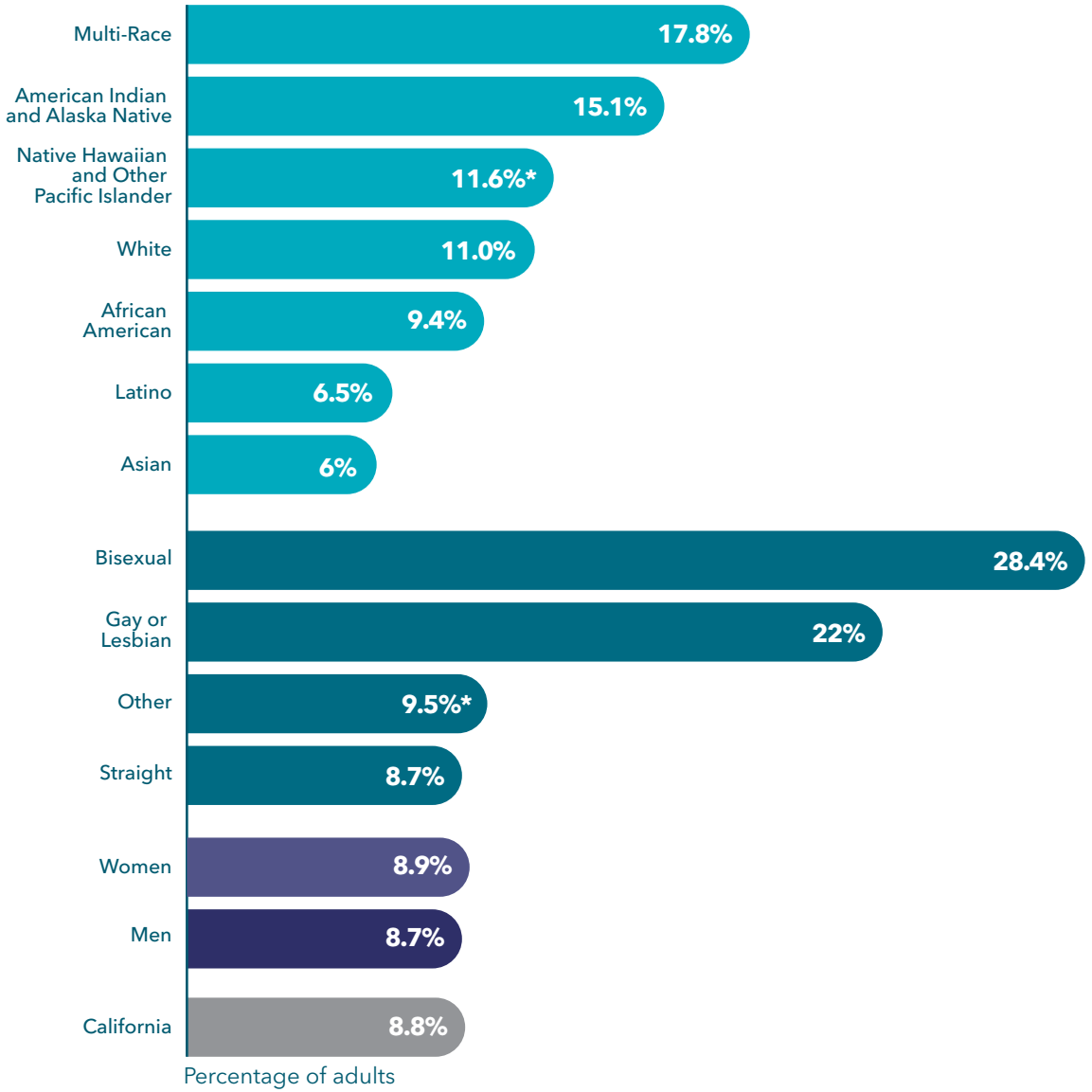


FIGURE 29: Percentage of adults who reported having seriously thought about committing suicide, by race/ethnicity and sexual orientation, California, 2011-2012.

Source: University of California Los Angeles, California Health Interview Survey, 2011-2012.
Note: "Other" includes not sexual/celibate/none.
**Statistically unreliable data*

Integrating Mental and Physical Health in New Minority Physicians

The Combined Internal Medicine/ Psychiatry Residency Training (IMP) Program at UC Davis Health System combines psychiatry with either family practice or internal medicine training, as well as board certification. The program, launched in 2007, is a response to the growing need to address mental and physical health needs in primary care settings, where most low-income minorities, especially Mexican Americans, first seek help for emotional problems. Most of the program's physicians-in-training come from underrepresented or culturally diverse backgrounds and plan to work in underserved settings and be future residency directors, policy makers, and thought leaders. Research shows that underrepresented minority physicians are more likely to work in health workforce shortage areas and to care for medically underserved populations, patients of their own ethnic group, and Medicaid recipients.

Source: The Physician Workforce: Projections and Research into Current Issues Affecting Supply and Demand. U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions, 2008.

Native Hawaiians and other Pacific Islanders is statistically unreliable). When the data is examined by sexual orientation, rates of suicidal thoughts are highest among Bisexual individuals, followed by those who identify as Gay or Lesbian *(see Figure 29)*.

Barriers to Care

Affordability of care and low rates of health insurance among vulnerable populations have been major barriers to care for certain underserved populations *(see Figure 30)*. African American, Latino, and Asian American teens who need help for emotional or mental problems are less likely to receive counseling than are White teens. About two-thirds of White teens who need counseling access it, compared with about half of African American, Latino, and Asian teens.[6] Studies show that rates of serious mental illness are more than four times as high among the lowest-income adults in California (less than 100 percent of the federal poverty level) than among those earning at least 300 percent of the poverty rate. Among children age 17 and under, serious emotional disturbance is more closely associated with family income than with race or ethnicity.[5]

Another key barrier to equity in mental health prevention and treatment is the wide cultural and linguistic gulf between underserved populations and health care and behavioral health professionals. For example, a recent University of California, Davis, study found that up to 75 percent of Latinos who seek mental health services opt not to return for a second appointment, due largely to cultural, social, and language barriers.[7] Although mental health services must be provided in native languages of major immigrant groups, the study found Spanish-speaking professionals few and far between within Latino communities.

On the positive side, changes in state and federal legislation on mental health, including mental health parity laws and the Affordable Care Act, are expected to increase access to mental health prevention and treatment for underinsured and uninsured Californians with mental health needs. In addition, funding for California's public mental health system is getting a boost from the expansion of Medi-Cal and increased revenue stemming from passage of the Mental Health Services Act in 2004 and the Mental Health Wellness Act of 2013.[7]

ACCESS TO HEALTH INSURANCE OR A USUAL SOURCE OF CARE IS LOWER AMONG MINORITY INDIVIDUALS WITH SERIOUS PSYCHOLOGICAL DISTRESS

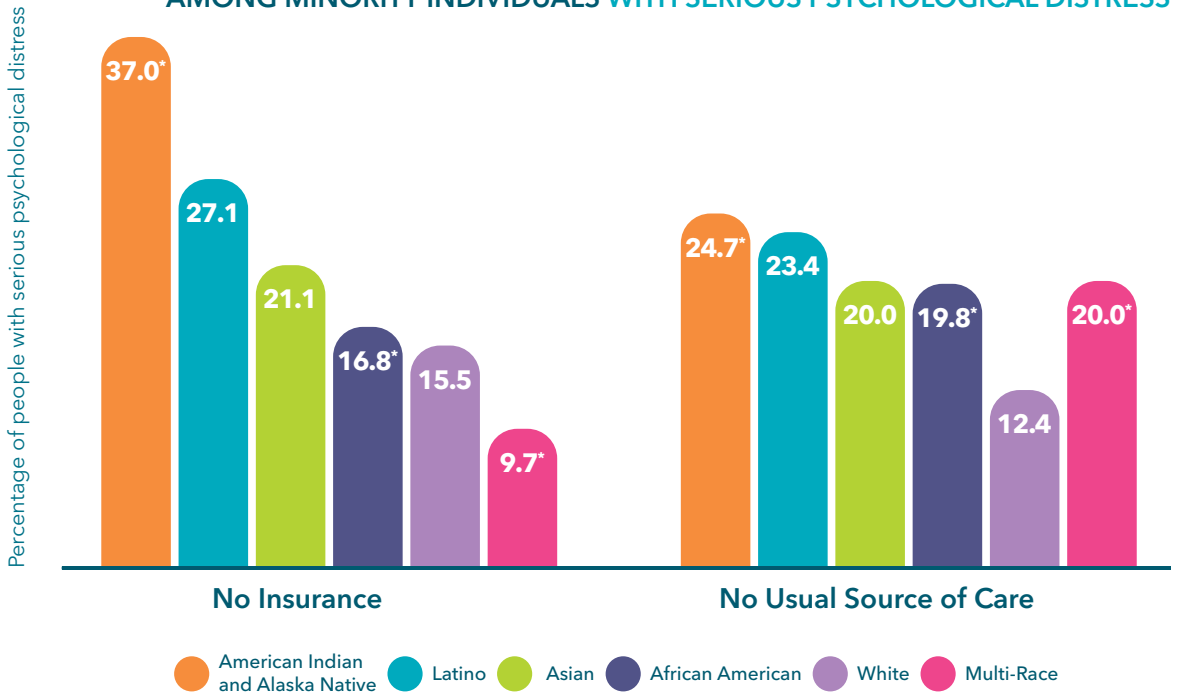


FIGURE 30: Percentage of people with serious psychological distress who reported not having health insurance or the usual source of care, by race/ethnicity, California, 2011-2012.

Source: University of California Los Angeles, California Health Interview Survey, 2011-2012.
Note: "Other" includes not sexual/celibate/none.
** Statistically unreliable data.*

THE CALIFORNIA STATEWIDE PLAN TO PROMOTE HEALTH AND MENTAL HEALTH EQUITY

VISION

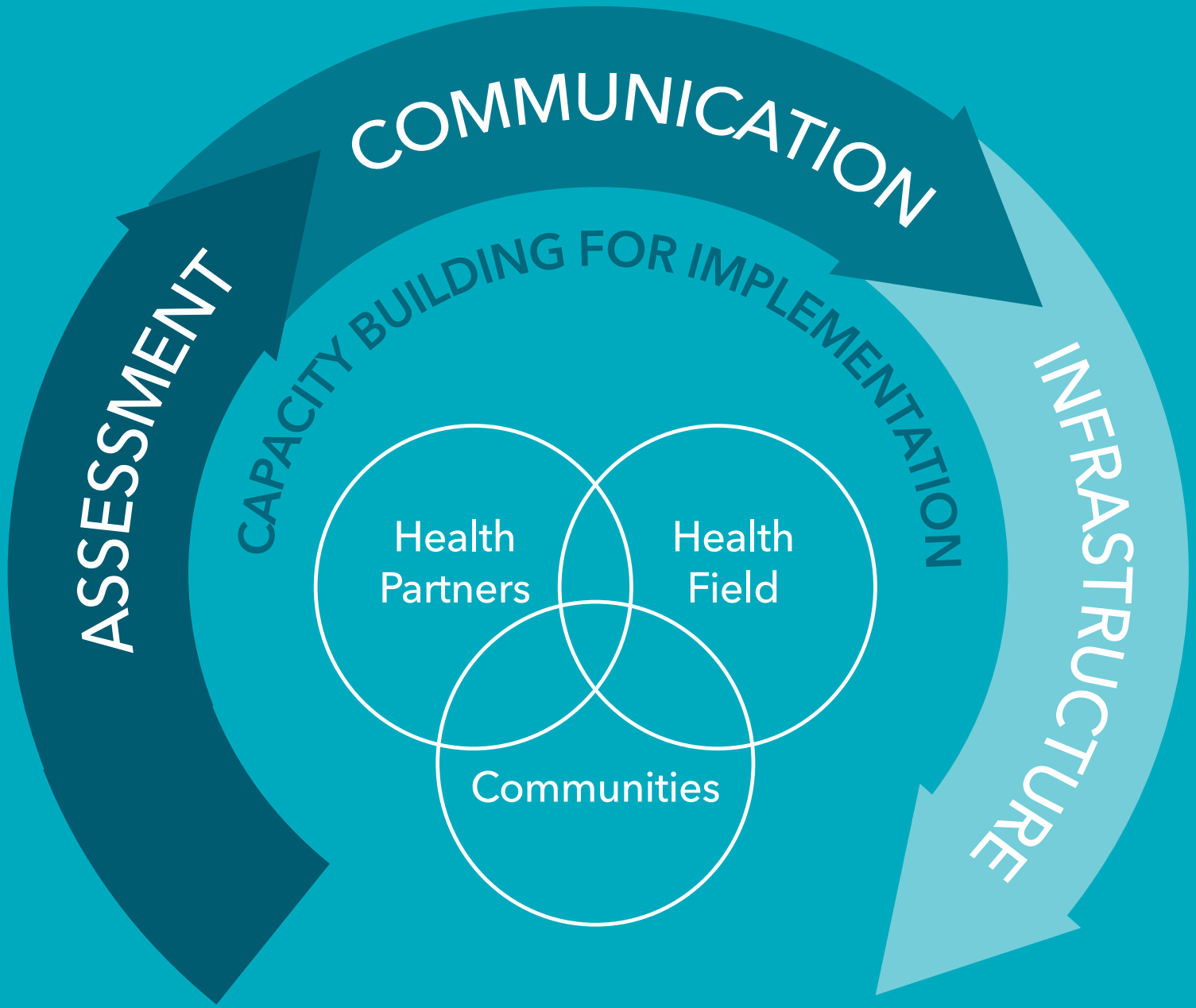
Everyone in California has equal opportunities for optimal health, mental health, and well-being.

MISSION

Promote equitable social, economic, and environmental conditions to achieve optimal health, mental health, and well-being for all.

CENTRAL CHALLENGE

Mobilize understanding and sustained commitment to eliminate health inequity and improve the health, mental health, and well-being of all.



Eliminate Health and Mental Health Inequities

PREFACE

We are grateful for the work of hundreds of stakeholders, as well as staff at other state departments, who have participated in the process of launching the first-ever Statewide Plan to Promote Health and Mental Health Equity. To move the Plan from a strategic conversation to a tactical one, we have embedded a set of goals to guide and support our implementation efforts.

Capacity Building for Implementation of the Strategic Priorities

As the facilitator of the planning and implementation processes, the Office of Health Equity (OHE) intends to build capacity for movement on its strategic priorities. First and foremost, we will be building mechanisms for ongoing public engagement and accountability. This will enable meaningful participation of stakeholders to engage in how the goals are prioritized, who will be involved in their implementation, and other important considerations that need to be made along the way. Mechanisms will likely include the use of both technology and personal interaction and will be designed for maximum participation and transparency.

The staff members at the OHE have had the honor and privilege of leading this planning process and will have the responsibility of maintaining accountability for its implementation. However, it should be acknowledged that the process has been highly inclusive and the content of the Plan is reflective of the hard work of the OHE Advisory Committee and hundreds of other stakeholders. This Plan belongs to all who participated in its creation and who will participate in and/or benefit from its implementation. Ultimately the OHE is the author and keeper of the Plan. As such, please note that the terminology "we" and "our" used in this Plan comes from the vantage point of the OHE, in consideration of the many contributions that have been offered in the Plan's development.

Strategic Priorities

Assessment, Communication, and Infrastructure

Health and mental health inequities have surfaced through a culmination of unjust policies and practices over multiple generations. As such, there is no one-to-one relationship in eliminating the inequities; it is a many-to-many relationship. The individuals who have been involved in developing this Plan have identified many intersecting, complementary interventions to turn the tide on the many inequities that are well documented in the accompanying report.

These interventions have as their basis; assessment, communication, and infrastructure development for California overall, as well as within the health field, among potential health partners, and within local communities. The next sections will detail our rationale for prioritizing these three intervention targets, but first we would like to describe the interventions themselves.

Assessment will yield knowledge of the problems and the possibilities. **Communication** will foster shared understanding. **Infrastructure** development will empower residents and their institutions to act effectively. This approach speaks to our intention to identify and disseminate actionable information on inequities and

disparities to develop and align sustainable multisectoral infrastructure and support.

There is growing interest in health and mental health equity, yet many do not know what this terminology means, how it impacts them and others, or why they should be involved in this work. We see an opportunity to build and strengthen the existing network of individuals, organizations, and institutions committed to promoting health and mental health equity—work that is also strongly linked to addressing the social determinants of health. Working to address the social determinants of health includes working to broadly improve the economic, service, and built environments in which people live, work, learn, and play. To expand this network, we must understand who is already engaged in this work and reach out to those who have a potential interest in engaging in it. In order to be both motivated and successful in reducing the inequities caused by the social determinants of health, partners need access to one another, models that work, and data that is relevant and user friendly. They also need as much support as they can get in building their capacity to effectively implement and sustain their interconnected, mutually advancing infrastructures.

Assessment

Readily available assessment data, including what interventions work under what circumstances, is vital to the implementation of this plan. Research and case studies on evidence-based, evidence-informed, and community-based practices for reducing health and mental health disparities and inequities, as well as issue briefs, should be used to guide our efforts. Data that allows us to see disparities at the level of social determinants of health, and that is disaggregated in ways that make our often-invisible communities visible, has been hard to obtain but is vitally important. Failing to account for a community in data means missing the opportunity to understand and address that community's unique challenges, needs, and assets. Although there are a number of major surveys conducted to help us understand our health challenges, such as the American Community Survey and the California Health Interview Survey, not all groups are covered by these surveys. There are particular data challenges for small communities and overlooked groups (e.g., LGBTQQ, people with disabilities, multiracial individuals), and our aim is to increase the availability of this disaggregated data.

In addition to collecting meaningful data, it is important to deliver data in a way that is accessible and understandable to multiple audiences, including various communities, policy makers, and health industry partners. Both qualitative and quantitative data are valuable, and we intend to capture and present both in order to best tell the story of the disparities and inequities that exist and how we are addressing them.

The Healthy Places Team in the Office of Health Equity will continue to build the Healthy Communities Data and Indicators Project (HCI). The goal of the HCI is to enhance public health by providing data, a standardized set of statistical measures, and tools that a broad array of sectors can use for planning healthy communities and by evaluating the impact of plans, projects, policies, and environmental changes on community health. With funding from the Strategic Growth Council (SGC), the HCI was initiated as a two-year collaboration of the California Department of Public Health (CDPH) and the University of California, San Francisco (UCSF), to pilot the creation and dissemination of indicators linked to the Healthy Communities Framework ("Framework"). The Framework was developed by the California Health in All Policies Task Force, with extensive public discussion and input from community stakeholders and public health organizations. The Framework identifies 20 key attributes of a healthy community (of 60 total), clustered in five broad categories: 1) basic needs of all (housing, transportation, nutrition, health care, livable communities, physical activity); 2) environmental quality and sustainability; 3) adequate levels of economic and social development; 4) health and social equity; and 5) social relationships that are supportive and respectful. Indicators are associated with each attribute, and the goal is to present the

data for each indicator for local assessment and planning down to the census tract or zip code wherever possible. CDPH will continue the work beyond the two-year collaboration as existing resources allow.

Communication

Health and mental health equity are new concepts for many – communicating what they are and what they are not to multiple sectors and fields will have major implications moving forward. The same will be true for communicating about the Office of Health Equity and the California Statewide Plan to Promote Health and Mental Health Equity. There has already been much discussion about how to communicate the strategies and for whom the Plan is intended. Ultimately a goal was added to create a comprehensive marketing and communications plan, which will address the many questions that have surfaced and inspired rich dialogue.

Communication plays a meaningful role overall and is particularly important in each of the three intervention targets – health partners, health field, and communities. While these goals are intended to stand alone, the proposed website and issue briefs will be important components of the marketing and communications plan. They will be successful when they reach their target audience with timely, accurate, actionable information. Actions may include utilizing data for decision making, replicating a promising practice, or joining others to move a particular issue forward.

So that these efforts are not taking place in isolation, we will seek to coordinate and convene those involved. We will capitalize on technology and on face-to-face interaction, utilizing the communication avenues that have already been established, such as summits and forums, and building new ones as necessary. California is a vast state, and we want everyone to be included in these efforts, so special attention will be paid to reaching the corners of the state and the individuals and communities that have historically been challenged to participate in statewide dialogue and action.

Infrastructure

We envision a robust, statewide community of people engaged in conducting their work and advocating for their needs through a health and mental health equity lens. Our vision is to have a workforce with the capacity to effectively dismantle health and mental health inequities. This will require education, training, guidance, support, and accountability at multiple levels throughout multiple sectors. It will also require strong partnerships to leverage the resources, tools, and incentives to facilitate such workforce development. We intend to bring together partners in the national, state, local, tribal, and private spheres to consider how we can capitalize on our expertise and resources to accomplish this common vision. We see opportunities for further embedding health and mental health equity outcomes into funding criteria and accompanying technical assistance.

We also see opportunities for California to benefit from the implementation efforts under way through the U.S. Department of Health and Human Services' Action Plan to Reduce Racial and Ethnic Health Disparities and other plans and entities that are addressing the needs of historically underserved communities. Many of these efforts have resources connected to the shared vision of workforce development; monitoring them and seeking a role for California and its communities will allow us to align with national and other efforts and to leverage resources when available.

Strategic Intervention Target: Health Partners

Embed Health and Mental Health Equity into Institutional Policies and Practices Across Fields with Potential Health Partners

In order to advance health and mental health equity, our work will extend beyond the traditional boundaries of public health and health care to address the other factors that contribute to overall health. These factors include educational attainment, income, housing, safe places, and clean environments. Fortunately, this work has begun with many willing partners, and many more will have the opportunity to engage. We will identify the equity practices currently being conducted across a spectrum of fields and work with both existing and new partners.

At the level of state government, exciting work is being done with the Health in All Policies (HiAP) Task Force created administratively in 2010 and accountable to the Strategic Growth Council. Pending available resources, the Office of Health Equity helps staff the HiAP Task Force in partnership with the Public Health Institute, with primary funding from The California Endowment. The HiAP Task Force is specifically identified in the statute that created the Office of Health Equity (California Health and Safety Code Section 131019.5), naming it as a partner in the creation of this statewide plan.

We will foster a HiAP approach to embed health equity criteria in decision making, grant programs, guidance documents, and strategic plans.

A key area for dialogue and action that will require the cooperation of interests across a spectrum of fields is climate change.[1] We anticipate that the most profound consequences of climate change will disproportionately impact the state's most vulnerable populations.[2] As such, we will engage in partnerships to enhance understanding of climate change and its impact on the health of Californians. There are opportunities through the Climate and Health Team in the Office of Health Equity to incorporate health equity into the state's Climate Action Team, share data and tools, and participate in cross-sector planning and consultation.

Strategic Intervention Target: Health Field

Embed Equity into Institutional Policies and Practices across the Health Field

Promoters of health and mental health equity abound throughout the health field, and they are among the first to identify the challenges in their own field. Equity policies and practices are not consistent, and learning still needs to take place around the social determinants of health and the National Culturally and Linguistically Appropriate Services (CLAS) Standards. We will take stock of the equity policies and practices in the field to determine how widespread they are, providing a basis for subsequent engagement.

California Health and Human Services (CHHS) oversees departments, boards, and offices that provide a wide range of health care services, social services, mental health services, alcohol and drug treatment services, public health services, income assistance, and services to people with disabilities. Initially, we will facilitate a common understanding of health and mental health equity and the social determinants of health between the departments, boards, and offices within CHHS and then extend that conversation to health, behavioral health, and social services departments

outside of the state system. Awareness may be raised through film or speaker series, online learning communities, in-person and online trainings, or other mechanisms. The OHE Climate and Health Team will be a natural resource to engage in this outreach.

There is also an opportunity to synchronize our efforts with the National CLAS Standards, which were enhanced in 2013 to move toward a health equity model inclusive of health and health care. We envision widespread assessment, technical assistance, and training to align California's practitioners with the National CLAS Standards. This attention to cultural and linguistic competence will strengthen the capacity of organizations, institutions, and systems to assess, plan, implement, evaluate, and communicate their efforts.

The health field is changing dramatically with the implementation of the Affordable Care Act (ACA), a historic health care reform law designed to improve health care coverage and access while putting in place new protections for people who already have health insurance. Under the law, health insurance coverage is becoming affordable and accessible for millions of California residents, a factor that will help reduce health disparities. The United States' foreign-born population is currently over 2.5 times more likely than native-born Americans to be uninsured. The ACA has expanded health care coverage to certain refugees and documented immigrants.[3] However, we anticipate that health coverage disparities will increase for California residents who are undocumented immigrants, and it is possible that the disparities will widen also for those residing in mixed-status households, who may fear triggering immigration investigations upon ACA enrollment. We intend to explore how to maximize coverage opportunities for California's residents while assisting those who will remain uninsured. There is great potential for partnering with health plans to pursue innovations in this area.

Strategic Intervention Target: Communities

Empower Communities in Inequity and Disparity Reduction Initiatives

Tremendous work in reducing formal and informal inequities and disparities is being conducted throughout the state, in organizations and communities large and small, rural and urban. We will gain a better understanding of this work so that it can be networked, spotlighted, elevated, and replicated. Communities that have identified effective ways to reduce inequities and disparities have much to share, and the entire state has much to learn from their successes—including how they are resourced, how they are building local capacity for sustainability, and how they are measuring their success. Our vision is to integrate these lessons statewide and to identify the partnerships and available resources that will allow that to happen.

One exciting possibility is the launch of local initiatives to increase health and mental health equity in all policies. These initiatives could build upon local, state, and national efforts to ensure that their local policies consider equity and the social determinants of health. This would be an opportunity to build alliances across local public health departments, county mental health or behavioral health departments, local social services, local mental health agencies, and other local agencies that address key health determinants, including but not limited to housing, transportation, planning, education, parks, and economic development. We have heard from stakeholders that these alliances have been difficult to forge because it is hard to make the case for common interests in a way that can be easily understood and appreciated. With this in mind, we intend to explore the feasibility of local initiatives inspired by HiAP approaches. Ideally, we will establish avenues for learning from the lessons of existing local efforts and enlist them in technical assistance for their colleagues statewide.

Such HiAP-inspired initiatives might draw from the experiences of place-based models established in other states. The Division of Community, Family Health, and Equity at the Rhode Island Department of Health has created a model for cross-program integration that includes pooled community investment grants in high-need communities called Health Equity Zones, each with a Center for Health Equity and Wellness. The model includes a statewide Healthy Places Learning Collaborative, with web-based resources, tools, and on-site technical assistance for communities; uniform contract language for all health contracts to communicate expectations for implementation of health equity work; a collaborative network of state/local stakeholders from multiple coalitions and interest groups doing cross-program, state-level strategic thinking; and an online relational mapping database of community assets and gaps to ensure that investments and partnerships result in the greatest reach and impact. We intend to further research Health Equity Zones and other place-based models to assess the feasibility of replicating them in high-need California communities.

To immediately mobilize resources to reduce health and mental health disparities, we will initially act through the California Reducing Disparities Project (CRDP) within the Office of Health Equity. CRDP Phase 2 provides $60 million dollars in Mental Health Services Act (MHSA) funding over five years to implement the practices and strategies identified in the CRDP Strategic Plan. Phase 2's focus is to demonstrate the effectiveness of community-defined practices in reducing mental health disparities. Through a multicomponent program, the California Department of Public Health plans to fund selected approaches across the five CRDP-targeted populations with strong evaluation, technical assistance, and infrastructure support components. These populations are African Americans; Asians and Pacific Islanders; Latinos; Lesbian, Gay, Bisexual, Transgender, Queer, and Questioning (LGBTQQ) individuals; and Native Americans. After successful completion of this multiyear investment in community-defined evidence, California will be in a position to better serve these communities and to provide the state and the nation a model to replicate the new strategies, approaches, and knowledge. As partnerships become available, we will further seek to mobilize resources at the community level.

Two priority areas that relate to the CRDP Strategic Plan and have been identified by a range of stakeholders throughout the state are 1) the possible extension of the California MHSA Multicultural Coalition beyond 2015 and its utilization as a major advisor to the Office of Health Equity regarding the CRDP, in addition to its other purposes; and 2) the possible creation of new Strategic Planning Workgroups (SPWs) in order to continue the critical work of identifying promising practices for underserved communities not covered by the original SPWs.

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Appendix A:
Goals to Support the Strategic Priorities

The following are the Plan's five-year strategic priorities:

Through **assessment**, yield knowledge of the problems and the possibilities.

Through **communication**, foster a shared understanding.

Through **infrastructure** development, empower residents and their institutions to act effectively.

Goals for each of the strategic priorities were crafted for California overall as well as within the health field, among potential health partners, and within local communities, for Stage 1 (2015-2018) and Stage 2 (2018-2020) of the Plan. As an inaugural effort, goals have also been created aimed at building capacity for implementation of the strategic priorities.

The goals for both Stage 1 and Stage 2 are presented in the first matrix of this appendix. These goals are aspirational and will include substantial cross-sector collaboration.

We will strategize how to best implement the goals over time. The preliminary activities and resources planned by the California Department of Public Health for the implementation of Stage 1 goals are presented in the second matrix of this appendix.

KEY TO GOAL CODING:

STRATEGIES

A = Assessment
C = Communication
I = Infrastructure
CB = Capacity Building

TARGET AUDIENCES

O = Overall
HP = Health Partners
HF = Health Field
C = Communities

1 AND 2 FOLLOWING THESE CODES:

Stage 1 (2015-2018)
Stage 2 (2018-2020)

Numbers after the dot distinguish the goals from one another.

Stage 1 and Stage 2 Goals by Strategy and Target Audience

ASSESSMENT

Overall

AO1&2.1 Monitor continuously each of the goals to ensure that the Plan is progressing appropriately, and present updates at the quarterly Office of Health Equity Advisory Committee (OHE-AC) meetings and post a corresponding report online

AO1&2.2 Collect and analyze data that highlights the social determinants of health, and encourage this data for planning purposes

AO1.3 Assess health and mental health equity data shortcomings, and explore the feasibility of creating new data and/or disaggregating existing data

AO2.3 Build on Stage 1 by creating new data and/or disaggregating existing data, as feasible

Health Partners

AHP1.1 Identify the health and mental health equity practices in fields with potential health partners.

Health Field

AHF1.1 Identify the health and mental health equity practices throughout state departments and state-funded programs in the health field

Communities

AC1.1 Identify how local communities are currently mobilizing to address the social determinants of health and how they are measuring their efforts toward progress

Stage 1 and Stage 2 Goals by Strategy and Target Audience

COMMUNICATION

Overall

CO1.1 Create a comprehensive marketing and communications plan for health and mental health equity, the Office of Health Equity, and the California Statewide Plan to Promote Health and Mental Health Equity

CO1.2 Build a network of communication and support for health and mental health equity work statewide, to include practitioners, community members, community-based organizations, consumers, family members/those with lived experience with mental health conditions, policy leaders, and other stakeholders

CO1&2.3 Develop, host, and regularly update an interactive, informative, and engaging state-of-the-art website with timely, accurate data; relevant research; and evidence-based and community-defined practices

CO1&2.4 Develop and disseminate issue briefs based on recommendations from the OHE-AC and other stakeholders

CO1&2.5 Provide leadership in sharing California's health and mental health equity efforts for adoption as appropriate throughout the state, nationally, and internationally

Health Partners

CHP1&2.1 Facilitate common understanding of health and mental health equity and the social determinants of health between potential health partner agencies and organizations

Health Field

CHF1.1 Facilitate common understanding of health and mental health equity and the social determinants of health between all departments that fall under California Health and Human Services (CHHS), while beginning this dialogue with key health-related state programs outside of CHHS

CHF1.2 Enhance understanding of and action on climate change as a critical public health issue that is likely to impact vulnerable populations in disparate ways

CHF2.1 Facilitate a common understanding of, and the ability to operationalize, health and mental health equity and the social determinants of health between all health, behavioral health, and social service departments inside and outside of the state system – and their grantees – through access to training, technical assistance, and leveraged funding relationships

Communities

CC1&2.1 Build broad-based community support on health and mental health equity issues through education and dialogue, heightening awareness of the social determinants of health

Stage 1 and Stage 2 Goals by Strategy and Target Audience

INFRASTRUCTURE

Overall

IO1&2.1 Partner on existing health and mental health equity summits for practitioners and policy makers

IO1&2.2 Catalyze workforce development opportunities aimed at increasing California's capacity to effectively address health and mental health inequities and disparities, starting with state employees and moving beyond the state system as resources and partnerships are secured

IO1&2.3 Recommend that health and mental health equity goals be considered during the allocation of existing funding streams

IO1&2.4 Closely monitor progress of the U.S. Department of Health and Human Services' Action Plan to Reduce Racial and Ethnic Health Disparities and of other health and mental health equity efforts that are addressing the needs of historically underserved communities, and seek opportunities to increase California's role and/or adopt successful models

IO1&2.5 Promote the use of a gender lens as appropriate when assessing health and mental health equity models to increase the likelihood of improving the often-distinct health needs of women and girls and of men and boys, particularly those of color and/or low income

IO2.6 Leverage the community support, relationships, and networks built in Stage 1 to coordinate impact on health and mental health equity issues statewide

Health Partners

IHP1&2.1 Use a Health in All Policies approach to embed health and equity criteria in decision-making, grant programs, guidance documents, and strategic plans

IHP1&2.2 Enhance understanding of climate change as a public health issue of increasing importance for the state's most vulnerable populations, and promote widespread efforts to reduce greenhouse gas emissions, achieve health co-benefits, and enhance climate resilience for vulnerable and disadvantaged communities

IHP2.3 Utilize results from the identification of health and mental health equity practices conducted in Stage 1 to make recommendations for addressing inequities and their social determinants in potential health partner practices

IHP2.4 Facilitate access to training and technical assistance for agencies and grantees of state programs on health and mental health equity, including incorporating health and mental health equity modules into current training provided by state and federal programs

Health Field

IHF1&2.1 Support the expansion of the National Culturally and Linguistically Appropriate Services (CLAS) Standards, including assessment, technical assistance, and training

IHF1.2 Explore health and mental health equity implications of the Affordable Care Act (ACA) as they relate to access, expanded coverage, and community-based prevention strategies

IHF2.2 Support health care institutions to partner with health allies (e.g., transportation and land use) to develop policies and programs that improve access to health, mental health, and health care services

IHF2.3 Utilize results from the exploration of health and mental health equity implications of the ACA conducted in Stage 1 to evaluate actionable next steps

Communities

IC1&2.1 Mobilize resources to reduce health and mental health inequities and disparities

IC1&2.2 Identify opportunities to build upon existing initiatives, implement new initiatives, replicate initiatives, and leverage local resources to increase health and mental health equity in all policies

IC1.3 Research Health Equity Zones and other place-based models to assess the feasibility of replicating or expanding such interventions at the neighborhood level in California

IC2.3 Increase the civic participation of the communities most impacted by health and mental health inequities and disparities

IC2.4 Incentivize, recognize, and publicize local efforts addressing health and mental health equity and the social determinants of health, both emerging and established

IC2.5 Connect local efforts with partners and resources to build health and mental health equity into strategic plans; train staff and volunteers; evaluate impact; and engage with funders, colleagues, and other communities

IC2.6 As feasible and appropriate, initiate or expand Health Equity Zones and/or other place-based models

Stage 1 and Stage 2 Implementation Goals

CB1&2.1. Build mechanisms for the OHE to establish ongoing public engagement and accountability on the strategic priorities, ensuring community participation in all goals at all levels of the Plan.

CB1&2.2. Strengthen the health and mental health equity workforce development pipeline by utilizing fellows and interns in the implementation of the strategic priorities, throughout the Plan's multiple partners.

CB1&2.3. Seek additional resources, including in-kind assistance, federal funding, and foundation support.

CB1&2.4. Develop and implement a process to foster public and private partnerships for all appropriate strategic priorities, including governmental, corporate, educational, research, and philanthropic institutions.

Stage 1 CDPH Preliminary Activities and Resources for Implementation

ASSESSMENT

Overall

AO1.1 Monitor continuously each of the goals to ensure that the Plan is progressing appropriately, and present updates at the quarterly Office of Health Equity Advisory Committee (OHE-AC) meetings and post a corresponding report online.

► The Supervisor for the OHE Health Research and Statistics Unit will provide leadership in further identifying the activities to support each of the goals for each of the target audiences in this strategy.

► OHE Health Research and Statistics Unit will prepare quarterly reports, and OHE's deputy director will present them at the OHE-AC meetings.

AO1.2 Collect and analyze data that highlights the social determinants of health, and encourage this data for planning purposes.

► The Healthy Places Team in the OHE will continue to build the Healthy Communities Data and Indicators Project by: a) completing all 60 indicators identified in the research and development phase by December 2016 as resources allow, b) developing supporting materials for each indicator by December 2016 as resources allow, and c) conducting training workshops to disseminate knowledge and skills about the indicators among stakeholders by December 2016 as resources allow.

► Per the OHE mandate and through the Interagency Agreement with the California Department of Health Care Services (DHCS), the OHE will continue meeting with DHCS in the established Data Workgroup to discuss opportunities to coordinate data capacity.

► The OHE Community Development and Engagement Unit (CDEU) will continue to update and collaborate with DHCS through its Mental Health Services Division to partner, collaborate, inform, and offer technical assistance. CDEU will continue ongoing cultural and linguistic sensitivity technical assistance to DHCS such as with the Cultural Competence Plan Requirements that collect data from all county mental health plans.

AO1.3 Assess health and mental health equity data shortcomings, and explore the feasibility of creating new data and/or disaggregating existing data.

► The OHE Health Research and Statistics Unit will work with other CDPH offices in a joint effort with California HealthCare Foundation's Free the Data project, which consists of a gateway for external data users to use one online portal for access to all our data at CDPH.

► The OHE Community Development and Engagement Unit will a) provide technical assistance (TA) on lessons learned and community recommendations relative to the data and disaggregation of the data (this information is documented in five target population-specific California Reducing Disparities Project [CRDP] Phase I Population Reports), b) provide TA on lessons learned and community recommendations relative to CRDP target population data evaluation efforts, and c) encourage CRDP contractors to share subject matter expertise on population-specific tools to collect culturally and linguistically appropriate data.

Health Partners

AHP1.1 Identify the health and mental health equity practices in fields with potential health partners.

Health Field

AHF1.1 Identify the health and mental health equity practices throughout state departments and state-funded programs in the health field.

Communities

AC1.1 Identify how local communities are currently mobilizing to address the social determinants of health and how they are measuring their efforts toward progress.

► Identification will be strengthened by data generated from the California Wellness Plan.

Stage 1 CDPH Preliminary Activities and Resources for Implementation

COMMUNICATION

Overall

CO1.1 Create a comprehensive marketing and communications plan for health and mental health equity, the Office of Health Equity, and the California Statewide Plan to Promote Health and Mental Health Equity

► A management-level position with expertise in both communications planning and execution will provide leadership in further identifying the activities to support each of the goals for each of the target audiences in this strategy.

CO1.2 Build a network of communication and support for health and mental health equity work statewide, to include practitioners, community members, community-based organizations, consumers, family members/those with lived experience with mental health conditions, policy leaders, and other stakeholders

► The OHE Community Development and Engagement Unit will continue California Reducing Disparities Project (CRDP) efforts, including the following: a) email regular communications through the OHE e-blast function to hundreds of stakeholders to keep them apprised of CRDP activities, b) post online and then update the CRDP contractor roster regularly, and c) encourage a continuous feedback loop from community stakeholders via meet-and-greets and an open-door policy (email/phone/at meetings in the community).

CO1.3 Develop, host, and regularly update an interactive, informative, and engaging state-of-the-art website with timely, accurate data; relevant research; and evidence-based and community-defined practices

► Subject to the availability of resources to fund such activities, the OHE Community Development and Engagement Unit will share critical outcome information associated with the following community-defined practices and evaluation efforts: a) host a CRDP webpage that is regularly updated; b) create a webpage posting of deliverable reports from the community participatory evaluation being conducted throughout Phase 2 activities; c) post online the categories of community-defined practices identified by the CRDP Population Reports; d) use a translation service contract to translate webpage information; and e) use a cultural competence consultant contract to incorporate recommendations made to the state by subject matter experts in cultural and linguistic competence, with the goal of improving culturally and linguistically appropriate mental health web information.

CO1.4 Develop and disseminate issue briefs based on recommendations from the OHE-AC and other stakeholders

► The OHE Community Development and Engagement Unit will support CRDP contractors in sharing issue briefs with their communities.

CO1.5 Provide leadership in sharing California's health and mental health equity efforts for adoption as appropriate throughout the state, nationally, and internationally

Health Partners

CHP1.1 Facilitate common understanding of health and mental health equity and the social determinants of health between potential health partner agencies and organizations

► The HiAP Task Force will a) hold quarterly meetings to engage nonhealth state agencies in developing collaborative approaches to promoting health, equity, and sustainability; and b) hold at least three collaborative learning sessions to provide leaders and staff at potential health partner state agencies with opportunities to explore the links between health and mental health equity and the social determinants of health.

Health Field

CHF1.1 Facilitate common understanding of health and mental health equity and the social determinants of health between all departments that fall under California Health and Human Services (CHHS), while beginning this dialogue with key health-related state programs outside of CHHS

CHF1.2 Enhance understanding of and action on climate change as a critical public health issue that is likely to impact vulnerable populations in disparate ways

► The OHE Climate and Health Team will a) work with local health departments, OHE-AC members, health equity and environmental justice advocates, and stakeholders in the public health and mental health arenas to build capacity to incorporate climate change issues into training and strategic planning;

b) offer online trainings, presentations, and resources to enhance awareness and understanding of climate change, with a focus on health equity; and

c) utilize the CAT Public Health Workgroup as an educational forum in which to raise climate and health equity issues, needs, and strategies with a variety of stakeholders.

Communities

CC1.1 Build broad-based community support on health and mental health equity issues through education and dialogue, heightening awareness of the social determinants of health

► The OHE Community Development and Engagement Unit will continue CRDP efforts to meaningfully engage diverse community stakeholders by a) meeting with local stakeholders around the state to hear concerns and feedback that will continue meaningful dialogue and build upon community engagement momentum, and b) collecting data pertaining to mental health equity outcomes, inequities, and community participatory evaluation processes.

INFRASTRUCTURE

Overall

IO1.1 Partner on existing health and mental health equity summits for practitioners and policy makers.

► The OHE Community Development and Engagement Unit will encourage CRDP contractors to participate in health and mental health equity summits to share population-specific, community-defined practices and recommendations relative to CRDP efforts.

IO1.2 Catalyze workforce development opportunities aimed at increasing California's capacity to effectively address health and mental health inequities and disparities, starting with state employees and moving beyond the state system as resources and partnerships are secured.

► CDPH has a Public Health Management Team that is committed to movement on this goal.

IO1.3 Recommend that health and mental health equity goals be considered during the allocation of existing funding streams.

► CDPH has a Public Health Management Team that is committed to movement on this goal.

IO1.4 Closely monitor progress of the U.S. Department of Health and Human Services' Action Plan to Reduce Racial and Ethnic Health Disparities and other health and mental health equity efforts that are addressing the needs of historically underserved communities, and seek opportunities to increase California's role and/or adopt successful models.

► OHE will monitor external health and mental health equity plans.

IO1.5 Promote the use of a gender lens as appropriate when assessing health and mental health equity models, to increase the likelihood of improving the often distinct health needs of women and girls and of men and boys, particularly those of color and/or low income.

► OHE will coordinate with gender experts and stakeholders to assist in the assessment of viable health and mental health equity models.

Health Partners

IHP1.1 Use a Health in All Policies approach to embed health and mental health equity criteria in decision-making, grant programs, guidance documents, and strategic plans.

► The HiAP Task Force will embed health equity as a key consideration in five decision-making processes, grant programs, state guidance documents, and/or strategic plans.

► The OHE Community Development and Engagement Unit will continue participation on the State Interagency Team Workgroup to Eliminate Disparities and Disproportionality (WGEDD), which has a special interest and a history in developing and implementing a racial impact tool to assist state agencies in making decisions that do not adversely impact vulnerable populations.

IHP1.2 Enhance understanding of climate change as a public health issue of increasing importance for the state's most vulnerable populations, and promote widespread efforts to reduce greenhouse gas emissions, achieve health co-benefits, and enhance climate resilience for vulnerable and disadvantaged communities.

► The OHE Climate and Health Team will a) incorporate health equity into the state's Climate Action Team and into specific climate mitigation and adaptation plans and policies; b) develop and share data and tools to identify climate risks, health impacts, and vulnerabilities in the state's diverse communities and populations for use in multi-sectoral planning efforts; and c) participate in cross-sector planning and consultation on climate mitigation and adaptation efforts that promote health equity and enhance the resilience of vulnerable and disadvantaged communities.

INFRASTRUCTURE

Health Field

IHF1.1 Support the expansion of the National Culturally and Linguistically Appropriate Services (CLAS) Standards, including assessment, technical assistance, and training

► The California Wellness Plan's second goal is "Optimal Health Systems Linked with Community Prevention." The OHE will work closely with the other CDPH offices implementing the objectives in Goal 2 that speak to CLAS. In particular, the OHE Community Development and Engagement Unit will continue to update and collaborate with DHCS to share in learning opportunities and provide technical assistance related to cultural and linguistic competence.

IHF1.2 Explore health and mental health equity implications of the Affordable Care Act (ACA) as they relate to access, expanded coverage, and community-based prevention strategies

► CDPH's partners on the California Wellness Plan are interested in focusing on a) building on strategic opportunities, current investments, and innovations in the Patient Protection and Affordable Care Act; and b) prevention and expanded managed care to create a systems approach to improving patient and community health. OHE and other CDPH offices will continue partnering with Covered California to ensure that the uninsured are moved into programs for which they are eligible.

Communities

IC1.1 Mobilize resources to reduce health and mental health inequities and disparities

► The OHE Community Development and Engagement Unit will oversee $60 million in resource allocation through the California Reducing Disparities Project over a four-year period.

IC1.2 Identify opportunities to build upon existing initiatives, implement new initiatives, replicate initiatives, and leverage local resources to increase health and mental health equity in all policies

► Through the implementation of CRDP Phase 2, community-based promising practices and strategies will be identified, implemented, and evaluated, utilizing a robust community-based participatory approach to demonstrate the effectiveness of community-defined practices in reducing mental health disparities. This will position community-defined practices for replication and additional resource acquisition.

IC1.3 Research Health Equity Zones and other place-based models to assess the feasibility of replicating or expanding such interventions at the neighborhood level in California

► The OHE Health Research and Statistics Unit will initiate research on Health Equity Zones and other place-based models.

Stage 1 CDPH Preliminary Activities and Resources for Implementation

All goals will be led by the OHE Deputy Director.

CB1&2.1. Build mechanisms for the OHE to establish ongoing public engagement and accountability on the strategic priorities, ensuring community participation in all goals at all levels of the Plan.

CB1&2.2. Strengthen the health and mental health equity workforce development pipeline by utilizing fellows and interns in the implementation of the strategic priorities, throughout the Plan's multiple partners.

Additional CDPH Activities and Resources: The California Epidemiologic Investigation Services (Cal-EIS) Fellowship and the Preventive Medicine Residency Program (PMRP) are two postgraduate programs that train epidemiologists and physicians. The Cal-EIS Fellowship's and the PMRP's mission is to build the public health workforce by training well-qualified candidates in preventive medicine and public health practice. Fellows and residents receive training that addresses health equity and social determinants of health, conducted through preventive medicine seminars. Focused discussions on these topics help build trainees' awareness of these issues and develop related competencies as they prepare for careers in public health. The training results in adding skilled epidemiologists and public health physicians to the state (and local) workforce (e.g., research scientists, public health medical officers, local health officers and administrators). If resources were identified for placement opportunities, Cal-EIS fellows and PMRP residents could be placed in local health departments or state programs and could train with a focus on health and mental health equity. During fellows' and residents' placement, major projects and activities could be developed that have a specific focus in this area, and fellows and residents could be utilized to help implement the strategic priorities.

CB1&2.3. Seek additional resources, including in-kind assistance, federal funding, and foundation support.

CB1&2.4. Develop and implement a process to foster public and private partnerships for all appropriate strategic priorities, including governmental, corporate, educational, research, and philanthropic institutions.

Additional CDPH Activities and Resources: The California Wellness Plan's fourth goal was established, due to external partner input, as "Prevention Sustainability and Capacity." Our partners are interested in focusing on a) collaborating with health care systems, providers, and payers to show the value of greater investment in community-based prevention approaches that address underlying determinants of poor health and chronic disease; b) exploring dedicated funding streams for community-based prevention; and c) aligning newly secured and existing public health and cross-sectoral funding sources to support broad community-based prevention. Partners selected the short-term strategy of Wellness Trust creation, with dedicated streams of funding for community-based prevention at the local, regional, and state levels.

Appendix B:
Health in All Policies Task Force

The California Health in All Policies Task Force ("Task Force") provides a venue for 22 state agencies to develop collaborative approaches to promote health and health equity outcomes across California. The Task Force was created administratively in 2010, out of recognition that nearly all policy fields have an impact on health, as well as the complex relationship between health, equity, and environmental sustainability.

- In order to promote health, equity, and environmental sustainability, the Task Force:
- Reviews existing state efforts and best/promising practices used by other jurisdictions and agencies;
- Identifies barriers to and opportunities for interagency/inter-sector collaboration;
- Convenes regular public workshops and solicits input from stakeholders; and
- Develops and implements multi-agency programs to improve the health of Californians.

The Task Force's initial recommendations and implementation plans were developed by the Task Force and endorsed by the Strategic Growth Council (SGC) between 2010 and 2012. As new windows of opportunity emerge, staff and Task Force members vet ideas and create new recommendations and implementation plans, pending available resources and alignment with Task Force priorities.

Following are key highlights of the Task Force that are relevant to the goals of the Office of Health Equity.

Food Security and Access to Healthy Food:

The multi-agency Office of Farm to Fork (http://cafarmtofork.com/) was created in August 2012, when an interagency agreement was executed between the California Department of Education, the California Department of Food and Agriculture, and the California Department of Public Health, drawing resources from all three agencies to "help all Californians eat healthy, well-balanced meals." The office aims to increase "access to healthy, nutritious food for everyone in the state" by "connecting individual consumers, school districts, and others directly with California's farmers and ranchers, and providing information and other resources."

The Task Force gave rise to the creation of a multi-agency Food Procurement Working Group, a successful community-supported agriculture (CSA) pilot program on state property, and a partnership with the Department of General Services and the Department of Corrections and Rehabilitation as they integrate nutrition criteria into food purchasing contracts. This will effectively improve the nutritional content of food provided to over 100,000 inmates and will also create opportunities for other agencies to purchase healthier foods.

Active Transportation:

Health in All Policies staff gathered lessons learned from the Task Force and partnered with TransForm to develop and disseminate a report called *Creating Healthy Regional Transportation Plans*, released in January 2012 and available at http://www.transformca.org/resource/creating-healthy-regional-transportation-plans. This report was disseminated to metropolitan planning organizations and other stakeholders.

The Task Force hosted an orientation workshop, Complete Streets: Designing for

Pedestrian and Bicycle Safety, for staff from nine agencies, providing an opportunity for multisectoral dialogue among agencies with a stake in creating streets that serve all users, including bicyclists, pedestrians, and people with disabilities.

The Southern California Association of Governments created a public health subcommittee to support its Regional Transportation Plan and included Task Force staff on that committee to help the region make links to health and equity as it develops policy proposals for the upcoming plan.

Task Force members are currently engaged in a creative process to renew their active transportation goals and generate new action steps based upon current and emerging opportunities.

Healthy Housing:

The Department of Housing and Community Development facilitates a multi-agency workgroup that provides resources to support local communities in harmonizing goals related to housing, air quality, location efficiency, transit-oriented development, and public health.

Parks and Community Greening:

The Department of Forestry and Fire Protection worked with the Governor's Office of Planning and Research to develop a webpage resource for local governments to use in planning for a healthy urban forest that optimizes benefits to the environment, public health, and the economy.

The Task Force supported the Department of Forestry and Fire Protection in conducting an urban forest inventory and assessment pilot project in the city of San Jose that can be used to develop and demonstrate a feasible approach for mapping the state's urban forests and quantifying the value of ecosystem services they provide.

Health in All Policies staff regularly serve as reviewers for the SGC Urban Greening for Sustainable Communities grant applications

Integration of Health and Equity into Land Use Policy:

The Governor's Office of Planning and Research is engaging health partners and the Task Force as they revise California's General Plan Guidelines, with a particular focus on health, equity, and environmental sustainability.

The California Department of Education, the Governor's Office of Planning and Research, the SGC, and the Task Force formed the Land Use, Schools, and Health (LUSH) Working Group to explore the linkages between health, sustainability, and school infrastructure and to promote these goals through the state's General Plan Guidelines, K-12 school siting guidance, and school facilities' construction and rehabilitation.

Health in All Policies staff worked with the SGC to integrate health language into its Sustainable Communities Planning Grants Program in order to incentivize applicants to partner with local health departments and incorporate health into their planning processes.

The Healthy Community Framework, developed with input from the Task Force, has been incorporated into programs and reports such as the ***2010 California Regional Progress Report***, which provides a framework for measuring sustainability using place-based and quality-of-life regional indicators.[1]

Neighborhood Safety:

The Task Force is working with the Local Government Commission and others to develop guidelines for local communities to use design elements to promote community safety while also promoting social cohesion; active transportation; and healthy, livable communities.

Detailed information about the recommendations, priorities, implementation plans, and progress of the Health in All Policies Task Force is available through a variety of documents posted on the Strategic Growth Council (SGC) website at www.sgc.ca.gov/.

Appendix C: **Glossary**

Active physicians are currently licensed physicians who are not retired, semiretired, working part time, temporarily not in practice, or inactive for other reasons and who work 20 or more hours per week. (American Medical Association and Medical Board of California)

Age checkpoints are defined according to whether or not children are up to date for age- appropriate doses of DTaP, polio, and MMR vaccines at 3, 5, 7, 13, 19, and 24 months. (CA Department of Public Health)

Bisexual is of or relating to persons who experience sexual attraction toward and responsiveness to both males and females. (CA Department of Justice)

Determinants of equity are defined as the social, economic, geographic, political, and physical environmental conditions that lead to the creation of a fair and just society. (CA Health and Safety Code Section 131019.5)

Ethnic bias is a preformed negative opinion or attitude toward a group of persons of the same race or national origin who share common or similar traits in language, custom, and tradition. (CA Department of Justice)

Ethnicity refers to two "ethnic" classifications: "Hispanic or Latino" and "not Hispanic or Latino." (U.S. Census Bureau)

Food insecurity is limited or uncertain availability of nutritionally adequate and safe foods or limited or uncertain ability to acquire acceptable foods in socially acceptable ways. (U.S. Department of Agriculture via Life Sciences Research Office)

Food security means access by all people at all times to enough food for an active, healthy life. (U.S. Department of Agriculture)

Gay (homosexual male) is of or relating to males who experience a sexual attraction toward and responsiveness to other males. (CA Department of Justice)

Health equity refers to efforts to ensure that all people have full and equal access to opportunities that enable them to lead healthy lives. (CA Health and Safety Code Section 131019.5)

Health and mental health disparities are differences in health and mental health status among distinct segments of the population, including differences that occur by gender, age, race or ethnicity, sexual orientation, gender identity, education or income, disability or functional impairment, or geographic location, or the combination of any of these factors. (CA Health and Safety Code Section 131019.5)

Health and mental health inequities are disparities in health or mental health, or the factors that shape health, that are systemic and avoidable and, therefore, considered unjust or unfair. (CA Health and Safety Code Section 131019.5)

Heterosexual is of or relating to persons who experience a sexual attraction toward and responsiveness to members of the opposite sex. (CA Department of Justice)

Homosexual is of or relating to persons who experience sexual attraction toward and responsiveness to members of their own sex. (CA Department of Justice)

Household includes all the people who occupy a housing unit (e.g., house, apartment, mobile home). (U.S. Census Bureau)

Lesbian (homosexual female) is of or relating to females who experience sexual attraction toward and responsiveness to other females. (CA Department of Justice)

Limited English proficiency (LEP) refers to those who reportedly speak English less than "very well" (i.e., those who reported speaking English well, not well, or not at all). This definition is based on the results of the English Language Proficiency Survey (ELPS) conducted by the U.S. Census Bureau in 1982.

Married-couple household is a family in which the householder and his or her spouse are listed as members of the same household. (U.S. Census Bureau)

Net worth (wealth) is the sum of the market value of assets owned by every member of the household minus liabilities owed by household members. (U.S. Census Bureau)

Pollution burden scores are derived from the average percentile of the seven Exposure indicators (ozone concentrations, PM2.5 concentrations, diesel PM emissions, pesticide use, toxic releases from facilities, traffic density, and drinking water contaminants) and the five Environmental Effects indicators (cleanup sites, impaired water bodies, groundwater threats, hazardous waste facilities and generators, and solid waste sites and facilities). Indicators from the Environmental Effects are given half the weight of the indicators from the Exposures component. The calculated average percentile (up to 100th percentile) is divided by 10, for a pollution burden score ranging from 0.1 to 10. (CalEnviroScreen version 1.1)

Poverty status is determined by using a set of dollar-value thresholds that vary by family size and composition. If a family's total income in the past 12 months is less than the appropriate threshold of that family, then that family and every member in it are considered "**below the poverty level.**" (U.S. Census Bureau)

Race refers to five "racial" classifications: American Indian or Alaska Native, Asian, Black or African American, Native Hawaiian or other Pacific Islander, and White. (U.S. Census Bureau)

Reading proficiency is measured by the percentage of third-graders in public schools who score proficient or higher on the English Language Arts California Standards Test (CST). In order to score proficient on the CST, a student must demonstrate a competent and adequate understanding of the knowledge and skills measured by this assessment, at this grade, in this content area. (www.kidsdata.org)

Religious bias is a preformed negative opinion or attitude toward a group of persons based on religious beliefs regarding the origin and purpose of the universe and the existence or nonexistence of a supreme being. (CA Department of Justice)

Serious psychological distress is a dichotomous measure of mental illness using the Kessler 6 (K6) series. (CA Health Interview Survey)

Sexual orientation bias is a preformed negative opinion or attitude toward a group of persons based on sexual preferences and/or attractions toward or responsiveness to members of their own or opposite sexes. (CA Department of Justice)

Usual source of care means having a usual place to go when sick or in need of health advice. (CA Health Interview Survey)

Victim is an individual, a business or financial institution, a religious organization, government, or other. For example, if a church or synagogue is vandalized or desecrated, the victim would be a religious organization. (CA Department of Justice)

Violent crimes are composed of murder, forcible rape, robbery, aggravated assault, simple assault, and intimidation. (Federal Bureau of Investigation)

Vulnerable communities include, but are not limited to women; racial or ethnic groups; low-income individuals and families; individuals who are incarcerated or have been incarcerated; individuals with disabilities; individuals with mental health conditions; children; youth and young adults; seniors; immigrants and refugees; individuals who are limited English proficient (LEP); and Lesbian, Gay, Bisexual, Transgender, Queer, and Questioning (LGBTQQ) communities, or combinations of these populations. (CA Health and Safety Code Section 131019.5)

Vulnerable places are places or communities with inequities in the social, economic, educational, or physical environment or environmental health and that have insufficient resources or capacity to protect and promote the health and well-being of their residents. (CA Health and Safety Code Section 131019.5)

Appendix D:
Data Limitations

The findings in this report should be interpreted within the context of the limitations discussed in this section. First, the data limitations of vulnerable population groups and vulnerable places defined by California Health and Safety Code Section 131019.5 are still an issue. Data on sexual orientation (Lesbian, Gay, Bisexual, Transgender, Queer, and Questioning [LGBTQQ]) and vulnerable places is limited in most data sets used in this report. For example, the American Community Survey (ACS) still does not collect data on LGBTQQ population groups. Although we attempted to capture the vulnerable places to include in this report, data is very limited in existing data sources.

Second, data on race and ethnicity is limited for some population groups. American Indian/Alaska Native, Native Hawaiian and other Pacific Islander (NHOPI), and subpopulations (e.g., Asian subpopulations such as Korean, Chinese, Vietnamese) data has to be analyzed with caution due to insufficient sample size and unstable data. For example, most NHOPI data in the California Health Interview Survey is represented as unstable due to the small sample size. Also, some data variables available in the ACS at the national level are not collected for California.

Third, data on discrimination stratified by vulnerable population groups identified in this report is limited and not available for California. Although there are numerous published journals and information for this topic available, the data is not often collected on most surveys. Even when the data is collected, usually it is considered "sensitive" data that are not available for public use.

Fourth, within the context of vulnerable population groups, mental health data is very limited in most data sets. Although there is data available on mental health, some people are not willing to answer survey questions relating to mental health issues because mental health issues are still considered a stigma or even taboo in some cultures. This data is sometimes considered "sensitive" and is therefore not available for public use.


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AGENDA ITEM 3

Information

May 24, 2018 Commission Meeting

Governor's May Budget Revise Update 2018

Summary: Kris Cook and Elena Humphreys from the Department of Finance will review the Governor's May Budget Revision and discuss its impact on the Mental Health Services Act and the community mental health system.

Presenters:

- Kris Cook, Principal Program Budget Analyst, Department of Finance
- Elena Humphreys, Finance Budget Analyst, Department of Finance

Enclosures (2): (1) May Revision 2018-19 Summary, Selected Pages; (2) May 11, 2018 Letters from Department of Finance to Senate and Assembly Budget Committees

Handouts (1): May Revision 2018-19 Budget Details will be provided at the meeting.

Recommended Action: Information Item Only.

Motion: None.

Agenda Item 3, Enclosure 1: May Revision 2018-19 Summary, Selected Pages
May 24, 2018 Commission Meeting

Included below are selected pages drawn from the May Revision 2018-19 Summary, available at http://www.ebudget.ca.gov/FullBudgetSummary.pdf.

Attached are the following:

- Pages 33-35: Health and Human Services, Mental Health Initiatives
- Pages 35-38: Health and Human Services, Department of Health Care Services

Health and Human Services

The Health and Human Services Agency oversees departments and other state entities that provide health and social services to California's vulnerable and at-risk residents.

The May Revision includes $158.7 billion ($38.9 billion General Fund and $119.8 billion other funds) for all health and human services programs, an increase of $1.5 billion General Fund compared to the Governor's Budget.

Mental Health Initiatives

The state's mental health system includes services provided by both the state and counties. Most mental health services are provided in the community by counties, with significant state and federal funding participation. Funding sources, totaling approximately $8 billion annually, include 1991 Realignment, 2011 Realignment, the Mental Health Services Act (Proposition 63), as well as General Fund and matching federal funds through the Medi-Cal program. Additionally, mental health services are provided at the Department of State Hospitals and the California Department of Corrections and Rehabilitation.

Despite substantial funding and some recent efforts to enhance mental health services, many challenges remain in the mental health system. These include continued growth in incompetent to stand trial referrals, increasing interactions between individuals with mental illness and the criminal justice system, and the prevalence of mental illness (and co-occurring substance use disorder issues) in California's homeless population.

In recognition of these challenges, especially for incompetent to stand trial referral rates, the Governor's Budget included proposals that focused on expanding community placements and services rather than incarceration or referral to a state hospital. Targeted funding was provided to Los Angeles County (about $15 million General Fund when fully operational), the county with the highest number of severely mentally ill individuals and the majority of referrals to state hospitals. The Governor's Budget also included $100 million General Fund over three years for the expansion and development of county diversion programs with the majority of funding going to the 15 counties with the highest referrals to state hospitals. To support this effort, the Governor's Budget also included $5 million from Mental Health Services Act funds over two years to assist counties in developing innovation plans that incorporate new approaches to the diversion of mentally ill individuals away from law enforcement to community-based programs.

Other efforts incorporated into existing safety net programs are not included in the previously mentioned mental health totals, such as the state's 1115 Medicaid waiver, which includes the Medi-Cal Whole Person Care Pilot, to coordinate the health, behavioral health, and social services needs of Medi-Cal beneficiaries. This pilot program provides $1.5 billion in additional federal funds over five years to coordinate services for vulnerable Medi-Cal beneficiaries who have been identified as frequent users of multiple systems and have poor health outcomes. Of the 25 pilots, 23 target homeless populations or those at risk of homelessness and 13 of those specifically target (though all have a focus on) individuals with mental health and/or substance use disorder conditions—all with the goal of providing comprehensive, coordinated care for the beneficiary and better health outcomes.

Additional Investments in the Mental Health System

The May Revision includes additional resources to both build upon earlier efforts and strengthen cross-sector collaboration to help counties support identification, treatment, and services at various points in the mental health system. These targeted investments will enhance and encourage local mental health efforts and benefit other program areas by decreasing homelessness and reducing the number of mentally ill individuals involved in the criminal justice system—including the number of individuals incarcerated in county jails and state prisons, as well as those awaiting placement in state hospitals.

No Place Like Home—The May Revision proposes placing the No Place Like Home program on the November 2018 ballot. Voters will have an opportunity to validate the No Place Like Home program, which allocates $2 billion from Mental Health Services Act funds to provide housing for individuals who are in need of mental health services and are experiencing homeless or at risk of homelessness. The Department of Housing and Community Development will issue an initial Notice of Funding Availability prior to November and make awards before the end of the calendar year, contingent on voter approval of the measure.

Children's Mental Health Mandate Repayment—The May Revision includes repayment of approximately $254 million plus interest for repealed state mandates related to services provided by counties to seriously emotionally disturbed children (AB 3632), as referenced in the Statewide Issues and Various Departments Chapter. The costs were incurred by the counties between 2004 and 2011. The Administration expects counties to use this funding for early intervention and prevention of mental health services for youth, with an emphasis on teens.

Homeless Mentally Ill Outreach and Treatment—The May Revision proposes a one-time augmentation of $50 million for the Department of Health Care Services to provide counties with targeted funding for multi-disciplinary teams to support intensive outreach, treatment and related services for homeless persons with mental illness, as referenced in the Statewide Issues and Various Departments Chapter. The funding allocation will be targeted to local entities based on the principles of Chapter 518, Statutes of 2000 (AB 2034) and Chapter 617, Statutes of 1999 (AB 34). Counties are encouraged to match these funds with local mental health funding as well as federal matching funds, where appropriate. This type of intervention is expected to result in earlier identification of mental health needs, prevention of criminal justice involvement, and improved coordination of care for this population at the local level.

Graduate Medical Education—To address the lack of mental health professionals, the May Revision proposes an increase of $55 million one-time General Fund to support psychiatric graduate medical education programs serving Health Professional Shortage Areas or Medically Underserved Areas in rural portions of the state, as referenced in the Higher Education Chapter.

Oversight and Planning—The May Revision proposes $6.7 million for 48 staff at the Department of Health Care Services to support oversight of county mental health programs and review of Mental Health Services Act expenditures, as well as planning efforts for system and data improvements to support the evaluation of county mental health programs.

DEPARTMENT OF HEALTH CARE SERVICES

Medi-Cal, California's Medicaid program, is administered by the Department of Health Care Services. Medi-Cal is a public health care coverage program that provides comprehensive health care services at no or low cost for low-income individuals. The federal government mandates basic services, including: physician services; family nurse practitioner services; nursing facility services; hospital inpatient and outpatient services; laboratory and radiology services; family planning; and early and periodic screening, diagnosis, and treatment services for children. In addition to these mandatory services, the state provides optional benefits such as outpatient drugs, dental, home and community-based services, and medical equipment. The Department also operates the California Children's Services and the Primary and Rural

Health programs, and oversees county-operated community mental health and substance use disorder programs.

Medi-Cal was established more than 50 years ago, but has changed significantly in recent years. Since 2011, the number of individuals receiving coverage through Medi-Cal and the Children's Health Insurance Program (CHIP) increased from 8.5 million to 13.3 million. Compared to the 2011 Budget Act, total program costs increased from $45.5 billion ($14.7 billion General Fund) to an estimated $103.9 billion ($22.9 billion General Fund) in 2018-19.

Unlike most programs, Medi-Cal operates on a cash, rather than an accrual, accounting basis. Both the rapid expansion of the program and federal constraints have significantly increased the difficulty and uncertainty of budgeting for this program on a cash basis.

Many of the complexities in forecasting program expenditures have resulted in a Medi-Cal shortfall compared to the 2017 Budget Act that now totals $830.5 million General Fund. This is an increase of $286.9 million compared to the Governor's Budget. As reflected in Figure HHS-01, there are many adjustments within the Medi-Cal estimate that contribute to this change.

Figure HHS-01
Significant General Fund Adjustments
2017-18
(Dollars in Millions)

Category	Program	Governor's Budget Expenditures	May Revision Expenditures	Impact on General Fund
Financing Complexities	Drug Rebates	-$1,106.7	-$831.4	$275.3
	Managed Care Organization Taxes	-2,175.2	-1,747.0	428.2
	Managed Care Financing	10,187.4	10,009.8	-177.6
Federal Actions	Hospital Quality Assurance Fee	-851.8	-1,328.9	-477.1
	Children's Health Insurance Program Reauthorization	640.2	396.7	-243.5
	Deferred Claims	71.7	754.0	682.3
	Base Program[1]	13,243.9	13,043.2	-200.7
Total General Fund		**$20,009.5**	**$20,296.4**	**$286.9**

[1] Includes net adjustments for various policies in the Medi-Cal May 2018 Local Assistance Estimate.

These changes are primarily attributed to:

- Drug Rebates—Savings are lower due primarily to retroactive payments to the federal government tied to the rapid changes allowed under the Affordable Care Act.

- Managed Care Organization Tax—Offsets to General Fund costs are lower due to updated caseload projections and rate adjustments that reduced the tax on health plans.
- Managed Care Financing—Costs have decreased since the Governor's Budget due to lower than projected caseload, retroactive rate adjustments, and lower Hepatitis C costs.
- Hospital Quality Assurance Fee—Delays in federal approval of this fee changed the timing of anticipated revenue, offsetting additional current year costs.
- CHIP Reauthorization—In December 2017, Congress reauthorized a short-term extension of enhanced federal funding. Through two actions at the end of January and early February 2018, the federal government passed a ten-year extension, continuing the enhanced 88-percent federal share of costs through September 30, 2019. The enhanced funding then decreases incrementally over time to the historic sharing ratio of 65 percent federal funds and 35 percent state funds. These reductions in federal funding will increase General Fund costs beginning in 2019-20. In the short term, the reauthorization results in a combined two-year, General Fund decrease of $898.1 million in 2017-18 and 2018-19 compared to the Governor's Budget.
- Deferred Claims— Increased costs as a result of new federal requirements, which require the state to repay disputed claims while the Department works to substantiate them.

Significant Adjustments:

- Specialty Mental Health Services Federal Audit Repayment—A recent audit by the U.S. Department of Health and Human Services, Office of the Inspector General is expected to result in the disallowance of approximately $180.7 million in federal Medi-Cal claims for county specialty mental health services. These funds will initially be paid by the state in 2018-19 with repayments from counties occurring over the next four years to prevent the removal of significant local funds from the mental health delivery system in a single year.
- Proposition 56—Updated revenues from this tobacco tax increased slightly compared to the estimate in January. Net revenues after backfill amounts total $1.3 billion in 2018-19, an increase of $32 million since the Governor's Budget. The May Revision forecasts expenditures of $629.9 million in 2018-19 for supplemental payments and rate increases, a decrease of $51.6 million compared to the Governor's Budget. Based on year-to-date expenditures in 2017-18, claims for physicians were lower than expected. However, the May Revision maintains the increase of approximately $163 million for physician payments and $70 million for dental payments in 2018-19. The May Revision also reflects an increase of $55.3 million to support new growth in Medi-Cal in 2018-19. The Administration will

continue to work with the Legislature and stakeholders on a 2018-19 supplemental payment structure for submission to the federal government by September 2018.

- Pharmacy Reimbursement—The May Revision maintains the Administration's proposal to prohibit the use of federal 340B Drug Pricing Program reimbursements within the Medi-Cal program beginning July 1, 2019, to prevent duplicate discounts and overpayments, and reduce drug rebate disputes. The Administration estimates this proposal will result in $16.6 million General Fund savings annually beginning in 2020-21.
- Expand Hepatitis C Treatment Clinical Guidelines—An increase of $70.4 million ($21.8 million General Fund) in 2018-19 to authorize treatment for all patients ages 13 and above with Hepatitis C, regardless of liver fibrosis stage or co-morbidity, except for patients with a life expectancy of less than 12 months. Currently, Medi-Cal authorizes treatment for individuals with stage two or above liver fibrosis, or at any stage if they have a qualifying co-morbid condition.
- California Medicaid Management Information System (CA-MMIS)—An increase of $41.7 million ($9.7 million General Fund) in 2018-19 to provide resources for the existing Medi-Cal fiscal intermediary contracts and the implementation of a modular modernization strategy for the CA-MMIS project.

Department of Social Services

The Department of Social Services serves, aids, and protects needy and vulnerable children and adults in ways that strengthen and preserve families, encourage personal responsibility, and foster independence. The Department's major programs include CalWORKs, CalFresh, In-Home Supportive Services (IHSS), Supplemental Security Income/State Supplementary Payment (SSI/SSP), Child Welfare Services, Community Care Licensing, and Disability Determination.

Caseload Adjustments:

- IHSS—The overall cost for IHSS increased by $105.6 million General Fund in 2017-18, and $174.7 million General Fund in 2018-19, due primarily to a projected increase in costs associated with IHSS overtime, average hours per case, and average cost per case. These increases were offset partially by slower caseload growth compared to the prior forecast, with caseload projected to be over 544,000 in 2018-19.

Statewide Issues and Various Departments

This Chapter describes items in the Budget that are statewide issues or related to various departments.

Housing and Homelessness

California has 25 percent of the nation's homeless population. According to 2017 data from the U.S. Department of Housing and Urban Development (HUD), California's homeless population has risen to nearly 135,000 individuals, up 13.7 percent since 2016. Of this number, more than 91,000 are considered unsheltered—meaning their primary nighttime location was a public or private space not ordinarily used for sleeping, such as a vehicle, park, or street. The majority of individuals experiencing homelessness belong to vulnerable populations including those with severe mental illness (34,673), victims of domestic violence (32,217), individuals with chronic substance use disorders (24,500), and unaccompanied youth (15,458).

Homelessness is fundamentally a local government responsibility, with cities responsible for the zoning and siting for housing and counties responsible for the provision of health and social services. Local jurisdictions are best positioned to address homelessness and identify solutions to meet local needs. Addressing homelessness requires collaboration between cities and counties to provide facilities and wraparound services. Many local jurisdictions have taken steps to mitigate homelessness but efforts to address identified problems have often been hindered by resistance to permitting and financing housing for this population. Over the years, the state

has provided supplemental funding and a number of policy solutions to address homelessness—including the establishment of Enhanced Infrastructure Financing Districts and Community Revitalization and Investment Authorities, which utilize property taxes and other available funds for affordable housing projects, California Environmental Quality Act (CEQA) streamlining, and planning and zoning density bonuses.

More recently, the state has made sizeable investments to tackle the state's growing homelessness problem. Notably, on July 1, 2016, Governor Brown signed legislation enacting the No Place Like Home program, which dedicates $2 billion in bond proceeds to invest in the development of permanent supportive housing for persons who are in need of mental health services and are experiencing homelessness, chronic homelessness, or who are at risk of chronic homelessness. The bonds are to be repaid by funding from the Mental Health Services Act. The issuance of the bonds, however, has been delayed by legal challenges to the program.

The May Revision proposes placing the No Place Like Home program on the November 2018 ballot, allowing voters to validate the bonds, rather than waiting for validation through the courts. In anticipation of voter approval, the May Revision includes a $1.2 million General Fund loan to the Department of Housing and Community Development to issue an initial Notice of Funding Availability prior to November and make awards before the end of the calendar year.

The 2017 Budget Act included a housing package with various long-term statutory solutions that collectively shorten the housing development approval process, promote local accountability to adequately plan for needed housing, and invest in affordable housing production through dedicated real estate transaction fee revenues, as well as a $4 billion housing bond that will be on the November 2018 ballot.

The Governor's Budget included $4.4 billion in state and federal funding across various departments and programs to develop affordable housing, provide assistance to first-time homebuyers, and offer various supports for individuals experiencing homelessness.

Many of these policy changes and construction investments will take time to result in additional units.

In recognition of the longer time frame existing investments and policies may take to implement, the May Revision includes targeted local dollars to provide assistance to local governments in tackling homelessness. These largely one-time investments will serve as a funding bridge to continue and/or initiate local efforts until additional, significant dollars are available or programs are implemented—in particular, the housing bond and revenues from the real estate transaction fees.

The May Revision proposes $359 million one-time and $64 million General Fund ongoing (see Figure SWE-01) to focus state homelessness funding on planning, prevention, and emergency aid.

Figure SWE-01
Homelessness Response Proposal
(Dollars in Millions)

Department	Program	2018-19	Ongoing
Homeless Coordinating and Financing Council[1/]	Emergency Homeless Aid Block Grants	$250.0	-
	Council Administration	0.5	0.5
Department of Social Services	CalWORKs Housing Support Program	24.2	48.3
	CalWORKs Homeless Assistance Program	8.1	15.3
	Senior Home Safe Program	15.0	-
Office of Emergency Services	Domestic Violence Shelters and Services	10.0	-
	Homeless Youth and Exploitation Program	1.0	-
Department of Health Care Services	Homeless and Mental Illness Program	50.0	-
Total		**$358.8**	**$64.1**

[1/] Housed within the Business, Consumer Services, and Housing Agency.

PLANNING

Given the many state resources that will be available in the coming years, the May Revision proposes $500,000 and three positions to expand the Homeless Coordinating and Financing Council established by Chapter 847, Statutes of 2016 (SB 1380), and move it to the Business, Consumer Services, and Housing Agency. The Council will provide statewide guidance on homelessness issues and develop a statewide plan, in collaboration with state and local entities, to support the coordination of the various housing and homelessness investments throughout the state. Additionally, the Council will work in collaboration with other stakeholders to evaluate grant proposals for a $250 million General Fund homelessness emergency aid block grant described in more detail below.

PREVENTION

The May Revision proposes $47.3 million in 2018-19 and $63.6 million ongoing to support safety net programs operated by the Department of Social Services to prevent vulnerable Californians from becoming homeless or help them obtain housing, as referenced in the Health and Human Services Chapter:

- Establish a senior homelessness prevention pilot program with $15 million in one-time funding over three years, and require participating counties to match funds received.

- Expand the existing $47 million CalWORKs housing support program with an increase of $24.2 million in 2018-19. With an additional increase in 2019-20, the program will reach $95 million ongoing to provide assistance to low-income families obtaining and maintaining permanent housing.
- Increase funding for the CalWORKs Homelessness Assistance program by $8.1 million in 2018-19 and $15.3 million ongoing to raise the payment from $65 per day to $85 per day to provide families with up to 16 days of temporary shelter.

EMERGENCY AID

To assist locals in addressing homelessness until more state resources are available next year, the May Revision proposes emergency assistance funds as follows:

- Create a one-time Homelessness Emergency Aid block grant of $250 million administered through Continuums of Care (federal HUD designations) for cities, counties or joint powers authorities that declare a local shelter crisis and identify city-county coordination. Grants can be used for emergency housing vouchers, rapid rehousing, emergency shelter construction, and use of armories to provide temporary shelters, among other activities.
- Provide one-time funding of $1 million through the California Office of Emergency Services to augment the Homeless Youth and Exploitation Program for homeless and exploited youth shelters that serve unaccompanied minors.
- Increase funding by $10 million through the California Office of Emergency Services for additional domestic violence service providers for projects that include emergency "safe" homes or shelters for victims and their families.
- Provide a one-time augmentation of $50 million for the Department of Health Care Services to provide counties with funding for intensive outreach, treatment and related services for homeless persons in need of mental health services, as referenced in the Health and Human Services Chapter.

WILDFIRE RESPONSE AND RECOVERY

California was faced with unprecedented and historic disasters in 2017—floods, wildfires and mudslides—leading to the loss of lives and homes. The Governor's Budget included funding of $419.1 million for various recovery, response, and preparation activities. The May Revision includes additional investments for recovery efforts and to create a stronger emergency response system in California.

Significant Adjustments:

- Agricultural Diesel Engine Replacement and Upgrades—An increase of $30 million General Fund on a one-time basis to the Air Resources Board to replace existing diesel agricultural vehicles and equipment with the cleanest available diesel or advanced technologies. Emissions from agricultural equipment are a significant source of air pollution, especially in the San Joaquin Valley, and reducing these emissions is critical for meeting federal ozone and particulate matter air quality standards.
- Agricultural Energy Efficiency Program—An increase of $30 million General Fund on a one-time basis for the Energy Commission to fund innovative projects that reduce energy costs, increase efficiency, and reduce greenhouse gas emissions in the food processing sector. Funded technologies will accelerate the adoption of advanced energy efficiency and renewable energy technologies, and help contribute to meeting the state's energy efficiency and greenhouse gas reduction goals.

Payment of Expired and Repealed State Mandates

The May Revision includes a one-time payment of $282.2 million General Fund plus interest to repay local agencies for costs incurred for 14 state mandates that have expired or been repealed. The repayment amount represents the retirement of state obligations to local agencies for costs incurred between 2004 and 2011. The majority of the repayment, $253.9 million plus interest, is owed as a result of mandates associated with mental health services for severely emotionally disturbed children (AB 3632), and local agencies are expected to use the repayment toward services for youth, as referenced in the Housing and Homelessness section and related issue in Health and Human Services Chapter.

State Retirement Contributions

The May Revision includes the following adjustments for retirement contributions:

- State contributions to the California Public Employees' Retirement System (CalPERS) have decreased by $18.1 million ($12.4 million General Fund) relative to the Governor's Budget. The reduction is a result of CalPERS' adjustment to the state's contribution rates, which is mainly driven by CalPERS' higher than expected investment return in 2016-17, the benefit of the state's additional $6 billion pension payment in 2017-18, and higher than projected enrollment of members under the Public Employees' Pension Reform Act of 2013, who have lower benefit formulas.

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May 11, 2018

Honorable Holly Mitchell, Chair
Senate Budget and Fiscal Review Committee

Attention: Mr. Joe Stephenshaw, Staff Director (2)

Honorable Phil Ting, Chair
Assembly Budget Committee

Attention: Mr. Christian Griffith, Chief Consultant (2)

Amendment to and Addition of Various Budget Bill Items and Reimbursements, Support and Local Assistance, and Trailer Bill Language, Department of Health Care Services—Medi-Cal and Family Health

Support

Electronic Visit Verification Multi-Departmental Planning Team (Issue 401)—It is requested that Items 4260-001-0001 and 4260-001-0890 both be increased by $143,000 to support planning workload to comply with federal Electronic Visit Verification requirements related to Waiver Personal Care Services and Home and Community-Based Services programs.

Mental Health Services Fiscal Oversight and Behavioral Health Data Modernization (Issue 402)—It is requested that Item 4260-001-0001 be increased by $2,781,000 and 8 positions, Item 4260-001-0890 be increased by $3,219,000 and 8 positions, and Item 4260-001-3085 be increased by $725,000 and 5 positions, to support oversight of county mental health programs and review of Mental Health Service Act expenditures, as well as planning efforts for system and data improvements to support the evaluation of county mental health programs.

California Medicaid Management Information Legacy and Modernization Resources (CA-MMIS) (Issue 406)—It is requested that Item 4260-001-0001 be increased by $9,675,000 and 3 positions and Item 4260-001-0890 be increased by $32,040,000 and 14 positions to provide resources for the existing Medi-Cal fiscal intermediary contracts and the implementation of a modular modernization strategy for the California Medicaid Management Information System project.

New and Additional CA-MMIS Modernization Modules—It is requested that provisional language be added to Items 4260-001-0001 and 4260-001-0890 to allow for an augmentation of $5,298,000 General Fund and $47,684,000 federal funds for project activities related to additional modules for the CA-MMIS modular modernization efforts, subject to verified satisfactory progress that incorporates lessons learned, or completion of milestones related to CA-MMIS modernization modules that are in progress (see Attachment 1).

Distributed Administration Technical Change (Issue 411)—It is requested that Item 4260-001-0001 be amended by increasing Schedule (2) by $1.5 million and making a conforming action decreasing Schedule (3) to reflect a change in the display of administrative costs.

Local Assistance

The average monthly caseload for fiscal year 2018-19 is projected to be 13,328,200 beneficiaries, which represents a decrease of 147,500 beneficiaries from the Governor's Budget. The decrease in caseload is primarily attributable to a recovering economy. Total Medi-Cal expenditures for 2018-19 are projected to be $103,881,080,000 ($22,938,499,000 General Fund), which is an increase of $2,376,423,000 total funds and an increase of $1,349,407,000 General Fund from the Governor's Budget.

Current Year Operating Shortfall (Issue 411)—Medi-Cal program expenditures are expected to exceed the appropriation by approximately $830,532,000 in 2017-18. This is an increase of $286,878,000 since Governor's Budget. Unlike most programs, Medi-Cal operates on a cash, rather than accrual, accounting basis. The rapid expansion of the program and federal constraints have significantly increased the difficulty and uncertainty of budgeting for this program on a cash basis. The Administration will seek a supplemental appropriation bill to fund this increase, which is primarily attributable to the intricacies in forecasting the program expenditures for repayments to the federal government for deferrals and decreased offsets for the Managed Care Organization taxes and drug rebates. These increases are partially offset by increased savings from the Hospital Quality Assurance Fee, reauthorization of the Children's Health Insurance Program at 88-percent federal share, and lower managed care costs. Until supplemental funding is provided, the Department will utilize the loan authorized by Government Code section 16531.1 and will work with the Legislature to increase the existing loan authority to prevent a disruption in payments to various Medi-Cal providers.

May 2018 Medi-Cal Estimate (Issues 401 and 412)—It is requested that the adjustments below be made to the following items to reflect caseload and other miscellaneous adjustments outlined in the Medi-Cal estimate:

- Item 4260-101-0001 be increased by $1,346,759,000, and reimbursements be decreased by $36,503,000
- Item 4260-101-0232 be decreased by $2,245,000
- Item 4260-101-0233 be increased by $764,000
- Item 4260-101-0236 be increased by $1,687,000
- Item 4260-101-0890 be decreased by $880,267,000
- Item 4260-101-3305 be increased by $3,717,000
- Item 4260-102-0001 be decreased by $4,763,000
- Item 4260-102-0890 be increased by $25,377,000
- Item 4260-106-0890 be increased by $ 3,794,000
- Item 4260-117-0001 be increased by $40,000
- Item 4260-117-0890 be increased by $326,000

Reauthorization of Children's Health Insurance Program (CHIP) (Issue 413)—It is requested that Item 4260-113-0001 be decreased by $847,390,000 and Item 4260-113-0890 be increased by $543,001,000 to reflect an 88-percent federal share of costs. In December 2017, Congress reauthorized a short-term extension of enhanced federal funding. Through two actions at the end of January and early February 2018, the federal government passed a

ten-year extension, continuing the 88-percent federal share of cost through September 30, 2019. The enhanced funding then decreases incrementally over time to the historic sharing ratio of 65 percent federal funds and 35 percent state funds. In the short-term, the reauthorization results in a combined two-year General Fund decrease of $898.1 million in 2017-18 and 2018-19.

Repayment for Claims Potentially Ineligible for Federal Matching Funds (Issue 414)—It is requested that Item 4260-101-0001 be increased by $674,679,000 and Item 4260-101-0890 be decreased by $299,679,000 to repay the federal government for claims that have been identified as potentially ineligible for federal matching funds. Consistent with the Special Terms and Conditions of the California Medi-Cal 2020 Demonstration, the state must immediately return the federal matching funds to the Centers for Medicare and Medicaid while the claims are examined and resolved. When a deferral is resolved in favor of the Department, the funds are returned to the state.

Federal Substance Abuse and Mental Health Services Administration Grant Award (Issue 402)—It is requested that Item 4260-115-0890 be increased by $15,675,000 and Item 4260-116-0890 be increased by $2,262,000 to reflect the revised federal grant amounts awarded to provide additional funding for county mental health and substance use disorder services.

Specialty Mental Health Services Federal Audit Settlement (Issue 403)—It is requested that Item 4260-101-0001 be increased by $180.7 million and Item 4260-101-0890 be decreased by $180.7 million to repay the federal government for specialty mental health disallowances. The responsibility for specialty mental health services was realigned to counties as part of 2011 Realignment. These funds will be paid by the state in 2018-19 with repayments from counties occurring over the next four years to prevent significant funds from being removed from the mental health delivery system in a single year.

General Fund Reappropriation (Issue 405)—It is requested that Item 4260-491 be added to reappropriate the balances of specified General Fund items and supplemental appropriations for the same purposes detailed in the preceding May Revision Medi-Cal estimate (see Attachment 2).

Federal Substance Abuse and Mental Health Services Administration Emergency Grant Award (Issue 413)—It is requested that Item 4260-115-0890 be increased by $5.4 million to reflect the revised grant amount awarded for the Regular Service Program Crisis Counseling Program, which provides counseling services to Californians affected by the recent wildfires.

Lawsuits and Claims Payment Notification (Issue 414)—It is requested that Provision 6 of Item 4260-101-0001 be eliminated. This provision waives legislative notification for payment of attorney fees below a certain amount. Current practice involves notification of estimated costs of all Medi-Cal lawsuit, judgments, settlements and attorney fees via the semiannual estimates of Medi-Cal expenditures provided to the Legislature in January and May.

Homeless Mentally Ill Outreach and Treatment (Issue 415)—It is requested that Item 4260-118-0001 be added in the amount of $50 million in one-time funding for the Department to provide counties with targeted funding for multi-disciplinary teams to provide intensive outreach, treatment, and related services for homeless persons with mental illness (see Attachment 3).

Family Health May Revision Estimates (Issue 402)—It is requested that Item 4260-111-0001 be increased by $22,218,000 and reimbursements be increased by $43,000. It is also requested that Item 4260-114-0001 be decreased by $3,354,000 and Item 4260-114-0890 be increased by $619,000. These changes reflect revised expenditures in the four Family Health programs based on: (1) one-time increased costs in the Genetically Handicapped Persons Program attributable to a backlog in processing applications, (2) lower estimated utilization and increased federal grant funding for direct service contracts and claims in the Every Woman Counts program, and (3) other miscellaneous adjustments.

Reduction of Excess Reimbursement Authority (Issue 403)—It is requested that Item 4260-111-0001 be amended by decreasing reimbursements by $36,010,000 in the children's medical services program to reflect an accurate representation of actual expenditures.

Intermediate Care Facility/Developmentally Disabled and Home Health Provider Payments (Issue 415)—It is requested that Provision 3 of Item 4260-101-3305 be amended to extend supplemental payments to facilities providing continuous skilled nursing care to developmentally disabled individuals pursuant to the pilot project established by Welfare and Institutions Code section 14132.20, and a rate increase for home health providers of medically necessary in-home services (see Attachment 4).

Trailer Bill Language

Medi-Cal General Fund Loan—Trailer bill language is requested to increase the amount of the General Fund loan to the Medical Providers Interim Payment Fund authorized in Government Code section 16531.1.

Cost-Based Reimbursement Clinic Directed Payment Program—Trailer bill language is requested to establish a directed payment program for certain cost-based reimbursement clinics, effective no sooner than July 1, 2019.

The effect of my requested action is reflected on the attachment.

If you have any questions or need additional information regarding this matter, please call Guadalupe Manriquez, Principal Program Budget Analyst, at (916) 445-6423.

MICHAEL COHEN
Director
By:

/s/ Amy M. Costa

AMY M. COSTA
Chief Deputy Director

Attachment
cc: On following page

cc: Honorable Ricardo Lara, Chair, Senate Appropriations Committee
Attention: Mr. Mark McKenzie, Staff Director
Honorable Jim Nielsen, Vice Chair, Senate Budget and Fiscal Review Committee
Attention: Mr. Kirk Feely, Budget Fiscal Director
Honorable Lorena Gonzalez Fletcher, Chair, Assembly Appropriations Committee
Attention: Mr. Jay Dickenson, Chief Consultant
Honorable Jay Obernolte, Vice Chair, Assembly Budget Committee
Attention: Ms. Cyndi Hillery, Staff Director
Honorable Richard Pan, Chair, Senate Budget and Fiscal Review Subcommittee No. 3
Honorable Joaquin Arambula, Chair, Assembly Budget Subcommittee No. 1
Mr. Mac Taylor, Legislative Analyst (4)
Mr. Christopher W. Woods, Senate President pro Tempore's Office (2)
Mr. Jason Sisney, Assembly Speaker's Office (2)
Ms. Cheri West, Deputy Chief of Staff, Policy, Assembly Republican Leader's Office
Mr. Jim Richardson, Policy and Fiscal Director, Assembly Republican Leader's Office
Ms. Michelle Baass, Undersecretary, California Health and Human Services Agency
Mr. Robert Ducay, Assistant Secretary, California Health and Human Services Agency
Ms. Julie Souliere, Assistant Secretary, California Health and Human Services Agency
Ms. Jennifer Kent, Director, Department of Health Care Services
Ms. Mari Cantwell, Chief Deputy Director, Department of Health Care Services
Ms. Erika Sperbeck, Chief Deputy Director, Department of Health Care Services
Ms. Lindy Harrington, Deputy Director, Department of Health Care Services
Ms. Rene Mollow, Deputy Director, Department of Health Care Services
Ms. Sarah Brooks, Deputy Director, Department of Health Care Services
Ms. Melody Hayes, Deputy Director, Department of Health Care Services
Ms. Lisa Lassetter, Deputy Director, Department of Health Care Services
Ms. Brenda Grealish, Assistant Deputy Director, Department of Health Care Services
Ms. Kathleen Dong, Budget Officer, Department of Health Care Services
Mr. Marc Lowry, Chief, Fiscal Forecasting Division, Department of Health Care Services

4260-118-0001—For local assistance, the State Department of Health Care Services.....50,000,000

Schedule:
(1) 3960050-Other Health Care Services.....50,000,000

Provisions:
1. The distribution of funds appropriated in this item shall be allocated by the State Department of Health Care Services, in consultation with the Department of Finance and California State Association of Counties, and shall consider a county incidence of homeless individuals with serious mental illnesses and county population. The initial allocation will be completed and shared no later than July 31, 2018. Allocations to local entities may include counties with Whole Person Care pilots, but are not limited to counties with such pilot programs. Other counties with demonstrated need, including populations with recent involvement in the criminal justice system or release from incarceration are eligible to receive funding under this item.
   a. Interested counties may submit requests for an allocation pursuant to this item within 90 days of enactment of this act. This request shall be accompanied by a resolution, adopted by the county's board of supervisors, supporting the use of funds for the intended purpose of this item.
   b. Counties may use all available and appropriate funding to leverage other fund sources, such as federal grants in serving individuals with severe mental illness who are also homeless or at immediate risk of being homeless.
   c. These funds shall pay for only that portion of the costs of services not otherwise provided by federal funds or other state funds and shall not supplant other funds for these purposes.
   d. Counties that receive an allocation pursuant to this item shall be required to report to the State Department of Health Care Services within 90 days after the full expenditure of funding pursuant to this item. This report shall include the disposition of such funds, the services provided and the number of individuals receiving services.
   e. These allocations shall be implemented only to the extent that federal financial participation is not otherwise jeopardized.
   f. Notwithstanding any other law, for any fiscal years in which the State Department of Health Care Services implements the allocations described in this provision, the amount of state funding provided shall not be included as revenues for purposes of determining an applicable county's redirection obligation pursuant to Article 12 or Article 13 of Chapter 6 of Part 5 of Division 9 of the Welfare and Institutions Code.
   g. The funds appropriated in this item shall be available for encumbrance or expenditure until June 30, 2020.
   h. These funds shall be distributed by the Controller according to a schedule provided by the Department of Finance for counties that comply with provision (a).
   i. Notwithstanding subdivision (h) of Section 14184.60 of the Welfare and Institutions Code, local entities may participate and apply for an allocation pursuant to this item.
2. Of the funds appropriated in Schedule (1), $150,000 shall be available to the State Department of Health Care Services for the activities described in Provision 1. The Department of Finance may authorize the transfer of expenditure authority from Schedule (1) of this item to Schedule (1) of Item 4260-001-0001.

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May 11, 2018

Honorable Holly Mitchell, Chair
Senate Budget and Fiscal Review Committee

Attention: Mr. Joe Stephenshaw, Staff Director (2)

Honorable Phil Ting, Chair
Assembly Budget Committee

Attention: Mr. Christian Griffith, Chief Consultant (2)

Amendment to Budget Bill Items 4440-011-0001, 4440-017-0001, and Reimbursements, Support, Department of State Hospitals

Metropolitan State Hospital Bed Expansion (Issue 300)—It is requested that Item 4440-011-0001 be decreased by $28,304,000 and 183.3 positions to reflect the delayed activation of 140 incompetent to stand trial beds at Metropolitan State Hospital. Activation of the first unit is estimated to shift from September 2018 to March 2019.

Jail-Based Competency Treatment Program Expansions (Issues 310, 320, 330, 340)—It is requested that Item 4440-011-0001 be decreased by $6,514,000 to reflect reduced costs and fewer beds in the Jail-Based Competency Treatment program expansions included in the Governor's Budget. This change reflects recent contract negotiations and activation delays. The loss of beds is partially offset by a new 15-bed activation for a net decrease of 13 beds in budget year.

Enhanced Treatment Program Implementation (Issues 350, 360)—It is requested that Item 4440-011-0001 be decreased by $7,406,000 and 80.1 positions to reflect savings associated with the delayed activation of four Enhanced Treatment Program units at Atascadero and Patton State Hospitals. The timeline has shifted from activating the first unit in September 2018 to March 2019. This decrease is net of a requested one-time increase of $2,140,000 to install communication and safety systems for the second two units to be activated.

Los Angeles County Incompetent to Stand Trial Treatment in Community Setting (Issues 230, 260)—It is requested that Item 4440-011-0001 be decreased by $1,666,000 to reflect a phased-in approach for community placements. This net decrease assumes a limited-term request for contract resources to treat and divert an additional number of incompetent to stand trial referrals while in jail to avoid being admitted to state hospitals.

Napa Earthquake Repairs Adjustment (Issue 290)—It is requested that Item 4440-011-0001 be amended by increasing reimbursements by $1,217,000, to reflect the expected increase in Federal Emergency Management Agency funding to repair damages sustained at Napa State Hospital during the August 2014 earthquake.

Protected Health Information Implementation (Issue 001)—It is requested that Item 4440-011-0001 be increased by $988,000 and 8 three-year, limited-term positions to implement a system to track protected health information when paying claims for patients receiving outside medical services and treatment.

Metropolitan State Hospital Central Utility Plant (Issue 270)—It is requested that Item 4440-011-0001 be increased by $2,580,000 to provide the Department the resources necessary to continue operating the existing central utility plant providing heating and cooling throughout Metropolitan State Hospital.

Hepatitis C Treatment Expansion (Issue 370)—It is requested that Item 4440-011-0001 be increased by $3.3 million to expand the treatment schedule for patients diagnosed with the chronic Hepatitis C virus. The May Revision also includes a similar expansion of Hepatitis C clinical guidelines for the California Department of Corrections and Rehabilitation and the Department of Health Care Services.

Miscellaneous Technical Adjustments (Issues 250)—It is requested that Item 4440-017-0001 be amended by decreasing reimbursements by $1,154,000 to remove excess authority that remained after the transition of the Department of Mental Health to the Department of State Hospitals. In addition, it is requested that Item 4440-011-0001 be amended by increasing reimbursements by $150,000 on a one-time basis to reflect an increase in funding received from local community colleges for training provided by the State Hospital Police Officer Academy.

The effect of my requested action is reflected on the attachment.

If you have any questions or need additional information regarding this matter, please call Kris Cook, Principal Program Budget Analyst, at (916) 445-6423.

MICHAEL COHEN
Director
By:

/s/ Amy M. Costa

AMY M. COSTA
Chief Deputy Director

Attachment
cc: On following page

AGENDA ITEM 4

Information

May 24, 2018 Commission Meeting

Executive Director Report Out

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 (7): (1) The Motions Summary from the April 26, 2018 Commission Meeting; (2) Evaluation Dashboard; (3) Calendar of Commission activities; (4) Innovation Review Outline (5) Innovation Dashboard; (6) Department of Health Care Services Revenue and Expenditure Reports status update; and (7) Youth Innovation Project Brief

Handout: None.

Recommended Action: Information item only.

Motions Summary

Commission Meeting
April 26, 2018

Motion #: 1

Date: April 26, 2018

Time: 9:46AM

Motion:

The Commission approves the March 22, 2018 Meeting Minutes.

Commissioner making motion: Vice-Chair Aslami-Tamplen
Commissioner seconding motion: Commissioner Bunch

Motion carried 7 yes, 0 no, and 1 abstain, per roll call vote as follows:

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

Motion #: 2

Date: April 26, 2018

Time: 11:39AM

Motion:

The MHSOAC approves Los Angeles County's Innovation Projects, as follows:

> **Name:** Mobile Transcranial Magnetic Stimulation
> **Amount:** $2,499,102
> **Project Length:** Three (3) Years

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

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

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

Motion #: 3

Date: April 26, 2018

Time: 11:40AM

Motion:

The MHSOAC approves Los Angeles County's Innovation Projects, as follows:

> **Name:** Peer Support Specialist Full Service Partnership
> **Amount:** $9,874,886
> **Project Length:** Four (4) Years

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

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

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

Motion #: 4

Date: April 26, 2018

Time: 2:34PM

Motion:

The MHSOAC approves Modoc County's Innovation plan listed below with the condition that the Commission will be provided information on the vendor procurement process, the evaluation, and the coordination of the multicounty aspect of this project.

Name: Increasing Access to Mental Health Services and Supports Utilizing a Suite of Technology-Based Mental Health Solutions
Amount: $270,000
Project Length: Three (3) Years

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

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

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

Motion #: 5

Date: April 26, 2018

Time: 2:36PM

Motion:

The MHSOAC approves Orange County's Innovation plan listed below with the condition that the Commission will be provided information on the vendor procurement process, the evaluation, and the coordination of the multicounty aspect of this project.

Name: Mental Health Technology Solutions
Amount: $24,000,000
Project Length: Four (4) Years

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

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

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

Motion #: 6

Date: April 26, 2018

Time: 2:47PM

Motion:

- The MHSOAC awards the 0-21 Triage Personnel Grants to the following counties that received the highest scores for the specified amounts listed and directs the Executive Director to issue a Notice of Intent to make the following awards:

Butte County $333,263	Sacramento County $2,386,811
Calaveras County $492,291	San Luis Obispo County $525,989
Humboldt County $726,446	Santa Barbara County $1,250,266
Los Angeles County $19,489,116	Stanislaus County $598,099
Placer County $1,468,049	Yolo County $294,597
Riverside County $2,035,073	

- The MHSOAC establishes May 10, 2018 as the deadline for unsuccessful applicants to submit an Appeal consistent with the ten working days standard set forth in the Request for Applicants.

- The MHSOAC directs the Executive Director to notify the Commission Chair and Vice Chair of any appeals within two working days of the submission and to adjudicate the appeals consistent with the procedure provided in the Request for Applications.

- The MHSOAC directs the Executive Director to execute the contracts upon expiration of the appeal period or consideration of the appeals, whichever comes first.

- The MHSOAC directs any additional funds that may become available for the 0-21 triage grants to be allocated first to applicants who are partially funded due to lack of funding and then to the next highest scoring counties that were not funded until all funds are allocated.

- The MHSOAC authorizes the Executive Director to negotiate with partially funded counties including, but not limited to, terms such as delayed implementation while awaiting possible additional funds.

Motion #: 6 (Continued)

Commissioner making motion: Commissioner Danovitch
Commissioner seconding motion: Commissioner Mitchell

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

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

Motion #: 7

Date: April 26, 2018

Time: 3:48PM

Motion:

The Commission approves San Diego County's request to spend $100,000 of Innovation funds to support a Human-Centered Design strategy to develop its next Innovation Project. Commission directs staff to develop and present to the Commission a strategy for approving use of Innovation funds to support counties' planning for Innovation projects.

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

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

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

Motion #: 8

Date: April 26, 2018

Time: 4:19PM

Motion:

The Commission authorizes the Executive Director to enter into one or more contracts, not to exceed $1,400,000, to support the development and implementation of a statewide strategy for MHSA evaluation, including establishing statewide outcomes goals, outcomes tracking, component evaluation, and ongoing evaluation and staff will report on the decisions and rationale for those decisions by June 30, 2018.

Commissioner making motion: Commissioner Anthony
Commissioner seconding motion: Commissioner Wooton

Motion carried 4 yes, 0 no, and 0 abstain, per roll call vote as follows:

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

MHSOAC Evaluation Dashboard

Summary: The Mental Health Services Oversight and Accountability Commission Evaluation Dashboard assists in monitoring the major evaluation efforts currently underway. The Evaluation Dashboard provides information, objectives, and the status of all current deliverables for internal and external evaluation contracts and projects. Below is a list of all changes/updates to all evaluation projects, which are highlighted in red within the Dashboard.

Changes/Updates:

External Evaluation Contracts

- **DOJ Criminal Data Linkage & Analysis** *Mental Health Data Alliance*
  Update: Deliverables 4 second monthly assignment and payment complete last one is still in progress. Contract's Total Spent increased.

Enclosures: MHSOAC Evaluation Dashboard

Recommended Action: None

Presenter: None

Motion: None

MHSOAC Evaluation Dashboard May 2018

(updated 5/11/18)

Current MHSOAC Evaluation Contracts & Deliverables

Mental Health Services
Oversight & Accountability Commission

Mental Health Data Alliance

DOJ Criminal Data Linkage & Analysis (16MHSOAC027)

MHSOAC Staff: Pu Peng & Ashley Mills

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

Total Contract Amount: $98,450

Total Spent: $47,976

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 May 2018

(updated 5/11/18)

Mental Health Services
Oversight & Accountability Commission

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: $500,000

Objective: To make data from reports on programs funded under the Mental Health Services Act, available to the public via a Visualization Portal. The portal will provide transparency through the publication of information and statistics to various stakeholders. Resources will be provided to allow MHSOAC staff to evaluate, merge, clean, and link all relevant datasets; develop processes and standards for data management; identify and configure analytics and visualizations for publication on the MHSOAC public website; and manage the publication of data to the open data platform.

Deliverables & Due Dates

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)**		**12/31/18**		
3	**Providers, Programs, and Services Tool 1.0- (Design specs, Configuration & Related Datasets, Test Results, Visualization & Dataset Deployed)**			**07/01/18**	
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 May 2018

(updated 5/11/18)

Mental Health Services
Oversight & Accountability Commission

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

1325 J ST STE 1700
SACRAMENTO CA 95814
(916) 445-8696
www.mhsoac.ca.gov

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 **Location TBD**
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
MAY 2018

INN Proposals CALENDARED:

TOTAL # of CALENDARED INN PROPOSALS	COUNTY	TOTAL INN AMOUNT
1 (JULY) 1 (AUGUST)	IMPERIAL and TEHAMA	$1,292,413

INN Proposals to be CALENDARED:

TOTAL # of DRAFT INN PROPOSALS RECEIVED	# of COUNTIES THAT SUBMITTED	TOTAL INN AMOUNT REQUESTED
23	14	$57,611,910

INN Concepts being DEVELOPED:

TOTAL # of INNOVATIVE CONCEPTS RECEIVED	# of COUNTIES THAT SUBMITTED	TOTAL INN AMOUNT REQUESTED
7	4	$11,665,000

INN Concepts PLANNED

TOTAL # of PLANNED INN CONCEPTS	# of COUNTIES THAT ARE PLANNING	TOTAL INN AMOUNT EXPECTED
10	1	$40,323,826

APPROVED INNOVATION PLANS-FIVE (5) FISCAL YEARS

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%**

2017-2018
- Total INN Dollars : **$134,391,059**
- Total INN Extensions: $5,172,606
- Total # of Projects: 29
- **# of Counties Submitted: 17**

2016-2017
- Total INN Dollars : **$66,347,688**
- Total INN Extensions: $2,008,608
- Total # of Projects: 27
- **# of Counties Submitted: 18**

2015-2016
- Total INN Dollars : **$46,920,919**
- Total INN Extensions: $5,587,378
- Total # of Projects: 17

# of Counties Submitted: 15

2014-2015
- Total INN Dollars : **$127,742,348**
- Total INN Extensions: $1,111,054
- Total # of Projects: 26
- **# of Counties Submitted: 16**

2013-2014
- Total INN Dollars : **$7,867,712**
- Total INN Extensions: $0.00
- Total # of Projects: 14
- **# of Counties Submitted: 8**

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 May 11th, 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. Additionally, County RERs for reporting year FY 2016-17 can be accessed at the following webpage: http://www.dhcs.ca.gov/services/MH/Pages/Annual_MHSA_Revenue_and_Expenditure_Reports_by_County_FY_16-17.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 Validated RER Status Table

	FY 12-13		FY 13-14		FY 14-15		FY 15-16		FY 16-17	
County	Electronic Copy Submission Date	Final Review Completion Date	Electronic Copy Submission Date	Final Review Completion Date	Electronic Copy Submission Date	Final Review Completion Date	Electronic Copy Submission Date	Final Review Completion Date	Electronic Copy Submission Date	Final Review Completion Date
Alameda	1/4/2015	1/6/2015	1/10/2017	1/5/2017	9/14/2017	9/29/2017	9/29/2017	9/29/2017	1/2/2018	1/3/2018
Alpine	9/12/2016	9/13/2016	9/12/2016	9/13/2016	6/26/2017	6/26/2017	11/22/2017	11/27/2017		
Amador	10/30/2015	9/9/2016	9/8/2016	3/27/2017	3/27/2017	3/27/2017	4/7/2017	4/10/2017	4/12/2018	4/13/2018
Berkeley City	7/6/2015	7/17/2015	4/18/2016	5/2/2016	5/2/2016	7/26/2016	4/13/2017	4/13/2017	1/25/2018	2/1/2018
Butte	4/10/2015	4/13/2015	3/7/2016	3/7/2016	4/4/2016	6/23/2016	4/17/2017	4/18/2017	5/4/2018	5/7/2018
Calaveras	12/1/2015	12/1/2015	12/18/2015	1/19/2016	1/4/2016	1/13/2016	4/18/2017	4/19/2017		
Colusa	3/27/2015	8/4/2015	11/16/2015	11/16/2015	1/8/2016	2/10/2016	5/17/2017	5/17/2017	5/8/2018	5/9/2018
Contra Costa	4/13/2015	4/14/2015	3/8/2016	3/14/2016	3/8/2016	3/14/2016	4/17/2017	4/18/2017	12/29/2017	1/24/2018
Del Norte	4/1/2015	4/15/2015	11/2/2015	1/4/2016	5/13/2016	5/16/2016	4/17/2017	5/19/2017	2/23/2018	2/26/2018
El Dorado	4/1/2015	4/7/2015	12/15/2015	8/29/2016	2/9/2016	2/11/2016	4/17/2017	4/19/2017	12/29/2017	1/24/2018
Fresno	3/25/2015	4/21/2015	10/30/2015	11/12/2015	12/14/2015	12/18/2015	4/17/2017	4/18/2017	12/29/2017	5/7/2018
Glenn	4/30/2015	5/1/2015	10/30/2015	11/4/2015	3/17/2016	3/24/2016	7/20/2017	7/20/2017	2/22/2018	2/22/2018
Humboldt	2/10/2015	4/8/2015	6/3/2016	6/6/2016	9/30/2016	10/3/2016	4/13/2017	4/18/2017	12/21/2017	4/25/2018
Imperial	4/1/2015	4/8/2015	10/28/2015	11/3/2015	12/31/2015	1/4/2016	4/27/2017	4/27/2017	12/28/2017	1/9/2018
Inyo	5/29/2015	6/29/2015	11/19/2015	12/5/2015	2/24/2016	2/24/2016	5/9/2017	5/9/2017		
Kern	3/27/2015	4/2/2015	11/12/2015	11/12/2015	10/31/2016	10/31/2016	5/30/2017	2/7/2018	1/30/2018	2/7/2018
Kings	4/17/2015	6/5/2015	4/7/2016	7/26/2016	4/7/2016	5/2/2017	5/2/2017	5/24/2017	1/29/2018	1/29/2018
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	5/18/2017	5/25/2017		
Los Angeles	5/6/2015	7/29/2015	10/17/2016	10/19/2016	4/20/2017	4/21/2017	1/31/2018	2/1/2018		
Madera	4/1/2015	11/8/2016	11/13/2016	12/7/2016	12/6/2016	12/7/2016	5/12/2017		3/27/2018	
Marin	3/11/2015	3/12/2015	9/6/2016	9/6/2016	10/21/2016	10/21/2016	5/10/2017	5/11/2017	1/31/2018	2/1/2018
Mariposa	6/26/2015	6/29/2015	9/23/2016	9/23/2016	9/23/2016	9/28/2016	5/18/2017	5/19/2017	3/14/2018	3/14/2018
Mendocino	5/1/2015	5/1/2015	10/28/2015	10/28/2015	5/31/2017	5/31/2017	8/31/2017	8/31/2017	4/27/2018	4/30/2018
Merced	5/9/2015	10/15/2015	10/20/2015	10/21/2015	3/28/2017	3/29/2017	7/21/2017	7/21/2017	2/1/2018	2/1/2018
Modoc	3/11/2015	3/12/2015	10/27/2015	11/10/2015	3/24/2016	3/25/2016	4/17/2017	4/19/2017	4/20/2018	4/23/2018
Mono	5/1/2015	6/2/2015	3/30/2016	4/4/2016	3/30/2016	4/6/2016	4/25/2017	6/20/2017		
Monterey	4/27/2015	5/6/2015	10/20/2017	10/23/2017	3/29/2018	4/23/2018				
Napa	6/17/2015	8/25/2017	8/18/2017	8/25/2017	8/18/2017	8/25/2017	11/9/2017	11/13/2017		
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	12/27/2016	4/13/2017	12/29/2017	1/25/2018
Placer	4/1/2015	12/16/2017	10/4/2016	10/5/2016	11/15/2016	11/17/2016	4/14/2017	4/18/2017	12/22/2017	1/23/2018
Plumas	11/3/2015	11/3/2015	4/10/2017	4/10/2017	6/8/2017	6/23/2017	3/27/2018	3/28/2018		
Riverside	4/1/2015	4/6/2015	10/30/2015	11/2/2015	5/12/2017	5/15/2017	6/9/2017	6/12/2017	12/29/2017	1/25/2018
Sacramento	12/11/2015	12/11/2015	9/21/2016	9/21/2016	5/8/2017	5/8/2017	6/19/2017	6/20/2017	12/29/2017	1/25/2018
San Benito	4/8/2015	4/14/2015	4/18/2016	4/19/2016	10/24/2016	3/8/2016	9/8/2017	9/12/2017		
San Bernardino	4/1/2015	4/14/2015	11/17/2015	11/17/2015	5/19/2016	5/19/2016	5/1/2017	5/1/2017		
San Diego	4/8/2015	4/8/2015	12/2/2015	9/28/2016	12/18/2015	5/26/2017	5/26/2017	5/26/2017		
San Francisco	4/17/2015	4/21/2014	10/30/2015	11/2/2015	3/4/2016	3/4/2016	7/5/2017	9/18/2017	3/21/2018	3/27/2018
San Joaquin	4/2/2015	4/7/2015	11/10/2016	11/10/2016	6/8/2017	6/13/2017	10/3/2017	10/4/2017	12/29/2017	1/25/2018
San Luis Obispo	4/3/2015	4/6/2015	11/6/2015	9/29/2016	1/15/2016	1/15/2016	5/12/2017	5/16/2017	2/15/2018	2/16/2018
San Mateo	3/15/2016	3/17/2016	9/28/2016	10/3/2016	5/9/2017	5/9/2017	10/10/2017	10/18/2017	4/20/2018	4/30/2018
Santa Barbara	4/2/2015	5/8/2015	5/24/2017	5/24/2017	5/24/2017	6/20/2017	5/24/2017	6/20/2017	12/22/2017	1/25/2018
Santa Clara	4/18/2017	4/20/2017	4/18/2017	4/20/2017	5/5/2017	5/11/2017	12/18/2017	1/4/2018	4/20/2018	4/23/2018
Santa Cruz	4/2/2015	4/17/2014	3/18/2016	3/23/2016	4/5/2018	4/9/2018				
Shasta	10/29/2015	11/2/2015	10/29/2015	9/30/2014	10/7/2016	10/7/2016	4/14/2017	4/17/2017	3/29/2018	4/23/2018
Sierra	10/9/2015	11/2/2015	10/17/2016	10/18/2016	10/17/2016	10/17/2016	8/16/2017			
Siskiyou	10/30/2015	3/24/2017	6/30/2017	7/10/2017	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	3/23/2017	4/4/2017	12/28/2017	1/25/2018
Sonoma	12/18/2015	11/20/2016	12/6/2016	12/6/2016	4/10/2017	4/10/2017	6/26/2017	6/27/2017		
Stanislaus	3/19/2015	4/3/2015	10/27/2015	10/28/2015	12/22/2015	12/22/2015	4/5/2017	4/5/2017	4/27/2018	4/30/2018
Sutter-Yuba	11/19/2015	12/22/2015	4/3/2018		4/3/2018		4/3/2018		4/3/2018	
Tehama	5/29/2015	6/19/2015	3/31/2016	4/4/2016	4/29/2016	5/11/2017	5/8/2017	5/16/2017		
Tri-City	4/3/2015	4/16/2015	10/30/2015	2/3/2016	12/30/2015	2/3/2016	4/6/2017	4/6/2017	12/29/2017	2/15/2018
Trinity	10/9/2015	10/14/2015	3/23/2016	3/23/2016	9/19/2016	9/23/2016	7/14/2017	7/14/2017		
Tulare	3/26/2015	6/9/2015	12/3/2015	12/3/2015	3/17/2016	3/22/2016	4/12/2017	4/12/2017	12/26/2017	1/25/2018
Tuolumne	4/1/2015	4/7/2015	10/26/2015	11/2/2015	12/23/2015	12/28/2015	4/10/2017	5/18/2017	2/16/2018	3/1/2018
Ventura	6/19/2015	6/30/2015	10/29/2015	11/3/2015	12/31/2015	1/4/2016	4/14/2017	4/27/2017	4/27/2018	
Yolo	4/2/2015	4/7/2015	6/16/2017	6/21/2017	6/21/2017	6/21/2017	3/9/2018	3/12/2018	3/23/2018	3/26/2018
Total	59	59	59	58	57	56	55	52	39	36

Current Through: 05/11/2018

MHSOAC Youth Innovation Project Brief

To strengthen engagement and support for youth and transition age youth, the California Mental Health Services Oversight and Accountability Commission is proposing a youth engagement process to support the development of youth-led proposals for innovation that improve services and outcomes for youth.

The Commission proposes to establish a Youth Advisory Council to first review and modify this proposal, then facilitate the project proposed here. The proposed project has three goals: (1) identify challenges facing youth, (2) identify potential solutions to those challenges, and (3) present the solutions to county leaders for innovation investment.

In order to identify challenges facing youth, the Youth Council will convene a series of youth-focused, regional community events or forums. These listening sessions will provide an opportunity to hear from youth across the state and gather feedback about their experiences and challenges to accessing appropriate and effective mental health services. Following the listening sessions, the Youth Council will provide guidance to distill down the information gathered to 3-4 core challenges. The Youth Council will then facilitate ideation sessions to develop potential innovations to address solutions to the identified challenges. The engagement and ideation sessions will culminate with a Youth Innovation Summit where the Youth Council will present the innovative solutions to an audience of county leaders and community partners for potential support and funding.

Background

The Commission has spent the last year partnering with counties, mental health leaders, stakeholders, foundations, private sector and non-profit partners and others to strengthen opportunities to leverage innovation to support transformational change in mental health.

The Commission has identified four key challenges associated with innovation under the MHSA:

- Identify opportunities for strategic collaboration on innovation across counties.
- Expand technical assistance to support county innovations that have the potential for transformational change.
- Strengthen strategies to evaluate mental health innovations that can create confidence and take successful innovations to scale.
- Disseminate the results of innovations to improve public understanding and support for innovation and support the implementation of successful innovations across the state.

On February 2, 2018, the Commission hosted its first innovation summit. The event was designed to energize the innovation conversation and to connect California's mental health community with the state's innovation sector using a human-centered design approach. Participants included county representatives, consumers, family members, youth, community representatives, business, healthcare, and technology industry representatives, as well as state and federal leaders.

Commission staff received feedback from youth participants that youth did not feel represented in the planning of the event. Youth also expressed that they do not feel represented in the innovation process at the county level or at Commission meetings.

This proposal is intended to respond to those concerns.

Project Structure

The project's structure is designed to facilitate public involvement to develop a shared understanding of the opportunity to improve outcomes for youth and transition age youth by utilizing youth-driven designs in the delivery of mental health services.

Youth Advisory Council. To ensure that youth perspective and guidance informs all aspects of this project, the Commission will form a Youth Advisory Council. The Youth Council will be comprise youth, ages 16-25 from across the state with an emphasis on recruitment of individuals from diverse racial and ethnic communities, LGBTQ, and those with multi-systems perspective/experience. The Youth Council's role will be to provide guidance and feedback throughout the project to ensure the planning for and process of the community engagement events, ideation period and Youth Innovation Summit are consistent with the needs and considerations of youth and transition age youth. The first priority of the Youth Council will be to review and modify this draft proposal.

Community Engagement Events: Listening Sessions. The Commission will support the Youth Council to convene a series of youth-focused, regional community events/forums to facilitate listening sessions with youth. These may be Commission sponsored meetings or at independently organized events that are youth focused such as the annual TeenzTalk conference in September. These listening sessions will provide an opportunity for the Commission to engage with youth across the state.

Information gathered at the community engagement events will be distilled down to identify 3-5 priority issues/challenges.

Community Engagement Events: Ideation Sessions. Following the identification of priority challenges, the Commission will sponsor a series of ideation sessions to allow for brainstorming and the development of innovation proposals that can be presented to county leaders as potential innovation projects. Like the listening sessions, the Youth Council will help facilitate ideation sessions.

Youth Innovation Summit. The culmination of the engagement period and ideation phase will be a Youth Innovation Summit. The goal for this event is to present youth- developed innovation plans to county leaders and community partners. Attendees will represent a diverse group of young people, county leaders, community providers and other public and private partners.

Project Timeline and Next Steps

This project is to be completed by April 2019.

Next Steps

Recruit and appoint the Youth Advisory Council. Staff have identified a number of existing youth engagement events that would provide an opportunity to recruit youth, host a listening session, and/or provide information on this project. They include:

- Stanford Adolescent Mental Wellness Conference – April 2018
- California Mental Health Advocates for Children & Youth (CMHACY) Conference – May 2018
- Stomp Out Stigma! – June 2018
- Sacramento County Office of Education (SCOE) Youth Summit – June 2018
- TeenzTalk Annual Conference – September 2018

Additional event partnerships exist under current Commission stakeholder contractors that may provide an opportunity to reach youth in targeted regions as needed.

AGENDA ITEM 5

Action

May 24, 2018 Commission Meeting

Butte County Innovation Plan

Summary: The Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission) will consider approval of Butte County's request to fund a new Innovative project: Physician Committed. Butte County Behavioral Health proposes to promote interagency collaboration by partnering with the Butte-Glenn Medical Society, Butte County Office of Education and local primary care physicians in order to expand their ability to identify and intervene with adolescents who have risk factors of experiencing mental health and substance use issues.

The Mental Health Services Act (MHSA) requires that an Innovation (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:

- Dorian Kittrell, LMFT, Behavioral Health Director;
- Danelle Campbell, Prevention Unit Program Manager;
- Sesha Zinn, Psy.D., Systems Performance Manager;
- Phillip R. Filbrandt, M.D., Physician Coordinator for local high schools;
- Holli Drobny, Community Services Program Manager

Enclosures (3): (1) Biographies for Butte County Innovation Presenters (2) Staff Innovation Summary (3) County Project Brief

Handout (1): PowerPoint Presentation

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

http://mhsoac.ca.gov/document/2018-05/butte-county-inn-plan-description-physician-committed

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

Name: Physician Committed
Amount: $767,900
Project Length: Three (3) Years

Biographies for Butte County Presenters
Physician Committed

Danelle Cambell

Danelle Campbell is a California Certified Prevention Specialist with over 27 years' experience in the prevention field. She wears multiple hats, one of which is the Program Manager of the Prevention Unit for Butte County Behavioral Health. She provides consultation, facilitation and training at the local, state and national level in areas such as strategic planning, mental health and substance use disorder prevention, family supportive services, and youth development. She has developed four nationally recognized Exemplary Substance Abuse Prevention Award winning programs, is the recipient of the CADCA Coalition of the Year Got Outcomes award and has participated in the Service to Science initiatives. Danelle has developed, implemented and supported the replication of the Committed Programs in schools and communities throughout California. This includes Parent Committed, Merchant Committed and the Committed Chapter model. Danelle brought the first Life of an Athlete Program – Athlete Committed – to California in 2010 and has since replicated that program in over 25 schools throughout California. In 2012, Danelle received two prestigious awards including the California Department of Alcohol and Drug Programs "State Leader in the Field" award and the American Athletic Institute "National Preventionist of the Year" awards.

Dorian Kittrell

Dorian Kittrell joined Butte County in May of 2014 as the Director of Behavioral Health. Prior to coming to work for Butte County, he was the Director of Behavioral Health for Sacramento County. A graduate of the School for International Training, Dorian holds a Bachelor's Degree in International Studies. Dorian obtained a Master's of Science degree in clinical psychology from San Francisco State University and subsequently became a licensed Marriage and Family Therapist. In his early career he worked with the City of Berkeley, Mobile Crisis Team, as well as Haight Ashbury Free Clinics. Dorian has been working in the field of behavioral health for over 25 years.

Phillip Filbrandt, M.D.

Phillip Filbrandt is a Physical Medicine and Rehabilitation physician who works with the local high schools for sports injury treatment and prevention. He is the current physician coordinator for pre-participation physical examinations for the high school sports teams. He has spearheaded the education of other physicians involved in the program to identify mental health and substance use issues during the sports physicals - and even in their offices and clinics. He completed medical school at Wayne State University School of Medicine in Detroit, Michigan and residency at Northwestern University in Chicago, Illinois.

Holli Drobny

Holli Drobny is a Community Services Program Manager at Butte County Behavioral Health. Her position encompasses three different roles; MHSA Coordinator, Cultural Competency Coordinator, and Public Information Officer. Holli began her career at Behavioral Health in the Systems Performance, Research and Evaluation Unit as an Administrative Analyst where she gained experience as a key part of the implementation and evaluation team for various projects, including the *Investment in Mental Health Wellness Act of 2013*. Holli is passionate about Behavioral Health services because of her lived experience as a family member of someone living with a severe mental health diagnosis. Holli holds a Bachelor's degree in Communication Studies with an emphasis on Organizational Communication from California State University, Chico.

Dr. Sésha Zinn, Psy.D

Dr. Sésha Zinn is a Licensed Clinical Psychologist who has led the Systems Performance Research and Evaluations team at Butte County Behavioral Health for the past ten years and also has a private practice specializing in childhood trauma. Dr. Zinn holds a Master's degree in Research Psychology and a Doctorate in Clinical Psychology. Prior to her research career she was a social worker with a local foster family agency which led her to serve Butte County as a foster parent for the past 8 years working directly with youth and teens who have experienced trauma.

STAFF ANALYSIS—BUTTE COUNTY

Name of Innovative (INN) Project:	**Physician Committed**
Total INN Funding Requested:	**$767,900**
Duration of Innovative Project:	**Three (3) Years**

Review History:

Approved by the County Board of Supervisors:	February 27, 2018
County submitted INN Project:	February 12, 2018
MHSOAC consideration of INN Project:	May 24, 2018

Project Introduction:

Butte County Behavioral Health proposes to promote interagency collaboration by partnering with the Butte-Glenn Medical Society, Butte County Office of Education and local primary care physicians in order to expand their ability to identify and intervene with adolescents who have risk factors of experiencing mental health and substance use issues.

In the balance of this brief we address specific criteria that the MHSOAC looks for when evaluating Innovation Plans, including:

- What is the unmet need that the county is trying to address?
- Does the proposed project address the need?
- Are there clear learning objectives that link to the need?
- Will the proposed evaluation allow the county to make any conclusions regarding their learning objectives?

In addition, the MHSOAC checks to see that the Innovation meets regulatory requirements, that the proposed project aligns with the core MHSA principles, promotes learning, funds exploration of a new and/or locally adapted mental health approach/practice, and targets one of the four (4) allowable primary purposes.

The Need

Butte County has a population of 229,294 including approximately 10,200 high school age students at 31 public schools (Census, 2017; Public School, 2018).

Butte County reports that they have the highest ACES (Adverse Childhood Experiences) Score in the State of California. In addition, the American Academy of pediatrics and the California Healthy Kids Survey indicated that 29% of Butte County 7th graders, 32% of 9th graders and 33% of 11th graders reported feeling sad and hopeless most days that they stopped doing their usual activities. The same surveys reported that 22% of 9th graders, 17% of 11th graders and 37% of non-traditional high school students reported that they had seriously considered attempting suicide within the past 12 months.

National data indicates that 20% of adolescents, ages 13-18, live with mental illness and that 50% of students age 14 and older with a mental illness drop out of high school. In addition, half of lifetime cases of mental illness begin by age 14 (NAMI, nd; NIMH, 2017).

Butte County asserts that early screening and detection for physical health issues of adolescents is common but that routine screening for behavioral health issues is not common and represents an opportunity for collaboration to incorporate simple screening tools into annual physicals and other encounters with primary care physicians.

Butte County states that in their rural county, primary care physicians play an important role in the lives of children and their families but are often unfamiliar with behavioral health problems. If properly trained and supported, primary care physicians are in a unique position to identify behavioral health symptoms early and often. Butte County hopes to demonstrate that by building collaborative relationships, traditional health screening processes can be transformed to increase capacity of medical providers and result in easier access to intervention, support and/or treatment for adolescents.

The Response

To address the mental health needs of adolescents in Butte County, the Butte-Glenn Medical Society (BGMS) and Butte County Behavioral Health brought together service providers and agency partners (including: Chico Unified school District, Pleasant Valley High School, Chico High School, Butte county Office of Education, local physicians and Butte County Office of Public Health) to discuss how to educate primary care physicians about integrating behavioral health screening into their existing physical health screenings. The group then embarked on a two-year planning and development phase resulting in an established framework to inform, educate and standardize integration efforts. The group adopted two screening protocols, (1) Alcohol Screening and Brief Intervention for Youth (as cited in National Institute on Alcohol Abuse and Alcoholism) for the alcohol portion of the screening and (2) the Brief Mental Health Update (as cited in American Academy of Pediatrics, David S. Rosen MD, MPH) for the mental health portion of the screening process.

During the two-year planning and development period, Butte County Behavioral Health partnered with the BGMS to determine interest in the training. Sixty-seven (67) volunteer

physicians and medical staff were trained and subsequently screened a total of 1,000 youth in 2016 and 2017. The screenings resulted in 48 referrals for further mental health assessment. The County determined that the development phase produced promising results and validated the need to test the program as a county-wide Innovation.

In order to increase the capacity and comfort of physicians, a training plan was developed and will be implemented by a collaborative training team including Butte County's Prevention Unit, Dr. Phillip Filbrandt and other providers. This team will provide all trainings to primary care physicians and other medical staff who participate in this project.

Butte County intends to make the physician training and tools available regionally and anticipates that Glenn County may implement the project as well.

The County may wish to discuss how physicians will be trained to provide behavioral health screenings in a culturally competent manner. County may wish to indicate how training will address the unique experiences of underserved populations including communities of color and the LGBTQ community.

Intervention specialists will be trained and dedicated to this project to work with medical staff when adolescents are determined to need further mental health assessment and will ensure a "warm hand off" each time a referral is made. The intervention specialists will contact the adolescent within two business days and the adolescent will be invited to meet with the specialist for three follow-up sessions. The brief intervention sessions will incorporate Cognitive Behavioral Therapy and Motivational Interviewing techniques. Following the three sessions, the adolescent and the specialist will determine next steps, which may include closure or a transition to a longer-term treatment plan.

If there is an immediate need for crisis intervention, the physician will contact Butte County Behavioral Health Crisis Services directly.

During the technical assistance process with MHSOAC staff, concerns were raised about adolescent privacy concerning their health record being shared with their high school. The County states that there will be a mutually agreed upon memorandum of understanding between Butte County Behavioral Health and school districts to ensure confidentiality for the adolescent and the outcomes of their screening.

Butte County asserts that there are studies and tools available for the screening of substance use and abuse in behavioral health settings but that the screenings are not incorporated in primary and pediatric care settings. Initial research indicates that there may be an opportunity for Butte County to reach out to other counties to hear lessons learned as they begin to scale up this project.

The following counties have related projects: Nevada County implemented a project called "Integrated Healthcare" in March of 2011 where they sought to develop a mental health screening and assessment to be used in three community clinics. Butte County may wish to communicate with Nevada County to review their screening and assessment tools and evaluation.

The City of Berkeley worked with the Niroga Institute in February of 2012 and implemented a holistic health services program for transition age youth to understand the impact and outcomes for youth who received mental and physical health interventions simultaneously. Butte County may wish to communicate with the City of Berkeley to review their evaluation of the holistic care delivery model.

Butte County may be interested in communication with San Francisco County about their "Building Bridges: Linking Schools and Community Clinics Innovation project that began in March 2011.

Nationally, there are several programs identified by the American Academy of Pediatrics that focus on integrating behavioral health care with primary care. Two programs that Butte County may wish to research are: (1) North Carolina, Northern Pediatrics incorporates an Integrated Care Model for behavioral health services. Primary care physicians meet with a behavioral health counselor to determine the best patient-centered interventions. Northern Pediatrics developed systems of care for patients to be seen for mental health concerns the same day as their appointment with their physician. (2) In Vermont, a pediatric practice employs 4 mental health therapists and two mentors on site to ensure that the pediatricians can secure timely mental health appointments for their patients in a less stigmatizing environment.

Butte County may also wish to discuss lessons learned from their 2010 Innovation "Early Interventions Systems for Youth Task Force" where the County sought to develop an effective model for services.

This project proposes to build upon the initial findings and introduce behavioral health screenings in a multitude of healthcare settings by building collaborative relationships with primary care providers who will be trained and supported to integrate the screening protocols into existing physical health screenings. Butte County is proposing to further collaborate with local school districts to incorporate the behavioral health screening into the required annual athlete physical. *By incorporating the screening into annual athlete physicals, Butte County states that they are introducing a new application into the mental health system of a promising community-driven practice that has been successful in the physical health setting.*

The Community Planning Process (CPP)

Butte County reports that the Butte-Glenn Medical Society introduced the idea of this proposal in 2015 as a way to gain necessary knowledge and skills related to adolescent behavioral health. Butte County reports that they began a CPP process in the Fall of 2016 and held four community meetings in the four largest towns. The meetings were advertised through email distribution lists. Butte County reports that community feedback was received via survey and verbal responses and that the desire of the community was to move forward with this proposed project. In November 2017, this project was listed for 30-day public comment and six additional community meetings were scheduled. These meetings were promoted on Butte County's MHSA website, at each service site and via community email distribution lists. Stakeholder meetings, which include various advisory groups, were also shown the Innovation presentation. All community and stakeholder

meetings concluded with the opportunity for verbal and/or written feedback. In addition, a survey was developed and 105 responses were received.

The County may wish to include survey results mentioned in their proposal, identify how many community members participated in the two rounds of meetings, include any demographics and identify if meaningful participation from consumers and family members occurred.

This Innovation project was shared with MHSOAC stakeholders on February 21, 2018 and no letters of support or opposition were received in response.

Learning Objectives and Evaluation

Butte County has proposed implementing a project that will allow for a more standardized approach to screening for adolescent behavioral health issues. Physicians and Physician Assistants will be provided with training and support relative to the adoption of the Alcohol Screening and Brief Intervention for Youth tool, as well as the Brief Mental Health Update tool. These screening tools will then be used to identify the early onset of behavioral health issues that may require intervention, support, and/or treatment. The target population for this project is two-fold: (1) a group of 30-45 physicians and physician assistants will be targeted for training on screening tools that will be used in the project; and (2) the County estimates that 500 adolescents will be screened in the first year of the project, with increases in subsequent years.

Butte County has identified three main learning goals for the project:

1. Physicians will experience an increased comfort level screening adolescents for behavioral health issues
2. Physicians will effectively incorporate behavioral health screening into comprehensive health screenings
3. The Physician Committed project model will be successful on a countywide scale, including improved outcomes among adolescents.

In order to meet these learning goals, the County has identified four main learning questions:

1. Can behavioral health screenings be effectively and efficiently integrated into the comprehensive adolescent health physical?
2. Does this project provide the physician/primary care provider with more confidence and capacity in regards to screening for behavioral health issues?
3. Will physicians' comfort levels with discussing behavioral health and adolescents increase with comprehensive training and the implementation of a standardized tool?
4. Do adolescents feel more capable of managing early symptoms of behavioral health issues?

Outcomes that the County hopes to achieve include: an increase in comfort level among physicians screening adolescents for behavioral health, adolescents feeling more capable of managing early symptoms, the prevention of the need for more intensive treatment among adolescents, an increase in adolescent coping skills, and a reduction in

depression, anxiety, and stress among adolescents. *Measures* to arrive at these outcomes include: number of completed screenings by primary care physicians, number of physicians trained, number of adolescents identified as high-risk, number of adolescents referred to mental health services, among others (**see pg. 13 of County plan**).

Data to measure outcomes relative to physicians and training will be gathered through pre-post training surveys, as well as 30-day follow up surveys. Data to measure outcomes relative to adolescents will be gathered through post intervention surveys, Child and Adolescent Needs & Strengths (CANS) outcomes data, as well as information from electronic health records (Avatar). **The County may wish to address how they will establish baseline data for comparisons, as well as what types of "outcomes reported in clinical documentation" will be used for the evaluation (see pg. 14). It is important for the County to clarify if other clinical tools/scales will be used (i.e. Beck Depression Inventory, Hamilton Depression Rating Scale, etc.)**. All data will be gathered by program staff, and analyzed by the Butte County Systems, Performance, Research and Evaluation team.

The Budget

The proposed budget for this innovation project is $767,900 over three (3) years. Butte County reports that they have $430,570 of fiscal year 15/16 funds subject to reversion that they will utilize for this project. The remaining budget will be funded with funds available through Assembly Bill 114. The project is proposed to begin July 1, 2018 and end June 30, 2021.

Butte County is encouraged to identify which fiscal year of funding will be utilized for this project after the 15/16 funds are expended.

The majority of the budget is going towards the costs of personnel which includes funding for 2 FTE Behavioral Health Education Specialists and a potential peer position in the role of Behavioral Health Specialist. Personnel costs total $556,918.

The County lists total administration costs as $56,882, 7.4% of the total budget; operating costs as $48,600, 6.3% of total budget and one-time costs of $27,500 for desk packages and the production of a training video. The evaluation will be conducted by the Butte County Systems Performance Research and Evaluation team, led by Dr. Sésha Zinn, Psy.D. and is budgeted at $64,025 (8.3% of the total budget).

Butte County is encouraged to identify how many personnel positions will be funded with this project.

Additional Regulatory Requirements

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

References

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Full project proposal can be accessed here:

http://mhsoac.ca.gov/document/2018-05/butte-county-inn-plan-description-physician-committed

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Butte County Innovation Brief: Physician Committed

Project Category
Apply to the mental health system a promising community-driven practice or approach that has been successful in non-mental health contexts of settings.
Primary Purpose
Promote interagency collaboration related to mental health services, supports, or outcomes.

Physician Committed will transform the primary healthcare setting that traditionally focuses on physical health, into a comprehensive system of care that includes behavioral health and emotional wellness. Behavioral health screening typically only occurs in the behavioral health setting, creating greater likelihood that adolescent behavioral health issues are going undetected in the health care system and in educational settings. This project implements and standardizes mental health and substance use screening process into the primary care settings, as well as high school sports physical screenings. In addition, Physician Committed designates an Intervention Team to provide real time consultation as well as face-to-face interventions (within 48 hours) for the at-risk youth to potentially facilitate a seamless transition into behavioral health services.

This initiative includes:

- Increasing the capacity and reach of the Behavioral Health system of care by integrating primary care facilities as potential access points to services.
- Low cost/no cost high school athletic physicals; access to everyone regardless of insurance coverage or economic status.
- Provide assessments to a significant number of the adolescent population, including diverse populations.
- Increasing skills and comfort level of primary care providers to address behavioral health issues through extensive support and training.
- Behavioral health access line for primary care physicians to relate at-risk youth.
- Promoting early intervention of behavioral health issues.

Practitioners will receive the training and support from Butte County Behavioral Health (BCBH) that they need to enhance their healthcare screening processes. As they practice and experience the dialogue associated with a behavioral health screening, they will feel more comfortable and less apprehensive about addressing these critical issues. By including questions about mental health and substance use in a routine health physical, adolescents will have the opportunity to start a conversation with their physician and determine if their risk level requires a referral to the Intervention Team. If a young person is screened to be at-risk by the physician, an intervention specialist meets with him/her within two days. The follow-up intervention consists of three sessions intended to:

- provide a forum for a young person to talk about their issues,
- give accurate history and information,
- identify related issues,
- empower the young person to set goals and make informed choices,
- assist the young person in accessing other services when appropriate

The brief intervention sessions infuse Cognitive Behavioral Therapy (CBT) and Motivational Interviewing (MI) approaches.

Expected Outcomes

Clients:

- Early detection and access to care for behavioral health issues.
- Reduction in mental health symptoms including depression, anxiety, and stress; increase in coping skills.

Medical Professionals:

- Physicians, nurse practitioners and physicians' assistants will increase their knowledge, skill, comfort level, and capacity for implementing the screening questions for behavioral health issues.
- Standardize processes for adolescent behavioral health screening will be incorporated into comprehensive health physicals in pediatric offices.
- Increase in referrals for intervention and/or treatment for behavioral issues in adolescents.

Learning Questions

1. Can behavioral health screenings be effectively and efficiently integrated into the comprehensive adolescent health physical?
2. Does this project provide the physician/primary care provider with more confidence and capacity in regards to screening for behavioral health issues?
3. Will physicians' comfort levels with discussing behavioral health and adolescents increase with comprehensive training and the implementation of a standardized tool?
4. Do adolescents feel more capable of managing early symptoms of behavioral health issues?

Evaluation

The evaluation will be conducted by the Butte County Systems Performance Research and Evaluation team, led by Dr. Sésha Zinn, PsyD and is budgeted at $64,025 (8.3% of the total budget).

Project Outcome	Project Measurement
Will physicians experience increased comfort level screening adolescents for behavioral health issues?	This will be measured through the pre/post training surveys, 30-day follow up surveys and qualitative feedback received.
Can behavioral health screenings be effectively and efficiently integrated into the comprehensive adolescent health physical?	This will be measured through the pre/post training surveys, 30-day follow up surveys and qualitative feedback received.
Will adolescents feel more capable of managing early symptoms as a result of the intervention received (motivational interviewing and cognitive behavioral therapy techniques)?	This will be measured through the post intervention survey completed by the adolescent on the last session.
Does early identification and intervention prevent the need for more intensive treatment?	Intervention Specialist and client feedback
Will adolescents coping skills increase as a result of the intervention received?	This will be measured through the post intervention survey completed by the adolescent on the last session.
Will adolescents' mental health symptoms, such as depression, anxiety, and stress be reduced?	This will be measured through: • The pre-survey/baseline will be the results of the screening tools that determine the youth's risk level. • The post intervention survey completed by the adolescent on the last session. • by outcomes reported in clinical documentation for clients who are admitted to BCBH

Was the interagency collaboration between BCBH, BGMS, pediatric offices, and local school districts a success?	This will be measured through: • feedback from the staff who participated in the collaboration • by the number of physicians trained • the number of physicians actively using the screening tool

The Budget
$767,900 over three years will include:

- Salaries for 2 FTE (full-time employment) Behavioral Health Education Specialists
- Salary for .5 FTE peer provider
- Training for medical providers
- Production of screening toolkits
- Evaluation of project, .25 FTE Administrative Analyst dedicated
- Administrative costs

Reversion Considerations
Pending DHSC approval, Butte plans to spend all MHSA funding subject to reversion first. This may result in FY 2015-16 and FY 2016-17 funding being spent prior to funding identified as AB 114 funding.

Cultural Competency
All BCBH staff and its providers are required to engage in Cultural Competency Training on an annual basis. The Intervention Team will meet the BCBH Cultural Training requirements. BCBH facilitates Cultural Grand Rounds training on a quarterly basis, which are provided by our local community based organizations. In 2018, Grand Rounds are provided by Butte County NAMI, the Hmong Cultural Center, Stonewall Alliance (LGBTQI+), and the African American Family & Cultural Center, as well as others.

Screening materials and toolkits are translated in Spanish, with future plans to translate into Hmong. Youth who are screened to be at-risk may potentially be referred to our cultural provider partners (e.g., African American Family & Cultural Center, Zoosiab: Hmong Cultural Center, Promotores, Live Spot).

The BCBH Cultural Competency Committee review approved this Innovation project. This Committee currently seats 30 participants. There are individuals who represent African American, Native American, Latino, Hmong, Consumers, Family Members (NAMI), Substance Use Disorder, Veteran, Homeless Adult, Homeless Youth, and LGBTQI+.

Community Input Process
Physician Committed has been included in three different Community Input Processes. The comprehensive outcomes of these meetings can be found in the respective Plan Updates. Overall, community response to Physician Committed has been very favorable.

- **Innovation Community Input 2016** (47 participants): There were four community meetings held; one in each of the most populated towns in Butte County (Chico, Oroville, Paradise, and Gridley). The meetings included a presentation from the MHSA Coordinator that described the MHSA and detailed the Innovation component and its requirements. Physician Committed was presented as one of four innovative projects to be considered for further development. Community feedback was gathered via survey and verbal response. The outcome of these

meetings confirmed the desire of the community for Physician Committed to move forward in the Innovation process to implement these services county-wide.

- **MHSA Three Year Plan Community Input 2017** (182 participants): Physician Committed was presented for Community Input during the development of the Three Year Plan.

Three Year Plan Meetings	
African American Family & Cultural Center	Chico (3 meetings)
Iversen Center	Gridley (2 meetings)
Hmong Cultural Center*	Oroville (3 meetings)
Promotores (2 meetings)*	Paradise (2 meetings)
Stonewall Alliance	

**Translator provided*

There were significant interactions with the community about MHSA overall, however, there was a lack of feedback in regards to Innovation. Therefore we determined the need for another round of Community Input in November 2017.

- **Innovation Community Input 2017** (105 participants): On November 1st, 2017, a 30-day public comment period began for the Innovation component. BCBH chose to initiate another round of community meetings to be held to a) focus on the Innovation component; b) refresh on Physician Committed: c) inform the community on another potential projects; and d) solicit new Innovative ideas. During this time period, there were six community meetings (two in Chico and Oroville, one in Paradise and Gridley) that included a presentation to educate the community on the Innovation component and its requirements. In addition, a survey was developed to gain meaningful insight from community members. The survey was designed to also briefly inform the participants that were not able to attend community meetings, although that was strongly recommended. This Innovation presentation was demonstrated to the Behavioral Health Board, BCBH Quality Improvement Committee, and the BCBH Cultural Competency Committee. The results from the 30-day period garnered insightful feedback for each proposed project, along with recommendations from the participants for new Innovation projects.

Summary of Community Input

Actions BCBH took based off community response are:

- Include a budget to increase the line staff at the county agencies to ensure the referring agency has enough staff to support all the referrals.
- Target all providers no matter what type of clientele they serve (low income, middle class, etc.)
- Referral tracking and follow-up
- Making certain that the presentation to new physicians will get them excited about the project.

Feedback on how to strengthen this project:

- “Could you partner with the area hospitals as well? Since they have certain requirements for their affiliated physicians, they could ensure that their providers are participating in the Physician Committed Project.”
- “I would love to see public education on the matter should it get funded. We've all seen the commercials about which medications we should ask our doctor about - what if we also knew we could talk to our doctor about mental health and they would be open to it?”

Top concerns or perceived barriers:

- Finding physicians who want to participate; physician’s level of commitment and participation.
- “There is a shortage of doctors in Butte County so that is something that should be addressed as opposed to just adding more paperwork for families to fill out.”
- The increase of screenings with a lack of services and treatment options for youth.

AGENDA ITEM 6

Action

May 24, 2018 Commission Meeting

Sacramento County Innovation Plan

Summary: The Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission) will consider approval of Sacramento County's request to fund the following Innovative project: Behavioral Health Crisis Services Collaborative.

Sacramento County proposes to implement the Behavioral Health Crisis Services Collaborative in partnership with Placer County Behavioral Health and Dignity Health. To address the needs of the behavioral health population in the Northeastern segment of Sacramento County, the County wishes to provide adult crisis stabilization services on the Mercy San Juan Medical Center hospital campus. The location of the adult crisis stabilization will serve residents, 18 and older, within both Sacramento and Placer Counties.

The Mental Health Services Act (MHSA) requires that an INN project does one of the following: (a) introduces a new mental health practice or approach, including but not limited to prevention and early intervention; (b) makes a change to an existing mental health practice or approach, including, but not limited to, adaptation for a new setting or community; (c) introduces to the mental health system a promising community-driven practice/approach, that has been successful in non-mental health contexts or settings; or (d) participates in a housing program designed to stabilize a person's living situation while also providing supportive services on site. The law also requires that an INN project address one of the following as its primary purpose: (1) increase access to underserved groups, (2) increase the quality of services including measurable outcomes, (3) promote interagency and community collaboration, or (4) increase access to services.

Presenters:

- Supervisor Patrick Kennedy, District Two, Sacramento County Board of Supervisors (Introductory Remarks)
- Uma K. Zykofsky, LCSW, Sacramento County Mental Health Director, Alcohol & Drug Services Administrator
- Rosemary Younts, Senior Director of Behavioral Health, Dignity Health
- Tara Niendam, Ph.D., Associate Professor in Psychiatry, Executive Director, University of Davis Early Psychosis Programs
- Amy R. Ellis, MFT, Placer County Mental Health Administrator, Drug and Alcohol Administrator, Public Administrator, and Public Guardian
- Leslie Napper, Peer/Self-Advocacy Supervising Coordinator

Enclosures (3): (1) Biographies for Sacramento County Innovation Presenters; (2) Behavioral Health Crisis Services Collaborative Project Brief; (3) Behavioral Health Crisis Services Collaborative Staff Analysis.

Handout (2): (1) A PowerPoint will be presented at the meeting; (2) Any letters of support.

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

http://mhsoac.ca.gov/document/2018-05/sacramento-county-inn-plan-description-behavioral-health-crisis-services

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

Name: Behavioral Health Crisis Services Collaborative
Amount: $18,781,381
Project Length: Four (4) Years

Sacramento County Division of Behavioral Health Services

Innovation Project 3 Plan: Behavioral Health Crisis Services Collaborative Presentation Biographies

Uma K. Zykofsky, LCSW, is a Deputy Director for Sacramento County's Department for Health Services (DHS). She represents DHS as the Behavioral Health Director -- Mental Health Director and the Alcohol and Drug Administrator. Ms. Zykofsky has worked for Sacramento County since 1997. Prior to work at the County, she worked in local community based non-profit agencies in a variety of areas touched by health and human services. Her wide-ranging experience with this County includes mental health direct service across both children and adult programs, clinical supervision and administration in both the county and contract provider system. Her experience also includes a wide range of skills as a multilingual, multicultural Licensed Social Worker. She represents Sacramento County in various local and statewide committees and associations designing and promoting mental health and alcohol and drug service initiatives.

Amy R. Ellis, MFT, is the director for Placer County's Behavioral Health Services. In her role as the director, she serves as the Mental Health Administrator, Drug and Alcohol Administrator, Public Administrator, and Public Guardian. Her prior experience and work includes providing direct mental health children services and adult services which included crisis services. She also supervised and managed multiple mental health and substance use adult services programs. Ms. Ellis has been involved in many community stakeholder and planning initiatives and believes in strong collaboration and integration of services to improve the experience of consumers and staff. She represents Placer County who is a collaborating partner in this Proposed Innovation Project.

Supervisor Patrick Kennedy is Supervisor for District 2 on the Sacramento County Board of Supervisors. He serves on the Sacramento County Mental Health Board as the Board of Supervisors' representative. Supervisor Kennedy is a Governor's Appointee serving on the No Place Like Home (NPLH) Advisory Committee representing Large County Boards of Supervisors. He has convened and participated in a variety of initiatives including local stakeholders to address innovative approaches to mental health and co-occurring services for all ages in Sacramento County. As a champion for mental health/behavioral health services, he led efforts to bring forth a Resolution, in partnership with the National Alliance on Mental Illness (NAMI) Sacramento, proclaiming May 2017 as "Mental Health Awareness Month" in Sacramento County to increase public understanding of the importance of mental health and to promote identification and treatment of mental illness. Supervisor Kennedy was represented on the Workgroup that developed the recommendation for this Innovation Project and actively supports and advocates for mental health and substance use disorder services across the community.

Rosemary Younts is the Sr. Director of Behavioral Health for Dignity Health's Greater Sacramento Service Area, providing leadership and strategic oversight for behavioral health services at six member

hospitals within a three-county region. She is responsible for facilitating and developing behavioral health practice and process improvements to enhance access, quality, coordination and timeliness of care, and leads efforts to integrate behavioral health care into the acute medical hospital setting. Working in collaboration with clinical teams and community partners, her efforts have resulted in the integration of Psychiatric RNs into the emergency department, implementation of best practice workflows, establishment of community-based navigation and outpatient partnerships, and the addition of onsite specialty care and tele-medicine. Ms. Younts serves as a member on Sacramento County's Mental Health Services Act Steering Committee. She represents Dignity Health who is a collaborating partner in the Sacramento County's Proposed Innovation Project.

Tara Niendam, Ph.D. is an Associate Professor in Psychiatry and a licensed clinical psychologist with specialized training in psychodiagnostic and cognitive assessment in youth, particularly for individuals at risk for or in the early stages of psychosis. Dr. Niendam is the Executive Director of the University of Davis, Early Psychosis Programs (EDAPT and SacEDAPT Clinics). In this role, she supervises clinic activities and staff, and coordinates outreach and educational presentations within the community. She also serves as the Co-Director for the HRSA funded pre-doctoral Trauma and Adolescent Mental Illness (TAMI) internship, which is a collaboration with the UC Davis CAARE Center to provide evidence-based trauma informed care to youth with early psychosis. In her research, Dr. Niendam is interested in improving outcomes and supporting recovery for youth in the early stages of psychosis. She leads a variety of research projects that focus on reducing the duration of untreated psychosis through technology-assisted interventions, examining the use of smartphones as part of clinical care for youth with psychosis, and evaluating program-related outcomes for early psychosis clinics across California. She represents UC Davis Early Psychosis Programs, also a collaborating partner in this proposed project.

Leslie Napper is a Peer/Self-Advocacy Supervising Coordinator for Disability Rights California (DRC) and a former Patients' Rights Advocate in Sacramento, Yolo, Napa, and San Joaquin Counties. Ms. Napper has served as Chair on the Protection and Advocacy for Individuals with Mental Illness (PAIMI) Advisory Council, DRC's Board of Directors, CalMHSA Advisory Council, as well as served on Sacramento County's Mental Health Board. She currently serves on Sacramento County's MHSA Steering Committee representing Adult Mental Health Consumers. As a consultant to California Institute for Mental Health (CIMH) Ms. Napper developed and lead a statewide African American Mental Health Consumer Leadership trainings, as well as facilitated and assisted in the development of trainings providing technical advice to California's Local Mental Health Boards/Commissions. Ms. Napper worked closely with DRC's legal team in litigation in support of consumer services. She is passionate about empowering others to advocate for themselves and others to eliminate the stigma associated with mental illness and effect change. She identifies as a person living with a Mental Health disability and has been a respected Mental Health Advocate for over 15 years. Ms. Napper participated as a panelist, sharing her personal story, and workgroup member, contributing invaluable input, in the development of this proposed project.

STAFF ANALYSIS–SACRAMENTO COUNTY

Innovation (INN) Project Name: Behavioral Health Crisis Services Collaborative

Total INN Funding Requested: $18,781,381

Duration of Innovative Project: Four (4) Years

Review History:

Approved by the County Board of Supervisors:	Pending MHSOAC Approval
County submitted Innovation (INN Project):	March 22, 2018
MHSOAC consideration of INN Project:	May 24, 2018

Project Introduction:

Sacramento County proposes to implement the Behavioral Health Crisis Services Collaborative in partnership with Placer County Behavioral Health and Dignity Health. To address the needs of the behavioral health population in the Northeastern segment of Sacramento County, the County wishes to provide adult crisis stabilization services on the Mercy San Juan Medical Center hospital campus. The location of the adult crisis stabilization will serve residents, 18 and older, within both Sacramento and Placer Counties.

In the balance of this brief we address specific criteria that the MHSOAC looks for when evaluating Innovation Plans, including:

- What is the unmet need that the county is trying to address?
- Does the proposed project address the need?
- Are there clear learning objectives that link to the need?
- Will the proposed evaluation allow the county to make any conclusions regarding their learning objectives?

In addition, the MHSOAC checks to see that the Innovation meets regulatory requirements, that the proposed project aligns with the core MHSA principles, 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 better outcomes; promotes interagency collaboration; and increases access to services, including, but not limited to, services provided through permanent supportive housing. Sacramento County states this project meets all four (4) of the primary purposes of innovation projects and meets the innovation criteria of introducing

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

The Need

Sacramento County states they continue to actively seek ways to address the lack of crisis services available for consumers and their families within the County. The County has offered various programs addressing crisis services and wishes to expand upon what has been previously implemented.

In January 2014, Sacramento County was granted Senate Bill (SB) 82 Triage Funds in the amount of $4,474,908 to implement a Triage Navigator Program within local Emergency Departments, the County Jail, and local homeless services campus; however, the County states the efforts have not been enough to provide assistance and relief to consumers. The term of their contract began March 24, 2014 and concluded on June 30, 2017; however, a one-year contract extension was given and their triage program will end on June 30, 2018. **The County is encouraged to explain how this innovation project is different from the Triage Navigator Program that was implemented with SB 82 Triage Grant Funds, scheduled to end June 30, 2018.**

There are four local Emergency Departments that serve communities in northern Sacramento: Mercy San Juan Medical Center, Sutter Roseville Medical Center, Kaiser Roseville Hospital, and Mercy Hospital of Folsom. In FY 16/17, Sacramento's Mental Health Treatment Center and Intake Stabilization Unit received 1,431 referrals from Emergency Departments located in the northern areas in Sacramento, resulting in 340 clients (24%) needing admission into the Intake Stabilization Unit or requiring inpatient psychiatric services.

Mercy San Juan Medical Center provides broad services for 28 different zip codes for residents living within Sacramento County extending into Placer County. A large amount of Mercy San Juan's service area include underserved populations as being medically underserved. These areas include: North Highlands, McClellan, Rio Linda, Antelope, Carmichael, Citrus Heights, Orangevale, Fair Oaks and parts of Roseville and Lincoln. The County claims that over half (56%) of those insured by Medi-Cal in the County reside in Mercy San Juan's primary service area.

The County asserts the primary communities served by Mercy San Juan Medical Center scored second highest for communities with significant barriers to health care access. These communities were scored utilizing a Community Needs Index tool which was developed by Dignity Health and Truven Health Analytics. The Community Needs Index analyzes data utilizing zip codes to assess five factors known to contribute to barriers in accessing health care: income, culture/language, education, housing status, and insurance coverage. Sacramento County states that communities with highest scores experience hospital admissions twice as much compared to those with lowest scores. Given the need of these communities served by Mercy San Juan Medical Center and the geographic barriers of the region, the County feels creating a partnership with Placer County and Dignity Health would address the medically underserved and behavioral health underserved communities in need.

Sacramento County asserts that Placer County also experiences similar challenges regarding the lack of available crisis resources within their County. Placer County does have a Psychiatric Health Facility which provides 16 beds; however, there are no other psychiatric treatment facilities in the County. If there are no beds available in Placer County, clients are referred to other counties, sometimes several hours from their home.

As a result of challenges similar to Sacramento, Placer County partnered with Sutter Health, local law enforcement agencies, the Placer County Jail and contracted providers to work in partnership to address resources surrounding mental health crisis services. These agencies meet on a quarterly basis to find ways to effectively provide treatment for those in crisis without delaying needed treatment. Placer County claims there were 3,067 crisis evaluations completed in fiscal year (FY) FY15/16, and that number increased by 5% to 3,215 in FY 16/17. Of the 3,215 crisis evaluations completed in FY 16/17, 2,033 (63%) were assessed at Sutter Roseville and 698 (21%) were assessed at Sutter Auburn Faith Hospital. Both Placer and Sacramento Counties contend that 50% of individuals waiting for psychiatric placements will wait more than eight hours and nearly 25% will wait over 24 hours from the time they seek a crisis evaluation.

Sacramento County's Mental Health Treatment Center provides short term acute inpatient services for adults 18 and older, which is adjacent to the Intake Stabilization Unit. The Intake Stabilization Unit provides 50 inpatient psychiatric beds and provides up to 23-hours of crisis stabilization. Although the Intake Stabilization Unit works closely with hospital Emergency Department staff and law enforcement agencies to provide around- the-clock crisis stabilization services, the location of both of these Centers are a significant distance away from the northern Sacramento area, where both Sacramento and Placer County wish to partner with Dignity Health to provide crisis stabilization services on the hospital campus of Mercy San Juan Medical Center.

The Response

The County claims Mercy San Juan Medical Center is the only acute medical center located in northern Sacramento County and sees more than 200 adults and children per day. Furthermore, both Sacramento and Placer Counties indicate a significant number of adult patients that are seen in the Emergency Department are in need of mental health care and providing appropriate care can be a challenge that can require patients to wait an average of 32 hours when needing to be transferred to an inpatient psychiatric hospital.

Due to the geographic challenge of residents who need crisis care and do not live near Sacramento County's Mental Health Treatment Center, the lack of access to behavioral health services continues to be a concern for residents in Northern Sacramento communities along with those living in Placer County.

By incorporating emergency care with crisis stabilization services on the hospital campus of Mercy San Juan, the Counties state that it will be able to provide timely access for mental health services for Sacramento and Placer County residents, 18 years and older, who are experiencing a mental health crisis. Upon being medically stabilized in the Emergency Department, the individual would immediately be transitioned to a modular facility adjacent to the Emergency Department to receive crisis stabilization services. The facility and the ongoing maintenance of the building will be paid for and provided by

Dignity Health and will be built to meet the Office of Statewide Health Planning and Development standards for licensed clinics. The modular facility will have an initial capacity to provide services for 12 consumers at any given time.

Crisis stabilization services will receive nursing, clinical, and psychiatric assessments to assist in determining whether admission to an inpatient facility is needed or if clients can be discharged with appropriate referral linkages and/or a treatment plan. Additional services will include:

- Behavioral health assessment
- Psychiatric assessment
- Medication evaluation and management
- Administering first break screening for early identification and intervention of psychotic disorders
- Evaluation for voluntary or involuntary detention
- Admissions evaluations for inpatient psychiatric hospitalizations, if needed
- Peer and Family Support
- Transportation, if needed
- A Resource Center that will offer aftercare planning and linkages to community services for both Sacramento and Placer County residents
- Secure clinical information exchange among hospital, county, and other providers to ensure continuity of care

Sacramento County claims this is innovative as it will incorporate crisis stabilization services into an acute care hospital setting and form meaningful collaborations in an effort to deliver quality emergency and human-centered mental health crisis care. Community based organizations within both Sacramento and Placer County will be part of this collaborative to provide services and support to consumers and their families. Sacramento County Behavioral Health Services, Placer County Mental Health, and Dignity Health will develop an agreement to clarify roles, responsibilities and governance.

Additionally, Sacramento states that Placer County will assume financial responsibility for their clients who receive services through this project and will develop an agreement to clarify Placer County's roles and financial responsibilities.

The County asserts this project is innovative as it provides an opportunity within the hospital system to serve residents, regardless of health insurance coverage, from two separate counties to partner up to build a model of care that may be replicated in other counties.

The Community Planning Process

Sacramento County began their Community Planning Process (CPP) for this innovation project at a Steering Committee meeting in May 2017. The County reports that an overall recurring community concern has focused on the lack of crisis services available for consumers. The County further reports that stakeholders and the community participated in, and provided input on, CPP discussions dating back to 2010 which has led the County to the development of a Prevention and Early Intervention project as well as SB 82 triage funds being awarded to implement a Crisis Residential Program and Mobile Crisis

Support Team. Although these programs were implemented, community concerns continue to focus on those experiencing a mental health crisis.

Dignity Health approached Sacramento County with a concept to develop a partnership with Sacramento and Placer Counties with intent to explore mental health services focused around crisis services. The proposed project was introduced and discussed at the Steering Committee in May 2017. The County received full support to convene a workgroup whose primary task would be to solicit and incorporate additional community input. Workgroup meetings for this project began in July 2017. Community members reviewed Innovation guidelines, the project's purpose, the learning objectives, and participated in robust discussions which were then reported back to the Steering Community in August 2017. The Steering Committee reviewed and discussed the feedback brought forward by the Workgroup and recommended moving this Innovation Project forward to MHSOAC for consideration and approval. **The county may wish to discuss the early development of the Innovation Plan, and whether or not it originated with the County or as a result of community input.**

Upon approval by the MHSOAC, Sacramento County will seek approval from their Board of Supervisors, although the Board of Supervisors issued approval on April 10, 2018 of the County's three-year spending plan, which included this Innovation Project.

Sacramento County also attached letters of support from Dignity Health, Anthem Blue Cross, Office of the Sacramento City Manager, Health Net, Hospital Council of Northern & Central California, Sacramento Metropolitan Fire District, Sierra Sacramento Valley Medical Society, and the Steinberg Institute.

During the 30-day posting of Sacramento County's FY 2016/17 Annual Plan, stakeholders which included consumers, family members, community members, and community partners, offered support to continue to focus efforts surrounding the lack of crisis services available. As a result, stakeholders encouraged the County to explore a partnership and collaboration with other health systems in an effort to continue building upon the County's previous plans to address and focus on crisis services for consumers and their families.

The MHSOAC shared this Innovation Project with stakeholders beginning March 28, 2018. No letters of opposition or support were received in response.

Learning Objectives and Evaluation

Sacramento County has proposed implementing a project that will integrate emergency care and crisis stabilization services. This collaborative will take place on the campus of Mercy San Juan Medical Center, providing services to individuals in Sacramento and Placer County. Specifically, the project will target adults 18 years or older who present a mental health crisis in an emergency department, are stabilized, and would benefit from multi-disciplinary mental health evaluation and crisis services. The County estimates that the project will serve approximately 2,000 individuals annually.

Sacramento County has identified three main learning questions to guide the project:

1. Is integrated and coordinated emergency medical and mental health crisis services provided through a public and private collaboration an effective strategy in removing existing barriers in accessing mental health crisis stabilization services?
2. Do the services provided through a public/private partnership improve the quality and scope of crisis stabilization services and improve mental health outcomes for consumers?
3. Does an interagency collaboration with shared governance and regulatory responsibility improve the efficacy and integration of emergency medical and mental health crisis stabilization services?

Outcomes the County hopes to achieve include:

1. Increased access to emergency medical and crisis stabilization services for those who are geographically isolated in the Northern Area of Sacramento.
2. Improved quality of crisis services, including better outcomes for clients being served by the project.
3. Effective interagency collaboration.

In order to evaluate barriers and increases in quality, the County has identified several *indicators,* including: utilization of crisis services, timely access, utilization of resources, early psychosis identification, and consumer satisfaction, among others. To evaluate the public/private collaboration, the County will utilize the Measuring Effective Collaborations and Partnerships (MECAP) tool. The MECAP tool examines three levels of involvement by identifying characteristics and behaviors that are present in collaborations and partnerships. This allows for the assessment of measures that are used in examining effectiveness as well as areas for improvement (MECAP, 2009). *Indicators* to evaluate the improved efficacy of the integration of emergency medical and health crisis stabilization services include: partnership accessibility, continuity of care, consumer satisfaction, and interoperability. Additionally, several *measures* have been identified by the County to evaluate each indicator (**see pgs. 24-26 of County plan**).

While specifics to how each learning question/objective will be evaluated are provided, **the county may wish to identify specific methods that will be used to gather these data, and also identify what baseline data will be utilized to arrive at each outcome.** Data for the evaluation will be collected by program staff. An outside evaluator will be contracted to analyze and complete the final evaluation of the project.

The Budget

The total cost of this Innovation Project is $18,781,381 for a total of four (4) years. The largest portion of the budget is for personnel expenses totaling $11,475,663, or 61% of the budget.

The following staff will be hired to provide direct service: 1 Full-Time Equivalent (FTE) Manager, 8.42 FTE Psychiatric Nurses, 2.0 FTE Licensed Psychiatric Technicians, 2.0 FTE Peer Mentors, 0.50 FTE Social Worker, 1.0 FTE Peer Advocate, 1.0 FTE Family Advocate, 1.75 FTE Psychiatrist, 0.53 FTE Tele-psychiatrist Consults. The adult crisis

stabilization will be staffed 24 hours per day, 7 days per week. **The County may wish to provide information on the compensation for the Peer Advocate.**

Dignity Health will be investing a total of $2,808,000 (15%) towards the design and construction of the modular facility along with paying for the associated operating costs. The facility will be located on the hospital campus of Mercy San Juan. The County will furnish the modular facility with computer equipment, and interior/exterior furnishings to exude a warm, friendly environment. Equipment and furniture are one-time costs estimated to be $500,000 (2.7% of total budget).

The evaluation component is $1,262,304 (6.7%) of the total budget and the County estimates Federal Financial Participation (Medi-Cal) reimbursement in the amount of $2,088,020 will be received as additional revenue.

Dependent upon the success of the Innovation Project, the County indicates they would like to sustain the project by utilizing Community Service and Support (CSS) funds leveraged with Medi-Cal reimbursement, as appropriate.

In reference to Assembly Bill 114 regarding reversion of funds, the County states they will be using funding from Fiscal Years 08/09, 12/13, 13/14, and 14/15. **County will need to provide detail on the specific dollar amount of reverted funds that will be utilized for each of the fiscal years (08/09, 12/13, 13/14, and 14/15).**

Additional Regulatory Requirements

The proposed project appears to meet the minimum requirements listed under MHSA Innovation regulations; however, if Innovation Project is approved, the MHSOAC must receive and inform the MHSOAC of this certification of approval from the Sacramento County Board of Supervisors before any Innovation Funds can be spent.

References:

http://www.telecarecorp.com/placer-county-psychiatric-health-facility/

https://www.oshpd.ca.gov/FDD/regulations/index.html

MECAP. (2009). Measuring Effective Collaborations and Partnerships. Retrieved from https://mecap.wordpress.com/2009/03/31/56/

Full project proposal can be accessed here:

http://mhsoac.ca.gov/document/2018-05/sacramento-county-inn-plan-description-behavioral-health-crisis-services

Proposed Innovation Project 3: Behavioral Health Crisis Services Collaborative

Project Overview

Sacramento County's proposed innovation project, the Behavioral Health Crisis Services Collaborative, will establish adult crisis stabilization and intensive mental health support services on a hospital campus (Mercy San Juan Medical Center) located in the underserved and high need northeastern section of Sacramento County.

This innovative emergency care integration initiative advances the standard for existing crisis services in several distinctive ways:

- It is a unique public/private collaboration between Sacramento County, Placer County and Dignity Health, and engages multiple Plan and community-based partners to serve residents of both Counties.
- It represents a commitment from a large hospital system, Dignity Health, to provide quality and integrated medical and behavioral health services under the hospital's license and make a financial investment that includes:
    - Dedicated hospital campus space and construction of facilities, designed to meet crisis stabilization services specifications
    - Ongoing facility operations and maintenance
    - Client transportation
    - Funding for a hospital navigator position
- Project services will:
    - Be sited in the northern region of Sacramento *which lacks sufficient crisis service programs* across two counties with growing populations
    - Serve adults, 18 years and older, who:
        - Present in the emergency department (ED), are medically treated and stabilized, and would benefit from multi-disciplinary mental health evaluation and crisis stabilization services for up to 23 hours
        - Voluntarily or involuntarily elect to receive services with the expressed goal of minimizing the time being on an involuntary 5150 hold
    - Provide front door integrated medical emergency and mental health crisis stabilization services that embrace the concept of whole person care, wellness and recovery.
    - Promote prevention by incorporating an assessment tool for early identification and intervention of first episodic psychosis that will be developed by the University of California Davis Medical Center's (UCDMC) Sacramento Early Diagnosis and Preventive Treatment Program (SacEDAPT). Project services will also connect Sacramento County clients to ongoing care with the SacEDAPT program, a project partner.
- It presents a new opportunity to serve both publically and privately insured residents from both Sacramento and Placer Counties.
- It creates an opportunity to develop a model for:
    - Shared governance and regulatory responsibilities related to delivering seamless integrated medical emergency and crisis stabilization care on a hospital emergency department campus
    - Electronic medical records exchange for both clinical coordination of care and claiming processes with the goal of delivering effective and efficient seamless integrated crisis care
- A robust resource center under the same roof will allow multiple community-based partners to support the project by providing care coordination, peer support and navigation, and social services support at the point of care. This will ensure consumers are directly linked to aftercare and other resources necessary for ongoing management of conditions and wellness.
- Local Health Plans operating in Sacramento and Placer Counties will provide navigation and support services to their private and public enrollees that utilize project services.
- The project is a natural fit with collaborative efforts between Sacramento County and Sacramento City's Whole Person Care (WPC) initiative, and will serve as a direct access point for assessing eligibility, continuity of care, and referral opportunities for homeless individuals with serious mental health conditions in the northern part of Sacramento County.

By integrating mental and physical health care and social support services in one location, the project will ensure continuity of care and strengthen the region's continuum of care for an estimated 2,000 or more public and private clients annually.

Project Purpose

The primary purpose of this emergency care integration innovation project is to demonstrate improved behavioral health outcomes through a public/private collaboration that removes existing barriers to care, increases access to, and the quality and scope of, crisis stabilization and supportive mental health services that are integrated and coordinated. Project services, sited in the northern region of Sacramento County, will increase access to crisis services for underserved area residents.

The secondary purpose of this project is to improve the efficacy and integration of medical and mental health crisis stabilization services through a public/private partnership between a licensed acute care general hospital and an onsite provider of mental health rehabilitative crisis stabilization services. The project will result in the development of assessment, stabilization and treatment protocols between a hospital emergency department (ED) and an onsite mental health crisis stabilization service focused on timely intervention and restoration of civil rights, early psychosis identification and intervention, and reduced ED patient boarding. Treatment protocols will apply to two adjoining counties as well as Health Plans and will include best practices to change the trajectory of care for individuals seeking crisis services.

Community Planning Process

Throughout all of Sacramento County's Mental Health Services Act (MHSA) Community Planning Processes (CPP), crisis services and help in a crisis has been a recurring community concern. Since the inception of Sacramento County's MHSA CPP, stakeholders and community members have provided input and participated in CPP and discussions related to the need for building a continuum of crisis prevention and intervention services.

In 2010, through CPP activities, stakeholders and community members participated in planning meetings to develop a Prevention and Early Intervention (PEI) component Suicide Prevention Project. This comprehensive project included suicide prevention strategies and programs such as a consumer warm line, suicide prevention/crisis line, training related to suicide prevention awareness and ethnic specific programs for depression and suicide prevention. It also laid the groundwork for future planning of crisis services programs such as the Community Support Team and mobile crisis teams.

The CPP for Sacramento County's Innovation Project 1 in February 2016 resulted in the development and implementation of respite programs for many unserved and underserved communities. These respite programs provide individuals experiencing crisis with services that aim to reduce stress and ameliorate crisis.

The Investment in Mental Health and Wellness Act of 2013 / Senate Bill 82 provided Sacramento County several opportunities to develop and implement alternative strategies and services that address crisis. With the support of the MHSA Steering Committee and the community, the County responded to SB82 request for applications and was awarded funding for a Triage and Peer Navigator Program, Mobile Crisis Support Teams (MCST), and Crisis Residential Programs (CRP). These applications were presented and reviewed with stakeholders and community members at MHSA Steering Committee meetings. Members of the Steering Committee offered strong support in favor of the County's submission of these applications. Furthermore, they supported and recommended MHSA funding for several MCST staff positions and for services for a new CRP.

The MHSA Steering Committee and community members were also involved in the development and shaping of Sacramento County's second Innovation Project, Mental Health Crisis/Urgent Care Clinic through a robust CPP in

2015. This project offers immediate outpatient mental health crisis services to individuals of any age that are experiencing a mental health crisis.

During the 30-day posting of Sacramento County's MHSA FY 2016-17 Annual Update, a variety of stakeholders, including consumers, community members, family members, system partners and others expressed support for continued progress towards implementation of the new Mental Health Crisis/Urgent Care Clinic which created an alternative to unnecessary/inappropriate emergency department visits and resulting psychiatric hospitalizations. Stakeholders also encouraged Sacramento County Division of Behavioral Health Services (DBHS) to look for opportunities to build off of this program and explore additional opportunities to partner with health systems in innovative ways to help address the needs of Sacramento County consumers and families experiencing a mental health crisis.

The CPP for the third Innovation Project builds off of these previous CPP processes. Dignity Health approached DBHS with the concept of a partnership with Sacramento and Placer Counties to explore innovative mental health services that could be sited on a hospital campus to address crisis. In alignment with the recommendation from stakeholders and the Division's commitment to explore new opportunities to improve the crisis services sector, this proposed project concept, which would establish adult crisis stabilization services on a hospital campus serving both Sacramento and Placer County residents, was introduced and discussed at the May 18, 2017, Mental Health Services Act (MHSA) Steering Committee meeting. At this meeting, an overview of the Innovation component, including component requirements, planning and implementation process was provided and the current crisis services delivery system was reviewed, including the discontinuity that can occur when individuals in crisis seek help and the need for crisis services. The Steering Committee voted in full support of DBHS moving this proposed third Innovation Project forward through the formation and convening of a Workgroup that would bring a recommendation to the Steering Committee prior to finalization.

Consistent with DBHS practice and the support of the MHSA Steering Committee, the Division designed and conducted a CPP to inform the development this proposed Innovation Project #3. This process included the formation of an Innovation Project #3 Workgroup and community input.

DBHS facilitated the Innovation Project #3 Workgroup and Community Input Session on July 20, 2017. At this meeting, workgroup and community members reviewed the Innovation component guidelines and the proposed project's purpose, learning and services. Panelists representing consumer, family members, psychiatry, and emergency physician stakeholders shared their thoughts on the benefit and value of the proposed project. In small groups, workgroup and community members discussed the importance of the project services, the benefits to co-locating crisis services at a hospital campus, strategies that can be embedded into services, and how principles of wellness and recovery and cultural competence could be incorporated into services. Workgroup and community members engaged in robust discussion and reported out on their input and feedback for this proposed project.

On August 17, 2017, the Workgroup presented their recommendation to the MHSA Steering Committee. The Committee reviewed and discussed Workgroup and community members input and feedback and fully supported moving this proposed project forward for inclusion in the MHSA Three-Year Plan for submission to the Sacramento County Board of Supervisors and the Mental Health Services Oversight and Accountability Commission.

Learning Objectives and Evaluation

There are two (2) primary learning objectives for this innovation project. The learning objectives and associated measures are listed below.

Learning Objective 1: Is integrated and coordinated emergency medical and mental health crisis services provided through a public and private collaboration an effective strategy in removing existing barriers in accessing mental health crisis stabilization services? Do the services provided through a public/private partnership improve the quality and scope of crisis stabilization services, improve consumers' experience, and improve mental health outcomes for consumers?

Objective	Indicator(s)	Measures
Remove Barriers to Accessing Mental Health Crisis Stabilization Services	Utilization of Crisis Services	• Number of individuals served • Pre-Post Utilization of crisis services within the service area
	Timely access	• Time from ED arrival to medical clearance • ED to crisis services • Left without being seen
Increase the quality and scope of Mental Health Crisis Services	Least Restrictive Intervention	• Community dispositions • Conversion to voluntary status • Restraint use (hours/rate)
	Utilization of Resource	• Number of individuals utilizing Resource Center • Linkage to mental health services • Referrals made
	Utilization of Peer Services	• Number of peer services provided • Satisfaction with peer services (as part of consumer survey)
	Early psychosis identification	• Number of individuals identified • Linkages to mental health services
	Consumer Satisfaction	TBD - satisfaction with timely access, functional status as a result of services, service provided, etc.
Improved Mental Health Outcomes	Effectiveness of Services	• Return to ED visits • Community disposition • Psychiatric hospitalizations • Linkages to mental health services
	Consumer Satisfaction	TBD - satisfaction with timely access, functional status as a result of services, service provided, experience of care, etc.

Learning Objective 2: Does an interagency collaboration with shared governance and regulatory responsibilities improve the efficacy and integration of emergency medical and mental health crisis stabilization services?

Objective	Indicator(s)	Measures
To establish an effective private/public collaboration that works together to accomplish a shared vision and mission using joint resources*	Service Access: • Point of Entry • Co-Location/ Coordination of Services	Extent to which: • Intake forms and procedures are integrated • Office space/location is shared
	Communication • Key Staff • Guiding Committee	Extent to which: • Management and line staff communicate • Committee exists and meets
	Program Enhancement • Sharing of Resources • Cross Training • Information Sharing	Extent to which: • Resources are shared • Staff from each partner receive cross training • Consumer information is shared across partners

Objective	Indicator(s)	Measures
	Accountability • Roles/Responsibilities • Decision Making • Mission/Values • Consumer Input • Project Planning/Coordination	Extent to which: • Partners establishes roles/responsibilities • Partners engage in decision making • Partners share a common mission/values • Partners solicit and utilize consumer feedback • Partners participate in joint project planning/coordination
	Outcomes • Consumer Outcomes • Goals & Objectives • Monitoring of Collaboration	Extent to which: • Establish, monitor and utilize results consumer outcomes • Partners establish goals & objectives • Partners participate in the monitoring of collaboration
Improvement in the efficacy and integration of medical and mental health crisis stabilization services	Partnership Accessibility	• Time from referral to acceptance/transfer • Denied referrals for reasons other than capacity (% of referrals denied admission to the crisis program for any reason other than overcapacity) • Hours on Divert (% of hours crisis center was unable to accept transfers from ED due to overcapacity)
	Continuity of Care	• Transfer of ED evaluation information (% of transfers that are accompanied by ED evaluation information)
	Consumer Satisfaction	TBD - consumer satisfaction with transfer, coordination or care
	Interoperability	• The ability to electronically share clinical data and billing information

*The MECAP (Measuring Effective Collaborations and Partnerships) will be used to evaluate the private/public collaboration. The MECAP tool was created to measure existing partnerships as well as to define key components of partnerships and help structure conversations among partners to assist in their successful collaboration.

This project will be reviewed and assessed through on-going data collection, monitoring and review by Sacramento County, Division of Behavioral Health Services staff (DBHS) as well as a formal evaluation through a third party independent evaluator.

Project Implementation

Need for Crisis Services in the norther region of Sacramento County / Siting Project Services

Located in the northern region of Sacramento, Dignity Health's Mercy San Juan Medical Center (MSJ) serves a broad area that encompasses numerous communities in 28 zip codes within Sacramento County and extending to south Placer County. A number of communities within this service area are designated as having underserved populations and as being medically underserved. Over half of Sacramento County's total Medi-Cal insured population (56%) resides within MSJ's service area.

As the only acute medical center in north Sacramento County, MSJ's 31-bed Emergency Department (ED) is constantly busy with high total patient volumes of more than 200 adults and children per day. A significant number of these patients, ranging from 9 up to 20 on any given day, are adults who have turned to the ED in need of mental health care, either in crisis, or self-identified. Providing timely and appropriate care and treatment for these

individuals is a challenge in a crowded, fast-paced ED environment. Boarding times can be long; 32 hours on average for individuals needing to be transferred to an inpatient psychiatric hospital.

People needing mental health care experience even greater barriers in this part of the region, compounded by the lack of any crisis services and severely limited mental health treatment options altogether. Given the distance from existing crisis services that are more centrally located in Sacramento County, and more remotely located in Placer County, transportation is a significant problem for this area's underserved residents.

Through this proposed innovative project, the collaborative will site and provide an intensive mental health outpatient crisis services program in the unserved community in the northern region of Sacramento. This proposed project will test and develop a new model of integrated care, in lieu of replicating existing programs, through new partnerships.

Dignity Health will dedicate a financial investment that provides for space and operating expenditure. Specifically, Dignity Health will dedicate MJS hospital campus space and construction of a modular facility designed to meet crisis stabilization services specifications. The modular facility will be located adjacent to MSJ's ED.

Project Services

The intensive mental health outpatient crisis stabilization program will serve adults who present in the ED, are medically stabilized, and would benefit from multi-disciplinary mental health evaluation and crisis stabilization services for up to 23 hours. There will be continuity of care between the ED physicians and nurses and the mental health crisis stabilization program's clinical and support staff. Individuals needing mental health crisis stabilization will transition to the program once medically stabilized by ED staff. The primary objective is to provide timely integrated emergency care and crisis stabilization and support to the individual in the least restrictive therapeutic and calming environment possible.

Mental health outpatient crisis stabilization services will include: behavioral health assessments, psychiatric assessments, medication evaluation and management, crisis stabilization including recovery oriented interventions, evaluation for voluntary or involuntary detention, admissions evaluation for inpatient psychiatric hospitalization (if necessary), transportation assistance, and peer and family support. Additionally, a first break screening tool specific to the project will be developed by the UCDMC's SacEDAPT Program. The tool will be used to determine appropriate diagnoses that will guide referrals for ongoing treatment.

On-site resources center will be established that will offer aftercare planning, information, referrals, linkages to a broad range of health, mental health and community based services and resources for both Sacramento and Placer County residents utilizing project services. The following resources will be offered:

- Direct linkage for both Sacramento County Mental Health Plan (MHP) and Alcohol Drug Treatment Services
- Dignity Health community-based navigator (licensed clinical social worker) to ensure patients are linked to follow-up care and social support services
- Onsite partnership with Geographic Managed Care Plans for comprehensive, intensive and individualized care planning and case management
- Eligibility and referral into Sacramento City's Whole Person Care homeless initiative
- Sacramento County/TLCS Triage Navigator (funded by Senate Bill [SB] 82/Investment in Mental Health and Wellness 0f 2013 MHSOAC Grant) will guide and follow patients over time to provide support and ensure that patients have engaged in mental health services and other necessary resources and supports. Sacramento County has plans to sustain this program once the grant cycle has ended.
- Peer and Family support

Project Partners

This project will set a new standard for integrating medical emergency and mental health crisis stabilization services through collaboration with public systems, private systems, and community-based organizations to support the outpatient treatment and support that are essential to recovery, ongoing management of conditions and wellness of individuals served. Sacramento County, Placer County and the Geographic Managed Care (GMC) Plans operating in both counties will negotiate specific ways of collaborating on this project. Sacramento County collaborating and referring partners include:

- Sacramento County Division of Behavioral Health contracted out-patient and prevention programs
- Dignity Health/Turning Point LCSW Navigator program
- UCDMC's SacEDAPT Program
- Sacramento County/TLCS SB82 Triage Navigator Program
- El Hogar's ReferNet program for immediate intensive outpatient care
- Lutheran Social Services "Housing with Dignity" permanent supportive housing program
- Sacramento City WPC
- Local Law Enforcement
- Local in-patient psychiatric facilities

Placer County collaborating and referring partners include:

- Placer County Mobile Crisis Team
- Turning Point Community Programs
- Sierra Mental Wellness Group
- Telecare Corporation
- Advocates for Mentally Ill Housing
- Local Law Enforcement
- Placer County Whole Person Care
- Placer County Health 360 Services

Budget

This proposed project term will span 4 years, beginning July 2018. The budget for the entire project term will be $18,781,381, with $13,885,361 in MHSA Innovation Funds, $2,808,000 in funding from Dignity Health and an estimated $2,088,020 in Federal Financial Participation (Medi-Cal) reimbursement, as identified below:

Estimated Budget by Fiscal Year					
	FY 2018-19	**FY 2019-20**	**FY 2020-21**	**FY 2021-22**	**Total**
A. Expenditures					
1. Personnel Expenditures	$2,084,339	$3,578,114	$3,682,485	$3,792,960	$13,137,898
2. Operating Expenditures	$296,440	$470,000	$470,000	$470,000	$1,706,440
3. Non-recurring Expenditures	$2,188,000	$0	$0	$0	$2,188,000
4. Evaluation Costs	$315,576	$315,576	$315,576	$315,576	$1,262,304
5. Other Expenditures	$116,344	$119,834	$123,429	$127,132	$486,739
6. Total Proposed Work Plan Expenditures	**$5,000,699**	**$4,483,524**	**$4,591,490**	**$4,705,668**	**$18,781,381**
B. Revenues					
1. Existing Revenues	$0	$0	$0	$0	$0
2. Additional Revenues					
a. Dignity Operating Costs	$160,000	$320,000	$320,000	$320,000	$1,120,000
b. Dignity Building Purchase, etc.	$1,688,000	$0	$0	$0	$1,688,000
c. Federal Financial Participation	$0	$569,460	$759,280	$759,280	$2,088,020
3. Total Revenues	**$1,848,000**	**$889,460**	**$1,079,280**	**$1,079,280**	**$4,896,020**
C. Total INN Funding Requirements	**$3,152,699**	**$3,594,064**	**$3,512,210**	**$3,626,388**	**$13,885,361**

Leveraged Resources

Working in partnership with Sacramento and Placer Counties, Dignity Health is investing financial and in-kind support to establish crisis stabilization services program on the campus of Mercy San Juan Medical Center in Carmichael.

Dignity Health's commitment to the project includes:

- Facility, design and construction necessary to meet OSHPD 3 and CSU specifications in year one
- Facility maintenance
- Use of campus space
- Client transportation
- Supplies for program operation
- Use of Dignity Health Transfer Center for those patients who need more acute inpatient placement
- Other direct and indirect expenses

Existing hospital partnership program annual resources that will be aligned with this project include:

- Turning Point LCSW Navigation Program
- Lutheran Social Services Homeless Housing program
- El Hogar Immediate Outpatient Follow-Up Care
- Dignity Health funded transportation to resource linkages (County Urgent Care, Respite Centers, Regional Support Teams, etc.)
- SacEDAPT program extension working in collaboration with UC Davis

Placer County will take financial responsibility for Placer Specialty Mental Health Plan clients who receive services through this project. Placer County's annual resources for this project include:

- Client Services Practitioner (Mobile Crisis Team member)
- Program Manager for project coordination with Sacramento County
- Staff Analyst for project related data collection

Sustainability

If the project is determined to be successful, it is anticipated that MHSA Community Services and Supports (CSS) component funding, leveraged with Medi-Cal (as appropriate), will be identified to sustain the project services.

Project Timeline

This Innovation Project will span four (4) years and will be implemented in phases.

Phase One: July 2018 – December 2018 activities

1. In partnership, Sacramento County/Division of Behavioral Health Services (DBHS), Placer County Mental Health, and Dignity Health will develop an agreement that clarifies governance, roles and responsibilities, in implementing project services.
2. Partners will work through implementation details with state and local representatives to identify and address barriers to integrated emergency/mental health crisis care.
3. Partners will prepare program site, develop procedures and hire and train clinic staff.
4. Partners will share expertise and information during program start-up/initial implementation related to start-up tasks, data collection and evaluation framework.
5. DBHS will develop and facilitate a competitive selection process for third party evaluator to develop an evaluation core and framework.
6. DBHS will negotiate and enter into a contract/agreement with selected evaluator.

Phase Two: January 2019 – December 2019 activities

1. Services will be delivered.
2. Partners will outreach to the community, system partners, mental health service providers, local EDs, law enforcement, to provide information about project services and access.
3. Partners and third party evaluator will continue to share expertise and information related to project service delivery, data collection and evaluation activities.

Phase Three: January 2020 – June 2021 activities

1. Project services and evaluation framework will be fully implemented.
2. Routine meetings amongst the partners will be convened to report out on the evaluation framework and process.
3. Bi-Annual community meetings, to include consumers and family members, Workgroup members and MHSA Steering Committee, will be established to report out on the evaluation framework and process.
4. Sustainability options will be explored and discussed throughout project implementation.

Phase Four: July 2021 – June 2022

1. Evaluation framework and process will be in its final stages and a final report will be developed.
2. Feasibility of replication will be determined.

AGENDA ITEM 7

Action

May 24, 2018 Commission Meeting

Legislation

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

Enclosed for the Commission's review is a legislative report listing which lists the bills that staff is aware of that relate to mental health under the Mental Health Services Act. In addition, the Commission has been asked by the authors to consider supporting the following bills: Senate Bill 1101 (Pan), Assembly Bill 2287 (Kiley), and Assembly Bill 2843 (Gloria). Available information on these three bills is enclosed.

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

Enclosures (4): (1) 2018 Legislative Report to the Commission; (2) SB 1101 (Pan); (3) AB 2287 (Kiley); (4) AB 2843 (Gloria)

Enclosed within each bill:
- Staff Summary Sheet
- Factsheet
- Bill Text
- Policy committee analyses and if available, fiscal committee analyses

Handout: None

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

2018 Legislative Report to the Commission
May 14, 2018

LEGISLATION UNDER REVIEW

Senate Bill 1101 (Pan)

Title: Mental Health.

Summary: Would require the Commission, on or before January 1, 2020, to establish statewide objectives for the prevention, early intervention, and treatment of mental illness, the promotion of mental health and well-being, and innovation as a strategy for transformational change, and metrics by which progress toward each of those objectives may be measured.

Status/Location: Scheduled to be heard by Senate Appropriations Committee May 14, 2018, 10:00AM

Assembly Bill 2287 (Kiley)

Title: Mental Health Services Act.

Summary: Would require the Mental Health Services Oversight and Accountability Commission to develop a local government transparency and accountability strategy for local mental health programs that includes fiscal, program and outcome components, as specified. The bill would also require the Commission to develop a transparency and accountability strategy for state government that includes fiscal information, and information on programs and outcomes related to mental health.

Status/Location: Assembly Appropriations Committee

Assembly Bill 2843 (Gloria)

Title: Mental Health Services Fund.

Summary: Would state the intent of the Legislature to enact legislation that would require a county that receives reallocated funds from the Mental Health Services Fund to spend those funds within 2 years of adopting an expenditure plan for those funds. It would further state the intent of the Legislature that any funds not expended by a county within those 2 years would revert to the Mental Health Services Fund to be redistributed to cities, special districts, school districts, or other public entities for the provision of mental health services consistent with the intent of the Mental Health Services Act (MHSA).

Status/Location: Assembly Appropriations Committee

Senate Bill 1134 (Newman)

Title: Mental health services fund.

Summary: This bill would make technical, non-substantive changes.

Status/Location: Senate Rules.

Senate Bill 1206 (de León)

Title: Mental health services fund.

Summary: Would enact the No Place Like Home Act of 2018 and provide for submission of that act to the voters at the November 6, 2018, statewide general election. The bill would specify that the service contracts between the California Health Facilities Financing Authority and the Department of Housing and Community Development may be single-year or multiyear contracts and provide for payments to the department from amounts on deposit in the Supportive Housing Program Subaccount. The bill would declare that the voters ratify as being consistent with and in furtherance of the MHSA, and approve for purposes of specified provisions of the California Constitution relating to debt, specified statutes related to the No Place Like Home Program and related financial provisions.

Status/Location: Scheduled to be heard by Senate Appropriations Committee May 22, 2018, 10:00AM

Senate Bill 1458 (Hueso)

Title: County mental health plans.

Summary: Would state the intent of the Legislature to enact legislation that would require compliance from county mental health programs regarding reporting requirements established pursuant to the MHSA.

Status/Location: Senate Rules.

SPONSORED LEGISLATION

Senate Bill 1019 (Beall)

Title: Youth mental health and substance use disorder services.

Summary: Current law provides that funds appropriated by the Legislature to the California Health Facilities Financing Authority and the Mental Health Services Oversight and Accountability Commission for the purposes of the Investment in Mental Health Wellness Act of 2013 be made available to selected counties or counties acting jointly, except as otherwise provided, and used to provide, among other things, a complete continuum of crisis services for children and youth 21 years of age and under regardless of where they live in the state. The act requires the Commission to allocate funds to triage personnel, as specified. This bill would require the Commission, when making these funds available, to allocate at least one-half of those funds for services or programs targeted at children and youth 18 years of age and under.

Status/Location: Senate Appropriations

Senate Bill 1113 (Monning)

Title: Mental health in the workplace: voluntary standards.

Summary: Would authorize the Mental Health Services Oversight and Accountability Commission to establish a framework and voluntary standard for mental health in the workplace that serves to reduce mental health stigma, increase public, employee, and employer awareness of the recovery goals of the MHSA, and provide guidance to California's employer community to put in place strategies and programs, determined by the Commission, to support the mental health and wellness of employees.

Status/Location: Assembly Committee on Health

SUPPORTED LEGISLATION

Assembly Bill 2325 (Irwin)

Title: County mental health services: veterans.

Summary: Would prevent a county from denying an eligible veteran county mental or behavioral health services while the veteran is waiting for a determination of eligibility for, and availability of, mental or behavioral health services provided by the United States Department of Veterans Affairs. The bill would make specific findings and declarations about the county's duty to provide mental and behavioral health services to veterans.

Status/Location: Senate Desk

Senate Bill 215 (Beall)

Title: Diversion: mental disorders.

Summary: Would authorize a court, with the consent of the defendant and a waiver of the defendant's speedy trial right, to postpone prosecution of a misdemeanor or a felony punishable in a county jail, and place the defendant in a pretrial diversion program for up to 2 years if the court is satisfied the defendant suffers from a mental disorder, that the defendant's mental disorder played a significant role in the commission of the charged offense, and that the defendant would benefit from mental health treatment. For specified offenses, the bill would condition granting diversion on the consent of the prosecution.

Status/Location: Assembly Committee on Public Safety

Senate Bill 688 (Moorlach)

Title: Mental Health Services Act: revenue and expenditure reports.

Summary: Current law requires the State Department of Health Care Services, in consultation with the Commission and the County Behavioral Health Directors Association of California, to develop and administer instructions for the Annual Mental Health Services Act Revenue and Expenditure Report, which gathers specified information on mental health spending as a result of the MHSA, including the expenditures of funds distributed to each county. Current law requires counties to electronically submit the report to the department and the commission. This bill would require counties to prepare the reports in accordance with generally accepted accounting principles, as specified.

Status/Location: Assembly Committee on Health

Senate Bill 906 (Beall)

Title: Medi-Cal: mental health services: peer, parent, transition-age, and family support specialist certification.

Summary: Would require the State Department of Health Care Services to establish, no later than July 1, 2019, a statewide peer, parent, transition-age, and family support specialist certification program, as a part of the state's comprehensive mental health and substance use disorder delivery system and the Medi-Cal program. The bill would include four certification categories: adult peer support specialists, transition-age youth peer support specialists, family peer support specialists, and parent peer support specialists.

Status/Location: Scheduled to be heard by Senate Appropriations Committee May 14, 2018, 10:00AM

Senate Bill 1004 (Wiener) *

Title: Mental Health Services Act: prevention and early intervention.

Summary: Would require the Mental Health Services Oversight and Accountability Commission, on or before January 1, 2020, to establish priorities for the use of prevention and early intervention funds and to develop a statewide strategy for monitoring implementation of prevention and early intervention services, including enhancing public understanding of prevention and early intervention and creating metrics for assessing the effectiveness of how prevention and early intervention funds are used and the outcomes that are achieved. The bill would also prohibit funding for county prevention and early intervention programs from being distributed until after the approval of the county's prevention and early intervention plan by the Commission.

Status/Location: Scheduled to be heard by Senate Appropriations Committee May 14, 2018, 10:00AM

**Principles supported*

Senate Bill 1101 (Pan)

Senate Bill 1101 (Pan)
Mental Health Services Objectives

Introduced 2/13/18
Amended 04/17/2018

SUMMARY

This bill would require the MHSOAC by January 1, 2020, to establish statewide objectives and metrics by which progress towards each objective may be measured for the prevention, early intervention, and treatment of mental illness, the promotion of mental health and well-being, and innovation as a strategy for transformational change.

VOTES

DATE:	RESULT:	LOCATION:	AYES:	NOES:	NO VOTE:	MOTION:
04/25/18	(PASS)	Senate Committee on Health	8	0	1	Pass and Re-referred to the Committee on Appropriations
Ayes: Hernandez, Ed Leyva, Connie Mitchell, Holly Monning, William Newman, Josh Nguyen, Janet Pan, Richard Roth, Richard						
Noes:						
No Vote Recorded: Nielsen, Jim						

SUPPORT / OPPOSITION

SUPPORT	OPPOSE
✓ American Foundation for Suicide Prevention	✓ NONE

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Senate
California Legislature

Dr. Richard Pan
Senator, Sixth District

Committees
Public Employees' Retirement System
Agriculture
Budget
Education
Health
Labor & Industrial Relations

SB 1101 – Mental Health Statewide Objectives

PURPOSE

SB 1101 would require the Mental Health Services Oversight and Accountability Commission (MHSOAC) to establish a series of statewide objectives for the treatment and prevention of mental illness, along with metrics to measure progress toward each objective.

The objectives and metrics will be established by January 1, 2020 following consultation with appropriate stakeholders. Every five years thereafter they will be reviewed and potentially revised.

Additionally, all counties will be required to submit an annual report to the commission and the Legislature, starting at the end of Fiscal Year 2020-2021, detailing their progress toward each of the objectives using the associated metrics. In their reports, counties may include mental health programs and services funded through both the Mental Health Services Act (MHSA) and Medi-Cal.

BACKGROUND

California's mental health system is responsible for delivering a vast array of services to the approximately four million residents with mental health needs. Following realignments in 1991 and 2011, administrative responsibility for mental health services was shifted from the state to the county level.

Our 58 counties derive their funding from a variety of sources including Medicaid, Medi-Cal, and, most significantly, the Mental Health Services Act (MHSA). Passed via ballot initiative in 2004, the MHSA provided counties with a reliable and substantial revenue stream to address the treatment and prevention of mental health disorders.

Since 2012, the Department of Health Care Services has been responsible for overseeing all county mental health services. Additionally, the Mental Health Services Oversight and Accountability Commission (MHSOAC) oversees implementation of the MHSA and receives annual reports from counties on their related spending.

Due to multiple funding streams and the dispersal of responsibility among counties, there has been little cohesive, statewide strategy to provide guidance across the entirety of California's mental health system. Many counties have failed to maximize the potential of their funding streams, while others have maximized impact and achieved significant progress towards their goals.

The adoption of a set of statewide objectives will provide direction to counties on how to best target their spending to achieve local-level impact making progress towards the state's most urgent mental health needs.

SUMMARY

California's 58 counties are tasked with delivering programs to serve the roughly 1 in 6 residents who experience mental health needs. Programs and services are funded through a collection of sources including revenue from Medicaid, Medi-Cal, and the MHSA. Implementation of mental health systems has varied by county and been carried out with little state-level guidance.

SB 1101 would require the MHSOAC, which currently implements the MHSA, to establish statewide mental health objectives, along with corresponding metrics, and update these objectives every five years. Counties will be responsible for reporting their progress towards these objectives to both the MHSOAC and the Legislature at the end of each fiscal year. The objectives established as a result of SB1101 will provide counties with the guidance necessary to make the best use of their mental health revenue streams.

SUPPORT

American Foundation for Suicide Prevention

OPPOSITION

None

CONTACTS

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916-651-4006

AMENDED IN SENATE APRIL 17, 2018

AMENDED IN SENATE MARCH 22, 2018

SENATE BILL No. 1101

Introduced by Senator Pan

February 13, 2018

An act to add ~~Part 7 (commencing with Section 5953) to Division 5 of~~ *Section 5845.6 to* the Welfare and Institutions Code, relating to mental health.

LEGISLATIVE COUNSEL'S DIGEST

SB 1101, as amended, Pan. Mental health.

Existing law, the Mental Health Services Act (MHSA), an initiative measure enacted by the voters as Proposition 63 at the November 2, 2004, statewide general election, establishes the Mental Health Services Oversight and Accountability Commission to oversee the administration of various parts of the act. *The MHSA permits amendment by the Legislature by a 2/3 vote of each house if the amendment is consistent with, and furthers the intent of, the MHSA.*

~~In addition to its existing duties, this~~ *This* bill would require the commission, on or before January 1, 2020, to establish ~~5~~ statewide objectives for the ~~treatment and prevention of mental illness~~ *prevention, early intervention, and treatment of mental illness, the promotion of mental health and well-being, and innovation as a strategy for transformational change*, and metrics by which progress toward each of those objectives may be measured. The bill would require the commission to ~~work with appropriate stakeholders in establishing these objectives and metrics. The bill would require the objectives and metrics to be reviewed at least every 5 years and, if appropriate, revised. The bill would prohibit the commission from using MHSA funding to~~

~~carry out these additional duties.~~ *establish strategies to collect, analyze, and monitor the established metrics and for technical assistance, support, and evaluation to support the successful implementation of these provisions. The bill would require the commission to review specified existing requirements and other oversight and accountability efforts to see if the commission can streamline those requirements, and, periodically, but at least once every 5 years, to review the established objectives, metrics, and strategies. The bill would require the commission to work with appropriate stakeholders, subject matter experts, counties, providers, state officials, and others the commission deems necessary in implementing these provisions.*

The bill, beginning January 1, 2021, would require all counties to annually submit a report to the commission and the Legislature, by the end of each fiscal year, that documents its progress toward the statewide ~~objectives, using the metrics described above. The bill would also require each county to document specified mental health funding allocations in relation to the statewide objectives. The bill would prohibit counties from encumbering MHSA funding for purposes of complying with these provisions.~~ *objectives, or, if the county does not have all the data necessary to produce the report, to provide the commission with data requested by the commission, as specified. The bill would amend the MHSA by authorizing a county to use MHSA funds to comply with these requirements.* By requiring counties to submit annual ~~reports,~~ *reports or provide specified data,* this bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that, if the Commission on State Mandates determines that the bill contains costs mandated by the state, reimbursement for those costs shall be made pursuant to the statutory provisions noted above.

The bill would declare that its provisions further the intent of the MHSA.

Vote: ~~majority~~ $^2/_3$. Appropriation: no. Fiscal committee: yes. State-mandated local program: yes.

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

SECTION 1. Section 5845.6 is added to the Welfare and Institutions Code, to read:

5845.6. (a) On or before January 1, 2020, the Mental Health Services Oversight and Accountability Commission, in addition to its existing duties, shall establish statewide objectives for the prevention, early intervention, and treatment of mental illness, the promotion of mental health and well-being, and innovation as a strategy for transformational change. In establishing these statewide objectives, the commission shall establish a core set of objectives, ideally no more than five, that serve to bring focus to California's mental health system. The commission may identify a reasonable number of components for each objective.

(b) The commission shall establish corresponding metrics for each objective, and may establish metrics for each component. These established metrics shall allow the public to meaningfully understand whether progress is being made against the established objectives.

(c) The commission shall establish a strategy to collect, analyze, and monitor the established metrics, using existing data, if available, and proposing new data collection and reporting strategies, if necessary.

(d) The commission shall establish a strategy for technical assistance, support, and evaluation to support the successful implementation of the objectives, metrics, data collection, and reporting strategy.

(e) The commission shall periodically, but not less than once every five years, review the established objectives, components, if any, metrics, and strategies required under this section.

(f) Consistent with this section, the commission shall also review the outcome and performance monitoring, data collection, and reporting requirements, and other oversight and accountability efforts in existence on January 1, 2019, to see if the commission can streamline those requirements in order to reduce costs, improve the timeliness of relevant data, enhance the utility of reporting for decision-making, and support focus on the statewide objectives established pursuant to this section.

(g) The commission shall work with appropriate stakeholders, subject matter experts, counties, providers, state officials, and

others the commission deems necessary in implementing the requirements of this section.

(h) The commission may obtain relevant data and information from other state entities, as needed to assist with monitoring of county progress toward the statewide objectives.

(i) (1) Notwithstanding Section 10231.5 of the Government Code, each county, beginning January 1, 2021, shall annually submit a report to the commission and to the Legislature, by the end of each fiscal year, that documents the county's progress toward the statewide objectives, using the metrics described in subdivision (b). The report shall also document mental health funding allocations from Medi-Cal and the Mental Health Services Act in relation to the statewide objectives. A report submitted pursuant to this paragraph shall be submitted in compliance with Section 9795 of the Government Code.

(2) If a county does not have all the data necessary to produce the report specified in paragraph (1), the county shall instead provide data requested by the commission to assist with the monitoring of county progress towards the statewide objectives.

(3) A county may use Mental Health Services Act funds to comply with the requirements of this section.

(j) This section shall not be construed to require counties to allocate its mental health funding based on the statewide objectives established pursuant to subdivision (a). It is the intent of the Legislature that these statewide objectives work in concert with locally and regionally established goals to improve mental health outcomes statewide.

SEC. 2. If the Commission on State Mandates determines that this act contains costs mandated by the state, reimbursement to local agencies and school districts for those costs shall be made pursuant to Part 7 (commencing with Section 17500) of Division 4 of Title 2 of the Government Code.

SEC. 3. The Legislature finds and declares that this act furthers the intent of the Mental Health Services Act, enacted by Proposition 63 at the November 2, 2004, statewide general election.

~~SECTION 1. Part 7 (commencing with Section 5953) is added to Division 5 of the Welfare and Institutions Code, to read:~~

~~PART 7. STATEWIDE MENTAL HEALTH OBJECTIVES~~

~~5953. (a) On or before January 1, 2020, the Mental Health Services Oversight and Accountability Commission, in addition to its existing duties, shall establish five statewide objectives for the treatment and prevention of mental illness. The commission shall also establish corresponding metrics by which progress toward each objective may be measured. The commission shall work with appropriate stakeholders in establishing these objectives and metrics. Objectives and metrics established pursuant this section shall be reviewed at least every five years and, if appropriate, revised.~~

~~(b) The commission shall not use funding allocated for purposes of the Mental Health Services Act to carry out the duties described in this section.~~

~~(c)~~

~~Notwithstanding Section 10231.5 of the Government Code, each county, beginning January 1, 2021, shall annually submit a report to the commission and to the Legislature, by the end of each fiscal year, that documents the county's progress toward the statewide objectives, using the metrics described in subdivision (a). The report shall also document mental health funding allocations from Medi-Cal and the Mental Health Services Act in relation to the statewide objectives. A report submitted pursuant to this subdivision shall be submitted in compliance with Section 9795 of the Government Code.~~

~~(d) Counties shall not encumber funding received pursuant to the Mental Health Services Act to comply with the reporting requirements described in this section.~~

~~(e)~~

~~This section shall not be construed to require counties to allocate its mental health funding based on the statewide objectives established pursuant to subdivision (a). It is the intent of the Legislature that these statewide objectives work in concert with locally and regionally established goals to improve mental health outcomes statewide.~~

~~SEC. 2. If the Commission on State Mandates determines that this act contains costs mandated by the state, reimbursement to local agencies and school districts for those costs shall be made~~

~~pursuant to Part 7 (commencing with Section 17500) of Division 4 of Title 2 of the Government Code.~~

O

SENATE COMMITTEE ON HEALTH
Senator Ed Hernandez, O.D., Chair

BILL NO:	SB 1101
AUTHOR:	Pan
VERSION:	April 17, 2018
HEARING DATE:	April 25, 2018
CONSULTANT:	Reyes Diaz

SUBJECT: Mental health

SUMMARY: Requires the Mental Health Services Oversight and Accountability Commission (MHSOAC) to establish statewide objectives and metrics, as specified, to bring focus on the state's mental health system and to assist the public in understanding whether progress is being made toward meeting the goals of the Mental Health Services Act, as specified. Requires the MHSOAC to collect data and monitor the established metrics, and to work with specified stakeholders to monitor counties' progress toward meeting the statewide objectives, as specified. Requires counties to report to the MHSOAC and the Legislature, as specified.

Existing law:

1) Establishes the MHSOAC to oversee the implementation of the Mental Health Services Act (MHSA), enacted by voters in 2004 as Proposition 63, to provide funds to counties to expand services, develop innovative programs, and integrate service plans for mentally ill children, adults, and seniors through a 1% income tax on personal income above $1 million. [WIC §5845]

2) Permits the MHSOAC to perform various functions in carrying out its duties and responsibilities, such as:

    a) Meeting at least once quarterly in locations convenient and open to the public;
    b) Establishing technical advisory committees, such as a committee of consumers and family members;
    c) Obtaining data and information from state or local entities that receive MHSA funds, as specified, to allow the MHSOAC to utilize in its oversight, review, training and technical assistance, accountability, and evaluation capacity, as specified;
    d) Assisting in providing technical assistance to accomplish the purposes of the MHSA; and,
    e) Working in collaboration with the Department of Health Care Services (DHCS), the California Behavioral Health Planning Council, and the California Mental Health Directors Association, as specified, to design a joint plan for a coordinated evaluation of client outcomes in the community-based mental health system, as specified. [WIC §5845]

3) Requires each county mental health program (counties) to prepare and submit a three-year program and expenditure plan, and annual updates, as specified, to the MHSOAC and DHCS within 30 days after adoption by the county board of supervisors. [WIC §5847]

This bill:

1) Requires, on or before January 1, 2020, the MHSOAC to establish statewide objectives for the prevention, early intervention, and treatment of mental illness; the promotion of mental health and well-being; and innovation as a strategy for transformational change. Requires the MHSOAC to establish a core set of objectives, as specified, that serve to bring focus to California's mental health system, as specified.

2) Requires the MHSOAC to establish corresponding metrics for each objective, and permits the establishment of metrics for each component. Requires the metrics to allow the public to meaningfully understand whether progress is being made against the established objectives.

3) Requires the MHSOAC to establish a strategy to collect, analyze, and monitor the established metrics, using existing data, and proposing new data collection and reporting strategies, if necessary. Requires the MHSOAC to establish a strategy for technical assistance, support, and evaluation to support the successful implementation of the objectives, metrics, data collection, and reporting strategy. Requires the MHSOAC to periodically, but not less than once every five years, review the established objectives, components, metrics, and strategies, as specified.

4) Requires the MHSOAC to review the outcome and performance monitoring, data collection, and reporting requirements, and other oversight and accountability efforts in existence on January 1, 2019, to allow the MHSOAC to streamline those requirements to reduce cost, improve timeliness of relevant data, enhance the utility of reporting for decision-making, and support focus on the statewide objectives established by this bill. Permits the MHSOAC to obtain relevant data and information from other state entities to assist with monitoring of counties' progress toward the statewide objectives.

5) Requires the MHSOAC to work with appropriate stakeholder, subject matter experts, counties, providers, state officials, and others the MHSOAC deems necessary in implementing the requirements of this bill.

6) Requires counties, beginning January 1, 2021, to annually submit a report to the MHSOAC and to the Legislature, by the end of each fiscal year, that documents progress toward the statewide objectives using the metrics established pursuant to 2) above. Requires the report to document mental health funding allocations from Medi-Cal and the MHSA in relation to the statewide objectives. Requires counties to provide datarequested by the MHSOAC, if a county does not have necessary data to produce the report, to assist with the monitoring of the county's progress toward the statewide objectives. Permits counties to use MHSA funds to comply with these requirements.

7) Prohibits the provisions in this bill from being construed to require counties to allocate mental health funding based on the statewide objectives. States Legislative intent that the statewide objectives work in concert with locally and regionally established goals to improve mental health outcomes statewide.

8) Declares that the requirements in this bill further the intent of the MHSA.

FISCAL EFFECT: This bill has not been analyzed by a fiscal committee.

COMMENTS:

1) *Author's statement.* According to the author, the goal of SB 1101 is to bring a cohesive leadership strategy to California's mental health system spanning all counties and funding streams across the state. With approximately four million residents with mental health needs, and significant efforts focused on prevention and early intervention, our mental health system delivers an expansive array of services across its 59 local mental health agencies (LMHAs) and derives funding from Medicaid, Medi-Cal, and, most significantly, the MHSA. However, a recent report by the California State Auditor (CSA), "The State Could Better Ensure the Effective Use of Mental Health Services Act Funding," found significant disparities between counties in the spending and use of MHSA funds. The CSA found that LMHAs had accumulated $231 million in unspent funds in FY 2015-16 and noted that lack of guidance from DHCS contributed significantly to the inability of LMHAs to maximize their potential. The CSA specifically called for increased guidance from the state and the need for the MHSOAC to develop statewide outcome metrics. Statewide leadership is needed to leverage our significant mental health resources into tangible change at the community level.

2) *MHSA.* The MHSA requires each county to prepare and submit a three-year plan to DHCS that must be updated each year and approved by DHCS after review and comment by the MHSOAC. In the three-year plans, counties are required to include a list of all programs for which MHSA funding is being requested and that identifies how the funds will be spent and which populations will be served. Counties also must submit their plans for approval to the MHSOAC before they can spend Innovation funds from the MHSA. The MHSA provides funding for programs the following components:

a) *Community Services and Supports (CSS)*: Provides direct mental health services to the severely and seriously mentally ill, such as mental health treatment, cost of health care treatment, and housing supports. Regulations require counties to direct the majority of its CSS funds to Full-Service Partnerships (FSPs). FSPs are county-coordinated plans, in collaboration with the client and the family, to provide the full spectrum of community services. These services consist of mental health services and supports, such as peer support and crisis intervention services; and non-mental health services and supports, such as food, clothing, housing, and the cost of medical treatment;
b) *Prevention and Early Intervention (PEI)*: Provides services to mental health clients in order to help prevent mental illness from becoming severe and disabling;
c) *Innovation*: Provides services and approaches that are creative in an effort to address mental health clients' persistent issues, such as improving services for underserved or unserved populations within the community;
d) *Capital facilities and technological needs*: Creates additional county infrastructure, such as additional clinics and facilities and/or development of a technological infrastructure for the mental health system, such as electronic health records for mental health services; and,
e) *Workforce education and training*: Provides training for existing county mental health employees, outreach and recruitment to increase employment in the mental health system, and financial incentives to recruit or retain employees within the public mental health system.

3) *CSA report.* In February 2018, the CSA issued Report 2017-117, "The State Could Better Ensure the Effective Use of Mental Health Services Act Funding," and noted that a general lack of oversight from the state, particularly DHCS, resulted in LMHAs amassing unspent MHSA funds. For FY 2015-16, LMHAs had accumulated $2.5 billion in unspent funds of which $231 million should have been returned to the state to be redistributed among the LMHAs. For the same fiscal year, LMHAs cumulatively held reserves of $535 million in MHSA funds of which the CSA estimated between $157 million and $274 million were excessive and should have been returned to the state. The CSA attributed this to DHCS not having developed a process for recovering the unspent funds, known as reversion, or developed a prudent reserve formula. The CSA stated that a lack of enforcement from DHCS, such as withholding funds, does not incentivize LMHAs to submit required annual revenue and expenditure reports, which would assist DHCS in tracking unspent funds. The CSA noted that in the same fiscal year, only one of the 59 LMHAs submitted the annual report by the regulatory deadline.

The CSA also noted that the MHSOAC is taking steps to implement its responsibility to evaluate the effectiveness of MHSA PEI and Innovation projects. In August 2017, the MHSOAC launched an online MHSA fiscal transparency tool that uses an interactive map to display the LMHAs' annual MHSA revenues, expenditures, and year-end balances of unspent funds. The CSA notes, however, that the effectiveness of this tool is contingent upon LMHAs submitting their annual revenue and expenditure reports on time, and DHCS has not enforced regulatory deadlines, and instead has regularly extended the timeframes for when LMHAs could submit the reports. The CSA recommended that the MHSOAC finalize itsinternal processes by July 2018 in order to track LMHAs' funding, services, and outcomes as it intends. The MHSOAC responded to that recommendation by saying it anticipates delays in receiving required reports from LMHAs.

The CSA report also highlights the requirement in the MHSA that the MHSOAC review and approve LMHAs' uses of Innovation funds before they can spend those funds. Of the $231 million in FY 2015-16 that should have been reverted to the state, 63% ($146 million) of that amount was Innovation funds. LMHAs told the CSA that several factors have led to difficulty getting Innovation projects approved, including the lack of clarity on the types of projects MHSOAC commissioners consider innovative. The MHSOAC formed a subcommittee in response to develop a flowchart for LMHAs and a template for them to present their projects, and also held a statewide meeting for LMHAs to share their innovative projects. The CSA report stated that from December 2015 through August 2017 the MHSOAC approved 83% of Innovation projects within three months of receipt. The MHSOAC stated that often the approval process is delayed because LMHAs submit and then withdraw their plans based on the readiness for review. The CSA stated that the MHSOAC's efforts to provide technical assistance and improve dialogue with LMHAs should help reduce any delays in the approval process.

4) *Related legislation.* SB 192 (Beall) requires counties, or counties acting jointly, seeking funding from the MHSA reversion fund, to demonstrate to the MHSOAC that funding will be used to create, or expand, existing capacity for services and supports that address unmet community needs. *SB 192 is pending in the Assembly Health Committee.*

SB 688 (Moorlach) requires each county to prepare its Annual Mental Health Services Act Revenue and Expenditure Report in accordance with generally accepted accounting principles and to electronically submit the report in a machine-readable format to specified entities. *SB 688 is pending in the Assembly.*

SB 1004 (Wiener) requires the MHSOAC to establish priorities for the use of MHSA PEI funds, as specified, and to develop a statewide strategy for monitoring the implementation of PEI programs, as specified. Requires, commencing with fiscal year 2020-2021, funding for PEI programs to be distributed only after the MHSOAC approves the PEI plans, as specified. *SB 1004 passed out of this Committee by a vote of 9-0 on April 11, 2018.*

SB 1113 (Monning) permits the MHSOAC to establish a framework and voluntary standard for mental health in the workplace, as specified, and to provide guidance to California's employer community to support the mental health and wellness of employees. *SB 1113 passed out of this Committee by a vote of 9-0 on April 4, 2018.*

AB 2843 (Gloria) adds cities, special districts, school districts, or other public entities to the list of entities eligible to receive MHSA funds subject to reversion for the provision of mental health services consistent with the intent of the MHSA. *AB 2843 is pending in the Assembly Appropriations Committee.*

5) *Prior legislation.* AB 462 (Thurmond, Chapter 403, Statutes of 2017) permits the Director of the Employment Development Department to share information with the MHSOAC related to quarterly wage data to assist the MHSOAC in fulfilling its duties under the MHSA, as specified.

AB 850 (Chau of 2017) would have added a Governor-appointed member to the MHSOAC who has knowledge and experience in reducing mental health disparities, especially for racial and ethnic communities. *AB 850 was vetoed by the Governor who stated that the MHSOAC as currently constituted is up to the task entrusted to it.*

AB 860 (Cooley of 2017) would have permitted the MHSOAC to conduct a fact-finding tour of a facility or location that is not open to the public, as specified. *AB 860 was vetoed by the Governor who stated that individual MHSOAC members can and do visit locked mental health facilities, jails, psychiatric hospitals, and schools to observe mental health care services firsthand, and that AB 860 could disrupt treatment programs or compromise the privacy of those receiving services.*

AB 974 (Quirk-Silva, Chapter 411, Statutes of 2017) requires counties to report spending on mental health services for veterans from MHSA funds.

AB 1134 (Gloria, Chapter 412, Statutes of 2017) permits the MHSOAC to establish a fellowship program, in accordance with specified principles, for the purpose of providing an experiential learning opportunity for a mental health consumer and a mental health professional.

6) *Support.* The American Foundation for Suicide Prevention (AFSP) states early intervention and treatment of Californians suffering with mental health issues may vary widely from county to county, but their goals should be the same: a healthy community. AFSP argues that with 58 counties working independently to meet the needs of their communities, there needs to be statewide common objectives to bring focus on the mental health of all Californians. AFSP states that this bill would establish a strategic, statewide focus for how counties treat those with mental illness and bring about measures to record and evaluate how counties are utilizing MHSA funds and other sources.

SUPPORT AND OPPOSITION:

Support: American Foundation for Suicide Prevention

Oppose: None received

-- END --

Assembly Bill 2287 (Kiley)

Assembly Bill 2287 (Kiley)
Mental Health Services Accountability Act

Introduced 2/13/18
Amended 04/17/2018

SUMMARY

This bill would require the Mental Health Services Oversight and Accountability Commission to develop a local government transparency and accountability strategy for local mental health programs that includes fiscal, program and outcome components, as specified. The bill would also require the commission to develop a transparency and accountability strategy for state government that includes fiscal information, and information on programs and outcomes related to mental health.

VOTES

DATE:	RESULT:	LOCATION:	AYES:	NOES:	NO VOTE:	MOTION:
04/24/18	(PASS)	Assembly Committee on Health	13	0	2	Pass and Re-referred to the Committee on Appropriations
Ayes: Bigelow, Franklin Bonta, Rob Carrillo, Wendy Flora, Heath Limón, Monique Mayes, Chad McCarty, Kevin Nazarian, Adrin Rodriguez, Freddie Santiago, Miguel Thurmond, Tony Waldron, Marie Wood, Jim						
Noes:						
No Vote Recorded: Aguiar-Curry, Cecilia Burke, Autumn						

SUPPORT / OPPOSITION

SUPPORT	OPPOSE
✓ NONE	✓ California Behavioral Health Directors Association

KEVIN KILEY
MEMBER OF THE 6TH ASSEMBLY DISTRICT

Assembly Bill 2287 – Mental Health Services Accountability Act

SUMMARY

Assembly Bill 2287 (Kiley) seeks to improve oversight of mental health dollars in California by requiring the Mental Health Services Oversight and Accountability Commission (MHSOAC) to develop a local and state transparency and accountability strategy focusing on the fiscal, program, and outcome components of the Mental Health Services Act.

BACKGROUND

Proposition 63, passed by the voters in 2004, is a 1% surtax on the wealthiest Californians to fund the MHSA. These funds comprise almost one-quarter of the state's mental health budget, generating almost $2 billion annually. Over 2.2 million Californians have a mental health need, and just over half of those reported they did not receive any treatment from a primary care doctor or a mental health professional. Left untreated, mental illness may result in prolonged suffering and is the leading cause of suicide and disability. Without intervention those suffering from untreated mental illness may be imprisoned, drop out of school, become unemployed, or be faced with homelessness.

MHSA consists of multiple priorities:

- **Community Services and Supports (CSS).** 80 percent of county funding from the Mental Health Services Act treats severely mentally ill Californians through CSS. Within this component counties fund a variety of programs and services to help people recover and thrive, including full-service partnerships and outreach and engagement activities aimed at reaching unserved populations. Full-service partnerships provide "whatever it takes" services to support those with the most severe mental health challenges.
- **Prevention and Early Intervention (PEI).** Counties may use up to 20 percent of their MHSA funds for PEI programs, which are designed to identify early mental illness before it becomes severe and disabling. PEI programs are intended to improve timely access to services for underserved populations and reduce negative outcomes from untreated mental illness.
- **Innovation.** Counties may use up to 5 percent of the funding they receive for CSS and PEI to pay for new and innovative programs that develop, test and implement promising practices that have not yet demonstrated their effectiveness.

MHSA is also overseen and administered by three different state agencies:

- The Department of Health Care Services (DHCS) has the sole authority to enter into performance contracts with counties, enforce compliance, and issue administrative sanctions if necessary.
- The Mental Health Services Oversight and Accountability Commission (MHSOAC) oversees programs funded by MHSA, and oversees the broader public mental health system as a whole. MHSOAC is also responsible for receiving all county plans for review and for approving Innovation programs.
- The Mental Health Planning Council (MHPC) is tasked with reviewing program performance of the overall mental health system, including programs funded by the Mental Health Services Act. It also annually reviews

program performance outcome data to identify successful programs and make recommendations for replication in other areas.

ISSUE

As recently as September 2016, the Little Hoover Commission reported in its follow-up review of MHSA that there are unaccountable, overlapping bureaucracies with no clear leadership structure or oversight. These multiple agencies lack clear direction and therefore no accountability and responsibility to fulfill the Act. A 2013 audit by the California State Auditor found that $7.4 billion in Prop 63 funds have not been used effectively or appropriately to treat mental illness.

Furthermore, a 2017 audit by the California State Auditor reported a number of troubling findings:

- Ineffective oversight of local mental health agencies and failure to develop effective processes by DHCS allowed $231 million to go unspent.
- DHCS was unable to identify the source or purpose of over $200 million in the Mental Health Services Fund.
- Minimal oversight and enforcement of local mental health agencies by DHCS has led to a lack of compliance from counties and a deficit of knowledge regarding program effectiveness.

While counties are required to provide information for purposes of evaluating the MHSA, no state agency reviews it to identify compliance issues, nor give a statewide snapshot of the Act's implementation. The state should have a reliable collection of data to inform whether is achieving MHSA goals and improving the quality and reach of mental health care services. It is critical that California prioritize oversight of this nearly $2 billion annual funding stream.

PROPOSED SOLUTION

AB 2287 would require MHSOAC to improve transparency and accountability in MHSA in the following three ways:

1. **Develop a fiscal, programmatic, and outcome transparency and accountability strategy for local government mental health.** This includes making available fiscal information to support public understanding of the availability of mental health funds to support the needs of mental health consumers and California's communities, program information on the geographic organization and demographic statistics of mental health programs, and outcome information about the how mental health funding is reducing instances of homelessness, unemployment, and suicide.
2. **Develop a fiscal, programmatic, and outcome transparency and accountability strategy for state government mental health.** This includes making available information that allows for public awareness and monitoring of state level mental health spending, activities, and outcomes by department, program, or other organizing unit.
3. **Assess the adequacy of existing statutory and regulatory data reporting requirements, strategies, and practices.** This includes making recommendations to the Governor and Legislature for streamlining and strengthening those strategies to reduce costs and improve the use of information to guide program, fiscal, and related decisions.

The bill would also require MHSOAC to report back to the Legislature no later than 2020 with an update on the progress of the transparency and accountability strategies. In order to achieve the intent of this bill, all relevant state agencies (such as the DHCS) would be required to share with MHSOAC the data and information necessary to develop the state and local strategies outlined in the bill.

FOR MORE INFORMATION

Joshua Hoover; (916) 319-2006; Joshua.Hoover@asm.ca.gov

AMENDED IN ASSEMBLY APRIL 17, 2018

CALIFORNIA LEGISLATURE—2017–18 REGULAR SESSION

ASSEMBLY BILL No. 2287

Introduced by Assembly Member Kiley

February 13, 2018

An act to ~~amend Sections 5813.5, 5821, 5840, 5840.2, 5845, 5846, 5847, 5848, 5878.3, 5890, 5891, 5892, 5897, 5898, and 5899 of, to amend the heading of Part 3.7 (commencing with Section 5845) of Division 5 of, and to add Section 5841 to,~~ *add Section 5845.3 to* the Welfare and Institutions Code, relating to mental health services.

LEGISLATIVE COUNSEL'S DIGEST

AB 2287, as amended, Kiley. Mental Health Services ~~Act.~~ *Act: transparency and accountability.*

Existing law, the Mental Health Services Act (MHSA), an initiative measure enacted by the voters as Proposition 63 at the November 2, 2004, statewide general election, establishes the continuously appropriated Mental Health Services Fund to fund various county mental health programs. Existing law requires the State Department of Health Care Services to, among other things, implement specified mental health services through contracts with county mental health programs or counties acting jointly. Existing law requires the department to conduct program reviews of performance contracts to determine compliance, as specified. If a county mental health program is not in compliance with its performance contract, existing law authorizes the department to request a plan of correction with a specific timeline to achieve improvements. *Existing law authorizes the act to be amended by a ⅔ vote of the Legislature if the amendments are consistent with, and further*

the intent of, the act. Existing law authorizes the Legislature to add provisions to clarify procedures and terms of the act by majority vote.

Existing law establishes the Mental Health Services Oversight and Accountability Commission to oversee various parts of the act, as specified. Existing law authorizes the commission to, among other things, obtain data and information from specified entities to utilize in its oversight, review, training and technical assistance, accountability, and evaluation capacity regarding projects and programs supported with MHSA funds.

~~Existing law requires each county mental health program to prepare and submit a 3-year program and expenditure plan, and annual updates, as specified, to the commission and the department within 30 days after adoption. Existing law authorizes the commission, if it identifies a critical issue related to the performance of a county mental health program, to refer the issue to the State Department of Health Care Services. Existing law authorizes the department to withhold mental health funding, upon a determination of noncompliance by the county, as specified, or if a county does not submit a specified annual revenue and expenditure report by the required deadline.~~

~~Existing law requires that funds be reserved for administrative costs, not to exceed 5% of the total of annual revenues received for the Mental Health Services Fund, for the department and the commission, among other specified entities, to implement duties pursuant to programs under the act, as specified. Existing law requires that those funds be subject to appropriation in the annual Budget Act.~~

~~This bill would establish the Office of Mental Health Services within the California Health and Human Services Agency, as specified. The bill would transfer various functions of the State Department of Health Care Services under the act to the office. Under this bill, the office would succeed to, and be vested with, all the duties, powers, responsibilities, and jurisdiction, vested in the department, regarding oversight of the Mental Health Services Fund, as specified. The bill would also require the office to assume certain duties, including, among others, initiating investigations, advising counties, conducting research, and reporting to the Legislature, by December 31, 2020, of any additional authority it deems necessary to complete its duties and to ensure county compliance with the act, as specified. The bill would make conforming changes to other provisions to reflect the transfer of those mental health responsibilities.~~

~~Existing law authorizes the act to be amended by a ⅔ vote of the Legislature if the amendments are consistent with, and further the intent of, the act. Existing law authorizes the Legislature to add provisions to clarify procedures and terms of the act by majority vote.~~

~~This bill would make legislative findings and declarations relating to mental health services in California and stating that the provisions of this bill are consistent with, and further the intent of, the act. By amending the provisions of the act, this bill would require a ⅔ vote of the Legislature.~~

This bill would require the commission to develop a local government transparency and accountability strategy for local mental health programs that includes fiscal, program and outcome components, as specified. The bill would also require the commission to develop a transparency and accountability strategy for state government that includes fiscal information, and information on programs and outcomes related to mental health. The state and local plans would include developing elements, information tools, materials, or other efforts that allow for public awareness and monitoring of state level mental health spending, activities, and outcomes, as specified. With respect to the program component of the local transparency and accountability strategy, the bill would require the State Department of Health Care Services to adopt, by January 1, 2020, and periodically update, regulations regarding demographic reporting or other requirements, that are consistent with regulations adopted by the commission and support the transparency and accountability strategy developed by the commission. The bill would require the commission to assess the adequacy of existing statutory and regulatory data reporting requirements, strategies, and practices, and make recommendations to the Governor and Legislature for streamlining and strengthening those strategies. The bill would require the commission, in developing the transparency and accountability strategy, to prepare and report to the Legislature on or before March 31, 2020, and periodically thereafter, on the commission's progress in complying with the requirements of the bill, and any funding, personnel, authority, or other resources the commission may need to achieve the bill's intent.

Vote: ⅔-*majority*. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

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

SECTION 1. The Legislature finds and declares all of the following:

(a) The federal Substance Abuse and Mental Health Services Administration (SAMHSA) reports that some 18 percent of Americans experience some form of mental health need, but many of those in need do not receive services.

(b) SAMHSA reports that about 43 percent of adults with some level of need receive care, suggesting more than half of adults who could benefit from care do not receive care. For adults with severe mental illness, the federal government reports that just 65 percent receive mental health services to meet their needs.

(c) Research suggests that half of adult mental illness begins before 14 years of age, and three-fourths before 24 years of age. More than 40 percent of youth between 13 and 17 years of age experience a mental health or related need before seventh grade. Suicide is the third leading cause of death among youth from 15 to 24 years of age.

(d) Research also suggests that unaddressed mental health issues can lead to homelessness, criminal justice involvement, school failure, and unemployment. For young people, mental health needs have the greatest impact in terms of disability. Yet research from 2014 indicates that among youth with a major depressive episode, which accounts for about 11.4 percent of all youth from 12 to 17 years of age, just four in ten received treatment or support.

(e) Despite the importance of accessible, culturally competent, and effective mental health services and supports, California has not developed an integrated strategy to support transparency and accountability for the state's public mental health system that allows the public and policymakers to better understand the services that are in place, how well they are functioning, and the outcomes that are achieved.

SEC. 2. Section 5845.3 is added to the Welfare and Institutions Code, to read:

5845.3. (a) The commission shall develop a transparency and accountability strategy that includes fiscal, program, and outcome components, as follows:

(1) (A) In developing a fiscal transparency and accountability strategy for local governments, the commission shall develop

elements, information tools, materials, or other efforts, as determined by the commission, that allow for public awareness and monitoring of local government mental health spending, statewide, by county, counties acting jointly, or other jurisdictions as determined by the commission. The commission shall make information available historically, to the extent possible, but at least for the most recently completed fiscal year, as required by Section 5899.

(B) In support of local government fiscal transparency and accountability, the commission shall make fiscal information available that reflects total mental health revenues, expenditures, and unspent funds, from the Mental Health Services Fund, as well as other funding sources, to support public understanding of how mental health services are funded, revenue and expenditure trends, and the availability of mental health funds to support the needs of mental health consumers and California's communities.

(C) In developing the fiscal transparency and accountability strategy, the commission shall consult with the Department of Finance, the State Department of Health Care Services, the State Controller's Office, the California State Auditor, and other entities as needed, to develop an approach that supports public accountability. Upon request, the State Department of Health Care Services, the Department of Finance, and the State Controller's Office shall make available to the commission all information, data, or other materials that are subject to public disclosure, to support this requirement.

(2) (A) In developing a program transparency and accountability strategy for local mental health programs, the commission shall develop elements, information tools, materials, or other efforts, as determined by the commission, that allow for public awareness and monitoring of publicly funded or supported mental health programs statewide, by county, counties acting jointly, or other jurisdictions as determined by the commission. To the extent possible, the commission shall make information on mental health programs available historically and for the most recently completed fiscal year.

(B) In support of the local government program transparency and accountability strategy, the commission shall make information publicly available that reflects the nature of services available,

how those services are organized and provided, the geographic location of services, and the intended population being served.

(C) As part of the program transparency and accountability strategy, the commission shall make information publicly available on the number of persons served, with information on demographic characteristics, including, but not limited to, age, race, ethnicity, gender, sexual orientation, language spoken, veteran status, and other characteristics intended to improve public understanding of who is being served by mental health programs.

(D) To the extent possible, the commission shall make information publicly available on funding and persons served, by program, strategy, or service, to support public understanding of how people are accessing services and care, and how those services are funded.

(E) In developing this strategy, the commission shall consider whether existing regulatory reporting requirements are adequate, and revise those requirements, on a basis determined by the commission, to support enhanced reporting, transparency and accountability.

(F) To support this effort, the State Department of Health Care Services shall adopt and periodically update regulations regarding demographic reporting or other requirements, that are consistent with regulations adopted by the commission and support the transparency and accountability strategy developed by the commission. The department shall adopt those regulations by January 31, 2020. If the department is unable to adopt regulations by that date, the department shall provide the relevant budget and policy committees of the Legislature, and the commission, a detailed explanation of the delay and a proposed deadline for the adoption of those regulations. The department shall provide this information in compliance with Section 9795 of the Government Code.

(3) (A) In developing a transparency and accountability strategy for local mental health programs, the commission shall develop elements, information tools, materials, or other efforts, as determined by the commission, that allow for public awareness and monitoring of outcomes achieved by publicly funded or supported mental health programs, statewide, by county, counties acting jointly, or other jurisdictions as determined by the commission. To the extent possible, the commission shall make

information on mental health outcomes available historically and for the most recently completed fiscal year.

(B) The commission shall develop a strategy for reporting and monitoring mental health outcomes that is consistent with subdivision (d) of Section 5840, including reporting on reductions in homelessness, unemployment, removal of children from their homes, suicide, incarcerations, school failure or dropout, and prolonged suffering. For purposes of this section, "removal of children from their homes" refers to involvement with the child welfare system, the juvenile justice system, or other placement as determined by the commission.

(C) In support of the outcome transparency and accountability strategy for local mental health programs, the commission shall, as it deems necessary, identify or develop other measures associated with access to mental health services and supports, the quality of those services and supports, and the outcomes that result from accessing those services and supports.

(D) Notwithstanding any other statute, regulation, or requirement, and subject to subparagraph (F), the commission shall have access to data, information, policies, procedures, and practices held or maintained by the departments within the California Health and Human Services Agency, the Department of Justice, the State Department of Education, the Employment Development Department, and other state and local agencies, as necessary, to comply with the requirements of this section.

(E) The departments within the California Health and Human Services Agency, the Department of Justice, the State Department of Education, Employment Development Department, and other state and local agencies, shall cooperate and share data with the commission, to support the intent of this section.

(F) In accessing data pursuant to this section, the commission shall comply with all applicable federal and state privacy and confidentiality laws.

(b) The commission shall develop a transparency and accountability strategy for state government that includes fiscal information, and information on programs and outcomes related to mental health. The commission shall develop elements, information tools, materials, or other efforts, as determined by the commission, that allow for public awareness and monitoring of state level mental health spending, activities, and outcomes, by

department, program, or other organizing unit, as determined by the commission. In developing this strategy, to the extent possible, the commission shall make information available historically and for the most recently completed fiscal year.

(c) To support enhanced transparency and outcome accountability, the commission shall assess the adequacy of existing statutory and regulatory data reporting requirements, strategies, and practices, and make recommendations to the Governor and Legislature for streamlining and strengthening those strategies to reduce costs and improve the use of information to guide program, fiscal, and related decisions.

(d) (1) In developing the transparency and accountability strategy required by this section, the commission shall prepare and report to the relevant policy and fiscal committees of the Legislature on or before March 31, 2020, and periodically thereafter, as needed, on its progress in complying with this section, and any funding, personnel, authority, or other resources the commission may need to achieve the intent of this section.

(2) A report submitted pursuant to this paragraph shall be submitted in compliance with Section 9795 of the Government Code.

~~SECTION 1. The Legislature finds and declares all of the following:~~

~~(a) Proposition 63 (2004) is an important initiative to improve the lives and health of Californians by reducing the adverse impacts from untreated serious mental illness.~~

~~(b) Left untreated, mental illness may result in prolonged suffering and is the leading cause of suicide and disability. Without intervention, those suffering from untreated mental illness may be incarcerated, drop out of school, or become unemployed or homeless.~~

~~(c) Since 2004, the Mental Health Services Act has generated $14.6 billion and now comprises almost one-quarter of the state's mental health care budget.~~

~~(d) Currently, over 2.2 million Californians have a mental health need, and just over one-half of those with these needs reported that they did not receive any treatment from a primary care doctor or a mental health professional.~~

~~(e) Since 2013, and as recently as September 2016, the California State Auditor's Office and the Little Hoover~~

~~Commission, respectively, have reported a continued failure to keep promises made to voters in 2004 with the passage of Proposition 63, the Mental Health Services Act, largely due to an ineffective governance system that has no oversight or accountability structure.~~

~~(f) The State Department of Health Care Services has been slow to publicly post county plans and reports of fiscal transparency. Currently, no state agency reviews, analyzes, or summarizes information supplied by local governments to ensure compliance with the Mental Health Services Act.~~

~~SEC. 2. Section 5813.5 of the Welfare and Institutions Code is amended to read:~~

~~5813.5. Subject to the availability of funds from the Mental Health Services Fund, the state shall distribute funds for the provision of services under Sections 5801, 5802, and 5806 to county mental health programs. Services shall be available to adults and seniors with severe illnesses who meet the eligibility criteria in subdivisions (b) and (e) of Section 5600.3. For purposes of this act, seniors means older adult persons identified in this part.~~

~~(a) Funding shall be provided at sufficient levels to ensure that counties can provide each adult and senior served pursuant to this part with the medically necessary mental health services, medications, and supportive services set forth in the applicable treatment plan.~~

~~(b) The funding shall only cover the portions of those costs of services that cannot be paid for with other funds including other mental health funds, public and private insurance, and other local, state, and federal funds.~~

~~(c) Each county mental health program's plan shall provide for services in accordance with the system of care for adults and seniors who meet the eligibility criteria in subdivisions (b) and (e) of Section 5600.3.~~

~~(d) Planning for services shall be consistent with the philosophy, principles, and practices of the Recovery Vision for mental health consumers:~~

~~(1) To promote concepts key to the recovery for individuals who have mental illness: hope, personal empowerment, respect, social connections, self-responsibility, and self-determination.~~

~~(2) To promote consumer-operated services as a way to support recovery.~~

~~(3) To reflect the cultural, ethnic, and racial diversity of mental health consumers.~~

~~(4) To plan for each consumer's individual needs.~~

~~(e) The plan for each county mental health program shall indicate, subject to the availability of funds as determined by Part 4.5 (commencing with Section 5890) of this division, and other funds available for mental health services, adults and seniors with a severe mental illness being served by this program are either receiving services from this program or have a mental illness that is not sufficiently severe to require the level of services required of this program.~~

~~(f) Each county plan and annual update pursuant to Section 5847 shall consider ways to provide services similar to those established pursuant to the Mentally Ill Offender Crime Reduction Grant Program. Funds shall not be used to pay for persons incarcerated in state prison or parolees from state prisons. When included in county plans pursuant to Section 5847, funds may be used for the provision of mental health services under Sections 5347 and 5348 in counties that elect to participate in the Assisted Outpatient Treatment Demonstration Project Act of 2002 (Article 9 (commencing with Section 5345) of Chapter 2 of Part 1).~~

~~(g) The Office of Mental Health Services shall contract for services with county mental health programs pursuant to Section 5897. After the effective date of this section, the term grants referred to in Sections 5814 and 5814.5 shall refer to those contracts.~~

~~SEC. 3. Section 5821 of the Welfare and Institutions Code is amended to read:~~

~~5821. (a) The California Behavioral Health Planning Council shall advise the Office of Statewide Health Planning and Development on education and training policy development and provide oversight for education and training plan development.~~

~~(b) The Office of Statewide Health Planning and Development shall work with the California Behavioral Health Planning Council and the Office of Mental Health Services so that council staff is increased appropriately to fulfill its duties required by Sections 5820 and 5821.~~

~~SEC. 4. Section 5840 of the Welfare and Institutions Code is amended to read:~~

~~5840. (a) The Office of Mental Health Services, in coordination with counties, shall establish a program designed to prevent mental illnesses from becoming severe and disabling. The program shall emphasize improving timely access to services for underserved populations.~~

~~(b) The program shall include all of the following components:~~

~~(1) Outreach to families, employers, primary care health care providers, and others to recognize the early signs of potentially severe and disabling mental illnesses.~~

~~(2) Access and linkage to medically necessary care provided by county mental health programs for children with severe mental illness, as defined in Section 5600.3, and for adults and seniors with severe mental illness, as defined in Section 5600.3, as early in the onset of these conditions as practicable.~~

~~(3) Reduction in stigma associated with either being diagnosed with a mental illness or seeking mental health services.~~

~~(4) Reduction in discrimination against people with mental illness.~~

~~(c) The program shall include mental health services similar to those provided under other programs effective in preventing mental illnesses from becoming severe, and shall also include components similar to programs that have been successful in reducing the duration of untreated severe mental illnesses and assisting people in quickly regaining productive lives.~~

~~(d) The program shall emphasize strategies to reduce the following negative outcomes that may result from untreated mental illness:~~

~~(1) Suicide.~~

~~(2) Incarcerations.~~

~~(3) School failure or dropout.~~

~~(4) Unemployment.~~

~~(5) Prolonged suffering.~~

~~(6) Homelessness.~~

~~(7) Removal of children from their homes.~~

~~(e) Prevention and early intervention funds may be used to broaden the provision of community-based mental health services by adding prevention and early intervention services or activities to these services.~~

~~(f) In consultation with mental health stakeholders, and consistent with regulations from the Mental Health Services~~

~~Oversight and Accountability Commission, pursuant to Section 5846, the Office of Mental Health Services shall revise the program elements in this section applicable to all county mental health programs in future years to reflect what is learned about the most effective prevention and intervention programs for children, adults, and seniors.~~

~~SEC. 5. Section 5840.2 of the Welfare and Institutions Code is amended to read:~~

~~5840.2. The Office of Mental Health Services shall contract for the provision of services pursuant to this part with each county mental health program in the manner set forth in Section 5897.~~

~~SEC. 6. Section 5841 is added to the Welfare and Institutions Code, immediately preceding Section 5845, to read:~~

~~5841. (a) The Office of Mental Health Services is hereby established within the California Health and Human Services Agency.~~

~~(b) The office is under the control of an executive officer, known as the Director of the Office of Mental Health Services, who shall be appointed by the Governor, subject to confirmation by the Senate, and hold office at the pleasure of the Governor.~~

~~(c) The office shall succeed to, and be vested with, all the duties, powers, responsibilities, and jurisdiction, vested in the State Department of Health Care Services, regarding oversight of the Mental Health Services Fund. All existing positions within the State Department of Health Care Services concerning those duties, powers, responsibilities, and jurisdiction shall be transferred to the office. The director shall have authority to hire persons for those positions.~~

~~(d) In addition to any duties set forth pursuant to subdivision (c), the office shall assume the following duties:~~

~~(1) Oversee the allocation of funds from the Mental Health Services Fund.~~

~~(2) Initiate investigations, at its own discretion or upon request, concerning potential county noncompliance with the Mental Health Services Act (MHSA) or concerning other critical issues related to the performance of a county mental health program.~~

~~(3) Ensure that public transparency is provided for the Mental Health Services Fund, that funding is allocated to those with mental health needs, that the public's safety is protected, and that the~~

~~required data to track performance outcomes are reported to the public in a practical and usable manner.~~

~~(4) Perform outreach to counties, advise counties, and conduct research, relating to the Mental Health Services Fund.~~

~~(5) (A) By December 31, 2020, report to the Legislature of any additional authority the office deems necessary to complete its designated duties and to ensure county compliance with the MHSA, including, but not limited to, broader authority to sanction, to withhold MHSA funds, or to assess a fine for misreported data or data reported late.~~

~~(B) This paragraph does not grant the office the authority to create new types of penalties. It is the intent of the Legislature that, based on the findings and reporting by the office, future legislation be enacted to impose automatic, nondiscretionary penalties, to be gradually applied to noncompliant counties, beginning with minor penalties, and increasing in severity as noncompliance is continued after collaboration and technical assistance have been offered.~~

~~(C) A report to the Legislature pursuant to this paragraph shall be submitted in compliance with Section 9795 of the Government Code.~~

~~SEC. 7. The heading of Part 3.7 (commencing with Section 5845) of Division 5 of the Welfare and Institutions Code is amended to read:~~

~~PART 3.7. TRANSPARENCY, OVERSIGHT, AND ACCOUNTABILITY~~

~~SEC. 8. Section 5845 of the Welfare and Institutions Code is amended to read:~~

~~5845. (a) The Mental Health Services Oversight and Accountability Commission is hereby established to oversee Part 3 (commencing with Section 5800), the Adult and Older Adult Mental Health System of Care Act; Part 3.1 (commencing with Section 5820), Human Resources, Education, and Training Programs; Part 3.2 (commencing with Section 5830), Innovative Programs; Part 3.6 (commencing with Section 5840), Prevention and Early Intervention Programs; and Part 4 (commencing with Section 5850), the Children's Mental Health Services Act. The commission shall replace the advisory committee established~~

~~pursuant to Section 5814. The commission shall consist of 16 voting members as follows:~~

~~(1) The Attorney General or his or her designee.~~

~~(2) The Superintendent of Public Instruction or his or her designee.~~

~~(3) The Chairperson of the Senate Health and Human Services Committee or another member of the Senate selected by the President pro Tempore of the Senate.~~

~~(4) The Chairperson of the Assembly Health Committee or another member of the Assembly selected by the Speaker of the Assembly.~~

~~(5) Two persons with a severe mental illness, a family member of an adult or senior with a severe mental illness, a family member of a child who has or has had a severe mental illness, a physician specializing in alcohol and drug treatment, a mental health professional, a county sheriff, a superintendent of a school district, a representative of a labor organization, a representative of an employer with less than 500 employees and a representative of an employer with more than 500 employees, and a representative of a health care services plan or insurer, all appointed by the Governor. In making appointments, the Governor shall seek individuals who have had personal or family experience with mental illness. At least one of the persons appointed pursuant to this paragraph shall have a background in auditing.~~

~~(b) Members shall serve without compensation, but shall be reimbursed for all actual and necessary expenses incurred in the performance of their duties.~~

~~(c) The term of each member shall be three years, to be staggered so that approximately one-third of the appointments expire in each year.~~

~~(d) In carrying out its duties and responsibilities, the commission may do all of the following:~~

~~(1) Meet at least once each quarter at any time and location convenient to the public as it may deem appropriate. All meetings of the commission shall be open to the public.~~

~~(2) Within the limit of funds allocated for these purposes, pursuant to the laws and regulations governing state civil service, employ staff, including any clerical, legal, and technical assistance as may appear necessary. The commission shall administer its~~

~~operations separate and apart from the Office of Mental Health Services and the California Health and Human Services Agency.~~

~~(3) Establish technical advisory committees such as a committee of consumers and family members.~~

~~(4) Employ all other appropriate strategies necessary or convenient to enable it to fully and adequately perform its duties and exercise the powers expressly granted, notwithstanding any authority expressly granted to any officer or employee of state government.~~

~~(5) Enter into contracts.~~

~~(6) Obtain data and information from the Office of Mental Health Services, the Office of Statewide Health Planning and Development, or other state or local entities that receive Mental Health Services Act funds, for the commission to utilize in its oversight, review, training and technical assistance, accountability, and evaluation capacity regarding projects and programs supported with Mental Health Services Act funds.~~

~~(7) Participate in the joint state-county decisionmaking process, as contained in Section 4061, for training, technical assistance, and regulatory resources to meet the mission and goals of the state's mental health system.~~

~~(8) Develop strategies to overcome stigma and discrimination, and accomplish all other objectives of Part 3.2 (commencing with Section 5830), Part 3.6 (commencing with Section 5840), and the other provisions of the act establishing this commission.~~

~~(9) At any time, advise the Governor or the Legislature regarding actions the state may take to improve care and services for people with mental illness.~~

~~(10) If the commission identifies a critical issue related to the performance of a county mental health program, it may refer the issue to the Office of Mental Health Services pursuant to Section 5655. For purposes of this paragraph, the office shall succeed to, and be vested with, all the duties, powers, responsibilities, and jurisdiction that are described in Section 5655 and vested in the State Department of Health Care Services.~~

~~(11) Assist in providing technical assistance to accomplish the purposes of the Mental Health Services Act, Part 3 (commencing with Section 5800), and Part 4 (commencing with Section 5850) in collaboration with the Office of Mental Health Services and in~~

consultation with the California Mental Health Directors Association.

(12) Work in collaboration with the Office of Mental Health Services and the California Behavioral Health Planning Council, and in consultation with the California Mental Health Directors Association, in designing a comprehensive joint plan for a coordinated evaluation of client outcomes in the community-based mental health system, including, but not limited to, parts listed in subdivision (a). The California Health and Human Services Agency shall lead this comprehensive joint plan effort.

SEC. 9. Section 5846 of the Welfare and Institutions Code is amended to read:

5846. (a) The commission shall adopt regulations for programs and expenditures pursuant to Part 3.2 (commencing with Section 5830), for innovative programs, and Part 3.6 (commencing with Section 5840), for prevention and early intervention.

(b) Any regulations adopted by the Office of Mental Health Services pursuant to Section 5898 shall be consistent with the commission's regulations.

(c) The commission may provide technical assistance to any county mental health plan as needed to address concerns or recommendations of the commission or when local programs could benefit from technical assistance for improvement of their plans.

(d) The commission shall ensure that the perspective and participation of diverse community members reflective of California populations and others suffering from severe mental illness and their family members is a significant factor in all of its decisions and recommendations.

SEC. 10. Section 5847 of the Welfare and Institutions Code is amended to read:

5847. Integrated Plans for Prevention, Innovation, and System of Care Services.

(a) Each county mental health program shall prepare and submit a three-year program and expenditure plan, and annual updates, adopted by the county board of supervisors, to the Mental Health Services Oversight and Accountability Commission and the Office of Mental Health Services within 30 days after adoption.

(b) The three-year program and expenditure plan shall be based on available unspent funds and estimated revenue allocations provided by the state and in accordance with established

~~stakeholder engagement and planning requirements as required in Section 5848. The three-year program and expenditure plan and annual updates shall include all of the following:~~

~~(1) A program for prevention and early intervention in accordance with Part 3.6 (commencing with Section 5840).~~

~~(2) A program for services to children in accordance with Part 4 (commencing with Section 5850), to include a program pursuant to Chapter 4 (commencing with Section 18250) of Part 6 of Division 9 or provide substantial evidence that it is not feasible to establish a wraparound program in that county.~~

~~(3) A program for services to adults and seniors in accordance with Part 3 (commencing with Section 5800).~~

~~(4) A program for innovations in accordance with Part 3.2 (commencing with Section 5830).~~

~~(5) A program for technological needs and capital facilities needed to provide services pursuant to Part 3 (commencing with Section 5800), Part 3.6 (commencing with Section 5840), and Part 4 (commencing with Section 5850). All plans for proposed facilities with restrictive settings shall demonstrate that the needs of the people to be served cannot be met in a less restrictive or more integrated setting, such as permanent supportive housing.~~

~~(6) Identification of shortages in personnel to provide services pursuant to the above programs and the additional assistance needed from the education and training programs established pursuant to Part 3.1 (commencing with Section 5820).~~

~~(7) Establishment and maintenance of a prudent reserve to ensure the county program will continue to be able to serve children, adults, and seniors that it is currently serving pursuant to Part 3 (commencing with Section 5800), the Adult and Older Adult Mental Health System of Care Act, Part 3.6 (commencing with Section 5840), Prevention and Early Intervention Programs, and Part 4 (commencing with Section 5850), the Children's Mental Health Services Act, during years in which revenues for the Mental Health Services Fund are below recent averages adjusted by changes in the state population and the California Consumer Price Index.~~

~~(8) Certification by the county behavioral health director, which ensures that the county has complied with all pertinent regulations, laws, and statutes of the Mental Health Services Act, including stakeholder participation and nonsupplantation requirements.~~

~~(9) Certification by the county behavioral health director and by the county auditor-controller that the county has complied with any fiscal accountability requirements as directed by the Office of Mental Health Services, and that all expenditures are consistent with the requirements of the Mental Health Services Act.~~

~~(e) The programs established pursuant to paragraphs (2) and (3) of subdivision (b) shall include services to address the needs of transition age youth 16 to 25 years of age. In implementing this subdivision, county mental health programs shall consider the needs of transition age foster youth.~~

~~(d) Each year, the Office of Mental Health Services shall inform the County Behavioral Health Directors Association of California and the Mental Health Services Oversight and Accountability Commission of the methodology used for revenue allocation to the counties.~~

~~(e) Each county mental health program shall prepare expenditure plans pursuant to Part 3 (commencing with Section 5800) for adults and seniors, Part 3.2 (commencing with Section 5830) for innovative programs, Part 3.6 (commencing with Section 5840) for prevention and early intervention programs, and Part 4 (commencing with Section 5850) for services for children, and updates to the plans developed pursuant to this section. Each expenditure update shall indicate the number of children, adults, and seniors to be served pursuant to Part 3 (commencing with Section 5800), and Part 4 (commencing with Section 5850), and the cost per person. The expenditure update shall include utilization of unspent funds allocated in the previous year and the proposed expenditure for the same purpose.~~

~~(f) A county mental health program shall include an allocation of funds from a reserve established pursuant to paragraph (7) of subdivision (b) for services pursuant to paragraphs (2) and (3) of subdivision (b) in years in which the allocation of funds for services pursuant to subdivision (c) is not adequate to continue to serve the same number of individuals as the county had been serving in the previous fiscal year.~~

~~(g) The Office of Mental Health Services shall post on its Internet Web site the three-year program and expenditure plans submitted by every county pursuant to subdivision (a) in a timely manner.~~

~~SEC. 11. Section 5848 of the Welfare and Institutions Code is amended to read:~~

~~5848. (a) Each three-year program and expenditure plan and update shall be developed with local stakeholders, including adults and seniors with severe mental illness, families of children, adults, and seniors with severe mental illness, providers of services, law enforcement agencies, education, social services agencies, veterans, representatives from veterans organizations, providers of alcohol and drug services, health care organizations, and other important interests. Counties shall demonstrate a partnership with constituents and stakeholders throughout the process that includes meaningful stakeholder involvement on mental health policy, program planning, and implementation, monitoring, quality improvement, evaluation, and budget allocations. A draft plan and update shall be prepared and circulated for review and comment for at least 30 days to representatives of stakeholder interests and any interested party who has requested a copy of the draft plans.~~

~~(b) The mental health board established pursuant to Section 5604 shall conduct a public hearing on the draft three-year program and expenditure plan and annual updates at the close of the 30-day comment period required by subdivision (a). Each adopted three-year program and expenditure plan and update shall include any substantive written recommendations for revisions. The adopted three-year program and expenditure plan or update shall summarize and analyze the recommended revisions. The mental health board shall review the adopted plan or update and make recommendations to the county mental health department for revisions.~~

~~(c) The plans shall include reports on the achievement of performance outcomes for services pursuant to Part 3 (commencing with Section 5800), Part 3.6 (commencing with Section 5840), and Part 4 (commencing with Section 5850) funded by the Mental Health Services Fund and established jointly by the Office of Mental Health Services and the Mental Health Services Oversight and Accountability Commission, in collaboration with the County Behavioral Health Directors Association of California.~~

~~(d) Mental health services provided pursuant to Part 3 (commencing with Section 5800) and Part 4 (commencing with Section 5850) shall be included in the review of program performance by the California Behavioral Health Planning Council~~

~~required by paragraph (2) of subdivision (c) of Section 5772 and in the local mental health board's review and comment on the performance outcome data required by paragraph (7) of subdivision (a) of Section 5604.2.~~

~~(e) The Office of Mental Health Services shall annually post on its Internet Web site a summary of the performance outcomes reports submitted by counties if clearly and separately identified by counties as the achievement of performance outcomes pursuant to subdivision (c).~~

~~SEC. 12. Section 5878.3 of the Welfare and Institutions Code is amended to read:~~

~~5878.3. (a) Subject to the availability of funds, as determined pursuant to Part 4.5 (commencing with Section 5890), county mental health programs shall offer services to severely mentally ill children for whom services under any other public or private insurance or other mental health or entitlement program is inadequate or unavailable. Other entitlement programs include, but are not limited to, mental health services available pursuant to Medi-Cal, child welfare, and special education programs. The funding shall cover only those portions of care that cannot be paid for with public or private insurance, other mental health funds, or other entitlement programs.~~

~~(b) Funding shall be at sufficient levels to ensure that counties can provide each child served all of the necessary services set forth in the applicable treatment plan developed in accordance with this part, including services where appropriate and necessary to prevent an out-of-home placement, such as services pursuant to Chapter 4 (commencing with Section 18250) of Part 6 of Division 9.~~

~~(c) The Office of Mental Health Services shall contract with county mental health programs for the provision of services under this article in the manner set forth in Section 5897.~~

~~SEC. 13. Section 5890 of the Welfare and Institutions Code is amended to read:~~

~~5890. (a) The Mental Health Services Fund is hereby created in the State Treasury. The fund shall be administered by the state. Notwithstanding Section 13340 of the Government Code, all moneys in the fund are, except as provided in subdivision (d) of Section 5892, continuously appropriated, without regard to fiscal years, for the purpose of funding the following programs and other related activities as designated by other provisions of this division:~~

~~(1) Part 3 (commencing with Section 5800), the Adult and Older Adult Mental Health System of Care Act.~~

~~(2) Part 3.2 (commencing with Section 5830), Innovative Programs.~~

~~(3) Part 3.6 (commencing with Section 5840), Prevention and Early Intervention Programs.~~

~~(4) Part 3.9 (commencing with Section 5849.1), No Place Like Home Program.~~

~~(5) Part 4 (commencing with Section 5850), the Children's Mental Health Services Act.~~

~~(b) The establishment of this fund and any other provisions of the act establishing it or the programs funded shall not be construed to modify the obligation of health care service plans and disability insurance policies to provide coverage for mental health services, including those services required under Section 1374.72 of the Health and Safety Code and Section 10144.5 of the Insurance Code, related to mental health parity. This act shall not modify the oversight duties of the Department of Managed Health Care or the duties of the Department of Insurance with respect to enforcing these obligations of plans and insurance policies.~~

~~(c) The Office of Mental Health Services shall seek approval of all applicable federal Medicaid approvals to maximize the availability of federal funds and eligibility of participating children, adults, and seniors for medically necessary care.~~

~~(d) Share of costs for services pursuant to Part 3 (commencing with Section 5800) and Part 4 (commencing with Section 5850) of this division, shall be determined in accordance with the Uniform Method of Determining Ability to Pay applicable to other publicly funded mental health services, unless this Uniform Method is replaced by another method of determining copayments, in which case the new method applicable to other mental health services shall be applicable to services pursuant to Part 3 (commencing with Section 5800) and Part 4 (commencing with Section 5850) of this division.~~

~~(e) The Supportive Housing Program Subaccount is hereby created in the Mental Health Services Fund. Notwithstanding Section 13340 of the Government Code, all moneys in the subaccount are reserved and continuously appropriated, without regard to fiscal years, to the California Health Facilities Financing Authority to provide funds to meet its financial obligations pursuant~~

~~to any service contracts entered into pursuant to Section 5849.35. Notwithstanding any other law, including any other provision of this section, no later than the last day of each month, the Controller shall, before any transfer or expenditure from the fund for any other purpose for the following month, transfer from the Mental Health Services Fund to the Supportive Housing Program Subaccount an amount that has been certified by the California Health Facilities Financing Authority pursuant to paragraph (3) of subdivision (a) of Section 5849.35, but not to exceed an aggregate amount of one hundred forty million dollars ($140,000,000) per year. If in any month the amounts in the Mental Health Services Fund are insufficient to fully transfer to the subaccount or the amounts in the subaccount are insufficient to fully pay the amount certified by the California Health Facilities Financing Authority, the shortfall shall be carried over to the next month. Moneys in the Supportive Housing Program Subaccount shall not be loaned to the General Fund pursuant to Section 16310 or 16381 of the Government Code.~~

~~SEC. 14. Section 5891 of the Welfare and Institutions Code is amended to read:~~

~~5891. (a) The funding established pursuant to this act shall be utilized to expand mental health services. These funds shall not be used to supplant existing state or county funds utilized to provide mental health services. The state shall continue to provide financial support for mental health programs with not less than the same entitlements, amounts of allocations from the General Fund or from the Local Revenue Fund 2011 in the State Treasury, and formula distributions of dedicated funds as provided in the last fiscal year that ended prior to the effective date of this act. The state shall not make any change to the structure of financing mental health services, which increases a county's share of costs or financial risk for mental health services unless the state includes adequate funding to fully compensate for such increased costs or financial risk. These funds shall only be used to pay for the programs authorized in Sections 5890 and 5892. These funds shall not be used to pay for any other program. These funds shall not be loaned to the General Fund or any other fund of the state, or a county general fund or any other county fund for any purpose other than those authorized by Sections 5890 and 5892.~~

~~(b) (1) Notwithstanding subdivision (a), and except as provided in paragraph (2), the Controller may use the funds created pursuant to this part for loans to the General Fund as provided in Sections 16310 and 16381 of the Government Code. Any such loan shall be repaid from the General Fund with interest computed at 110 percent of the Pooled Money Investment Account rate, with interest commencing to accrue on the date the loan is made from the fund. This subdivision does not authorize any transfer that would interfere with the carrying out of the object for which these funds were created.~~

~~(2) This subdivision does not apply to the Supportive Housing Program Subaccount created by subdivision (e) of Section 5890 or any moneys paid by the California Health Facilities Financing Authority to the Department of Housing and Community Development as a service fee pursuant to a service contract authorized by Section 5849.35.~~

~~(c) Commencing July 1, 2012, on or before the 15th day of each month, pursuant to a methodology provided by the State Department of Health Care Services, the Controller shall distribute to each Local Mental Health Service Fund established by counties pursuant to subdivision (f) of Section 5892, all unexpended and unreserved funds on deposit as of the last day of the prior month in the Mental Health Services Fund, established pursuant to Section 5890, for the provision of programs and other related activities set forth in Part 3 (commencing with Section 5800), Part 3.2 (commencing with Section 5830), Part 3.6 (commencing with Section 5840), Part 3.9 (commencing with Section 5849.1), and Part 4 (commencing with Section 5850).~~

~~(d) Counties shall base their expenditures on the county mental health program's three-year program and expenditure plan or annual update, as required by Section 5847. Nothing in this subdivision shall affect subdivision (a) or (b).~~

~~SEC. 15. Section 5892 of the Welfare and Institutions Code is amended to read:~~

~~5892. (a) In order to promote efficient implementation of this act, the county shall use funds distributed from the Mental Health Services Fund as follows:~~

~~(1) In 2005–06, 2006–07, and in 2007–08, 10 percent shall be placed in a trust fund to be expended for education and training programs pursuant to Part 3.1.~~

~~(2) In 2005–06, 2006–07, and in 2007–08, 10 percent for capital facilities and technological needs distributed to counties in accordance with a formula developed in consultation with the County Behavioral Health Directors Association of California to implement plans developed pursuant to Section 5847.~~

~~(3) Twenty percent of funds distributed to the counties pursuant to subdivision (c) of Section 5891 shall be used for prevention and early intervention programs in accordance with Part 3.6 (commencing with Section 5840) of this division.~~

~~(4) The expenditure for prevention and early intervention may be increased in any county in which the Office of Mental Health Services determines that the increase will decrease the need and cost for additional services to severely mentally ill persons in that county by an amount at least commensurate with the proposed increase.~~

~~(5) The balance of funds shall be distributed to county mental health programs for services to persons with severe mental illnesses pursuant to Part 4 (commencing with Section 5850) for the children's system of care and Part 3 (commencing with Section 5800) for the adult and older adult system of care. These services may include housing assistance, as defined in Section 5892.5, to the target population specified in Section 5600.3.~~

~~(6) Five percent of the total funding for each county mental health program for Part 3 (commencing with Section 5800), Part 3.6 (commencing with Section 5840), and Part 4 (commencing with Section 5850) of this division, shall be utilized for innovative programs in accordance with Sections 5830, 5847, and 5848.~~

~~(b) In any year after 2007–08, programs for services pursuant to Part 3 (commencing with Section 5800) and Part 4 (commencing with Section 5850) of this division may include funds for technological needs and capital facilities, human resource needs, and a prudent reserve to ensure services do not have to be significantly reduced in years in which revenues are below the average of previous years. The total allocation for purposes authorized by this subdivision shall not exceed 20 percent of the average amount of funds allocated to that county for the previous five years pursuant to this section.~~

~~(c) The allocations pursuant to subdivisions (a) and (b) shall include funding for annual planning costs pursuant to Section 5848. The total of these costs shall not exceed 5 percent of the total of~~

~~annual revenues received for the fund. The planning costs shall include funds for county mental health programs to pay for the costs of consumers, family members, and other stakeholders to participate in the planning process and for the planning and implementation required for private provider contracts to be significantly expanded to provide additional services pursuant to Part 3 (commencing with Section 5800) and Part 4 (commencing with Section 5850) of this division.~~

~~(d) Prior to making the allocations pursuant to subdivisions (a), (b), and (c), funds shall be reserved for the costs for the Office of Mental Health Services, the California Behavioral Health Planning Council, the Office of Statewide Health Planning and Development, the Mental Health Services Oversight and Accountability Commission, the State Department of Public Health, and any other state agency to implement all duties pursuant to the programs set forth in this section. These costs shall not exceed 5 percent of the total of annual revenues received for the fund. The administrative costs shall include funds to assist consumers and family members to ensure the appropriate state and county agencies give full consideration to concerns about quality, structure of service delivery, or access to services. The amounts allocated for administration shall include amounts sufficient to ensure adequate research and evaluation regarding the effectiveness of services being provided and achievement of the outcome measures set forth in Part 3 (commencing with Section 5800), Part 3.6 (commencing with Section 5840), and Part 4 (commencing with Section 5850) of this division. The amount of funds available for the purposes of this subdivision in any fiscal year shall be subject to appropriation in the annual Budget Act.~~

~~(e) In 2004–05, funds shall be allocated as follows:~~

~~(1) Forty-five percent for education and training pursuant to Part 3.1 (commencing with Section 5820) of this division.~~

~~(2) Forty-five percent for capital facilities and technology needs in the manner specified by paragraph (2) of subdivision (a).~~

~~(3) Five percent for local planning in the manner specified in subdivision (c).~~

~~(4) Five percent for state implementation in the manner specified in subdivision (d).~~

~~(f) Each county shall place all funds received from the State Mental Health Services Fund in a local Mental Health Services~~

~~Fund. The Local Mental Health Services Fund balance shall be invested consistent with other county funds and the interest earned on the investments shall be transferred into the fund. The earnings on investment of these funds shall be available for distribution from the fund in future years.~~

~~(g) All expenditures for county mental health programs shall be consistent with a currently approved plan or update pursuant to Section 5847.~~

~~(h) (1) Other than funds placed in a reserve in accordance with an approved plan, any funds allocated to a county that have not been spent for their authorized purpose within three years shall revert to the state to be deposited into the fund and available for other counties in future years, provided however, that funds for capital facilities, technological needs, or education and training may be retained for up to 10 years before reverting to the fund.~~

~~(2) If a county receives approval from the Mental Health Services Oversight and Accountability Commission of a plan for innovative programs, pursuant to subdivision (e) of Section 5830, the county's funds identified in that plan for innovative programs shall not revert to the state pursuant to paragraph (1) until three years after the date of the approval.~~

~~(3) Notwithstanding paragraph (1), any funds allocated to a county with a population of less than 200,000 that have not been spent for their authorized purpose within five years shall revert to the state as described in paragraph (1).~~

~~(4) Notwithstanding paragraphs (1) and (2), if a county with a population of less than 200,000 receives approval from the Mental Health Services Oversight and Accountability Commission of a plan for innovative programs, pursuant to subdivision (e) of Section 5830, the county's funds identified in that plan for innovative programs shall not revert to the state pursuant to paragraph (1) until five years after the date of the approval.~~

~~(i) If there are still additional revenues available in the fund after the Mental Health Services Oversight and Accountability Commission has determined there are prudent reserves and no unmet needs for any of the programs funded pursuant to this section, including all purposes of the Prevention and Early Intervention Program, the commission shall develop a plan for expenditures of these revenues to further the purposes of this act and the Legislature may appropriate these funds for any purpose~~

~~consistent with the commission's adopted plan that furthers the purposes of this act.~~

~~SEC. 16. Section 5897 of the Welfare and Institutions Code is amended to read:~~

~~5897. (a) Notwithstanding any other state law, the Office of Mental Health Services shall implement the mental health services provided by Part 3 (commencing with Section 5800), Part 3.6 (commencing with Section 5840), and Part 4 (commencing with Section 5850) through contracts with county mental health programs or counties acting jointly. A contract may be exclusive and may be awarded on a geographic basis. For purposes of this section, a county mental health program includes a city receiving funds pursuant to Section 5701.5.~~

~~(b) Two or more counties acting jointly may agree to deliver or subcontract for the delivery of those mental health services. The agreement may encompass all or any part of the mental health services provided pursuant to these parts. Any agreement between counties shall delineate each county's responsibilities and fiscal liability.~~

~~(c) The office shall implement the provisions of Part 3 (commencing with Section 5800), Part 3.2 (commencing with Section 5830), Part 3.6 (commencing with Section 5840), and Part 4 (commencing with Section 5850) through the annual county mental health services performance contract, as specified in Chapter 2 (commencing with Section 5650) of Part 2.~~

~~(d) The office shall conduct program reviews of performance contracts to determine compliance. Each county performance contract shall be reviewed at least once every three years, subject to available funding for this purpose.~~

~~(e) If a county mental health program is not in compliance with its performance contract, the office may request a plan of correction with a specific timeline to achieve improvements. The office shall post on its Internet Web site any plans of correction requested and the related findings.~~

~~(f) Contracts awarded by the office, the State Department of Public Health, the California Behavioral Health Planning Council, the Office of Statewide Health Planning and Development, and the Mental Health Services Oversight and Accountability Commission pursuant to Part 3 (commencing with Section 5800), Part 3.1 (commencing with Section 5820), Part 3.2 (commencing~~

~~with Section 5830), Part 3.6 (commencing with Section 5840), Part 3.7 (commencing with Section 5845), Part 4 (commencing with Section 5850), and this part may be awarded in the same manner in which contracts are awarded pursuant to Section 5814, and the provisions of subdivisions (g) and (h) of Section 5814 shall apply to those contracts.~~

~~(g) For purposes of Section 14712, the allocation of funds pursuant to Section 5892 that are used to provide services to Medi-Cal beneficiaries shall be included in calculating anticipated county matching funds and the transfer to the State Department of Health Care Services of the anticipated county matching funds needed for community mental health programs.~~

~~SEC. 17. Section 5898 of the Welfare and Institutions Code is amended to read:~~

~~5898. The Office of Mental Health Services, in consultation with the Mental Health Services Oversight and Accountability Commission, shall develop regulations, as necessary, for the office, the Mental Health Services Oversight and Accountability Commission, or designated state and local agencies to implement this act. Regulations adopted pursuant to this section shall be developed with the maximum feasible opportunity for public participation and comments.~~

~~SEC. 18. Section 5899 of the Welfare and Institutions Code is amended to read:~~

~~5899. (a) The Office of Mental Health Services, in consultation with the Mental Health Services Oversight and Accountability Commission and the County Behavioral Health Directors Association of California, shall develop and administer instructions for the Annual Mental Health Services Act Revenue and Expenditure Report. The instructions shall include a requirement that the county certify the accuracy of this report. This report shall be submitted electronically to the office and to the Mental Health Services Oversight and Accountability Commission. The office and the commission shall annually post each county's report on their Internet Web site in a timely manner.~~

~~(b) The office, in consultation with the commission and the County Behavioral Health Directors Association of California, shall revise the instructions described in subdivision (a) by July 1, 2017, and as needed thereafter, to improve the timely and accurate submission of county revenue and expenditure data.~~

~~(c) The purpose of the Annual Mental Health Services Act Revenue and Expenditure Report is as follows:~~

~~(1) Identify the expenditures of Mental Health Services Act (MHSA) funds that were distributed to each county.~~

~~(2) Quantify the amount of additional funds generated for the mental health system as a result of the MHSA.~~

~~(3) Identify unexpended funds, and interest earned on MHSA funds.~~

~~(4) Determine reversion amounts, if applicable, from prior fiscal year distributions.~~

~~(d) This report is intended to provide information that allows for the evaluation of all of the following:~~

~~(1) Children's systems of care.~~

~~(2) Prevention and early intervention strategies.~~

~~(3) Innovative projects.~~

~~(4) Workforce education and training.~~

~~(5) Adults and older adults systems of care.~~

~~(6) Capital facilities and technology needs.~~

~~(e) If a county does not submit the annual revenue and expenditure report described in subdivision (a) by the required deadline, the office may withhold MHSA funds until the reports are submitted.~~

~~(f) A county shall also report the amount of MHSA funds that were spent on mental health services for veterans.~~

~~(g) By October 1, 2018, and by October 1 of each subsequent year, the office shall, in consultation with counties, publish on its Internet Web site a report detailing funds subject to reversion by county and by originally allocated purpose. The report also shall include the date on which the funds will revert to the Mental Health Services Fund.~~

~~SEC. 19. The Legislature finds and declares that this act is consistent with, and furthers the intent of, the Mental Health Services Act within the meaning of Section 18 of the Mental Health Services Act.~~

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Date of Hearing: April 24, 2018

ASSEMBLY COMMITTEE ON HEALTH
Jim Wood, Chair
AB 2287 (Kiley) – As Amended April 17, 2018

SUBJECT: Mental Health Services Act: transparency and accountability.

SUMMARY: Requires the Mental Health Services Oversight and Accountability Commission (commission) to develop a transparency and accountability strategy that includes fiscal, program, and outcome components, as specified. Specifically, **this bill**:

1) Establishes legislative findings and declarations related to mental health services.

2) Requires the commission, in developing a fiscal transparency and accountability strategy for local governments, to develop elements, information tools, materials, or other efforts, as determined by the commission, that allow for public awareness and monitoring of local government mental health spending, statewide, by county, counties acting jointly, or other jurisdictions as determined by the commission.

3) Requires the commission to make information available historically, to the extent possible, but at least for the most recently completed fiscal year, as specified.

4) Requires the commission, in support of local government fiscal transparency and accountability, to make fiscal information available that reflects total mental health revenues, expenditures, and unspent funds, from the Mental Health Services Act Fund (MHSA Fund), as well as other funding sources, to support public understanding of how mental health services are funded, revenue and expenditure trends, and the availability of mental health funds to support the needs of mental health consumers and California's communities.

5) Requires the Commission, in developing the fiscal transparency and accountability strategy, to consult with the Department of Finance (DOF), the State Department of Health Care Services (DHCS), the State Controller's Office, the California State Auditor, and other entities as needed, to develop an approach that supports public accountability.

6) Requires, upon request, DHCS, DOF, and the State Controller's Office to make available to the commission all information, data, or other materials that are subject to public disclosure.

7) Requires the commission, in developing a program transparency and accountability strategy for local mental health programs, to develop elements, information tools, materials, or other efforts, as determined by the commission, that allow for public awareness and monitoring of publicly funded or supported mental health programs statewide, by county, counties acting jointly, or other jurisdictions as determined by the commission. To the extent possible, the commission shall make information on mental health programs available historically and for the most recently completed fiscal year.

8) Requires the commission, in support of the local government program transparency and accountability strategy, to make information publicly available that reflects the nature of services available, how those services are organized and provided, the geographic location of services, and the intended population being served.

9) Requires the commission, as part of the program transparency and accountability strategy, to make information publicly available on the number of persons served, with information on demographic characteristics, including, but not limited to, age, race, ethnicity, gender, sexual orientation, language spoken, veteran status, and other characteristics intended to improve public understanding of who is being served by mental health programs.

10) Requires the commission, to the extent possible, to make information publicly available on funding and persons served, by program, strategy, or service, to support public understanding of how people are accessing services and care, and how those services are funded.

11) Requires the commission, in developing the program transparency and accountability strategy, to consider whether existing regulatory reporting requirements are adequate, and revise those requirements, on a basis determined by the commission, to support enhanced reporting, transparency and accountability.

12) Requires DHCS to adopt and periodically update regulations regarding demographic reporting or other requirements that are consistent with regulations adopted by the commission and support the transparency and accountability strategy developed by the commission by January 31, 2020.

13) Requires DHCS to provide the relevant budget and policy committees of the Legislature, and the commission, a detailed explanation of the delay and a proposed deadline for the adoption of those regulations if the department is unable to adopt regulations by that date.

14) Requires the commission, in developing a transparency and accountability strategy for local mental health programs to develop elements, information tools, materials, or other efforts, as determined by the commission, that allow for public awareness and monitoring of outcomes achieved by publicly funded or supported mental health programs, statewide, by county, counties acting jointly, or other jurisdictions as determined by the commission.

15) Requires, to the extent possible, the commission to make information on mental health outcomes available historically and for the most recently completed fiscal year.

16) Requires the commission to develop a strategy for reporting and monitoring mental health outcomes including reporting on reductions in homelessness, unemployment, removal of children from their homes, suicide, incarcerations, school failure or dropout, and prolonged suffering. Specifies that for purposes of this bill, "removal of children from their homes" refers to involvement with the child welfare system, the juvenile justice system, or other placement as determined by the commission.

17) Requires the commission, in support of the outcome transparency and accountability strategy for local mental health programs, as it deems necessary, to identify or develop other measures associated with access to mental health services and supports, the quality of those services and supports, and the outcomes that result from accessing those services and supports.

18) Requires the commission to have access to data, information, policies, procedures, and practices held or maintained by the departments within the California Health and Human Services Agency (CHHSA), the Department of Justice (DOJ), the State Department of

Education (CDE), the Employment Development Department (EDD), and other state and local agencies, as necessary, to comply with the requirements of this bill.

19) Requires the CHHSA, DOJ, CDE, and EDD, and other state and local agencies, to cooperate and share data with the commission, to support the intent of this bill.

20) Requires the commission to comply with all applicable federal and state privacy and confidentiality laws in accessing data pursuant to this bill.

21) Requires the commission to develop a transparency and accountability strategy for state government that includes fiscal information, and information on programs and outcomes related to mental health. Requires the commission to develop elements, information tools, materials, or other efforts, as determined by the commission, that allow for public awareness and monitoring of state level mental health spending, activities, and outcomes, by department, program, or other organizing unit, as determined by the commission.

22) Requires, in developing this strategy, to the extent possible, the commission to make information available historically and for the most recently completed fiscal year.

23) Requires the commission to assess the adequacy of existing statutory and regulatory data reporting requirements, strategies, and practices, and make recommendations to the Governor and Legislature for streamlining and strengthening those strategies to reduce costs and improve the use of information to guide program, fiscal, and related decisions.

24) Requires the commission, in developing the transparency and accountability strategy required by this bill, to prepare and report to the relevant policy and fiscal committees of the Legislature on or before March 31, 2020, and periodically thereafter, as needed, on its progress in complying with this section, and any funding, personnel, authority, or other resources the commission may need to achieve the intent of this bill.

EXISTING LAW:

1) Establishes the MHSA, enacted by voters in 2004 as Proposition 63, to provide funds to counties to expand services, develop innovative programs, and integrated service plans for mentally ill children, adults, and seniors through a one percent income tax on personal income above $1 million.

2) Establishes the commission to oversee the implementation of MHSA, made up of 16 individuals appointed by the Governor and the Legislature, as specified.

3) Requires the commission to ensure that the perspective and participation of diverse community members reflective of California populations and others suffering from severe mental illness and their family members is a significant factor in all of its decisions and recommendations.

4) Specifies that the MHSA can only be amended by a two-thirds vote of both houses of the Legislature and only as long as the amendment is consistent with and furthers the intent of the MHSA. Permits provisions clarifying the procedures and terms of the MHSA to be added by majority vote.

5) Requires all expenditures for county mental health programs to be consistent with a currently approved mental health plan or update.

6) Establishes the MHSA Fund to be disbursed as follows:

   a) Twenty percent of funds distributed to counties to be used for prevention and early intervention programs;
   b) Five percent of the total funding for each county mental health program to be utilized for innovative programs;
   c) Requires the balance of funds to be distributed to county mental health programs for services to persons with severe mental illnesses, for the children's system of care, and for the adult and older adult system of care;
   d) Permits no more than 20% of the average amount of funds allocated to a county for the previous five years to be used for technological needs and capital facilities, human resource needs, and for counties to establish a prudent reserve to ensure services do not have to be significantly reduced in years in which revenues are below the average of previous years;
   e) Permits up to 5% of funds to be used for planning costs including for county mental health programs to pay for the costs of consumers, family members, and other stakeholders to participate in the planning process and for the planning and implementation required for private provider contracts to be significantly expanded to provide additional services; and,
   f) Requires, prior to making the allocations in a) through d) above, up to 5%t of funds to be reserved for the costs for DHCS, the California Mental Health Planning Council, the Office of Statewide Health Planning and Development (OHSPD), the commission, the State Department of Public Health, and any other state agency to implement all duties pursuant to the MHSA.

7) Requires all expenditures for county mental health programs to be consistent with a currently approved mental health plan or update.

8) Deems all unspent funds subject to reversion as of July 1, 2017, to have been reverted to the Fund and reallocated to the county of origin for the purposes for which they were originally allocated.

9) Requires DHCS, on or before July 1, 2018, in consultation with counties and other stakeholders, to prepare and submit a report to the Legislature identifying the amounts that were subject to reversion prior to July 1, 2017, including to which purposes the unspent funds were allocated.

10) Requires DHCS to provide to counties the amounts it has determined are subject to reversion, and provide a process for counties to appeal this determination.

11) Requires counties with unspent funds subject to reversion, that are deemed reverted and reallocated, to prepare and submit a plan (by July 1, 2018) to expend these funds on or before July 1, 2020.

12) Restarts the three-year clock on expenditure of Innovation funds when a county's Innovation Plan has received approval by the commission.

13) Authorizes small counties, with a population of less than 200,000, to expend MHSA funds for up to five years before unspent funds will be reverted to the state.

14) Requires DHCS, in consultation with the commission and the County Behavioral Health Directors Association of California (CBHDA), to develop and administer instructions for the Annual MHSA Revenue and Expenditure Report (Report). Requires that the instructions include a requirement that the county certify the accuracy of this report.

15) Requires counties to submit the Report electronically to DHCS and to the Commission. Requires DHCS and the commission to annually post each county's report on its Internet Web site in a timely manner. Requires DHCS, in consultation with the commission and CBHDA, to revise these instructions by July 1, 2017, and as needed thereafter, to improve the timely and accurate submission of county revenue and expenditure data. Specifies the purpose of the Report.

16) Requires DHCS, by October 1, 2018, and by October 1 of each subsequent year, in consultation with counties, to publish on its Internet Website a report detailing funds subject to reversion by county and by originally allocated purpose.

17) Requires that, on or after July 1, 2017, funds subject to reversion be reallocated to other counties for the purposes for which the unspent funds were initially allocated to the original county.

FISCAL EFFECT: This bill has not yet been analyzed by a fiscal committee.

COMMENTS:

1) **PURPOSE OF THIS BILL.** According to the author, the Legislature must work together to shine a light on the challenges facing our mental health care system, including finding ways to improve the delivery of mental health services in California. More than 2.2 million Californians have a mental health need, and just over half of those report that they do not receive any treatment from a primary care doctor or a mental health professional. Left untreated, mental illness can result in prolonged suffering and is the leading cause of suicide and disability. Without intervention those suffering from untreated mental illness may be imprisoned, drop out of school, become unemployed, or be faced with homelessness.

   The good news is, when used effectively, mental health dollars have the power to reduce homelessness, hospitalizations, incarcerations, and trauma these kinds of disruptions bring to children. However, despite the importance of accessible, culturally competent and effective mental health services and supports, California has not developed an integrated strategy to support transparency and accountability for the state's public mental health system that allows the public and policy makers to better understand the services that are in place, how well they are functioning and the outcomes that are achieved. The author states that this bill seeks to improve oversight of mental health dollars in California by requiring the commission to develop a local and state transparency and accountability strategy focusing on the fiscal, program, and outcome components of the MHSA. This bill also asks the commission to assess the adequacy of existing statutory and regulatory data reporting requirements and make recommendations to the Legislature by 2020. Finally, in order to ensure compliance, the bill also requires all relevant state agencies to share data with the

commission that is necessary for developing the local and state strategies. This is an important first step in ensuring that mental health funding in California is being used to help those who need it, not being wasted on ineffective programs and delivery methods.

2) **BACKGROUND.**

a) **Proposition 63.** Proposition 63 was passed by voters in November 2004. The MHSA imposes a one percent income tax on personal income in excess of $1 million and creates the 16 member Commission charged with overseeing the implementation of MHSA. The 2016-17 Governor's Budget projected that $1.9 billion in revenue would be deposited into the Fund in fiscal year 2017-18. The MHSA addresses a broad continuum of prevention, early intervention, and service needs, as well as provided funding for infrastructure, technology, and training needs for the community mental health system. In addition to local programs, the MHSA authorizes up to 5% of revenues for state administrative functions performed by a variety of state entities such as the DHCS and OSHPD. It also funds evaluation of the MHSA by the Commission, which was established by the MHSA. Unspent MHSA funds are required to be placed in a reserve in accordance with an approved plan, and funds allocated to a county that have not been spent for their authorized purpose within three years are required to revert those funds back to the state.

b) **Commission**. MHSA requires each county mental health department to prepare and submit a three-year plan to DHCS that must be updated each year and approved by DHCS after review and comment by the commission. In their three-year plans, counties are required to include a list of all programs for which MHSA funding is being requested and that identifies how the funds will be spent and which populations will be served. Counties must submit their plans for approval to the commission before the counties may spend certain categories of funding.

c) **Funding**. The MHSA provides funding for programs within five components:

i) **Community Services and Supports**: Provides direct mental health services to the severely and seriously mentally ill, such as mental health treatment, cost of health care treatment, and housing supports. Regulation requires counties to direct the majority of its Community Services and Supports funds to Full-Service Partnerships (FSPs). FSPs are county coordinated plans, in collaboration with the client and the family to provide the full spectrum of community services. These services consist of mental health services and supports, such as peer support and crisis intervention services; and non-mental health services and supports, such as food, clothing, housing, and the cost of medical treatment;

ii) **Prevention and Early Intervention**: Provides services to mental health clients in order to help prevent mental illness from becoming severe and disabling;

iii) **Innovation**: Provides services and approaches that are creative in an effort to address mental health clients' persistent issues, such as improving services for underserved or unserved populations within the community;

iv) **Capital Facilities and Technological Needs**: Creates additional county infrastructure such as additional clinics and facilities and/or development of a

technological infrastructure for the mental health system, such as electronic health records for mental health services; and,

v) **Workforce Education and Training**: Provides training for existing county mental health employees, outreach and recruitment to increase employment in the mental health system, and financial incentives to recruit or retain employees within the public mental health system.

d) **State Auditor Report and Recommendations.** On February 27, 2018, the State Auditor released a report entitled "Mental Health Services Act: The State Could Better Ensure the Effective Use of Mental Health Services Act Funding" (Audit Report), at the request of the Joint Legislative Audit Committee. The Audit Report concluded that despite having significant responsibility for the MHSA program since 2012, DHCS has not developed a process to recover unspent MHSA funds from local mental health agencies after the statutory time frames for spending the funds have elapsed, known as reversion. As a result, the local mental health agencies have had less incentive to spend MHSA funds in a timely manner and had amassed unspent funds of $231 million as of the end of fiscal year 2015–16 that they should have reverted to the State for it to reallocate to other local mental health agencies. This figure does not include funds held in reserves or interest earned on the unspent funds. However, the Audit Report noted that the Legislature enacted a one-time change in state law in 2017 that allowed local mental health agencies to retain all funds that were subject to reversion as of July 1, 2017. The Audit Report concluded that nevertheless, this one-time allowance did not resolve the larger issue that DHCS has been slow in implementing a process to revert unspent MHSA funds. The State Auditor recommended, in order to ensure that local mental health agencies spend MHSA funds in a timely manner, that DHCS implement a fiscal reversion process to reallocate to other local mental health agencies any MHSA funds that are unspent within the statutory reversion time frames. The State Auditor also recommended that DHCS clarify that the interest that local mental health agencies earn on unspent MHSA funds is also subject to reversion requirements and should establish an MHSA reserve level that is sufficient but not excessive.

3) **OPPOSITION.** CBHDA state in opposition to this bill that as currently drafted, this bill creates unnecessary and duplicative data collection and reporting in a number of areas. This bill outlines a lengthy list of requirements for making information publicly available about multiple aspects of the public mental health services, including but not limited to the MHSA (i.e., local finances, services delivered, populations, demographic data). However, much of this information is already collected from counties by DHCS and/or the commission. CBHDA further states that, as an example, For example, the commission currently has a Fiscal Transparency Tool and links to county MHSA plans on its web site illustrating the MHSA revenues and expenditures of each county. Additionally, DHCS has information on its web site about Medi-Cal Specialty Mental Health Services, describing the numbers and characteristics of individuals served, the services provided, the timeliness of those services, and a number of other required county reporting elements. As required under recently enacted statutes, DHCS also publishes each county's annual MHSA Revenue and Expenditure Report on its website.

CBHDA further states that DHCS is developing new quality and outcome reporting requirements, which will be published online, for Medi-Cal Specialty Mental Health

Services, pursuant to the new Federal Medicaid Managed Care Final Rule regulations. These regulatory requirements will identify the strengths or challenges of counties in delivering timely and accessible mental health services.

4) **RELATED LEGISLATION.**

a) AB 2843 (Gloria) Adds cities, special districts, school districts, or other public entities to the list of entities eligible to receive an excess of MHSA funds subject to reversion for the provision of mental health services consistent with the intent of the MHSA. This bill passed out of the Assembly Health Committee 15-0 on April 17, 2018, and is now pending in the Assembly Appropriations Committee.

b) AB 2619 (Allen) would appropriate $10 million from the General Fund to DHCS to allocate the appropriated funds to county mental health programs for the purpose of funding innovative programs to provide mental health services to California's homeless population. AB 2619 is pending in the Assembly Health Committee.

5) **PREVIOUS LEGISLATION.**

a) AB 462 (Thurmond), Chapter 403, Statutes of 2017, authorizes the Director of EDD to share information with the Commission related to quarterly wage data to assist the commission in fulfilling its duties under the MHSA, to the extent permitted under applicable federal statute and regulation. Declares it the intent of the Legislature to authorize the commission to receive information held by other state agencies, as it relates to outcomes established under the MHSA, for purposes of monitoring outcomes and improving the mental health system.

b) AB 1134 (Gloria), Chapter 412, Statutes of 2017, authorizes the Commission to establish a fellowship program for the purpose of providing an experiential learning opportunity for a mental health consumer and a mental health professional.

c) SB 192 (Jim Beall) would require counties, or counties acting jointly, seeking funding from the MHSA Reversion Fund, to demonstrate to the Mental Health Services Oversight and Accountability Commission that funding will be used to create, or expand, existing capacity for services and supports that address unmet community needs. SB 192 is pending in the Assembly Health Committee.

REGISTERED SUPPORT / OPPOSITION:

Support

None on file.

Opposition

California Behavioral Health Directors Association

Analysis Prepared by: Paula Villescaz / HEALTH / (916) 319-2097

Date of Hearing: May 9, 2018

ASSEMBLY COMMITTEE ON APPROPRIATIONS
Lorena Gonzalez Fletcher, Chair
AB 2287 (Kiley) – As Amended April 17, 2018

Policy Committee: Health Vote: 13 - 0

Urgency: No State Mandated Local Program: No Reimbursable: No

SUMMARY:

This bill requires the Mental Health Services Oversight and Accountability Commission (commission) to conduct a number of oversight duties to promote transparency and accountability in the delivery of state and local mental health services, as specified.

It also requires the Department of Health Care Services (DHCS) to issue regulations consistent with those adopted by the commission and requires a number of state departments to comply with commission requests for information.

FISCAL EFFECT:

Estimates below roughly reflect the additional cost for work beyond the commission's current activities. To the extent this bill reduces commission flexibility by requiring certain activities that are now discretionary, a higher cost could be attributed to this bill.

1) Ongoing annual staff costs to the commission in the range of $350,000 and information technology costs of $200,000 to oversee and conduct additional analytical, outreach, and reporting activities (Mental Health Services Act (MHSA) state administration funds).

2) One-time costs of $1.2 million for contracts to inventory data reporting, propose reforms, develop outcome metrics, consult with subject matter experts, build data infrastructure and visualization tools, analyze data, and develop reporting formats MHSA state administration funds).

3) Costs to DHCS to develop regulations are likely to be minor, as the department is currently working on two regulatory packages on the subject of MHSA transparency and accountability MHSA state administration funds). It is unclear whether this bill will affect ongoing regulatory workload.

4) Unknown, potentially significant costs to various departments to comply with commission data requests and requests for technical assistance. Departments include: the Department of Justice, the California Department of Education, the Employment Development Department (EDD), the Department of Finance, the State Controller's Office, the California State Auditor's Office, California Health and Human Services Agency, and DHCS (various funds).

COMMENTS:

1) **Purpose**. This bill seeks to enhance transparency and accountability in the state's mental health system to ensure money is being spent efficiently and in a manner that delivers positive outcomes.

2) **Background**. Proposition 63, the MHSA, was passed by voters in November 2004. The MHSA imposes a 1% income tax on personal income in excess of $1 million fund counties for a broad continuum of mental health prevention, early intervention, and other services. It also charges the commission with overseeing MHSA implementation and authorizes up to 5% of revenues for state administrative functions. The commission currently conducts some of the activities required by this bill, while others are new. In addition, this bill expands the scope of the commission's work to publicly funded mental health services broadly, not just programs or services funded by the MHSA.

3) **Prior Legislation**. AB 462 (Thurmond), Chapter 403, Statutes of 2017, authorized the director of EDD to share quarterly wage data to assist the commission in fulfilling its duties under the MHSA. It also declared the intent of the Legislature to authorize the commission to receive information held by other state agencies in order to monitor outcomes and improve the mental health system.

Analysis Prepared by: Lisa Murawski / APPR. / (916) 319-2081

Assembly Bill 2843 (Gloria)

Assembly Bill 2843 (Gloria)
Mental Health Services Fund

Introduced 2/16/18
Amended 03/23/2018

SUMMARY

This bill would allow Mental Health Services Act (MHSA) funds subject to reversion from counties to be redistributed to cities, special districts, school districts, or other public entities, in addition to counties. Current law allows reverted funds to be allocated only to counties. This bill would additionally require those funds subject to reversion to be reallocated to cities, special districts, school districts, or other public entities for the provision of mental health services consistent with the intent of the MHSA.

VOTES

DATE:	RESULT:	LOCATION:	AYES:	NOES:	NO VOTE:	MOTION:
04/17/18	(PASS)	Assembly Committee on Health	11	4	0	Pass and Re-referred to the Committee on Appropriations
Ayes: Aguiar-Curry, Cecilia Bonta, Rob Burke, Autumn Carrillo, Wendy Limón, Monique McCarty, Kevin Nazarian, Adrin Rodriguez, Freddie Santiago, Miguel Thurmond, Tony Wood, Jim						
Noes: Bigelow, Franklin Flora, Heath Mayes, Chad Waldron, Marie						
No Vote Recorded:						

SUPPORT / OPPOSITION

SUPPORT	OPPOSE
✓ City of San Diego, Council District Three	✓ California State Association of Counties ✓ Rural County Representatives of California (RCRC) ✓ Urban Counties of California ✓ California Behavioral Health Directors Association

ASSEMBLYMEMBER

Todd Gloria

REPRESENTING THE 78th DISTRICT

AB 2843: Reversion of Mental Health Services Act funds

Summary:
This bill makes reverted Mental Health Services Act (MHSA) funds available for redistribution to cities, special districts, school districts, or other public entities for the provision of mental health services consistent with the intent of the MHSA.

Background:
Every year 100,000 young adults in the U.S. experience their first psychotic episode; while, an additional one in 17 adults lives with a serious mental illness such as schizophrenia or major depression. Similarly, research also shows that 50% of all serious mental illness manifests by age 14 and 75% by age 24.

Recognizing the need to combat our mental health crisis, voters approved Proposition 63 in 2004, to change the way California treats mental illness. Proposition 63 expanded the availability of innovative and preventative programs, reduced stigma and long-term adverse impacts for those suffering from untreated mental illness, and held funded programs accountable for achieving those outcomes.

Despite the availability of significant funding specific to providing mental health services, the need for these services could not be more acute. To make matters worse, the State Auditor reported earlier this year, a significant amount of MHSA funds have gone unspent.

According to the State Auditor, as of fiscal year 2015-16, local mental health agencies had accumulated $2.5 billion in unspent MHSA funds. The Department of Health Care Services (DHCS) estimated that as of September 2017, local mental health agencies should have returned $231 million of that $2.5 billion. Although funds subject to reversion prior to July 1, 2017, were essentially forgiven as a result of budget trailer bill, a new clock has begun on MHSA funds potentially subject to reversion. While DHCS continues to establish the reversion process, the absence of an incentive by local mental health agencies to use their MHSA funds continues to exist.

Purpose
Unlike many other issues before the legislature, whether it is housing, water infrastructure, or road repairs, funding to try to combat our mental health crisis actually exists. In fact, the 2017-18 fiscal year Governor's Budget projected that $1.888 billion would be deposited into the Mental Health Services Fund.

When considering how mental illness intersects with other areas, like homelessness or public health emergencies like Hepatitis A, we must think of new ways to try to solve this issue by allowing other public entities to tap into these unspent funds.

Support:
San Diego City Council Member Chris Ward, District 3

Opposition:
California Behavioral Health Directors Association
California Behavioral Health Planning Council
California State Association of Counties
Orange County Board of Supervisors
Rural County Representatives of California
Urban Counties of California

Contact:
Juan Reyes
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916.319.2078

AMENDED IN ASSEMBLY MARCH 23, 2018

CALIFORNIA LEGISLATURE—2017–18 REGULAR SESSION

ASSEMBLY BILL No. 2843

Introduced by Assembly Member Gloria

February 16, 2018

An act *to amend Sections 5892 and 5899.1 of the Welfare and Institutions Code,* relating to mental ~~health.~~ *health, and making an appropriation therefor.*

LEGISLATIVE COUNSEL'S DIGEST

AB 2843, as amended, Gloria. Mental Health Services Fund.

Existing law, the Mental Health Services Act (MHSA), an initiative measure enacted by the voters by Proposition 63 at the November 2, 2004, statewide general election, establishes the continuously appropriated Mental Health Services Fund to fund various county mental health programs by imposing a tax of 1% on annual incomes above $1,000,000. ~~Existing law reallocates funds back to a county that failed to spend its initial funds within 3 years, and requires the county, by July 1, 2018, to prepare a plan to expend those funds on or before July 1, 2020. Under existing law,~~ *The MHSA requires* funds *allocated to a county that have* not *been* spent within a specified time ~~would~~ *to* revert to the Mental Health Services ~~Fund, as provided.~~ *Fund and to be reallocated to other counties for the purposes for which the unspent funds were initially allocated to the original county.* The MHSA permits amendment by the Legislature by a ⅗ vote of each house if the amendment is consistent with, and furthers the intent of, the MHSA.

This bill would ~~state the intent of the Legislature to enact legislation that would require a county that receives reallocated funds from the Mental Health Services Fund to spend those funds within 2 years of~~

~~adopting an expenditure plan for those funds. It would further state the intent of the Legislature that any funds not expended by a county within those 2 years would revert to the Mental Health Services Fund to be redistributed to cities within that county.~~ *additionally require those funds subject to reversion to be reallocated to cities, special districts, school districts, or other public entities for the provision of mental health services consistent with the intent of the MHSA. The bill would find and declare that its provisions are consistent with and further the intent of the MHSA. By allocating moneys in the Mental Health Services Fund for new purposes, this bill would make an appropriation.*

Vote: ~~majority 2/3~~. Appropriation: ~~no~~ *yes*. Fiscal committee: ~~no~~ *yes*. State-mandated local program: no.

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

SECTION 1. Section 5892 of the Welfare and Institutions Code is amended to read:

5892. (a) In order to promote efficient implementation of this act, the county shall use funds distributed from the Mental Health Services Fund as follows:

(1) In 2005–06, 2006–07, and in 2007–08, 10 percent shall be placed in a trust fund to be expended for education and training programs pursuant to Part 3.1.

(2) In 2005–06, 2006–07, and in 2007–08, 10 percent for capital facilities and technological needs distributed to counties in accordance with a formula developed in consultation with the County Behavioral Health Directors Association of California to implement plans developed pursuant to Section 5847.

(3) Twenty percent of funds distributed to the counties pursuant to subdivision (c) of Section 5891 shall be used for prevention and early intervention programs in accordance with Part 3.6 (commencing with Section ~~5840) of this division.~~ *5840)*.

(4) The expenditure for prevention and early intervention may be increased in any county in which the department determines that the increase will decrease the need and cost for additional services to severely mentally ill persons in that county by an amount at least commensurate with the proposed increase.

(5) The balance of funds shall be distributed to county mental health programs for services to persons with severe mental illnesses pursuant to Part 4 (commencing with Section 5850) for the

children's system of care and Part 3 (commencing with Section 5800) for the adult and older adult system of care. These services may include housing assistance, as defined in Section 5892.5, to the target population specified in Section 5600.3.

(6) Five percent of the total funding for each county mental health program for Part 3 (commencing with Section 5800), Part 3.6 (commencing with Section 5840), and Part 4 (commencing with Section ~~5850) of this division,~~ *5850),* shall be utilized for innovative programs in accordance with Sections 5830, 5847, and 5848.

(b) In any *fiscal* year after ~~2007–08,~~ *the 2007-08 fiscal year,* programs for services pursuant to Part 3 (commencing with Section 5800) and Part 4 (commencing with Section 5850) ~~of this division~~ may include funds for technological needs and capital facilities, human resource needs, and a prudent reserve to ensure services do not have to be significantly reduced in years in which revenues are below the average of previous years. The total allocation for purposes authorized by this subdivision shall not exceed 20 percent of the average amount of funds allocated to that county for the previous five *fiscal* years pursuant to this section.

(c) The allocations pursuant to subdivisions (a) and (b) shall include funding for annual planning costs pursuant to Section 5848. The total of these costs shall not exceed 5 percent of the total of annual revenues received for the fund. The planning costs shall include funds for county mental health programs to pay for the costs of consumers, family members, and other stakeholders to participate in the planning process and for the planning and implementation required for private provider contracts to be significantly expanded to provide additional services pursuant to Part 3 (commencing with Section 5800) and Part 4 (commencing with Section ~~5850) of this division.~~ *5850).*

(d) Prior to making the allocations pursuant to subdivisions (a), (b), and (c), funds shall be reserved for the costs for the State Department of Health Care Services, the California Behavioral Health Planning Council, the Office of Statewide Health Planning and Development, the Mental Health Services Oversight and Accountability Commission, the State Department of Public Health, and any other state agency to implement all duties pursuant to the programs set forth in this section. These costs shall not exceed 5 percent of the total of annual revenues received for the fund. The

administrative costs shall include funds to assist consumers and family members to ensure the appropriate state and county agencies give full consideration to concerns about quality, structure of service delivery, or access to services. The amounts allocated for administration shall include amounts sufficient to ensure adequate research and evaluation regarding the effectiveness of services being provided and achievement of the outcome measures set forth in Part 3 (commencing with Section 5800), Part 3.6 (commencing with Section 5840), and Part 4 (commencing with Section ~~5850) of this division.~~ *5850)*. The amount of funds available for the purposes of this subdivision in any fiscal year ~~shall be~~ *is* subject to appropriation in the annual Budget Act.

(e) In ~~2004–05,~~ *the 2004-05 fiscal year,* funds shall be allocated as follows:

(1) Forty-five percent for education and training pursuant to Part 3.1 (commencing with Section ~~5820) of this division.~~ *5820).*

(2) Forty-five percent for capital facilities and technology needs in the manner specified by paragraph (2) of subdivision (a).

(3) Five percent for local planning in the manner specified in subdivision (c).

(4) Five percent for state implementation in the manner specified in subdivision (d).

(f) Each county shall place all funds received from the State Mental Health Services Fund in a local Mental Health Services Fund. The Local Mental Health Services Fund balance shall be invested consistent with other county funds and the interest earned on the investments shall be transferred into the fund. The earnings on investment of these funds shall be available for distribution from the fund in future *fiscal* years.

(g) All expenditures for county mental health programs shall be consistent with a currently approved plan or update pursuant to Section 5847.

(h) (1) Other than funds placed in a reserve in accordance with an approved plan, any funds allocated to a county that have not been spent for their authorized purpose within three years shall revert to the state to be deposited into the fund and available for other ~~counties~~ *counties, or cities, special districts, school districts, or other public entities,* in future years, provided however, that funds for capital facilities, technological needs, or education and

training may be retained for up to 10 years before reverting to the fund.

(2) If a county receives approval from the Mental Health Services Oversight and Accountability Commission of a plan for innovative programs, pursuant to subdivision (e) of Section 5830, the county's funds identified in that plan for innovative programs shall not revert to the state pursuant to paragraph (1) until three years after the date of the approval.

(3) Notwithstanding paragraph (1), any funds allocated to a county with a population of less than 200,000 that have not been spent for their authorized purpose within five years shall revert to the state as described in paragraph (1).

(4) Notwithstanding paragraphs (1) and (2), if a county with a population of less than 200,000 receives approval from the Mental Health Services Oversight and Accountability Commission of a plan for innovative programs, pursuant to subdivision (e) of Section 5830, the county's funds identified in that plan for innovative programs shall not revert to the state pursuant to paragraph (1) until five years after the date of the approval.

(i) If there are still additional revenues available in the fund after the Mental Health Services Oversight and Accountability Commission has determined there are prudent reserves and no unmet needs for any of the programs funded pursuant to this section, including all purposes of the Prevention and Early Intervention Program, the commission shall develop a plan for expenditures of these revenues to further the purposes of this act and the Legislature may appropriate these funds for any purpose consistent with the commission's adopted plan that furthers the purposes of this act.

(j) For the 2011–12 fiscal year, General Fund revenues will be insufficient to fully fund many existing mental health programs, including Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), Medi-Cal Specialty Mental Health Managed Care, and mental health services provided for special education pupils. In order to adequately fund those programs for the 2011–12 fiscal year and avoid deeper reductions in programs that serve individuals with severe mental illness and the most vulnerable, medically needy citizens of the state, prior to distribution of funds under paragraphs (1) to (6), inclusive, of subdivision (a), effective July

1, 2011, moneys shall be allocated from the Mental Health Services Fund to the counties as follows:

(1) Commencing July 1, 2011, one hundred eighty-three million six hundred thousand dollars ($183,600,000) of the funds available as of July 1, 2011, in the Mental Health Services Fund, shall be allocated in a manner consistent with subdivision (c) of Section 5778 and based on a formula determined by the state in consultation with the County Behavioral Health Directors Association of California to meet the fiscal year 2011–12 General Fund obligation for Medi-Cal Specialty Mental Health Managed Care.

(2) Upon completion of the allocation in paragraph (1), the Controller shall distribute to counties ninety-eight million five hundred eighty-six thousand dollars ($98,586,000) from the Mental Health Services Fund for mental health services for special education pupils based on a formula determined by the state in consultation with the County Behavioral Health Directors Association of California.

(3) Upon completion of the allocation in paragraph (2), the Controller shall distribute to counties 50 percent of their 2011–12 Mental Health Services Act component allocations consistent with Sections 5847 and 5891, not to exceed four hundred eighty-eight million dollars ($488,000,000). This allocation shall commence beginning August 1, 2011.

(4) Upon completion of the allocation in paragraph (3), and as revenues are deposited into the Mental Health Services Fund, the Controller shall distribute five hundred seventy-nine million dollars ($579,000,000) from the Mental Health Services Fund to counties to meet the General Fund obligation for EPSDT for the 2011–12 fiscal year. These revenues shall be distributed to counties on a quarterly basis and based on a formula determined by the state in consultation with the County Behavioral Health Directors Association of California. These funds shall not be subject to reconciliation or cost settlement.

(5) The Controller shall distribute to counties the remaining 2011–12 Mental Health Services Act component allocations consistent with Sections 5847 and 5891, beginning no later than April 30, 2012. These remaining allocations shall be made on a monthly basis.

(6) The total one-time allocation from the Mental Health Services Fund for EPSDT, Medi-Cal Specialty Mental Health Managed Care, and mental health services provided to special education pupils as referenced shall not exceed eight hundred sixty-two million dollars ($862,000,000). Any revenues deposited in the Mental Health Services Fund in the 2011–12 fiscal year that exceed this obligation shall be distributed to counties for remaining fiscal year 2011–12 Mental Health Services Act component allocations, consistent with Sections 5847 and 5891.

(k) Subdivision (j) shall not be subject to repayment.

(*l*) Subdivision (j) shall become inoperative on July 1, 2012.

SEC. 2. Section 5899.1 of the Welfare and Institutions Code is amended to read:

5899.1. (a) On or after July 1, 2017, funds subject to reversion pursuant to subdivision (h) of Section 5892 shall be reallocated to other counties for the purposes for which the unspent funds were initially allocated to the original ~~county.~~ *county, or to cities, special districts, school districts, or other public entities for the provision of mental health services consistent with the intent of the Mental Health Services Act.*

(b) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department, without taking any further regulatory action, may implement, interpret, or make specific this section, Section 5892.1, and subdivision (h) of Section 5892, by means of all-county letters or other similar instructions, until applicable regulations are adopted in accordance with Section 5898, or until July 1, 2019, whichever occurs first. The all-county letters or other similar instructions shall be issued only after the department provides the opportunity for public participation and comments.

SEC. 3. The Legislature finds and declares that this act is consistent with, and furthers the intent of, the Mental Health Services Act within the meaning of Section 18 of the Mental Health Services Act.

~~SECTION 1. It is the intent of the Legislature to enact legislation that would require a county that receives reallocated funds from the Mental Health Services Fund to spend those funds within two years of adopting an expenditure plan for those funds. It is further the intent of the Legislature that any funds not expended by a county within those two years would revert to the~~

~~Mental Health Services Fund to be redistributed to cities within that county.~~

O

Date of Hearing: April 17, 2018

ASSEMBLY COMMITTEE ON HEALTH
Jim Wood, Chair
AB 2843 (Gloria) – As Amended March 23, 2018

SUBJECT: Mental Health Services Fund.

SUMMARY: Adds cities, special districts, school districts, or other public entities to the list of entities eligible to receive an excess of Mental Health Services Act (MHSA) funds subject to reversion for the provision of mental health services consistent with the intent of the MHSA.

EXISTING LAW:

1) Establishes the MHSA, enacted by voters in 2004 as Proposition 63, to provide funds to counties to expand services, develop innovative programs, and integrated service plans for mentally ill children, adults, and seniors through a 1% income tax on personal income above $1 million.

2) Specifies that the MHSA can only be amended by a two-thirds vote of both houses of the Legislature and only as long as the amendment is consistent with and furthers the intent of the MHSA. Permits provisions clarifying the procedures and terms of the MHSA to be added by majority vote.

3) Establishes the Mental Health Services Fund (Fund) to be disbursed as follows:

   a) Twenty percent of funds distributed to counties to be used for prevention and early intervention programs;

   b) Five percent of the total funding for each county mental health program to be utilized for innovative programs;

   c) Requires the balance of funds to be distributed to county mental health programs for services to persons with severe mental illnesses, for the children's system of care, and for the adult and older adult system of care;

   d) Permits no more than 20% of the average amount of funds allocated to a county for the previous five years to be used for technological needs and capital facilities, human resource needs, and for counties to establish a prudent reserve to ensure services do not have to be significantly reduced in years in which revenues are below the average of previous years;

   e) Permits up to 5% of funds to be used for planning costs including for county mental health programs to pay for the costs of consumers, family members, and other stakeholders to participate in the planning process and for the planning and implementation required for private provider contracts to be significantly expanded to provide additional services; and,

   f) Requires, prior to making the allocations in a) through d) above, up to 5% of funds to be reserved for the costs for the State Department of Health Care Services (DHCS), the California Mental Health Planning Council, the Office of Statewide Health Planning and Development (OHSPD), the Commission, the State Department of Public Health, and any other state agency to implement all duties pursuant to the MHSA.

4) Requires all expenditures for county mental health programs to be consistent with a currently approved mental health plan or update.

5) Deems all unspent funds subject to reversion as of July 1, 2017, to have been reverted to the Fund and reallocated to the county of origin for the purposes for which they were originally allocated.

6) Requires DHCS, on or before July 1, 2018, in consultation with counties and other stakeholders, to prepare and submit a report to the Legislature identifying the amounts that were subject to reversion prior to July 1, 2017, including to which purposes the unspent funds were allocated.

7) Requires DHCS to provide to counties the amounts it has determined are subject to reversion, and provide a process for counties to appeal this determination.

8) Requires counties with unspent funds subject to reversion, that are deemed reverted and reallocated, to prepare and submit a plan (by July 1, 2018) to expend these funds on or before July 1, 2020.

9) Restarts the three-year clock on expenditure of Innovation funds when a county's Innovation Plan has received approval by the Mental Health Services Oversight and Accountability Commission (Commission).

10) Authorizes small counties, with a population of less than 200,000, to expend MHSA funds for up to five years before unspent funds will be reverted to the state.

11) Requires DHCS, in consultation with the Commission and the County Behavioral Health Directors Association of California (CBHDA), to develop and administer instructions for the Annual MHSA Revenue and Expenditure Report (Report). Requires that the instructions include a requirement that the county certify the accuracy of this report.

12) Requires counties to submit the report electronically to DHCS and to the Commission. Requires DHCS and the Commission to annually post each county's report on its website in a timely manner. Requires DHCS, in consultation with the commission and CBHDA, to revise these instructions by July 1, 2017, and as needed thereafter, to improve the timely and accurate submission of county revenue and expenditure data. Specifies the purpose of the Report.

13) Requires DHCS, by October 1, 2018, and by October 1 of each subsequent year, in consultation with counties, to publish on its Internet Website a report detailing funds subject to reversion by county and by originally allocated purpose.

14) Requires that, on or after July 1, 2017, funds subject to reversion be reallocated to other counties for the purposes for which the unspent funds were initially allocated to the original county.

FISCAL EFFECT: This bill has not yet been analyzed by a fiscal committee.

COMMENTS:

1) **PURPOSE OF THIS BILL.** According to the author, California voters recognized the need to provide mental health services to some of our most vulnerable populations with the passage of Proposition 63 in 2004. They did not expect, however, that over the following decade since its passage, nearly $2.5 billion in MHSA funds would go unspent. More specifically, as of September 2017, $231 million of that $2.5 billion should have been reverted back to the state for reallocation as a result of local mental health agencies' failure to meet expenditure timelines. This bill allows other public entities the opportunity to step up to address our mental health crisis by making reverted MHSA funds – funds that local mental health agencies have not expended nor set aside in reserves – available for uses consistent with the MHSA.

2) **BACKGROUND.**

   a) **Proposition 63.** Proposition 63 was passed by voters in November 2004. The MHSA imposes a 1% income tax on personal income in excess of $1 million and creates the 16 member Commission charged

with overseeing the implementation of MHSA. The 2016-17 Governor's Budget projected that $1.9 billion in revenue would be deposited into the Fund in fiscal year 2017-18. The MHSA addresses a broad continuum of prevention, early intervention, and service needs, as well as provided funding for infrastructure, technology, and training needs for the community mental health system. In addition to local programs, the MHSA authorizes up to 5% of revenues for state administrative functions performed by a variety of state entities such as the DHCS and OSHPD. It also funds evaluation of the MHSA by the Commission, which was established by the MHSA. Unspent MHSA funds are required to be placed in a reserve in accordance with an approved plan, and funds allocated to a county that have not been spent for their authorized purpose within three years are required to revert those funds back to the state.

b) **Commission**. MHSA requires each county mental health department to prepare and submit a three-year plan to DHCS that must be updated each year and approved by DHCS after review and comment by the Commission. In their three-year plans, counties are required to include a list of all programs for which MHSA funding is being requested and that identifies how the funds will be spent and which populations will be served. Counties must submit their plans for approval to the Commission before the counties may spend certain categories of funding.

c) **Funding**. The MHSA provides funding for programs within five components:

   i) **Community Services and Supports**: Provides direct mental health services to the severely and seriously mentally ill, such as mental health treatment, cost of health care treatment, and housing supports. Regulation requires counties to direct the majority of its Community Services and Supports funds to Full-Service Partnerships (FSPs). FSPs are county coordinated plans, in collaboration with the client and the family to provide the full spectrum of community services. These services consist of mental health services and supports, such as peer support and crisis intervention services; and non-mental health services and supports, such as food, clothing, housing, and the cost of medical treatment;

   ii) **Prevention and Early Intervention**: Provides services to mental health clients in order to help prevent mental illness from becoming severe and disabling;

   iii) **Innovation**: Provides services and approaches that are creative in an effort to address mental health clients' persistent issues, such as improving services for underserved or unserved populations within the community;

   iv) **Capital Facilities and Technological Needs**: Creates additional county infrastructure such as additional clinics and facilities and/or development of a technological infrastructure for the mental health system, such as electronic health records for mental health services; and,

   v) **Workforce Education and Training**: Provides training for existing county mental health employees, outreach and recruitment to increase employment in the mental health system, and financial incentives to recruit or retain employees within the public mental health system.

d) **State Auditor Report and Recommendations.** On February 27, 2018, the State Auditor released a report entitled "Mental Health Services Act: The State Could Better Ensure the Effective Use of Mental Health Services Act Funding" (Audit Report), at the request of the Joint Legislative Audit Committee. The Audit Report concluded that despite having significant responsibility for the MHSA program since 2012, DHCS has not developed a process to recover unspent MHSA funds from local mental health agencies after the statutory time frames for spending the funds have elapsed, known as reversion. As a result, the local mental health agencies have had less incentive to spend MHSA funds in a timely manner and had amassed unspent funds of $231 million as of the end of fiscal year 2015–16 that they should have reverted to the State for it to reallocate to other local mental health agencies. This figure does not include funds held in reserves or interest earned on the unspent funds. However, the Audit Report noted that the Legislature enacted a one-time change in state law in 2017 that allowed local mental health agencies to retain all funds that were subject to reversion as of July 1, 2017. The Audit

Report concluded that nevertheless, this one-time allowance did not resolve the larger issue that DHCS has been slow in implementing a process to revert unspent MHSA funds. The State Auditor recommended, in order to ensure that local mental health agencies spend MHSA funds in a timely manner, that DHCS implement a fiscal reversion process to reallocate to other local mental health agencies any MHSA funds that are unspent within the statutory reversion time frames. The State Auditor also recommended that DHCS clarify that the interest that local mental health agencies earn on unspent MHSA funds is also subject to reversion requirements and should establish an MHSA reserve level that is sufficient but not excessive.

3) **SUPPORT.** San Diego City Councilmember Christopher Ward states in support of the bill that California is facing a severe mental health crisis despite the availability of significant funding specific to providing mental health services. The City of San Diego is suffering from a homelessness crisis and many of those unsheltered on our streets are in need of mental health services. The City's resources are insufficient to fully and appropriately respond to this specific need. This bill could provide additional support services to help handle mental health and social needs where the funds exist but are not otherwise serving the public.

4) **OPPOSITION.** The California Behavioral Health Directors Association, California State Association of Counties, Rural County Representatives of California, Urban Counties of California, write as a coalition (the Coalition) in opposition that the MHSA was created to support counties in addressing the urgent need for expanding accessible, recovery-based community health services. This funding has expanded and transformed the public mental health system to achieve results such as a reduction in incarcerations, school failures, unemployment and homelessness for individual living with mental health issues. The Coalition states that many of the most effective MHSA interventions are accomplished in collaboration with county affiliates, schools, school districts, and other local entities. Nothing in current law hinders such collaboration. In fact, the Coalition notes, there are hundreds of MHSA programs already operating in collaboration with local public schools, city policy departments, and other local public entities. The Coalition argues that this bill sidesteps the leadership role and legal responsibility that counties play in California in meeting the health and human service needs of low-income, vulnerable Californians with mental health needs. Shifting funds away from counties will result in a disruption of local planning and the priorities that have already been set in communities with respect to coordinated efforts between counties, schools, and other local agencies. The Coalition further notes that AB 114 (Committee on Budget), Chapter 38, Statutes of 2017, comprehensively addressed the issue of what happens to funds that remain in county accounts after a certain period of time, also known as "reversion." These recent statutory changes requires counties to submit a plan to DHCS for expending all unallocated funds by July 1, 2018, and the counties have until 2020 to expend these funds. The Coalition concludes that these changes have already established a balanced approach to MHSA reversion for both the past and the future, thereby providing continuity and predictability to counties and their local providers moving forward.

5) **RELATED LEGISLATION.** AB 2619 (Allen) would appropriate $10 million from the General Fund to DHCS to allocate the appropriated funds to county mental health programs for the purpose of funding innovative programs to provide mental health services to California's homeless population. This bill is pending in the Assembly Health Committee and is scheduled to be heard on April 17, 2018.

6) **PREVIOUS LEGISLATION.**

   a) AB 462 (Thurmond), Chapter 403, Statutes of 2017, authorizes the Director of Employment Development Department to share information with the Commission related to quarterly wage data to assist the Commission in fulfilling its duties under the MHSA, to the extent permitted under applicable federal statute and regulation. Declares it the intent of the Legislature to authorize the Commission to receive information held by other state agencies, as it relates to outcomes established under the MHSA, for purposes of monitoring outcomes and improving the mental health system.

   b) AB 1134 (Gloria), Chapter 412, Statutes of 2017, authorizes the Commission to establish a fellowship program for the purpose of providing an experiential learning opportunity for a mental health consumer

and a mental health professional.

c) SB 192 (Jim Beall) would require counties, or counties acting jointly, seeking funding from the MHSA Reversion Fund, to demonstrate to the Mental Health Services Oversight and Accountability Commission that funding will be used to create, or expand, existing capacity for services and supports that address unmet community needs. SB 192 is pending in the Assembly Health Committee.

d) AB 2279 (Cooley) of 2015 would have required DHCS to develop and administer instructions for the compilation of revenue and expenditure information related to the MHSA by counties, in consultation with the Commission and CBHDA, as specified. AB 2279 was vetoed, by the Governor, who stated:

> "I am returning Assembly Bill 2279 without my signature. This bill requires the DHCS to annually compile and publicly report financial data and program information from counties on their MHSA expenditures. DHCS is already in the process of collecting and posting county revenue and expenditure reports as well as updated three year program expenditure plans, which will provide much of the information outlined in this bill. I encourage the Legislature and interested stakeholders to continue to work with the department to identify useful information that can be integrated into the existing reports to improve transparency and accountability in the use of these funds."

6) **POLICY COMMENT.** As noted above, the State Auditor also recommended that DHCS clarify that the interest that local mental health agencies earn on unspent MHSA funds is also subject to reversion requirements and should establish an MHSA reserve level that is sufficient but not excessive. The author may wish to consider amending the bill to clarify that interest is subject to reversion.

REGISTERED SUPPORT / OPPOSITION:

Support

City of San Diego, Council District Three

Opposition

California Behavioral Health Directors Association
California State Association of Counties
Rural County Representatives of California
Urban Counties of California

Analysis Prepared by: Paula Villescaz / HEALTH / (916) 319-2097

Date of Hearing: May 9, 2018

ASSEMBLY COMMITTEE ON APPROPRIATIONS
Lorena Gonzalez Fletcher, Chair
AB 2843 (Gloria) – As Amended March 23, 2018

Policy Committee: Health Vote: 11 - 4

Urgency: No State Mandated Local Program: No Reimbursable: No

SUMMARY:

This bill allows Mental Health Services Act (MHSA) funds subject to reversion from counties to be redistributed to cities, special districts, school districts, or other public entities, in addition to counties. Current law allows reverted funds to be allocated only to counties.

FISCAL EFFECT:

As this bill simply allows money to be allocated to different public entities but does not develop a process to award money, it does not effectuate anything on its own. However, to award funds as this bill proposes, the Mental Health Services Oversight and Accountability Commission (commission) or another state agency would likely incur significant costs to develop and implement new funding programs relevant to these public entities (Mental Health Services Fund state administrative set-aside). The amount that may be reverted and available for allocation cannot be estimated.

COMMENTS:

1) **Purpose**. Current law generally allows counties three years to spend MHSA funds, after which the money reverts back to the state to be reallocated. This bill is intended to allow access to reverted funds to additional entities to ensure they are spent in a beneficial manner.

2) **Background**. Proposition 63, the MHSA, was passed by voters in November 2004. The MHSA imposes a 1% income tax on personal income in excess of $1 million to fund counties for a broad continuum of mental health prevention, early intervention, and other services. It also charges the commission and Department of Health Care Services (DHCS) with overseeing aspects of MHSA implementation.

   The state auditor, among others, has raised concerns about local mental health agencies accumulating MHSA funds. DHCS estimated local behavioral health agencies statewide had unspent funds of $231 million—not including reserves—as of the end of fiscal year 2015–16 that should have reverted to the state for reallocation. The auditor also noted local behavioral health agencies had amassed nearly $2 billion in unspent MHSA funds in excess of reserves as of this fiscal year.

   To address these issues, AB 114 (Committee on Budget), Chapter 38, Statutes of 2017, enacted a number of changes intended to enhance fiscal oversight. AB 114 also deemed all unspent funds subject to reversion as of July 1, 2017, to have been reverted to the Mental Health Services Fund and reallocated to the county of origin for their original purposes. However, if counties continue to amass funds, additional funds might become subject to reversion.

3) **Support and Opposition**. San Diego City Council Member Chris Ward supports this bill, noting many of the city's homeless persons are in need of mental health services. Counties oppose this bill, arguing it is a flawed approach to allocating MHSA funds that will result in less coordination and disrupt local planning processes.

4) **Staff Comment**. Because the MHSA was created by proposition, any amendment must be consistent with and further the purposes of the act. Because this bill changes the allocation of funds and because the ultimate use of the funds provided to other governmental entities is unknown, it is uncertain this bill is consistent with and further the purposes of the act.

Analysis Prepared by: Lisa Murawski / APPR. / (916) 319-2081

AGENDA ITEM 8

Information

May 24, 2018 Commission Meeting

Stakeholder Contract Update: California Youth Connection (CYC)

Summary: The Commission will hear an update on the progress of the advocacy, education and training, and outreach efforts of the Transition Age Youth (TAY) contract holder, California Youth Connection (CYC).

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 (TAY), and veterans through education, advocacy, and outreach efforts. These contracts are awarded on a competitive basis.

The first round of procurement for stakeholder contracts was completed in June 2016. As a result, CYC was awarded the contract for activities focused on activities and efforts supporting TAY. The contract was awarded for $500,000 per year, for a three year total of $1,500,000 and will continue through June 2019.

During the first round of procurement, through the Budget Act of 2016-2017, the Legislature increased the Commission's budget for all advocacy contracts to $670,000 per year for a three year total of $2,010,000. As a result of this increase, an additional $170,000 per year (a three year total of $510,000) was made available for the TAY population. The procurement process for the additional funds was completed in November 2017.

In March 2018, CYC was awarded the second contract for $170,000 per year for a three year total of $510,000. This contract is focused on local level activities and events designed to encourage and support youth engagement with local decision making bodies (i.e. Boards of Supervisors and Mental Health Boards).

Talking Points:

- The contractor may wish to explain how they provide local level advocacy and how they prioritize areas of the state for advocacy efforts.
- The contractor may wish to discuss the extent to which youth are involved in the planning and implementation of programs goals.
- The contractor may wish to provide a short overview of their outreach strategy and inform the Commission of the most important populations within the youth population where they plan to provide outreach.
- The contractor may wish to explain how the lead agency stays coordinated with the other agencies involved in the collaboration.

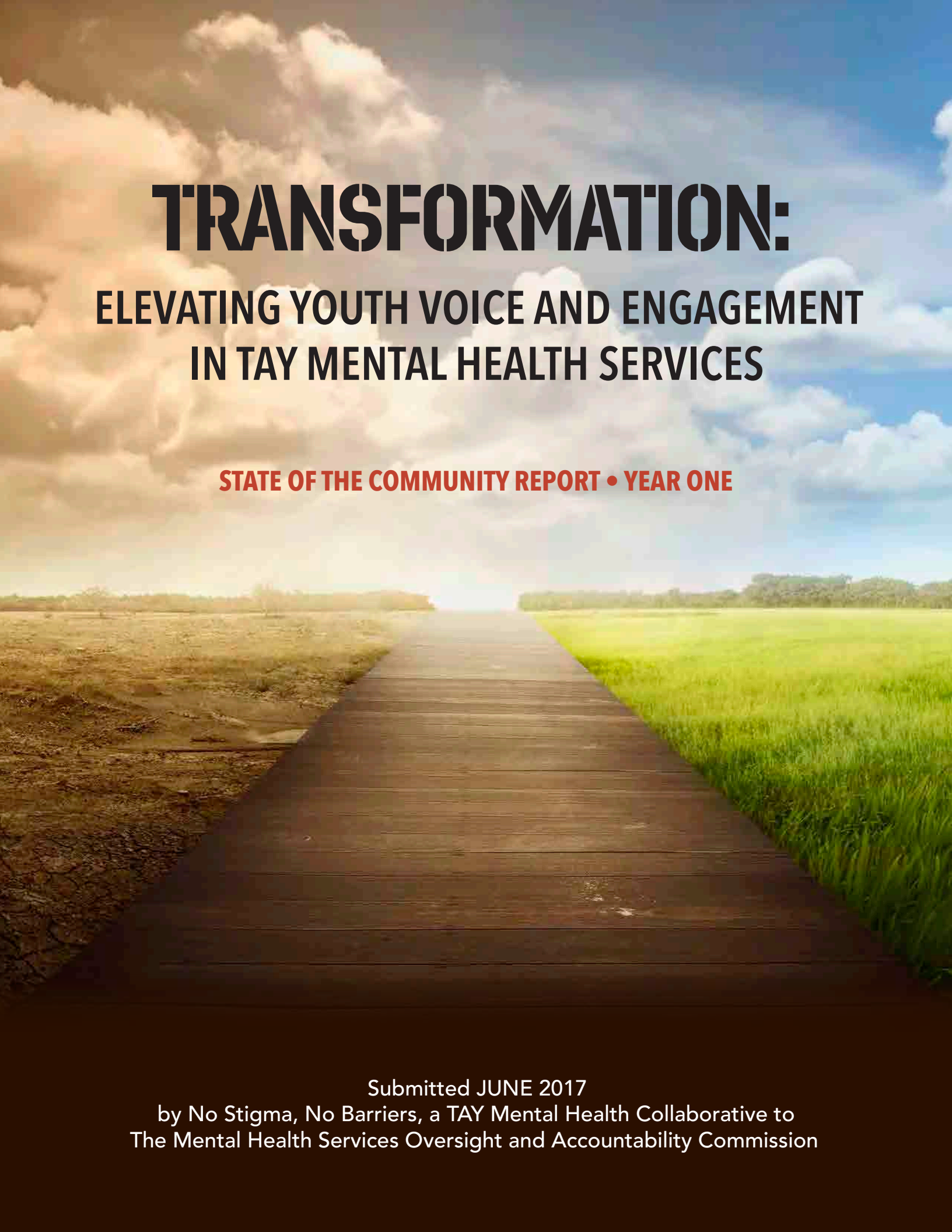
Presenters:

- Joy Anderson, Policy Coordinator, California Youth Connection
- “No Stigma, No Barriers” Youth Advisory Board Representatives

Enclosures (4): (1*) Transformations: Year One State of the Community Report*; (2) CYC Deliverable Tracking Tool; (3) CYC Collaboration Fact Sheet; (4) CYC Contract Overview

Handout: None.

Recommended Action: Information item only.



TRANSFORMATION:

ELEVATING YOUTH VOICE AND ENGAGEMENT IN TAY MENTAL HEALTH SERVICES

STATE OF THE COMMUNITY REPORT • YEAR ONE

Submitted JUNE 2017
by No Stigma, No Barriers, a TAY Mental Health Collaborative to
The Mental Health Services Oversight and Accountability Commission

ACKNOWLEDGMENTS

The No Stigma, No Barriers Collaborative partners, listed below, wish to thank the Mental Health Services Act Oversight & Accountability Commission for funding this three-year project, which seeks to facilitate the engagement of transition age youth (TAY) ages 16–25 with California's state and local mental health systems.

The Collaborative also extends enormous gratitude to the young people from around the state who share their experiences and perspectives in quotes throughout this report.

NO STIGMA NO BARRIERS
A TRANSITION AGE YOUTH MENTAL HEALTH COLLABORATIVE

MHSOAC
Mental Health Services
Oversight & Accountability Commission

California Youth Connection (CYC) is a statewide nonprofit organization comprised entirely of youth ages 14–24 with direct experience of our state's foster care, mental health, and juvenile justice systems. CYC facilitates youth-led organizing, education, and advocacy, providing a transformational experience of community and individual empowerment. www.calyouthconn.org

Youth In Mind (YIM) is a nonprofit organization founded and steered by youth affected by the mental health system. Youth In Mind members participate in multiple levels of leadership and advocacy, including member leadership summits, mental health conferences, and local advocacy activities with the purpose of promoting positive change through authentic youth engagement. www.yimcal.org

Young Minds Advocacy (YMA) is a nonprofit organization founded to address the number one health issue facing young people and their families—unmet mental health needs. Using a blend of policy research and advocacy, impact litigation, and strategic communications, YMA works to change attitudes towards mental illness and break down barriers to quality mental healthcare for young people and their families. www.ymadvocacy.org

VOICES brings together more than 40 partnering agencies to provide housing, education, employment and wellness services to transitioning youth, ages 16–24. Created and run by youth, each year VOICES serves more than 1,500 youth transitioning to adulthood from foster care, mental health, and juvenile justice settings. www.voicesyouthcenter.org

CYC
CALIFORNIAYOUTHCONNECTION

YOUNG MINDS ADVOCACY

voices

"Regardless of identity or specific system involvement, mental health connects all youth populations because we're all humans who have faced this adversity. And something we all share is an independent spirit, a strong will, and a tendency to not rely on anyone else or ask for help…It's that common ground that makes peer engagement such an effective way to get through to people."

—J. CORTEZ III, CYC ADVISORY BOARD CO-CHAIR, MEMBER, NSNB GOVERNANCE BOARD

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"I hope the No Stigma, No Barriers project shuts down the stigma. I'm really for having individuals be independent, and seeing their disorders are not who they really are. So I hope the training and education and advocacy builds a community of individuals who are able to send that message to other young people: that you can live with these disorders. My disorder doesn't define me but it gives me something special to live with."

—SUSAN PAGE, 25
YMA BLOGGER AND CYC SF CHAPTER MEMBER

OVERVIEW

Approximately 5,500,000 Californians are between the ages of 16 and 25. During these years—a time of intense neurological, emotional, and social development—young people transition from adolescence to adulthood, and so are often referred to as "transition age youth" or "TAY." In addition to achieving or being thrust into independence, many young people experience the initial onset of serious mental illness during these years.

During this time, the one in five TAY with mental health conditions also transition from the robust children's mental health service system to the adult system, which offers fewer services overall and requires more self-advocacy to access. Thus, depending on which part of the nine-year TAY age span youth are in, the services available to them and their access of them vary greatly.

Guided by a group of young people ages 16 to 25, the No Stigma, No Barriers Collaborative aims to ensure that California's many local and statewide systems provide access to high quality, responsive supports and services to improve mental health outcomes for transition age youth and their families.

Drawing on their personal and professional experience with California's mental health systems, the young people guiding the Collaborative affirm the importance of supports that go beyond the traditional medical, illness-based model. **They advocate for asset-based approaches, peer-led models, and full support for a range of paths to mental wellness.** These should include supports for engaging or persisting in employment, education, housing, and vital relationships.

The Collaborative aims to reach TAY at all stages of the age span to reduce feelings of stigmatization that may prevent these young people from accessing services when they need them.

California's Mental Health Services Act (MHSA), approved by voters in 2004, plays a major role in funding innovative mental health services, mental health treatment, prevention and early intervention, education and training to people of all ages affected by mental illness throughout the state. The **Mental Health Services Oversight and Accountability Commission** (MHSOAC) oversees the investment of MHSA dollars, and provides vision and leadership to California's public mental health systems, in collaboration with clients, their families, and underserved communities. The act requires that MHSOAC utilize transparent and collaborative processes to determine the mental health needs, priorities, and services for California mental health consumers. Contracting with the No Stigma, No Barriers Collaborative partners ensures that these values are upheld for transition age youth.

This is the first of three annual reports on the state of the community of transition age youth with mental health needs in California and the TAY leaders, providers, and systems engaged in serving them.

ABOUT THE COLLABORATIVE

The No Stigma, No Barriers Collaborative, directed by transition age youth (TAY) ages 16 to 24, was formed to end stigma towards mental illness and break down barriers to care for young people in California. We do this through trainings, outreach, and advocacy at the county and state level. The collaborative is a three-year project funded by the Mental Health Services Act (MHSA). Project partners include California Youth Connection, Youth In Mind, Young Minds Advocacy, and VOICES.

NO STIGMA NO BARRIERS
A TRANSITION AGE YOUTH MENTAL HEALTH COLLABORATIVE

www.nostigmanobarriers.org

INTRODUCTION

The years extending from adolescence to early adulthood are a time of **profound neurological, emotional, and social development.** Young people in this age range—around 16 to 25 or so—are often referred to as transition age youth or TAY. In addition to achieving or being thrust into independence, many young people experience the initial onset of serious mental illness during these transitional years. According to the National Institute of Mental Illness (NAMI), one in five teens and young adults live with a mental health condition, with half developing the condition by age 14 and three-quarters by age 24.[1]

As they cross into adulthood, California's approximately 5,500,000 transition age youth face the **daunting challenges of paying rent, entering and persisting in college and/or employment, and developing significant adult relationships.** For those who are transitioning out of the foster care or juvenile justice system, these tasks are even more formidable. For all TAY struggling with mental illness, the challenges typical during this time period are exacerbated many times over. Young people who need mental health services, and who have been able to access them during adolescence, must figure out how to navigate the transition to the adult system of care, which provides a significantly less robust array of services.

> "How do I feel when I'm well? I'm a person who has a lot of anxiety sometimes, so when I'm in a good state, I feel at peace and a lot calmer … There's a sense of feeling content and like you belong and you're doing what you love to do."
>
> —CECILIA TORRES, 21, MEMBER, NSNB GOVERNANCE BOARD & YOUTH ADVOCATE, VOICES YOUTH CENTER

WHAT DO TAY NEED TO THRIVE?

In order to thrive, young people first need their basic needs met: shelter, food/water, safety. They also need the support and love of at least one caring adult and strong connections in the community. **Connections build self-worth and resilience, but also provide opportunities for mentorship and can help break down barriers to treatment, housing, employment, and education for young people in need.**

Choice and voice are also important to the health and wellbeing of young people. Choice means having a say in key decisions in your life—in terms of mental health, it means helping to define what wellness means to you and what services and supports you need to reach your goals. Voice means having the support, opportunities, and confidence to share your experiences with others. It also means that young people have a seat at the table and a substantial role in decision-making about policies and programs that impact youth across the state. **Mental health systems can better serve young people by listening and treating youth and families as partners—putting young people's needs ahead of the "system's" needs.** This would go a long way in developing programs and services that address the challenges transition age youth face, while also celebrating their strengths and natural supports.

While California has been a leader in statewide youth-led policy advocacy in areas such as foster care and the impact of incarceration on families, **TAY mental health services in most of our 58 counties are still largely planned and implemented by adults.** Experience shows that these services are not effective for many of the youth who need them and who suffer long term disconnection from education, employment, and relationships as a result. The No Stigma, No Barriers (NSNB) Collaborative was formed to help change this, and joins hands with TAY-led organizations around the state working to provide mental health services and supports to change the trajectory of young people's lives. Part four of this report highlights several of these organizations.

Described by one young person as "having no hope or empowerment, thinking that you are just the way you are forever and you're doomed,"[2] untreated mental illness can halt a student's progress in school, cause a youth to be fired from a needed job, and damage personal relationships. The long-term impact can be devastating.

Directed by a group of young people ages 16 to 25, the No Stigma, No Barriers Collaborative aims to ensure that California's many local and statewide systems provide access to high quality, responsive supports and services to improve mental health outcomes for transition age youth and their families. Drawing on their personal and professional experience with California's mental health systems, the young people guiding the Collaborative affirm the importance of supports that go beyond the traditional medical, illness-based model. They advocate for asset-based approaches, peer-led models, and full support for a range of paths to mental wellness. These should include supports for engaging or persisting in employment, education, housing, and vital relationships.

NSNB advocates at Mental Health Matters Day


After a strategic storytelling training, a Youth In Mind member shows peers one of her favorite spots.

Over the three-year project, youth will direct efforts **to improve the effectiveness of mental health services and supports, reduce stigma, increase equity, and ensure TAY voices become central to the planning and oversight of California's mental health system through:**

- Community engagement and education
- Training for TAY and other community stakeholders
- Local and statewide advocacy

PART ONE: CALIFORNIA'S MENTAL HEALTH SYSTEM FOR TRANSITION AGE YOUTH

Throughout the country, there is an increasing awareness of the pervasiveness and complexity of mental health issues among adolescents and young adults. While most media coverage focuses on tragedies and extreme cases, youth-serving agencies have progressively developed a more nuanced and sophisticated understanding of how social, emotional, behavioral, and mental health needs shape young people's experiences and opportunities.

> "When I hear the phrase 'mental health,' I think of psych wards and the inflexible system that made me sicker and rarely met the needs of my peers or the young people in systems of care who I worked with at VOICES. My personal experience as a young person in two different California juvenile halls, the probation system and residential treatment left me feeling hopeless and angry about the phrase 'mental health' for years. **Now my own true understanding of mental health and wellness is a mind at ease, having peace in mind, body, and spirit.**"
>
> —IRIS HOFFMAN, 21
> HOLISTIC WELLNESS ADVOCATE, AVP FACILITATOR, VOICES SONOMA, FORMER YOUTH ADVOCATE, CYC MEMBER

The past two decades have also seen the emergence of the concept of transition age youth, generally thought of as minors and young adults ages 16 to 25. The general consensus—as recognized by advocates, researchers, and policymakers—is that this formulation is useful and necessary because it recognizes the profound neurological, emotional, and social development that takes place during this time, within a cultural and legal context that recognizes the additional rights and responsibilities of emerging adulthood.

The TAY concept is particularly relevant for children, youth, and families involved with one or more of our nation's systems of care, including the healthcare, foster care, education, and criminal justice systems. Until we started talking about TAY, the development and design of our service systems and policies were driven by the stark—but developmentally arbitrary—line of legal adulthood: age 18.

In one sense, the American mental health system is more developmentally attuned than are other child serving systems: Medicaid, through its Early, Periodic Screening Diagnosis and Treatment (EPSDT) program, provides access to a robust set

> "I think TAY do experience mental health differently [from older adults], partly because of the access to services and partly because of the stigma of services. TAY tell their peers, who make it seem like being in therapy or counseling of any sort is a bad thing …**It's hard to identify what the difference between each emotion is or how you're supposed to react** because it's different for everyone so if you don't fit into this category then you're looked as or seen as different. Mental health isn't normalized yet in the TAY population."
>
> —MARIAH CORDER, AGE 18
> MEMBER OF NSNB GOVERNANCE BOARD

of mental health services through age 21, rather than age 18. In comparison, until recently, children in foster care faced the complete withdrawal of supports and services on their 18th birthday; youth faced much stiffer penalties for crimes committed on their 18th birthday than the day before; and youth who hadn't finished high school were shuffled towards a system of adult schools and community college courses they weren't prepared to complete.

> "When you're under 18 and struggling, someone is going to notice at some point—your mom and dad, or if you're in foster care, a staff member or social worker. You're going to end up receiving some sort of support, whether you want it or not. After turning 18 and especially after turning 24, for a lot of young people there's not necessarily anybody looking out for them. Unfortunately, most of our communities aren't at that stage yet where support is something that's built in to everyday living and we all look out for each other as a way of being in the world. **So a lot of young people between the ages of 18–24 do slip through the cracks because they don't have mom and dad looking out for them, and they may not even realize that they need the support.** Plus, they're probably pissed off about the way they experienced the mental health system before they turned 18. So that's often the last place I see people going for help."
>
> —IRIS HOFFMAN, 21
> HOLISTIC WELLNESS ADVOCATE, AVP FACILITATOR, VOICES SONOMA, FORMER YOUTH ADVOCATE, CYC MEMBER

Research has recognized many significant developmental milestones that occur during the TAY age range—from the profound impact of cultural constructs like leaving home, to changes in the composition of one's primary peer group, to neurological development. Research has also recognized a more challenging aspect of development that takes place during this time—the initial onset of serious mental illness.

In contrast to an adult system that focuses primarily on serious mental illness generally considered to be neurological in character, the children's mental health system is designed to address a broad range of social, emotional, behavioral, and mental health needs. Diagnoses are made based on an assessment of symptoms and impairments that can arise from a range of factors—from experiential factors like childhood trauma, to neurological or biochemical conditions. Treatment services are intended to achieve symptom reduction, promote healing, and build internal skills and resilience.

The resulting children's mental health system, particularly the aspects financed by Medicaid, provides for (and indeed requires) a broad range of services to advance these goals—from case planning and management to individual therapy to facilitating access to non-clinical community resources.

Regardless of whether or not "children's mental health needs" arise from experiential or biological factors, what's clear is that the challenges and suffering that the system is designed to address—and the concerns of their parents and caregivers that lead to them sometimes being recognized—are extremely common. Nationwide estimates consistently establish rates of diagnosable mental health conditions among children of over 20 percent.[3]

Furthermore, this high prevalence of diagnosable mental health conditions is concentrated among adolescents—the older end of the 0–18 age range included in reports about "children." Behavioral challenges and substance use are also concentrated during the teenage years; thus, mental health issues and mental illness are often co-occurring with other problems and stressors.

APPROXIMATELY 5,500,000
TRANSITION AGE YOUTH LIVE IN CALIFORNIA.

Advocates and NSNB participants Matt Gallagher, Annabelle Gardner, Mariah Corder, Aisa Villarosa, Nisha Ajmani, and Wyatt Stokes at the 2017 CMHACY conference.

1 IN 5 TAY HAVE MENTAL HEALTH CONCERNS.

ONLY 20%
OF YOUNG PEOPLE WITH MENTAL HEALTH CHALLENGES RECEIVE SERVICES.

THE AVERAGE DELAY BETWEEN ONSET OF SYMPTOMS AND INTERVENTIONS IS
8-10 YEARS.

APPROXIMATELY
50%
OF STUDENTS 14 AND OLDER WITH MENTAL ILLNESS DROP OUT OF HIGH SCHOOL.

Matt Gallagher and Mariah Corder presenting on increasing youth voice and power within Mental Health Boards at CMHACY

THE STRUCTURE AND FUNDING OF CALIFORNIA'S MENTAL HEALTH SYSTEM

As will be further explored below, there are significant challenges when it comes to data about TAY—essentially, despite the change in consciousness about TAY as a developmental category useful for program development and policymaking, most available population-level data is still formulated on the preceding categories of children ages 0–18, and adults 18 and over.

Regardless, even a conservative back-of-the-envelope estimate illustrates the scale of the issue: approximately 5,500,000 transition age youth live in California today. If the national estimate of the prevalence of mental health issues holds, some 1,100,000 of them are likely to have a diagnosable mental health condition.

While these are rough estimates, it's clear that there is a **sizable population of transition age youth in California, and that a significant number of them may be in need of mental health services.** Yet estimates and statistics regarding actual service access paint a portrait of **a system that reaches only a fraction of the youth in need.**

Children and youth in California receive mental health services funded from a number of sources. Those who are covered by private insurance, primarily through a parent's plan, generally have access to some mental health benefit, though many parents report that navigating the benefits schedule and provider network can be a challenge. Those children and youth with private insurance coverage are in the minority, as over half of California children are eligible for or receive their healthcare from public benefits programs.

By far the largest source of mental health funding is Medicaid, referred to as Medi-Cal in California. Medi-Cal is available to low income Californians and those with disabilities. Over 5.5 million children in the state are enrolled in Medi-Cal, a rate of over 50 percent.[4] Through its EPSDT program, Medicaid provides all enrollees with an entitlement to "Specialty Mental Health Services," including case management, assessment, medication, individual and group psychotherapy, and other benefits.

In 2014–15, some 250,000 children and youth ages 0–21 received at least one Medi-Cal billable mental health service, compared with a Medi-Cal population of 5.5 million and a total child (0–18) population of 9.1 million.[5] It is important to note that publicly available Medi-Cal service receipt data provides only a rough estimate of access. Reports from the External Quality Review Organization only differentiate youth who in a given year received a single billable service and those who received five or more billable services; these figures do not sufficiently illustrate service appropriateness, quality, or effectiveness.

There are a number of other systems and funding streams that can and do provide TAY with access to mental health supports. Youth whose mental health condition constitutes a disability under federal law are entitled, through the Individuals

with Disabilities Education Act (IDEA), to the school-based mental health services necessary to facilitate their access to public education. Section 504 of the Rehabilitation Act of 1973 further underscores this right by prohibiting discrimination against students with disabilities.

Under federal law, children in California's public schools who are eligible for special education services due to a disability are guaranteed access to ameliorative or rehabilitative services as necessary to ensure that they are able to benefit from a free, appropriate public education. The qualifying disabilities include mental illness and mental health conditions.

Special education students with a mental health disability may have an Individualized Education Plan (IEP) that calls for a range of mental health services, from case management to individual or group counseling and even placement in a residential treatment program. These youth are served by a program currently called Educationally Related Mental Health Services (ERMHS). In 2011–12, some 100,000 California children received mental health services through ERMHS.[6] The program has been the subject of significant legislative and administrative change over the past several years, with responsibility (and funding) for providing mental health services called for in an IEP transferring back and forth between education agencies and county mental health departments. Unfortunately, there is some evidence that these various changes have resulted in a reduction in the total number of youth being served through the program, despite there being no evidence of a reduction in underlying need.[7]

> "A lot of young people I talk to know they're stressed out and know they're on the brink of exploding or doing something crazy, and that's what pushes them toward the point of no return mentally or emotionally. That's what we want to prevent. Mental wellness to relieve that stress is important, and **hopefully one thing to come out of this project is young people will know about counseling or other options** instead of loading themselves up so much that they can't take the stress."
>
> —WYATT STOKES, 22, STUDENT AT CSU MONTEREY BAY & CYC MEMBER

In 2004, California voters recognized the need for additional funding to provide mental health services and supports when they voted to pass Proposition 63, the Mental Health Services Act (MHSA). MHSA levied a tax on very high earners to create a fund to enhance existing programs and address gaps in the service array. MHSA funds are overseen by the Mental Health Services Oversight and Accountability Commission (MHSOAC).

MHSA funds provide for an array of direct services to individuals with significant mental health needs and specifically to transition age youth. These include intensive programs referred to as Full-Service Partnerships (FSPs). In FY 11–12, nearly 8,000 transition age youth received services through an FSP.[8]

Some of the young people most in need of mental health services are those who have suffered significant trauma due to abuse, neglect, or abandonment. There are over 60,000 children and youth in out-of-home care through California's foster care system, with hundreds of thousands more coming to the attention of child protective services every year.[9] Another 15,000 youth are detained in county and state facilities through the juvenile justice system.[10] Estimates of the incidence of diagnosable mental health conditions among these very vulnerable youth run as high as 70 percent.[11]

An array of additional, smaller programs also provide some mental health services, including Regional Centers that serve youth with disabilities, substance abuse programs, federal block grants, early childhood education programs, and victim of crime funds. These programs are administered by a number of different agencies or departments.

SERVICE ACCESS

Regardless of the funding source, a defining factor of young people's interaction with California's mental health systems is their ability to access providers and services. California has a county-administered system of social and health care services. **All major sources of funding for mental health services are planned, provided or purchased, and overseen by county-level agencies.** For young people in need of services, as well as for advocates, this means that services can vary greatly from county to county. However, it is important to remember that federal protections and mandates apply to the entire state, and are in no way diminished by the policy or administrative choices of a particular local agency.

Many children and youth with the most intensive need for mental health services or other supports have been identified by their schools or have had some interaction with a public system—whether through psychiatric hospitalization, involvement with the criminal justice system, or referral to child welfare or probation. For youth who have been identified as needing mental health services, administrators, social workers, or medical personnel are legally responsible for facilitating their access to appropriate services.

Youth feedback on the meaning of "wellness" at the 2017 Mental Health Matters Day

For example, county departments are required to ensure that youth in foster care are enrolled in healthcare coverage, receive regular medical care, and are provided with all medically necessary treatments, including mental health services. Foster youth do in fact receive mental health services at a higher rate than do children in the general population, though their rates of service access don't match estimates of need.[12] Furthermore, **California's county-operated system elicits extraordinary variation in local policies and resources.** Among the impacts are significant inequities regarding mental health service access among foster children living in different parts of the state.

Talking directly with foster youth provides additional evidence of room for improvement. In a survey of 105 Alameda County foster youth between the ages of 15 and 22 conducted by CYC for its "Other Side of Mental Health" project in 2015, 44 percent of respondents said they were not familiar with the types of mental health services available to them. Thirty-eight percent said they were only "somewhat familiar," and only 18 percent said they were "very familiar" with the types of mental health services available to them. Similarly, of 83 Contra Costa foster youth surveyed for the same study, 32 percent said they were not familiar, and 37 percent said they were somewhat familiar with the types of mental health services available to them.[13]

Children and youth in the community who have not been engaged with a public system, or who have not been identified as needing special education services, may have a significantly harder time accessing mental health services.

Under California's county-administered system, local mental health departments are responsible for building out a system that provides children and youth with the services they are entitled to under Medicaid law. Yet a cursory review of spending data reveals that counties'

Youth In Mind member at CMHACY conference

spending on children's mental health doesn't track levels of Medi-Cal enrollment, or of underlying child poverty, which research has consistently correlated with higher levels of mental health need. And no county comes anywhere near serving the 20 percent that epidemiological estimates would suggest might be in need.[14]

This variation in the performance among counties results from a number of factors. **Some areas have a significant provider network and structures in place to facilitate access, while in others the mental health infrastructure is less developed.** Costs vary from county to county, as well, as, of course, do the resources available to local government. In some counties, the county department itself provides service through community clinics or by referral through an access line; in others, the local mental health department may contract with a community-based organization to provide mental health services in schools. In the former case, youth and families have to go out and actively seek mental health services, while in the latter teachers and school staff who recognize a need may have resources near to hand.

Some counties have focused on increasing TAY engagement in existing mental health services as a way of encouraging TAY to access the services they need. Sonoma County Behavioral Health Division recently partnered with VOICES to launch a peer-to-peer youth engagement project in which Youth Advocates at VOICES work directly with TAY in the county mental health system to help them understand resources available to them and to support the TAY in visiting the local network of mental health supports. Early indicators demonstrate that overall engagement by TAY has increased, and more TAY are actively seeking and receiving the services to support their mental health.

Medicaid law is clear: mental health services are medically necessary, and part of the entitlement; every child who is eligible and in need is to be provided with the services they require.[15] The administration of that mandate may be complex in a state as diverse and complex as California, but there is a legal—not to mention, an ethical—mandate to actively work to expand and facilitate access.

As noted above, a primary reason for focusing on transition age youth as a category that spans the age of legal majority (18) and the upper age limit for mental health services provided by Medi-Cal (21), is that young people who need mental health services, and who have been able to access them during adolescence, must figure out how to navigate the transition to the adult system of care, which provides a significantly less robust array of services.

TAY-focused investments such as MHSA FSPs may support young people in bridging the two systems, but administrators, advocates, parents, and youth all recognize the need to continue to focus on ensuring that youth are able to connect with and benefit from services, regardless of the developmentally arbitrary age limits that define our service systems.

As will be further explored in this report, there are broad trends regarding the structure and performance of California's mental health system that suggest the need for continued advocacy, programming, and policy development. **The good news is that the combination of public entitlement programs (Medi-Cal, special education, foster care) and a robust source of flexible funding (MHSA), provides a solid foundation on which to build a system of care for young people** that supports them through the many transitions that define their life stage.

THE TAY DATA PROBLEM

As noted throughout this report, though the concept of "transition age youth" (TAY) has gained wide acceptance and understanding over the past several years, our public systems are still primarily structured around the legal definitions of "child" and "adult." This creates the very "transition" that gives the concept its name, but also results in significant difficulties in accessing data in order to better understand challenges and potential solutions.

Currently, whether looking at Medi-Cal spending or MHSA investments, we have found little to no hard data that spans the full age range of the TAY population as we've defined it. Data about smaller sets of youth can be found, such as foster care data about youth ages 16 to 18 or 18 to 20, or special education data about children by grade, but nothing that spans the entire TAY age range from 16 to 25.

The richest source of mental health data is about systems-involved transition age youth, particularly foster youth. Less data is available on TAY at large. Foster youth have both a higher level of need due to trauma, and have higher rates of service access due to advocacy and supervision by social workers, advocates, and the courts. It is unclear, however, how the experience of this population—for example, with regards to service outcomes—can and should be applied to the broader TAY population.

Youth In Mind members at CMHACY conference

The No Stigma, No Barriers Collaborative plans to work with MHSOAC and a range of partners over the next two years to continue to develop data-based analysis of the experiences of California's transition age youth with mental health needs.

The least detailed data is about 21–25 year olds, as these young people are not often differentiated in records kept about the adult mental health system's population. Unfortunately, this means that it is extremely difficult to understand the case- or population-level impact of the transition from the children's system funded primarily by EPSDT, and the adult system that relies on other Medi-Cal and MHSA programs.

Currently, no government agency or other entity is charged with the specific responsibility of collecting information about the characteristics, experiences, or outcomes of transition age youth. **California's young people between the ages of 16 and 25 straddle the children's service system and the adult system,** and as they move from one system to the next, some of their needs change while others persist.

In 2004, at the request of Assemblymembers Manny Diaz and Marco Firebaugh, the California Research Bureau published a report, "Profile of the Young Californian (Age Group 16–24): How Has It Changed Over the Last Three Decades?"[16] **An updated study of this sort would be useful to transition age youth service providers and advocates as well as policymakers.**

Given the lack of data about the state's 16 to 25-year-old youth, this report makes use of existing data sources which are all imperfect for the task. **Over the coming years, the Collaborative will seek to develop additional data that can help illuminate the experiences and needs of TAY,** and will include its findings in future State of the Community reports.

PART TWO: INFUSING YOUTH VOICE AND ENGAGEMENT INTO TAY MENTAL HEALTH SERVICES

In 2016, California Youth Connection and its partners Young Minds Advocacy (YMA), Youth In Mind (YIM), and VOICES submitted a collaborative proposal to the Mental Health Services Oversight and Accountability Commission (MHSOAC) to facilitate transition age youth stakeholder engagement with California's mental health systems. Drawing on the partners' long histories of youth-led outreach, training, organizing, and advocacy, and deep knowledge of the state's child serving systems, the Collaborative proposed **a youth-directed program designed around elevating youth voice as a strategy to improve and transform systems.**

The Collaborative was awarded a three-year contract with MHSOAC, and, in November 2016, began building a coordinated program of TAY-stakeholder engagement, education, and advocacy activities.

The Collaborative is guided by a governance board comprised of TAY representatives as well as non-TAY staff of the partner organizations. The partners are all firmly committed to youth-led advocacy and have extensive experience working together to improve services and supports for transition age youth.

Members of the board were selected by the executive directors of the partner organizations for their experience and enthusiasm. One partner organization that does not have TAY staff referred adult staff to serve on the board, making the board intergenerational.

The youth-driven and youth-focused governance board meets monthly to provide strategic guidance and oversight on the project while the project activities are carried out largely by other staff (many of whom are TAY) of the partner organizations.

> "I'm really excited about the No Stigma, No Barriers team. We're intergenerational, and that gives us a lot of different perspectives and ways to find better solutions."
>
> —CECILIA TORRES, 21, MEMBER, NSNB GOVERNANCE BOARD & YOUTH ADVOCATE, VOICES YOUTH CENTER

The board focused initially on creating collective identity for the project through naming, branding, and communications, and then began drafting a charter to provide operational guidance for the board and the Collaborative. Following extensive deliberation, the youth board named the Collaborative "No Stigma, No Barriers" (NSNB) to reflect their aim to end stigma towards mental illness and break down barriers to care for young people.

A meeting of the No Stigma, No Barriers Governance Board

OVERCOMING THE HARMFUL EFFECTS OF "OH, IT'S NOTHING"

When she was in high school, Cecilia Torres hit a rough patch. She found it hard to get up in the morning, she says, and when she managed to do so, she didn't want to be around anyone and found it hard to face the day. She began to miss school.

"I was very unhappy with myself and my life," Cecilia says. "It went on for a while. **I was having all these feelings and I wasn't quite sure what it was."**

Eventually, Cecilia went to her school counselor, and opened up about her experience. Instead of counseling Cecilia or referring her to mental health services the counselor brushed her off, telling her, "All teenagers go through this." **"The counselor basically just gave me a pep talk and sent me along,"** says Cecilia. "I didn't feel like he was interested in knowing what was really wrong. It kind of felt like, 'Oh, it's nothing.' I was really discouraged."

Cecilia eventually got the support she needed, but that experience of not being heard has stuck with her and is one reason she eagerly joined the No Stigma, No Barriers Collaborative governance board. She wants every young person who experiences depression in high school to have access to a counselor who will **"actually try to see what the issue is and not just assume it's something that happens to everyone."**

Equally importantly, Cecilia says, all counselors should be knowledgeable about the resources in their community so if they can't personally help the youth, they'll be able to connect them with a professional who can. When it came time to choose a name for the TAY Mental Health Collaborative, Cecilia wanted a name to reflect the need for eliminating stigma as well as internal and external barriers to receiving help.

"There's a lot of stigma around mental health," says Cecilia, "so **youth experience barriers not only in the community but also in themselves.** I put barriers on myself—I wouldn't allow myself to seek help again because of one bad experience that I had. There are barriers in the community but also internal barriers within ourselves."

The guiding strategy of NSNB is to **infuse youth voice and engagement into TAY mental health services.**

The partners' own missions are well aligned with the goals set out for the project by MHSOAC to engage diverse communities to provide TAY-led outreach, education, training, and advocacy activities to improve the systems and supports that address the mental health needs of TAY.

With most of the partners' work centered on youth voice and leadership, the Collaborative embraces the **goal of ensuring TAY voices become central to the planning and oversight** of California's mental health system.

To ensure that California's local and statewide systems provide better and more responsive supports and services to improve mental health outcomes for TAY and their families, the Collaborative engages in local and statewide:

- **Training and Education**
- **Outreach, Engagement, and Communication**
- **Advocacy**

"It's important to note the therapeutic value of making a difference in one's community, like the work that CYC and VOICES do. **Being in service is one of the most healing things we can do.** It really helps heal trauma."

—IRIS HOFFMAN, 21
HOLISTIC WELLNESS ADVOCATE, AVP FACILITATOR, VOICES SONOMA, FORMER YOUTH ADVOCATE, CYC MEMBER

NSNB Governance Board members Nathan Woolbright and Mariah Corder at the Mental Health Matters Day in Sacramento in May

"There was a time I realized that the services I was getting were not providing any personal growth for myself. I went online and looked up **how to share my real story with the world.** I love to write, and I found Young Minds Advocacy and started blogging about my personal experience with bipolar disorder. **So I found a way to paint a picture of myself** that wasn't the stigmatized bipolar picture because it's really hard to get diagnosed and to start looking at things that are typically bipolar and thinking, "Wait, that's not me," and so I found a way **to stand up for myself through advocacy**."

—SUSAN PAGE, 25, YMA BLOGGER AND CYC SF CHAPTER MEMBER

TRAINING AND EDUCATION

Our youth-led training and education activities are designed to equip TAY around the state to participate meaningfully in the planning and administration of California's mental health systems. Drawing upon the partners' many years of experience providing TAY-led training and education, the Collaborative engages, trains, and helps TAY advocate for their mental health needs.

Youth-delivered workshops, trainings, presentations, materials, and curricula for TAY are being presented in the five regions of the state: The Superior Region, Bay Area, Central Region, Southern Region, and Los Angeles. Training materials are adapted to be accessible across the full range of TAY diversity—including addressing differences in cultural norms and attitudes; intersectionality of mental health needs and services with race, class, gender, and sexuality; and the structural and cultural differences between child and adult service systems. The project partners collaborate with stakeholder and advocacy groups that focus on unserved and underserved populations to ensure all training activities are accessible to the broadest possible range of TAY.

"Too many people these days, when they talk about mental health, it is a diagnosis, a disorder, or a barrier. It is something that you have to fix—with therapy, pills, or institutions. Mental health is viewed as an individual struggle for a single person; something wrong or different about that one person.

As an Indigenous person, I feel that those beliefs about mental health are wrong. **What is labeled as a disorder or barrier is actually a tool or gift from Creator.** Often, on this colonized continent, we don't understand these gifts, but if we took the time as a people, a community, a village, we could work together to make sure that everyone's gifts are used, and that no one is made to be an isolated disorder."

—TRISTIN SEVERNS, 19, YOUTH ADVISORY BOARD MEMBER, HUMBOLDT COUNTY TRANSITION AGE YOUTH COLLABORATION

Staff and volunteers of Young Minds Advocacy, including youth blogger Susan Page, with San Francisco Mental Health Board Members after YMA's presentation on youth voice and "No Stigma, No Barriers"

The 2016-17 NSNB trainings have so far included:

- **Listening Circle and Strategic Sharing** in the central region using Youth in Mind's "Stomp Out Stigma" toolkit:
  - Participants at Fresno State identified signs of internal or external stigma resulting from personal experiences with trauma, and engaged in a group meditation and sharing exercise.
  - At the conclusion, several TAY participants reported an interest in learning more about how to improve and maintain their mental wellness as well as how to advocate for themselves within systems serving their needs.
- **Structure and Purpose of the California Public Mental Health System** in the southern region using "Mental Health 101" training materials from YMA:
  - Two TAY advocates were trained on this topic as well as on basic facilitation skills, and subsequently conducted a content knowledge workshop centered on the mental health system at a service provider in Camarillo. Attendees filled out system maps that illustrated the interaction between different local and state level entities involved in the delivery of mental health services.
- **How to Craft Public Narrative** workshop in the northern region:
  - TAY advocates held a workshop for TAY in Arcata to learn how to craft public narrative and develop youth-driven policy change recommendations that were later delivered to the Humboldt County Board of Supervisors.
- **The Many Faces of Youth Mental Health: Fostering Solutions, Resiliency & Hope** conference in the Bay Area region:
  - Collaborative partner VOICES, including TAY staff, presented a training that addressed intersectionality and the importance of using a client-centered approach when working with TAY and various types of mental health symptoms which may be situational or chronic/clinical. The training included ways to connect with youth and how to reduce stigma by tailoring language. Participants learned the importance of respecting TAY voice as part of the service delivery model as well as how to work in partnership with TAY to ensure they receive the mental health care they need.

TAY Input at Fresno Listening Circle

OUTREACH, ENGAGEMENT, AND COMMUNICATION

> "Youth are either not being heard about what they're struggling with, or they don't know where they can go to get any kind of help or resources relating to mental health. That's why youth aren't receiving the help that they need."
>
> —CECILIA TORRES, 21, MEMBER, NSNB GOVERNANCE BOARD & YOUTH ADVOCATE, VOICES YOUTH CENTER

Recognizing a need for broad and diverse community outreach strategies, as well as youth-led efforts to help shape the public conversation about mental health, the NSNB Collaborative has also begun conducting a series of youth-designed outreach and educational events to identify and empower young people and their supporters throughout the state. Resources for TAY will be distributed through the NSNB website at www.nostigmanobarriers.org.

The 2016-17 NSNB Outreach, Engagement, and Communication Activities have so far included:

- **Outreach Event in Kings County**
  TAY advocates introduced the goals and overall vision of the No Stigma, No Barriers project to TAY and supporters and solicited their input on how the California public mental health system struggles with or succeeds at serving TAY.

- **Presentation to Humboldt County Board of Supervisors**
  - Collaborative partner Youth In Mind (YIM) traveled to Humboldt County to facilitate a "Listening Circle," a 3-hour interactive community circle combining trauma-informed principles and the eight dimensions of wellness. The goal was to create a visual map of suggested changes to the mental health system and to highlight and promote community-driven solutions.
  - The youth learned the S.U.N. (Self, Us, Now) method of sharing as described below.
    - The Story of Self (connecting their individual experience to the recommendation)
    - The Story of Us (connecting their collective experiences)
    - The Story of Now (based on their personal connections, exploring what action steps they can take for policy shifts)
  - The listening session was followed by a "policy prep camp" the next day, in which TAY prepared to speak to the Humboldt County Board of Supervisors. They practiced strategic sharing of their personal stories within a public narrative.
  - After preparing to strategically share their stories in making recommendations about the mental health system, the youth presented to the Humboldt County Board of Supervisors the following day.

YIM Advocates in Humboldt

ADVOCACY

Collaborative partners met in March 2017 with the California Association of Local Mental Health Boards and Commissions (CALMHB/C) and the California Mental Health Planning Council (CMHPC). CALMHB/C assists local mental health boards and commissions in carrying out their mandated functions and advocates at the state level on behalf of the county entities. CMHPC, a majority consumer and family member advisory body to state and local government, the legislature, and residents of California on mental health services in California, chose "youth and adolescents" as their issue for 2017. County mental health boards will be focusing on this issue as well, making it even more important that youth are a central voice in the conversations around the state.

In San Francisco, the MHB has chosen children's advocacy as a priority for 2017. The Collaborative presented about youth mental health to the San Francisco MHB in March, and that board has since created a Children's Advisory Committee. Susan Page, age 25, was appointed to a three-year term on the board in June 2017.

YMA's Annabelle Gardner, member of the intergenerational NSNB Governance Board, gives a presentation on Mental Health Boards at the CMHACY conference.

"When you have mental health issues, things can hit you ten times harder than other people. Sometimes you can't get a hold of yourself and you feel lost within yourself. When you're well, you feel at ease with yourself, you feel like life is good even though we all experience sorrow and pain. When you're well, you move through it more quickly than someone who is experiencing mental health issues."

—CHRISTINA PARKER, 22, CYC MEMBER AND STUDENT AT CAL STATE SAN BERNARDINO

JOIN US!

THERE ARE THREE WAYS TO SUPPORT THE WORK OF THE COLLABORATIVE:

1. Sign up for our email list to stay connected at www.nostigmanobarriers.org/sign-up.
2. Learn more about our MHB campaign by visiting www.nostigmanobarriers.org or by emailing info@nostigmanobarriers.org.
3. Request a training or workshop for your staff by NSNB TAY Advocates. Email info@nostigmanobarriers.org for more information.

The Collaborative's Recommendations to the SF Mental Health Board:

- ✓ Include youth voice and participation in San Francisco's Mental Health Board decision making processes.
- ✓ Encourage other departments and committees to do the same.
- ✓ Increase awareness about mental health resources for youth in San Francisco.

PART THREE: ADVOCACY PRIORITY: BRINGING YOUTH VOICE TO CALIFORNIA'S MENTAL HEALTH BOARDS

While only sparse data exists about the mental health needs and experiences of California's youth ages 16 to 25, certain key trends and dynamics are evident. In any given county, programs funded to provide mental health services to youth are doing so. Some counties have an abundance of services while others have one or two.

While thousands of Californians ages 16-25 receive needed mental health services, many thousands more do not. Too many youth are referred to services that are inappropriate to their needs or inaccessible geographically, developmentally, and/or culturally.

Yet no matter where a young person lives in California, they are near too few services that are appropriate and accessible. A number of organizations, including those highlighted in section four of this report, are working to change this.

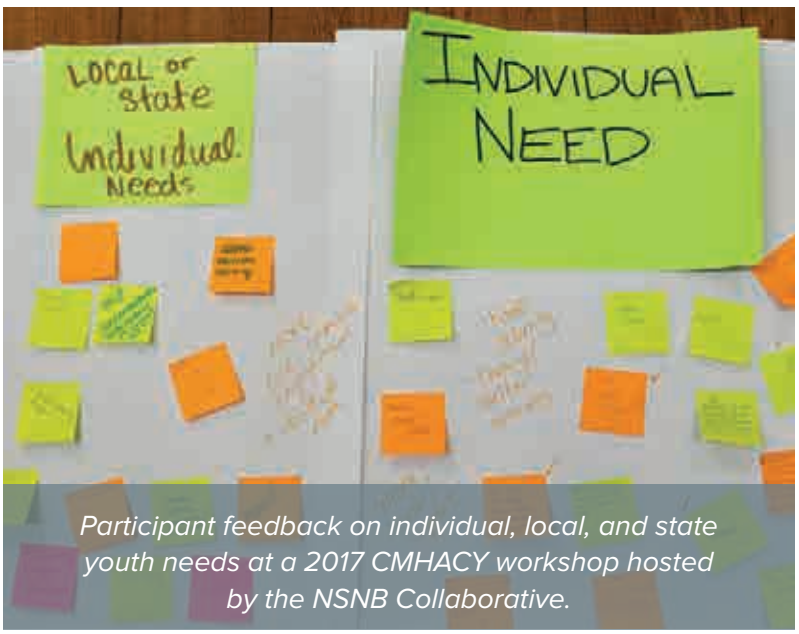
When a young person is referred for treatment, often as a result of a mental health crisis, they are typically referred for "talk therapy," often in places or at times that are inconvenient. Many of those who do manage to make it to their appointments say talk therapy does not work for them; yet, it is all they are offered.

The youth directing the No Stigma, No Barriers Collaborative apply their personal and professional experience to the questions: **What do young people need in order to thrive, and how can our mental health systems better serve them?**

> "For me, the 'sit down and talk in a dark room' type therapy does not work. I got referred to that at least like 20 times, and I'd show up for that first session, and then just not go back."
>
> —MARIAH CORDER, 18
> MEMBER OF NSNB GOVERNANCE BOARD

They are bringing their answers to these questions to venues around the state—to youth so they can be aware of what's possible and share their own perspectives; to policymakers so they can help make it happen; to service providers and others who engage with young people so they can implement the bold yet simple vision of **listening to young people and providing them with individualized, culturally appropriate services they can access**.

One of the first steps toward this vision is getting more youth to more tables where decisions are made on their behalf. In fact, the Collaborative



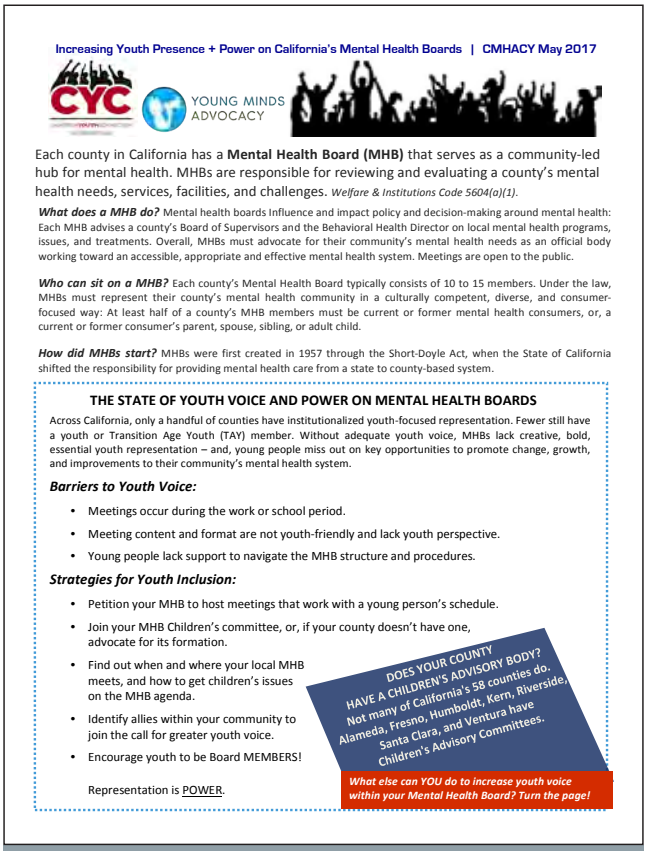
Participant feedback on individual, local, and state youth needs at a 2017 CMHACY workshop hosted by the NSNB Collaborative.

partners hold true the notion that decisions affecting TAY should never be made "on their behalf" but should be made with and alongside TAY. To this end, **the board chose as their first advocacy priority a campaign to create formalized structures within county mental health boards to allow for meaningful representation and participation of TAY in decision-making processes.**

> "**Having different perspectives is gold.** There are so many things that can be learned if you have multiple perspectives and forgotten if you don't. When you have a roomful of adults talking about youth, they think the youth are experiencing things in a certain way, and they're interpreting those things without a youth there to share their perspective about what it's like to be hospitalized or be on three different medications at a young age. What is that like and how can we be more sensitive to the youth's experience?"
>
> —SUNSHINE HARTWELL, 23, LGBTQ YOUTH ADVOCATE, VOICES

No Stigma, No Barriers partner Young Minds Advocacy has attended the San Francisco County Mental Health Board for nearly two years. In all that time, the unique experiences and challenges specifically facing transition age youth were largely not discussed or addressed in that forum until the Collaborative presented to the board in March 2017. Since then, the San Francisco Mental Health Board has formed a Children's Advisory Committee, and added a 25-year-old to the board.

The Collaborative partners operate from the premise that TAY should be part of any decision-making entities whose work directly impacts TAY. California has led the way in effective youth-directed policy advocacy in foster care and the impact of incarceration on families, yet TAY mental health services in most counties are still largely planned and implemented by adults. It is no surprise then these services are ineffective for many of the youth who need them and who experience poor outcomes in education, employment, and relationships as a result. County mental health boards (MHBs) are responsible for championing their local community's mental health needs with their local boards of supervisors, which make local determinations about funding. Behavioral Health Directors often attend their local board of supervisors' meetings.



Increasing Youth Presence + Power on California's Mental Health Boards | CMHACY May 2017

CYC YOUNG MINDS ADVOCACY

Each county in California has a **Mental Health Board (MHB)** that serves as a community-led hub for mental health. MHBs are responsible for reviewing and evaluating a county's mental health needs, services, facilities, and challenges. *Welfare & Institutions Code 5604(a)(1).*

What does a MHB do? Mental health boards Influence and impact policy and decision-making around mental health: Each MHB advises a county's Board of Supervisors and the Behavioral Health Director on local mental health programs, issues, and treatments. Overall, MHBs must advocate for their community's mental health needs as an official body working toward an accessible, appropriate and effective mental health system. Meetings are open to the public.

Who can sit on a MHB? Each county's Mental Health Board typically consists of 10 to 15 members. Under the law, MHBs must represent their county's mental health community in a culturally competent, diverse, and consumer-focused way: At least half of a county's MHB members must be current or former mental health consumers, or, a current or former consumer's parent, spouse, sibling, or adult child.

How did MHBs start? MHBs were first created in 1957 through the Short-Doyle Act, when the State of California shifted the responsibility for providing mental health care from a state to county-based system.

THE STATE OF YOUTH VOICE AND POWER ON MENTAL HEALTH BOARDS

Across California, only a handful of counties have institutionalized youth-focused representation. Fewer still have a youth or Transition Age Youth (TAY) member. Without adequate youth voice, MHBs lack creative, bold, essential youth representation – and, young people miss out on key opportunities to promote change, growth, and improvements to their community's mental health system.

Barriers to Youth Voice:

- Meetings occur during the work or school period.
- Meeting content and format are not youth-friendly and lack youth perspective.
- Young people lack support to navigate the MHB structure and procedures.

Strategies for Youth Inclusion:

- Petition your MHB to host meetings that work with a young person's schedule.
- Join your MHB Children's committee, or, if your county doesn't have one, advocate for its formation.
- Find out when and where your local MHB meets, and how to get children's issues on the MHB agenda.
- Identify allies within your community to join the call for greater youth voice.
- Encourage youth to be Board MEMBERS!

Representation is POWER.

DOES YOUR COUNTY HAVE A CHILDREN'S ADVISORY BODY? Not many of California's 58 counties do. Alameda, Fresno, Humboldt, Kern, Riverside, Santa Clara, and Ventura have Children's Advisory Committees.

What else can YOU do to increase youth voice within your Mental Health Board? Turn the page!

Flyer presented by the Collaborative at the May 2017 CMHACY conference to promote the Mental Health Board Campaign. The Collaborative will continue to build upon messaging from events such as CMHACY as it deeps its MHB advocacy. While this flyer was circulated as part of NSNB advocacy, the San Francisco Mental Health Board formed a children's committee.

TRUSTING YOUTH TO HELP BUILD THE SYSTEM

"Under the current statutory scheme for MHBs, California counties are not required to have a youth representative seat, though they are required to have seats for consumers, family members, and public interest. Youth applicants, therefore, must compete with adults for appointment to one of the existing categories. It is thus unsurprising that, even when youth apply to be on a MHB, the County Supervisors instead appoint adults for that seat. This is troubling. **For years I have heard counties, providers, and advocates all encourage youth representation in the local mental health planning process, but there has been no effort to translate this rhetoric into reality.**

When a young person speaks in a meeting, or on a board largely governed by older adults, an aroma of cynicism sometimes overtakes the room. Eyes roll, cell phones emerge, and people disengage. This is not an atypical problem at meetings, but it seems a constant occurrence when youth speak in these settings. **Adults, including myself, sometimes think we know everything, and we perceive youth as inexperienced.** This assumption is often incorrect, which is particularly evident in considering youth who may serve on the MHBs. For example, an eighteen-year-old Transition Age Youth ("TAY") may have only have eighteen years of life experience, but if they spent those entire eighteen years in foster care, would that not make them an expert on children's experiences in the Child Welfare System? I suggest it does. That lived personal experience is invaluable to the creation of systems, programs, and policies. This voice of experience is currently absent in the decision-making process in almost all California counties.

I believe that youth voices in decision making are lacking because there is general distrust of the youth perspective. Decision makers often overlook the value in having youth at the table. In some cases, people will purport to value the youth perspective, but will tokenize the youth voice. Tokenization occurs when one youth attends a meeting, someone says, "look we have youth participation," and the room bursts into applause because a single youth is in attendance. Such tokenization does not actually value or integrate the youth voice, but is rather perceived as patronizing, demeaning, and condescending. **Resolving these problems begins by valuing the youth perspective and by trusting youth to be experts on youth-related issues.** California's public mental health system currently serves children, youth, and adults; yet, youth are not involved in the creation of the system that serves their population. Then, when youth are critical of the system that has dismissed their input, they are frequently scorned for their criticism. On one hand, youth are told to trust the system to fulfill their mental health needs. On the other hand, youth are not trusted with positions that would allow them to provide meaningful insight about the system. Trust is a two-way street; if you want youth to trust the public mental health system of care, begin by trusting youth to help build that system."

Excerpt from a written statement by Matthew Gallagher, 27, District 3 Consumer Representative, Sacramento County Mental Health Board

Despite their capacity to drive change, most of the state's MHBs lack institutionalized, meaningful youth participation.

Established in 1957 to give mental health consumers the opportunity to provide insight to decision makers, California's county mental health boards by and large do not currently include or reflect the voices of transition age youth despite the fact that TAY make up a sizable portion of the consumer base in any county. According to the Welfare and Institutions Code Section 5604.2, "fifty percent of the board membership shall be consumers or the parents, spouses, siblings, or adult children of consumers, who are receiving or have received mental health services."

Yet out of all the MHB's in California—one in every county plus a few additional boards in cities such as Berkeley—it appears only two currently have TAY members. (Just before this report was completed, the San Francisco Mental Health Board added a TAY member.) A few others have children's or youth committees but no seated TAY members. Thus, in nearly all of California's 58 counties, **youth voice is absent from decision-making processes that impact the funding, quality, and focus of their mental health services.**

With CMHPC having chosen "youth and adolescents" as their issue for 2017, as noted above, there appears to be a growing willingness and even desire among MHBs to engage with youth. Thus, now is an opportune time to amplify youth voice to shape systems and hold them accountable.

Having TAY seated on the MHBs brings greater value to the decision-making processes because it brings a perspective that does not yet exist at those tables. Other members will no longer have to put themselves "in the shoes" of a TAY, or hark back a few decades to their own transition age years when discussing TAY mental health needs and services because those shoes will already be filled.

> "I noticed that there was a gap within mental health services just because of how hard it was for me to find a pathway that wasn't just therapy or prescription medications and instead was more about **finding out how you want to live in this world, and the way you want to take care of yourself,** and just bringing more awareness and education to it. That wasn't really present while growing up in the system. So I found that becoming a health and wellness advocate gave me the opportunity to bring that awareness and mentorship and the ability to teach others to find their way to a method of self-care. Because if you can take care of yourself even after aging out—that's ultimately what we would like to help people do.'
>
> —ANGELICA DE LA TORRE, 22
> ALCHEMY HEALTH AND WELLNESS YOUTH ADVOCATE, VOICES

Goals of the No Stigma, No Barriers Mental Health Board Campaign include:

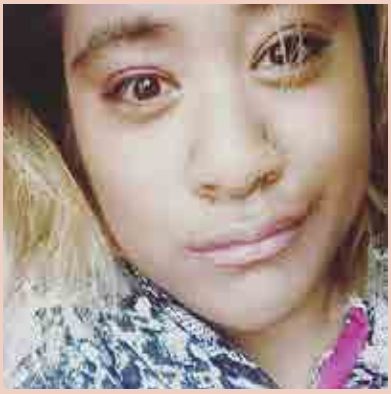
- **First:** To get a structured, meaningful process in place to involve TAY on MHBs where they're not already involved.
  - We will use the models of the MHBs that have youth seated on their boards or have children's or youth committees that involve youth somehow. The overarching goal is to make sure that TAY are involved in these MHBs—not just brought in to make a presentation but embedded into the framework, ideally seated on the board. Second best would be having a youth committee that meaningfully involves youth.
- **Second:** To ensure authentic engagement of TAY on these boards.
  - Because TAY have not been part of these structures, the structures are typically not prepared to draw the value out of TAY participation. Once TAY do get a seat at the table, they should be treated as equal participants who provide value and get value from their participation in the same way that the other members do-- in a way that isn't tokenizing. To this end, the Collaborative will embark on an education campaign with the MHBs about authentic youth engagement, drawing in large part on this very sort of work that CYC has been doing for its 30-year history.
- **Third:** To create and provide resources for counties who want to bring TAY onto their boards.
  - An offshoot benefit is that the TAY who are involved can teach the skills they learn to their peers and encourage them to get involved with civic engagement.

Several MHBs appear eager to bring TAY on as members but whether that is true throughout the state remains to be seen. How many boards bring TAY on and how authentically they want to engage youth also remains to be seen. The Collaborative will periodically assess the success of the campaign, and may need to consider advocacy to standardize the process for including TAY consumers on the MHBs.

What will success look like? Ideally over time, all MHB's will meaningfully include TAY on their MHBs or will be moving toward doing so, either through seats on the board or other meaningful engagement through youth committees. It is equally important that these TAY report feeling meaningfully involved and not tokenized. The partners' past experience predicts that this step will take longer, and involve ongoing education.

> "The effect of untreated mental illness is huge. It's suicide. Not having hope or empowerment, thinking that you are just the way you are forever and you're doomed. I was there at one point. I started spiraling down. I was in a pretty good place—employed in a good position but because my mental health wasn't being taken care of the way it should have been, I lost my hope and spiraled into a depression. It was really, really hard to build myself back up to the point where I could feel like I could handle what was going on in my life. **Leaving it untreated is so unfair to young people because everybody that has a typical family gets the opportunity to learn how to maneuver through school and through life's challenges, and their parents are there for them.** It's not fair to leave it up to us to learn how to maneuver through a world we're so unfamiliar with, especially when things come up and it gets challenging for us, and we don't know why. **It's like an invisible threat** that you have to figure out some way on your own even though you don't have the experience to do it or the mentorship to learn how."
>
> —ANGELICA DE LA TORRE, 22
> ALCHEMY HEALTH AND WELLNESS YOUTH ADVOCATE, VOICES

SUPPORT FOR GETTING BACK INTO LIFE



Although she didn't know what to call it at the time, Susan Page began having symptoms of bipolar 1 disorder when she was 13 years old. Now 25, Susan was 22 before she was diagnosed, and it took a "huge manic episode and suicidal ideation" to land her in the hospital, where she finally received a diagnosis and a referral to therapy.

Susan found therapy helpful for learning "how to deal with personal problems that come up with your disorder," she says, "but **there's not much support for getting back into life after your diagnosis."** What's needed, says Susan, especially for transition age youth who are just gaining their footing in independence, are **connections to education and employment.**

"After my diagnosis at 22, I got talk therapy and group therapy that taught me how to deal with being bipolar," says Susan. "But the services I got gave me no support to get back into life, which was really dependent on getting back to school and getting my confidence back, and simple things like how to get a place to live and do money management."

While therapists often make recommendations about school or work, Susan says young people need their therapists to help them make those connections. Susan shared this with the San Francisco Mental Health Board during a presentation with No Stigma, No Barriers. "I told the mental health board there really needs to be a connection to life skills," she says. "There's not a holistic approach to recovery for young people. **The goal of talk therapy is to get you stable, and I don't think they should leave you hanging there. There should be more advocating for the patient."**

Of the SF MHB, Susan says, "I saw in that meeting that there is a push to have those services available to young people, and they just don't know how to present those services and get them to young people."

Susan applied for a position on the San Francisco Mental Health Board so she can continue to advocate for more holistic services to help TAY with mental health needs "get back into life." On June 30, 2017, Susan was appointed to serve a three-year term on the San Francisco Board (Seat 1, District 11). With her appointment, Susan joins a small but growing cohort of youth advocates from Humboldt and Sacramento counties currently serving on their local boards. In expanding the MHB campaign and growing collaborative partnerships, members of No Stigma, No Barriers will work to ensure that successes like Susan's are duplicated across the state.

PART FOUR: CALIFORNIA'S YOUTH-LED MENTAL HEALTH ORGANIZATIONS

California has been a leader in developing organizations led or influenced by transition age youth. Lead partner CYC was founded 30 years ago by a group of transition age youth who had experienced the foster care system. Partners VOICES and YIM have many years of experience as well in youth-led advocacy, training, education, and outreach. Arising out of the call to decide **"nothing about us without us," these and other TAY-led organizations have transformed transition age youth services** throughout our state, and provide a model for others.

The Collaborative is looking at the **activities and roles** of public and private mental health organizations throughout the state that are either youth-led or meaningfully integrate youth voice into their governance, planning, and/or administration. **In this section, we highlight some standout organizations, several of which were founded by youth and continue to be led by youth, and all of which meaningfully involve youth in their governance and/or operations.** The list is not exhaustive but is intended to provide an instructive look at what makes TAY-led organizations tick.

Young people who have participated in TAY-led organizations indicate that programs operate best when they provide a youth-friendly drop-in environment, supports provided by TAY peers both on site and in the community, and connections to employment, housing, and other supports. Common offerings include wellness and recovery support, mindfulness, life skills, and support groups. These organizations draw TAY who have not typically accessed services through the traditional clinic system.

> "TAY should be viewed as a unique culture, therefore having a unique set of needs. Systems of care and their providers must **tailor approaches and services in ways that support young people's needs and their development** as they transition into adulthood. This can only be done by respecting and fostering young people's culture, goals and hopes for the future."
>
> —NATHAN WOOLBRIGHT, MEMBER, NO STIGMA, NO BARRIERS GOVERNANCE BOARD, YOUTH IN MIND CLINICAL SERVICES TECHNICIAN II, STANISLAUS COUNTY BEHAVIORAL HEALTH AND RECOVERY SERVICES

A scan of these organizations reveals **a number of valuable attributes:**

- Youth on staff
- Youth involved in hiring of other staff
- Youth peer support
- Youth on governance boards
- Youth involved in the planning of the organization, ideally even having founded it

In the coming years, the Collaborative seeks to partner with youth-led organizations around the state on all of our advocacy initiatives. In addition to those highlighted here, the Collaborative has identified a number of other youth-led projects addressing TAY mental health needs, and we look forward to collaborating with as many of them as possible. We also look forward to documenting their strategies and successes, and helping this vital part of the community advocate for what they need to be most impactful.

Know a TAY-led organization engaged in mental health work or a model we should know about? We'd love to connect! Find us at www.nostigmanobarriers.org or email info@nostigmanobarriers.org.

NATIONAL ORGANIZATIONS WITH CALIFORNIA PRESENCE

TEENZTALK

www.teenztalk.org

Let's create a global teen community where we share our experiences, inspire each other to chase our unique ambitions, and embrace the valuable growth that stems from facing difficulty. We focus on teen mental health and wellness, harnessing peer connections as a source of strength. Our vision is of a world where teens join together, start conversations, and tackle new challenges to better society, while embracing the contagion of happiness and compassion.

Programs/Services

- Online teen forums; advocacy campaigns
- Resource sharing

YOUTH MOVE

www.youthmovenational.org

The mission of Youth 'Motivating Others through Voices of Experience' (M.O.V.E.) National is to work as a diverse collective to unite the voices and causes of youth while raising awareness around youth issues. We will advocate for youth rights and voice in mental health and the other systems that serve them, for the purpose of empowering youth to be equal partners in the process of change.

Programs/Services:

- Youth leadership and personal development
- Youth program and chapter development
- Youth voice in systems change and quality improvement
- Development of formal and informal youth peer support

founded by youth

youth on staff

youth on board

youth plan, direct or implement programs/services, including advocacy

NATIONAL ORGANIZATIONS WITH CALIFORNIA PRESENCE

MENTAL HEALTH AMERICA OF CALIFORNIA

www.mhac.org

The mission of Mental Health America of California is to ensure that people of all ages, sexual orientation, gender, ethnicity, etc. who require mental health services and supports are able to live full and productive lives, receive the mental health services and other services that they need, and are not denied any other benefits, services, rights, or opportunities based on their need for mental health services. Through advocacy and education we strive to achieve these goals.

PROGRAMS INCLUDE:

CALIFORNIA YOUTH EMPOWERMENT NETWORK (CAYEN)

http://ca-yen.org/

The California Youth Empowerment Network (CAYEN) was formed to develop, improve and strengthen the voice of Transition Age Youth (TAY) in local and state-level policy. CAYEN's mission is to empower TAY to be leaders in community and mental health system transformation and to create positive change through the promotion of culturally appropriate supports, services and approaches that improve and maintain the mental health of California's TAY. CAYEN envisions a community in which Transition Age Youth in need of mental health services have access to resources and supports so they can lead self-fulfilling lives and be contributing members of society.

CAYEN influences policy and legislation by engaging youth and young adults from across the state. We engage in policy discussions and participate in state level committees to ensure youth voice and youth needs are included in all policy decisions around mental health services for TAY. We also empower and train youth to advocate within their local communities. Our active 100% TAY Board members are also actively involved in their local communities, by working in mental health agencies, engaging in their county stakeholder process, and chairing TAY mental health policy groups.

Programs/Services:

- Training and education
- Personal advocacy
- Legislative advocacy program development
- Technical assistance
- Youth leadership development

founded by youth

youth on staff

youth on board

youth plan, direct or implement programs/services, including advocacy

LARGE NONPROFITS

CALIFORNIA YOUTH CONNECTION

www.calyouthconn.org

California Youth Connection (CYC) is a statewide organization comprised entirely of youth ages 14–24 with direct experience of our state's foster care, mental health, and juvenile justice systems. CYC facilitates youth-led organizing, education, and advocacy, providing a transformational experience of community and individual empowerment. CYC develops leaders who empower each other and their communities to transform the foster care system through legislative, policy, and practice change. Our vision is that foster youth will be equal partners in contributing to all policies and decisions made in their lives. All youth in foster care will have their needs met and the support to grow into healthy and vibrant adults.

Programs/Services:

- Youth development and leadership
- Trainings and sharing of best practices
- Outreach and community education
- Statewide and local advocacy

NO STIGMA, NO BARRIERS PARTNER

"CYC is most successful when youth are at the center of identifying issues and creating solutions for legislative, policy, and practice transformation."

—HAYDÉE CUZA, EDD, EXECUTIVE DIRECTOR

TAY TUNNEL

www.pacificclinics.org

The TAY Tunnel, developed and run by peers, provides a drop in young-adult friendly environment for those who have experienced mental health and/or substance abuse issues.

Supports are provided by peers and offer resources to community supports. The program is a portal for service access, by offering supports commonly utilized by young adults with a serious mental illness without the pressure of enrolling in services. It is located in Oxnard, Ventura County, and outreaches to underserved TAY throughout the county, offering an array of on-site supports and referrals to TAY who historically have not accessed services through the traditional clinic system. The TAY Tunnel also provides supports for TAY as they transition out of other mental health programs on their journey of wellness and recovery.

Programs/Services:

Weekly classes are offered including: wellness and recovery; mindfulness, life skills, physical wellness, diversity and awareness; parent education and support groups. The TAY Tunnel empowers individuals to take an active role in creating positive lifestyle changes within a supportive, safe and understanding environment. By creating stepping stones to independent living, we can all light the path to happier and healthier lives.

founded by youth | youth on staff | youth on board | youth plan, direct or implement programs/services, including advocacy

LARGE NONPROFITS

PEERS

www.peersnet.org

Peers Envisioning and Engaging in Recovery Services (PEERS) is a diverse community of people with mental health experiences. Our mission is to promote innovative peer-based wellness strategies. We create culturally-rich, community-based mental health programs that honor diverse experiences and eliminate stigma and discrimination.

We envision a world where people can freely choose among many mental health options that address the needs of the whole person. We see a future where people with mental health experiences are valued for their essential contributions to society.

Located in Alameda County, PEERS delivers wellness tools through peer-led support groups and workshops. We are mental health advocates working to eliminate discrimination.

Programs/Services:

- Transition Age Youth (TAY) Leadership Program
- Speaker's Bureau
- Wellness Recovery Action Plan® or WRAP®

VOICES

www.voicesyouthcenter.org

Located in Sonoma and Napa Counties, VOICES' mission is to empower underserved youth, ages 16-24, by utilizing holistic services throughout their transition from systems of care, while building a loving community and establishing a solid foundation for a healthy future.

A program of On the Move, VOICES' innovative Youth-Engagement Model focuses on empowering each youth, integrating resources and services, and working with the entire community to address the barriers that youth face as they leave various systems of care. VOICES youth are not only recipients of social services, they are active leaders in supporting their peers, guiding the evolving vision of program delivery at each site, conducting capacity building to enable growing numbers of social service agencies to become "youth-friendly," and advocating to the community at large to listen and respond to youth voice.

Programs/Services:

- College and career exploration and readiness
- Housing and independent living skills
- Health and wellness
- Youth leadership and advocacy

NO STIGMA, NO BARRIERS PARTNER

"VOICES is most successful in our work with TAY when we ensure that all the services we provide support the ultimate goal of VOICES which is to make sure that every young person believes they are capable, lovable, and worthy."

–AMBER TWITCHELL, DIRECTOR OF VOICES

founded by youth | youth on staff | youth on board | youth plan, direct or implement programs/services, including advocacy

SMALL NONPROFITS

When is your organization most successful in its work with TAY? "When we allow the people we serve (TAY) to direct and guide the conversation, using creativity and art as means of exploration and collaboration."

—CARY MCQUEEN, FOUNDER & EXECUTIVE DIRECTOR OF ART WITH IMPACT

ART WITH IMPACT

www.artwithimpact.org

Art With Impact has a powerful mission: to promote mental wellness by creating a space for young people to learn and connect through art and media. We are committed to a future where artists are revered as cultural icons of courage and change, enabling young people to communicate freely and fearlessly about their mental health.

Programs/Services

- Art-based, interactive workshops facilitated at high schools, colleges, and universities in the U.S. and Canada.
- OLIVE, the world's most diverse library of short films about mental health, grows every month through an online film competition juried by TAY, filmmaking professionals, and mental health workers.

RESILIENT WELLNESS

www.resilientwellness.org

The mission of Resilient Wellness is to end multigenerational trauma and advance holistic health through policy advocacy, service delivery and health education. We envision a world where all beings can experience a fulfilling and healthy life free of trauma and have access to practices that heal them. Our program focuses on school age and TAY youth.

Programs/Services

- We provide access to culturally relevant mental health services in order to help participants understand historical events as a causative factor for their present day mental health challenges.
- We also provide access to workforce development for TAY who want to become health practitioners.

founded by youth

youth on staff

youth on board

youth plan, direct or implement programs/services, including advocacy

SMALL NONPROFITS

RYSE CENTER

www.rysecenter.org

RYSE is a youth center born out of the organizing efforts of Richmond and West Contra Costa County young people who were determined to create safe spaces for themselves and their peers. RYSE creates safe spaces grounded in social justice that build youth power for young people to love, learn, educate, heal, and transform lives and communities.

We envision a movement led by young people that ensures dignity for youth, their families, and communities. We envision youth and adults working together in partnership to hold all public systems and the private sector accountable to serving the community and not exploiting its people. We envision communities where equity is the norm and violence is neither desired nor required, creating a strong foundation for future generations to thrive.

Programming at RYSE is anchored in the belief that young people have the lived knowledge and expertise to identify, prioritize, and direct the programs, activities, and services necessary to benefit their well-being.

Programs/Services:

- Community health and wellness
- Education and career
- Media, arts, and culture
- Youth justice
- Youth organizing and leadership

YOUTH IN MIND

www.yimcal.org

Founded and steered by youth affected by the mental health system, Youth In Mind (YIM) improves the lives of young people, ages 12–28, impacted by the mental health system through education, advocacy, and collaboration. “Nothing About Us, Without Us.” Youth In Mind envisions a mental health system that involves youth in decision making on individual, as well as local, statewide, and national policy levels, to provide all youth with developmentally appropriate psycho-education, empowerment, alternative health care, and peer support services. Youth In Mind members participate in multiple levels of leadership and advocacy.

Programs/Services:

- Leadership summits
- Mental health conferences
- Local advocacy activities

NO STIGMA, NO BARRIERS PARTNER

founded by youth

youth on staff

youth on board

youth plan, direct or implement programs/services, including advocacy

THE EPICENTER

www.epicentermonterey.org

The Epicenter exists to empower at risk and system involved youth ages 16-24 to flourish by connecting them to community resources that provide opportunities for equity and hope in order to improve youth outcomes in Monterey County. The Epicenter is a replication of the VOICES centers in Napa and Sonoma Counties. We are a youth led and youth-run organization that works towards empowering at risk youth by providing them with a one-stop resource center. One of the ways we are able to provide multiple resources is by having co-located staff on site. Co-located staff are employees of other agencies that provide their services at our center. We provide the connection to resources like housing, education, employment, and mental/ physical health and wellness.

Programs/Services:

Support with:

- Housing
- Education
- Employment
- Health and wellness

founded by youth

youth on staff

youth on board

youth plan, direct or implement programs/services, including advocacy

FOR-PROFIT ORGANIZATION

VALLEY STAR COMMUNITY SERVICES ONE STOP TAY CENTER

www.starsinc.com/valley-star-behavioral-health/one-stop-tay-center

Located in Yucca Valley, the TAY One Stop, a program of Stars Behavioral Health Group, helps young adults ages 16-25 focus on their goals for employment and career, community life functioning, educational opportunities, and living situations. Amenities like showers, laundry, phone and internet services are also available on site. In addition to a staff of licensed and experienced professionals, the One Stop TAY Center employs peer mentors who are dedicated to helping other young people become confident and independent.

Programs/Services

- Community living skills
- Recovery from substance abuse
- Feeling empowered in their lives
- Developing supportive relationships
- Identifying and accessing community resources
- Obtaining and maintaining safe, stable housing
- Employment and career goals

founded by youth

youth on staff

youth on board

youth plan, direct or implement programs/services, including advocacy

PUBLIC ORGANIZATIONS

THE HUB

www.fcsfosteryouth.org

The Hub is a youth-led and organized community in Santa Clara County, dedicated to supporting current and former foster youth, ages 15-24, by providing a safe, welcoming center where foster youth feel a sense of belonging, empowerment, and are offered a variety of services by their peers and other caring community members. Our vision is that because of The Hub, youth experience growth and empowerment in a place where they feel safe and are encouraged to accomplish their goals so that they have the confidence to become youth leaders. The community and system will value and be committed to youth and adult partnerships promising support, services, resources, connections, and a safe and welcoming atmosphere where doors are always open.

Programs/Services

- Wellness/mental health counseling
- Education, employment, housing
- Independent Living Program (ILP)
- Legal services
- Shower, washer/dryer

HUMBOLDT COUNTY TRANSITION AGE YOUTH COLLABORATION

www.humboldtgov.org/542/Transition-Age-Youth-Programs

Humboldt County Transition Age Youth Collaboration (HCTAYC) is a youth engagement program for transition age youth, ages 16-26, created to improve county services by empowering youth who currently or formerly depended upon these services to provide thoughtful feedback directly to service providers. HCTAYC works to empower youth because it understands young people are experts in the systems that impact them, and this expertise is vital in system transformation. HCTAYC helps to foster and build skills in the areas of youth development, policy change, youth advocacy, community engagement, and wellness. HCTAYC provides training to youth, staff and community partners related to more effectively engaging youth and developing youth-informed approaches.

Programs/Services:

- "Open Space" hours are available to meet the staff and/or schedule an appointment with TAY Behavioral Health, ILS, HCTAYC, our TAY partners/peer mentors, vocational counselor or an alcohol or other drug counselor.


founded by youth


youth on staff


youth on board


youth plan, direct or implement programs/services, including advocacy

SCHOOL-BASED ORGANIZATION

NAMI ON CAMPUS

http://www.nami.org/Get-Involved/NAMI-on-Campus/NAMI-on-Campus-Clubs

NAMI works to keep family safety nets in place, to promote recovery and to reduce the burden on an overwhelmed mental health care delivery system. The organization works to preserve and strengthen family relationships challenged by severe and persistent mental illness. Student-led, student-run NAMI on Campus clubs work to end the stigma that makes it hard for students to talk about mental health and get the help they need. Clubs hold creative meetings, innovative awareness events, and signature NAMI programs through partnerships with NAMI State Organizations and Affiliates across the nation.

NAMI on campus programs are located in California at: California State University, Channel Islands; California State University, Los Angeles; California State University, Monterey Bay; California State University, Sacramento; California State University, Stanislaus; Chaffey College; De Anza College; East Los Angeles College; MiraCosta College; Modesto Junior College; Moorpark College; Santa Clara University; University of California, Berkeley; University of California, Davis; University of California, Los Angeles; University of California, Merced; University of Southern California; West Valley College, Saratoga.

founded by youth

youth on staff

youth on board

youth plan, direct or implement programs/services, including advocacy

WHAT DO PROVIDERS NEED TO KNOW IN ORDER TO SUPPORT YOUTH IN AUTHENTICALLY YOUTH-LED WORK?

"One of the first things I tell people is that **this is hard work!** It is not fair or realistic to expect to be able to just hand a young person a leadership role without truly supporting their growth and development as a leader. I think there's a misconception in the youth-led field that you can just jump into the work with no preparation or special training, and that's not true. **It takes planning and it takes a commitment to program development like no other I've seen before.**

In truly supporting youth led services, we are obligated to provide the necessary coaching and the willingness to engage in really hard conversations with young people. To do it right, you have to be able to share power with young people. I wish more people could understand what authentic youth engagement and leadership looks like and understand that it's not something that you just do. **It's something that you live.** It's something you design your entire agency around because it takes that level of commitment"

—AMBER TWITCHELL, DIRECTOR OF VOICES

WHAT DOES THIS WORK LOOK LIKE WHEN IT'S TRULY RUN BY YOUNG PEOPLE?

"Honestly, it's a beautiful thing because you have this group of young people who are on fire and super passionate. Everybody at the Epicenter wants to make some kind of change. We're all a little different. I'm more focused on foster care and systems involved youth, my coworker is focused on LGBTQ youth, and other colleagues have different focuses, but overall our main focus is to give other youth opportunities in the community to flourish and grow and take control of their lives. **So it looks beautiful. It's passion.** It can definitely be messy, too, because the coworkers are youth so they have baggage and things that they're working through, but it's even better because of that—I often see they use that to push them.

Epicenter is youth led and youth run. All but two of the Epicenter staff members are younger than 25—only the executive director and the program manager are older. **We hire, we fire, we plan programs—we decide what programs we want and what that's going to look like.** The center is our center. And that's really unusual because often in organizations youth aren't really heard because there's a hierarchy, and the older you are, the more prestigious you are, so youth are overlooked. They're not taken seriously. But that's the difference with the Epicenter. Just like CYC, the youth are at the forefront, and that's awesome. I was a member of CYC before I worked at the Epicenter, and CYC showed me that: I'm young but my words still matter. Now in my work at the Epicenter, when I have something to say, I'm going to say it."

—SUMMER RAE WORSHAM, 22, YOUTH ADVOCATE, THE EPICENTER & CYC MEMBER

CONCLUSION

The over five million Californians between the ages of 16 and 25 deserve to have access to the mental health supports and services they need in order to thrive during these years of great neurological, emotional, and social development. As they transition from adolescence to adulthood, many of them will develop mental health conditions that threaten to disconnect them from vital relationships as well employment and education. Stigma about mental illness may prevent them from seeking help, and at the same time, internal and external barriers to accessing services may hinder them.

Over the course of the three-year project, the No Stigma, No Barriers Collaborative aims to ensure that California's local and statewide systems provide access to high quality, responsive supports and services to improve mental health outcomes for these young people and their families. Drawing upon the personal and professional experience of the young people leading it, the Collaborative will elevate youth voice and engagement in mental health services planning and delivery locally and statewide. The Collaborative looks forward to joining other TAY leaders around the state in advocating for the supports they know to be effective in helping young people with mental health needs "get back into life."

> "You need to know who you are.
> You need to know what you can do in life.
> Having that, or not, really determines your future."
>
> **—SUSAN PAGE, 25 YMA BLOGGER AND CYC SF CHAPTER MEMBER**

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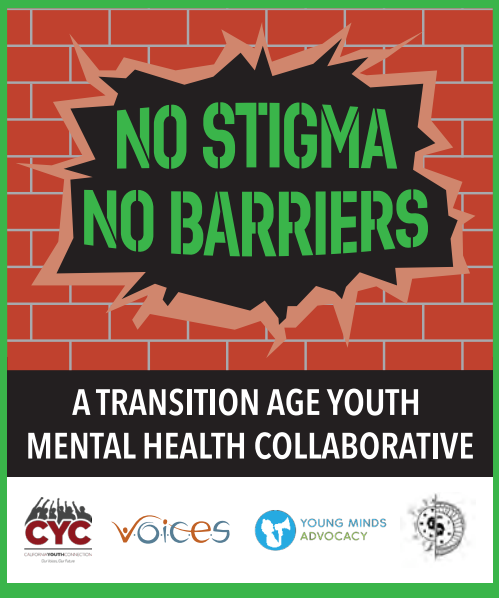
MHSOAC

Mental Health Services
Oversight & Accountability Commission



www.nostigmanobarriers.org

Quarterly Schedule

- Y2Q1: July 2017 –September 2107
- Y2Q2: October 2017 – December 2017
- Y2Q3: January 2018 – March 2018
- Y2Q4: April 2018 – June 2018

Deliverable 1: State of the Community (SOC) Report

REPORTING PERIOD	ACTIVITY	WORK PRODUCT	DUE DATE	COMPLETION DATE	NOTES	ATTACHMENT
Y2Q2	**Annual Report Development**	Outline	January 2018	January 2018	**Submitted to OAC 1/2018**	
Y2Q4	**Annual Report Development**	Draft 1	June 2018	*In Progress*		
Y2Q4	**Annual Report Development**	Final SOC	June 2018	*In Progress*		

Deliverable 2: Training and Education

REPORTING PERIOD	ACTIVITY	WORK PRODUCT	DUE DATE	COMPLETION DATE	NOTES	ATTACHMENT
Y2Q2	**Y2 Training and Education Plan**	Training Plan	December 2017	December 2017	**Submitted to OAC 1/2018**	
Y2Q2	**Catalogue of existing materials and curricula**	Materials List	December 2017	December 2017	**Submitted to OAC 1/2018**	
Y2Q4	**Local Training – Southern Region**	Materials/Sign-in	June 2018	*In Progress*		
Y2Q4	**Local Training - Superior Region**	Materials/Sign-in	June 2018	*In Progress*		
Y2Q4	**Local Training – Los Angeles Region**	Materials/Sign-in	June 2018	*In Progress*		
Y2Q4	**Local Training – Central Region**	Materials/Sign-in	June 2018	*In Progress*		
Y2Q4	**Local Training – Bay Area Region**	Materials/Sign-in	June 2018	*In Progress*		
Y2Q4	**TAY Training (additional/enhanced training #1)**	Materials/Sign-in	June 2018	*In Progress*		
Y2Q4	**TAY Training (additional/enhanced training #2)**	Materials/Sign-in	June 2018	*In Progress*		
Y2Q2	**Ongoing analysis and research to generate county specific training materials**	Y2Q2 Training Report	December 2017	December 2017	**Submitted to OAC 1/2018**	
Y2Q3		Y2Q3 Training Report	March 2018	*In Progress*	***Transition to new reporting template; completion 5/2018***	
Y2Q4		Y2Q4 Training Report	June 2018			
Y2Q2	**Ongoing 1:1 Mentoring / coaching efforts to support youth in local and/or state advocacy activities**	Y2Q2 Training Report	December 2017	December 2017	**Submitted to OAC 1/2018**	

Y2Q3		Y2Q3 Training Report	March 2018	*In Progress*	***Transition to new reporting template; completion 5/2018***	
Y2Q4		Y2Q4 Training Report	June 2018			
Y2Q4	**State-Level Youth-Led Training #1 on MH systems, stakeholders, and decision makers**	Materials/Sign-in	June 2018			
Y2Q4	**State-Level Youth Led Training #2 on MH systems, stakeholders, and decision makers**	Materials/Sign-in	June 2018			
Y2Q4	**Local Community/Stakeholder Education Event #1**	Materials/Sign-in	June 2018			
Y2Q4	**Local Community/Stakeholder Education Event #2**	Materials/Sign-in	June 2018			
Y2Q4	**Local Community/Stakeholder Education Event #3**	Materials/Sign-in	June 2018			
Y2Q4	**State-level Community/Stakeholder Education Event #1**	Materials/Sign-in	June 2018			
Y2Q4	**State-level Community/Stakeholder Education Event #2**	Materials/Sign-in	June 2018			
Y2Q2	**Legislature/State Administration engagement activities including presentations, testimony**	Y2Q2 Training Report	December 2017	December 2017	**Submitted to OAC 1/2018**	
Y2Q3		Y2Q3 Training Report	March 2018	*In Progress*	***Transition to new reporting template; completion 5/2018***	
Y2Q4		Y2Q4 Training Report	June 2018			

Deliverable 3: Outreach and Engagement

REPORTING PERIOD	ACTIVITY	WORK PRODUCT	DUE DATE	COMPLETION DATE	NOTES	ATTACHMENT
Y2Q1	**Y2 Communications Plan**	Communications Plan	September 2017	September 2017	**Submitted to OAC 10/2017**	
Y2Q2	**Ongoing Communication Efforts (web, social media, etc)**	Y2Q2 Comm Report	December 2017	December 2017	**Submitted to OAC 1/2018**	
Y2Q3		Y2Q3 Comm Report	March 2018	*In Progress*	***Transition to new reporting template; completion 5/2018***	
Y2Q4		Y2Q4 Comm Report	June 2018			
Y2Q4	**Outreach Event – Bay Area**	Materials/ Sign-in	June 2018			
Y2Q4	**Outreach Event – Superior Region**	Materials/ Sign-in	June 2018			
Y2Q4	**Outreach Event – Southern Region**	Materials/ Sign-in	June 2018			
Y2Q4	**Outreach Event – Los Angeles**	Materials/ Sign-in	June 2018			
Y2Q4	**Outreach Event – Central Region**	Materials/ Sign-in	June 2018			
Y2Q1	**Fact Sheet/Infographic**	Fact Sheet/Infographic	September 2017	September 2017	**Submitted to OAC 10/2017**	
Y2Q3	**Fact Sheet/Infographic**	Fact Sheet/Infographic	March 2018	*In Progress*	***Transition to new reporting template; completion 5/2018***	
Y2Q4	**Fat Sheet/Infographic**	Fact Sheet/Infographic	June 2018			

Y2Q1	**Regional Council Meeting #1**	Agenda	September 2017	September 2017	**Submitted to OAC 10/2017**	
Y2Q2	**Regional Council Meeting #2**	Agenda	December 2017	*In Progress*	***Transition to new reporting template; completion 5/2018***	
Y2Q3	**Regional Council Meeting #3**	Agenda	March 2018	*In Progress*	***Transition to new reporting template; completion 5/2018***	
Y2Q4	**Regional Council Meeting #4**	Agenda	June 2018			
Y2Q3	**Spring Conference Presentation**	Presentation	March 2018	*In Progress*	***Transition to new reporting template; completion 5/2018***	
Y2Q4	**Summer Conference Presentation**	Presentation	June 2018			

Deliverable 4: Advocacy

REPORTING PERIOD	ACTIVITY	WORK PRODUCT	DUE DATE	COMPLETION DATE	NOTES	ATTACHMENT
Y2Q1	**Y2Q1 advocacy activities to include reporting on *Setting the Strategic Agenda*, *Strategy to Action*, and *Assessment of Actions* including:** • **County research** • **Local partners/stakeholders** • **TAY recruitment/engagement** • **TAY training** • **TAY governance meetings** • **Technical assistance**	Y2Q1 Activity Report	September 2017	September 2017	**Submitted to OAC 10/2017**	
Y2Q2	**Y2Q2 advocacy activities to include reporting on *Setting the Strategic Agenda*, *Strategy to Action*, and *Assessment of Actions* including:** • **County research** • **Local partners/stakeholders** • **TAY recruitment/engagement** • **TAY training** • **TAY governance meetings** • **Technical assistance**	Y2Q2 Activity Report	December 2017	December 2017	**Submitted to OAC 1/2018**	

Y2Q3	**Y2Q3 advocacy activities to include reporting on *Setting the Strategic Agenda*, *Strategy to Action*, and *Assessment of Actions* including:** • **County research** • **Local partners/stakeholders** • **TAY recruitment/engagement** • **TAY training** • **TAY governance meetings** • **Technical assistance**	Y2Q3 Activity Report	March 2018	*In Progress*	***Transition to new reporting template; completion 5/2018***	
Y2Q4	**Y2Q4 advocacy activities to include reporting on *Setting the Strategic Agenda*, *Strategy to Action*, and *Assessment of Actions* including:** • **County research** • **Local partners/stakeholders** • **TAY recruitment/engagement** • **TAY training** • **TAY governance meetings** • **Technical assistance**	Y2Q4 Activity Report	June 2018			

CYC Launches Youth Mental Health Collaborative

"Regardless of identity or specific system involvement, mental health connects all youth populations because we're all humans who have faced this adversity. And something we all share is an independent spirit, a strong will, and a tendency to not rely on anyone else or ask for help...It's that common ground that makes peer engagement such an effective way to get through to people." *—J. CORTEZ III, CYC ADVISORY BOARD CO-CHAIR*

California Youth Connection and its partners Youth In Mind, Young Minds Advocacy, and PEERS have launched a joint effort to facilitate the direct engagement of transition aged youth (TAY) ages 16–25 with California's state and local mental health systems. Funded by a three-year contract with the Mental Health Services Oversight and Accountability Commission (MHSOAC), this youth-led collaborative will conduct Outreach, Training, and Advocacy activities at the state and local levels to improve outcomes among TAY.

Over the three-year project, youth will lead efforts focused on improving the effectiveness of services and supports, reducing stigma, and increasing equity through:

- Community engagement and education campaigns
- Training for TAY and other community stakeholders
- Local and statewide advocacy

California's Mental Health Services Act (MHSA), approved by voters in 2004, plays a major role in funding innovative mental health services, mental health treatment, prevention and early intervention, education and training to people of all ages affected by mental illness throughout the state. MHSOAC oversees the investment of MHSA dollars, and provides vision and leadership to California's public mental health systems, in collaboration with clients, their families, and underserved communities. The act requires that MHSOAC utilize transparent and collaborative processes to determine the mental health needs, priorities, and services for California mental health consumers—contracting with CYC and its partners ensures that these values are upheld for TAY.

For more information contact info@nostigmanobarriers.org

California Youth Connection (CYC) is a statewide organization comprised entirely of youth ages 14–24 with direct experience of our state's foster care, mental health, and juvenile justice systems. CYC facilitates youth-led organizing, education, and advocacy, providing a transformational experience of community and individual empowerment.

www.calyouthconn.org

PEERS confronts mental health stigma by delivering support groups, workshops, and community outreach. We are the premier peer-led mental health alternative for Alameda County residents.

www.peersnet.org

Youth In Mind (YIM) is a nonprofit organization founded and steered by youth affected by the mental health system. Youth In Mind members participate in multiple levels of leadership and advocacy, including member leadership summits, mental health conferences, and local advocacy activities with the purpose of promoting positive change through authentic youth engagement.

www.yimcal.org

Young Minds Advocacy (YMA) is a nonprofit organization founded to address the number one health issue facing young people and their families—unmet mental health needs. Using a blend of policy research and advocacy, impact litigation, and strategic communications, YMA works to change attitudes towards mental illness and break down barriers to quality mental healthcare for young people and their families.

www.ymadvocacy.org

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Stakeholder Contract Update | Transition Age Youth: California Youth Connection (CYC)

May 24, 2018 | MHSOAC Commission Meeting

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 (TAY), and veterans through education, advocacy, and outreach efforts. These contracts are awarded on a competitive basis.

Background

In November 2004, California voters passed Proposition 63, the Mental Health Services Act (MHSA). The passage of the MHSA initiated, at the state and local levels, the concept of transparent and collaborative processes to determine the mental health needs, priorities, and services for California mental health consumers.

Welfare and Institutions (W&I) Code Section 5892(d) requires the Mental Health Services administrative fund to "include funds to assist consumers and family members to ensure the appropriate state and county agencies give full consideration to concerns about quality, structure of service delivery, or access to services." In response, the Commission makes available Stakeholder advocacy funds through a series of contracts to support consumer and family member outreach, education and training, and advocacy. These contracts, originally awarded on a sole source basis, were transferred to the MHSOAC after the dissolution of the Department of Mental Health (DMH) in 2011.

Transition from Sole Source to Competitive Bid

Through 2015, the Commission administered four contracts for activities supporting consumers, family members, parent/caregivers, and transition age youth. These contracts were for varied amounts and activities and were awarded on a non-competitive basis.

The 2015/16 Budget Act increased the funds in the Commission's budget, adding funding to support advocacy for diverse racial and ethnic communities and veterans. In budget discussions, the Legislature required stakeholder contracts be awarded through a competitive process.

To prepare for the transition from sole source awards to a competitive bid process, Commission staff conducted interviews with current contractors and held public meetings to facilitate stakeholder discussions and activities to share lessons learned, highlight successes, and discuss challenges. These discussions provided an opportunity for the stakeholder community to provide feedback on potential opportunities and areas of need.

Budget Act Changes

In May 2016, consistent with the changes in the Budget Act, the Commission initiated a competitive request for proposal (RFP) process for contracts to conduct work focused on the following populations:

- Clients/Consumers
- Diverse Racial and Ethnic Communities
- Families of Clients/Consumers
- Parent/Caregivers of Children/Youth (under 18 years)
- Transition Age Youth (ages 16-25 years)
- Veterans

In July 2016, the Commission issued a Notice of Intent to award to CYC for a TAY contract. The remaining RFPs were cancelled as there were no other proposals that met the award criteria. The Commission directed staff to review and re-release the RFPs. The second procurement process was completed in March of 2017.

During the first round of procurement, through the Budget Act of 2016-2017, the Legislature added an additional contract for the LGBTQ community as well as increased the Commission's budget for all advocacy contracts, bringing the total for all contracts to $670,000 per year for a three year total of $2,010,000. As a result of this increase, an additional $170,000 per year (a three year total of $510,000) was made available for the TAY population to be awarded through a new competitive process. The procurement process for the additional TAY funding was completed in November 2017. In March 2018, CYC was awarded the second contract for $170,000 per year for a three year total of $510,000.

At this time, CYC holds two stakeholder contracts with the MHSOAC. One provides $500,000 per year and will continue through June 2019. The second, provides $170,000 and will continue through June 2021.

About California Youth Connection (CYC)

CYC is a statewide, youth-led organization focused on supporting youth leadership and advocacy to improve California's foster care system by promoting opportunities for youth to speak with policymakers and engaging youth in policy development. CYC has more than 30 local chapters and serves more than 500 youth members, ages 14-24, throughout the state. CYC members reflect the diversity of the state's 72,557 foster youth, the majority of whom are of color and 100% of whom are low-income. The mission of CYC is to develop leaders who empower each other and their communities to transform the system through legislative, policy, and practice change.

The work completed by CYC under these contracts is under the youth-developed and youth-led project *"No Stigma, No Barriers*". The project is a collaboration between CYC, and other youth-led organizations including Youth in Mind, Young Minds Advocacy, Humboldt County Transition Age Youth Collaborative, and PEERS.

Contract Scope of Work

Contract 1

Work on CYC's original contract is focused on four primary deliverables included in the scope of work as outlined in the Commission's Request for Proposals. The four deliverables are:

- Development of an Annual State of the Community Report
- Training and education for stakeholders, community member, and local and state decision makers
- Local and state-level outreach and engagement efforts
- Local and state-level advocacy activities

Deliverable 1: Annual State of the Community Report

The Annual State of the Community Report will present a cumulative portrait of the TAY population including details of the key mental health issues and will include an overview of the unique needs and characteristics of the target population, a summary of resources available, changes over the past year/years, and opportunities to improve mental health policy, programs, and outcomes.

Deliverable 2: Training and Education

The training and education deliverables include two separate components: one for TAY and one for local and state policy makers, providers, the general public, and those who work with and on behalf of the target population.

CYC conducts training and education activities at both the state and local level that are focused on skills development, and increasing knowledge, awareness, and understanding of TAY mental health issues. Training and education activities are designed for multiple audiences including TAY, community members, and mental health stakeholders. The state and local training activities are guided by a TAY Curriculum Development Team that will collect, evaluate, and adapt existing curricula, and/or identify community partners to support curriculum development.

Trainings take place across California, with at least one training per year in the Northern, Bay Area, Central Valley, Southern, and Los Angeles regions. Trainings are youth-led and youth-developed with a focus on systems understanding and navigation, advocacy skill development, and youth leadership.

Deliverable 3: Outreach, Engagement, and Communication

Outreach, engagement, and communication efforts support positive messaging around mental health to decrease stigma, discrimination, and negative attitudes, beliefs, and stereotypes around mental health and mental illness. These deliverables include activities at both the state and local level.

CYC's activities are focused on informing, engaging, and empowering TAY to effectively influence policies and programs at both the state and local level, encourage access and linkage to community services and supports, promote wellness and resiliency, and improve outcomes.

Through this contract, CYC conducts youth-led presentations, outreach events, and participates in state level conferences across the state to support the strategies as outlined above.

Local Level Strategy

Local-level outreach, engagement, and communication strategies are designed to identify, engage, and inform TAY with experience in mental health systems throughout the state, provide opportunities for youth to share their stories, develop a statewide network of local TAY-led and TAY-supportive advocacy and stakeholder groups, and enlist TAY and their supporters from around the state.

State Level Strategy

State-level outreach, engagement, and communications strategies are designed to provide a broad audience of stakeholders and potential allies with accessible information, amplify youth voice, and leverage outreach, engagement, and communications activities to support state-level advocacy.

Deliverable 4: Advocacy

Advocacy activities increase the voice and support meaningful participation of consumers and family members in the decision making process. Activities include support for collaboration among counties, community-based organizations, and stakeholders in mental health service delivery. These deliverables include activities at both the state and local level.

Local-level activities include advocacy for mental health services at county mental health departments, Boards of Supervisors, and with community based organizations and other local entities.

State-level activities include interaction with policy leaders and legislative staff, state agencies and entities, as well as participation in activities of the Commission.

The goal of CYC's advocacy activities include:

- Strengthen capacity to continually focus positive attention and activities on mental health issues as experienced by TAY
- Articulate, prioritize, and coordinate TAY needs
- Improve decision-making regarding mental health policies and programs locally and statewide to better reflect the TAY mental health needs
- Achieve better policy and program outcomes for TAY, consistent with their strengths and needs and the purposes of the MHSA

Contract 2

In March 2018, CYC was awarded the second contract for $170,000 per year for a three year total of $510,000. This contract is focused on local level activities and events designed to encourage and support youth engagement with local decision making bodies (i.e. Boards of Supervisors and Mental Health Boards).

Through this contract, CYC will conduct 5 local level events per year, one in the Northern, Bay Area, Central Valley, Southern and Los Angeles regions. Each event includes a youth-led outreach event as well as a presentation on TAY mental health needs to the county Board of Supervisors or local Mental Health Board. The goal for these activities is to increase representation of TAY in the local decision making process as well as increased representation of youth on local boards and commissions.

Contract Monitoring

All contract activities are monitored on a quarterly basis to ensure progress toward completion. CYC reports to the MHSOAC quarterly on activities completed and underway through the submission of a deliverable tracking tool. This tool includes all contract activities as outlined in the work plan of the proposal submitted during the procurement process. Each contractor submits their tracking tool within 30 days of the end of each quarterly activity period. Included with the tool are any work products or documentation that supports completion of contract activities. For example, for a training, documentation may include a sign in sheet and a copy of all training materials.

MHSOAC staff reviews the tracking tool and all associated work products. Staff then meets with CYC to review work completed. This quarterly meeting provides an opportunity to highlight achievements and successes as well as address any challenges or lessons learned as a result of the work underway.

Contract 1: CYC has completed tasks and activities through Year Two, Quarter 3 on their first contract and is working with the Commission to finalize reporting on those activities.

Contract 2: CYC is in progress on activities for Year One, Quarter One of their second contract.

Staff Comments

The contracts held by CYC are the first contracts awarded under the new competitive process conducted by the Commission.

Although there has been a learning curve involved for both CYC and the Commission, the transition to a competitive process has been positive. CYC brings many years of experience working with youth across many systems including mental health, and education.

As a child welfare youth-driven organization, CYC is dedicated to the support and expansion of youth leadership and voice in the decision-making process. They have a high level of engagement at both the state level and at the local level with their efforts resulting in a number of youth appointments on local boards and commissions. CYC's reports are received on time and activities have been completed as outlined in their proposal and work plan.

Recognizing that CYC began their Stakeholder contract work for the Commission in advance of other contract holders, CYC has provided support to other contractor holders through their lessons learned, specifically around the challenges of starting up a new and large state contract and the development and mechanics of operating a large collaboration with partner agencies.