



WELLNESS · RECOVERY · RESILIENCE



Commission Packet

Commission Meeting
July 26, 2018

MHSOAC
1325 J Street, Suite 1700
Sacramento, CA 95814

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

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

1325 J Street, Suite 1700
Sacramento, California 95814

Commission Meeting Agenda

July 26, 2018
8:45 AM – 4:05 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.

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John Boyd, Psy.D.
Chair

AGENDA
July 26, 2018

Khatera Aslami-Tamplen
Vice Chair

Approximate Times

8:45 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, Christina Parker. Roll call will be taken.

8:50 AM Announcements

8:55 AM Action

1: Approve May 9, 2018 and May 24, 2018 MHSOAC Meeting Minutes

The Commission will consider approval of the minutes from the May 9, 2018 and the May 24, 2018 meetings.

- Public Comment
- Vote

9:00 AM Recognition of Commissioner Emeritus Linford Gayle

Presenters:

- Vice Chair Aslami-Tamplen
- Jairo Wilches, Committee Member, California Mental Health and Spirituality Initiative
- Suzanne Aubry, Director, Office of Consumer and Family Affairs
- Claudia Saggese, Coordinator, Office of Consumer and Family Affairs

The Commission will recognize the work and contributions of the late Commissioner Emeritus Linford Gayle who passed away on April 4, 2018.

- Public Comment

9:30 AM Information

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

Presenters:

- Joy Anderson, Policy Coordinator, California Youth Connection
- Kimberly Coronel, Representative, "No Stigma, No Barriers"
- Smitha Gundavajhala, Representative, "No Stigma, No Barriers"
- Cecelia Najera, Representative, "No Stigma, No Barriers"
- Christina Parker, Representative, "No Stigma, No Barriers"

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

- Public Comment

10:00 AM **Action**
3: Budget Overview
Presenter: Norma Pate, Deputy Director

The Commission will consider approval of its Fiscal Year 2018-19 Operations Budget and will hear an update on expenditures.

- Public Comment
- Vote

10:10 AM **Action**
4: Triage Grant Funding
Presenter: Norma Pate, Deputy Director

The Commission will determine how to allocate Triage funding in recognition of funding reductions.

- Public Comment
- Vote

10:40 AM **Information**
5: Innovation Dashboard and Presentations
Presenter: Sharmil Shah, Psy.D., Chief of Program Operations

Commission staff will provide an overview of efforts to track county Innovation Plans and an update to the Innovation Toolkit.

10:50 AM **Action**
6: Ventura County Innovation Plans
Presenters:

- Kiran Sahota, MA, Senior Behavioral Health Manager, Ventura County
- Hilary Carson, MSW, Innovations Administrator, Ventura County
- Erik Sternad, Executive Director, Interface Children and Family Services

The Commission will consider approval of \$241,367 to support the Suicide Prevention Project: Bartenders as Gatekeepers Innovation Project, and \$438,933 to support the Push Technology Innovation Project for Ventura County.

- Public Comment
- Vote

11:45 AM **General Public Comment**
Members of the public may briefly address the Commission on matters not on the agenda.

12:00 PM **Lunch Break**

1:00 PM

Information

7: 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.

Enclosures:

(1) The Motions Summaries from the May 9, 2018 and the May 24, 2018;
(2) Evaluation Dashboard; (3) Calendar of Commission activities;
(4) Innovation Dashboard; (5) Department of Health Care Services Revenue and Expenditure Reports status update.

- Public Comment

1:10 PM

Action

8: Imperial County Innovation Plan

Presenters:

- Maria L. Wyatt, Behavioral Health Manager, Imperial County
- Jose Lepe, Behavioral Health Manager, Imperial County

The Commission will consider approval of \$531,120 to support extension of the Imperial County First Step to Success Innovation Project previously approved by the Commission in March 2014.

- Public Comment
- Vote

1:40 PM

Action

9: Del Norte County Innovation Plan

Presenters:

- Jack Breazeal, Clinical Services Manager, Department of Health and Human Services, Mental Health Branch
- Angela Glore, Ph.D., Executive Director, First 5 Del Norte

The Commission will consider approval of \$262,846 to support the Del Norte County Text 2 Grow: Giving Resource Outreach and Wellness Innovation Project.

- Public Comment
- Vote

2:10 PM

Action

10: Legislation

Presenters:

- Norma Pate, Deputy Director
- Gregory Cramer, Policy Consultant, Senator Beall's Office
- Angela Hill, Fellow, Senator Weiner's Office
- Adrienne Shilton, Government Affairs Director, Steinberg Institute

The Commission will consider legislative priorities. In addition, the Commission has been asked by the authors to consider supporting Senate Bill 192 (Beall) and Senate Bill 1004 (Weiner and Moorlach).

- Public Comment
- Vote

2:30 PM

Information

11: Innovation Incubator Draft Business Plan

Presenters:

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

The Commission will be presented with a draft Business Plan for the development of an Innovation Incubator.

- Public Comment

2:50 PM

Information

12: Technology Suite Collaborative Innovation Project Update

Presenters:

- Karin Kalk, Project Manager, Los Angeles County
- Tom Insel MD, Co-founder, Mindstrong Health, Advisor, 7 Cups
- Bill Walker, LMFT, Director, Kern County
- Ronald (Ronnie) Gilbert, Operations Manager at Sunray's of Hope

The Commission will hear an update on the Technology Suite Collaborative Innovation Project and explore next steps.

- Public Comment

3:50 PM

General Public Comment

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

4:05 PM

Adjourn

AGENDA ITEM 1

Action

July 26, 2018 Commission Meeting

Approve May 9, 2018 and May 24, 2018 MHSOAC Meeting Minutes

Summary: The Mental Health Services Oversight and Accountability Commission will review the minutes from the May 9, 2018 and May 24, 2018 meetings. Any edits to the minutes will be made and the minutes will be amended to reflect the changes and posted to the Commission Web site after the meeting. If an amendment is not necessary, the Commission will approve the minutes as presented.

Presenter: None.

Enclosures (2): (1) May 9, 2018; and (2) May 24, 2018 Meeting Minutes.

Handouts: None.

Proposed Motion: The Commission approves the May 9, 2018 and May 24, 2018 Meeting Minutes.

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

State of California

MENTAL HEALTH SERVICES OVERSIGHT AND ACCOUNTABILITY COMMISSION

Minutes of Meeting
May 24, 2018

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

866-817-6550; Code 3190377

Members Participating:

John Boyd, Psy.D., Chair
Khatera Aslami-Tamplen, Vice Chair
Reneeta Anthony
Lynne Ashbeck
Senator Jim Beall

Keyondria Bunch, Ph.D.
Itai Danovitch, M.D.
David Gordon
Mara Madrigal-Weiss
Gladys Mitchell

Members Absent:

Mayra Alvarez
Sheriff Bill Brown
Assemblymember Wendy Carrillo

Larry Poaster, Ph.D.
Tina Wooton

Staff Present:

Toby Ewing, Ph.D., Executive Director
Filomena Yeroshek, Chief Counsel
Norma Pate, Deputy Director, Program,
Legislation, and Technology

Brian Sala, Ph.D., Deputy Director,
Evaluation and Program Operations

CONVENE AND WELCOME

Chair John Boyd called the meeting of the Mental Health Services Oversight and Accountability Commission (Commission) to order at 9:12 a.m. and welcomed everyone. Filomena Yeroshek, Chief Counsel, called the roll and confirmed the presence of a quorum.

Chair Boyd reviewed the meeting protocols.

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 Julia Ransom to introduce herself.

Julia Ransom, a junior in high school in Orange County, stated she became involved with mental health after her younger brother, James, died by suicide in November of 2016. She stated she had become an advocate and works to represent the youth voice and bring about change for youth.

Meeting Calendar

There is no June Commission meeting. The July meeting location is yet to be determined.

New Personnel

Executive Director Toby Ewing introduced the new Interim Communications Director, Elisa Bupara, who is a retired annuitant, and fellows Hieu Mai and Elizabeth Pieper, who are with the California Capital Fellows Program.

Executive Director Ewing stated Moshe Swearingen will be relocating to the Central Valley. He thanked Mr. Swearingen for his contributions during his years with the Commission.

Consumer/Family Voice

Chair Boyd suggested at the February Commission meeting that future Commission meetings should begin with an individual with lived experience sharing their story. He stated the hope that this will be a part of Commission meetings hereafter. In keeping with that suggestion, the Commission has invited Courtney Ransom to share her story of recovery and resilience.

Courtney Ransom shared the story of her son James, who received a head injury while playing sports and began exhibiting mental health issues. He was hospitalized for one month and released without a treatment plan or help to navigate the system, and, after several attempts over a period of time, died by suicide at the age of 13, approximately one and a half years ago. She stated the things that improved his mental health during difficult times were physical therapy, philanthropy, pet therapy, religion, his psychiatrist, and medication. She suggested several things to help suicidal clients and their family members. These suggestions included, early childhood evaluation, base-lining relationships with pediatricians and psychologists, evaluating family history, community

planning to improve ways for kids to connect, resources for children, programs for children with anxiety, peers and parent support groups, better insurance reimbursement mechanisms, collaboration between practitioners and insurance companies, and cooperatives.

Ms. Ransom stated her son's story is not isolated to underserved communities – everyone in California is underserved right now in this area.

Commissioner Questions and Discussion

Commissioner Mitchell stated what Ms. Ransom went through is unconscionable – to send a child home after a 30-day stay in a hospital with basically nothing and nowhere to go other than more appointments when it was clear that something was going on. She asked the Commission to imagine the children of color who do not have the personal resources and family members that Ms. Ransom had. She stated this issue is serious. There are lives at stake. Everything the Commission does has to be intentional to close the gaps.

ACTION

1: Approve April 26, 2018, MHSOAC Meeting Minutes

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

The Commission approves the April 26, 2018, Meeting Minutes.

Motion carried 8 yes, 0 no, and 2 abstain, per roll call vote as follows:

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

The following Commissioners abstained: Commissioners Ashbeck and Madrigal-Weiss.

INFORMATION

2: Suicide Prevention Project

Chair Boyd stated the Legislature gave \$100,000 to the Commission to lead this project to develop a statewide strategic plan for suicide prevention.

Vice Chair Aslami-Tamplen stated there was a Suicide Prevention Subcommittee meeting yesterday. She stated Ashley Mills, Project Lead, has done great work in bringing excellent individuals together to discuss this important subject with a clear focus on how to make a difference in individuals' lives and prevent suicides.

Ms. Mills welcomed the speakers for the three panels. She stated this is incredibly important work and is honored to support the Commission in helping to develop this Statewide Suicide Prevention Plan to save lives.

Panel 1: Survivors of Suicide Loss and Attempt

- 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

John Black

John Black, B.A., L.E., CEO of Peer Recovery Art Project Inc., and loss survivor, stated he has had many friends who have died by suicide. He shared the story of his wife Linda, who was an advocate, helped peers across the state, and started a nonprofit organization that won awards across the county for helping peers support one another; yet, she took her own life approximately two years ago.

Mr. Black stated he operates on the Bruce Anderson core gift theory but found that his giving could never outrun his wound. He stated Mr. Anderson told him that in rare circumstances a person cannot outgive to run away from a wound – and that Mr. Black had given too much and now needed to receive from others. Mr. Black stepped back from all he was doing, started seeing his wife's therapist, endured several medication changes, hired a health coach, and today is continuing on his journey to heal.

Kelechi Ubozoh

Kelechi Ubozoh, Senior Program Associate, Resource Development Associates, and attempt survivor, shared her story of surviving multiple suicide attempts from a young age. Her mother is a primary care physician, and was able to advocate bad hospitalization situations on her behalf. She pointed out that many other people of color do not have that.

Ms. Ubozoh stated her grandmother helped raise her and, when she passed away, Ms. Ubozoh felt her world had ended. This caused her to go through many hospitalizations during ages 13 to 15, which was terrifying. The Black community told her mental health is not a Black issue – that she needed to pray it away and get over herself. That and the terrifying experience of the hospital taught her to pretend she was okay. She put on a mask, presented well, and told no one even though every day she was suicidal.

Ms. Ubozoh stated she could no longer pretend to be okay after she was attacked. She reached out for help by going to a psychiatric hospital and asking for help because of her thoughts of suicide. They told her she presented well. She told them she has no choice but to present well because she is a Black woman. The hospital staff did not understand; they told her she did not need anything because she was able to articulate that she needed something. Communities of color present mental health very differently. Some people think it is anger when it is trauma; those people end up being incarcerated and not given the psychiatric help they need. She stated, when she presented her mental health issues, the psychiatric hospital rejected her so she attempted suicide a week later and ended up in that same hospital, which was a terrifying experience that gave her no help.

Ms. Ubozoh stated, when she left that psychiatric hospital, her mother suggested that they get some real help, something different. She got some trauma-informed care, which meant that individuals acknowledged that she should be part of her own recovery. This was very expensive. Ms. Ubozoh learned to remove toxic people, create boundaries, reflect on why she pretends to be happy and healthy, and work on actually becoming happy and healthy. She said happiness is fluid; healthiness is the goal. This creates a safety net so when the suicidal thoughts return there is a plan – who to call, where to go, and what services are needed.

Ms. Ubozoh stated she reached out to peers, family members, and crisis support networks to gather culturally-relevant strategies for the MHSOAC's work on the Statewide Suicide Prevention Plan. The feedback she received is as follows:

- Create a safety net for the state.
- Consider employing culturally-specific mental health ambassadors to support suicide prevention planning. Blue suicide is wrongly labeled homicide.
- Involve the voices of suicide attempt survivors and suicide loss survivors in each county.
- Develop culturally-specific suicide prevention outreach tools that feature communities of color.
- Create opportunities for people of color with lived experience or survivors to connect and share their experiences.
- Create alternatives to 9-1-1. Many communities of color avoid calling 9-1-1 because of stigma.
- Strengthen discourse and 5150 education for law enforcement.
- Recognize that outcome-based, evidence-based practices are not always responsive to what consumers need in the moment.
- Increase overall capacity for county crisis support services.
- Strengthen data collection on suicide deaths by incentivizing partnerships with coroners' offices.
- Financially incentivize and hire more peers who are diverse and other behavioral health providers.
- Collaborate with primary care doctors and faith-based congregations/leaders.
- Create clinical support training for first responders such as EMS/EMT and emergency room nurses.
- Provide information and resources to family/friends helping someone that is suicidal.
- Develop several options for suicide prevention trainings.
- Establish statewide peer respite centers.
- Integrate the Zero Suicide model.
- Partner with clinical programs to integrate mandatory intensive and robust suicide prevention training.
- Provide more education and training on assessment for suicide risk and ensure it includes cultural considerations.

Commissioner Questions and Discussion

Vice Chair Aslami-Tamplen encouraged everyone to review the materials Ms. Ubozoh provided, which were included in the meeting packet.

Commissioner Bunch asked about the application shown in one of the slides. Ms. Ubozoh stated there are applications that are isolated and do not connect to individuals in person, but there are other applications that connect individuals to services, crises services, and local resources.

Panel 2: Challenges and Opportunities for Prevention Across the Lifespan

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

Caitlin Ryan

Caitlin Ryan, Ph.D., ACSW, Director, Family Acceptance Project, San Francisco State University, provided an overview, with a slide presentation, on Preventing Suicide and Promoting Well-Being for LGBT Children and Youth and the Family Acceptance Project (FAP), which was included in the meeting packet. She asked the Commission to think about the needs of ethnically, racially, and culturally diverse families with LGBT children who do not have anywhere to go for services. She stated that FAP looked at family acceptance and rejection in communities statewide and identified over 100 ways that parents and caregivers express acceptance and rejection.

Ms. Ryan stated FAP found that parents are the gatekeepers and so much of what is called “conversion efforts” happens at home. She stated, instead of spending money on legislation and regulation lobbying, these efforts should be directed at the home in every language and in every culturally-grounded way. The future can be changed if parents can learn to understand how to love and care for their children in ways that are healthy for them. Ms. Ryan encouraged Commissioners to look at the materials she provided in the meeting packet.

Sharon Birman

Sharon Birman, Psy.D., Center for Deployment Psychology, West Los Angeles Veterans Affairs Medical Center, highlighted the risks in veteran populations. She reviewed the National Suicide Rates: Fact and Figures charts, which were included in the meeting packet. The charts included data that came out of a research study done by the Office of Suicide Prevention published in 2016, the largest epidemiological study in the nation’s history, looking at over 55 million charts to better understand veteran suicide decedents.

Dr. Birman stated veterans present with a higher risk because they come out of service with acquired ability – they have been exposed to death and atrocities, they have a knowledge of lethal means, and they have pain tolerance. She stated 67 percent of suicide deaths in the veteran population are by firearms. She stated there is a need to

reduce access to lethal means. Studies show there is a significant reduction in suicide rates when service members leave their firearms on base when they go home. She stated firearms have the highest fatality ratio in suicides attempts. Other means of suicide attempts offer opportunities for rescue or for change of heart. Individuals can be found or they have the opportunity to call 9-1-1 when they change their mind.

Dr. Birman stated there is a loss of a sense of meaning, a lack of connectedness, and a sense of alienation during the first year after separation from service. It is important to engage community partners, work collaboratively, and reach out to the veteran community. She discussed the Mayor's Challenge for Suicide Prevention to bring together a holistic team of collaborators consisting of law enforcement, 2-1-1 representation, peer support representatives, and others who will start to think about how the community can collaborate more effectively, how to better communicate, how to share resources, and how to share data systems so there can be a continuity of care.

Dr. Birman stated surveillance is one of the most important solutions to target to better understand what is happening in California, to identify the geographical areas at risk, and to target interventions for those populations. She suggested working with the medical examiners and coroners, having standardized templates to pull data, starting to pay more attention to mean safety efforts, providing opportunities for mean safety such as gun locks and lockers, looking at legislation that creates barriers to firearms, disseminating knowledge and recognizing that this is not just a mental health issue, and ensuring that individuals are trained across different types of services. She stated the State of Washington has a model of requirements for suicide prevention education. She stated the need to require that everyone gets this education so they can engage in the assessment and make appropriate referrals.

Carolyn Stead

Carolyn Stead, Psy.D., Senior Director, Integrated Behavioral Health, Institute on Aging (IOA), stated there are common themes among the panel members, even though they serve very different populations, and some of the potential solutions are the same. She stated the IOA is a nonprofit with the mission of enhancing the quality of life for older adults to help them live happy, healthy lives at home. One of the services the IOA provides is behavioral health services.

Dr. Stead stated several years ago, the IOA set up a program called the Center for Elderly Suicide Prevention and included the hotline, Friendship Line program. The 45th anniversary of the Friendship Line will be celebrated this year. The Friendship Line is not only a hotline but a warm line targeting older adults.

Dr. Stead stated it is called the Friendship Line because it was discovered that older adults are not likely to call a line that has suicide or crisis in the name because it is off-putting. The Friendship Line focuses on social connection. It operates tollfree nationwide 24 hours a day, seven days a week, and is staffed by nine staff members and 120 volunteers, many of whom are older adults or peers. Part of the program that is most successful is that only two-thirds of the calls are individuals who call in. The other third are the operators calling out to individuals. Sometimes individuals refer themselves or are referred by a provider or family member. Their names are put on a list and operators call them once a week, once a day, or sometimes twice a day, when needed.

Dr. Stead stated the founder of the Friendship Line says the connection to others is what binds us to life. The idea is to get to know someone and to reach out to them regularly. The operators talk about their partners, pets, things as simple as what they had for breakfast that day or what their daily routine will be. When things maybe do get worse and they feel lonely, struggle with depression, or start to feel suicidal, the operator of the Friendship Line is the first person they call because they know them and they have that connection.

Dr. Stead stated individuals do not only call an 800 number and get somebody on the end of the line – many times they call and reach that one volunteer or staff member that they speak with every week. The main focus is relationships. The program makes and receives approximately 148,000 calls per year.

Dr. Stead stated depression is often missed by primary care providers. Also, older adults are more likely to die by suicide through self-neglect or poor medical care, which may never be acknowledged as suicide. She listed factors that increase risk of suicide in older adults: social isolation and loneliness; recent loss of family, friends, or pets; chronic pain or major illness; changes in mobility; loss of independence; recent hospitalization; substance abuse; and difficulty asking for help.

Dr. Stead suggested ways that the state could support local efforts:

- 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.

Commissioner Questions and Discussion

Commissioner Mitchell asked how to get information for the Friendship Line to doctors' offices and in-home support workers so they can give that number to clients for a simple, user-friendly resource. Dr. Stead stated the IOA does outreach and education and has magnets and brochures. Part of the challenge is the call volume has gone up from 90,000 calls per year four years ago to likely over 150,000 this year. The budget has not changed during those four years. The Friendship Line is a free service but needs support to handle providing the service statewide.

Vice Chair Aslami-Tamplen asked about the budget. Dr. Stead stated it is under \$1 million, which includes rent in San Francisco.

Commissioner Gordon asked if there is a relationship between the University of California, the medical centers, and the Veterans Administration (VA), which does more than host services. Dr. Birman stated not all the UCs are connected to the VA system. It depends on the geographical area. The reality is that veterans receive care outside of the VA or do not receive care at all.

Commissioner Bunch stated many veterans in Los Angeles are not receiving care, not because they do not want to receive care but because they are on long wait lists to go to the VA. She asked what can be done to decrease the wait list and to support

intensive services for veterans who are dealing with suicidal thoughts on a daily basis. Dr. Birman stated there is a variance site to site. The VA has tried to improve access to services but there is a lack of resources and, even if access is given within a short period of time, follow-up is not always available.

Commissioner Anthony suggested establishing an easy resource for physicians to access those resources. Dr. Ryan referred to the suggested solutions on page 5 of her materials.

Ms. Ransom stated Dr. Ryan discussed getting families involved in LGBT issues for their children. She asked about middle school or high school students who do not want to tell their parents first but would rather receive care and resources before having that conversation. She asked how to ensure that the conversation is confidential and that teenagers will feel safe before trying to make their families accept them.

Dr. Ryan stated almost everything that young people hear about families is negative. She agreed that young people need confidential spaces to learn and get support. College counseling centers are exploding nationwide with the need for services for young people dealing with behavioral health situations that need care and support. Not many schools have asked for training on how to serve and support families.

Commissioner Ashbeck stated the Commission needs to be mindful that this is not about always having to have a new idea and that some things do not fit the criteria because it is now new. She asked how to accelerate good work rather than always feeling the urge to create something different or new. The panelists are all doing good work and are good examples. She suggested that the Commission find a way to support the things that are already working. Innovation comes not only in new ideas but maybe in spreading something that already works.

Panel 3: Preventing Suicide and Suicide Attempt Statewide

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

Rajeev Ramchand

Rajeev Ramchand, Ph.D., Senior Behavioral Scientist, RAND Corporation, stated he has been conducting research to help policy makers and practitioners better address and prevent suicide in their communities for the past ten years. As part of that work, Dr. Ramchand led RAND's evaluation of California Suicide Prevention and Early Intervention Initiatives funded under the Mental Health Services Act (MHSA), and administered by the California Mental Health Services Authority (CalMHSA).

Dr. Ramchand highlighted three goals the Commission should consider in designing the statewide suicide prevention plan:

- To provide better care to individuals at risk for suicide and support their families. There are four pathways to achieving this goal: (1) Implement care strategies that

work; (2) Invest in new treatments; (3) Use collaborative care; and (4) Support family members.

- To identify individuals who may be at risk of suicide but who might not yet be benefiting from support services, such as emergency rooms, screenings
- To create environments that are designed to prevent death from suicide, but to do so in a way that is fair and balanced, such as child access prevention laws, monitor the requirement on ligature risk, and support hospitals to enforce it

Commissioner Questions and Discussion

Commissioner Danovitch asked about the top three strategies, how to introduce better incentives, and what measures should be used.

Dr. Ramchand stated much of RAND's suicide prevention efforts are directed toward finding individuals and getting them into mental health treatment. Without good mental health systems in place to deal with individuals who need effective mental health treatment, efforts to get them into mental health treatment will have limited success. Ensuring that a strong mental health system is in place that is prepared to treat suicide risk specifically is a critical component that is often overlooked.

Dr. Ramchand stated, in terms of incentivizing, money does not always need to be thrown at things to get individuals to do them. He suggested making things easier for people. He used the electronic health record (EHR) as an example. It is not incentivized; it is built into what people are already doing. Asking busy emergency departments to screen every patient for suicide risk will be met with resistance and will require a lot of collaboration to figure out a system that will work.

Commissioner Bunch agreed that so much goes into triage and bringing individuals in and then there is nowhere for them to go, and fundamental things such as a stepdown program for individuals who have been on a 30-day hold do not exist. She asked in what way social media can interface.

Dr. Ramchand stated Facebook uses artificial intelligence to monitor and track posts and automatically conducts outreach when things meet their prediction algorithm that are concerning. One way the Friendship Line can think about revenue streams is to partner with hospitals and inpatient facilities so that they can be the ones who do the outreach calls. If inpatient hospitals or emergency departments are required to follow up with patients that screen positive, they can partner with organizations such as the IOA and the Friendship Line to be the ones that do the outreach and provide resources to do what they are already doing.

Brenda Grealish

Brenda Grealish, Acting Deputy Director, Mental Health and Substance Use Disorder Services, Department of Health Care Services (DHCS), provided an overview of the history of the now-defunct Department of Mental Health, the 1991 and 2011 Realignment, suicide prevention campaigns of the past, and current activities of DHCS. She stated behavioral health went from being a centralized process to a decentralized process during Realignment. DHCS has a suicide prevention inbox and receives 10 to 20 emails per

week, analyzes legislative bills, developed a suicide hotline report, and is currently developing a contract with the National Suicide Prevention Lifeline (NSPL).

Karen Smith

Karen Smith, M.D., MPH, Director and State Public Health Officer, California Department of Public Health (CDPH), stated the CDPH categorizes suicide as a form of violence. She stated suicide is an issue at every age. She discussed the impact of violence on Californians. To prevent violence, the underlying social determinants of health and mental health need to be addressed, including the root causes of inequities and social disadvantage. By addressing shared risk factors and increasing the known protective factors, violence can be prevented, including suicide, and overall health can be improved.

Dr. Smith stated public health approaches violence from a population perspective rather than one individual at a time and takes a primary prevention approach by working as far upstream as possible. The CDPH first uses data to understand the issue and describe the problem, and then implements environmental and system-level strategies, policies, and actions to prevent the first-time perpetration of violence. The CDPH also does a lot of facilitation of collaboration among multisector partners to promote effective interventions and support policies that build and sustain not just healthy people but healthy communities.

Dr. Smith stated the CDPH conducts surveillance and studies the epidemiology of different forms of violence. The CDPH's Safe and Active Communities branch administers the California Violent Death Reporting system (CalVDRS), which is part of the Centers for Disease Control's (CDC) National Violent Death Reporting System (NVDRS). This system recently received additional federal funding to expand to all 50 states.

Dr. Smith stated the CDPH also has a California Injury Data Online web-based query system, known as EpiCenter, a resource that can be used by anyone to monitor injury- and violence-related deaths, hospitalizations, and emergency departments in California.

Dr. Smith summarized the programmatic activities at the CDPH, such as the Domestic Violence Training and Education Program, the Rape Prevention and Education Program, and the Teen Dating Violence Prevention Program. She stated these activities are within the CDPH's Safe and Active Communities branch and are described in the handouts.

Dr. Smith stated the goal of the California Essentials for Childhood Initiative is to reduce early childhood exposure to violence and to reduce exposure to other chronic adversity and toxic stress, such as the Adverse Childhood Experiences (ACEs), because of the harm that these have to early brain development, which can lead to lifelong effects on learning, behavior, and health.

Dr. Smith stated the Office of Health Equity within the CDPH has important projects that address mental health and suicide, such as the California Reducing Disparities Project (CRDP), which focuses on the prevention and early intervention of mental illness within five priority populations.

Dr. Smith stated she is convening a state and local public health leadership conversation about the Violence Prevention Initiative to engage in robust discussion on the role of public health in addressing the root causes of violence that are most relevant to communities. These conversations have to occur with many other stakeholders as well. Violence is a

cross-sectoral issue and involves significant partners to address the underlying determinants of violence and suicide. Through coordinated efforts, more can be done to recognize violence and address it.

Dr. Smith stated the need to move upstream to look at what is causing the trauma and violence that creates communities where people feel despair and the interconnections between the other issues in the communities such as the opioid epidemic. These all stem from very clear underlying determinants of the way lives are lived and communities are built. Consideration of shared risk and shared protective factors around suicide can help address overall health as well.

Dr. Smith stated, through the Violence Prevention Initiative, the CDPH plans to promote a collaborative vision for addressing violence prevention, track population-based indicators, and provide technical assistance to local partners on evidence-informed public health strategies. At the same time, the CDPH will continue to provide actionable data and serve as a convener to facilitate engagement across sectors, systems, and initiatives. The CDPH is committed to taking a leadership role in highlighting and facilitating the role of public health as well as the public health approaches to preventing all forms of suicide.

Commissioner Questions and Discussion

Commissioner Danovitch asked what the panel members see as the significant roadblocks to implementing strategies and what the Commission can do to help overcome those roadblocks.

Ms. Grealish stated decentralized funding with Prevention and Early Intervention (PEI) funds going out to the counties has been the biggest challenge. The framework that the Commission is currently working on will help bring information together. She suggested that the Commission come up with creative ways and guidance to counties on what would fit into a statewide plan, consistencies that need to be across the system, and other things that can be tailored to particular communities based on demographic characteristics.

Dr. Smith stated that is the model the CDPH uses for almost all of their programs. The CDPH would be happy to discuss how to split what is mandated versus what is allowed. Communities are unique. It is important that that be respected. What works in a community or even within a community differs from place to place. The CRDP is unique in many ways. What is most exciting is that it is a project that identifies existing programs at the community level that have been developed by that community that the community believes are effective, and then helps build capacity within those programs for them to evaluate what they are doing so that they can create a sustainable funding source. That is critically important. Communities know what works and each community is different.

Dr. Smith stated one of the areas where there is acute need is data. It is important to know that guidance and programs are targeted at the right thing and that the intervention is rational. In the absence of information, that is difficult to do. There is limited, crude data available on violence and suicide. That is where the promise of the Violent Death Registry System is; however, because it is pulling data from many systems, it is also labor-intensive.

Dr. Smith stated the Los Angeles Public Health Department is entering data into a data system from written records on instances of suicide and homicide, which is an incredibly arduous process. The challenge is trying to expand that. There may be a role for the Commission to support in building this system, whether it has to do with building electronic systems that interface with coroners, for example, which is a source of much of this data, or finding ways to support personnel for doing the data management and getting information into the system.

Commissioner Anthony asked Dr. Smith how effective the efforts have been and how that is measured. Dr. Smith stated, because the 220 programs within the CDPH are federally funded, they are very siloed. They are all carried out at the local level with state activities as well. The question of program effectiveness on violence prevention cannot be answered, which is a huge problem. She stated she hopes to discuss with her colleagues in June how to think about it and what should be measured.

Commissioner Mitchell asked if counties are required to have basic suicide prevention strategies as part of the \$32 million decentralized funding. Ms. Grealish stated, in the Medi-Cal system, every county is required to have a 24-hour access line. The MHSA does not outline minimum requirements.

Dr. Ramchand stated one requirement for all counties will not work because every community is different. One thing that might work in common is a process for determining what the problem is and a process for identifying interventions that will work for each community as opposed to one model program.

Dr. Smith stated a needs assessment should be done at a minimum to learn the issues in each community, then a plan could be put in place to address those needs, and a series of metrics could be developed to measure how the plan is doing.

Commissioner Ashbeck stated her concern that suicide is included on a list of forms of violence because a person could go to jail for everything on that list except suicide. Including suicide on that list does not help the stigma associated with suicide.

Dr. Smith stated that report was for local health jurisdictions and other partners who want to work on prevention of all forms of violence. It is categorized in the realm of public health science as self-violence and therefore it is on the list, but that is not how the CDPH messages around suicide. The national framework must be used to access the data, but it is not the way to message around suicide.

Commissioner Beall asked if there is an accepted practice for violence prevention, including sports injury incidents, such as head injuries, that schools should incorporate into their programs. Dr. Smith stated there is no general accepted practice.

Commissioner Beall asked if one is needed. Dr. Smith stated the schools are an incredibly important partner. The issue of how to translate that willingness and desire into a curriculum that fits into the school day is akin to how to take screening and intervention around suicide and fit it into all the other things a primary care doctor has to include in a 15-minute interview. It has to happen but is less straightforward than it ought to be.

Commissioner Beall stated in his high school football days it was the big thing to slam the opponents and to win at all cost. Coaches sometimes go too far to win. He suggested a

protocol to protect the child. This is important to talk about. He asked what to recommend to the schools. It is hard to talk about relationships and bullying when a coach is encouraging beating up an opponent to win a game. He stated in his county there are incidents where the perpetrators of violence against students are students that engage in sports. There are many issues there that should be dealt with. He stated the need to come up with solutions for the schools. He stated he has written legislation on this issue and asked what can be done in that area.

Dr. Ramchand stated that RAND Corporation did a report recently on the role of technology in K-12 safety. The research points to school climate, which requires culture change so there is justice for infractions and all students feel they are treated fairly and the same. There are issues about school climate that could come a long way from an early intervention perspective. In terms of concussions, studies are in the early stages of learning about the relationship between traumatic brain injury and later suicide or other violent behavior. Some schools require parents to go through concussion training.

Commissioner Beall stated, to do something meaningful, school culture must change. He stated the need to begin at the root cause and work through to change the culture. He asked if there is a study on this issue. Changing school culture needs to be part of violence prevention. Dr. Smith agreed. It is ultimately about the culture and what is valued.

Ms. Ransom stated that what schools are doing to talk about suicide is not the conversation that the students want to be having. The way it is presented is oftentimes cheesy, such as showing a video from the 1990s about people who die by suicide and start giving away their personal belongings, but the video is not targeted to the students, how they are feeling, and what they see in their friends. She stated there is a need to make it personal, not law enforcement coming in and offering solutions if students feel a certain way. She suggested asking a college student to come in who has gone through what the junior high and high school students are going through and sharing their story, how things have changed, and how they have gotten better. Making it personal to the students is most effective.

Public Comment on All Panels

Maureen Bauman, Consultant, California Behavioral Health Directors Association (CBHDA), stated the national suicide hotline is in place because of county commitment to answer the phones. Mental Health First Aid is another program that spreads awareness about mental health and suicide.

Richard Krzyzanowski, Board Director, Disability Rights California, and member of the MHSOAC Client and Family Leadership Committee, stated Joiner's theory of suicidality points to three contributing factors: social marginalization, feelings of burdensomeness, and access to means. He suggested widening the lens in the mental health systems, such as reaffirming and expanding the use of peer support and addressing root causes.

Arden Tucker, California Behavioral Health Planning Council (CBHPC), stated it is evident that funds are required to provide services, but funding will not happen without the data and science behind it. She spoke as a peer and stated silence leads to invisibility, which leads to isolation, which leads to hopelessness. The silence comes from stigma. There is a need

for more ambassadors to reach out to the individuals who are not at the table. Ms. Tucker volunteered to be an ambassador to reach those individuals in communities who would not otherwise hear about these kinds of meetings and issues.

Sandra Marley, client advocate, stated individuals in recovery are a high-risk group that should be considered. Mr. Black stated his medications were increased. Sandra Marley stated pharmaceutical companies have not done studies and asked how many psychiatrists have ever had a break, or have mental health issues, or had to take medications. Volunteers need recognition on the state level. Older adults were not listed in the CRDP priority populations.

Mandy Taylor, Health Access, California LGBT Health and Human Services Network, asked to include alternatives to 9-1-1, community-defined practices, and youth involvement and engagement in the Statewide Suicide Prevention Plan.

Tai'Rance "Chuckii" Kelly stated people cannot be connected until they first know themselves. It is important to first involve the parents in the communities, not just individuals who want to support that community.

Susan Gallagher, Executive Director, Mental Health America of Northern California (NorCal MHA), suggested supporting community connections and community-defined practices. It is hard to get funding for these kinds of programs. These are the kinds of programs that should be funded with reversion dollars.

Christopher Barton, NorCal MHA, shared about yesterday's Mental Health Matters Day event held at the capitol. Warm lines throughout the state are important.

Ms. Mills thanked the Commission for providing a safe place for individuals to share their stories. She stated another conversation is scheduled on June 13th in San Diego. More information is posted on the website.

GENERAL PUBLIC COMMENT

Maureen Bauman stated that CBHDA has been involved in the Innovation Incubator design labs. She asked that the current approval process be expedited.

Susan Gallagher raised the issue around the tech suites and the importance of data protection laws and client protection. The speaker provided information to staff. An institutional review board (IRB) is required for tech suites because they deal with vulnerable populations. The Commission needs to see the informed consents to ensure that individuals are not being coerced into being a part of those projects. The speaker asked the Commissioners to send acknowledgements to stakeholders who write them letters. NorCal MHA has not yet received a response to its letter.

Sandra Marley suggested that the Commission create a special unit to give volunteers recognition from the state and to get answers from pharmaceutical companies. Pharmaceutical companies have not done research into detoxing from their medications or how long their medications can be taken. She opined that the psychiatrists have not taken these medications.

Kat Wantz, Ambassador, Advancing Client and Community Empowerment through Sustainable Solutions (ACCESS California), shared that her 7-year-old great-grandson spent most of April in a psychiatric hospital and received his fourth diagnosis. The speaker asked the Commission to put out the funds to catch children at the onset for the best results.

LUNCH BREAK

INFORMATION

3: Governor's May Budget Revise Update 2018

Presenter:

- Kris Cook, Department of Finance

Kris Cook, Department of Finance (DOF), reviewed the Revised Financial Report, which was included in the meeting packet. He stated projected revenues for 2018-19 are approximately \$2.2 billion, which is a marginal decrease since the last projection. The revenues for 2016-17 came in \$31 million lower than expected, 2017-18 are projected to be \$34 million lower, and 2018-19 are projected to be \$1 million lower than previously assumed.

Mr. Cook reviewed two charts: The Mental Health Services Fund Directed Purposes Chart and the State Administrative Cap Chart, which were included in the meeting packet. He stated, over the past couple of years, the appropriations allocated have exceeded anticipated revenues due in part to lower expenditure in prior fiscal years.

Mr. Cook stated there are two proposals in the May Revision since the Governor's Budget. There is a one-time augmentation of \$215,000 for closeout activities for the Office of Statewide Health Planning and Development (OSHPD) Workforce, Education, and Training (WET) Program. There is also a request for \$725,000 for DHCS for increased oversight over the MHSA.

Mr. Cook stated, as of 2016-17, approximately \$1.8 billion was distributed directly to counties. As of May, \$1.6 billion has been distributed to counties in the current year, and it is estimated that approximately \$1.9 billion will be allocated by year end.

Commissioner Questions and Discussion

Commissioner Anthony asked what the reapportionment of the University of California funds of \$1.83 million covers. Mr. Cook stated he will take that question back to DOF and send staff what those activities were.

Public Comment

Steve Leoni, consumer and advocate, stated he hoped this will follow the rules of the WET documented in the MHSA. The provision in the MHSA includes training and materials for clients and family members and all individuals involved in training in the WET Program. He stated a trailer bill had been developed before this announcement

came through to fill in that last year. It is the hope of all involved to use this year to figure out a way to keep this program going.

INFORMATION

4: Executive Director Report Out

Presenter:

- Toby Ewing, Ph.D., Executive Director

Executive Director Ewing presented his report as follows:

Personnel

Consulting Psychologist Anna Naify, Psy.D. has joined the Commission. She will be introduced at the next Commission meeting.

Budget Priorities

The Assembly Budget Committee met today to vote on a series of health-related budget measures. The Senate Budget Committee met last week. The two Committees will be merged into a Conference Committee to negotiate with the Administration over the finalized budget.

The DOF agreed to include \$2.5 million in the budget for each of the next three years to support the Innovation Incubator work with the emphasis on reducing the number of individuals who are deemed incompetent to stand trial. It was in the Governor's Budget, approved by the Senate last week, and is currently in the Assembly. The Governor's office, however, did not support the additional \$5 million for Innovation around the needs of children and youth, but the Assembly was poised to support it. The Commission remains hopeful.

Both houses agreed to support the augmented budget to support stakeholder advocacy on behalf of immigrants and refugees and strategies to reduce criminal justice involvement. It is in the Assembly's package today.

The Assembly is proposing to put ongoing revenues from the MHS fund State Administrative Cap into the Commission's budget to support suicide hotlines.

The Administration has proposed a \$100 million investment in strategies to reduce the number of individuals who are deemed incompetent to stand trial through a series of grants to counties for community-based strategies to better serve those individuals. The proposal is to put those dollars into the Department of State Hospitals consistent with their history of working with this population. The Senate modified the Governor's proposal by suggesting that the Commission have an approval role for the grants that would go out to the counties for that purpose. This is on the table for negotiation between the Administration and the Legislature.

It was anticipated that the unspent funds for the first round of Senate Bill (SB) 82 Triage grant funds allocated to counties would be rolled back into the program to support the second round of grants. The Legislature is uncertain on that issue and therefore there

may not be sufficient funding to support all of the plans previously approved by the Commission in their motions to award funds to grantees.

Mental Health Policy Fellowship

A draft proposal and timeline was included in the meeting packet. The Commission's intent is to offer a viable salary and health insurance for the fellows. Staff is starting the process of engaging subject matter experts from the consumer and practitioner communities as well as individuals who have expertise running fellowships. A proposal for adoption will be presented at a future Commission meeting.

MHSA Audit Outcome

The Governor's Budget includes adding six to seven additional staff to DHCS to strengthen their fiscal oversight of the counties.

Project Updates

Innovation

Staff is in the process of drafting a business plan for the Innovation Incubator and has been holding workshop-style design lab meetings statewide.

Executive Director Ewing reviewed the MHSOAC Youth Innovation Project Brief, which was included in the meeting packet, in response to the Chair's request to host a youth-focused Innovation event.

PEI and Innovation (INN) Regulations

The Office of Administrative Law notified the Commission last week that the PEI and INN regulations will take effect on July 1, 2018.

Statewide Suicide Prevention Plan

Ashley Mills, Project Lead, has been participating in national conferences and engaging individuals and organizations across the country on this issue. The Legislature is interested in this work.

Triage Grants

Executive Director Ewing reviewed the Triage Grant Request for Applications (RFA) Process Flow Chart, which was prepared by Kristal Antonicelli, Project Lead for the Triage Grants. The Chart is included in the meeting packet and was created in response to the Chair's request for greater detail on the RFA process. Executive Director Ewing outlined the process used for creating the RFA, scoring the applications, and handling the appeals process. Subject Matter Experts were used to design the Schools-County RFA as there were no Commission staff available with an adequate level of expertise to provide the input needed. Executive Director Ewing explained that because he makes the determination on the appeals he is kept out of all aspects of the procurement process. After all appeals have been resolved, contracts are executed between the Commission and the grantees.

Commissioner Questions and Discussion

Commissioner Anthony asked how the Governor's Budget will address funding to support the increased activities regarding inmate release and the suicide hotline. Executive Director Ewing stated part of the dialogue will be to discuss required staffing and authority. The Assembly version envisioned adding three positions to the Commission's budget.

Chair Boyd reminded the Commission that Vice Chair Aslami-Tamplen volunteered to take the lead and work with staff on the youth-focused Innovation event. He asked to include the youth from Humboldt County, who had stepped forward at a past Commission meeting, to help refine the process. Trying to design something without including youth in the process is a path to failure.

Commissioner Anthony suggested including youth with lived experience.

Public Comment

Stacie Hiramoto, Director, Racial and Ethnic Mental Health Disparities Coalition (REMHDCO), stated mental health and seniors is an important issue. She stated there was a report on seniors that was completed in the last several months in conjunction with UCLA that the MHSOAC Evaluation Committee had designed and approved. She urged the Commission to invite individuals who worked on this project to present the report at a future Commission meeting.

Ms. Hiramoto stated REMHDCO has often asked the Commission to invite the CDPH Office of Health Equity to present on the CRDP at a Commission meeting. Their programs are related to everything the Commission does and can be used as a resource.

Rory O'Brien, LGBTQ Program Coordinator, NorCal MHA, Project Coordinator, Out for Mental Health, urged the Commission to identify the youth advisory council first and provide them with a large menu of options regarding the contractor to hire, the parts of the structure to include or not include, and which would be most beneficial according to the youths.

ACTION

5: Butte County Innovation Plan

Presenters:

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

Dorian Kittrell, MFT, Director, Behavioral Health, provided an overview, with a slide presentation, of the demographics and the need in Butte County. He stated this program is focused on the early detection of youth at risk for mental illness and substance abuse. Workforce is a challenge in Butte County and impedes the ability to identify youth who

might otherwise go undetected. In response to this, the county plans to use primary care pediatricians throughout the community to extend the safety net to capture these youth.

Holli Drobny, Community Services Program Manager, continued the slide presentation and discussed the community input process.

Danelle Campbell, Program Manager, Behavioral Health, continued the slide presentation and discussed the three major goals of the proposed project, the proposed Innovation, and the pilot project and expansion. She shared a story demonstrating how quickly the county receives referrals – a student was identified last night. Within two days this student will have the opportunity to explore brief intervention and, if needed, access to a greater level of care.

Phillip Filbrandt, M.D., Butte-Glenn Medical Society, highlighted the ease of using the tool to identify risk; the sensitivity of identifying these youth compared to the time spent on the physical examination aspect is high.

Sesha Zinn, Psy.D., Systems Performance Manager, continued the slide presentation and discussed the evaluation design, outcome data, and deliverables.

Tess Juarez, one of the youth now working with the county who was impacted by the pilot program, shared her story and experience participating in this program. She stated she recommends this program for those who need a helping hand, someone to talk to, or a sense of connection.

Commissioner Questions

Commissioner Anthony asked if physicians can bill for any of the expense related to doing a screening and if the proposed project will help make billing allowable. Mr. Kittrell stated it cannot currently be billed. He stated the data that would be collected on the number of youth identified and the number of youth with positive outcomes could go into the collection of data for those proponents for finding greater opportunities for billing.

Commissioner Gordon stated it is smart to start with students having athletic physicals; yet, he stated his concern about the students who are not reached. Ms. Campbell stated the county is exploring as many avenues as possible to help reach those who may not be reached through this intervention, such as school counselors, probation, teachers, other intervention specialists, and after school youth centers.

Commissioner Bunch stated she was surprised that behavioral health screenings are not already common practice for pediatricians and individuals who work with children. She asked what the training of the physicians looks like and what the county is doing to ensure screenings are done in a culturally sensitive manner.

Ms. Campbell stated it is not currently part of the normal screening process. The county is committed to changing that by integrating the proposed project into as many healthcare settings as possible. She stated she was there during the pilot training with the doctors to help provide information on the mental health and substance use issues that local youth were reporting to help represent how high of a need and how urgent it is that the county does something in response to that. She stated Dr. Filbrandt was there to help doctors imagine what this might look and feel like in their normal practice so that they could maybe demystify that it would take too long or be too complicated, complex, or uncomfortable.

The way that it was accomplished was by providing them with a prototype of the screening questions and roleplaying.

Commissioner Madrigal-Weiss stated she is struggling with the innovation part of the proposed project. She read the screening questions that the county trained their physicians on. She stated these questions already come up in conversations in well checks with primary care physicians. Ms. Campbell stated the county looked at models used or recommended by associations and other experts. Those screening questions came from the American Academy of Pediatrics. The county internally tested the questions and the youth stated they felt these questions were more conversational so that they felt more comfortable responding to those questions.

Commissioner Madrigal-Weiss stated these questions have been in practice for a long time. She questioned whether the project was innovative. Mr. Kittrell stated the county is not suggesting that the tool is innovative. One innovative part of the proposed project is the ability to reach a much larger workforce in the medical community. There is a significant amount of stigma in the medical community on addressing or intervening or trying to discover behavioral health issues. Another innovative part is the intervention specialist so that physicians have immediate contact for consultation.

Commissioner Madrigal-Weiss stated she did not hear a response to Commissioner Bunch's question on cultural competency and sensitivity. Ms. Drobny stated there are annual requirements at the Cultural Grand Rounds for different types of cultural training for all behavioral health staff and providers. Also, behavioral health just started facilitating Cultural Grand Rounds trainings on a quarterly basis where local community-based organizations provide training.

Commissioner Madrigal-Weiss stated those trainings are for staff. She asked about the training for physicians doing the screenings. Ms. Drobny stated they could be invited to the Cultural Grand Rounds.

Dr. Filbrandt stated there are opportunities for cultural training through the hospital and other organizations. He stated he does not know that all physicians participate in those. Mr. Kittrell stated the prevention staff represent the community as a whole in terms of diversity and they could assist the physicians with cultural issues. Cultural training would be promoted as part of their volunteering or participation in the program.

Vice Chair Aslami-Tamplen stated screenings often came up in today's earlier conversation on suicide prevention and how to train primary care physicians on how to recognize signs and to talk about suicide and suicide prevention. She asked if there is an opportunity to include training on cultural competency and sensitivity. Ms. Campbell stated the county started small with its pilot but hopes to learn about other tools that have been tested and shown to be effective that can be added in the expansion.

Commissioner Ashbeck stated she loved all of the pieces of the proposed project but is having a hard time getting them together. She stated 67 physicians were trained during the pilot but noted that there are only 100 primary care physicians in the whole county. She stated she is also struggling with the comment about how this would provide opportunities for the athletes to talk with a trusted person. She stated her sense is during an athletic sports physical, if it is not done by the student's pediatrician, it is not a trusted

relationship. She was surprised that, in the pilot, it was presented that the screening numbers were well below the county statistics. She also asked about the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Ms. Campbell stated the number of professionals trained also included physician assistants, nurses, and support teams. It included hospital staff, public health nurses, a plastic surgeon, and an orthopedist.

Commissioner Ashbeck asked why a plastic surgeon was trained. Ms. Campbell stated the plastic surgeon and physicians in other specialty areas in Butte County volunteer their time to do sports physicals. She stated the number of youth identified were from the California Healthy Kids Survey data. Regarding HIPAA, the parents sign off that the screening will be part of the eligibility process. Although the parents are aware that an intervention could happen, they are not involved in the sessions with the intervention specialist. The school knows that there will be follow-up care if a young person is referred but they do not know who those students are.

Ms. Ransom stated sports physicals are done with as many students at once as possible. She stated she was in a line with all her friends when she had her sports physical. It may be confidential between the parents and the kids, but the physical is done in a big room with everyone together. It is a difficult environment for kids to speak up on personal issues. Ms. Campbell stated that in their county the students wait in a line together but the physicians see each child separately in individual classrooms or offices.

Public Comment

Mandy Taylor suggested that every child be screened. Sometimes training makes physicians think they know how to be culturally affirming when actually they ask invasive questions. She suggested ensuring that the intervention specialists get extensive training on cultural humility and affirming practices and not just the Grand Rounds. She asked for a way for a student to indicate they need support without having to out themselves to a practitioner.

Maureen Bauman spoke in support of the proposed project.

August Moore, Butte County Behavioral Health, spoke in support of the proposed project.

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

Heather Senske, Butte County Office of Education, spoke in support of the proposed project.

Pam Nelson, Butte County Medical Society, spoke in support of the proposed project. She read a letter of support from the Butte-Glenn Medical Society Alliance.

Andrea Crook, ACCESS California, Advocacy Director, NorCal MHA, asked about the stakeholder process and the role of peer providers.

Rory O'Brien stated LGBTQ residents noted they feel safer in Chico than in the rest of the county. There were no specific plans for LGBTQ or communities of color competency trainings as part of this initiative. The training should include a focus on creating safe connections within families and schools. The post-evaluation includes the Child and Adolescent Needs and Strengths (CANS) tools when it is best used as pre- and post-

evaluation. It would be too intensive for physicians to include CANS tools while providing care because it takes more than an hour to go through.

Sandra Marley spoke in support of the proposed project.

Commissioner Discussion

Commissioner Anthony made a motion for approval of the proposed project and Commissioner Gordon seconded.

Commissioner Madrigal-Weiss asked if they would accept a friendly amendment to adopt the plan with the condition that training physicians and other medical personnel include training on culturally sensitive practices from subject matter experts in this area.

Commissioners Anthony and Gordon accepted the friendly amendment.

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

The MHSOAC approves Butte County's Innovation Plan with the condition that the training of the physicians and other medical personnel include training on culturally sensitive practices from subject matter experts in this area.

Name: Physician Committed

Amount: \$767,900

Project Length: Three (3) Years

Motion carried 4 yes, 1 no, and 0 abstain, per roll call vote as follows:

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

The following Commissioner voted "No": Commissioner Ashbeck.

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

Supervisor Patrick Kennedy, Sacramento County Board of Supervisors, provided a brief history of Sacramento County's Innovation plans and spoke in support of the proposed project.

Uma K. Zykofsky, LCSW, Mental Health Director, provided an overview, with a slide presentation, of the need and how the project is innovative. An external evaluator for the project will be secured to gather client-level data and data around the collaborative nature of the project. She stated Placer County has offered to partner in this project.

Leslie Napper, Consumer Representative, shared about her experience participating in the project. She stated she supports this project because it put mental health on the same footing as physical health in the emergency room and offers critical resources onsite at the resource center.

Rosemary Younts, Senior Director, Behavioral Health, Dignity Health, discussed the meaning of shared governance and why the county chose to do it this way versus other ways of approaching the same issue. She stated the emergency department strives to treat the whole person. This project will give them the tools and data required to better accomplish this and to better serve the community.

Tara Niendam, Ph.D., Associate Professor in Psychiatry, Executive Director, University of California, Davis, Early Psychosis Programs, continued the slide presentation and discussed the work around the first episode psychosis screening that is incorporated into the crisis service collaborative.

Amy R. Ellis, MFT, Mental Health Administrator, Drug and Alcohol Administrator, Placer County, stated Placer County is excited to partner with Sacramento County on this project. Placer County is committed to helping make it a success by offering resources and support to the project.

Commissioner Questions and Discussion

Commissioner Ashbeck asked if the proposal is for \$18 million or \$13 million as indicated on the budget slide. Jane Ann Zachary, the MHSA Program Manager, Sacramento Behavioral Health, stated the overall budget is \$18.7 million, but only \$13.8 million of that will come from Innovation dollars.

Commissioner Ashbeck asked if the proposed project will serve children. Ms. Zykofsky stated this project focuses on individuals who are 18 years and older as per Dignity Health directions. The county is open to thinking about how to include children in a different way.

Commissioner Ashbeck asked if there is an anticipated decrease in the length of stay in emergency departments. Ms. Zykofsky stated, after medical clearance, there currently is not a place to take patients, which extends their stay in emergency departments. This project will decrease the length of stay in emergency departments because patients will immediately go into a crisis stabilization unit after medical clearance.

Ms. Younts added that the county has already changed the approach to the way mental health is addressed by assessing patients immediately upon triage during their physical assessment. This could potentially reduce the medical clearance and length of stay down to two to four hours. Currently, that period is approximately 32 hours. It could make a huge difference for patients.

Ms. Napper stated with this model the resource center will link to community services hoping to reduce any transfer to an inpatient hospital.

Public Comment

Mandy Taylor asked how the decision was made about North versus South Sacramento. She asked why only a half-time social worker. Social workers are critical to ensuring stability when patients leave – it is important to create that bridge. She stated her concern about the choice of a Catholic facility through Dignity Health. Catholic facilities through Dignity Health act in accordance with the ethical and religious directives for Catholic health care services and the medical staff bylaws. Mercy San Juan is currently being litigated for refusal of trans-affirming care. She asked how the proposed project addresses this issue and ensures when referring queer and trans community members to this facility that they will be supported and affirmed and receive the care they need that is supportive of their gender and sexual orientation.

Maureen Bauman spoke in support of the proposed project.

Brad Schumacher, Sacramento Fire District, spoke in support of the proposed project.

Adrienne Shilton spoke in support of the proposed project.

Aileen Wetzel, Sierra Sacramento Valley Medical Society, spoke in support of the proposed project.

David Bain, Executive Director, NAMI Sacramento, spoke in support of the proposed project.

Seth Thomas, M.D., Mercy San Juan Medical Center, spoke in support of the proposed project.

Brian Jensen, Hospital Council, spoke in support of the proposed project.

Michael Korpiel, M.D., Dignity Mercy San Juan, spoke in support of the proposed project.

Abbie Totten, HealthNet, spoke in support of the proposed project.

Rory O'Brien echoed Ms. Taylor's comments. The speaker was concerned that the project does not include South Sacramento and hoped for a future proposal for those communities.

Sandra Marley spoke in support of the proposed project.

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

The MHSOAC approves Sacramento County's Innovation Project as follows.

Name: Behavioral Health Crisis Services Collaborative

Amount: \$13,885,361

Project Length: Four (4) Years

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

The following Commissioners voted "Yes": Commissioners Ashbeck, Gordon, and Madrigal-Weiss, and Chair Boyd.

ACTION

7: Legislation

Presenters:

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

This agenda item was not discussed.

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

This agenda item was not discussed.

GENERAL PUBLIC COMMENT

No members of the public addressed the Commission.

ADJOURN

There being no further business, the meeting was adjourned at 5:04 p.m.

State of California

MENTAL HEALTH SERVICES OVERSIGHT AND ACCOUNTABILITY COMMISSION

Minutes of Meeting Teleconference
May 9, 2018

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

866-817-6550; Code 3190377

Additional Public Locations

1315-10th Street,
Sacramento, CA 95814

3712 Apple Hill Road
Modesto, CA 95355

10474 Mather Blvd, Mather, CA
95655

2000 Embarcadero Cove, Suite 400
Oakland, CA 94606

3071 West Bullard Avenue
Fresno, CA 93711

315 Camino Del Remedio,
Santa Barbara, CA

91-2301 Old Fort Weaver Road
Ewa Beach, HI 96706

811 Wilshire Blvd, Suite 1000
Los Angeles, CA 90017

Members Participating:

John Boyd, Psy.D., Chair
Khatera Aslami-Tamplen, Vice Chair
Mayra Alvarez
Reneeta Anthony
Lynne Ashbeck
Senator Jim Beall

Keyondria Bunch, Ph.D.
David Gordon
Gladys Mitchell
Larry Poaster, Ph.D.
Tina Wooton

Members Absent:

Assemblymember Wendy Carrillo
Itai Danovitch, M.D.

Mara Madrigal-Weiss

Staff Present:

Toby Ewing, Ph.D., Executive Director
Filomena Yeroshek, Chief Counsel
Norma Pate, Deputy Director, Program,
Legislation, and Technology

Brian Sala, Ph.D., Deputy Director,
Evaluation and Program Operations

CONVENE AND WELCOME

Chair John Boyd called the meeting of the Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission) to order at 3:00 p.m. and welcomed everyone. Filomena Yeroshek, Chief Counsel, called the roll and confirmed the presence of a quorum.

Chair Boyd reviewed the meeting protocols.

ACTION

1: Award Senate Bill 82 Schools-County Partnership Triage Program Grants

Presenters:

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

Vice Chair Aslami-Tamplen and Commissioner Gordon recused themselves from the discussion and decision-making with regard to this agenda item pursuant to Commission policy.

Tom Orrock, Chief, Commission Operations and Grants, provided an overview of the background, purpose, and goals of the School-County Collaborative. The goal of the Schools-County collaborative Request for Application (RFA) grants is to hire personnel to enhance an existing county partnership with school-based programs and to expand access on school campuses to a continuum of services and supports for children and families.

Kristal Antonicelli, Project Lead, continued the presentation and discussed the timeline, and eligibility criteria for the RFA. Applications for the School-County collaborative RFA were due on April 19, 2018 and were scored by MHSOAC staff. The eligibility criteria set by statute provides that California counties, counties acting jointly, and city mental health/behavioral health departments are eligible to compete for the grants. In addition, Welfare and Institutions Code §5848.5(h), gives the Commission discretion to award the grants to private nonprofit corporations and public agencies if a county affirmatively supports this designation and collaboration in lieu of a county government directly receiving grant funds.

Ms. Antonicelli stated that the following four applicants received the highest scores and the recommendation is to award the Schools-County collaborative Triage Personnel Grants to:

- Tulare County Office of Education
- California Association of Health and Education Linked Professionals Joint Power Authority
- Placer County
- Humboldt County

Commissioner Questions

Commissioner Mitchell asked if the counties provided an estimated number of students that would be reached by these services. Ms. Antonicelli stated that information was not provided. Mr. Orrock mentioned that 80 personnel were proposed to be hired through the grants. These programs are open to all students so it would be challenging to obtain a specific number of students that would be reached.

Chair Boyd asked if there is a projected number of people that can be reached based on the population size for each county. Mr. Orrock stated that counties were considering school sites and there may be a similar number of students in each school site regardless of the population size of the county.

In response to a question from Commissioner Alvarez, Mr. Orrock stated that there were 17 applications submitted.

Public Comment

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

Commissioner Discussion

Chair Boyd requested that examples and a general outline of the RFA process be provided at the next Commission meeting.

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

- *The MHSOAC awards the School-County Triage Personnel Grants to the following four applicants that received the highest scores. Each Grant is in the amount of \$1,875,000.00 per year for a four year total of \$7.5 million and directs the Executive Director to issue a Notice of Intent to make the following awards:*
 - *Tulare County Office of Education*
 - *California Association of Health and Education Linked Professionals Joint Power Authority*
 - *Placer County*
 - *Humboldt County*
- *The MHSOAC establishes May 23, 2018 as the deadline for unsuccessful applicants to submit an Appeal consistent with the ten working days standard set forth in the Request for Applications.*
- *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.*

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

The following Commissioners voted "Yes": Commissioners Alvarez, Anthony, Ashbeck, Beall, Brown, Mitchell, Wooton, and Chair Boyd.

The following Commissioner abstained: Commissioner Poaster.

ACTION

2: Legislation

Presenters:

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

Executive Director Ewing stated the Commission is in the middle of the policy process with the Legislature. Assembly Bill 2287, authored by Assemblymember Kiley, parallels much of the work currently happening at the Commission, with some additions. AB 2287 would require the Commission to develop a local government transparency and accountability strategy for local mental health programs, and also would require the Commission to develop a transparency and accountability strategy for state government. The bill has passed the Assembly Committee on Health and is currently held in the Appropriations Committee.

Commissioner Anthony stated that the Commission should vote on whether to support each bill individually rather than all together.

Chair Boyd asked what is the value of the bill if the Commission is already doing the work that the bill dictates.

Executive Director Ewing stated that the bill codifies and validates the Commission's positions. It also ties the hands of the Commission because it makes mandatory what is now discretionary.

Chair Boyd stated he wants to better understand the broader context of the bills and asked if there are any time sensitive issues.

Executive Director Ewing stated that AB 2287 (Kiley), AB 2843 (Gloria), and Senate Bill 1101 (Pan) are all in the first house and under review in the fiscal Committees. Clarification on AB 114 is time sensitive. Chair Boyd recommended the Commission discuss the AB 114 issue now and discuss AB 2287, AB 2843, and SB 1101 during a future in-person meeting.

Executive Director Ewing stated that the Commission pointed out to the California Behavioral Health Directors Association (CBHDA) a need to clarify the treatment of Innovation funds that were subject to reversion as of July 1, 2017 under AB 114. It is unclear whether under AB 114 counties must spend the reverted Innovation funds by 2020 or whether counties have additional time to spend the Innovation funds after Commission approval. Senator Pan has requested the opinion of the Commission on this matter. The question is whether the AB 114 requires counties to spend their funding by 2020 or gives them additional time- potentially up to 2025.

Commissioner Alvarez asked if staff have written any letters of recommendation, which Executive Director Ewing responded that staff do not provide recommendations on legislation.

Chair Boyd asked if CBHDA can work on having the legislators clarify AB 114. Executive Director Ewing stated that CBHDA is asking legislators for clarification that the Innovation funds not revert in 2020.

Commissioner Mitchell stated that the Commission is more inclined to hold counties to the deadlines and suggested the motion would be to support the 2020 deadline. Counties need to be incentivized to spend the money.

Public Comment

Robb Layne, Director of Communications and External Affairs, County Behavioral Health Directors Association (CBHDA), described the effort to clarify AB 114 with legislators as a technical cleanup and not as new policy. Counties will not be the only ones to be hurt. The speaker provided Orange County and Sacramento County as examples.

Senator Beall asked how AB 114 is related to the California State Auditor's report. Executive Director Ewing stated that the Commission raised this issue with the Auditor but was told that this was not within the scope of the audit. The report is due July 2018 and it is not yet known how much money will be available. As of a few weeks prior, 34 counties have submitted. Senator Beall stated that he does not know if this is really a technical cleanup. Executive Director Ewing stated that the MHSOAC is not obligated to take a position. Currently, it is unclear if the Commission approves an Innovation plan whether the approval extends the deadline to spend Innovation funds by 3 or 5 years.

Stacie Hiramoto, Director, Racial and Ethnic Mental Health Disparities Coalition (REMHDCO) supports CBHDA's position on the issue. The speaker also requests that the Commission review its policy paper on Prevention and Early Intervention before supporting AB 1004. Seven organizations have requested the Commission to adhere to the policy paper.

Rory O'Brien, LGBTQ Program Coordinator, NorCal MHA, Project Coordinator, Out for Mental Health Stakeholder Project, supports Stacie Hiramoto's position as well. Rory O'Brien shared concerns of an extension being allowed to continue.

Steve Leoni supports Stacie Hiramoto and Rory O'Brien. The OAC should not be rushed to vote on Innovation plans.

Commissioner Discussion

Commissioner Mitchell asked how far back the unspent funds go and what happens to the unspent funds. Executive Director Ewing stated that Fiscal Year 2005-06 is the oldest year that funds have not been spent. Funding that isn't spent is reverted and is distributed back to the counties. AB 114 includes language to keep funds in the component and redirects them to all counties.

Commissioner Mitchell requested that the Commission hold to the original deadline of 2020.

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

The Commission supports legislative technical clean up to Assembly Bill 114 (Stats. 2017, ch. 2017) to clarify that the 2020 deadline for counties to spend the funds deemed reverted under AB 114 applies to Innovation funds.

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

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

The following Commissioners voted "No": Vice Chair Aslami-Tamplen, Commissioners Poaster, and Wooton.

Vice Chair Aslami-Tamplen stated that clarity is needed but also Innovation plans should not be rushed because stakeholder involvement in the process is critical.

Chair Boyd stated that the reverted money goes back to the counties and the public process will take place. Counties have had a lot of time to engage stakeholders.

Executive Director Ewing stated that he had misspoken earlier and that Innovation funds only go back to 2008 and not Fiscal Year 2005-06.

Chair Boyd stated that Executive Director Ewing inform Senator Pan that the Commission was split on the issue and explain the Commissioners' key concerns.

ADJOURN

There being no further business, the meeting was adjourned at 4:34 p.m.

AGENDA ITEM 2

Information

July 26, 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 from the Transition Age Youth contract holder, California Youth Connection.

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 have been awarded on a competitive basis.

The contract for Transition Age Youth advocacy is held by 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 with 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 percent 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 first round of procurement for this stakeholder contract was completed in June 2016. CYC was awarded a contract lasting three years for activities focused on supporting TAY. The contract will continue through June 2019.

In March 2018, CYC was awarded a second contract for \$170,000 per year for a three year total of \$510,000. This second 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 segments 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
- Kimberly Coronel, Representative, “No Stigma, No Barriers”
- Smitha Gundavajhala, Representative, “No Stigma, No Barriers”
- Cecelia Najera, Representative, “No Stigma, No Barriers”
- Christina Parker, Representative, “No Stigma, No Barriers”

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

Handouts: A PowerPoint will be presented at the meeting.

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.

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



“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.

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

“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**

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.

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.

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.

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

“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

“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.

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

“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

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.

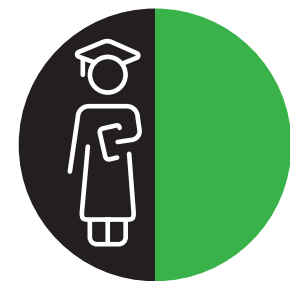


1 IN 5 TAY HAVE MENTAL HEALTH CONCERNS.



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

“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

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

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.

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

“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

on the project while the project activities are carried out largely by other staff (many of whom are TAY) of the partner organizations.

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.



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.

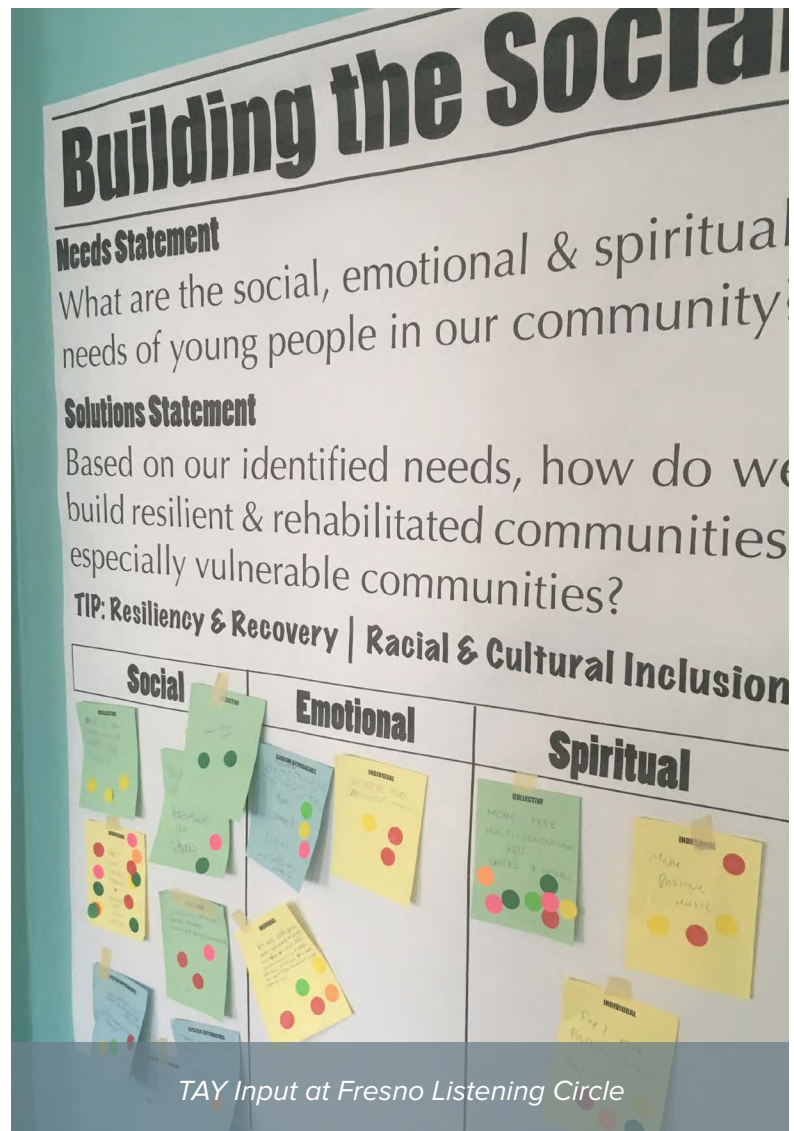
As an Indigenous person, I feel that those beliefs about mental health are wrong. **What is labeled as a disorder or barrier is actually a tool or gift from Creator.** Often, on this colonized continent, we don’t understand these gifts, but if we took the time as a people, a community, a village, we 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



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.



OUTREACH, ENGAGEMENT, AND COMMUNICATION

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

“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**

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.



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



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 deepens 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

"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

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.

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.nostigmanobarrriers.org or email info@nostigmanobarrriers.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



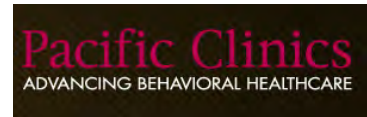
“CYC is most successful when youth are at the center of identifying issues and creating solutions for legislative, policy, and practice transformation.”

—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

SMALL NONPROFITS

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.humboldt.gov/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**

ENDNOTES

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Mental Health Services
Oversight & Accountability Commission



**NO STIGMA
NO BARRIERS**

**A TRANSITION AGE YOUTH
MENTAL HEALTH COLLABORATIVE**



www.nostigmanobarrriers.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	<i>In Progress</i>		
Y2Q4	Annual Report Development	Final SOC	June 2018	<i>In Progress</i>		

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	<i>In Progress</i>		
Y2Q4	Local Training - Superior Region	Materials/Sign-in	June 2018	<i>In Progress</i>		
Y2Q4	Local Training – Los Angeles Region	Materials/Sign-in	June 2018	<i>In Progress</i>		
Y2Q4	Local Training – Central Region	Materials/Sign-in	June 2018	<i>In Progress</i>		
Y2Q4	Local Training – Bay Area Region	Materials/Sign-in	June 2018	<i>In Progress</i>		
Y2Q4	TAY Training (additional/enhanced training #1)	Materials/Sign-in	June 2018	<i>In Progress</i>		
Y2Q4	TAY Training (additional/enhanced training #2)	Materials/Sign-in	June 2018	<i>In Progress</i>		
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	<i>In Progress</i>	<i>Transition to new reporting template; completion 5/2018</i>	
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	<i>In Progress</i>	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		Y2Q2 Training Report	December 2017	December 2017	Submitted to OAC 1/2018	
Y2Q3	Legislature/State Administration engagement activities including presentations, testimony	Y2Q3 Training Report	March 2018	<i>In Progress</i>	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	<i>In Progress</i>	<i>Transition to new reporting template; completion 5/2018</i>	
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	<i>In Progress</i>	<i>Transition to new reporting template; completion 5/2018</i>	
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	<i>In Progress</i>	<i>Transition to new reporting template; completion 5/2018</i>	
Y2Q3	Regional Council Meeting #3	Agenda	March 2018	<i>In Progress</i>	<i>Transition to new reporting template; completion 5/2018</i>	
Y2Q4	Regional Council Meeting #4	Agenda	June 2018			
Y2Q3	Spring Conference Presentation	Presentation	March 2018	<i>In Progress</i>	<i>Transition to new reporting template; completion 5/2018</i>	
Y2Q4	Summer Conference Presentation	Presentation	June 2018			

Deliverable 4: Advocacy

REPORTING PERIOD	ACTIVITY	WORK PRODUCT	DUE DATE	COMPLETION DATE	NOTES	ATTACHMENT
Y2Q1	<p>Y2Q1 advocacy activities to include reporting on <i>Setting the Strategic Agenda, Strategy to Action, and Assessment of Actions</i> including:</p> <ul style="list-style-type: none"> • 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	<p>Y2Q2 advocacy activities to include reporting on <i>Setting the Strategic Agenda, Strategy to Action, and Assessment of Actions</i> including:</p> <ul style="list-style-type: none"> • 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	<p>Y2Q3 advocacy activities to include reporting on <i>Setting the Strategic Agenda, Strategy to Action, and Assessment of Actions</i> including:</p> <ul style="list-style-type: none"> • County research • Local partners/stakeholders • TAY recruitment/engagement • TAY training • TAY governance meetings • Technical assistance 	Y2Q3 Activity Report	March 2018	<i>In Progress</i>	<i>Transition to new reporting template; completion 5/2018</i>	
Y2Q4	<p>Y2Q4 advocacy activities to include reporting on <i>Setting the Strategic Agenda, Strategy to Action, and Assessment of Actions</i> including:</p> <ul style="list-style-type: none"> • 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



Stakeholder Contract Update | Transition Age Youth: California Youth Connection (CYC)

July 26, 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 under 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.

AGENDA ITEM 3

Action

July 26, 2018 Commission Meeting

Budget Overview

Summary: The Commission will consider approval of its Fiscal Year 2018-19 Operations Budget and hear an update on expenditures.

Background:

The Commission's 2018-19 Budget is \$36.5 million which includes a significant reduction for the Triage grant program in the amount of \$12 million, an increase of \$670,000 annually to support immigrants and refugees advocacy efforts and \$2.5 million each year for the next two years for the Innovation Incubator focusing on the Incompetent to Stand Trial population.

The Governor's 2018-19 Budget provides more than \$450 million in new funding with the goal of enhancing local mental health efforts, decreasing homelessness and reducing the number of individuals with mental illness 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.

Significant Adjustments:

- **Incompetent to Stand Trial Diversion:** The Budget includes \$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.

In addition, targeted funding of approximately \$15 million will be provided to Los Angeles County, the county with the highest number of severely mentally ill individuals and the majority of referrals to state hospitals as well as \$5 million Mental Health Services Fund over two years to help counties develop innovative plans to increase access and quality of county mental health services. These augmentations will help mitigate the incompetent to stand trial pending placement list, which is currently over 800 individuals.

- **No Place Like Home:** The Budget places the No Place Like Home program on the November 2018 ballot to accelerate the issuance of \$2 billion in bond funds. The bonds will help provide housing for individuals experiencing mental illness who are homeless or at risk of homelessness and will be repaid from the Mental Health Services Fund.

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 Budget 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). 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 Budget includes 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 provide intensive outreach, treatment and related services for homeless persons with mental illness. This type of intervention is expected to result in earlier identification of mental health needs, prevention of criminal justice involvement, and better coordination of care for this population at the local level.
- **Workforce Education Training:** The Budget includes a one-time augmentation of \$10 million Mental Health Services Fund for the Office of Statewide Health Planning and Development for targeted investments to support stipends for Psychiatric Nurse Practitioners, Clinical Psychologists, and Social Workers and increase education capacity for Psychiatric Nurse Practitioners.
- **Childhood Trauma:** The Budget includes \$10 million one-time Mental Health Services Fund for the Department of Public Health to support a three-year All Children Thrive pilot program to address childhood trauma. This targeted investment will be used to provide up to 12 cities and counties with grants to implement local public health strategies to prevent childhood trauma.
- **Suicide Hotlines:** The Budget includes \$4.3 million ongoing Mental Health Services Fund for the Department of Health Care Services to contract with a suicide hotline provider for statewide access to suicide prevention services.
- **Criminal Justice Involved Mental Health Coordination:** The Budget includes \$945,000 Mental Health Services Fund for the Council on Criminal Justice and Behavioral Health to help address the prevalence of mental illness within the criminal justice-involved population. Of this amount, \$795,000 ongoing will be used for stakeholder advocacy contracts and associated program administration, to support mental health outreach and services for criminal justice-involved populations. In addition, the Budget includes \$150,000 for three years for the Council to consult with the Department of State Hospitals on the evaluation of

counties' plans that are submitted under the Incompetent to Stand Trial Diversion program.

- **Veterans Mental Health:** To help address the mental health needs of California's veterans, the Budget includes an increase of \$1 million ongoing Mental Health Services Fund to the California Department of Veterans Affairs to increase access to mental health services for veterans.
- **Immigrant and Refugee Mental Health:** The Budget includes \$670,000 ongoing Mental Health Services Fund for the Mental Health Services Oversight and Accountability Commission to provide stakeholder advocacy contracts that support mental health outreach and services for immigrant and refugee populations.

Presenter(s): Norma Pate, Deputy Director

Enclosures: None.

Additional Materials (1): A PowerPoint will be provided at the meeting.

Proposed Motion: The Commission approves the Fiscal Year 2018-19 Operations Budget.

AGENDA ITEM 4

Action

July 26, 2018 Commission Meeting

Triage Grant Funding

Summary: Earlier this year, the Commission awarded Triage grants through three Request for Applications: 1) Adult/TAY (\$48 million); 2) Children/Youth (\$29.6 million); and 3) School-County Collaborative (\$30 million), for a total of \$107.6 million. The Commission reviewed 54 applications for funding opportunities and awarded funds to 30 recipients. The grants are intended to support efforts to provide crisis mental health intervention and targeted case management for individuals who are experiencing a mental health crisis.

Additionally, the Commission authorized the Executive Director to execute a statewide evaluation contract for no more than \$10 million to the UC Davis and UC Los Angeles Behavioral Health Centers of Excellence to evaluate the programs and also to sustain these investments. The grants and statewide evaluation were to be supported through three sources of funding:

1. The Commission's annual Triage budget of \$32 million per year (\$96 million from fiscal years 2017/18, 2018/19, and 2019/20)
2. SB 833 funds, which were a one-time allocation of \$3 million meant for crisis intervention services for children and youth and training for parents and caregivers of children and youth in crisis
3. Unspent Triage funds from Round I, about \$28.6 million¹ (FY 2013/14: \$5,010,508.55; 2014/15: \$5,903,251.42; 2015/16: \$913,709.51; 2016/17 \$16,843,657)

Total: \$127,671,126

It was estimated that these three sources of revenue would allow the Commission to provide over \$117 million to fund Triage programs and \$10 million to evaluate them. There was \$10,671,127.27 in additional Triage funds which could have been used to fully fund additional counties in the Adult/TAY and/or the Children/Youth components.

In response to negotiations with the Governor's Departments of Finance, the Commission delayed signing contracts with the awardees to receive their funding. More specifically, the re-appropriation of prior years' funding (\$31,671,127.27) for this purpose required new budget authority.

On June 27, 2018, Governor Brown signed the 2018/19 budget which reduced funding for Triage programs in the following ways: reduced base funding from \$32 million to \$20 million in FY 2017/18, and in future years and denied the Commission's request to re-appropriate unspent funds from Round I of Triage.

* Uncertain due to Round I program dollars still being spent down

As a result, the Commission has \$63 million in funds available – or 53 percent of the initial awards –\$20 million from FY 2017/18, 2018/19, and 2019/20 and the \$3 million from SB 833.

The Commission has the option of using FY 2020/21 Triage funds (\$20 million) to support the program, increasing available funds from \$63 million to \$83 million – or 71 percent of the initial awards. Doing so would expand access to funds but would delay by one year the next round of Triage funding.

To address this funding shortfall, the Commission should consider the following options:

Option #1: Reduce awards for all recipients and statewide evaluation by an even percentage.

Component	Released for	Applied/ Awarded	Award: 53%	Award: 71%	Awarded
Adult/TAY	\$48,000,000	20/15	\$25,714,285	\$33,877,551	15
Children/Youth	\$29,600,000	17/11	\$15,913,820	\$20,891,156	11
School-County Collaborative	\$30,000,000	17/4	\$16,071,429	\$21,173,469	4
Evaluation	\$10,000,000	N/A	\$5,357,142	\$7,057,823	N/A
Total	\$117,600,000	54/30	\$63,056,677	\$83,000,000	30

Option #2: Reduce available funding for each component (Adult/TAY, Children/Youth, and School-County Collaborative) and award available funds based on rank of proposals.

Component	Released for	Applied/ Awarded	Award 53 %	Award 71 %	Awarded
Adult/TAY	\$48,000,000	20/15	\$25,440,000	\$33,877,551	8/12
Children/Youth	\$29,600,000	17/11	\$15,688,000	\$20,891,156	9/11
School-County Collaborative	\$30,000,000	17/4	\$15,900,000	\$21,173,469	2/3
Evaluation	\$10,000,000	N/A	\$5,300,000	\$7,057,823	N/A
Total	\$117,600,000	54/30	\$62,328,000	\$83,000,000	19/26

Option #3: Cancel the current procurement and release new RFAs.

Presenter: Norma Pate, Deputy Director

Enclosure: None.

Handout: A PowerPoint will be presented at the meeting.

Proposed Motion: The Commission adopts one of the options outlined by staff and directs Commission staff to implement it including notify grantees from the recent procurement process of the option impact.

AGENDA ITEM 5

Information

July 26, 2018 Commission Meeting

Innovation Dashboard and Presentations

Summary: Sharmil Shah, Psy.D, Chief of Program Operations for the Mental Health Services Oversight and Accountability Commission (Commission), will review the Innovation Dashboard and provide an overview of efforts to track county Innovation plans and an update to the Innovation Toolkit.

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

Enclosures (2): (1) Innovation Dashboard-July 2018; (2) Commission Meeting Recommendations

Handouts: None.

Motion: None.



INNOVATION DASHBOARD - JULY 2018 (Current)

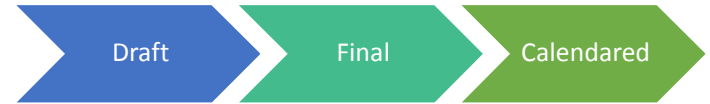
CALENDARED*
DRAFT PROPOSALS RECEIVED
TOTAL

NUMBER OF PLANS
7
29
36

COUNTIES
5
18
23

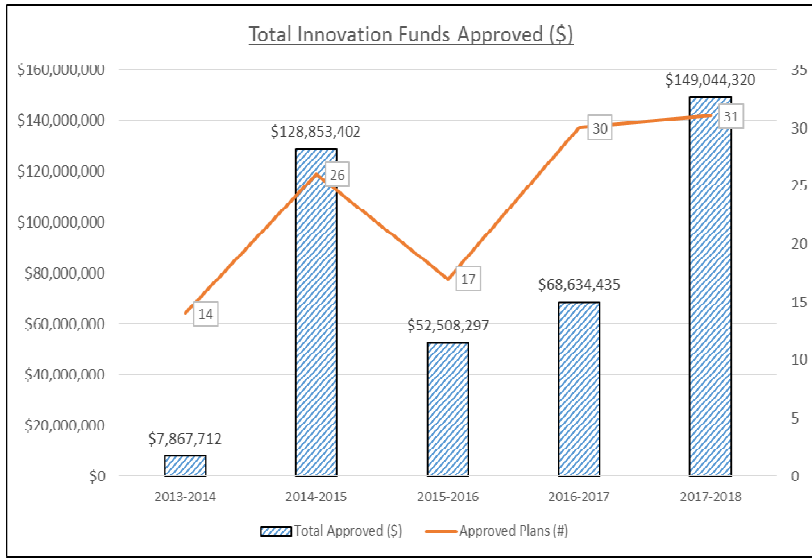
FUNDS REQUESTED
\$5,488,993
\$109,033,239
\$114,522,232

AVERAGE TIME FROM FINAL to COMMISSION CALENDAR
58.25 days



* July: Imperial (1), Ventura (2), Del Norte (1)
August: San Luis Obispo (2), Santa Barbara (1 Extension)

Previous FY Trends:



2017-2018

- APPROVED Innovation Funds: \$143,871,714
- APPROVED Extension Funds: \$5,172,606
- Plans Received: 34
- Plans APPROVED: 31 (91%)
- Participating Counties: 19 (32%)
- Participating Counties APPROVED: 16 (84%)

2016-2017

- APPROVED Innovation Funds: \$66,625,827
- APPROVED Extension Funds: \$2,008,608
- Plans Received: 33
- Plans APPROVED: 30 (91%)
- Participating Counties: 18 (31%)
- Participating Counties APPROVED: 17 (94%)

2015-2016

- APPROVED Innovation Funds: \$46,920,919
- APPROVED Extension Funds: \$5,587,378
- Plans APPROVED: 17
- Participating Counties: 15

2014-2015

- APPROVED Innovation Funds: \$127,742,348
- APPROVED Extension Funds: \$1,111,054
- Plans APPROVED: 26
- Participating Counties: 16

2013-2014

- APPROVED Innovation Funds: \$7,867,712
- APPROVED Extension Funds: \$0
- Plans APPROVED: 14
- Participating Counties: 8

Number of Counties that have presented an INN Plan to the Commission since 2013:
53 Counties **89%**

Percent of Counties that have NOT presented an INN Plan to the Commission since 2013:
6 Counties **10%**

STATUS	COUNTY	PLAN NAME	FUNDING AMOUNT REQUESTED	PROJECT DURATION	DRAFT PROPOSAL SUBMITTED TO OAC	FINAL PLAN SUBMITTED TO OAC	COMMISSION MEETING
CALENDARED	Imperial	First Step to Success	\$531,120	15 Months	3/8/2018	4/18/2018	JULY
CALENDARED	Ventura	Suicide Prevention Project: Bartenders as Gatekeepers	\$241,367	3 Years	3/5/2018	6/8/2018	JULY
CALENDARED	Ventura	Push Technology Project	\$438,933	3 Years	3/5/2018	6/8/2018	JULY
CALENDARED	Del Norte	Text 2 Grow-Giving Resource Outreach & Wellness	\$262,846	3 Years	5/2/2018 5/22/2018	6/18/2018	JULY
CALENDARED	San Luis Obispo	Affirming Cultural Competence Education & Provider Training: Offering Innovative Solutions to Increased LGBTQ Mental Health Care Access (SLO ACCEPTance)	\$554,729	4 Years	4/20/2018	6/8/2018	AUGUST
CALENDARED	San Luis Obispo	3-by-3 Developmental Screening Partnership Parents and Pediatric Practices	\$859,998	4 Years	4/20/2018	6/8/2018	AUGUST
CALENDARED	Santa Barbara	Resiliency Interventions for Sexual Abuse (RISE)	\$2,600,000	2 Years	N/A	4/12/2018	AUGUST

CALENDARED: County has met all the minimum regulatory requirements for Innovation - Section 3580.010, and three (3) local approval steps; 30 day public comment, Local Mental Health Board/Commission hearing, and Board of Supervisor (BOS) approval

STATUS	COUNTY	PLAN NAME	FUNDING AMOUNT REQUESTED	PROJECT DURATION	DRAFT PROPOSAL SUBMITTED TO OAC	FINAL PLAN SUBMITTED TO OAC	COMMISSION MEETING
DRAFT	Tuolumne	Building a Compassionate Response to Trauma in a Rural Community	\$1,248,073	5 Years	3/26/2018	6/19/2018	
DRAFT	Santa Clara	headspace Implementation Project	\$5,388,913		6/21/2018	Expected 7/16/2018	
DRAFT	San Diego	ADAPT (INN 18)	\$4,773,040	5 years	1/3/2018	6/21/2018	
DRAFT	Kings	The Multiple-Organization Shared Telepsychiatry (MOST) Project	\$1,663,631	3 Years	6/13/2018		
DRAFT	Monterey	Activities for Increasing Latino Engagement	\$1,240,000	3 Years	5/2/2018		
DRAFT	Monterey	Transportation Coaching by Wellness Navigators	\$1,234,000	3 Years	5/2/2018		
DRAFT	Los Angeles	Enhancing Workforce Training through Mixed Reality Approaches	\$6,683,164	5 Years	6/22/2018		
DRAFT	Los Angeles	Therapeutic Transportation	\$7,463,576	3 Years	6/22/2018		
DRAFT	Los Angeles	Ongoing Focused Support to Improve Recovery Rates for Conservatees Living in the Community	\$13,888,914	5 Years	6/22/2018		
DRAFT	Tehama	TECH SUITE	\$118,088	2 Years	3/28/2018	4/6/2018	
DRAFT	Tri-City	TECH SUITE	\$1,674,755	4 Years	4/5/2018		
DRAFT	City of Berkeley	TECH SUITE	\$462,916	3 Years	4/24/2018		
DRAFT	Riverside	TECH SUITE	\$25,950,000	4 Years	4/9/2018		

STATUS	COUNTY	PLAN NAME	FUNDING AMOUNT REQUESTED	PROJECT DURATION	DRAFT PROPOSAL SUBMITTED TO OAC	FINAL PLAN SUBMITTED TO OAC	COMMISSION MEETING
DRAFT	Monterey	TECH SUITE	\$2,526,000	3 Years	5/2/2018		
DRAFT	San Mateo	TECH SUITE	\$3,872,167	2 Years	5/9/2018	6/4/2018	
DRAFT	Marin	TECH SUITE	\$638,000	21 Months	4/30/2018		
DRAFT	San Francisco	TECH SUITE	\$2,273,000	5 Years	5/17/2018		
DRAFT	Santa Barbara	TECH SUITE	\$4,912,852	5 Years	6/6/2018		
DRAFT	Santa Clara	TECH SUITE	\$4,373,886				
DRAFT	Inyo	TECH SUITE	\$448,757	3 Years	7/2/2018		
DRAFT	Alameda	Cannabis Policy and Education Project	\$1,484,375	3 Years, 3 months	3/12/2018	Expected Late June	
DRAFT	Alameda	Community Assessment and Transport Team (CAT)	\$9,916,894	5 Years	3/22/2018	Expected Late June	
DRAFT	Alameda	Transitional Age Youth Emotional Emancipation Circles	\$454,907	2 Years, 6 Months	3/22/2018	Expected Late June	
DRAFT	Alameda	Introducing Neuroplasticity to Mental Health Services for Children	\$1,734,813	4 Years	4/18/2018	Expected Late June	
DRAFT	San Francisco	Wellness in the Streets	\$1,750,000	5 Years	5/17/2018		
DRAFT	Tulare	Addressing Metabolic Syndrome and Its Components in Consumers Taking Antipsychotic Medication	\$1,382,734	5 Years	12/15/2017		
DRAFT	Tulare	Connectedness2Community	\$765,175	5 Years	12/15/2017		
DRAFT	Calaveras	Enhancing the Journey to Wellness/Peer Navigator Program	\$710,609	5 Years	6/6/2018		
DRAFT	City of Berkeley	Trauma-Informed Care for Educators	\$0		6/29/2018		

DRAFT: A County plan submitted to the OAC that contains some of the regulatory requirements, including but not limited to a full budget and budget narrative; still may require technical assistance and is considered the last version before the FINAL is submitted



COMMISSION MEETING RECOMMENDATIONS

These recommendations for Innovation plan presentations have been developed to support the dialogue between the Commission and the counties. Please note that the recommendations below regarding length, the county brief, PowerPoint presentation and presenter information are to ensure that counties and the Commission have ample opportunity to engage in a dialogue to gain a better understanding of the needs in the county, how the Innovation plan meets those needs, why it is innovative, and how will it be evaluated to support shared learning.

1. Length of Presentation
 - a. County presentations should be no more than 10-15 minutes in length
 - b. The Commission will have received the Innovation Project Plan as well as the Staff Analysis prior to the meeting
 - c. The remaining time on the agenda is reserved for dialogue with the Commission and for public comment

2. County Brief
 - a. Recommend 2-4 pages total and should include the following three (3) items:
 - i. Summary of Innovation Plan / Project
 - ii. Budget
 - iii. Address any areas indicated in the Staff summary

3. PowerPoint Presentation
 - a. Recommend 5 slides and include the following five (5) items:
 - i. Presenting Problem / Need
 - ii. Proposed Innovation Project to address need
 - iii. What is innovative about the proposed Innovation Project? How will the proposed solution be evaluated (learning questions and outcomes)?
 - iv. Innovation Budget
 - v. If successful, how will Innovation Project be sustained?

4. Presenters and Biographies
 - a. We request no more than a few (2-4) presenters per Innovation Project
 - i. If the county wishes to bring more presenters, support may be provided during the public comment period
 - b. Recommend biography consisting of brief 1-2 sentences for individuals presenting in front of the Commission
 - i. Include specific names, titles, and areas of expertise in relation to Innovation Plan / Project

Note: Due dates will be provided by the Innovation Team upon Commission calendaring for the following items: Presenter Names, Biographies, County Brief, and PowerPoint presentation.

AGENDA ITEM 6

Action

July 26, 2018 Commission Meeting

Ventura County Innovation Plans

Summary: The Mental Health Services Oversight and Accountability Commission (Commission) will consider approval of Ventura County's request to fund the following Innovative projects for a total amount of \$680,300. There are two programs for consideration: (1) a three year project for \$438,933 called Push Technology Project; and (2) a three year project for \$241,367 called the Suicide Prevention Project: Bartenders as Gatekeepers.

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.

Ventura County proposes to implement the Push Technology Project to assist individuals discharged from county inpatient psychiatric hospitals and residential crisis stabilization units by utilizing mobile behavioral intervention technology.

In an effort to reduce the suicide rates of men between the ages of 45-64, Ventura County proposes to engage in a prevention program and media campaign, and will provide suicide prevention training for servers of alcohol.

Presenters for Push Technology Project:

- Kiran Sahota, MA, Senior Behavioral Health Manager, Ventura County
- Hilary Carson, MSW, Innovations Administrator, Ventura County
- Erik Sternad, Executive Director, Interface Children and Family Services

Presenters for Bartenders as Gatekeepers Project:

- Kiran Sahota, MA, MHSA Senior Behavioral Health Manager, Ventura County Behavioral Health
- Hilary Carson, MSW, MHSA Innovations Administrator, Ventura County Behavioral Health

Enclosures (5): (1) Biographies for Ventura County’s Innovation Presenters; (2) Push Technology Staff Analysis; (3) Push Technology Project Brief; (4) Suicide Prevention Project: Bartenders as Gatekeepers Staff Analysis; (5) Suicide Prevention Project: Bartenders as Gatekeepers Project Brief

Handouts (1): PowerPoint will be presented at the meeting for both Projects.

Additional Materials (1): Links to the County’s Innovation Plans are available on the MHSOAC website at the following URLs:

<http://mhsoac.ca.gov/document/2018-06/ventura-county-innovation-plan-push-technology-project-july-2018>

<http://mhsoac.ca.gov/document/2018-06/ventura-county-innovation-plan-bartenders-gatekeepers-july-2018>

Proposed Motion: The MHSOAC approves Ventura County’s Innovation Projects, as follows:

Name:	Push Technology Project
Amount:	\$438,933
Project Length:	Three (3) Years

Name:	Suicide Prevention Project: Bartenders as Gatekeepers
Amount:	\$241,367
Project Length:	Three (3) Years



Kiran Sahota, MA

Mental Health Services Act Senior Behavioral Health Manager
Ventura County Behavioral Health

Kiran has managed all MHSOAC activities in Ventura County since 2015. She has worked in Ventura County Social Services for over 20 years. She has experience in the child welfare system, law enforcement, and community collaboration. Her advanced education is in Clinical and Community Psychology.

Hilary Carson, MSW

MHSOAC Administrator, Innovations
Ventura County Behavioral Health

Hilary received her MSW from NYU in Policy and Programs; she has a background in working with Community-Based Organizations specializing in parents and families involved in the criminal justice system. She joined Ventura County Behavioral Health in June 2016.

Erik Sternad

Executive Director, Interface Children & Family Services

Since 2007, Erik Sternad has served as the Executive Director of Interface Children & Family Services, a family strengthening agency in Ventura County that responds to more than 42,000 family members each year through mental health services, youth and family strengthening programs, family violence intervention, human trafficking response, returning offender programs and 2-1-1 information and referral assistance.



STAFF ANALYSIS— VENTURA COUNTY

Innovation (INN) Project Name:	Push Technology Project
Total INN Funding Requested:	\$ 438,933
Duration of Innovative Project:	Three (3) Years

Review History:

Approved by the County Board of Supervisors:	April 10, 2018
County submitted INN Project:	June 8, 2018
MHSOAC consideration of INN Project:	July 26, 2018

Project Introduction:

Ventura County is proposing to develop a program for individuals aged 6-59 who have been discharged from psychiatric hospitalization or crisis stabilization units in an effort to reduce the individual's re-hospitalization rate. The County intends to utilize automated push technology in partnership with the County's local 211 services provider whose primary function is to provide community information and referral services for county residents. Push technology is defined as a service that pushes information to a client from a server. Examples of push technology can include email, instant messaging, and notifications.

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. The County states this Innovation Project meets the primary purpose of increasing the quality of mental health services, including measured outcomes.

The Need

Ventura County states the lack of crisis beds in their County has resulted in individuals who may need mental health services waiting for protracted lengths of time in the emergency room department. Further, adding to the shortage of available crisis services in Ventura County is because Vista del Mar Psychiatric Hospital, one of the only two psychiatric hospitals in the County, sustained heavy damage from the Thomas Fire, which was not completely contained until January 12, 2018. This has resulted in individuals requiring crisis services being temporarily relocated out of the County.

Research shows that individuals discharged from psychiatric hospitals are most at-risk of suicide attempts in the following first few weeks after being discharged. As a result, individuals who are at higher risk for suicide would benefit from immediate community follow-up post-discharge (Bickley, Hunt, and et.al). The County states the simple solution would be to increase the number of crisis beds available, however that would take time to procure the land, to build another facility, to obtain the necessary licensing, etc. Due to County residents currently needing to seek treatment within other Counties, sometimes as far as the Bay Area, the County would like to focus on reducing the risk of re-hospitalizations post-discharge in order to prevent individuals from re-entering psychiatric facilities.

In the County's research of ways to provide mental health services with the limited availability of psychiatric beds, literature and previous studies were reviewed which concluded that Behavioral Intervention Technologies are an effective way to test Ecological Momentary Interventions. Behavioral Intervention Technologies (BIT) are applications that utilize technologies to support positive behaviors to improve health, mental health, and overall wellness (Schueller, 2014). In comparison, Ecological Momentary Interventions (EMI) incorporates mobile technology in order to provide treatments to people in their everyday life, in real time (Heron & Smyth, 2010). Ventura County would like to test the feasibility of sending EMI messaging to clients post-discharge in an effort to reduce re-hospitalization rates.

Despite the research conducted, the County was unable to find articles relating to the use of EMIs in order to reduce re-hospitalization rates and the County would like to explore the efficacy of EMIs for those who have been recently discharged from a psychiatric facility. Additionally, the County found that existing research shows that family support during and after hospitalization plays a pivotal role in terms of an individual's success upon discharge, regardless of age and as a result, would like to include a support person as part of this project.

The Response

In order to reduce the rate of re-hospitalizations from psychiatric facilities both in and out of the County, Ventura County proposes to utilize automated technology in partnership with the County's local 211 services provider, to improve post-discharge outcomes.

The County's current local 211 services provider offers a range of resources within the community via their website, <http://www.211ventura.org/>. Individuals needing to locate services within the community can visit this website to locate nearby resources and programs to address various topics including, but not limited to: crisis services, transportation, education, legal assistance, substance abuse, housing & homeless services, reentry, county food programs, youth and senior services.

Working in collaboration with the contractor, the County began to study if there would be enough interest generated for receiving text-based communications. The contractor held focus groups for youth and adults and decided to test the need of the 211 service by going live. After going live, the County states they continue to receive an average of 167 requests for information received on the 211 line on a monthly basis. Since the County's success with the local 211 service, the County and the contractor wish to expand upon the services that have been previously offered and hope to incorporate text-based communications for those discharged from psychiatric hospitals and crisis units within the first 90 days. This project plan would like to conduct additional research into these findings to determine the efficacy of push technology to reduce re-hospitalization rates post-discharge.

The local 211 services provider, Interface, would like to incorporate the use of Ecological Momentary Interventions (EMI) to deliver daily and weekly assessments via cell phone for participating individuals post-discharge. Upon discharge, the program will be discussed and participants may elect to enroll, along with a designated support person who will also receive weekly assessments. Support participants will be able to provide valuable input regarding the participant's progress and any contact the support has had with the participant since discharge to the contractor. Minors must select a parent or guardian as their person of support and adults may select a person of support who they believe is, or has been, a positive influence in their wellness. Participants will also sign consent forms and if not available to sign in-person, may give their authorization and signature through text messaging capability. **County may wish to discuss with Commissioners the informed consent of participants to ensure participants are aware of who will be collecting data, what the data will be used for and the access of identifiable information of participants: what safeguards are in place for the protection of privacy?**

Once voluntary enrollment occurs, individuals between the ages of 6-59 will receive daily text messages for the initial 30 days following discharge. These text messages will be used to assess the participant's mood utilizing a 10-point scale and will be monitored by the contractor who will also be responsible creating self-reporting surveys, the collection of data, and follow up resources. After the initial 30 days of receiving daily text messages, participants will then receive weekly text messaging to assess mood for the remainder of

the 60 days. It is the County's desire to monitor participants for the entire 90 day period post-discharge.

Responses from participants will be tracked and analyzed; any downward dip in mood will trigger an automatic follow-up trend offering one of these following options:

- Connect participant to a clinic
- Connect participant to a warm line
- Have an operator call them immediately
- Provide a referral to county resources
- Connect the participant to a crisis team
- No action taken

The data that will be collected will include demographics of the participant, the number of responses to text messages, re-hospitalization rates, as well as outpatient attendance rates. In addition to text messages sent to assess mood, both participants and their designated support person will also receive first appointment reminder, which the County claims is also a helpful intervention.

The County claims this project is innovative as it uses technology in combination with EMI to ensure participants are monitored and connected to resources, if needed, within 90 days of discharge. **In the event that a participant choose to take no additional action, the County may wish to discuss and provide detail as to what contingency plan is in place if the participant chooses to take no action: will this result in the participant being monitored more closely? Is there a protocol in place for participants with consistent downward trends who choose no follow up action to be taken?**

The Community Planning Process

Ventura County held Community forums in three different geographic regions within their county with translation services provided for its various monolingual communities. In an effort to seek input from its community, the County trained its members on MHSA regulations and innovation criteria during these forums and then solicited ideas from the community for innovative concepts that were needed in the community. Community members were encouraged to submit their ideas by attending any of these forums or going online to the County website to provide input. As a result of community input, a total of 52 innovation concepts were compiled in addition to a list of needs established by the community.

All of the 52 innovation concepts submitted were then reviewed by Ventura County's MHSA Planning Committee, comprised of consumers, youth, transitional age youth, law enforcement, older adults, and adults. The innovation concepts were reviewed along with innovation regulations to assist the Planning Committee in sorting out what concepts could be considered innovative. Submitted concepts were eliminated until the most popular five (5) concepts – indicated by receiving the highest number of votes - were presented to the MHSA Planning Committee Board for approval.

As part of MHSA General Standards for cultural competency, text messages will be provided in multiple languages including English, Spanish, Mandarin, Arabic, Farsi, Russian and Vietnamese. Additionally, the County states they will be collaborating with other local county agencies so that when participants call in to the 211 service, they will also be able to reach resources that are already built into the current 211 model including, but not limited to, housing, employment, and food assistance.

The MHSOAC shared this Innovation Project with stakeholders beginning March 9, 2018 while the project was in the 30-day review at the County level. It is not known whether comments were received at the County level; however, no letters of opposition or support were received at MHSOAC in response.

Learning Objectives and Evaluation

Ventura County has proposed implementing a post-discharge ecological momentary intervention (EMI) project that will utilize push technology. The project will target individuals that are discharged from hospitalization or crisis stabilization services aged 6-59, whom are also at risk of serious mental illness or serious emotional disturbance. It is estimated that 500 individuals will be served annually through the push technology project.

In order to guide the project, The County has laid out five learning questions:

1. Are clients satisfied with EMI technology?
2. Do clients find EMI technology valuable in their mental health recovery?
3. Do participants make it to their follow up appointment more frequently with text support?
4. Does using mobile EMI increase treatment engagement?
5. Does using mobile EMI reduce the rate of re-hospitalization?

Through the use of EMI technology, the County expects to see improvements in post-discharge outcomes, including increased treatment engagement (*defined as*: attending outpatient appointments and taking prescribed psychotropic medication), as well as a reduction in rates of re-hospitalization. A number of measures will be utilized to determine if the learning goals and these outcomes are met, including: responses to EMI outpatient attendance rates, hospitalization rates, satisfaction with services, and overall engagement with push technology services (**see pgs. 7-8 of County plan**).

To establish comparison groups, Ventura County will use self-report surveys to evaluate participant satisfaction with EMI technology; technology platform analytics to evaluate overall EMI engagement; and patient electronic health records [to evaluate treatment engagement and re-hospitalizations. All participants will give their full consent prior to enrolling into this program. As part of Ventura County's internal process, the County vetted this project with their internal Institutional Review Board (IRB) as a courtesy to avoid any problematic issues that may arise. The County states that if IRB approval is not granted, specific milestones based upon research and literature will be utilized. The County will enter into a contract with Evalcorp to assist with data collection methods and data analytics in order to complete the final evaluation.

The Budget

The proposed budget for this Innovation Project is \$438,933 over three (3) years. A total of \$57,252 (13%) are for indirect costs associated with County administrative costs which includes personnel, equipment, office space, and taxes.

The largest portion of the budget is for consultant and evaluation costs totaling \$381,681, accounting for 87% of the total budget. The proposed consultant and evaluation costs are comprised of the following: evaluation component is estimated to be \$87,429; contracted personnel costs total \$219,146; and contracted operating and indirect costs for expenses in the amount of \$75,106.

At the end of the project duration, if successful, the County indicates they would like to sustain the project by utilizing Prevention and Early Intervention funds for the following year. If the project is unsuccessful in meeting any of the learning goals, the project will not be continued.

In reference to Assembly Bill 114 regarding reversion of funds, the County states they will be using funding from Fiscal Year 2009/2010 to fund this project entirely in the amount of \$438,933.

Additional Regulatory Requirements

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

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<http://www.211ventura.org/>

Full project proposal can be accessed here:

<http://mhsoc.ca.gov/document/2018-06/ventura-county-innovation-plan-push-technology-project-july-2018>

Innovation Project Brief

Ventura County: Push Technology Project

Primary Problem

The number of psychiatric beds in the United States has been decreasing dramatically over the past few decades. The Treatment Advocacy Center recently published estimates of state hospital bed needs, noting in 1955 (before deinstitutionalization), the nation was served by roughly 337 state beds per 100,000 persons, and by 2016, there were fewer than 12 beds per 100,000 persons¹. Since 1998, there has been a 35% reduction in available beds per 100,000 people². Ventura County has experienced similar declines in the number of available beds – a problem exasperated by the recent Thomas Fire that burned one of only two psychiatric facilities in the County. The affected hospital treated adults and was the only facility in the County licensed to treat youth. The result has been a recent spike in youth hospitalizations out-of-county, 77 in the immediate 15 weeks after the fire. The youth are often transported away from family as far as Bakersfield or the San Francisco Bay area. Adult facilities were also affected by the fire. However, even prior to the fire, in FY 16/17, the local inpatient unit at the county hospital had roughly an additional 700 individuals that could not be served due to capacity limitations.

Research has demonstrated a lack of available hospital beds leads to higher occupancy rates, shorter inpatient rates of stay and prolonged emergency department waiting times³. This causes the most vulnerable patients in crisis to wait for hours or days, crowding hospital hallways while they wait for a bed to become available, only to then be released back into the community at faster rates than in the past.

Individuals with a current or recent inpatient psychiatric hospitalization are also at an elevated risk for suicide. Significant clustering of suicides has been found soon after discharge from psychiatric care – the most critical period being the first 28 days⁴. This This reinforces the need for additional beds and supports during the critical period between discharge and treatment.

¹ La E.M, Lich, K.H. Wells, R. Ellis, A. Swartz, M.S. Zhu, R. Morrissey, J.P. (2014) Increasing Access to State Psychiatric Hospital Beds: Exploring Supply Side Solutions, *Psychiatric Services*, Vol 67, (5) Pages 523-528 <https://doi.org/10.1176/appi.ps.201400570>

² Bastiampillai, T. Sharfstein, S. Allison, S (2016) Increase in US Suicide Rates and the Critical Decline in Psyciatric Beds, *JAMA*, Vol 316 (24) Pages 2591-2592

³ *Ibid*

⁴ Goldacre M., Seagroatt V., Hawton K. (1993) Suicide after discharge from psychiatric inpatient care, *The Lancet*, Vol 342 (8866), Pages 283-286

Program Summary

The proposed project will focus on individuals exiting county inpatient psychiatric hospitals and residential crisis stabilization units. The project is designed to increase the quality of mental health services. The primary goal of the project is to improve post-discharge outcomes through the employment of enterprise-mobile integration (EMI), through automated push technology provided in partnership with the local 211 services provider. The project makes a change to an existing mental health practice by utilizing EMI to reduce re-hospitalization through repeated mini-assessments and appropriate follow-up during the first 90 days post hospitalization. According to repeated research, this is the period when individuals are at the highest risk for re-hospitalization or attempted suicide⁵.

Youth and adults will be invited to enroll in the trial upon discharge and participants will receive a daily text assessment measuring mood on a scale of 1-10 for the first 30 days after discharge, then weekly for the remaining 60 days. Any downward trend in the assessments or sudden dip will automate a follow-up text offering one of the following options:

- Connect the patient to their clinic
- Connect the patient to a warm line
- Have the operator call them
- Provide a resources referral
- Connect to the crisis team
- No action

In addition, enrollees may identify a support person (i.e., a friend, parent, sibling, spouse, etc.) to participate in the program. These support participants will receive weekly assessments asking for their perception as to how they perceive the person is doing and what contact they have had with the participant. Similarly, these individuals will receive follow-up texts after downward trends or sharp declines with the same menu of services.

Appointment reminders are another important intervention recommended by the literature review. Therefore, both the participants and their support person will receive a reminder first appointment text in addition to the 90 days of EMI. The project attempts to utilize the most consistent recommendations from the literature to build a best practice into the innovative program design. The goal of the program is to intervene with the already available support services prior to decomposition of the patient needing re-hospitalization.

⁵ James, S., Charlemagne, S.J., Gilman, A.B. et al. (2010) Post-Discharge Services and Psychiatric Rehospitalization Among Children and Youth, *Administration and Policy in Mental Health and Mental Health Services Research*. Vol 37 (5) 433-445.

Evaluation Plan

The proposed innovative program will work with the county’s third-party investigator (Evalcorp), to examine the implementation and impact of the EMI-Push Technology.

Learning Goals

- Are clients satisfied with EMI technology and do they find it valuable in their mental health recovery?
- Do participants make it to their follow up appointment more frequently with text support?
- Does using mobile EMI increase treatment engagement?
- Does using mobile EMI reduce the rate of re-hospitalizations?

Question	Indicator	Measures/Sources being Considered
1. Are clients satisfied with EMI technology and do they find it valuable in their mental health recovery?	Participant engagement rates with EMI and positive response to satisfaction survey	Technology platform analytics data reported monthly. Text survey designed by Evalcorp measuring satisfaction and value
2. Do participants make it to their follow up appointment more frequently with text support?	First appointment attendance rate increases	Comparison group utilizing electronic health records (EHR) (pending IRB) or benchmark
3. Does using mobile EMI increase treatment engagement?	Higher services utilization rates.	Services tracked in the EHR records and compared with participants and individuals in the comparison group (pending IRB approval) or benchmark
4. Does using mobile EMI reduce the rate of re-hospitalizations?	Lower recidivism rates one-year post-intervention	Recidivism rates tracked by EHR records and self-report surveys with participants and comparison group or with participant’s previous EHR history.

Learning Goal	Indicator	Measure/Sources Being Considered
1.	Increased website traffic-suicide prevention	Website analytics
2.	Increase in use of crisis hotline	Local Suicide Prevention Hotline total calls by age group
3.	Improved assessment scores on pre vs. post-test on perceived knowledge and self-efficacy	Question Persuade Refer pre and post curriculum survey
4.	Number of times participants identified and intervened with patrons six months post training. Of those how many were middle age men.	Survey to be developed by Evalcorp to evaluate the change in behavior post training modeled off previous findings of QPR research
5.	Measure of relevance to work	Survey to be developed by Evalcorp modeled on previous findings of QPR research. Focus groups in year three.
6.	Lower rates of completed suicides among men ages 45-60	Annual Medical Examiners Statistics

Project Budget

The project will be contracted with Interface, a current contractor for 211 services throughout the state of California, located in Ventura County. They currently use EMI within their organization and have a proven record of success in outreach to the community. The County will provide project management, data analysis, regulation compliance, and evaluation throughout each phase of the project.

BUDGET TOTALS	FY 2019	FY 2020	FY 2021	Total
Personnel (included in contractor costs)				
Direct Costs	108,234	110,430	124,636	343,300
Indirect Costs	30,535	31,274	33,824	95,633
TOTAL INNOVATION BUDGET	138,169	141,704	158,460	438,933



STAFF ANALYSIS— VENTURA COUNTY

Innovation (INN) Project Name:	Suicide Prevention Project: Bartenders as Gatekeepers
Total INN Funding Requested:	\$ 241,367
Duration of Innovative Project:	Three (3) Years

Review History:

Approved by the County Board of Supervisors:	April 10, 2018
County submitted final INN Project:	June 8, 2018
MHSOAC consideration of INN Project:	July 26, 2018

Project Introduction:

Ventura County proposes to create and engage in a program and campaign consisting of targeted advertisements and training for bartenders and alcohol servers to address the suicide rates for middle aged men between 45-64 years of age.

In conjunction with a contracted graphic design agency, men with lived experience (defined as men in the targeted age range who are survivors of attempts, have experience with suicidal ideation, or family members of those who have committed suicide) and bar owners will work together to create the campaign design, materials, and messaging.

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.

The County states this Innovation Project meets the primary purpose of increasing access to mental health services and meets the innovation project category by making a change to an existing mental health practice that has not yet been demonstrated to be effective, including but not limited to, adoption for a new setting, population, or community. In this instance, the County states this practice has not been demonstrated to be effective among the population of bartenders serving as gatekeepers and would like to assess the feasibility of this population in observing those at risk of suicide.

The Need

Ventura County states that men between the ages of 45-64 years of age experience the highest rates of suicide in America (19.7 deaths per population size of 100,000) and between 1997 and 2014, that amount amplified by 43% during that time period. Causes for the increase may be attributable to high rates of divorce, economic recession resulting in the loss of homes and jobs, as well as alcohol and substance abuse often viewed as a method of coping with the aforementioned stressors.

The Centers for Disease Control and Prevention also indicate that suicide rates have risen almost 30% since 1999, citing mental health conditions as being one of the factors that may contribute to suicide. Statistics also show that consumption of alcohol increases suicidal risk and at least one-third of the people who committed suicide met the criteria for alcohol abuse disorders. Additionally, research indicates that suicide risk among alcoholics increases with age, meaning that those who are middle age and older are more vulnerable to suicide compared to those who are younger and who abuse alcohol.

The County states that reaching the target population of middle aged men between the ages of 45-64 years is difficult since they are not typically treated or reached by conventional methods such as behavioral health clinics. In the County's research into this area, the County determined that previous attempts to reach this target group have included other counties working in collaboration with their local chapters of the National Rifle Association to provide information and resources at local gun shops and ranges regarding suicide prevention. Other efforts to study the efficacy of suicide prevention campaign materials in an effort to reach this target population of 45-64 year old men have also been conducted by San Diego and Santa Clara County. In 2010, San Diego began a campaign to empower their community to talk openly about mental health issues and the stigma that is attached; part of this campaign focused largely upon men. Santa Clara's research involved studying the efficacy of suicide prevention campaign materials in reaching men and reducing stigma. These counties found that this particular population was difficult to effectively reach and engage. Ventura would like to learn if bartenders are an appropriate group to reach the target population of men between the ages of 45-64 years of age.

The Response

For this project, Ventura County would like to address the risk of suicide in middle aged men by expanding upon previous campaign efforts that have been completed in other counties; in addition, the County would like to collaborate with community partners to provide training for bartenders and alcohol servers who may assist in recognizing individuals who may be showing signs of being at risk for suicide and provide referrals to resources within the County. Additionally, Ventura County will also use findings from previous campaign efforts and incorporate men with lived experience and family members who will assist in the development of this outreach campaign.

Ventura County proposes to offer an evidence-based training during the first two years of the innovation project. This training, known as Question, Persuade, and Refer (QPR) was recommended by Cal MHSAs previous campaign "Know the Signs" and is designed to teach lay and professional gatekeepers (those who may have control or access to something) to recognize the warning signs of suicide crisis and how to respond appropriately. The "Know the Signs" media campaign is deemed to be aligned with best practices and a well-known media campaign in regards to suicide prevention.

According to the Suicide Prevention Resource Center, the premise of QPR training is to follow three (3) basic steps:

1. Question the individual's desire or intent regarding suicide
2. Persuade the person to seek and accept help
3. Refer the individual to appropriate resources

Individuals receiving QPR training will receive a booklet and a wallet card as a memory reminder that will also include local resource referrals.

The County would like to provide QPR training for alcohol servers in three target areas within the county: Ventura, Simi Valley, and Conejo Valley, where completed suicides appear to be at the highest.

Although the County indicates this project is for the prevention of suicide, the County also states it is innovative because there appears to be very little research conducted in the past 40 years that involve training bartenders as gatekeepers. What little research there is seems to propose that bartenders may be a suitable group to train in providing referrals and limited crisis intervention, but thorough research has yet to be conducted regarding the training of bartenders to assess the risk in the prevention of suicide. For this reason, the County contends that this piloted research campaign is suitable for innovation funding as opposed to Community Service and Supports or Prevention and Early Intervention funding.

As part of the media campaign, the County will hire a graphic design company to coordinate with men who have lived experience and bar owners to collaborate and develop campaign materials consisting of messages promoting hope and will guide individuals in accessing suicide prevention websites, crisis lines, and county resources, as needed. These campaign materials will be distributed in liquor stores, bars, bartending schools, and restaurants that are located in areas having the County's highest suicide

rates. Additional visual media will be developed to include an interactive website, coasters, pens, bathroom advertisements and social media ads. To assist in addressing the stigma that can accompany mental health, a local celebrity with lived experience will be the face of the campaign and will share his story on the interactive website and has offered to be a spokesperson in the County and provide images and video testimony of his/her personal story.

The Community Planning Process

Ventura County held Community forums in three different geographic regions within their county with translation services provided for its community. In an effort to seek input from its community, the County trained its members on MHSA regulations and innovation criteria during these forums and then solicited ideas from the community for innovative concepts that were needed in the community. Community members were encouraged to submit their ideas by attending any of these forums or going online to the County website to provide input. As a result of community input, a total of 52 innovation concepts were compiled in addition to a list of needs established by the community.

All of the 52 innovation concepts submitted were then reviewed by Ventura County's MHSA Planning Committee, comprised of consumers, youth, transitional age youth, law enforcement, older adults, and adults. The innovation concepts were reviewed with literature to include training materials and resources to assist the Planning Committee in sorting out what concepts could be considered innovative. Submitted concepts were eliminated until the most popular five (5) concepts – indicated by receiving the highest number of votes - were presented to the MHSA Planning Committee Board for approval.

In addition to the MHSA Planning Committee, Ventura County's Suicide Prevention Council has conducted monthly meetings over the past three (3) years and is active within the community bringing forward suicide prevention strategies and outreach into the community. The Suicide Prevention Council includes, community members who are suicide survivors, family members, members of the LGBTQ+ community, crisis line workers, school district employees, law enforcement, and mental health workers. As part of the Community Planning Process, the Suicide Prevention Council has provided valuable input and support over the past year in the development of this project.

As part of MHSA General Standards and meaningful stakeholder involvement, the County has included individuals with lived experience from the targeted age group, who will continue to be part of the ongoing project and evaluation.

The MHSAOAC shared this Innovation Project with stakeholders beginning March 9, 2018 while the project was in the 30-day review at the County level. It is unknown if any comments or letters were received at the County; however, no letters of opposition or support were received at MHSAOAC in response.

Learning Objectives and Evaluation

Ventura County has proposed implementing a suicide prevention project that centers on creating an outreach and training plan for bartenders as mental health gatekeepers. There are two targeted populations for this project; 1) 12 bars or 50 bartenders will be

targeted for QPR training, and 2) the focus of these preventative trainings will be males aged 45-64 years who are at risk of serious mental illness.

In order to guide the project, The County has laid out five research questions:

1. Will a targeted outreach campaign increase the online traffic on the local suicide prevention site?
2. Will a targeted outreach campaign increase the number of calls to the local crisis line for men ages 45-64?
3. Does a suicide prevention training increase the knowledge, skills, and abilities of alcohol vendors to address a customer exhibiting risk signs of suicidality?
4. Are alcohol servers an appropriate population to target in suicide prevention training?
5. Will the combined effect of a sustained, targeted outreach campaign and mental health training for alcohol servers lower the rates of completed suicides for men ages 45-64 in the county?

The County states that their evaluation plan focuses on two parts: 1) evaluating the effectiveness of the outreach campaign, and 2) evaluating the effectiveness of the QPR training. Campaign materials will be developed and tested through focus groups, with the goal of directing the targeted age group to access local websites and helplines.

To measure increased access to these services, the County will monitor website traffic and total calls to helplines by age group. In order to measure the effectiveness of the QPR training, the County will examine changes in knowledge among bartenders on QPR literature, number of times bartenders identified and intervened with patrons, and rates of suicide among men aged 45-64. Expected outcomes include: increased use of services, improved knowledge and self-efficacy, and lower rates of completed suicides among men ages 45-64 (**see pgs. 7-8 of County plan**). The County will enter into a contract with Evalcorp to assist with data collection methods and data analytics in order to complete the final evaluation.

The Budget

The proposed budget for this Innovation Project is \$241,367 over three (3) years. The largest portion of the budget is for consultant and contract costs totaling \$189,643, or 79% of the total budget. The proposed consultant and contract costs are comprised of the following: the total evaluation component is estimated to be \$25,000 (13.2%); the information technology and design is estimated to cost \$151,043 (80%); a celebrity/talent unlimited spokesperson fee of \$10,000 (5.3%); and consultants who will provide training to bartenders and servers for a proposed amount of \$3,600 (1.9%).

A total of \$51,724 (21.4%) is proposed for the County's operating costs. Direct operating costs total \$20,240 (8.4%) which accounts for training materials, training for the trainers, and spot training for turnovers and the indirect costs total \$31,484 (13%) and will be for County administrative costs to include personnel who will be overseeing the project in addition to equipment, office space, and taxes.

Dependent upon the success of this Innovation Project, the County indicates they would like to sustain the project by utilizing Prevention and Early Intervention funds to be able to offer the training on a permanent basis in addition to continuing its advertising efforts. In reference to Assembly Bill 114 regarding reversion of funds, the County states they will be using \$241,367 from Fiscal Year 2009/2010 to fund this project entirely.

Additional Regulatory Requirements

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

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Full project proposal can be accessed here:

<http://mhsoac.ca.gov/document/2018-06/ventura-county-innovation-plan-bartenders-gatekeepers-july-2018>

Innovation Project Brief

Ventura County Suicide Prevention Project: Bartenders as Gatekeepers

Primary Problem

High profile suicides such as Linkin Park's Chester Bennington, designer Kate Spade and beloved travel author Anthony Bourdain, have highlighted the issue as well as the continued rising rates of suicide in middle age men. Men aged 45-64 experience the highest rates of suicide in America¹, with a 43 percent increase in suicide deaths from 1997 to 2014². Causes have not been substantiated but include a range of topics from high rates of divorce, job loss during the recent recessions and self-harming coping mechanisms such as substance abuse and isolation. Substance misuse significantly increases the risk of suicide, with 22 percent of deaths by suicide in the United States involving alcohol intoxication³. A diagnosis of alcohol misuse or dependence is associated with a suicide risk that is ten times greater than the suicide risk in the general population and acute alcohol intoxication is present in approximately 30-40 percent of suicide attempts⁴.

Local rates of suicide for middle-aged men have echoed national trends, which is one of the reasons the community has expressed on going concern about suicide rates for many years. In fact, the Ventura County Suicide Prevention Council and Ventura County Behavioral Health have led a variety of efforts to curb suicide completions locally by providing SafeTALK classes and community conferences. In the County, there are roughly 90 completed suicides per year, an average of 41 percent in 2014-2017 were men ages 45-64. This same age group of men also compose some of the lowest rates of calls to the local crisis support line, making up only 21 percent of the 820 annual calls. Middle-aged men are completing suicide at a disproportionate rate and utilizing crisis services equally disproportionately in the County.

One of the challenges in preventing suicide in middle-aged men is being unable to reach them through traditional methods like medical facilities or behavioral health clinics. Some counties have worked with their local chapters of the National Rifle Association to provide suicide prevention pamphlets at local gun shops and ranges. Ventura County plans to modify this approach by increasing community collaboration through targeted advertising in alcohol establishments and training alcohol servers to intervene with patrons who exhibit signs of being at risk for suicide.

¹ Substance Use and Suicide: A Nexus Requiring A Public Health Approach Health and Human Services (HHS) Publication No. SMA-16-4935 Printed 2016.

² California Department of Mental Health (2008). California Strategic Plan on Suicide Prevention. Sacramento, CA: California DMH. March 6, 2012 CALmhsa http://cccstudentmentalhealth.org/docs/CalMHSA_SuicidePreventionOverview.pdf

³ *Ibid*

⁴ Cherpitel, C.J., Borges, G.L., & Wilcox, H.C. (2004). Acute alcohol use and suicidal behavior: A review of the literature. *Alcoholism, Clinical and Experimental Research*, 28, 18S-28S. <http://www.ncbi.nlm.nih.gov/pubmed/15166633>.

Program Summary

The proposed project is a short-term selective prevention program that consists of targeted advertisements for men ages 45-64 and mental health gatekeeper training for bartenders and alcohol servers focused on the same population.

The media campaign will be a combination of print and visual media, including an interactive website, social media ads, coasters, pens and bathroom advertisements. A core group consisting of men with lived experience and bar owners in the targeted communities, will work on the campaign design and message with the graphic design team. A local celebrity with lived experience has agreed to be the face of the campaign and share his story. The messaging will build on the literature that has already taken place reaching this demographic. Materials will promote messages of hope and help and direct recipients to access local websites and helplines. The campaign materials will be distributed in bars, bartending schools and restaurants that serve alcohol in geographic areas with the highest rates of completed suicides. Recruitment for suicide prevention intervention training will take place in these same institutions and locations.

The outreach campaign will focus on local chambers of commerce, restaurant associations and responsible beverage sales and service training providers. The goal of this outreach is to advertise the initiative and send servers of alcohol for suicide prevention training. Media and law enforcement public information officers will be invited to participate in a training on reporting completed suicides and suicide statistics without inciting contagion.

The gatekeeper training Question, Persuade, and Refer (QPR), recommended by Cal MHSA's campaign "Know the Signs," will be offered to bars in the three target areas (Ventura, Simi Valley, and Conejo Valley) where suicide completions have been clustered at the highest rates. The evidence-based one-hour training will be provided during program years one and two of the innovation project timeline. QPR focuses on identifying risk factors, encouraging intervention and referring to services. Follow up evaluation will include surveys that take place six months post training to determine whether bartenders and servers are an appropriate target for intervening and preventing suicide in middle-aged men

Innovative Component

The project makes a change to an existing mental health model for training non-mental health occupations as mental health gatekeepers. The literature review and search of counties' MHSA programs have been unable to find any published within the past 40 years that train bartenders as mental health gatekeepers. A small body of research suggests that bartenders would be a suitable group to train in this role, but this research has not been tested. Therefore, this pilot is more suited for innovation funding than CSS or PEI dollars.

Evaluation Plan

The proposed innovative program will work with the county’s third-party investigator (Evalcorp), to examine the implementation and impact of QPR training for bartenders, the reduction of suicide within the male demographic age group of 45-64, and finally to see if there is an increase in crisis call within this age group.

Learning Goals

1. Will a targeted outreach campaign increase the traffic on the local suicide prevention site?
2. Will a targeted outreach campaign increase the number calls to the local crisis line for men ages 45-64?
3. Does a suicide prevention training increase the knowledge, skills and abilities of alcohol vendors to address a customer exhibiting risk signs of suicidality?
4. Are alcohol servers an appropriate population to target in suicide prevention training?
5. Long-term learning goal: Will the combined effect of a sustained, targeted outreach campaign and mental health training for alcohol servers lower the rates of completed suicides for men ages 45-64 in the County?

Learning Goal	Indicator	Measure/Sources Being Considered
1.	Increased website traffic-suicide prevention	Website analytics
2.	Increase in use of crisis hotline	Local Suicide Prevention Hotline total calls by age group
3.	Improved assessment scores on pre vs. post-test on perceived knowledge and self-efficacy	Question Persuade Refer pre and post curriculum survey
4.	Number of times participants identified and intervened with patrons six months post training. Of those how many were middle age men.	Survey to be developed by Evalcorp to evaluate the change in behavior post training modeled off previous findings of QPR research
5.	Measure of relevance to work	Survey to be developed by Evalcorp modeled on previous findings of QPR research. Focus groups in year three.
6.	Lower rates of completed suicides among men ages 45-64	Annual Medical Examiners Statistics

Project Budget

The project will be contracted with Idea Engineering, a current provider with a proven record of success in outreach and substance abuse campaigns. They have a good standing relationship with the County. The County will provide project management, data analysis, technical support, regulation compliance, and evaluation throughout the project.

BUDGET TOTALS	FY 2019	FY 2020	FY 2021	Total
Personnel (included in contractor costs)				
Direct Costs	117,557	46,163	46,163	209,883
Indirect Costs	17,634	6,925	6,925	31,484
TOTAL INNOVATION BUDGET	135,191	53,088	53,088	241,367

AGENDA ITEM 7

Information

July 26, 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(s): Toby Ewing, Executive Director

Enclosures (5): (1) The Motions Summary from May 9, 2018 and May 24, 2018; (2) Evaluation Dashboard; (3) Calendar of Commission activities; (4) Innovation Dashboard; (5) Department of Health Care Services Revenue and Expenditure Reports status update

Handouts: None.



Motions Summary
Commission Teleconference Meeting
May 9, 2018

Motion #: 1

Date: May 9, 2018

Time: 3:23PM

Motion:

- The MHSOAC awards the School-County Triage Personnel Grants to the following four applicants that received the highest scores. Each Grant is in the amount of \$1,875,000.00 per year for a four year total of \$7.5 million and directs the Executive Director to issue a Notice of Intent to make the following awards:
 - ❖ Tulare County Office of Education
 - ❖ California Association of Health and Education Linked Professionals Joint Power Authority
 - ❖ Placer County
 - ❖ Humboldt County Mental Health Department
- The MHSOAC establishes May 23, 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.



Motion #: 1 (Continued)

Commissioner making motion: Commissioner Anthony

Commissioner seconding motion: Commissioner Mitchell

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

Name	Yes	No	Abstain
1. Commissioner Alvarez	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Commissioner Anthony	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Commissioner Ashbeck	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Commissioner Beall	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Commissioner Brown	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Commissioner Bunch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Commissioner Carrillo	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Commissioner Danovitch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Commissioner Gordon	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Commissioner Madrigal-Weiss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Commissioner Mitchell	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Commissioner Poaster	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
13. Commissioner Wooton	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Vice-Chair Aslami-Tamplen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Chair Boyd	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



Motion #: 2

Date: May 9, 2018

Time: 4:25PM

Motion:

The Commission supports legislative technical clean up to Assembly Bill 114 (Stats. 2017, ch. 2017) to clarify that the 2020 deadline for counties to spend the funds deemed reverted under AB 114 applies to Innovation funds.

Commissioner making motion: Commissioner Mitchell

Commissioner seconding motion: Commissioner Anthony

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

Name	Yes	No	Abstain
1. Commissioner Alvarez	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Commissioner Anthony	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Commissioner Ashbeck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Commissioner Beall	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Commissioner Brown	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Commissioner Bunch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Commissioner Carrillo	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Commissioner Danovitch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Commissioner Gordon	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Commissioner Madrigal-Weiss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Commissioner Mitchell	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Commissioner Poaster	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
13. Commissioner Wooton	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
14. Vice-Chair Aslami-Tamplen	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
15. Chair Boyd	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



Motions Summary
Commission Meeting
May 24, 2018

Motion #: 1

Date: May 24, 2018

Time: 9:47AM

Motion:

The Commission approves the April 26, 2018 Meeting Minutes.

Commissioner making motion: Commissioner Anthony

Commissioner seconding motion: Commissioner Mitchell

Motion carried 8 yes, 0 no, and 2 abstain, per roll call vote as follows:

Name	Yes	No	Abstain
1. Commissioner Alvarez	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Commissioner Anthony	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Commissioner Ashbeck	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Commissioner Beall	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Commissioner Brown	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Commissioner Bunch	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Commissioner Carrillo	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Commissioner Danovitch	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Commissioner Gordon	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Commissioner Madrigal-Weiss	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
11. Commissioner Mitchell	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Commissioner Poaster	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Commissioner Wooton	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Vice-Chair Aslami-Tamplen	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Chair Boyd	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



Motion #: 2

Date: May 24, 2018

Time: 4:24PM

Motion:

The Commission approves the following Butte County’s Innovation plan with the condition that the training of the physicians and other medical personnel include training on cultural sensitivity practices from subject matter experts in the area:

Name: Physician Committed
Amount: \$767,900
Project Length: Three (3) Years

Commissioner making motion: Commissioner Anthony

Commissioner seconding motion: Commissioner Gordon

Motion carried 4 yes, 1 no, and 0 abstain, per roll call vote as follows:

Name	Yes	No	Abstain
1. Commissioner Alvarez	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Commissioner Anthony	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Commissioner Ashbeck	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4. Commissioner Beall	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Commissioner Brown	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Commissioner Bunch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Commissioner Carrillo	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Commissioner Danovitch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Commissioner Gordon	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Commissioner Madrigal-Weiss	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Commissioner Mitchell	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Commissioner Poaster	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Commissioner Wooton	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Vice-Chair Aslami-Tamplen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Chair Boyd	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



Motion #: 3

Date: May 24, 2018

Time: 5:02PM

Motion:

The Commission approves Sacramento County’s Innovation plan as follows:

Name: Behavioral Health Crisis Services Collaborative

Amount: \$13,885,361

Project Length: Four (4) Years

Commissioner making motion: Commissioner Gordon

Commissioner seconding motion: Commissioner Ashbeck

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

Name	Yes	No	Abstain
1. Commissioner Alvarez	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Commissioner Anthony	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Commissioner Ashbeck	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Commissioner Beall	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Commissioner Brown	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Commissioner Bunch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Commissioner Carrillo	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Commissioner Danovitch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Commissioner Gordon	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Commissioner Madrigal-Weiss	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Commissioner Mitchell	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Commissioner Poaster	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Commissioner Wooton	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Vice-Chair Aslami-Tamplen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Chair Boyd	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

MHSOAC Evaluation Dashboard July 2018

(updated 6/08/18)



Current MHSOAC Evaluation Contracts & Deliverables

Mental Health Data Alliance

DOJ Criminal Data Linkage & Analysis (16MHSOAC027)

MHSOAC Staff: Pu Peng & Ashley Mills

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

Total Contract Amount: \$98,450

Total Spent: \$57,976

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

*Content italicized and bolded indicates updated information * Indicates that a deliverable has undergone a status change

MHSOAC Evaluation Dashboard July 2018

(updated 6/08/18)



The iFish Group

Visualization Configuration & Publication Support Services (16MHSOAC021)

MHSOAC Staff: Brandon McMillen

Active Dates: 10/31/16 – 7/27/19

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 2019		
1	Fiscal Transparency Tool 1.0- (Design specs, Configuration & Related Datasets, Test Results, Visualization & Dataset Deployed)	10/31/16		
2	<i>Configuration and Publication for Providers, Programs, and Services Tool 1.0, & Full Service Partnerships Tool 1.0- (Design specs, Configuration & Related Datasets, Test Results, Visualization & Dataset Deployed)</i>		05/30/19	
3	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

*Content italicized and bolded indicates updated information * Indicates that a deliverable has undergone a status change

MHSOAC Evaluation Dashboard July 2018

(updated 6/08/18)



The iFish Group

Hosting and Managed Services (17MHSOAC024)

MHSOAC Staff: Pu Peng

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

Total Contract Amount: \$423,923

Total Spent: \$273,943

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

Deliverables & Due Dates

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

Legend: Deliverable Not Started Deliverable In Progress Deliverable Under Review Deliverable Complete

*Content italicized and bolded indicates updated information * Indicates that a deliverable has undergone a status change



Commission Meeting Calendar

Dates and Locations

July 26, 2018
MHSOAC, Sacramento, CA
Business/Innovation Plans

August 23, 2018
MHSOAC, Sacramento, CA
Business/Innovation Plans

September 26-27, 2018
Los Angeles County
Strategic Planning Meeting/Business/Innovation Plans/Elections

October 25, 2018
Alameda County
Policy Project-Suicide Prevention, Oct. 24 Site Visit (optional) Business/Innovation Plans

November 14-15, 2018
Tulare County (tentative)
Strategic Planning Meeting/Business/Innovation Plans

January 24, 2019
MHSOAC, Sacramento, CA
Business/Innovation Plans/State Budget Presentation/Legislation

February 28, 2019
Location Tentative

March 28, 2019
Location Tentative

April 25, 2019
Location Tentative

May 23, 2019
Location Tentative
May Budget Revise

July 25, 2019
Location Tentative
Final Budget

August 22, 2019
Location Tentative

Agenda Item 7, Enclosure 5: DHCS Status Chart of County RERs Received
July 26, 2018 Commission Meeting

Attached below is a Status Report from the Department of Health Care Services regarding County MHSA Annual Revenue and Expenditure Reports received and processed by Department staff, dated July 12th, 2018.

This Status Report covers the FY 2012-13 through FY 2016-17 County RERs.

For each reporting period, the Status Report provides a date received by the Department of the County's RER and a date on which Department staff completed their "Final Review."

The Department provides MHSOAC staff with weekly status updates of County RERs received, processed, and forwarded to the MHSOAC. MHSOAC staff process data from County RERs for inclusion in the Fiscal Reporting Tool only after the Department determines that it has completed its Final Review.

The Department also publishes on its website a web page providing access to County RERs. This page includes links to individual County RERs for reporting years FY 2006-07 through FY 2015-16. This page can be accessed at <http://www.dhcs.ca.gov/services/MH/Pages/Annual-Revenue-and-Expenditure-Reports-by-County.aspx>. 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.

On July 1, 2018 DHCS published a report detailing MHSA funds subject to reversion for allocation years FY 2005-06 through FY 2014-15 to satisfy Welfare and Institutions Code (W&I), Section 5892.1 (b). The report details all funds deemed reverted and reallocated to the county of origin for the purpose the funds were originally allocated. The report can be accessed at the following webpage: http://www.dhcs.ca.gov/formsandpubs/Documents/Legislative%20Reports/MHSA_Reversion_Funds_Report.pdf

Agenda Item 7, Enclosure 5

DHCS MHSa Annual Revenue and Expenditure Status Update											
County	FY 12-13		FY 13-14		FY 14-15		FY 15-16		FY 16-17		
	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	Return to County Date	Final Review Completion Date
Alameda	1/4/2015	1/6/2015	1/10/2017	1/5/2017	9/14/2017	9/29/2017	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	6/1/2018	6/14/2018	
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	1/5/2018	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	1/5/2018	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	1/8/2018	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	1/3/2018	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	5/14/2018	5/16/2018	
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	6/29/2018		
Madera	4/1/2015	11/8/2016	11/13/2016	12/7/2016	12/6/2016	12/7/2016	5/12/2017	6/13/2018	3/27/2018	6/14/2018	
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	5/18/2018	5/22/2018	6/13/2018
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	5/15/2018		5/15/2018
Nevada	4/1/2015	4/2/2015	11/3/2015	11/23/2015	6/21/2018	6/21/2018					
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	1/17/2018	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	1/24/2018	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	1/24/2018	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	6/29/2018		7/2/2018
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	5/11/2018		6/11/2018
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	1/24/2018	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	1/22/2018	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	5/25/2018	6/28/2018	6/28/2018	
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	1/23/2018	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	1/24/2018	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	6/29/2018		7/2/2018
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	1/22/2018	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		5/25/2018
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	58	57	55	54	48		42

Current Through: 07/12/2018



INNOVATION DASHBOARD - JULY 2018 (Current)

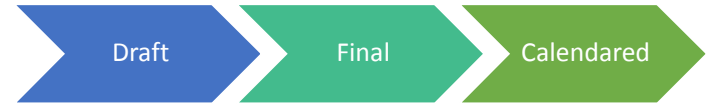
CALENDARED*
DRAFT PROPOSALS RECEIVED
TOTAL

NUMBER OF PLANS
7
29
36

COUNTIES
5
18
23

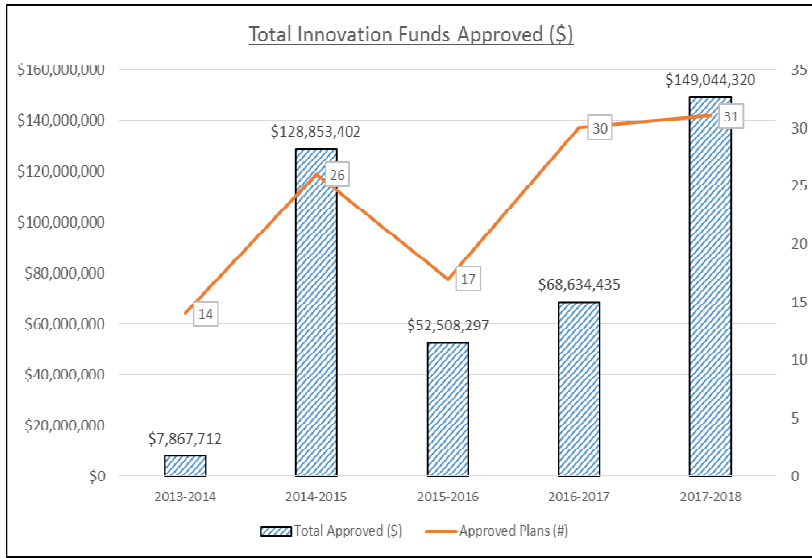
FUNDS REQUESTED
\$5,488,993
\$109,033,239
\$114,522,232

AVERAGE TIME FROM FINAL to COMMISSION CALENDAR
58.25 days



* July: Imperial (1), Ventura (2), Del Norte (1)
August: San Luis Obispo (2), Santa Barbara (1 Extension)

Previous FY Trends:



2017-2018

- APPROVED Innovation Funds: \$143,871,714
- APPROVED Extension Funds: \$5,172,606
- Plans Received: 34
- Plans APPROVED: 31 (91%)
- Participating Counties: 19 (32%)
- Participating Counties APPROVED: 16 (84%)

2016-2017

- APPROVED Innovation Funds: \$66,625,827
- APPROVED Extension Funds: \$2,008,608
- Plans Received: 33
- Plans APPROVED: 30 (91%)
- Participating Counties: 18 (31%)
- Participating Counties APPROVED: 17 (94%)

2015-2016

- APPROVED Innovation Funds: \$46,920,919
- APPROVED Extension Funds: \$5,587,378
- Plans APPROVED: 17
- Participating Counties: 15

2014-2015

- APPROVED Innovation Funds: \$127,742,348
- APPROVED Extension Funds: \$1,111,054
- Plans APPROVED: 26
- Participating Counties: 16

2013-2014

- APPROVED Innovation Funds: \$7,867,712
- APPROVED Extension Funds: \$0
- Plans APPROVED: 14
- Participating Counties: 8

Number of Counties that have presented an INN Plan to the Commission since 2013:	
53 Counties	89%

Percent of Counties that have NOT presented an INN Plan to the Commission since 2013:	
6 Counties	10%

STATUS	COUNTY	PLAN NAME	FUNDING AMOUNT REQUESTED	PROJECT DURATION	DRAFT PROPOSAL SUBMITTED TO OAC	FINAL PLAN SUBMITTED TO OAC	COMMISSION MEETING
CALENDAR	Imperial	First Step to Success	\$531,120	15 Months	3/8/2018	4/18/2018	JULY
CALENDAR	Ventura	Suicide Prevention Project: Bartenders as Gatekeepers	\$241,367	3 Years	3/5/2018	6/8/2018	JULY
CALENDAR	Ventura	Push Technology Project	\$438,933	3 Years	3/5/2018	6/8/2018	JULY
CALENDAR	Del Norte	Text 2 Grow-Giving Resource Outreach & Wellness	\$262,846	3 Years	5/2/2018 5/22/2018	6/18/2018	JULY
CALENDAR	San Luis Obispo	Affirming Cultural Competence Education & Provider Training: Offering Innovative Solutions to Increased LGBTQ Mental Health Care Access (SLO ACCEPTance)	\$554,729	4 Years	4/20/2018	6/8/2018	AUGUST
CALENDAR	San Luis Obispo	3-by-3 Developmental Screening Partnership Parents and Pediatric Practices	\$859,998	4 Years	4/20/2018	6/8/2018	AUGUST
CALENDAR	Santa Barbara	Resiliency Interventions for Sexual Abuse (RISE)	\$2,600,000	2 Years	N/A	4/12/2018	AUGUST

CALENDAR: County has met all the minimum regulatory requirements for Innovation - Section 3580.010, and three (3) local approval steps; 30 day public comment, Local Mental Health Board/Commission hearing, and Board of Supervisor (BOS) approval

STATUS	COUNTY	PLAN NAME	FUNDING AMOUNT REQUESTED	PROJECT DURATION	DRAFT PROPOSAL SUBMITTED TO OAC	FINAL PLAN SUBMITTED TO OAC	COMMISSION MEETING
DRAFT	Tuolumne	Building a Compassionate Response to Trauma in a Rural Community	\$1,248,073	5 Years	3/26/2018	6/19/2018	
DRAFT	Santa Clara	headspace Implementation Project	\$5,388,913		6/21/2018	Expected 7/16/2018	
DRAFT	San Diego	ADAPT (INN 18)	\$4,773,040	5 years	1/3/2018	6/21/2018	
DRAFT	Kings	The Multiple-Organization Shared Telepsychiatry (MOST) Project	\$1,663,631	3 Years	6/13/2018		
DRAFT	Monterey	Activities for Increasing Latino Engagement	\$1,240,000	3 Years	5/2/2018		
DRAFT	Monterey	Transportation Coaching by Wellness Navigators	\$1,234,000	3 Years	5/2/2018		
DRAFT	Los Angeles	Enhancing Workforce Training through Mixed Reality Approaches	\$6,683,164	5 Years	6/22/2018		
DRAFT	Los Angeles	Therapeutic Transportation	\$7,463,576	3 Years	6/22/2018		
DRAFT	Los Angeles	Ongoing Focused Support to Improve Recovery Rates for Conservatees Living in the Community	\$13,888,914	5 Years	6/22/2018		
DRAFT	Tehama	TECH SUITE	\$118,088	2 Years	3/28/2018	4/6/2018	
DRAFT	Tri-City	TECH SUITE	\$1,674,755	4 Years	4/5/2018		
DRAFT	City of Berkeley	TECH SUITE	\$462,916	3 Years	4/24/2018		
DRAFT	Riverside	TECH SUITE	\$25,950,000	4 Years	4/9/2018		

STATUS	COUNTY	PLAN NAME	FUNDING AMOUNT REQUESTED	PROJECT DURATION	DRAFT PROPOSAL SUBMITTED TO OAC	FINAL PLAN SUBMITTED TO OAC	COMMISSION MEETING
DRAFT	Monterey	TECH SUITE	\$2,526,000	3 Years	5/2/2018		
DRAFT	San Mateo	TECH SUITE	\$3,872,167	2 Years	5/9/2018	6/4/2018	
DRAFT	Marin	TECH SUITE	\$638,000	21 Months	4/30/2018		
DRAFT	San Francisco	TECH SUITE	\$2,273,000	5 Years	5/17/2018		
DRAFT	Santa Barbara	TECH SUITE	\$4,912,852	5 Years	6/6/2018		
DRAFT	Santa Clara	TECH SUITE	\$4,373,886				
DRAFT	Inyo	TECH SUITE	\$448,757	3 Years	7/2/2018		
DRAFT	Alameda	Cannabis Policy and Education Project	\$1,484,375	3 Years, 3 months	3/12/2018	Expected Late June	
DRAFT	Alameda	Community Assessment and Transport Team (CAT)	\$9,916,894	5 Years	3/22/2018	Expected Late June	
DRAFT	Alameda	Transitional Age Youth Emotional Emancipation Circles	\$454,907	2 Years, 6 Months	3/22/2018	Expected Late June	
DRAFT	Alameda	Introducing Neuroplasticity to Mental Health Services for Children	\$1,734,813	4 Years	4/18/2018	Expected Late June	
DRAFT	San Francisco	Wellness in the Streets	\$1,750,000	5 Years	5/17/2018		
DRAFT	Tulare	Addressing Metabolic Syndrome and Its Components in Consumers Taking Antipsychotic Medication	\$1,382,734	5 Years	12/15/2017		
DRAFT	Tulare	Connectedness2Community	\$765,175	5 Years	12/15/2017		
DRAFT	Calaveras	Enhancing the Journey to Wellness/Peer Navigator Program	\$710,609	5 Years	6/6/2018		
DRAFT	City of Berkeley	Trauma-Informed Care for Educators	\$0		6/29/2018		

DRAFT: A County plan submitted to the OAC that contains some of the regulatory requirements, including but not limited to a full budget and budget narrative; still may require technical assistance and is considered the last version before the FINAL is submitted

AGENDA ITEM 8

Action

July 26, 2018 Commission Meeting

Imperial County Innovation Plan

Summary: The Mental Health Services Oversight and Accountability Commission (MHSOAC) will consider approval of Imperial County's request to extend the funding and project duration for its Innovative project: First Step to Success, for a total amount of \$531,120 and a project duration of thirteen (13) months.

(A) First Step to Success – \$531,120 – EXTENSION

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.

- Imperial County is requesting an extension of time and funds so that the behavioral health and education collaborative introduced in the first year of the Innovation project, and modified in the subsequent two years can implement lessons learned in the last years of the project. The County intends to use this adapted concept to bring the program to the last of its County schools.

Presenter(s):

- Maria L. Wyatt, Behavioral Health Manager
- Jose Lepe, Behavioral Health Manager

Enclosures (3): (1) Biographies for Imperial County Presenters (2) Staff Summary, First Step to Success; (3) County Project Brief, First Step to Success

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

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

<http://mhsoac.ca.gov/document/2018-06/imperial-county-first-steps-success-innovation-plan-description-2018>

Proposed Motion: The MHSOAC approves Imperial County's request for \$531,120 additional funding and extension of time for its First Step to Success previously approved by the Commission on March 27, 2014 as follows:

Name: First Step to Success

Additional Amount: \$531,120 for a total INN project budget of \$2,568,465

Additional Project Length: (13) thirteen months for a total project duration of (4) four years and (1) one month.



Biographies for Imperial County Presenters First Step to Success

Maria L. Wyatt, Behavioral Health Manager

Maria Wyatt has been employed with Imperial County Behavioral Health Services since 1997. From 1997 to 2013, Maria worked in a substance use disorder program providing SUD prevention, early intervention and treatment to adolescents as well as working in the Perinatal program for pregnant and post-partum women with SUDs. In 2000, Maria was promoted from a Substance Abuse Counselor to a Program Supervisor overseeing the adolescent SUD program, expanding services under her supervision from 7 school sites to 18. In 2003, Maria was promoted to a Behavioral Health Manager. In 2005, Maria assisted in the development and implementation of 3 MHSA FSP programs under the Community Supports and Services (CSS) component: Transitional Age Youth, Ward Assess to Supports and Services and the Adolescent Dual Diagnosis programs. Since 2013, Maria is the Behavioral Health Manager under the Children's program, overseeing the MHSA PEI program and a children's mental health socialization program collocated at 3 elementary schools. In 2014, Maria developed and implemented the MHSA Innovation Project: First Step to Success. Maria holds a Master's Degree in Educational Counseling from Redlands University.

Jose Lepe, Behavioral Health Manager

Jose Lepe has been employed with Imperial County Behavioral Health Services since 2007. From 2007 to 2014, Jose worked as a Mental Health Rehabilitation Technician in a variety of programs and clinics serving children ages 0 to 14 with severe emotional, mental and/or behavioral problems. Jose's passion lies in working with families to break the stigma of mental health. In 2014, Jose was promoted to a Behavioral Health Manager. Currently, he oversees the functions of several programs and clinics for ICBHS Children Services. He has about 40 employees under his direction, which include program supervisors, psychiatrists, nurses, clinicians, and mental health rehabilitation technicians.



STAFF INNOVATION SUMMARY—IMPERIAL COUNTY

Name of Innovative (INN) Project: First Step to Success (Extension)

Extension Funding Requested for Project: \$531,120

Duration of Extension: 13 months

Review History

MHSOAC Original Approval Date: March 27, 2014

- Original Program Dates: July 1, 2014 through June 30, 2017 (3 years)

- Extension Dates: September 01, 2017 through November 30, 2017
 - ED Approval of time only-3 months
 - July 1, 2018 through April 30, 2019 (10 months)

- Original Budget: \$1,498,366
- New Budget: \$1,070,099

- New Total Budget with Evaluation Costs: \$2,568,465

Approved by the County Board of Supervisors: June 6, 2018

County Submitted Innovation (INN) Project: April 18, 2018

MHSOAC Consideration of INN Project: July 26, 2018

Project Introduction:

The County is requesting an extension of time and funding for this Innovation. Initially approved in 2014 as a three-year project, First Step to Success (FSS) was designed to address the lack of coordination and collaboration between County behavioral health and the education system, specifically for children in Kindergarten. County data indicated that the penetration rate for children ages 0-5 accessing services was 1.16%, lower than small counties and statewide rates. Through First 5, the County established a school based First Step to Success (FSS) intervention model to serve as a process for identifying children in need of services and to serve as the platform for the county/education collaborative.

Over the course of the first three years of this Innovation, the County discovered it needed to modify its approach to the schools. In the beginning, the County approached school administrators about the idea and relied on the school's internal process to "deliver the message." By restructuring their approach, the County discovered that training and addressing the teachers first, particularly in the individual teachers' classrooms would elicit a stronger and better participation in the program. The County wants to strengthen this strategy especially since a secondary benefit to this system/collaboration has been a reduction in stigma about mental health by both teachers and parents/children.

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

The Need

The County reports that while there is a strong collaboration between itself and the schools serving children, second grade through high school, there was only a one (1) percent penetration rate for providing mental health intervention services to children ages 0-5. It therefore, brought the idea of establishing networks and communication systems for this population to its stakeholders. Although past efforts to reach this population had not been successful, the County felt that the First Step to Success model was appropriate. Over the course of the first three years of this Innovation, the County discovered it needed to modify its approach to the schools. In the beginning, the County approached school administrators about the idea and relied on the school's internal process to "deliver the message." By restructuring their approach, the County discovered that training and addressing the teachers first, particularly in the individual teachers' classrooms would elicit a stronger and better participation in the program.

The Response

In the first year of the program, (FY14-15), seven (7) Kindergartens implemented the FSS model; in FY 15-16 thirteen (13) Kindergartens implemented the FSS model and in FY 16-17 twenty-four (24) Kindergartens implemented the FSS model. The County reports that although the FSS model was implemented in these classrooms, teacher buy-in for the process was not obtained. In fact, the County believes that the on-site facilitator was utilized to provide services and that there was no net increase in collaboration or an increase in child referrals. During the first three years of implementation, the County developed and attempted to facilitate better communication and teacher buy-in so that data could be collected as to the efficacy of the intended program. Clarus, the County's contracted researcher for this project, indicated that there was insufficient data to draw any conclusions.

However, the County may wish to share why it did not modify the school approach sooner, lessons learned, challenges and why there wasn't earlier engagement with its evaluator.

Because “each year the approach has been modified and it is unclear if the modified approach implemented during the third year will give the desired result or sustain a long term relationship with education serving kindergarten age children” (p. 2), the County is requesting an additional two years for this project to “implement lessons learned” (p. 2), from the first three years of the project.

The extension request is being made to give the county time to determine if this new approach is a more effective way of introducing the FSS program in the schools. It is anticipated that by introducing teachers to education about mental illness/health issues that they would be more comfortable with presenting the program to parents. The county reports that teachers reported feeling more supported and as a result, more willing to participate in the project. This extension therefore is to allow the county to finalize the implementation process of this project, gather as much data as possible and make a determination as to process, product and outcome for the First Steps to Success.

It is anticipated that an additional 176 children and 2 new elementary schools will be served with this extension. Previously 376 children and their families were served in 16 schools.

The County's concerns about teacher “buy-in” is not unique and are echoed in research into the area of this particular type of collaboration which shows similar problems at all age and grade levels. Although Holly J. Curran studied an older group of students, in her doctoral dissertation abstract she writes:

Interprofessional collaboration among school-based and community-based mental health providers in children's mental has been studied in relation to specific providers and as part of program evaluation however, limited information exists as to how to overcome barriers to collaborative relationships. . . Although participants viewed aspects of collaboration positively, barriers frequently interfered with collaborative relationships. Support for collaboration from state, district or organization administration was considered necessary for widespread collaboration across settings. To reduce time constraints on existing school staff, school-based professionals suggested it might be necessary to employ additional staff to manage collaborative relationships. Participants' ideas for funding included cutting costs, reducing risks, and grant writing. Jointly developing procedures, increasing accessibility by having services available within the school setting, and collecting outcome data regularly to share with stakeholders were discussed. Understanding the experiences of collaboration among school and community mental health providers has the potential to ignite social change by helping schools and community agencies overcome barriers to collaboration through improved coordination of services for children with unmet mental health needs.

Further, in an more empirical study of a systems collaboration project similar to the one that Imperial County Mental Health is trying to initiate with its local schools the author concludes,

Although the present study provided preliminary evidence as to the benefits of systems collaboration with schools on family and child outcomes, findings of the study should be interpreted with caution because of the small sample size. Future research is needed to fully examine the effectiveness of systems collaboration as an intervention, as well as to refine the mechanisms of change related to it. (Page 12) “Systems Collaboration with Schools and Treatment of Severely Emotionally Disturbed Children or Adolescents”, (2013) by Lee, et al.,

The Community Planning Process

The county reports that updates on the original plan were provided on a regular and ongoing basis to Community members, the MHSA Steering Committee, Mental Health Board and school district personnel. When it became apparent that additional time and money should be directed to those schools who had not had the opportunity to participate in this program, the County recommended this expansion to the MHSA Steering Community and community members on December 19, 2016 and on April 10, 2017. The County reports that at the meeting(s) Clarus presented its data to the County who then shared it with its stakeholders and the idea to extend this to April 2019 was agreed upon by all present.

Learning Objectives and Evaluation

Imperial County is requesting an extension of their project in order to allow for the continued development of strategies to improve the collaboration between County behavioral health and the education system. Imperial County will build upon the successes, challenges, and lessons learned during the first three years of the project. Through the extension, modifications will be made from the initial project. Specifically, the County will provide teachers with education around childhood mental health, as well as the FSS model in order to obtain buy-in. This is a new approach as the initial project sought buy-in from teachers *through* administrators. The County states that their contracted evaluator, Clarus, has recommended that further evaluation is needed. Further evaluation will allow for the County to gather additional referral data, and to determine if the FSS intervention has been implemented and a collaboration established between behavioral health and education. **The County may wish to clarify how modifications to the initial project inform the need for further evaluation.**

The County’s main learning goals have not changed since the initial project was approved by the Commission (see pg. 4 of County plan). The expected outcomes of the project also remain the same, and include:

1. Imperial County Behavioral Health Services (ICBHS) and education will develop and sustain effective collaborative relationships through the joint implementation of an intervention model in the school setting

2. Through the process of working together, will evaluate and identify the following:
 - a. Effective collaborative skills
 - b. Strengths in collaborative relationship
 - c. Barriers to effective collaborative relationships
 - d. Effective collaborative attitudes and behaviors
3. Will develop inter-agency methods and policies needed to establish effective communication and referral processes
4. ICBHS and education will develop a common mission and culture to address the mental health needs of young children
5. The learned approach of collaboration will be sustainable at the end of the 3 year work plan and replicated through trainings at different county wide school sites
6. Will establish a method for developing collaborative relationship between these two agencies that may be expanded to other school districts in Imperial County

The methods that will be used to gather data will include: surveys to measure collaboration factors, interviews to identify implementation strengths and challenges, as well as referral data to analyze changes in referral rates. The measures and way in which the County will determine if these outcomes have been met are unclear. **The County may want to clarify how it will determine if outcomes, as anticipated are met (or not).** Clarus will collect the data necessary to complete final evaluation of the project.

The Budget

The County is committing \$538,979 “other funds,” (such as Federal Financial Participation, Behavioral Health Subaccount) as part of the total request for this Innovation and \$531,120 Innovation funds. (See below for fiscal year breakout). **The County may want to identify any contingency plan if the other funds, as anticipated, are not collected.** The county reports that seventy-seven (77) percent (\$824,899.00) of the total budget (\$1,070,099) will be used for staff; 14 of whom are directly related to the implementation of the project in the schools and four (4) staff who are related to administrative processes. Training costs (for teachers in the schools) will be less than three (3) percent (\$33,000) of the budget; evaluation costs will be four (4) percent (\$46,340) of the total new budget. There are no other changes to the budget requested with this extension. The County will use FY 2015-16 Innovation funds in the amount of \$300,371 and FY 2016-17 Innovation funds in the amount of \$230,749 for this extension request.

Additional Regulatory Requirements

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

References

Curran, Holly J., “Facilitating Collaboration Among School and Community Providers In Children’s Mental Health”

<https://scholarworks.waldenu.edu/cgi/viewcontent.cgi?article=5537&context=dissertations> (Accessed May 28, 2018)

Lee, Mo Yee, Treater, Barbra, Hsu, Kai Shyang, Greene, Gilbert J., Fraser, J. Scott, Solovey, Andrew D., Grove, David, “Systems Collaboration with Schools and Treatment of Severely Emotionally Disturbed Children or Adolescents”

https://www.researchgate.net/publication/264416974_Systems_collaboration_with_schools_and_treatment_of_severely_emotionally_disturbed_children_or_adolescents (Accessed May 28, 2018)

Full project proposal can be accessed here:

<http://mhsoac.ca.gov/document/2018-06/imperial-county-first-steps-success-innovation-plan-description-2018>



MHSA Innovation Project:

First Step to Success

Summary: First Step to Success

The goal of the Innovation Project is to develop and maintain an effective interagency collaboration between ICBHS and the local education system. This collaboration will allow us to implement a structured system to increase access to services to children ages four to six, who are experiencing behavioral and emotional problems or at risk of serious mental illness. This group is considered to be an unserved or underserved population in Imperial County. Through the joint implementation of an intervention program at schools, it is expected for ICBHS will identify a process for establishing and sustaining a collaborative relationship. This innovative process will then be replicated in school districts across Imperial County which will yield to the development of a strong and effective collaborative relationship. The intervention used is First Step to Success (FSS), an evidence-based, early intervention model that historically has been implemented by school personnel and focuses on kindergarten population. In the Innovation Project, mental health staff, rather than school staff, lead the interventions in the classroom. The expected outcomes of the Innovation Project are the following:

- Increase access to mental health services for young children at risk of serious mental illness.
- Increase access to mental health services to young children by providing services in non-traditional setting to:
 - Increase awareness of mental health;
 - Increase awareness of available resources;
 - Reduce stigma associated with mental health;
- Provide services tailored to young children at risk of developing a serious mental illness.

Imperial County is a rural community comprised of 17 small school districts. During the first year of the Innovation Project, FY 2014-2015, FSS was implemented in seven kindergarten classrooms at three different schools in the El Centro School District. During the second year of implementation, FY 2015-2016, FSS was implemented in thirteen kindergarten classrooms at three elementary schools in the Brawley and Meadows Districts. During FY 2016-2017, FSS was implemented in twenty-four additional kindergarten classrooms in eight elementary schools in the Westmorland, Seeley, Heber, Calexico and San Pasqual School Districts. A total of forty-four classrooms in fourteen elementary schools, in eight cities spread to eight school districts in Imperial County, have implemented the FSS Program.

During the three-year implementation period, modifications were made each year as new challenges emerged when additional schools were incorporated into this project. ICBHS is requesting an extension of the Innovation Project until April 2019 to implement the modified approach and lessons learned in additional school. This additional time will allow us to evaluate if the modifications have proven to be effective in developing a collaborative relationship with education. The following new strategies that will be implemented are based on lessons learned from the initial three-year project:

Improve teachers’ cooperation and willingness, “buy-in”, to participate in the program. Teachers will participate in a meeting prior to implementation of FSS where they will be provided with a presentation of the FSS model. During this meeting they will have the opportunity to review and provide feedback on protocols, roles and responsibilities. They will also hear about testimonies from teachers who have participated and seen positive results, and ask any questions that they might have.

Increase teachers’ awareness of mental illness and reduce stigma associated with mental illness. To assist with stigma reduction related to mental illness, teachers will be provided training and information on early signs and symptoms of children’s emotional and behavioral problems. Training will include the importance of early identification and the benefits of early interventions. They will also be provided with information of available mental health services and programs and ways of referring children for services.

Assist in the process of identifying children in need of FSS or other ICBHS Services. ICBHS staff will provide training on assessing children’s behaviors and identify those that could benefit from early intervention. Staff will assist teachers by conducting classroom observations and consulting with them to identify and refer to appropriate services.

Improve parent’s acceptance of FSS program. ICBHS staff, rather than teachers, will introduce the FSS program to parents. ICBHS will discuss importance of early identification and early intervention and available services. Staff will also provide psycho-education to improve awareness and reduction of stigma related to mental health.

Continue the effective collaboration. ICBHS staff will continue to meet individually with school administrators and teachers on a monthly basis or as needed. To overcome the previously encountered implementation challenges, teachers and parents will be involved from the beginning of implementation of FSS. It is anticipated that these new strategies will facilitate teachers’ “buy-in”, obtain parental acceptance of services and reduce the stigma associated with mental illness.

Budget

Imperial County is requesting to extend the Innovation Project: First Step to Success until April 2019. The County is requesting the following:

Revenue	Total
MHSA FY 15/16	\$300,371
MHSA FY 16/17	\$230,749
Total MHSA Revenue	\$531,120
Other Revenue	
Realignment	\$23,030
Federal Medi-Cal	\$498,215
Other	\$17,734
Total Other Revenue	\$539,979
TOTAL REVENUES	\$1,070,099

Expenses	Total
Personnel	\$824,899
Total Personnel	\$824,899
Operating Expenses	
Training	\$33,000
Evaluation	\$35,000
Contracted Services	\$11,340
Program Expenses	\$68,578
Total Operating Expenses	\$147,918
Administrative Expenses	\$97,282
Total Administrative Expenses	\$97,282
TOTAL EXPENSES	\$1,070,099

MHSOAC Analysis

The following outlines the strategies implemented, and modifications made over the three years of the Innovation Project:

FY 14/15 – During the initial year, meetings were held with principals from 3 schools within the same school district. School administrators participated in joint meetings where they were involved in the planning and development of protocols, roles and responsibilities, and where they decided to implement the FSS program in 7 classrooms, cohort 1. The *first challenge* faced during the first year was obtaining teachers’ “buy-in”. School administrators made the decision to participate in the Innovation Project. They presented the FSS program to teachers only once a decision had already been made, lacking teacher involvement in the initial planning process. The *second challenge* was the FSS program was implemented during the time when Common Core was also being implemented. Teachers felt overwhelmed by the added task which pushed for a new approach on how to involve teachers to obtain their “buy-in”.

FY 15/16 - During the second-year, strategies were modified to mitigate the challenge of increasing teachers’ cooperation and buy-in into the project. ICBHS manager approached school administrators to offer the implementation of FSS to the cohort 2. School administrators were informed to better prepare teachers for the implementation of the program, it was important for teachers to participate in a meeting where they would be provided a presentation on the FSS model and its benefits. These meetings would give teachers the opportunity to review and provide feedback on protocols, roles and responsibilities and ask any questions that they might have. Principals were in agreement, however not all teachers were able to attend the meeting. During this second year, the *first challenge* was that as the program was implemented in additional schools, it became very difficult to coordinate meetings where all school administrators from cohort 1 and 2 at the same location and time. The strategy for meeting with school administrators to problem solve and discuss program progress was modified to meeting individually rather than as a group. A *second challenge* was that as new teachers from cohort 2 were being trained they did not believe that identifying and referring children to ICBHS was a goal for this project. Teachers reported being satisfied with having the FSS program at the school. They saw the benefits of having mental health staff on the school campus as they could consult with mental health staff when experiencing problems with children. A new strategy was implemented which consisted of mental health staff

assigned to the schools to provide education to teachers on early signs of mental health, available services, and process for referring children to services.

FY 16/17 – During the third year of implementation eight new schools were identified, cohort 3, expanding the implementation of the model to a total of 44 classrooms. Meeting with administrators continues to be conducted individually. New strategies were implemented in efforts to increase teachers' and parents' awareness of mental illness and decrease stigma associated with mental illness. This included educating on identification of early signs and symptoms of children's emotional and behavioral problems, the importance of early identification and early interventions, and providing information on available mental health services and programs. Another new modification was made during this third year as it was identified that a high number of parents were not agreeing to their child's participation in the FSS program. The FSS program was being introduced by the teachers to the parents and they were not able to motivate them to accept services. It was then decided to have ICBHS mental health staff, rather than the teacher, introduce the program to determine if they would obtain better outcomes in obtaining parent's agreement.

Communication with Program Evaluators – Clarus Research

Since the implementation of the Innovation Project, ICBHS communicated with Clarus Research on the challenges faced during the implementation process. Communication in the form of telephone conferences, surveys, telephone interviews and annual reports were conducted on a consistent basis between Clarus, ICBHS and education. During the three years of the Innovation Project, Clarus Research recommended on ways to overcome the challenges by implementing new strategies and modifying the implementation process. Based on the findings Clarus reported collaboration was getting stronger between mental health and education. However, participating schools rated factors of the collaboration differently given that each school had implemented the FSS program at different times. One method of evaluating increase access to services was by measuring the number of referrals that were generated to ICBHS for this target population. Based on survey results, enrolling children in FSS or making referrals to ICBHS was not endorsed by all schools. Additionally, Clarus Research reported not having sufficient data on why schools did not perceive *increasing referrals* as a goal. One probability is that participating schools did not see the need to make referrals since mental health staff was already available at their school campus. Clarus Research recommended the need to improve communication with all the schools on the last goal of the project and to further evaluate this project given the continuous modifications.

Extension request needing further evaluation:

Based on the results of the evaluation study for the initial three years, there were a number of positive findings about the collaboration between the mental health and education in implementing the First Step to Success program. Overall, the collaboration between the mental health and participating schools is becoming strong, and many aspects of the collaboration have shown positive results. These aspects include flexibility; open and frequent communication; shared objectives; and unique purpose of the collaboration. However, the approach used to develop a collaborative relationship between mental health and education in additional new schools could not be replicated. Due to various project modifications and the implementation of new strategies, there is an existing need to evaluate if the modified approach that will be implemented during the extension, will be effective in developing a long

lasting collaborative relationship between mental health and education. Additionally, if the implementation of the new strategies proves to be effective in developing a collaborative relationship, the projected outcomes of this project would be achieved. These desired outcomes include the following:

- An increase in access to services for young children at risk of serious mental illness who are also an unserved and underserved population in Imperial County;
- An increase in awareness of mental health;
- An increase in awareness of available resources in the community and;
- A reduction of stigma associated with having a mental illness.

ICBHS will continue to contract with Clarus Research to evaluate the findings on the following objectives:

- *Develop and maintain a new approach to collaborative relationships between mental health and education to improve access to services to unserved and underserved population of children in TK and Kindergarten.*
- *Develop an effective system that can be duplicated when developing a collaborate relation between mental health and education.*
- *Identify the strategies to effective collaborative relationships that can be replicated in different school districts in Imperial County.*
- *Identify the organizational supports at all levels needed that contribute to effective collaborations.*
- *Identify mental health and education staff's strengths, attitudes and character that contribute to effective collaborations.*
- *Through the development of this collaborate relationship; expand parents and teachers' awareness on the extent of how mental illness reaches into this age group of children to decrease the stigma related to mental health.*

Clarus Research will collect data on number of referrals to measure increase access to services. They will also conduct surveys and interviews to measure the commitment to the collaboration and perceptions related to mental health in young children. Based on evaluation results from surveys and interviews it will be determined if there was a decrease in stigma, an increase in teachers' awareness of early signs and symptoms of behavioral and emotional problem in young children. Similarly, evaluation will be conducted to determine if FSS contributed to an increase in parental awareness and acceptance of services.

Sustainability

Once the Innovation Project: First Step to Success has completed, the program will transition into one of the MHSA components: Prevention and Early Intervention (PEI). Eligible services will be billed as Specialty Mental Health Services.

AGENDA ITEM 9

Action

July 26, 2018 Commission Meeting

Del Norte County Innovation Plan

Summary: The Mental Health Services Oversight and Accountability Commission (Commission) will consider approval of Del Norte County's request to fund the TEXT 2 Grow: Giving Resource Outreach & Wellness Innovative project for \$262,846.

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.

- Del Norte County proposes to implement an expansion of a text-based parent support system for parents with children between the ages of 0-5 years of age. Text messages will focus on early literacy as well as social and emotional learning in an effort to prepare their children for kindergarten.

Presenters for Del Norte County Innovation Project:

- Jack Breazeal, Clinical Services Manager, Dept. of Health & Human Services, Mental Health Branch
- Angela, Glore, Ph.D, Executive Director, First 5 Del Norte

Enclosures (4): (1) Biographies for Del Norte County's Innovation Presenters; (2) Text 2 Grow Staff Analysis; (3) Text 2 Grow Project Brief; (4) Text 2 Grow Project Plan.

Handout (1): PowerPoint will be presented at the meeting for the Project.

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/2018-06/del-norte-county-inn-plan-text2grow-july-26-2018>

Proposed Motion: The MHSOAC approves Del Norte County's Innovation Project, as follows:

Name: Text 2 Grow: Giving Resource Outreach & Wellness
Amount: \$262,846
Project Length: Three (3) Years



Angela Glore, Ph.D.

Dr. Glore is the Executive Director of First 5 Del Norte Children and Families Commission. She holds an MA and Ph.D. in Anthropology from Washington University in St. Louis. Dr. Glore brings a diverse background to her work with First 5, having lived in four countries and worked in fields as diverse as children’s library services to environmental education to food policy work. She is passionate about equal opportunities for all children and works to find innovative ways to deliver programs, information, and services to families.

Jack Breazeal

Jack Breazeal is a licensed Marriage and Family Therapist with the State of California. He graduated with his Masters from California Baptist University in Riverside California in 2002, and has worked in the mental health field since graduation. He currently works for the Department of Health and Human Services Mental Health Branch as the Clinical Services Manager. As the Clinical Services Manager, he oversees the day to day operations for county mental health providing guidance and support to agency employees in their efforts to help consumers lead healthy, happy, and productive lives. In addition, he also oversees system compliance both with DHCS Medi-Cal and the Mental Health Service Act. Prior to coming to Del Norte County, he was the Director of Behavioral Health for Lake County Oregon. Much of his professional career has been in working with the County mental health populations in both an outpatient basis and in psychiatric hospitals as well. He started his career as a therapist for a group home in Riverside County, and based upon his early work there, he developed a tremendous passion for foster children and promoting positive outcomes for them. Jack is a single parent of two small children, who are his pride and joy, and definitely considers himself a “Soccer Dad!”



STAFF ANALYSIS – DEL NORTE COUNTY

Innovation (INN) Project Name:	Text2Grow
Total INN Funding Requested:	\$262,846
Duration of Innovative Project:	Three (3) Years

Review History:

Approved by the County Board of Supervisors:	March 27, 2018
County submitted INN Project:	June 19, 2018
MHSOAC consideration of INN Project:	July 26, 2018

Project Introduction:

In order to provide support for parents with children ages 0-5 who live in isolated, rural locations within Del Norte County, the County would like to implement a texting program that will offer tips on family strengthening, parental mental health and self-care, and linkage to resources and services. The County will work in collaboration with First 5 Del Norte, Parent Powered, Applied Survey Research, the Child Abuse Prevention Center, families, service providers, and other community members to help develop and test the content of the texting program to ensure efficacy.

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.

The County states this Innovation Project meets the primary purpose of increasing access to mental health services to underserved groups and meets the innovation project category by taking a promising community driven practice from other fields (text-based programs) and applying it to the mental health system.

The Need

The County states there are geographically isolated regions within Del Norte where individuals residing in the community live in poverty in contrast with other California residents. As of 2016, Del Norte County households had a median annual income of \$42,363, which is less than the median annual income of the United States (\$55,322) and considerably less than the median annual income of other California residents (\$63,783). Additionally, the poverty rate for the United States is 14% compared with the poverty rate in Del Norte County, 23.7%.

In initial discussions regarding the development of this project, the need for families to feel supported arose (explained later in the Response and Community Program Planning sections of this analysis). The County hopes to reach out to those families, address those needs as expressed and provide parental support for families. Although there are family strengthening programs currently being offered in Crescent City (at least 20 minutes away from most rural communities), these programs are typically offered in the evening when the public transportation system does not operate which makes traveling to and from the program impractical.

To address the barriers of not being able to reach families living in rural areas of the County along with addressing the needs expressed by parents during interviews leading up to this project, the County would like to implement a texting program to provide familial strengthening and support.

The Response

Research to address the need for parental support began in January 2016 when a total of 27 families and 11 early childhood educators were interviewed by non-profit and public agency leaders in an effort to understand the low literacy rates within the County. For example, Del Norte indicated that half of the third grade students are able to read at that grade level. Through the interview of families and childhood educators, it became apparent that families were in need of more supportive networks and available county resources.

This innovation project was developed after a series of interviews conducted with parents regarding the low literacy rates within the County. These interviews resulted in several findings including, but not limited to:

- Parents feeling they are not connected to supportive networks or resources
- Parents expressing concern over the mental health of their children

- Parents not being able to know how to properly support their children's kindergarten readiness

To address the needs of parents not feeling they receive family strengthening support and available resources within the County, Del Norte is proposing to implement a text-based program for parents of children 0-5 years of age by developing and expanding upon an existing text-based model geared to assist young children prepare for school readiness. **The County may wish to provide rationale as to why this is not a Prevention and Early Intervention project as the plan seems to focus on healthy child development and works in conjunction with First 5 Del Norte.**

The County will work in collaboration with First 5 Del Norte, the Literacy Core Design Team (original creator of existing school readiness texting model), ParentPowered (innovation project contractor), stakeholders, service/program providers, along with the parents living within the Community to develop messaging content.

Outreach and enrollment into Text2Grow texting program will be assisted by the Wonder Bus Program which is essentially a mobile children's library and Family Resource Center. Funded predominantly by First 5 Del Norte, the Wonder Bus Program will enter into a contract with the Child Abuse Prevention Center to obtain two (2) AmeriCorps volunteers whose primary responsibility will be to recruit and enroll parents into the Text2Grow program.

Text content will be culturally informed by Tribal, Latino, and Hmong communities with the expectation of being able to provide thoughtful tips and advice on how to strengthen the family unit. Parts of the Klamath and Smith River communities have large populations of Native and Latino families, so enrollment into this project will be a priority. Text messages will be available in English and Spanish and each family will have the option of choosing a program specific to their culture, if desired.

Del Norte states this texting program will be customized for parents in their County and may become a template for other counties to replicate. The County indicates First 5 Del Norte and ParentPowered (the contractor) will co-author a white paper at the conclusion of the project and present the findings at various early childhood conferences. The County also states that other First 5 agencies from other jurisdictions are watching Del Norte County's innovation project carefully and the County hopes this project, if successful, can be replicated statewide.

The County may wish to provide clarity regarding whether parents are able to respond to text messages and how the county will be prepared to respond to family questions and/or respond to possible crises.

The Community Planning Process

This project came to fruition after a series of interviews were held with families and early childhood educators. Families that were interviewed represented random sampling of the community to include ethnicity, economic status, education, and the various areas of the county where these families resided. As this innovation project has progressed, these

same families that were interviewed continued to be an integral part of the development and planning of this project.

As part of MHPA General Standards for cultural competency, the content of the text messaging will be developed by the Yurok and Tolowa Dee-Ni' Tribal Communities, the Latino Community, and the Hmong Community, joining in collaboration with their respective cultural service providers. In terms of community collaboration, Del Norte indicates this project has been developed alongside First 5 Del Norte and will be the first collaboration between these agencies regarding the delivery of mental health services. The County also states the project is client-driven as it was initiated and will continue to be developed with the input of parents (clients).

The County shared this Innovation Project with local stakeholders beginning January 4, 2018 and received letters of support along with a letter of concern during the public comment period (County attached letters with the project plan). The letter of concern that was received indicated that certain parts of the County to include Klamath and Gasquet, remain unserved in many ways and urged the County to address the needs in those areas. The County has included the individual to assist in the development of this project and to ensure culturally appropriate messages are generated; additionally, the County will work with the stakeholder to address his needs and the needs of the Klamath community.

Learning Objectives and Evaluation

Del Norte County has proposed implementing a text-based parent support program that is partially based on the Ready4K school readiness texting program. Text2GROW will expand upon Ready4K by introducing localized and culturally-relevant family strengthening content that is geared toward parents and families. The County will target parents of children ages 0 to 5 years. Del Norte County will serve approximately 250 families in the project's first year, and 100 families in subsequent years.

In order to guide the project, The County has identified three main learning questions:

1. Is texting an effective tool for providing preventative mental health services to a county-wide population?
2. Will providing families with specific, purposefully-timed information about available programs and services, especially around mental health, increase participation in those services and increase families' connection to support networks?
3. Will providing families with broad-based, multi-domain support lead to children being better prepared for kindergarten both academically and social-emotionally?

Del Norte County intends to use an experimental and control group to evaluate the changes to the Ready4K program compared to Text2GROW program. Using the last digit of the participant's telephone number, parents will be randomly placed in the Ready4K control group, or the Text2GROW experimental group. Although the County states Ready4K has proven to be successful in their County, having two (2) control groups will allow Del Norte to evaluate the efficacy of those who receive Text2Grow messaging in comparison with those who will be receiving Ready 4K messaging.

The County may wish to identify intended outcomes of the Text2GROW project.

In order to address each learning question, the County has identified a number of different measures. These include: satisfaction and usage of the texting program over time; frequency of resource contact/usage; and improvements in social and emotional readiness for kindergarten (**see pgs. 10-12 of county plan**). In order to gather the data necessary, the County will use a number of different methods, including: pencil-and-paper surveys, and online surveys to participants as well as organizations; focus groups with parents; text-based feedback analysis conducted by ParentPowered; and kindergarten readiness assessments administered through First 5 along with Applied Survey Research (ASR-evaluator). Survey instruments and other methods will be developed through a collaboration with First 5 and ASR—ASR will be primarily responsible for data analysis.

Throughout the duration of the project, regular progress meetings will be held between project staff and the Local Mental Health Board and County Board of Supervisors. Results from the project will be presented at childhood/childhood development conferences as well as shared with all other First 5 commissions.

The Budget

The proposed budget for this Innovation Project is \$262,846 over three (3) years. The largest portion of the budget is for consultant and contract costs totaling \$189,504, or 72% of the budget. The specific breakdown of the \$189,504 allotted for consultant and contract costs are comprised as follows: Parent Powered (\$125,433), Applied Survey Research (\$39,900); and Child Abuse Prevention Center (\$24,171). The amount allocated for the evaluation component is \$8,565 (3.3%).

The personnel costs for this project totals \$47,077, or 18% of the total budget. Salaries and benefits will help pay for the First 5 Executive Director and First 5's accounting technician for the three years of the project duration. The First 5 Director will be the primary contact for the contractor, ParentPowered. The accounting technician will be responsible for the processing of contract payments, travel, and project operating costs.

A total \$15,200 (5.8%) is for operating costs for the County that will cover the cost of recruitment materials, parent focus groups and the travel costs associated with the dissemination of findings after the project has ended. Non-recurring costs of \$2,500 are for the purchase of two iPads, which will help facilitate online enrollment, as well as a purchase of a shared laptop, which will be used for data entry purposes.

If the evaluation determines that this innovation project is successful, First 5 Del Norte will continue offering this innovation project. The bulk of the project cost occurs in the beginning to assist in the development and testing the right combination of texts in conjunction with the timing of the text messages. The maintenance and continuous costs are relatively minor in comparison, so the County indicates this project would be able to be sustained by First 5.

In reference to Assembly Bill 114 regarding reversion of funds, the County states they will be using current Innovation funds as there are no Innovation funds set for reversion. The entire amount for this project will be drawn from Innovation funding from the Mental Health Services Act.

Additional Regulatory Requirements

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

References

<https://datausa.io/profile/geo/del-norte-county-ca/>

<https://datausa.io/profile/geo/del-norte-county-ca/?compare=united-states>

<https://www.census.gov/quickfacts/fact/table/delnortecountycalifornia/PST045217>

Full project proposal can be accessed here:

<http://mhsoac.ca.gov/document/2018-06/del-norte-county-inn-plan-text2grow-july-26-2018>

Text2GROW (Giving Resource Outreach and Wellness)
MHSA INN Project | Del Norte County

Project Summary: Our Innovation project, Text2GROW, will develop a text-based support system for parents and families, providing information and resource connections for mental health and other community services and programs. We will use an existing child development texting program (Ready4K) as our base and co-create additional, locally-relevant content with parents, mental health providers, and family services providers.

This project is innovative in two primary ways. First, it is a broad community collaboration addressing community-identified needs with a community-developed solution. Local families, educators, and service providers have been at the center of this work from the beginning and will remain deeply engaged in the creation, implementation, and evaluation of the project. Second, our project is focused on a new way of delivering information and connecting people to services in a rural community. With fewer than 25 people per square mile and inadequate internet access, it can be difficult to connect to families across the whole county. Texting does not require travel or an internet connection.

The Problems We Are Addressing: This project grew out of needs identified during empathetic interviews with 27 families during early stages of a community-wide literacy project. The interviews were conducted by a team with members from our county-wide school district, early childhood educators, First 5 Del Norte, the Del Norte Child Care Council, the Family Resource Center of the Redwoods, and our local community foundation. This team is still connected to the Text2GROW project and has grown to include an emerging coalition focused on reducing exposure to adverse childhood experiences (ACEs) and building community resilience. Our County Board of Supervisors, the Crescent City Council, Library Board of Trustees, and three out of four Tribal Councils (Yurok Tribe, Tolowa Dee-Ni' Nation, and the Elk Valley Rancheria) have all officially endorsed the literacy campaign, called "3Read23." This is truly a community-based and community-wide effort, always with families at the center.

The families interviewed represent a cultural, geographic, and economic cross-section of our county, and we found they had a lot in common. Their shared concerns were about much more than early literacy, although all families expressed feelings of stress around helping their child be school ready and able to read. Among other insights, we learned that most or all families:

- Are time-poor: We titled this insight, "Rush, rush, rush," to capture the descriptions parents gave us of their typical days. Parents lamented having little time with their children and even less time they could devote to learning and child development activities;

- Feel isolated and alone: Parents are isolated from support networks and resources. They don't feel they can rely on family networks because of substance abuse and mental illness among their extended families. When they need resources, they often don't know what resources exist or don't know how to access them;
- Don't know how to support their child's learning and development: All families want their children to be successful, but many expressed their fear of not knowing how to help their children reach success in school or in life; and
- Are concerned about their child's mental health and/or development: Several parents wept during interviews because they were concerned about their child's (or their own) mental health and didn't know where to turn for help. Parents described untreated learning or developmental delays in their young children, even though their children would be eligible for services. Parents simply do not know about resources in the community and how to access them.

Many parents also talked about how the past has shaped their present. Families in Del Norte have experienced generational under-education, poverty, and trauma. From Native genocide and Indian boarding to schools to the destruction of two towns in 1964 (Crescent City to a tsunami and Klamath to a record flood), from the loss of valuable timber and fishing industries to the Hmong refugee experience, many families have a history of deep trauma. There is a long-term narrative of scarcity and lack of hope that came through in these interviews.

These are the problems we are trying to solve.

Texting Gives Equal Access to Information: In one-on-one follow-up interviews with parents and in idea-generating sessions with the whole community, texting kept coming up as a quick, non-stressful way to communicate with parents. Texting has been shown to be effective in other behavioral health contexts like smoking cessation. Over 95% of adults under 50 receive texts, and over 95% of texts are read within three minutes of delivery. Texts are short and contain bite-sized pieces of information. This makes them very effective in reaching busy parents in a rural, isolated region.

Del Norte County is geographically isolated from the rest of California, and thanks to large tracts of state- and federally-owned land, communities within Del Norte are isolated from each other. Most services, including most parent education and mental health services, are concentrated in Crescent City, the only incorporated community in the county. Parts of the county still lack access to high-speed internet, so many families do not have internet at home. Texting allows us to reach virtually all families to provide information and connections to resources. We believe texting is the best way to connect our rural community to mental health

and community resources and to give busy parents the information they need to support healthy development in their children.

Members of our coalition have been working to meet these needs in other ways as well. First 5 funds Parent Cafes in the four largest communities in Del Norte. These are the only parent education programs currently offered outside Crescent City. A variety of partners are working to expand home visiting programs that are effective at connecting families to resources. These programs (Nurse-Family Partnership, Early Head Start home visiting, and a public health nurse program) are expensive and serve relatively few families, even though our interviews and other information indicate that most, if not all families would benefit from a continuous flow of information and resource connection.

In short, we know parents and families need information, resources, and connections to services that exist in our community. Traditional methods of creating those connections are not reaching most families, as our interviews showed. We believe that our community-driven text-based program has the potential to reach all families and significantly improve the lives and mental health of Del Norte County families.

Budget: We are requesting \$262,846 in MHSA INN Funding. As seen below, the bulk of this funding is in three contracts with our outside project partners:

- ParentPowered is the public benefit corporation responsible for Ready4K. They will provide assistance in co-creating new, localized messaging and the back-end of the texting technology.
- Applied Survey Research is familiar with Del Norte County through many years of work with First 5. They will design and help implement a rigorous evaluation process.
- The Child Abuse Prevention (CAP) Center operates large AmeriCorps service projects throughout California. We will use two AmeriCorps volunteers to promote the Text2GROW program and enroll families through the First 5-funded Wonder Bus program.

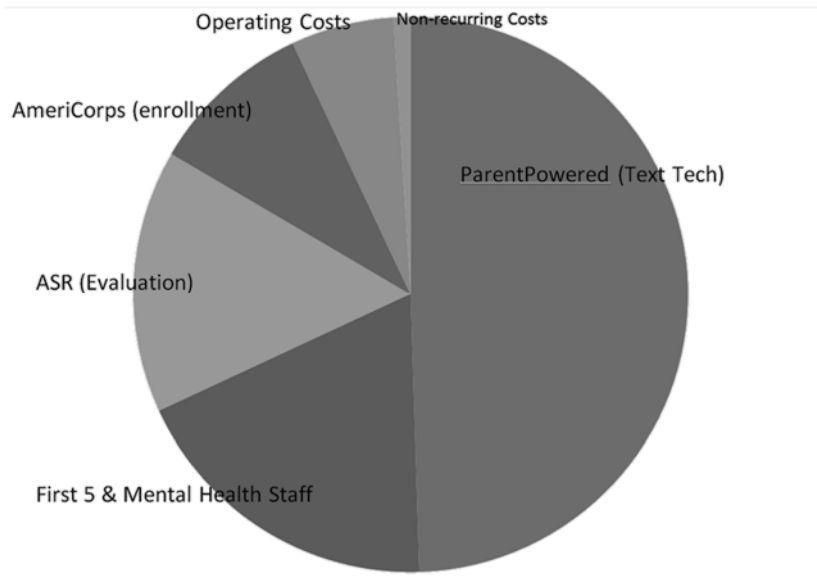


Table 1: Proxy Indicators for ACEs Exposure in Del Norte County	Del Norte	CA	Hum	Mendo	Butte
Percentage of children with 2 or more ACEs (parent reported)	?	18.2	24.6	22.9	23.5
Percentage of adults who smoke	20	11.7	17.9	13.2	18.2
Alcohol/drug use in past month, percentage of 9 th grade students	37.4	23.2	31.9	35.1	23.4
Suicide ideation, percentage of 9 th grade students	33.8	19.3	18.4	17.6	15.7
Domestic violence calls, per 1,000 calls to police	45.9	6.0	8.9	8.4	6.1
Substantiated child abuse/neglect cases per 1,000 residents	22.8	8.2	10.7	19.0	9.8

Sources: KidsData.org, CA Tobacco Facts and Figures, CHIS

These proxy measures, if an accurate reflection of ACEs exposure in Del Norte, indicate a public health crisis with long-term implications for mental and physical health needs. Unless new approaches to family strengthening, resilience-building, and broad-based prevention are instituted, Del Norte will likely struggle with a new generation of residents with high needs for mental health intervention and treatment.

Family strengthening programs have been proven effective in a wide range of problematic behaviors in adolescents including substance use, violence, and school suspensions. Kumpfer and Alvarado note that effective parenting is a powerful way to reduce problematic adolescent behavior, writing:

The effectiveness of parenting and family interventions to prevent many types of adolescent problems (e.g., conduct disorders, violent and aggressive behaviors, delinquency, substance abuse, depression, suicide, teen pregnancy, HIV disease, school failure, and eating disorders) has considerable empirical support in the research literature (Kumpfer and Alvarado 2003: *Family-Strengthening Approaches for the Prevention of Youth Problem Behaviors*).

However, meta-reviews of the data show problems with scaling family strengthening programs to larger, more culturally-diverse populations; motivating high-needs families to participate; providing a sufficient number of exposures or contacts for fidelity; and more (Fox et al., 2004: *Challenges in Disseminating Model Programs: A Qualitative Analysis of the Strengthening Washington DC Families Program*). Family strengthening programs exist in Del Norte, but with few exceptions, are offered only in Crescent City, which is at least 20 minutes from most outlying communities. Many are offered during the evening, when our limited public transportation system does not operate.

The Text2GROW project uses a promising practice in behavioral health to provide family strengthening services in a continuous-contact model. Texting is a low-input delivery method

that requires very little of participants. No travel is required, no internet service is needed, and parents can interact with the tool at their convenience. As described in the section below, these variables address concerns voiced by local parents during a series of interviews about early literacy.

Our primary problem is how to provide parents with sustained, multi-domain support for their child's health and development (including social and emotional health) in a dispersed, rural population. Using three-to-four texts a week, Text2GROW will provide over 850 contacts with parents during the first five years of their child's life. The texts will address all five Strengthening Families protective factors and integrate the science of resilience to break generational cycles of ACEs exposure, increase school readiness, and minimize the long-term mental health issues associated with high ACEs scores.

b) Describe what led to the development of the idea for your INN project and the reasons you have prioritized this project over alternative challenges identified by your county.

This project grew out of a collaborative research project that started in January, 2016. Non-profit and public agency leaders interviewed 27 families and 11 early childhood educators to gain understanding of low literacy rates in local elementary schools. Only half of all third grade students could read at grade level. The insights gained from these interviews extended far beyond barriers to early literacy: they demonstrated tremendous need for more family support delivered through new methods.

Parents told interviewers about their day to day routines, their own experiences with education and reading, and how they helped their child prepare for school and reading. Ten major insights were gleaned from these interviews and include:

- **Parents are not connected to support networks or resources:** Many parents told researchers that they had nobody they could count on for help with their children. Parents reported that they either didn't know about resources that could help their family or that they didn't know how to access resources.
- **Parents were concerned about their child's and their own mental health:** One Native parent described her fear for her son's mental health, but felt there were no culturally-appropriate resources available to her family. Other parents expressed concern about their own coping skills and described feeling overwhelmed by the number of tasks they faced every day.
- **Parents do not have time for self-care:** Only two parents described making time for their own self-care through exercise or relaxation techniques. All parents lamented about the busy-ness of their daily schedules and a feeling of "rush, rush, rush."
- **Many parents voiced concerns about affording basic needs for their family:** Parents talked about a lack of financial resources, inadequate housing due to high costs, and a feeling that they were unable to provide everything their children need.
- **Parents do not understand kindergarten readiness or how to support their child's school readiness:** Almost no parent, regardless of education or income level, was able to describe kindergarten readiness or the skills their child needs to be successful in school. As school readiness involves basic social-emotional skills, this also suggests that children are lacking basic life skills more generally.

Solutions for these challenges and more were solicited from the families and the larger community. Many hundreds of solutions were offered and tested with parents. Texting emerged as a possible delivery system for a variety of information. Many parents said they relied on texts as their preferred communication tool and wished the school district would use it. Suggestions for a text-based parent support program were tested with families using a simple paper prototype and were received positively. The initial prototype was based on similar texting programs for smoking cessation, weight loss, pregnancy and early childhood development (Text4Baby), and student support.

While developing the prototype, the research team (Core Design Team or CDT) learned about an existing texting program called Ready4K. Ready4K, at the time, provided parents of children aged 3 to 5 with three texts a week to support their child's early literacy. The program, designed by researchers at Stanford University, was implemented in San Francisco public preschools. Initial research showed the program was effective in raising child literacy scores, but also in parent involvement and engagement in their child's learning, in and out of school.

The CDT chose a text-based parent support system as one of several Phase 2 projects because it appeared to address multiple concerns expressed by parents, including method of information delivery. We initially reached out to the developers of Ready4K to ask if they could provide tech support to create a new program that including more than school readiness. One of the creators of Ready4K had launched a community-benefit corporation called ParentPowered to further develop, improve, and implement the Ready4K program. ParentPowered offered to make Ready4K available to parents in Del Norte immediately, while also working with the CDT and the community to create a broader texting program that addressed all of the protective factors, resilience, and parental self-care. A pilot program with two dozen families showed a positive acceptance of the Ready4K program.

The CDT brought this project to the Local Mental Health Board as a potential Innovation Project because it addresses many factors for family strengthening and child mental health through a unique delivery system designed by and for Del Norte communities. The CDT is committed to designing all solutions with families and this project is no different. Families, service providers, and other community members will help develop and test the content of our new texting program. The project is called Text2GROW, recognizing that the end product will be fundamentally different from the original Ready4K.

2) What has been done elsewhere to address your primary problem?

a) Describe the methods you have used to identify and review relevant published literature regarding existing practices or approaches. What have you found? Are there existing evidence-based models relevant to the problem you wish to address? If so, what limitations to those models apply to your circumstances?

We researched two bodies of work in establishing the innovative quality of our project. The first is family strengthening model. Family strengthening programs, as noted above, have been shown to be effective in reducing childhood and adolescent problematic behaviors. The limitations of family strengthening programs are:

- They typically require in-person learning sessions;
- They are finite in length with parents attending a limited number of sessions;
- They are generalized and are not tailored to the culture or community of parents; and
- They are relatively expensive to implement, as many of them have both a parent and a child component, requiring multiple facilitators at each session.

We also looked at models for text-based programs for behavioral change. Text-based smoking cessation programs send reminders and tips to help smokers quit and have been shown to be effective. Text-based support for first-generation community college students has increased graduation rates and decreased drop-out rates for this vulnerable population. Text4Baby is a health messaging program of the US Department of Health and Human Services that has been effective in improving prenatal care behavior among participants. Ready4K itself was rigorously tested when first introduced to San Francisco public preschools by Stanford University. They found that Ready4K increased parental involvement in their child's learning, increased parental engagement with teachers, and provided a two-month boost in kindergarten readiness.

Texting is effective, in part, because it is so ubiquitous. Over 95% of American adults under the age of 50 have a cell phone capable of receiving texts. Texts are opened at high rates: over 98% of texts are opened and over 90% are opened within three minutes of being received. Few other outreach methods have such reach into the community.

The texting programs created to date are generalized. The Text4Baby program, for example, provides contact information for a variety of services, such as smoking cessation. The information it provides, however, is a national contact. Parents looking for local resources do not receive it through such a general service. In talking with ParentPowered, we learned that many communities have inquired about adding local content, but that, to their knowledge, we would be the first community to actually do so. We have not found any texting programs providing parents with local content.

b) Describe the methods you have used to identify and review existing, related practices in other counties, states, or countries. What have you found? If there are existing practices addressing similar problems, have they been evaluated? What limitations apply to your circumstances?

As noted above, there are other text-based support programs with proven effectiveness in providing prevention and intervention services across a variety of issues. There are also other ways to provide parenting support outside of texting. Home visiting programs using both nurses and lay counsellors have proven effective in supporting high-risk parents. The Nurse-Family Partnership is a well-known and effective model in use in Del Norte County and around the country. It is also an expensive model, relying on highly trained and educated nurses to provide prevention and intervention services to a small number of clients. The Child Abuse Prevention Center, based in Sacramento, has pioneered a volunteer-based home visiting using AmeriCorps volunteers. This model is significantly cheaper than nurse-based programs and has proven to be very effective in decreasing substantiated cases of child abuse and neglect.

A new or expanded home visiting program could have the same effect we expect from Text2GROW. However, even if staffed by AmeriCorps volunteers or lay-counsellors, such a

program would be expensive and difficult to sustain. Even a large program would provide services to a small portion of the parent population of the county. Text2GROW has the potential of reaching a large percentage of families at a minimal cost. There are significant up-front costs to develop and test the messages, but implementation is very low-cost. In a rural county, a texting program can reach a much-higher percentage of families than a home-visiting program at a much-lower cost. It can also provide more continuous support over a longer period of time than any existing home visiting or family strengthening programs.

3) The Proposed Project

Include sufficient details so that a reader without prior knowledge of the model or approach you are proposing can understand the relationship between the primary problem you identified and the potential solution you seek to test. You may want to identify how you plan to implement the project, the relevant participants/roles, what participants will typically experience, and any other key activities associated with development and implementation.

a) Provide a brief narrative overview description of the proposed project.

The Text2GROW project will create a text-based parent support system based on the model and partial content of the existing Ready4K school-readiness texting program. The partners in this work include:

- **Del Norte County Department of Mental Health:** providing fiscal and programmatic guidance for Mental Health Services Act funding and helping generate messaging content around mental health resources;
- **First 5 Del Norte and the Literacy Core Design Team:** providing co-design expertise in crafting messaging content with families and providers, coordinating all partners, and providing messaging content; also coordinating outreach and enrollment through the Wonder Bus and other First 5-funded programs;
- **ParentPowered:** providing expertise in crafting text messages and the technical knowledge of building a text-based system; also providing the base messaging of Ready4K as desired;
- **Yurok Tribe Education and Language Department, Tolowa Dee-Ni' Nation Language Department, and the Hmong Cultural Center:** providing cultural content for text messages; texts will be available in English and Spanish (Ready4K is already available in both languages), and families will have the option of choosing a culturally-specific version of the program;
- **Del Norte families:** co-generating content and providing feedback on messaging content, timing, frequency, and usefulness; families will be recruited to ensure participation across cultural groups, income levels, geographic location, educational attainment, and other appropriate measures of diversity;
- **Service and program providers:** generating content about their services and programs for dissemination via text;
- **The Child Abuse Prevention Center:** the CAP Center operates several grants with the Corporation for National and Community Service (CNCS) for AmeriCorps programs; First

5 will contract with them for two First 5 Service Corps AmeriCorps volunteers for outreach and enrollment of families through the Wonder Bus program and other venues; and

- **Applied Survey Research (ASR):** assisting in the design and implementation of project evaluation

Together, these partners will create and evaluate a texting program, Text2GROW, that combines Ready4K child development texts with local and family strengthening content. Ready4K texts have expanded since our original pilot. Ready4K now offers texts for children 0 to 5 years in age, covering early literacy, early numeracy, and social and emotional learning. First 5 has been enrolling families in Ready4K for almost nine months and we know that families like the format and content of the basic program.

Our project will co-design new content that will either be added to or replace Ready4K content. The additional content will focus on family strengthening; parental mental health and self-care; and connection to local resources and services, especially mental health. Parents and providers will help create the new content in a number of settings, including focus groups, one-on-one interviews, and less formal interactions.

Texts will follow the basic format of Ready4K texts, which send information on Mondays, a tip on Wednesdays, and a follow-through or extension on Fridays. For example, one week of texts may focus on postpartum disorders:

Mon: Time to take care of YOU! Did the Baby Blues hit in the first days after birth? It's completely normal to cry over little things and feel overwhelmed for a couple weeks.

Wed: Are your Baby Blues going away? If you don't feel better after 2 or 3 weeks, you could have postpartum depression. Call your doctor or midwife - this is a serious condition, but it is also treatable and temporary.

Fri: Signs of postpartum depression include inability to eat or sleep and feeling disconnected from your baby. If your "blues" stick around, call your doctor or midwife to get help.

Others will focus on concrete family needs such as child care (and a boost to a tired parent's ego):

Mon: Congratulations! You made it through your first month as a parent. Parenting can be tough, but you can be a great parent!

Wed: Thinking about returning to work soon? The Del Norte Child Care Council can help you find (and pay for, if eligible!) quality child care for your baby. Call them at 464-8311.

Fri: Not sure what quality child care looks like? Check out this list of questions to ask providers and what to look for as you visit child care homes or centers.

Providing the direct contact information for local programs and services is a key part of this project. Families told the CDT that they felt isolated and that they were "on their own" as parents. Connecting families to resources is a critical need in our community. Even if parents never use a program or service they learn about through Text2GROW, they receive a benefit.

Because the protective factor of “concrete support in times of need” is measured as “perceived support,” simply knowing a resource exists builds parental resilience.

When complete, Text2GROW will provide comprehensive parent support across many domains of life. It will be easy (and free) for parents to enroll in the program. It will be scalable across our county and provide a template for other counties to use. For example, in the second set of texts above, changing the childcare resource and referral agency’s name and phone number makes the set work in any county.

b) Identify which of the three approaches specified in CCR, Title 9, Sect. 3910(a) the project will implement (introduces a practice or approach that is new to the overall mental health system; makes a change to an existing practice in the field of mental health; or applies to the mental health system a promising community-driven practice approach that has been successful in non-mental health contexts or settings).

This project takes a promising community-driven practice from other fields (text-based programs for behavioral health and support) and applies it to the mental health system.

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

As described above, this project grew out of interviews with Del Norte families. The CDT investigated texting programs *because families told us that texting was their preferred method of communication*. We have tested a paper prototype of this program and offered the base program, Ready4K. Parents have reacted positively to both. We believe the proven efficacy of texting programs in behavioral health will transfer to the Text2GROW program.

4) Innovative Component

Describe the key elements of approaches that will be new, changed, or adapted in your project (potentially including project development, implementation, or evaluation). What are you doing that distinguishes your project from similar projects that other counties and/or providers have already tested or implemented.

a) N/A

b) If you applying an approach or practice from outside of mental health or that is entirely new, what key aspects of that approach or practice do you regard as innovative in mental health, and why?

Our project is innovative in a number of ways:

- **The method of delivery (text):** Text delivery allows the program to be affordably offered to ALL families, unlike most publicly-funded mental health services, which are available only to families with an identified mental health need or who are considered “at risk”;
- **The co-design of content with parents and providers:** By including parents and providers in the content design process, we will produce a product that addresses the needs of multiple communities within our county;

- **The broad-based definition of “prevention” that underlies our work:** We believe that all parents need and deserve support in raising children who are physically and mentally healthy, and that this support must cross multiple domains of their lives; and
- **Our two-generation approach:** We are providing parents with support for their own needs and self-care, while also supporting their ability to engage and participate in their child’s growth and development. Wrap-around mental health services for families that address both parents and children do exist (even in Del Norte), but they are money- and resource-intensive and can be offered only to families in or near crisis.

5) Learning Goals/Project Aims

The broad objective of the Innovative Component of the MHSA is to incentivize learning that contributes to the spread of effective practices in the mental health system. Describe your learning goals/specific aims and how you hope to contribute to the spread of effective practices.

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

Our primary learning goals are:

1. Is texting an effective tool for providing preventative mental health services to a county-wide population?
2. Will providing families with specific, purposefully-timed information about available programs and services, especially around mental health, increase participation in those services and increase families’ connection to support networks?
3. Will providing families with broad-based, multi-domain support lead to children being better-prepared for kindergarten both academically and social-emotionally?

We prioritized these learning goals because of the insights from our parent interviews. The parents interviewed represented the full range of families in Del Norte County, although it was not a statistically representative group. We talked with parents of all socio-economic status; parents representing all major cultural groups in the county; parents with graduate degrees and parents with GEDs. Across the board, they all faced similar problems: lack of time, skills, and knowledge to support their child’s healthy development. Some parents had higher needs than others, but no parent expressed a feeling that they were fully prepared and able to support their child.

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

Learning Goal 1: Parents told us they are time-poor and that their preferred method of communication is text. Texts are quickly read and contain a small amount of information. We are therefore, relying on texts to provide information parents told us they want and need.

Learning Goal 2: Parents told us they either don’t know about or don’t know how to access resources and services their families need. We are providing information about available programs, resources, and services for families in our communities. We are hoping this

continual referral process will increase both families' perception of available support and their use of available programs, resources, and services.

Learning Goal 3: This work started through an investigation of challenges and barriers to early literacy and literacy-attainment in third grade. We learned that many of the challenges are seemingly unrelated to academic preparedness or success, but that they nevertheless affect school readiness and achievement. We hope that providing multi-domain parent supports throughout early childhood will result in children being better-prepared for school across academic and social-emotional domains.

6) Evaluation or Learning Plan

For each of your learning goals or specific aims, describe the approach you will take to determine whether the goal or objective was met. What observable consequences do you expect to follow from your project's implementation? How do they relate to the project's objectives?

a) Who are the target participants and/or data sources?

For all three learning objectives, our target participants are parents with children 0 to 5. We have been enrolling parents in the existing Ready4K program through a variety of channels and will increase recruitment efforts once the Text2GROW program launched. In order to compare Text2GROW to Ready4K (our control group), we will assign new participants to either Text2GROW or Ready4K based on the last digit of their telephone number. We are choosing to split participants into experimental and control groups for better evaluation. Ready4K has multiple studies showing its efficacy; we are interested in whether the addition of local and culturally-relevant information yields better results than Ready4K alone. The children themselves are also participants, especially for Learning Goal 3.

Learning Goal 1: Is texting an effective tool for providing preventative mental health services to a county-wide population?

b) What is the data to be collected?

Working with Applied Survey Research (ASR), we will conduct regular assessments with parents for their satisfaction and usage of the program, both in person and through text message links to online surveys. Questions will include how often they read the texts, how often they have used the information or activities included in texts, and how often they followed up by reaching out to an agency or organization highlighted in the texts. We will also track the percentage of parents participating over time, including a geographic analysis to assess the reach into underserved communities in the county.

c) What is the method for collecting data?

We will conduct focus groups with parents and provide links to online surveys. ParentPowered will also be testing other text-based feedback tools over the course of the project.

d) How is the method administered?

As noted above, there will be control and experimental groups for comparison purposes. ASR will conduct pre- and post-testing for baseline information. Focus groups with a fixed make up will be used throughout the process to get continual feedback from a core group of participating parents.

Learning Goal 2: Will providing families with specific, purposefully-timed information about available programs and services, especially around mental health, increase participation in those services and increase families' connection to support networks?

b) What is the data to be collected?

In addition to asking families what services/resources they use based on the texts, we will also do regular surveys with resource providers highlighted in texts to see if they receive more clients based on the texting program. We will ask partners who use intake forms with a question like, "How did you hear about our services?" to add Text2GROW as an option. We will work with our partners to develop other ways to measure increases in client services due to Text2GROW.

c) What is the method for collecting data?

See above.

d) How is the method administered?

For parents' connection to social networks, we will rely on questions asked on existing parent surveys. First 5 Del Norte has parent intake/feedback surveys that are given during pregnancy, when families use some of our funded services, and when children are entering kindergarten. We have been working to add questions that measure parents feeling of connection to community and the strength of their support networks.

Learning Goal 3: Will providing families with broad-based, multi-domain support lead to children being better-prepared for kindergarten both academically and social-emotionally?

b) What is the data to be collected?

Every incoming kindergarten student throughout Del Norte County is assessed for school readiness. ASR has an existing MOU with the Del Norte Unified School District to use this data. The assessment covers both academic and social-emotional readiness.

c) What is the method for collecting data?

First 5 and ASR collaborate on a kindergarten readiness assessment every year. We will monitor improvements in school readiness through this existing assessment that combines kindergarten readiness assessments (conducted by the Del Norte Unified School District) with parent questionnaires, which are included in required documents for kindergarten registration. This will let us see improvements in kindergarten readiness, including social and emotional readiness, although it will not be tightly linked to use of the program. First 5 Del Norte will add Text2GROW as an option for how parents learn about resources on the parent questionnaire.

d) How is the method administered?

This is an existing process. First 5 provides copies of a parent information form to the school district for inclusion in the kindergarten registration packets. The district conducts school readiness assessments on all students. ASR receives data from both tools from the school district.

e) What is the preliminary plan for how the data will be entered and analyzed?

For all three objectives, ASR will be primarily responsible for data entry and analysis. ASR and First 5 Del Norte have worked together for over a decade to track school readiness and family demographics of entering kindergarten students. This long-standing partnership will strengthen the ASR's work on the Text2GROW project.

7) Contracting

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

There are four contractual relationships connected with this project. First 5 Del Norte and the Mental Health Branch are working in close partnership and will likely need a Memorandum of Understanding or other agreement to clarify roles and responsibilities. There will be additional contracts or MOUs with ParentPowered for content implementation and technical assistance; Applied Survey Research for evaluation services, and the Child Abuse Prevention Center for two AmeriCorps volunteers.

The Mental Health Branch will utilize current staff to oversee various compliance and regulatory issues with the project and report back to the state as required. The Mental Health Branch will have regular meetings with ParentPowered, ASR, and First 5 to ensure adequate evaluation of the project.

In addition to these measures, First 5 is itself a county-level government agency. All First 5 funds are held and monitored by the Del Norte County Auditor's Office, all checks are issued by the Auditor's Office, and First 5 undergoes an annual third-party audit. First 5's contracts with outside entities are reviewed and approved by First 5's pro bono counsel, who previously worked as Del Norte County Counsel. First 5 has contracted with the Child Abuse Prevention Center for three years for AmeriCorps programs. In addition, the Director of the Del Norte Department of Health and Human Services is a member of the First 5 Del Norte Children and Families Commission and therefore has direct oversight on all fiscal and contractual business conducted by First 5.

Additional Information for Regulatory Requirements

1) Certifications (all Certifications and requesting documents to follow)

2) Community Program Planning

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

This project grew directly out of interviews with 27 Del Norte families. The families represented a cross-section of Del Norte residents in terms of geographic location, ethnicity, economic status, and educational attainment, although it was not a statistically representative sample. As this project has developed, families were included in the planning and prototyping. The project was also included in a community-wide literacy symposium for more community feedback and input.

The project has had developmental support from the Literacy CDT. This team represents a number of non-profits and public agencies that support children and families. The project was introduced at a stakeholders' meeting for MHS Innovation Projects on 1/12/2017 and has been discussed at meetings of the Local Mental Health Board.

Department of Mental Health staff have met with First 5 staff to review the requirements for MHS Innovation funds and to provide guidance in the writing of the plan.

Notice for the thirty day public comment period was given on January 4th 2018 by advertising in the local paper. The public comment period was held from January 4th to February 3rd. The Public meeting and Local Mental health approval took place on February 5th. There was one comment on this plan during the 30 day comment period and during the public meeting. The individual who provided the comment was provided additional education on Innovation funding and its purpose and also its limits. The individual was understanding of this and agreed to work with Del Norte First Five and County Mental Health on this project to ensure his insight into culturally appropriate messaging and to see if his needs and the needs of the Klamath community could be met through other sources of funding. There was support for the plan by Del Norte Child Care Council Director Melody Fugate. We had one peer advocate to express support on the plan. The Innovation plan was voted on by the LMHB and passed unanimously. The meeting was open to all members of the community, and was advertised in the local paper and at County buildings.

3. Primary Purpose

a) Increase access to mental health services to underserved groups

4. MHS Innovation Project Category

c) Introduces a new application to the mental health system of a promising community-driven practice or an approach that has been successful in a non-mental health context or setting.

5. Population (if applicable)

Innovative Project Plan Description – Del Norte County Text2GROW

a) If your project includes direct services to mental health consumers, family members, or individuals at risk of serious mental illness/serious emotional disturbance, please estimate the number of individuals expected to be served annually.

We hope to enroll a minimum of 250 families in the first year and an additional 100 families in each subsequent year. This would be approximately 1/3 of babies born in Del Norte County each year.

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

Participants will be the parents or caregivers of children ages 0 to 5. We will recruit families through a variety of programs and providers who serve this population. Special initiatives will be undertaken to reach families in underserved areas such as Klamath, CA, and Smith River, CA, that have higher populations of Native American and Latino families.

c) Does the project plan to serve a focal population?

Participants must have or interact with children ages 0 to 5.

6. MHSA General Standards

Using specific examples, briefly describe how your INN Project reflects and is consistent with all potentially applicable MHSA General Standards set forth in Title 9 California Code of Regulations. If one or more general standards do not apply to your INN Project, please explain why.

a) Community Collaboration

This project was developed as a collaboration between Del Norte County DHHS Mental Health Branch and First 5 Del Norte. It is the first joint effort between these two agencies related to mental health service delivery. The original concept grew out of the multi-stakeholder Literacy CDT's interviews and work with families throughout Del Norte. In addition, this project was vetted through the Innovation Planning meeting, multiple Local Mental Health Board meetings, and various sub-meetings with community partners including Open Door Community Health Center.

b) Cultural Competency

This project is intended to serve all parents and caregivers of children ages 0 to 5. Culturally-specific content will be developed with Native, Latino, and Hmong families and service providers, including the language, education, and culture departments of the Yurok Tribe and Tolowa Dee-Ni' Nation. The outlying communities of Klamath and Smith River have high populations of Native and Latino families and we will have targeted enrollment drives in those communities for Text2GROW. Enrollment activities for Ready4K have been present at the Bi-National Health Fair and Cinco de Mayo celebrations, and at the Yurok Tribe's Spring Fling, among other culturally-specific events.

c) Client-driven

This project was conceived in direct response to client (parent) information. The additional content will be co-designed and evaluated with parents.

d) Family-driven

Our two-generation approach is designed to support all members of a family by supporting parent needs and providing parents with information and skills to support their child's healthy growth and development. Families are at the center of this project from planning to implementation to evaluation.

e) Wellness, Recovery, and Resilience-Focused

Text2GROW is explicitly intended to build resilience in parents, children, and families, and to support overall health and wellness. It additionally creates meaningful connections to support for individuals and families.

f) Integrated Service Experience for Clients and Families

The messaging content will focus on multiple domains of health, wellness, and development for all individuals in a family. Messaging will support mental health, physical health, and social-emotional health. Messaging will also connect families to the full range of programs and services they need from nutrition assistance to child care services to child enrichment activities to school readiness tools to developmental screening services.

7. Continuity of Care for Individuals with Serious Mental Illness

Will individuals with serious mental illness receive services from the proposed project?

No. Although it is possible that individuals with serious mental illness will connect with services through this project, it does not offer any direct treatment services to individuals with serious mental illness.

8) INN Project Evaluation Cultural Competence and Meaningful Stakeholder Involvement

a) Explain how you plan to ensure that the project evaluation is culturally competent.

This project is intended to serve all families in Del Norte. In order to adequately serve Latino, Hmong, and Native American populations, we will work closely with families to develop culturally-appropriate content. The texting program will be available in our threshold language of Spanish. In addition, participants may choose a Text2GROW version with specific cultural content, including Hmong, Tolowa, and Yurok options. We intend to work closely with local Tribal governments and the Hmong Cultural Center to ensure cultural competence of both the content and evaluation. ASR will work closely to screen all evaluations tools with relevant cultural groups and entities. In addition, Dr. Glore, the Executive Director of First 5 Del Norte, holds a Masters and Ph.D. in anthropology and is well-versed in creating culturally-appropriate data collection and evaluation tools.

b) Explain how you plan to ensure meaningful stakeholder participation in the evaluation.

Multiple stakeholder groups are involved in this project. The Literacy CDT and the School System Implementation Team have been involved for almost two years from concept to prototype to this MHSA application, and represent a wide range of business owners, teachers, school administrators, and non-profit leaders, many of whom are also parents of school-age children. They will also be involved in the evaluation of the project.

Parents of children ages 0 to 5 are the most important stakeholders in this work and they will be a regular part of the evaluation work. Focus groups of parents will be held regularly throughout the project development, implementation, and evaluation. We will be sure to include parents representing the full diversity of our county.

9. Deciding whether and how to continue the project without INN funds

If the evaluation demonstrates the efficacy of this project, First 5 Del Norte intends to continue offering the resulting texting program, Text2GROW. The bulk of the costs associated with this project are the upfront costs of developing and testing the right combination and timing of messages. Once that is complete, there is minor work to keep information current each year, but the primary recurring cost is the cost of sending the texts. Neither the cost of upkeep or sending texts is prohibitive; First 5 can sustain this program without INN funds.

If the evaluation shows there is little to no difference between Ready4K and Text2GROW, First 5 will most likely continue offering only Ready4K. It is an effective, evidence-based program that has fewer costs and maintenance than Text2GROW over the long-term.

10. Communication and dissemination plan

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

We will provide regular reports of progress and evaluation to the Local Mental Health Board and County Board of Supervisors throughout project development. First 5 and ParentPowered intend to co-author a white paper at the end of the project and also to present findings at appropriate early childhood/childhood development conferences. Travel funds have been included for this purpose. We will also communicate our results to the other 57 First 5 Commissions through the First 5 Association and First 5 California, which will reach all California counties. Several other First 5 Commissions are currently offering Ready4K and are watching our localization process carefully. First 5 is an excellent partner in this work because of the close, networked relationship between county First 5 Commissions, the First 5 Association, and First 5 California.

b) How will program participants or other stakeholders be involved in communication efforts?

Parent voices have been important from the beginning of this work. We will continue to find ways for program participants to be involved in all aspects of the project, including providing

testimonials or other feedback in public presentations. On an informal level, we hope participants will help recruit new participants through word of mouth.

c) KEYWORDS for search:

“parent support” “resilience” “family mental health” “text-based support”

11. Timeline

a) Specify the total timeframe (duration) of the INN project

Three years

b) Specify the expected start date and end date of your INN project

July, 2018 to June, 2021

c) Include a timeline that specifies key activities and milestones, and a brief explanation of how the project timeframe will allow sufficient time for:

- Development and refinement of the new or changed approach;
- Evaluation of the INN Project;
- Decision-making, including meaningful involvement of stakeholders, about whether and how to continue the project; and
- Communication of results and lessons learned

Year One

- Formalize roles, including executing contracts and/or MOUs as needed with First 5 Del Norte, ParentPowered, the Child Abuse Prevention Center, and Applied Survey Research (first three months)
- Begin content creation and implementation through focus groups and stakeholder meetings, starting with content for first 12 months of life, to roll out no later than nine months into the project
- ASR develops and implements pre-surveys and works with ParentPowered to deliver text-based survey tools
- First 5 coordinates AmeriCorps volunteer-led enrollment campaign throughout county
- By end of Year One, five years of content is rolled out in preliminary form
- Mental Health Branch staff and First 5 Del Norte meet monthly to evaluate progress

Year Two

- First full round of evaluation of content is completed; content is reworked in accordance to evaluation data
- Cultural components are completed in collaboration with the Yurok Tribe, Tolowa Dee-Ni' Nation, and Hmong Cultural Center, among other stakeholders; cultural options for Text2GROW are opened to enrollment
- ASR continues on-going evaluation with parents (for satisfaction with and feedback on content and delivery), with providers (for increases in use of programs and services), and with First 5 and Literacy CDT (for improvements in school readiness)

- Mental Health Branch staff and First 5 Del Norte meet monthly to evaluate progress
- Initial findings are presented and/or published in appropriate venues

Year Three

- Results of second full round of evaluation of content are reported
- Final editing of messaging content for all Text2GROW options
- ASR continues on-going evaluation in preparation for final evaluation
- By April, 2021, final evaluation results are presented to all local stakeholders
- Mental Health Branch, First 5 Del Norte, and other local stakeholders make determination as to success and efficacy of the Text2GROW project (May, 2021)
- Communication of results and lessons learned are provided to all local and state stakeholders including the Local Mental Health Board, Del Norte County Board of Supervisors, First 5 Del Norte Commission, First 5 California Commission, Mental Health Services Act Oversight and Accountability Commission, as required and necessary, in approved formats
- Communication of results and lessons learned are presented to First 5 Network and at state and national conferences as appropriate

12. INN Project Budget and Source of Expenditures

a) Budget Narrative

This project requires the collaborative effort of multiple partners: Del Norte County Department of Health and Human Services Mental Health (DHSMH), First 5 Del Norte (First 5), Parent Powered (PP), Applied Survey Research (ASR), the Wonder Bus, and the Del Norte community. The budget reflects the needs and responsibilities of each partner.

- DHSMH will have fiscal oversight of MHSA funds and will coordinate with partners on all fiscal matters. DHSMH will work with First 5 on mental health content and reporting;
- First 5 will have primary responsibility for working with PP and ASR to develop content, conduct evaluation, and disseminate results. First 5 will also recruit and coordinate parent focus groups and new participants for the texting program. First 5 will work with DHSMH on evaluation and reporting, as well as sustainability of the project after INN funds are done.
- PP will work with First 5 and the community to develop local and culturally-responsive content for the texting program. PP will be solely responsible for the technical side of this project - sending out texts and maintaining accurate participant information. PP will also work with First 5 and ASR to conduct evaluation.
- ASR will design and implement the project evaluation, coordinating with First 5 and PP.
- The Wonder Bus program, funded primarily by First 5 Del Norte with supplementary funding provided by the County of Del Norte, the County Office of Education, the Del Norte Child Care Council, the City of Crescent City, and the Del Norte County Library,

operates a mobile children’s library/Family Resources Center in a modified school bus. First 5 will contract with the Child Abuse Prevention Center for two AmeriCorps volunteers to assist with recruitment and enrollment.

- The community will help drive and create the content of new texts through focus groups, one-on-one parent meetings, and other pathways. Parents face barriers to participation in meetings including lack of transportation, child care, and interference with family meal times and other events. To facilitate meaningful parent engagement in the creation and evaluation processes, we will provide transportation, child care, and meals to families as needed for their participation.

Personnel Costs: \$47,077

Salary: \$37,807

The First 5 Executive Director will be the primary point of contact for PP and ASR and will coordinate local content generation, participate in evaluation, and travel to conferences to disseminate results. The ED expects to spend .15 FTE on this project. \$23,504 is 10% of the ED’s salary (only) for the three years of the project. First 5’s Accounting Technician will process payments on contracts, travel and operating costs, estimated at .05 FTE or \$5,738 of salary over three years. MHP staff time for review and implementation of project as well as fiscal process and payments has a projected salary cost of \$8,565 over 3 years.

Direct costs: \$9,270

The agency costs for ED retirement (FICA and PERS) at 10% of total are \$9,270 over three years of the project.

Operating Costs: \$15,200

Copies: \$600/year for three years = \$1,800 (Enrollment forms, recruitment materials, etc.)

Parent Focus Group Support: \$3,900/year for one year plus \$1,300/year for year two plus \$2,600 year three = \$7,800

Meals, child care, and transportation, as needed, for parent focus group: 30 meeting over the three years @ \$260/meeting: \$100/food for ten people, \$60/child care providers, and \$100 for gas cards.

Travel costs for dissemination: \$2,800/year for two years = \$5,600

Two conferences each for two years @ 1,400/conference = \$2,800/year.

\$800/air fare or mileage, \$360/hotel (three nights at \$120/night), \$52/day meals and incidentals, conference fee and parking (varies).

Travel for PP staff is included in their contract.

Non-recurring costs: \$2,500

Equipment: \$2,500

Purchase of two iPads for online enrollment at sites with wi-fi available, including screen protectors and cases @ \$450 each.

Purchase of a shared laptop for data entry, program material design, etc., for AmeriCorps members @ \$1,600.

Consultant Costs: \$189,504

Parent Powered: \$125,433

ParentPowered's contract covers travel to Del Norte for community meetings; crafting text messages from community content/input; all technical matters involved with sending text messages; refining messages based on evaluations and parent feedback; participating in evaluation; and traveling to conferences to disseminate results.

Applied Survey Research: \$39,900

ASR will help develop, implement, and analyze evaluation tools and data for the project. They will supply annual reports, including materials to be used in public presentations of results.

Child Abuse Prevention Center: \$24,171

AmeriCorps First 5 Service Corps members for staffing the Wonder Bus will serve through a contract with the CAP Center in Sacramento. One 900-hour AmeriCorps member will fully dedicated to promoting Ready4K and enrolling new families (\$4,661/year in 2018-2019), with .25 FTE of a 1700 AmeriCorps member assisting with the project (\$2,345/year in 2018/19). (The total for this item allows for an increase in costs of up to 15% over the three year project.)

Other Expenditures: \$8,565

Evaluation: \$8,565

This is the direct costs associated with Del Norte County Mental Health in ensuring that the program has oversight related to content and all of the reporting requirements of Mental Health Services Act Innovation Funding. In addition these costs will be for any other evaluation of the project, such as for state learning.

The total for the project will be \$262,846. This will be drawn completely from the Innovations funding of the Mental Health Services Act. Del Norte County DHHS-Mental Health Branch will be utilizing current Innovation funds, as we do not have Innovation funds set for reversion.

A. BUDGET BY FISCAL YEAR AND SPECIFIC BUDGET CATEGORY*							
EXPENDITURES							
PERSONNEL COSTS (salaries, wages, benefits)		FY 18/19	FY 19/20	FY 20/21	FY xx/xx	FY xx/xx	TOTAL
1.	Salaries	12,119	12,725	12,963			37,807
2.	Direct Costs	2,990	3,140	3,140			9,270
3.	Indirect Costs						
4.	Total Personnel Costs	15,109	15,865	16,103			47,077
OPERATING COSTS		FY 18/19	FY 19/20	FY 20/21	FY xx/xx	FY xx/xx	TOTAL
5.	Direct Costs	7,300	4,700	3,200			15,200
6.	Indirect Costs						
7.	Total Operating Costs	7,300	4,700	3,200			15,200
NON RECURRING COSTS (equipment, technology)		FY 18/19	FY 19/20	FY 20/21	FY xx/xx	FY xx/xx	TOTAL
8.	Purchase of iPads and laptop	2,500					2,500
9.							
10.	Total Non-recurring costs	2,500					2,500
CONSULTANT COSTS / CONTRACTS (clinical, training, facilitator, evaluation)		FY 18/19	FY 19/20	FY 20/21	FY xx/xx	FY xx/xx	TOTAL
11.	Direct Costs	57,168	55,593	76,743			189,504
12.	Indirect Costs						
13.	Total Consultant Costs	57,168	55,593	76,743			189,504
OTHER EXPENDITURES (please explain in budget narrative)		FY 18/19	FY 19/20	FY 20/21	FY xx/xx	FY xx/xx	TOTAL
14.							
15.							
16.	Total Other Expenditures	2,717	2,853	2,995			8,565
BUDGET TOTALS							
Personnel (line 1)		12,119	12,725	12,963			37,807
Direct Costs (add lines 2, 5 and 11 from above)		67,458	63,433	83,083			213,974
Indirect Costs (add lines 3, 6 and 12 from above)							
Non-recurring costs (line 10)		2,500					2,500
Other Expenditures (line 16)		2,717	2,853	2,995			8,565
TOTAL INNOVATION BUDGET		84,794	79,011	99,041			262,846

*For a complete definition of direct and indirect costs, please use DHCS Information Notice 14-033. This notice aligns with the federal definition for direct/indirect costs.

A. BUDGET CONTEXT - EXPENDITURES BY FUNDING SOURCE AND FISCAL YEAR (FY)							
ADMINISTRATION:							
A.	Estimated total mental health expenditures for ADMINISTRATION for the entire duration of this INN Project by FY & the following funding sources:	FY 18/19	FY 19/20	FY 20/21	FY xx/xx	FY xx/xx	TOTAL
1.	Innovative MHSA Funds	2,717	2,853	2,995			8,565
2.	Federal Financial Participation						
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other funding*						
6.	Total Proposed Administration	2,717	2,853	2,995			8,565
EVALUATION:							
B.	Estimated total mental health expenditures for EVALUATION for the entire duration of this INN Project by FY & the following funding sources:	FY 18/19	FY 19/20	FY 20/21	FY xx/xx	FY xx/xx	TOTAL
1.	Innovative MHSA Funds	2,717	2,853	2,995			8,565
2.	Federal Financial Participation						
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other funding*						
6.	Total Proposed Evaluation	2,717	2,853	2,995			8,565
TOTAL:							
C.	Estimated TOTAL mental health expenditures (this sum to total funding requested) for the entire duration of this INN Project by FY & the following funding sources:	FY 18/19	FY 19/20	FY 20/21	FY xx/xx	FY xx/xx	TOTAL
1.	Innovative MHSA Funds	84,794	79,011	99,041			262,846
2.	Federal Financial Participation						
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other funding*						
6.	Total Proposed Expenditures	84,794	79,011	99,041			262,846
*If "Other funding" is included, please explain.							

Public Comments during Thirty day comment period and public hearing
Public Comment submitted 2/1/18



Children & Families Commission

It's All About the Kids

Commissioners

Jeff Harris, Chair

Alicia McKellar

Heather Snow

Warren Rehwaldt, M.D.

Executive Director

Angela Glore

Lonnie Reyman, Vice Chair

Chris Howard

2 February 2018

To Whom It May Concern:

I am writing in support of the Text 2 GROW proposal for the Mental Health Services Act Innovation Funding. First 5 Del Norte strongly advocates for funding for this proposal to address two primary community needs.

First, families feel isolated and don't know how to access existing community resources, including mental health resources. We know this from a series of family interviews conducted in January, 2016, and from numerous sources since those interviews were completed. A need for more or better mental health services were explicitly called out in several family interviews, whether those were services for children, parents, or both.

Research demonstrates that families without support networks and access to concrete help in times of need are less resilient and successful than families without those protective factors. In looking for solutions to the isolation and lack of access to resources, we tested a text-based solution with parents and providers. The response was very positive. MHSa Innovation funding for Text 2 GROW will allow our community to customize an existing texting program to connect parents with mental health and other community resources they need, at the time in their child's life they are most in need of those resources. The additional content will be guided by community input and the five protective factors for strong families: concrete support in times of need; social connections; parental knowledge of child development; children's social and emotional learning; and parental resilience.

The second need is to support early childhood learning in the family and home. While this may not seem to have a direct link to mental health, it is prevention at its finest. Living in poverty has been shown to cause toxic levels of stress in people's day to day lives. For children, toxic stress affects brain development and ability to learn. Children living in poverty tend to enter school at a deficit compared to their middle and upper class peers, including a significant deficit in language development, and therefore, they tend to have lower educational achievement throughout their lifespan. Lower educational achievement is consistently linked to lower wages over the course of a person's life.

This is a vicious cycle and one of the best ways to move families out of a cycle of poverty is through education.

continued

Learning starts at birth and parents and caregivers are a child's first teachers. Ready4K is an existing texting program that coaches parents and caregivers in providing positive experiences to their 0 to 5 year old child that support healthy brain development, social and emotional learning, early literacy, and early numeracy. This evidence-based program is free for parents and all the early-adopters in our community like receiving the texts and report using the information with their children.

By insuring that children are socially, emotionally, and academically ready to succeed in school; that parents are supported and can access resources they need; that parents and children with mental health needs are connected to services; and that parents are connected to each other and the community, the Text 2 GROW expansion of Ready4K will improve the mental health, family health, and future of our community.

I urge the Local Mental Health Board, the County Board of Supervisors, and the California Mental Health Services Oversight and Accountability Commission to approve funding for this project. It is an innovative, prevention-focused program with a long-term ability to change lives for the better.

Thank you,



Angela Glore
Executive Director

Public comment submitted 2/5/18

Felice Pace

28 Maple Road Klamath, Ca. 95548 707-954-6588 Unofelice@gmail.com

Comment for the February 5th, 2018 Public Hearing Record on the Draft INNOVATIVE PROJECT PLAN for Del Norte County prepared by Del Norte County Health & Human Services

My name is Felice Pace. I reside at Klamath Glen California.

My credentials include:

- past director of social services for the Yurok Tribe
- past coordinator of Drug Education and Prevention for Siskiyou County
- lifetime credentialed teacher with an MA in Education
- outdoor adventure-based education instructor and program developer
- current member of the Klamath Local Organizing Committee (KLOC)

First, this hearing should have been scheduled in the evening or on a Saturday so that working people from working families could participate. This scheduling serves the preferences of those working at HHS and not those of the people of Del Norte County. That's not good. I hope I never again see that a Del Norte Health and Human Services hearing is being held at a time working people can't participate.

The Draft Plan is a disappointment primarily because it once again ignores the feedback that has been given to the Department during this process and as comments on other DN Mental Health planning processes, as well as the data on where those actually being served by Del Norte Mental Health Services live. The draft plan ignores the fact that existing programs overwhelmingly serve folks in the Crescent City Area and underserve folks in outlying areas, including Klamath and Gasquet. Klamath, which I need to inform you is located within Del Norte County, has more poverty and greater need for mental health services as compared to anywhere else in Del Norte County. And yet there is no effort by the county to addressing the need. That is profoundly disappointing.

The attached graph obtained from DNMHS confirms that most mental health services in this county are delivered to folks who live in the Crescent City Area and that Klamath, as well as Gasquet, are underserved.

One indicator of community mental health need is school performance which we know from research is closely linked to parental effectiveness; parents with mental health need are often not effective parents. Data on school performance indicates that Del Norte Elementary Schools rank below the state average for math and language arts. However, among Del Norte Elementary Schools, Klamath's school, Margaret J. Keating, has the lowest performance and ranks considerably below the next poorest performing DNC elementary school.

KLOC, the Yurok Tribe and others, are working to change that. In order to get that job done, however, we need ALL services to be available to those in need in Klamath's several neighborhoods. But the attitude of DN Health and Human Services seems to be: "let the Tribe do

Continued

it.” That attitude is not acceptable. To fix our school we need to fix our poorly functioning families and to do that we need Del Norte County, and in particular Del Norte Health and Human Services, to step up and be an effective partner. We need Del Norte Health and Human Services to be a partner in fact, including in resources expended, and not just rhetorically. The rhetoric is good but good words need to be backed up by good deeds, in this case by the commitment of staff time and resources.

We need a Family Resource Center in Klamath where the County will deliver services that families in need in Klamath can not travel to Crescent City to access. We need First Five and other programs funded by Del Norte Health and Human Services delivered in Klamath where our families in need can access them.

It is good that the IPP Plan focuses on young children, an age group largely ignored by DN Mental Health Services previously. It is also good that the texting program proposed can be delivered throughout the county without actually traveling to the remote communities. It is good that the Plan mentions the need for culturally appropriate text messages. However, the Plan relies on First Five to deliver the new program. First Five is a good organization. It acknowledges, however, that it underserves Klamath because it does not have adequate funding to serve Klamath. It also has no to very little expertise in crafting culturally appropriate messages for Indigenous natives of this area. Furthermore, the Plan is to rely on tribes and other Native American organizations to provide First Five with culturally appropriate messages. But the IP Plan puts no resources into that. The Plan needs to pay more than lip service to culturally appropriate messaging. It needs to contract with individuals and organizations that can assist First Five in crafting culturally appropriate messages.

But one texting program for young families is not enough. We need and we deserve a Family Resource Center in Klamath where all county and tribal services can be delivered effectively to our families in need in a setting in which our families feel comfortable. This IP Plan should be redone to include, in addition to the texting program, the goal of establishing a Family Resource Center in Klamath, including concrete actions and funds directed toward that goal.

Klamath IS part of Del Norte County. It is time to end once and for all the “Let the Tribe take care of it” attitude at Del Norte Health and Human Services. Because it is without doubt the community most in need of social and mental health services, Del Norte Health and Human Services has a responsibility to step up and take the lead in bringing a Family Resource Center and a fair share of Del Norte Health and Human Services programs to Klamath.

Will Del Norte Health and Human Services do what most needs to be done? The Klamath Local Organizing Committee, KLOC, will be watching closely to see what comes down. We will be looking for concrete acts, not rhetoric. The final Innovative Project Plan will be one indicator.

Public Comments submitted at Public Hearing 2/5/18

- An attendee asked what the purpose of the plan was, Angela Glore described the plan to the audience
- An attendee asked if we had contacted the library.
- Felice Pace presented the Local Mental Health Board with a written comment. He stated that the Public Hearing should be scheduled in the evening and not at noon. As part of the document he included a graph showing service distribution by zip code. The graph displays that services are underrepresented in the Klamath region. He mentioned that there is no allocation of budgetary funds for cultural competency experts
- A member of the Juvenile Justice commission asked if Angela Glore received input and buy in from the school district. He stated that he likes that if it is aimed at children.
- Melodee Fugate discussed how various agencies in the county have given feedback and support to the Innovation Plan.
- An attendee asked if the Innovation funding was competitive.
- An attendee asked how this program will become financially self-sufficient.
- An attendee asked what this project does for individuals who are not tech savvy or do not have access to cellular phones.
- An attendee asked if Angela Glore had investigated free cell phone services for lower income families, she also stated that group learning could be helpful.

AGENDA ITEM 10

Action

July 26, 2018 Commission Meeting

Legislation

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

Enclosed for the Commission's review is a legislative report that lists bills related 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 192 (Beall) and Senate Bill 1004 (Weiner and Moorlach). Information on the bills are enclosed.

Presenters:

- Norma Pate, Deputy Director
- Gregory Cramer, Policy Consultant, Senator Beall's Office
- Angela Hill, Fellow, Senator Wiener's Office
- Adrienne Shilton, Government Affairs Director, Steinberg Institute

Enclosures (3):

- 2018 Legislative Report to the Commission
- SB 192 (Beall)
 - Bill Text
 - Committee Analysis
- SB 1004 (Weiner and Moorlach)
 - Bill Text
 - Committee Analysis

Handouts: None.

Proposed Motion: The Commission authorizes the Executive Director to provide a letter of support for the legislation consistent with the direction given by the Commission.

2018 Legislative Report to the Commission July 11, 2018

LEGISLATION UNDER REVIEW

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 require the commission to establish a strategy for technical assistance, support, and evaluation to support the successful implementation of the objectives, metrics, data collection, and reporting strategy.

Status/Location: 6/20/18: Do pass and re-refer to Assembly Committee on Appropriations. (Ayes 15. Noes 0.)

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: Held in Senate Appropriations Committee and under submission.

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: DEAD Failed Deadline pursuant to Rule 61(b)(8) (Last location was A. APPR. SUSPENSE FILE on 5/9/2018).

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 MHSA.

Status/Location: 5/31/18 Read third time. Refused passage. (FAILED).

Senate Bill 1134 (Newman)

Title: Mental health services fund.

Summary: This bill would make technical, non-substantive changes.

Status/Location: Senate Rules Committee.

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: 6/11/18 Referred to Assembly Committee on Health.

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 Committee

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 1/2 of those funds to local educational agency and mental health partnerships. The bill would require this funding to be made available to support prevention, early intervention, and direct services, as determined by the commission.

Status/Location: 7/5/18 Read second time and amended. Re-referred to Assembly Committee on 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 Mental Health Services Act, 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: 7/5/18 from consent calendar on motion of Assembly Member Calderon.

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: 7/10/18 Enrolled and presented to the Governor.

Senate Bill 192 (Beall)

Title: Mental Health Services Fund.

Summary: The MHSA authorizes a county to maintain a prudent reserve to ensure that services do not have to be significantly reduced in years in which revenues are below the average of previous years. The MHSA, except as specified, requires any funds allocated to a county that have not been spent for their authorized purpose within 3 years to revert to the state to be deposited into the fund and available for other counties in future years. This bill would clarify that the value of a prudent reserve shall not exceed the greatest reduction in revenue received pursuant to the MHSA in the last 10 years and would require the county to reassess the maximum amount of the prudent reserve every 5 years.

Status/Location: 6/20/18: Do pass and re-refer to Assembly Committee on Appropriations with recommendation: To consent calendar. (Ayes 15. Noes 0.)

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: 6/27/18: Set for first hearing - canceled at the request of author.

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: 6/28/18 Read second time. Ordered to consent calendar. From consent calendar on motion of Assembly Member Calderon. Ordered to third reading.

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 4 certification categories: adult peer support specialists, transition-age youth peer support specialists, family peer support specialists, and parent peer support specialists.

Status/Location: 6/19/18: Do pass and re-refer to Assembly Committee on Appropriations.
(Ayes 15. Noes 0.)

AMENDED IN ASSEMBLY JUNE 12, 2018

AMENDED IN SENATE APRIL 18, 2017

AMENDED IN SENATE MARCH 28, 2017

SENATE BILL

No. 192

Introduced by Senator Beall

January 30, 2017

An act to amend ~~Sections 5891, 5892, and 5892.5 of, and to add Section 5892.3 to, Sections 5892 and 5892.1 of the Welfare and Institutions Code, relating to mental health.~~

LEGISLATIVE COUNSEL'S DIGEST

SB 192, as amended, Beall. Mental Health Services ~~Act Reversion~~ Fund.

Existing law, the Mental Health Services Act (the 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 by imposing a tax of 1% on incomes above \$1,000,000. Existing law requires the State Department of Health Care Services, among other things, to implement specified mental health services through contracts with county mental health programs or counties acting jointly. The MHSA establishes the Mental Health Services Oversight and Accountability Commission to oversee various parts of the act, as specified.

Under the MHSA, funds are distributed to counties for local assistance for designated mental health programs according to a specified county plan. *The MHSA authorizes a county to maintain a prudent reserve to ensure that services do not have to be significantly reduced in years in*

which revenues are below the average of previous years. The MHSA, except as specified, requires any funds allocated to a county that have not been spent for their authorized purpose within 3 years to revert to the state to be deposited into the fund and available for other counties in future years. The MHSA permits amendment by the Legislature by a $\frac{2}{3}$ vote of each house if the amendment is consistent with, and furthers the intent of, the MHSA, and also permits the Legislature to add provisions to clarify procedures and terms of the MHSA by a majority vote.

~~This bill would amend the MHSA by instead requiring that any funds allocated since the 2008–09 fiscal year, except as specified, to a large, medium, small, or very small county, as defined, that have not been spent for their authorized purpose within 3 years of being allocated, and any interest earned on unspent funds, revert to the state for deposit into the newly established Mental Health Services Act Reversion Fund. The bill would authorize a very small county to apply for a waiver, subject to approval by the commission, requesting a delay of the reversion of funds, but not for more than 5 fiscal years from the time of allocation of funds. The bill would require the state to distribute the reverted funds to counties, or counties acting jointly, to fund prevention and early intervention or innovation programs that are consistent with mental health funding priorities established by the Legislature and the MHSA, as specified. The bill would make the amount of funds available to counties in any fiscal year subject to an annual appropriation by the Legislature in the annual Budget Act.~~

~~This bill would require the counties, or counties jointly, seeking funding to demonstrate to the commission that funding will be used to create, or expand the capacity for, services and supports to address unmet community needs. The bill would impose certain restrictions on eligibility for subsequent funding for counties that previously have been allocated funds. The bill would authorize the Legislature to give specific consideration to very small counties and small counties when making an appropriation from the Mental Health Services Act Reversion Fund.~~

~~This bill would require the commission to submit to the Legislature an annual report of its recommendations for recipients of funding and the amount of funding for each recipient in a manner that ensures that allocation of funds results in specified outcomes and to take into account certain criteria when recommending recipients and amounts of funding. The bill would also require the commission to require participating counties to submit outcome data within one year of receiving funding,~~

~~and would require the commission to aggregate and report the outcome data to the Legislature, as specified. The bill would require the department to annually report to the Legislature and the commission the amount of funds that are subject to reversion and the interest earned by counties, and to update necessary regulations, processes, and guidance to allow counties to revise or correct their annual revenue and expenditure reports.~~

~~This bill would also make conforming changes to related provisions.~~

~~This bill would clarify that the value of a prudent reserve shall not exceed the greatest reduction in revenue received pursuant to the MHSA in the last 10 years and would require the county to reassess the maximum amount of the prudent reserve every 5 years. By requiring a new assessment to be made by the counties, this bill would impose a state-mandated local program.~~

~~This bill would establish the Reversion Account within the fund, and would require that MHSA funds reverting from the counties, and the interest accrued on those funds, be placed in that account.~~

~~Existing law deems all unspent MHSA funds that were subject to reversion as of July 1, 2017, as having been reverted and reallocated to the county of origin for the purposes for which they were originally allocated. Existing law requires each county with these reallocated funds, by July 1, 2018, to prepare a plan to expend those funds before July 1, 2020.~~

~~This bill would require the counties to submit the plans to expend the reallocated funds to the commission. The bill would require the reallocated funds to revert to the state if a county has not submitted a plan for the expenditure of the reallocated funds by January 1, 2019. Additionally, the bill would require the reallocated funds in the plan that have not been spent or encumbered by July 1, 2020, to revert to the state, as specified.~~

~~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.~~

Vote: $\frac{2}{3}$ -majority. Appropriation: no. Fiscal committee: yes.
State-mandated local program: ~~no~~-yes.

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

1 SECTION 1. Section 5892 of the Welfare and Institutions Code
2 *is amended to read:*

3 5892. (a) In order to promote efficient implementation of this
4 act, the county shall use funds distributed from the Mental Health
5 Services Fund as follows:

6 (1) In *the* 2005–06, 2006–07, and ~~in 2007–08~~, 2007–08 *fiscal*
7 *years*, 10 percent shall be placed in a trust fund to be expended
8 for education and training programs pursuant to Part ~~3.1~~. 3.1
9 (*commencing with Section 5820*).

10 (2) In *the* 2005–06, 2006–07, and ~~in 2007–08~~, 2007–08 *fiscal*
11 *years*, 10 percent for capital facilities and technological needs *shall*
12 *be* distributed to counties in accordance with a formula developed
13 in consultation with the County Behavioral Health Directors
14 Association of California to implement plans developed pursuant
15 to Section 5847.

16 (3) Twenty percent of funds distributed to the counties pursuant
17 to subdivision (c) of Section 5891 shall be used for prevention and
18 early intervention programs in accordance with Part 3.6
19 (~~commencing with Section 5840~~) of ~~this division~~. 5840).

20 (4) The expenditure for prevention and early intervention may
21 be increased in any county in which the department determines
22 that the increase will decrease the need and cost for additional
23 services to ~~severely mentally ill~~ persons *with severe mental illness*
24 in that county by an amount at least commensurate with the
25 proposed increase.

26 (5) The balance of funds shall be distributed to county mental
27 health programs for services to persons with severe mental illnesses
28 pursuant to Part 4 (*commencing with Section 5850*) for the
29 children’s system of care and Part 3 (*commencing with Section*
30 *5800*) for the adult and older adult system of care. These services
31 may include housing assistance, as defined in Section 5892.5, to
32 the target population specified in Section 5600.3.

33 (6) Five percent of the total funding for each county mental
34 health program for Part 3 (*commencing with Section 5800*), Part
35 3.6 (*commencing with Section 5840*), and Part 4 (*commencing*
36 *with Section* ~~5850~~) of ~~this division~~, 5850), shall be utilized for
37 innovative programs in accordance with Sections 5830, 5847, and
38 5848.

1 (b) (1) In any *fiscal* year after ~~2007–08~~, the 2007–08 *fiscal*
2 *year*; programs for services pursuant to Part 3 (commencing with
3 Section 5800) and Part 4 (commencing with Section 5850) ~~of this~~
4 ~~division~~ may include funds for technological needs and capital
5 facilities, human resource needs, and a prudent reserve to ensure
6 services do not have to be significantly reduced in years in which
7 revenues are below the average of previous years. The total
8 allocation for purposes authorized by this subdivision shall not
9 exceed 20 percent of the average amount of funds allocated to that
10 county for the previous five *fiscal* years pursuant to this section.

11 (2) *A county shall calculate an amount to establish the prudent*
12 *reserve not to exceed the greatest reduction in revenue received*
13 *for the fund in the last 10 years. The county shall reassess the*
14 *maximum amount of this reserve every five years.*

15 (c) The allocations pursuant to subdivisions (a) and (b) shall
16 include funding for annual planning costs pursuant to Section 5848.
17 The total of these costs shall not exceed 5 percent of the total of
18 annual revenues received for the fund. The planning costs shall
19 include funds for county mental health programs to pay for the
20 costs of consumers, family members, and other stakeholders to
21 participate in the planning process and for the planning and
22 implementation required for private provider contracts to be
23 significantly expanded to provide additional services pursuant to
24 Part 3 (commencing with Section 5800) and Part 4 (commencing
25 with Section ~~5850~~ ~~of this division.~~ 5850).

26 (d) Prior to making the allocations pursuant to subdivisions (a),
27 (b), and (c), funds shall be reserved for the costs for the State
28 Department of Health Care Services, the California Behavioral
29 Health Planning Council, the Office of Statewide Health Planning
30 and Development, the Mental Health Services Oversight and
31 Accountability Commission, the State Department of Public Health,
32 and any other state agency to implement all duties pursuant to the
33 programs set forth in this section. These costs shall not exceed 5
34 percent of the total of annual revenues received for the fund. The
35 administrative costs shall include funds to assist consumers and
36 family members to ensure the appropriate state and county agencies
37 give full consideration to concerns about quality, structure of
38 service delivery, or access to services. The amounts allocated for
39 administration shall include amounts sufficient to ensure adequate
40 research and evaluation regarding the effectiveness of services

1 being provided and achievement of the outcome measures set forth
2 in Part 3 (commencing with Section 5800), Part 3.6 (commencing
3 with Section 5840), and Part 4 (commencing with Section ~~5850~~)
4 ~~of this division. 5850~~). The amount of funds available for the
5 purposes of this subdivision in any fiscal year ~~shall be~~ *is* subject
6 to appropriation in the annual Budget Act.

7 (e) ~~In 2004-05, the 2004-05 fiscal year,~~ funds shall be allocated
8 as follows:

9 (1) Forty-five percent for education and training pursuant to
10 Part 3.1 (commencing with Section ~~5820~~) ~~of this division. 5820~~).

11 (2) Forty-five percent for capital facilities and technology needs
12 in the manner specified by paragraph (2) of subdivision (a).

13 (3) Five percent for local planning in the manner specified in
14 subdivision (c).

15 (4) Five percent for state implementation in the manner specified
16 in subdivision (d).

17 (f) Each county shall place all funds received from the State
18 Mental Health Services Fund in a local Mental Health Services
19 Fund. The Local Mental Health Services Fund balance shall be
20 invested consistent with other county funds and the interest earned
21 on the investments shall be transferred into the fund. The earnings
22 on investment of these funds shall be available for distribution
23 from the fund in future *fiscal* years.

24 (g) All expenditures for county mental health programs shall
25 be consistent with a currently approved plan or update pursuant
26 to Section 5847.

27 (h) (1) Other than funds placed in a reserve in accordance with
28 an approved plan, any funds allocated to a county that have not
29 been spent for their authorized purpose within three ~~years~~ *years*,
30 *and the interest accruing on those funds*, shall revert to the state
31 to be deposited into the ~~fund~~ *Reversion Account, hereby established*
32 *in the fund*, and available for other counties in future years,
33 ~~provided~~ *provided*, however, that funds for capital facilities,
34 technological needs, or education and training may be retained for
35 up to 10 years before reverting to the ~~fund. Reversion Account.~~

36 (2) If a county receives approval from the Mental Health
37 Services Oversight and Accountability Commission of a plan for
38 innovative programs, pursuant to subdivision (e) of Section 5830,
39 the county's funds identified in that plan for innovative programs

1 shall not revert to the state pursuant to paragraph (1) until three
2 years after the date of the approval.

3 (3) Notwithstanding paragraph (1), any funds allocated to a
4 county with a population of less than 200,000 that have not been
5 spent for their authorized purpose within five years shall revert to
6 the state as described in paragraph (1).

7 (4) Notwithstanding paragraphs (1) and (2), if a county with a
8 population of less than 200,000 receives approval from the Mental
9 Health Services Oversight and Accountability Commission of a
10 plan for innovative programs, pursuant to subdivision (e) of Section
11 5830, the county's funds identified in that plan for innovative
12 programs shall not revert to the state pursuant to paragraph (1)
13 until five years after the date of the approval.

14 (i) If there are ~~still additional~~ revenues available in the fund
15 after the Mental Health Services Oversight and Accountability
16 Commission has determined there are prudent reserves and no
17 unmet needs for any of the programs funded pursuant to this
18 section, including all purposes of the Prevention and Early
19 Intervention Program, the commission shall develop a plan for
20 expenditures of these revenues to further the purposes of this act
21 and the Legislature may appropriate these funds for any purpose
22 consistent with the commission's adopted plan that furthers the
23 purposes of this act.

24 ~~(j) For the 2011-12 fiscal year, General Fund revenues will be~~
25 ~~insufficient to fully fund many existing mental health programs,~~
26 ~~including Early and Periodic Screening, Diagnosis, and Treatment~~
27 ~~(EPSDT), Medi-Cal Specialty Mental Health Managed Care, and~~
28 ~~mental health services provided for special education pupils. In~~
29 ~~order to adequately fund those programs for the 2011-12 fiscal~~
30 ~~year and avoid deeper reductions in programs that serve individuals~~
31 ~~with severe mental illness and the most vulnerable, medically~~
32 ~~needy citizens of the state, prior to distribution of funds under~~
33 ~~paragraphs (1) to (6), inclusive, of subdivision (a), effective July~~
34 ~~1, 2011, moneys shall be allocated from the Mental Health Services~~
35 ~~Fund to the counties as follows:~~

36 ~~(1) Commencing July 1, 2011, one hundred eighty-three million~~
37 ~~six hundred thousand dollars (\$183,600,000) of the funds available~~
38 ~~as of July 1, 2011, in the Mental Health Services Fund, shall be~~
39 ~~allocated in a manner consistent with subdivision (e) of Section~~
40 ~~5778 and based on a formula determined by the state in~~

~~1 consultation with the County Behavioral Health Directors
2 Association of California to meet the fiscal year 2011–12 General
3 Fund obligation for Medi-Cal Specialty Mental Health Managed
4 Care.~~

~~5 (2) Upon completion of the allocation in paragraph (1), the
6 Controller shall distribute to counties ninety-eight million five
7 hundred eighty-six thousand dollars (\$98,586,000) from the Mental
8 Health Services Fund for mental health services for special
9 education pupils based on a formula determined by the state in
10 consultation with the County Behavioral Health Directors
11 Association of California.~~

~~12 (3) Upon completion of the allocation in paragraph (2), the
13 Controller shall distribute to counties 50 percent of their 2011–12
14 Mental Health Services Act component allocations consistent with
15 Sections 5847 and 5891, not to exceed four hundred eighty-eight
16 million dollars (\$488,000,000). This allocation shall commence
17 beginning August 1, 2011.~~

~~18 (4) Upon completion of the allocation in paragraph (3), and as
19 revenues are deposited into the Mental Health Services Fund, the
20 Controller shall distribute five hundred seventy-nine million dollars
21 (\$579,000,000) from the Mental Health Services Fund to counties
22 to meet the General Fund obligation for EPSDT for the 2011–12
23 fiscal year. These revenues shall be distributed to counties on a
24 quarterly basis and based on a formula determined by the state in
25 consultation with the County Behavioral Health Directors
26 Association of California. These funds shall not be subject to
27 reconciliation or cost settlement.~~

~~28 (5) The Controller shall distribute to counties the remaining
29 2011–12 Mental Health Services Act component allocations
30 consistent with Sections 5847 and 5891, beginning no later than
31 April 30, 2012. These remaining allocations shall be made on a
32 monthly basis.~~

~~33 (6) The total one-time allocation from the Mental Health
34 Services Fund for EPSDT, Medi-Cal Specialty Mental Health
35 Managed Care, and mental health services provided to special
36 education pupils as referenced shall not exceed eight hundred
37 sixty-two million dollars (\$862,000,000). Any revenues deposited
38 in the Mental Health Services Fund in the 2011–12 fiscal year that
39 exceed this obligation shall be distributed to counties for remaining~~

1 ~~fiscal year 2011–12 Mental Health Services Act component~~
2 ~~allocations, consistent with Sections 5847 and 5891.~~

3 ~~(k) Subdivision (j) shall not be subject to repayment.~~

4 ~~(l) Subdivision (j) shall become inoperative on July 1, 2012.~~

5 *SEC. 2. Section 5892.1 of the Welfare and Institutions Code*
6 *is amended to read:*

7 5892.1. (a) All unspent funds subject to reversion pursuant to
8 subdivision (h) of Section 5892 as of July 1, 2017, are deemed to
9 have been reverted to the fund and reallocated to the county of
10 origin for the purposes for which they were originally allocated.

11 (b) (1) The department shall, on or before July 1, 2018, in
12 consultation with counties and other stakeholders, prepare a report
13 to the Legislature identifying the amounts that were subject to
14 reversion prior to July 1, 2017, including to which purposes the
15 unspent funds were allocated pursuant to Section 5892.

16 (2) Prior to the preparation of the report referenced in paragraph
17 (1), the department shall provide to counties the amounts it has
18 determined are subject to reversion, and provide a process for
19 counties to appeal this determination.

20 (c) (1) By July 1, 2018, each county with unspent funds subject
21 to reversion that are deemed reverted and reallocated pursuant to
22 subdivision (a) shall prepare a plan to expend these funds on or
23 before July 1, 2020. *The plan shall be submitted to the commission*
24 *for review.*

25 (2) *A county with unspent funds that are deemed reverted and*
26 *reallocated pursuant to subdivision (a) that has not prepared and*
27 *submitted a plan to the commission pursuant to paragraph (1) as*
28 *of January 1, 2019, shall remit the unspent funds to the state*
29 *pursuant to paragraph (1) of subdivision (h) of Section 5892 no*
30 *later than July 1, 2019.*

31 (d) *Funds included in the plan required pursuant to subdivision*
32 *(c) that are not spent as of July 1, 2020, shall revert to the state*
33 *pursuant to paragraph (1) of subdivision (h) of Section 5892.*

34 ~~(e)~~

35 (e) (1) The requirement for submitting a report imposed under
36 subdivision (b) is inoperative on July 1, 2022, pursuant to Section
37 10231.5 of the Government Code.

38 (2) A report to be submitted pursuant to subdivision (b) shall
39 be submitted in compliance with Section 9795 of the Government
40 Code.

1 (e)

2 (f) Notwithstanding Chapter 3.5 (commencing with Section
3 11340) of Part 1 of Division 3 of Title 2 of the Government Code,
4 the department, without taking any further regulatory action, may
5 implement, interpret, or make specific this section, Section 5899.1,
6 and subdivision (h) of Section 5892, by means of all-county letters
7 or other similar instructions, until applicable regulations are
8 adopted in accordance with Section 5898, or until July 1, 2019,
9 whichever occurs first. The all-county letters or other similar
10 instructions shall be issued only after the department provides the
11 opportunity for public participation and comments.

12 *SEC. 3. If the Commission on State Mandates determines that*
13 *this act contains costs mandated by the state, reimbursement to*
14 *local agencies and school districts for those costs shall be made*
15 *pursuant to Part 7 (commencing with Section 17500) of Division*
16 *4 of Title 2 of the Government Code.*

17 ~~SECTION 1. Section 5891 of the Welfare and Institutions Code~~
18 ~~is amended to read:~~

19 ~~5891. (a) The funding established pursuant to this act shall be~~
20 ~~utilized to expand mental health services. Except as provided in~~
21 ~~subdivision (i) of Section 5892 due to the state's fiscal crisis, these~~
22 ~~funds shall not be used to supplant existing state or county funds~~
23 ~~utilized to provide mental health services. The state shall continue~~
24 ~~to provide financial support for mental health programs with not~~
25 ~~less than the same entitlements, amounts of allocations from the~~
26 ~~General Fund or from the Local Revenue Fund 2011 in the State~~
27 ~~Treasury, and formula distributions of dedicated funds as provided~~
28 ~~in the last fiscal year which ended prior to the effective date of~~
29 ~~this act. The state shall not make any change to the structure of~~
30 ~~financing mental health services, which increases a county's share~~
31 ~~of costs or financial risk for mental health services unless the state~~
32 ~~includes adequate funding to fully compensate for such increased~~
33 ~~costs or financial risk. These funds shall only be used to pay for~~
34 ~~the programs authorized in Sections 5890 and 5892. These funds~~
35 ~~may not be used to pay for any other program. These funds may~~
36 ~~not be loaned to the General Fund or any other fund of the state,~~
37 ~~or a county general fund or any other county fund for any purpose~~
38 ~~other than those authorized by Sections 5890 and 5892.~~

39 ~~(b) (1) Notwithstanding subdivision (a), and except as provided~~
40 ~~in paragraph (2), the Controller may use the funds created pursuant~~

1 to this part for loans to the General Fund as provided in Sections
2 16310 and 16381 of the Government Code. Any such loan shall
3 be repaid from the General Fund with interest computed at 110
4 percent of the Pooled Money Investment Account rate, with interest
5 commencing to accrue on the date the loan is made from the fund.
6 This subdivision does not authorize any transfer that would
7 interfere with the carrying out of the object for which these funds
8 were created.

9 (2) This subdivision does not apply to the Supportive Housing
10 Program Subaccount created by subdivision (f) of Section 5890
11 or any moneys paid by the California Health Facilities Financing
12 Authority to the Department of Housing and Community
13 Development as a service fee pursuant to a service contract
14 authorized by Section 5849.35.

15 (e) Commencing July 1, 2012, on or before the 15th day of each
16 month, pursuant to a methodology provided by the State
17 Department of Health Care Services, the Controller shall distribute
18 to each Local Mental Health Service Fund established by counties
19 pursuant to subdivision (f) of Section 5892, all unexpended and
20 unreserved funds on deposit as of the last day of the prior month
21 in the Mental Health Services Fund, established pursuant to Section
22 5890, for the provision of programs and other related activities set
23 forth in Part 3 (commencing with Section 5800), Part 3.2
24 (commencing with Section 5830), Part 3.6 (commencing with
25 Section 5840), Part 3.9 (commencing with Section 5849.1), and
26 Part 4 (commencing with Section 5850).

27 (d) Counties shall base their expenditures on the county mental
28 health program's three-year program and expenditure plan or
29 annual update, as required by Section 5847. Nothing in this
30 subdivision shall affect subdivision (a) or (b).

31 SEC. 2. Section 5892 of the Welfare and Institutions Code is
32 amended to read:

33 5892. (a) In order to promote efficient implementation of this
34 act, the county shall use funds distributed from the Mental Health
35 Services Fund as follows:

36 (1) In 2005-06, 2006-07, and in 2007-08, 10 percent shall be
37 placed in a trust fund to be expended for education and training
38 programs pursuant to Part 3.1.

39 (2) In 2005-06, 2006-07, and in 2007-08, 10 percent for capital
40 facilities and technological needs distributed to counties in

1 accordance with a formula developed in consultation with the
2 County Behavioral Health Directors Association of California to
3 implement plans developed pursuant to Section 5847.

4 (3) ~~Twenty percent of funds distributed to the counties pursuant
5 to subdivision (c) of Section 5891 shall be used for prevention and
6 early intervention programs in accordance with Part 3.6
7 (commencing with Section 5840).~~

8 (4) ~~The expenditure for prevention and early intervention may
9 be increased in any county in which the department determines
10 that the increase will decrease the need and cost for additional
11 services to severely mentally ill persons in that county by an
12 amount at least commensurate with the proposed increase.~~

13 (5) ~~The balance of funds shall be distributed to county mental
14 health programs for services to persons with severe mental illnesses
15 pursuant to Part 4 (commencing with Section 5850) for the
16 children's system of care and Part 3 (commencing with Section
17 5800) for the adult and older adult system of care.~~

18 (6) ~~Five percent of the total funding for each county mental
19 health program for Part 3 (commencing with Section 5800), Part
20 3.6 (commencing with Section 5840), and Part 4 (commencing
21 with Section 5850), shall be utilized for innovative programs in
22 accordance with Sections 5830, 5847, and 5848.~~

23 (b) ~~In any fiscal year after the 2007-08 fiscal year, programs
24 for services pursuant to Part 3 (commencing with Section 5800)
25 and Part 4 (commencing with Section 5850) may include funds
26 for technological needs and capital facilities, human resource
27 needs, and a prudent reserve to ensure services do not have to be
28 significantly reduced in years in which revenues are below the
29 average of previous years. The total allocation for purposes
30 authorized by this subdivision shall not exceed 20 percent of the
31 average amount of funds allocated to that county for the previous
32 five fiscal years pursuant to this section.~~

33 (c) ~~The allocations pursuant to subdivisions (a) and (b) shall
34 include funding for annual planning costs pursuant to Section 5848.
35 The total of these costs shall not exceed 5 percent of the total of
36 annual revenues received for the fund. The planning costs shall
37 include funds for county mental health programs to pay for the
38 costs of consumers, family members, and other stakeholders to
39 participate in the planning process and for the planning and
40 implementation required for private provider contracts to be~~

1 significantly expanded to provide additional services pursuant to
2 Part 3 (commencing with Section 5800) and Part 4 (commencing
3 with Section 5850):

4 (d) ~~Prior to making the allocations pursuant to subdivisions (a),
5 (b), and (c), funds shall be reserved for the costs for the State
6 Department of Health Care Services, the California Mental Health
7 Planning Council, the Office of Statewide Health Planning and
8 Development, the Mental Health Services Oversight and
9 Accountability Commission, the State Department of Public Health,
10 and any other state agency to implement all duties pursuant to the
11 programs set forth in this section. These costs shall not exceed 5
12 percent of the total of annual revenues received for the fund. The
13 administrative costs shall include funds to assist consumers and
14 family members to ensure the appropriate state and county agencies
15 give full consideration to concerns about quality, structure of
16 service delivery, or access to services. The amounts allocated for
17 administration shall include amounts sufficient to ensure adequate
18 research and evaluation regarding the effectiveness of services
19 being provided and achievement of the outcome measures set forth
20 in Part 3 (commencing with Section 5800), Part 3.6 (commencing
21 with Section 5840), and Part 4 (commencing with Section 5850).
22 The amount of funds available for the purposes of this subdivision
23 in any fiscal year is subject to appropriation in the annual Budget
24 Act.~~

25 (e) ~~In the 2004-05 fiscal year, funds shall be allocated as
26 follows:~~

27 (1) ~~Forty-five percent for education and training pursuant to
28 Part 3.1 (commencing with Section 5820):~~

29 (2) ~~Forty-five percent for capital facilities and technology needs
30 in the manner specified by paragraph (2) of subdivision (a):~~

31 (3) ~~Five percent for local planning in the manner specified in
32 subdivision (e):~~

33 (4) ~~Five percent for state implementation in the manner specified
34 in subdivision (d):~~

35 (f) ~~Each county shall place all funds received from the State
36 Mental Health Services Fund in a local Mental Health Services
37 Fund. The Local Mental Health Services Fund balance shall be
38 invested consistent with other county funds and the interest earned
39 on the investments shall be transferred into the fund. The earnings~~

1 on investment of these funds shall be available for distribution
2 from the fund in future fiscal years.

3 (g) All expenditures for county mental health programs shall
4 be consistent with a currently approved plan or update pursuant
5 to Section 5847.

6 (h) If there are revenues available in the fund after the Mental
7 Health Services Oversight and Accountability Commission has
8 determined there are prudent reserves and no unmet needs for any
9 of the programs funded pursuant to this section, including all
10 purposes of the Prevention and Early Intervention Program, the
11 commission shall develop a plan for expenditures of these revenues
12 to further the purposes of this act and the Legislature may
13 appropriate these funds for any purpose consistent with the
14 commission’s adopted plan that furthers the purposes of this act.

15 (i) For the 2011–12 fiscal year, General Fund revenues will be
16 insufficient to fully fund many existing mental health programs,
17 including Early and Periodic Screening, Diagnosis, and Treatment
18 (EPSDT), Medi-Cal Specialty Mental Health Managed Care, and
19 mental health services provided for special education pupils. In
20 order to adequately fund those programs for the 2011–12 fiscal
21 year and avoid deeper reductions in programs that serve individuals
22 with severe mental illness and the most vulnerable, medically
23 needy citizens of the state, prior to distribution of funds under
24 paragraphs (1) to (6), inclusive, of subdivision (a), effective July
25 1, 2011, moneys shall be allocated from the Mental Health Services
26 Fund to the counties as follows:

27 (1) Commencing July 1, 2011, one hundred eighty-three million
28 six hundred thousand dollars (\$183,600,000) of the funds available
29 as of July 1, 2011, in the Mental Health Services Fund, shall be
30 allocated in a manner consistent with subdivision (c) of Section
31 5778 and based on a formula determined by the state in
32 consultation with the County Behavioral Health Directors
33 Association of California to meet the fiscal year 2011–12 General
34 Fund obligation for Medi-Cal Specialty Mental Health Managed
35 Care.

36 (2) Upon completion of the allocation in paragraph (1), the
37 Controller shall distribute to counties ninety-eight million five
38 hundred eighty-six thousand dollars (\$98,586,000) from the Mental
39 Health Services Fund for mental health services for special
40 education pupils based on a formula determined by the state in

1 consultation with the County Behavioral Health Directors
2 Association of California.

3 (3) Upon completion of the allocation in paragraph (2), the
4 Controller shall distribute to counties 50 percent of their 2011–12
5 Mental Health Services Act component allocations consistent with
6 Sections 5847 and 5891, not to exceed four hundred eighty-eight
7 million dollars (\$488,000,000). This allocation shall commence
8 beginning August 1, 2011.

9 (4) Upon completion of the allocation in paragraph (3), and as
10 revenues are deposited into the Mental Health Services Fund, the
11 Controller shall distribute five hundred seventy-nine million dollars
12 (\$579,000,000) from the Mental Health Services Fund to counties
13 to meet the General Fund obligation for EPSDT for the 2011–12
14 fiscal year. These revenues shall be distributed to counties on a
15 quarterly basis and based on a formula determined by the state in
16 consultation with the County Behavioral Health Directors
17 Association of California. These funds shall not be subject to
18 reconciliation or cost settlement.

19 (5) The Controller shall distribute to counties the remaining
20 2011–12 Mental Health Services Act component allocations
21 consistent with Sections 5847 and 5891, beginning no later than
22 April 30, 2012. These remaining allocations shall be made on a
23 monthly basis.

24 (6) The total one-time allocation from the Mental Health
25 Services Fund for EPSDT, Medi-Cal Specialty Mental Health
26 Managed Care, and mental health services provided to special
27 education pupils as referenced shall not exceed eight hundred
28 sixty-two million dollars (\$862,000,000). Any revenues deposited
29 in the Mental Health Services Fund in the 2011–12 fiscal year that
30 exceed this obligation shall be distributed to counties for remaining
31 fiscal year 2011–12 Mental Health Services Act component
32 allocations, consistent with Sections 5847 and 5891.

33 (j) Subdivision (i) shall not be subject to repayment.

34 (k) Subdivision (i) shall become inoperative on July 1, 2012.

35 SEC. 3. Section 5892.3 is added to the Welfare and Institutions
36 Code, to read:

37 5892.3. (a) There is hereby established in the State Treasury
38 the Mental Health Services Act Reversion Fund.

39 (b) (1) Other than funds placed in a reserve in accordance with
40 an approved plan, any funds allocated since the 2008–09 fiscal

1 year to a large, medium, small, or very small county that have not
2 been spent for their authorized purpose within three years of being
3 allocated, and any interest earned on unspent funds, shall revert
4 to the state to be deposited into the Mental Health Services Act
5 Reversion Fund. However, funds for capital facilities, technological
6 needs, or education and training may be retained for up to 10 years
7 before reverting to the Mental Health Services Act Reversion Fund.

8 (2) (A) For purposes of this subdivision, the following
9 definitions apply:

10 (i) “Large county” is a county with a population greater than
11 750,000.

12 (ii) “Medium county” is a county with a population between
13 200,000 and 750,000, inclusive.

14 (iii) “Small county” is a county with a population of 100,000
15 or greater and less than 200,000.

16 (iv) “Very small county” is a county with a population less than
17 100,000.

18 (B) The populations provided in subparagraph (A) shall be based
19 on annual demographic information released annually by the
20 Department of Finance.

21 (3) Notwithstanding paragraph (1), a very small county may
22 apply for a waiver, subject to approval by the Mental Health
23 Oversight and Accountability Commission, requesting a delay of
24 the reversion of funds beyond three fiscal years from the time of
25 allocation of funds, but not for more than five fiscal years from
26 the time of allocation of funds.

27 (e) (1) The state shall distribute funds reverted to the Mental
28 Health Services Act Reversion Fund to counties, or counties acting
29 jointly, to fund prevention and early intervention or innovation
30 programs that are consistent with mental health funding priorities
31 established by the Legislature and the Mental Health Services Act,
32 including, but not limited to, all of the following:

33 (A) Providing evidence-based prevention and early intervention
34 services to children under five years of age.

35 (B) Providing evidence-based intervention services and supports
36 for prevention, early detection, and treatment of psychosis, mood
37 disorders, or other mental health issues in educational settings, up
38 to and including higher education.

39 (C) Providing evidence-based early intervention services and
40 supports for prevention, early detection, and treatment of psychosis,

1 ~~mood disorders, or other mental health issues for youth and~~
2 ~~transition-age youth involved in the juvenile justice system.~~

3 ~~(2) The amount of funds available to counties, or counties acting~~
4 ~~jointly, for the purposes of this subdivision in any fiscal year is~~
5 ~~subject to an annual appropriation by the Legislature in the annual~~
6 ~~Budget Act.~~

7 ~~(3) Counties, or counties acting jointly, seeking funding from~~
8 ~~the Mental Health Services Act Reversion Fund shall demonstrate~~
9 ~~to the Mental Health Services Oversight and Accountability~~
10 ~~Commission that funding will be used to create, or expand existing~~
11 ~~capacity for, services and supports that address unmet community~~
12 ~~needs. The commission shall submit to the Legislature an annual~~
13 ~~report of its recommendations for recipients of funding and the~~
14 ~~amount of funding for each recipient in a manner that ensures that~~
15 ~~allocation of funds results in cost-effective and evidence-based~~
16 ~~services and supports that comprehensively address identified~~
17 ~~needs in counties and regions selected for funding. The commission~~
18 ~~shall also take into account at least the following criteria when~~
19 ~~recommending recipients of funding and the amount of funding~~
20 ~~for each recipient:~~

21 ~~(A) A description of need, including community need, the target~~
22 ~~population to be served, linkage with other public systems of health~~
23 ~~and mental health care, linkage with community social services,~~
24 ~~and related assistance as applicable, and a description of the request~~
25 ~~for funding.~~

26 ~~(B) A description of all programmatic components, including~~
27 ~~outreach and clinical aspects, of local services and supports.~~

28 ~~(C) A description of any contractual relationships with~~
29 ~~contracting providers, as applicable, including a memorandum of~~
30 ~~understanding among any project partners.~~

31 ~~(D) A description of local funds, including amounts, to~~
32 ~~contribute toward the services and supports, as required by the~~
33 ~~commission, implementing guidelines, and regulations.~~

34 ~~(E) A project timeline.~~

35 ~~(F) The ability of the county, or counties acting jointly, to~~
36 ~~effectively and efficiently implement or expand services and~~
37 ~~supports.~~

38 ~~(G) A description of core data collection and a framework for~~
39 ~~evaluating outcomes, including improved access to services and~~
40 ~~supports and the cost benefit of the project.~~

1 (H) ~~A description of the sustainability of program services and~~
2 ~~supports in future years.~~

3 ~~(4) The commission shall determine any minimum or maximum~~
4 ~~funding recommended to the Legislature for appropriation, shall~~
5 ~~take into consideration the level of need, the population to be~~
6 ~~served, and related criteria as described in paragraph (3) and in~~
7 ~~any guidance or regulations, and shall reflect reasonable costs.~~

8 ~~(5) Funds appropriated by the Legislature for purposes of this~~
9 ~~section may be used to supplement, but shall not supplant, existing~~
10 ~~financial and resource commitments of the county or counties~~
11 ~~acting jointly.~~

12 ~~(6) The Legislature, when making an appropriation from the~~
13 ~~Mental Health Services Act Reversion Fund, may give specific~~
14 ~~consideration to very small counties and small counties, as defined~~
15 ~~in subdivision (b).~~

16 ~~(7) Counties that previously have been allocated funds under~~
17 ~~this subdivision shall be eligible for subsequent funding only if~~
18 ~~the county or counties acting jointly demonstrate improved~~
19 ~~outcomes or increased levels of service with the use of the~~
20 ~~previously allocated funds.~~

21 ~~(8) In order to evaluate the success of the use of these funds,~~
22 ~~the Mental Health Services Oversight and Accountability~~
23 ~~Commission shall require participating counties to submit outcome~~
24 ~~data within one year of receiving funding, and the commission~~
25 ~~shall aggregate and report to the Legislature the outcome data for~~
26 ~~each participating county or counties acting jointly.~~

27 ~~(9) The State Department of Health Care Services shall annually~~
28 ~~report to the Legislature and the commission the amount of funds~~
29 ~~that are subject to reversion and the interest earned by counties.~~

30 ~~(10) The department shall update necessary regulations,~~
31 ~~processes, and guidance to allow counties, as appropriate, to revise~~
32 ~~or correct their annual revenue and expenditure reports. The~~
33 ~~department shall report any revisions to a county's annual revenue~~
34 ~~and expenditure report within the annual report described in~~
35 ~~paragraph (9).~~

36 ~~(11) A report submitted by the commission or the department~~
37 ~~pursuant to paragraph (3), (4), (8), (9), or (10) shall be in~~
38 ~~compliance with Section 9795 of the Government Code.~~

39 ~~SEC. 4. Section 5892.5 of the Welfare and Institutions Code~~
40 ~~is amended to read:~~

1 ~~5892.5. (a) (1) The California Housing Finance Agency, with~~
2 ~~the concurrence of the State Department of Health Care Services,~~
3 ~~shall release unencumbered Mental Health Services Fund moneys~~
4 ~~dedicated to the Mental Health Services Act housing program upon~~
5 ~~the written request of the respective county. The county shall use~~
6 ~~these Mental Health Services Fund moneys released by the agency~~
7 ~~to provide housing assistance to the target populations who are~~
8 ~~identified in Section 5600.3.~~

9 ~~(2) For purposes of this section, “housing assistance” means~~
10 ~~each of the following:~~

11 ~~(A) Rental assistance or capitalized operating subsidies.~~

12 ~~(B) Security deposits, utility deposits, or other move-in cost~~
13 ~~assistance.~~

14 ~~(C) Utility payments.~~

15 ~~(D) Moving cost assistance.~~

16 ~~(E) Capital funding to build or rehabilitate housing for homeless,~~
17 ~~mentally ill persons or mentally ill persons who are at risk of being~~
18 ~~homeless.~~

19 ~~(b) For purposes of administering those funds released to a~~
20 ~~respective county pursuant to subdivision (a), the county shall~~
21 ~~comply with all of the requirements described in the Mental Health~~
22 ~~Services Act, including, but not limited to, Sections 5664, 5847,~~
23 ~~and 5899, and subdivision (b) of Section 5892.3.~~

Date of Hearing: June 19, 2018

ASSEMBLY COMMITTEE ON HEALTH
Jim Wood, Chair
SB 192 (Beall) – As Amended June 12, 2018

SENATE VOTE: 38-2

SUBJECT: Mental Health Services Fund.

SUMMARY: Establishes a state Mental Health Services Act (MHSA) Reversion Account for the purpose of depositing any MHSA funds allocated to a county that have not been spent for their authorized purpose, as specified, and establishes reporting and planning requirements for counties regarding unspent MHSA funds, as specified. Specifically, **this bill:**

- 1) Establishes a state MHSA Reversion Account for the purpose of depositing any MHSA funds allocated to a county that have not been spent for their authorized purpose within three years, including interest accruing on those funds.
- 2) Requires counties to calculate an amount to establish the prudent reserve of MHSA funds not to exceed the greatest reduction in revenue received for the fund in the last 10 years and requires counties to reassess the maximum amount of this reserve every five years.
- 3) Requires counties with unspent MHSA funds to submit the plan required by 8) below of existing law to the Mental Health Services Oversight and Accountability Commission (Commission).
- 4) Requires a county with unspent funds that are deemed reverted and reallocated that has not prepared and submitted a plan to the Commission as of January 1, 2019, to remit the unspent funds no later than July 1, 2019.
- 5) Requires MHSA funds included in the plan in 3) above that are not spent as of July 1, 2020, to be reverted to the state.

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 a 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 California Department of Health Care Services (DHCS), the California Mental Health Planning Council, the Office of Statewide Health Planning and Development, the Commission, the California 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 from the 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 MHSAs 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 a 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 been significantly amended and the amended version has not yet been analyzed by a fiscal committee.

COMMENTS:

- 1) **PURPOSE OF THIS BILL.** According to the author, under the MHSAs, funds allocated to a county that have not been spent within three years of allocation shall revert to the state Fund for reallocation to counties in future years. The purpose of reversion is to incentivize counties to expend their allocations in a timely manner. In recent years, some counties have withheld spending MHSAs dollars, in part to strengthen reserves in preparation for the next economic downturn. The total funds in county reserves vary significantly by municipality, in part because no standards have been established to prescribe prudent reserve totals. With established prudent reserve caps, more dollars will be spent on urgently needed county mental health services and also ensures counties have adequate funds on hand to prepare for uncertain economic conditions.

As many MHSAs dollars remain unspent, significant sums of interest continue to accumulate and existing law does not provide clarity on whether these funds are subject to reversion, or if these funds may be used for a different purpose. Local mental health agencies accumulated \$81 million in unspent interest and set aside between \$157 million and \$274 million in excessive reserves that they could better use to provide additional mental health services. This bill addresses these issues by establishing standards for prudent reserves, enhances accountability by strengthening fiscal reporting requirements by counties, and clarifies that interest earned on unspent MHSAs funds is also subject to existing laws on reversion.

- 2) **BACKGROUND.**

- a) **MHSAs.** Proposition 63 was passed by voters in November 2004. The MHSAs 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 and to advise the Governor and the Legislature on mental health policy. The fiscal year (FY) 2017-18 Governor's Budget projected that \$2.2 billion in revenue would be deposited into the MHSA Fund in FY 2018-19. The MHSA addresses a broad continuum of prevention, early intervention, and service needs, as well as provides funding for infrastructure, technology, and training needs for the community mental health system. 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 (PEI):** 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 should have reverted to the State for reallocation 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) RELATED LEGISLATION.

- a) SB 98 (Committee on Budget and Fiscal Review), is a trailer bill and among other provisions, 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.
- b) SB 1101 (Pan) would have required the Commission 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 MHSA, as specified. SB 1101 was held on suspense in the Senate Appropriations Committee.
- c) SB 1004 (Weiner and Moorlach) would require the Commission to establish priorities for the use of MSHA PEI funds and to develop a statewide strategy for monitoring the implementation of PEI programs, as specified. SB 1004 is pending in the Assembly Health Committee.
- d) SB 1019 (Beall) would require the Commission in consultation with the California Department of Education and DHCS to develop guidelines for the use of funds from the Mental Health Services Fund by a county for innovative programs and PEI programs. SB 1019 is pending in the Assembly Health Committee.
- e) AB 2287 (Kiley) would have required the Commission to develop a transparency and accountability strategy that includes fiscal, program, and outcome components, as specified. AB 2287 was held on suspense file in the Assembly Appropriations Committee.

- f) AB 2843 (Gloria) would have added cities, special 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 MHSA. AB 2843 failed passage in the Assembly Floor.

4) 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) 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.”

REGISTERED SUPPORT / OPPOSITION:

Support

None on file.

Opposition

None on file.

Analysis Prepared by: Paula Villescaz / HEALTH / (916) 319-2097

AMENDED IN ASSEMBLY JUNE 13, 2018

AMENDED IN SENATE MAY 25, 2018

AMENDED IN SENATE APRIL 16, 2018

AMENDED IN SENATE MARCH 22, 2018

SENATE BILL

No. 1004

Introduced by Senators Wiener and Moorlach

(Principal coauthor: Assembly Member Mullin)

(Coauthor: Senator Portantino)

(Coauthors: Assembly Members Arambula, Chiu, Eggman, Kiley,
Maienschein, Mayes, and Waldron)

February 6, 2018

An act to add a heading to Chapter 1 (commencing with Section 5840) of, and to add Chapter 2 (commencing with Section 5840.5) to, Part 3.6 of Division 5 of the Welfare and Institutions Code, relating to mental health.

LEGISLATIVE COUNSEL'S DIGEST

SB 1004, as amended, Wiener. Mental Health Services Act: prevention and early intervention.

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. The MHSA establishes the Mental Health Services Oversight and Accountability Commission to oversee various parts of the act, as specified. Under the MHSA, funds are distributed to counties to be expended pursuant to a local plan for specified purposes, including,

but not limited to, prevention and early intervention. Existing law specifies that prevention and early intervention services include outreach, access, and linkage to medically necessary care, reduction in stigma, and reduction in discrimination. The MHSA permits amendment by the Legislature by a $\frac{2}{3}$ vote of each house if the amendment is consistent with, and furthers the intent of, the MHSA.

This bill would require the 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 require the commission to establish a strategy for technical assistance, support, and evaluation to support the successful implementation of the objectives, metrics, data collection, and reporting strategy. The bill would amend the Mental Health Services Act by requiring the portion of the funds in the county plan relating to prevention and early intervention to focus on the priorities established by the commission. The bill would authorize a county to include other priorities, as determined through the stakeholder process, either in place of, or in addition to, the established priorities. If the county chooses to include other programs, the bill would require the plan to include a description of why those programs are included and metrics by which the effectiveness of those programs are to be measured. The bill would require the commission to review the plans and approve them if they meet specified requirements. This bill would declare that its provisions further the intent of the MHSA.

By requiring counties to include additional information in their local plans, 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.

Vote: $\frac{2}{3}$. Appropriation: no. Fiscal committee: yes.
State-mandated local program: yes.

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

1 SECTION 1. The Legislature finds and declares all of the
2 following:

3 (a) Mental illness affects one in four people in the United States
4 and is the leading cause of disability worldwide.

5 (b) Every year, 100,000 young adults in the United States
6 experience their first psychotic episode, frequently involving
7 debilitating hallucinations and delusions.

8 (c) The average delay in receiving appropriate diagnosis and
9 treatment is an astonishing 18.5 months after the illness takes root
10 and the patient suffers their first psychotic break.

11 (d) The longer a mental illness goes untreated, the more likely
12 it is that a young person will spiral down a damaging course and
13 find themselves unable to graduate, form relationships, or hold a
14 job.

15 (e) Fifty percent of all mental illness begins by 14 years of age
16 and 75 percent by 24 years of age, yet young people are often
17 reluctant and afraid to seek help.

18 (f) One in 10 college students has considered suicide. Suicide
19 is the second leading cause of death among college students,
20 claiming more than 1,100 lives nationally every year.

21 (g) The Adverse Childhood Experiences Study, an observational
22 study of the relationship between trauma in early childhood and
23 morbidity, disability, and mortality in the United States,
24 demonstrated that trauma and other adverse experiences are
25 associated with lifelong problems in mental health, addiction, and
26 general health.

27 (h) *Toxic stress, which is the result of frequent or prolonged*
28 *biological responses to adversity, can damage a developing brain*
29 *and increase the likelihood of significant mental illness and*
30 *problems that may emerge immediately or in years to come.*

31 (i) *In California, nearly one in 7 children have experienced*
32 *abuse or neglect.*

33 (~~h~~)

34 (j) In the United States, more than 6 in 10 young people have
35 been exposed to violence within the past year, including witnessing
36 violence, assault with a weapon, sexual victimization, child
37 maltreatment, and dating violence. Nearly one in 10 was injured.

38 (~~i~~)

1 ~~(k) Older adults are also at risk of experiencing a number of~~
2 ~~symptoms associated with mental health conditions, such as face~~
3 ~~a significant risk of mental health conditions due to failing health,~~
4 ~~isolation, economic insecurity, and vulnerability to exploitation,~~
5 ~~often leading to depression, anxiety, and psychological traumas.~~

6 ~~(j)~~

7 (l) Early intervention in mental illness comes with a measurable
8 cost benefit. A joint analysis by the National Academies of
9 Sciences, Engineering, and Medicine determined that every \$1
10 invested in prevention and early intervention for mental illness
11 and addiction programs yields \$2 to \$10 in savings related to health
12 costs, criminal and juvenile justice costs, and low productivity.

13 ~~(k)~~

14 (m) A multiyear review by the National Institute of Mental
15 Health found that patients with first episode psychosis who
16 received early intervention, with coordinated specialty care,
17 experienced greater improvement in their symptoms, relationships,
18 and quality of life. They were also more involved in work or school
19 compared with patients who did not receive these services.

20 ~~(j)~~

21 (n) A report conducted by the University of California at Los
22 Angeles Center for Health Policy Research in 2015 states that
23 more than 70 percent of behavioral health conditions are diagnosed
24 and treated within the primary care setting, underscoring the critical
25 role of primary care in linking clients to ~~care~~. *care across their*
26 *lifespans.*

27 (o) *As documented in “Mental Health: A Report of the Surgeon*
28 *General” and its supplement, “Mental Health: Culture, Race, and*
29 *Ethnicity,” racial and ethnic minorities have less access to mental*
30 *health services, are less likely to receive needed care, and are*
31 *more likely to receive poor quality care when treated.*

32 SEC. 2. The heading of Chapter 1 (commencing with Section
33 5840) is added to Part 3.6 of Division 5 of the Welfare and
34 Institutions Code, to read:

35

36 CHAPTER 1. PREVENTION AND EARLY INTERVENTION PROGRAMS

37

38 SEC. 3. Chapter 2 (commencing with Section 5840.5) is added
39 to Part 3.6 of Division 5 of the Welfare and Institutions Code, to
40 read:

1 CHAPTER 2. PREVENTION AND EARLY INTERVENTION PROGRAM
2 PLANNING

3
4 5840.5. It is the intent of the Legislature that this chapter
5 achieve all of the following:

6 (a) Expand the provision of high quality Mental Health Services
7 Act (MHSA) Prevention and Early Intervention (PEI) programs
8 at the county level in California.

9 (b) Increase the number of PEI ~~programs~~, *programs and systems*,
10 including those utilizing community-defined practices, that focus
11 on reducing disparities for unserved, underserved, and
12 inappropriately served racial, ethnic, and cultural communities.

13 (c) Reduce unnecessary hospitalizations, homelessness, suicides,
14 and inpatient days by appropriately utilizing community-based
15 services and improving timely access to prevention and early
16 intervention services.

17 (d) Increase participation in *community activities*, school
18 attendance, social interactions, physical and primary health care
19 services, personal bonding relationships, and rehabilitation,
20 including employment and daily living function development for
21 clients.

22 (e) Create a more focused approach for PEI requirements.

23 (f) Increase programmatic and fiscal oversight of county
24 MHSA-funded PEI programs.

25 (g) *Encourage counties to coordinate and blend funding streams*
26 *and initiatives to ensure services are integrated across systems.*

27 (h) *Leverage innovative technology platforms.*

28 ~~(g)~~

29 (i) Reflect the stated goals as outlined in the PEI component of
30 the MHSA, as stated in Section 5840.

31 5840.6. For purposes of this chapter, the following definitions
32 shall apply:

33 (a) *“Commission” means the Mental Health Services Oversight*
34 *and Accountability Commission established pursuant to Section*
35 *5845.*

36 (b) *“County” also includes a city receiving funds pursuant to*
37 *Section 5701.5.*

38 (c) *“Prevention and early intervention funds” means funds from*
39 *the Mental Health Services Fund allocated for prevention and*

1 *early intervention programs pursuant to paragraph (3) of*
2 *subdivision (a) of Section 5892.*

3 ~~(a)~~

4 *(d) “Childhood trauma prevention and early intervention” refers*
5 *to a program that targets children exposed to, or who are at risk*
6 *of exposure to, adverse and traumatic childhood—events: events*
7 *and prolonged toxic stress in order to deal with the early origins*
8 *of mental health needs and prevent long-term mental health*
9 *concerns. This may include, but is not limited to, all of the*
10 *following:*

11 *(1) Focused outreach and early intervention to at-risk and*
12 *in-need populations.*

13 *(2) Implementation of appropriate—trauma-related trauma and*
14 *developmental screening and assessment—tools: tools with linkages*
15 *to early interives.*

16 *(3) Collaborative, strengths-based approaches that appreciate*
17 *the resilience of trauma—survivors: survivors and support their*
18 *roles as parents and caregivers when appropriate.*

19 *(4) Support from peers and community health workers trained*
20 *to provide mental health services.*

21 ~~(5) Family education and support.~~

22 *(5) Two-generational family engagement, education, and support*
23 *for navigation and service referrals across systems that aid the*
24 *healthy development of children and families.*

25 *(6) Linkages to primary care health settings, including federally*
26 *qualified health centers, rural health centers, and school-based*
27 *health—centers: centers and programs.*

28 *(7) Leveraging the healing value of traditional cultural*
29 *connections, including policies, protocols, and processes that are*
30 *responsive to the racial, ethnic, and cultural needs of individuals*
31 *served and recognition of historical trauma.*

32 ~~(b) “Commission” means the Mental Health Services Oversight~~
33 ~~and Accountability Commission established pursuant to Section~~
34 ~~5845.~~

35 ~~(e) “County” also includes a city receiving funds pursuant to~~
36 ~~Section 5701.5.~~

37 *(8) Coordinated and blended funding streams to ensure*
38 *individuals and families experiencing toxic stress have*
39 *comprehensive and integrated supports across systems.*

40 ~~(d)~~

1 (e) “Early psychosis and mood disorder detection and
2 intervention” has the same meaning as set forth in paragraph (2)
3 of subdivision (b) of Section 5835 and may include programming
4 across the age span.

5 ~~(e)~~

6 (f) “Outreach and engagement” means strategies that target
7 *secondary school and* transition age youth, with a priority on
8 partnerships with college mental health programs that educate and
9 engage students and provide either on-campus, off-campus, or
10 linkages to mental health services not provided through the campus
11 to students who are attending colleges and universities, including,
12 but not limited to, public community colleges. ~~This *Outreach and*~~
13 ~~*engagement* may include, but is not limited to, all of the following:~~

14 (1) Meeting the mental health needs of students that cannot be
15 met through existing education funds.

16 (2) Establishing direct linkages for students to community-based
17 mental health services.

18 (3) Addressing direct services, including, but not limited to,
19 increasing college mental health staff-to-student ratios and
20 decreasing wait times.

21 (4) Participating in evidence-based and community-defined best
22 practice programs for mental health services.

23 (5) Serving underserved and vulnerable populations, including,
24 but not limited to, lesbian, gay, bisexual, transgender, and queer
25 persons, victims of domestic violence and sexual abuse, and
26 veterans.

27 (6) Establishing direct linkages for students to community-based
28 mental health services for which reimbursement is available
29 through the students’ health coverage.

30 (7) Reducing racial disparities in access to mental health
31 services.

32 (8) Funding mental health stigma reduction training and
33 activities.

34 (9) Providing college employees and students with education
35 and training in early identification, intervention, and referral of
36 students with mental health needs.

37 ~~(f) “Prevention and early intervention funds” means funds from~~
38 ~~the Mental Health Services Fund allocated for prevention and early~~
39 ~~intervention programs pursuant to paragraph (3) of subdivision (a)~~
40 ~~of Section 5892.~~

1 (10) *Interventions for youth with signs of behavioral or*
2 *emotional problems who are at risk of, or have had any, contact*
3 *with the juvenile justice system.*

4 (11) *Integrated youth mental health programming.*

5 (12) *Suicide prevention programming.*

6 (g) *“Culturally competent and linguistically appropriate*
7 *prevention and intervention” refers to a program that creates*
8 *critical linkages with community-based organizations, including,*
9 *but not limited to, clinics licensed or operated under subdivision*
10 *(a) of Section 1204 of the Health and Safety Code, or clinics exempt*
11 *from clinic licensure pursuant to subdivision (c) of Section 1206*
12 *of the Health and Safety Code.*

13 (1) *“Culturally competent and linguistically appropriate” means*
14 *the ability to reach underserved cultural populations and address*
15 *specific barriers related to racial, ethnic, cultural, language,*
16 *gender, age, economic, or other disparities in mental health*
17 *services access, quality, and outcomes.*

18 (2) *“Underserved cultural populations” means those who are*
19 *unlikely to seek help from any traditional mental health service*
20 *because of stigma, lack of knowledge, or other barriers, including*
21 *members of ethnically and racially diverse communities, members*
22 *of the gay, lesbian, bisexual, and transgender communities, and*
23 *veterans, across their lifespans.*

24 5840.7. (a) On or before January 1, 2020, the commission
25 shall establish priorities for the use of prevention and early
26 intervention funds. These priorities shall include, but are not limited
27 to, the following:

28 (1) Childhood trauma prevention and early intervention to deal
29 with the early origins of mental health needs.

30 (2) *Early psychosis and mood disorder detection and*
31 *intervention, including mood disorder programming that occurs*
32 *across the lifespan.*

33 ~~(2)~~

34 (3) Outreach and engagement strategies that target *secondary*
35 *school and transition age youth, with a priority on partnership with*
36 *college mental health programs.*

37 ~~(3) Early psychosis and mood disorder detection and~~
38 ~~intervention.~~

39 (4) *Culturally competent and linguistically appropriate*
40 *prevention and intervention.*

1 ~~(4)~~

2 (5) Other programs the commission identifies, with stakeholder
3 participation, that are proven effective in achieving, and are
4 reflective of, the goals stated in Section 5840.

5 (b) On or before January 1, 2020, the commission shall develop
6 a statewide strategy for monitoring implementation of this part,
7 including enhancing public understanding of prevention and early
8 intervention and creating metrics for assessing the effectiveness
9 of how prevention and early intervention funds are used and the
10 outcomes that are achieved. The commission shall analyze and
11 monitor the established metrics using existing data, if available,
12 and shall propose new data collection and reporting strategies, if
13 necessary.

14 (c) The commission shall establish a strategy for technical
15 assistance, support, and evaluation to support the successful
16 implementation of the objectives, metrics, data collection, and
17 reporting strategy.

18 (d) The portion of funds in the county plan relating to prevention
19 and early intervention shall focus on the priorities established by
20 the commission. A county may include other priorities, as
21 determined through the stakeholder process, either in place of, or
22 in addition to, the established priorities. If the county chooses to
23 include other programs, the plan shall include a description of why
24 those programs are included and metrics by which the effectiveness
25 of those programs is to be measured.

26 (e) If the commission requires additional resources for these
27 purposes, it may prepare a proposal for consideration by the
28 appropriate policy committees of the Legislature.

29 5840.8. Notwithstanding the rulemaking provisions of the
30 Administrative Procedure Act (Chapter 3.5 (commencing with
31 Section 11340) of Part 1 of Division 3 of Title 2 of the Government
32 Code), the commission may implement this chapter without taking
33 regulatory action until regulations are adopted. The commission
34 may use information notices or related communications to
35 implement this chapter.

36 SEC. 4. The Legislature finds and declares that this act furthers
37 the intent of the Mental Health Services Act, enacted by
38 Proposition 63 at the November 2, 2004, statewide general election.

39 SEC. 5. If the Commission on State Mandates determines that
40 this act contains costs mandated by the state, reimbursement to

- 1 local agencies and school districts for those costs shall be made
- 2 pursuant to Part 7 (commencing with Section 17500) of Division
- 3 4 of Title 2 of the Government Code.

O

Date of Hearing: June 19, 2018

ASSEMBLY COMMITTEE ON HEALTH
Jim Wood, Chair
SB 1004 (Wiener) – As Amended June 13, 2018

SENATE VOTE: 38-0

SUBJECT: Mental Health Services Act: prevention and early intervention.

SUMMARY: Requires, on or before January 1, 2020, the Mental Health Services Oversight and Accountability Commission (Commission) to establish priorities, a statewide strategy for monitoring, and a strategy for technical assistance to support the successful implementation of prevention and early intervention (PEI) funds provided by the Mental Health Services Act (MHSA). Specifically, **this bill:**

- 1) Requires, on or before January 1, 2020, the Commission to establish priorities for the use of PEI funds. Requires these priorities to include, but not be limited to, the following:
 - a) Childhood trauma prevention and early intervention to deal with the early origins of mental health needs;
 - b) Early psychosis and mood disorder detection and intervention;
 - c) Outreach and engagement strategies that target transition age youth, with a priority on partnership with college mental health programs;
 - d) Culturally competent and linguistically appropriate prevention and intervention; and,
 - e) Other programs the Commission identifies, with stakeholder participation, that are proven effective in achieving, and are reflective of, the goals of PEI programs to prevent mental illnesses from becoming severe and disabling.
- 2) Requires, on or before January 1, 2020, the Commission to develop a statewide strategy for monitoring implementation of this bill, including enhancing public understanding of PEI and creating metrics for assessing the effectiveness of how PEI funds are used and the outcomes that are achieved. Requires the Commission to analyze and monitor the established metrics using existing data, if available, and propose new data collection and reporting strategies, if necessary.
- 3) Requires the Commission to establish a strategy for technical assistance, support, and evaluation to support the successful implementation of the objectives, metrics, data collection, and reporting strategy.
- 4) Requires the portion of funds in a county plan relating to PEI to focus on the priorities established by the Commission, but permits a county to include other priorities, as determined through the stakeholder process, either in place of, or in addition to, the established priorities. Requires, if the county chooses to include other programs, the plan to include a description of why those programs are included and metrics by which the effectiveness of those programs is to be measured.
- 5) Defines several terms, including:

- a) “Prevention and early intervention funds” as funds from the Mental Health Services Fund (Fund) allocated for PEI programs;
- b) “Childhood trauma prevention and early intervention” as a program that targets children exposed to, or who are at risk of exposure to, adverse and traumatic childhood events, including, but not limited to, all of the following:
 - i) Focused outreach to at-risk and in-need populations;
 - ii) Implementation of appropriate trauma and developmental screening and assessment tools with linkages to early intervention services;
 - iii) Collaborative, strengths-based approaches that appreciate the resilience of trauma survivors and support their roles as parents and caregivers when appropriate;
 - iv) Support from peers and community health workers trained to provide mental health services;
 - v) Two-generational family engagement, education, and support for navigation and service referrals across systems that aid the healthy development of children and families;
 - vi) Linkages to primary care health settings, including federally qualified health centers, rural health centers, and school-based health centers;
 - vii) Leveraging the healing value of traditional cultural connections, including policies, protocols, and processes that are responsive to the racial, ethnic, and cultural needs of individuals served and recognition of historical trauma; and,
 - viii) Coordinated and blended funding streams to ensure individuals and families experiencing toxic stress have comprehensive and integrated supports across systems.
- c) “Early psychosis and mood disorder detection and intervention” as a program that utilizes evidence-based approaches and services to identify and support clinical and functional recovery of individuals by reducing the severity of first, or early, episode psychotic symptoms, other early markers of serious mental illness, such as mood disorders, keeping individuals in school or at work, and putting them on a path to better health and wellness and may include programming across the age span;
- d) “Outreach and engagement” means strategies that target secondary school and transition age youth, with a priority on partnerships with college mental health programs that educate and engage students and provide either on-campus, off-campus, or linkages to mental health services not provided through the campus to students who are attending colleges and universities, including, but not limited to, public community colleges, including but not limited to, all of the following:
 - i) Meeting the mental health needs of students that cannot be met through existing education funds;
 - ii) Establishing direct linkages for students to community-based mental health services;
 - iii) Addressing direct services, including, but not limited to, increasing college mental health staff-to-student ratios and decreasing wait times;
 - iv) Participating in evidence-based and community-defined best practice programs for mental health services;

- v) Serving underserved and vulnerable populations, including, but not limited to, lesbian, gay, bisexual, transgender, and queer persons, victims of domestic violence and sexual abuse, and veterans;
 - vi) Establishing direct linkages for students to community-based mental health services for which reimbursement is available through the students' health coverage;
 - vii) Reducing racial disparities in access to mental health services;
 - viii) Funding mental health stigma reduction training and activities;
 - ix) Providing college employees and students with education and training in early identification, intervention, and referral of students with mental health needs;
 - x) Interventions for youth with signs of behavioral or emotional problems who are at risk of, or have had any, contact with the juvenile justice system;
 - xi) Integrated youth mental health programming; and,
 - xii) Suicide prevention programming.
- e) "Culturally competent and linguistically appropriate" means the ability to reach underserved cultural populations and address specific barriers related to racial, ethnic, cultural, language, gender, age, economic, or other disparities in mental health services access, quality, and outcomes.
- f) "Underserved cultural populations" means those who are unlikely to seek help from any traditional mental health service because of stigma, lack of knowledge, or other barriers, including members of ethnically and racially diverse communities, members of the gay, lesbian, bisexual, and transgender communities, and veterans, across their lifespans.
- 6) Permits the Commission to prepare a proposal for consideration by the appropriate policy committees of the Legislature for additional resources if necessary.
- 7) Permits the Commission to implement necessary provisions without taking regulatory action until regulations are adopted and permits the Commission to use information notices or related communications to implement the provisions of this bill.
- 8) Establishes Legislative findings related to lack of mental health services for youth and racial and ethnic minorities and declares that this act furthers 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 Fund to be disbursed as follows:
 - a) Twenty percent of funds distributed to counties to be used for PEI 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 California Department of Health Care Services (DHCS), the California Mental Health Planning Council, the Office of Statewide Health Planning and Development (OHSPD), the Commission, the California 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, 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.
 - 8) 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.

FISCAL EFFECT: According to the Senate Appropriations Committee:

- 1) One-time Commission administrative costs of approximately \$288,000 to establish priorities for the use of PEI funds prior to 2020, plus additional contracting costs of approximately \$300,000 for consultation with subject matter experts and public engagement (Fund);
- 2) One-time Commission administrative costs of approximately \$220,000 to develop a statewide monitoring and implementation strategy prior to 2020, plus additional contracting costs of approximately \$200,000 for consultation with subject matter experts and public engagement (Fund); and,
- 3) Unknown potential reimbursable mandate costs (General Fund). To the extent that an affected county mental health program incurs costs to include additional information in their local plans and the county files a successful reimbursement claim with the Commission on State Mandates, the state would be responsible for reimbursement of eligible costs. Since county costs associated with revising plans would appear to be covered from state allocations of MHSA funds, it appears unlikely that the bill's requirements would be deemed a state-reimbursable mandate.

COMMENTS:

- 1) **PURPOSE OF THIS BILL.** According to the author, this bill aims to standardize and scale up high-quality PEI programs funded by the MHSA, ensuring access to effective, quality care for young people in counties across the state. This bill establishes a strategic, statewide focus for how counties utilize funds generated by the MHSA for prevention and intervention in the early stages of mental illness. This bill helps ensure that all children, transition-age youth, and young adults have access to effective, research-based treatment that can stem the progression of a serious brain illness well before it becomes disabling and pave the way for a stable, loving and successful life.

The author states that this bill provides essential structure and guidance to ensure counties are using their PEI funds on programs that have proven effective. It standardizes best-practices for PEI programs across the state, and helps close the glaring and unjust gaps in treatment access and quality that now persist at the local level. These steps to improve prevention and early intervention efforts will ensure that all children, transition-age youth, and young adults can access effective mental health care, regardless of their ZIP code. This bill marks an important step to solving our mental health crisis by scaling up best practices in prevention and early intervention. The author concludes that this shift will allow us to break the cycle of severe mental illness by promoting early intervention with young people to help them learn to manage, live with and thrive with a brain illness, exactly as would happen if they had cancer, kidney disease or other types of serious physical illness.

- 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 and creates the 16 member Commission charged with overseeing the implementation of MHSA. 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.

- a) **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) **PEI:** 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.
- 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) **PEI.** The 2017-18 fiscal year Governor's Budget projected that \$1.888 billion would be deposited into the Fund, with an estimated \$340.9 million dedicated to the PEI component. The MHSA requires each local mental health agency (LMHA) to prepare and submit a three-year plan to DHCS and the Mental Health Services Oversight and Accountability Commission (MHSOAC) that must be updated each year and approved by DHCS after review and comment by the MHSOAC. (LMHAs are those entities that receive MHSA funds and consist of the City of Berkeley, Tri-City Mental Health Services [Claremont, La Verne, and Pomona], Sutter-Yuba Behavioral Services [counties of Sutter and Yuba], and agencies representing the 56 other counties.) In the three-year plans, LMHAs are required to include a list of all programs for which MHSA funding is being requested, to identify how the funds will be spent, and which populations will be served. The goal of PEI is to help counties implement services that promote wellness,

foster health, and prevent the suffering that can result from untreated mental illness. The PEI component requires collaboration with consumers and family members in the development of PEI projects. According to DHCS's MHSA Expenditure Report for 2017-18, the MHSOAC is responsible for providing PEI policy direction in the form of regulations to support the following key MHSA-intended outcomes: increased recognition of and response to early signs of mental illness; increased access and linkage to treatment for people with serious mental illness; improved timely access to services for underserved communities; reduced stigma associated with either being diagnosed with a mental illness or seeking mental health services; and, reduced discrimination against people with mental illness.

- 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 LMHAs after the statutory time frames for spending the funds have elapsed, known as reversion. As a result, the LMHAs 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 LMHAs. 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 LMHAs 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 ensuring that LMHAs spend MHSA funds in a timely manner, that DHCS implement a fiscal reversion process to reallocate to other LMHAs any MHSA funds that are unspent within the statutory reversion time frames. The State Auditor also recommended that DHCS clarify that the interest that LMHAs 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.** The Steinberg Institute, sponsor of this bill, and other supporters, including mental health and youth advocates, students, colleges, and health care providers, argue that this bill will establish a strategic, statewide focus for how counties use PEI funds from the MHSA, and helps ensure children, transition-age youth, and young adults have access to effective, research-based treatments that can stem the progression of a serious brain illness well before it becomes disabling. Supporters also argue that more than \$400 million are set aside for PEI programs, but there is a marked and inequitable disparity across the state as to how each county spends these funds and the quality of services provided. Supporters state that 50% of all serious mental illness manifests by age 14 and 75% by age 24. Research also shows that early intervention with intensive, comprehensive services dramatically improves outcomes for young people in the early stages of mental illness, and that they can learn to manage and even thrive with their illness. The Steinberg Institute states that the bulk of \$230 million that the State Auditor faulted DHCS for failing to recover was targeted for PEI and Innovation programs, underscoring the confusion in many counties about how best to spend these dollars, and the state's failure to provide clear and consistent guidance. The California State Student Association argues that with the majority of college students being under the

age of 24, and 76.9% of California State University students reporting they experienced a life issue or event that was traumatic or very difficult to deal with in the past 12 months, this bill would help earmark funds for counties to support students' mental health. Supporters further argue that this bill provides essential structure and guidance to ensure counties are using PEI funds on programs that have proven effective.

- 4) **OPPOSE UNLESS AMENDED.** The California Behavioral Health Directors Association, California Women's Law Center (CWLC), and others state in opposition that focusing PEI programs almost exclusively on children and youth will be detrimental and result in a fewer number of programs serving other populations, including older adults, and underserved minority groups. Opponents argue that the bill would direct counties to focus their PEI dollars primarily on students, even though outreach and engagement are essential approaches to overcoming stigma and bringing services to underserved populations of all ages.

CWLC notes that older adults are in the only age group that is certain to face one or more of the following: loss of career/purpose, failing health, the death of friends and loved ones, isolation, economic insecurity, and vulnerability to exploitation. These factors place them at significant risk for depression, anxiety, psychological trauma and suicide and, keep in mind that older adults are the nation's fastest growing segment of the population. LGBT elderly also suffer disproportionate levels of discrimination, victimization, anxiety, isolation, and substance abuse. According to SAGE, more than 50% of LGBT elders in a national study had been diagnosed with depression, and 39% reported having seriously considered suicide, yet have few mental health resources available to them.

- 5) **RELATED LEGISLATION.** SB 1101 (Pan) would have required the MHSOAC to establish five statewide objectives for the treatment and prevention of mental illness and metrics, to be reviewed and revised, as specified, by which progress toward each of those objectives may be measured. Would have required all counties to annually submit a report to the MHSOAC and the Legislature that documents their progress toward the statewide objectives, as specified. SB 1101 was held in the Senate Appropriations Committee.

6) **PREVIOUS LEGISLATION.**

- a) AB 1315 (Mullin), Chapter 414, Statutes of 2017, establishes the Early Psychosis Intervention Plus Program whereby specified programs use evidence-based approaches and services to identify and support clinical and functional recovery of individuals by reducing the severity of first, or early, episode psychotic symptoms and mood disorders, as specified.
- b) AB 917 (Arambula) of 2017 would have required the Board of Governors of the California Community Colleges and the Trustees of the California State University, and encouraged the Regents of the University of California, to adopt policies on student suicide prevention. AB 917 was held was held on the Assembly Appropriations suspense file.
- c) AB 2017 (McCarty) of 2016 would have required the MHSOAC, subject to appropriation by the Legislature, to create a grant program for public colleges and universities to improve access to mental health services on those campuses, as specified, and would have required the MHSOAC to submit a report to the Legislature evaluating the impact of

the program, as specified. AB 2017 was vetoed by the Governor who stated that while well-intentioned the bill was premature as it commits to a particular program structure without specifying the amount or source of funding.

- d) AB 253 (Roger Hernández) of 2015 would have required specified government entities responsible for administering the Veterans Housing and Homeless Prevention Act of 2014 (VHHP) to give preference to applicants for funding from the VHHP for supportive housing projects, as specified. Would have required the Governor to appoint two additional members to the MHSOAC with mental health experience, including mental health disparities. Would have required DHCS to post specified information from mental health plans to a dedicated Internet Web page and to notify appropriate committees of the Legislature, as specified. AB 253 was not heard in the Senate Transportation and Housing Committee.

REGISTERED SUPPORT / OPPOSITION:

Support

Steinberg Institute (sponsor)
 2020 Mom
 American Academy of Pediatrics, California
 American Foundation for Suicide Prevention
 America's Physicians Groups
 Association of Community Human Service Agencies
 California Association of Veteran Service Agencies
 California Chapter of the American College of Emergency Physicians
 California Hospital Association
 California Medical Association
 California Psychiatric Association
 California School-Based Health Alliance
 California State PTA
 California State Student Association
 CaliforniaHealth+ Advocates
 Californians for Safety and Justice
 Children Now
 Children's Defense Fund- California
 Common Sense Kids Action
 Depression and Bipolar Support Alliance
 Disability Rights California
 Fight Crime: Invest in Kids
 First 5 Association of California
 First 5 Humboldt
 First 5 Sonoma County
 First 5 Yolo
 JERICHO
 Juvenile Court Judges of California
 Racial and Ethnic Mental Health Disparities Coalition (if amended)
 Numerous Individuals

Opposition

California Association of Area Agencies on Aging (unless amended)
California Behavioral Health Directors Association (unless amended)
California Commission on Aging (unless amended)
California Women's Law Center (unless amended)
MAGNA Systems Incorporated (unless amended)
Monterey County Behavioral Health Contractors
Multipurpose Senior Services Program Site Association
Muslim American Society – Social Services Foundation (unless amended)
Native Directions Inc./Three Rivers Indian Lodge
Neighborhood Wellness Foundation (unless amended)
Union of Pan Asian Communities – EMASS (unless amended)
Numerous Individuals

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AGENDA ITEM 11

Information

July 26, 2018 Commission Meeting

Innovation Incubator DRAFT Business Plan

Summary: The Governor has included in his budget proposal \$5 million in funding for the Commission to establish an Innovation Incubator as a strategy to support county mental health innovations. The Governor's proposal would require these funds to focus on strategies to reduce the number of mental health consumers who become involved with the criminal justice system.

In support of this funding proposal, the Commission retained California Forward and X-SECTOR LAB to support the development of a business plan for the Innovation Incubator for the Commission's consideration.

Executive Director Ewing will provide a brief overview of the project. David Smith, with X-SECTOR LAB, will provide an update on the five (5) Innovation Design Meetings and a DRAFT Business plan for Commission review and discussion.

Presenters:

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

Enclosures (2): (1) Innovation Incubator Introductory Memo; (2) DRAFT Business Plan

Proposed Motion: None.

July 26, 2018

RE: Innovation Incubator-DRAFT Business Plan

In 2016, the Commission identified four opportunities to support the Innovation component of the Mental Health Services Act. In 2017, the Commission directed staff to develop a proposal for an Innovation Incubator to address the four goals as follows;

1. **Provide Strategic Guidance**: to promote collective innovation strategies across counties and provide them with external experts who can provide advice, support, and mentoring to assist them in identifying statewide collaboration opportunities.
2. **Support Technical Assistance and Training**: to tap into California's broad innovation sector to support the innovation goals of the MHSA.
3. **Enhance Evaluation**: to allow California's mental health sector to better understand the need for evaluation, to build evaluation strategies into the design of the innovation and provide support and technical assistance for high quality, independent innovation evaluations.
4. **Disseminate Information**: allow the Commission to disseminate lessons learned from individual/collective innovations as a strategy to promote scalable improvements.

The Commission's budget includes \$5 million (\$2.5 million in 2018-2019 and \$2.5 million in 2019-2020) to establish an Innovation Incubator to support county mental health innovation. It requires these funds to focus on strategies to reduce the number of mental health consumers who become involved with the criminal justice system.

The Commission retained California Forward and X-Sector Labs to develop a business plan for the innovation incubator. Attached is a DRAFT business plan for Commission comment and review.

Background

From April to July 2018, the Commission, in partnership with California Forward and X-Sector Labs, convened a series of stakeholder meetings and Design Labs to explore the necessary functions of an innovation incubator, build a business plan and develop criteria for the management of an organization or strategy that can support mental health innovation in California.

As a result of that work, please see the attached DRAFT Business Plan for Commission comment. The plan includes three distinct components.

1. **Developing an Innovation Roadmap**: The Commission staff continue to work on the internal process for review and approval of County innovation plans. Stakeholders highlighted the opportunity for an Innovation Incubator to further refine this process, through clear definitions and criteria for approval and the option for the Incubator to certify a proposal as meeting Commission criteria and be eligible for expedited review.
2. **Build a Learning Community**: The Learning Community would serve as a resource for California's Mental Health System that would bring together content experts, a clearinghouse of information and data to support the system and provide transformation.

3. **Establish an Innovation Incubator:** The Innovation Incubator would provide strategic and technical assistance to counties through all phases of innovation; planning, development, implementation, evaluation and reporting.

In discussions with counties and other stakeholders, a tension emerged over whether the focus of this effort is on using innovation funding or an effort to innovate in all areas of the mental health system.

A second tension emerged over whether the Learning Community should be limited to innovation funding or would it have a broader application for overall continuous improvement. As such, there have been questions on whether the Learning Community should be a standalone entity or part of the Incubator.

In addition to exploring the value of these functions, the design process also explored these potential models for implementation.

The proposed Model for Management and Operation (p.18):

1. **Build from Scratch:** contract with an entity to build the incubator with all the essential services within a standalone organization.
2. **Connect the Dots:** contract with an existing organization that functions as a curator to connect the current service providers in the mental health and behavioral health fields.
3. **Hybrid Model (Recommended):** contract with a new or existing entity that builds an infrastructure that connects service providers and creates products and services that are useful to the counties and indicated to be missing within the mental health field.

Today's presentation is the first opportunity for the Commission and the public to review the proposed DRAFT Business Plan. Based on feedback and guidance received, we will continue our work with the consultants and support further stakeholder involvement with the goal of providing the Commission with a more developed proposal later in the year.

MHSOAC Innovation Incubator – For Commissioners’ July 2018 Meeting

Executive Summary

Ensuring access to appropriate and effective mental health services is a challenge that touches on health, safety, education, housing, and the economic and social needs of millions of Californians, their families and our communities. This challenge presents a golden opportunity to leverage innovation to transform how we approach mental health by focusing on prevention, early intervention, recovery and outcomes that promote health, safety, independence and opportunity.

The goal of innovation should not just be to serve more people, but to serve people better. The focus of innovation should not just be to expand interventions, but to transform processes, policies, regulations and systems to remove barriers getting in the way of success. The role of county behavioral health departments should not just be direct service, but to collaborate with and empower cross-sector partners to expand reach and impact. The measured outcomes of mental health services should not just be number of people served, but sustained reduction of homelessness, incarceration, suicide, and unemployment.

The Innovation Incubator has the potential to transform and improve the efficiency of the mental and behavioral health system to become more consumer-centric and data-driven, while focusing on community engagement, quality improvement, and capacity building.

Five key problems have been consistently identified during the facilitated discussions with more than 100 members of the mental and behavioral health field, including behavioral health directors, county and statewide staff, academics and researchers, human-centered design experts, business leaders and entrepreneurs, service providers and practitioners, stakeholders and advocates, and consumers and family members¹:

1. Stakeholders at every level expressed frustration that the current state of innovation is not meeting its promise of being a driver of transformational change, often pointing to the structural, regulatory, and systemic barriers of government.
2. Consumers, family members, and other community members often feel disconnected from Counties’ innovation processes and that their needs are not being met.
3. Stakeholders at every level expressed frustration that there’s a lack of a clear definition of transformational innovation, and some county behavioral health departments find it challenging to get their innovation projects approved by the Commission due to the opaque requirements.
4. Many county behavioral health departments find it challenging to identify, implement, and robustly evaluate truly innovative projects.

5. Many county behavioral health departments find it challenging to learn from each other’s experiences and discover applicable ideas and practices from other fields and industries.

The following changes could address these problems:

1. A cultural shift that would encourage, support and rewards experimentation and learning could benefit stakeholders at every level.
2. Regular and continuous engagement between behavioral health departments, consumers, and family members at every point in the innovation process, from identifying needs and data gathering to prototyping and scaling, could create better solutions and generate more positive impact.
3. Clarifying what transformational innovation looks like, how proposals are evaluated, and how the Commission prioritizes and makes final funding decisions could improve the innovation approval process.
4. A deeper understanding of how to engage in a transformational innovation process, from identifying needs and data gathering to prototyping and scaling, could benefit behavioral health departments.
5. Creating a way to access data and learnings across counties to more efficiently and effectively address problems and design solutions could benefit the entire mental health ecosystem and improve outcomes.
6. Being able to work with a cross-sectoral team that can help engage and leverage the necessary knowledge, skills, and resources to effectively and efficiently drive innovation could benefit local government staff and elected officials.

The following solutions could effectively deliver these desired changes:

1. Assemble a cross-sectoral cohort of leaders across counties who are well-trained in innovation processes to be advocates for and drivers of innovation, responsible for “reimagining the system,” and finding better ways to approach and solve problems
2. Establish processes for engaging consumers and family members, including incentives for data gathering and training in human centered design and empathy interviews
3. Offer a clear definition of and roadmap for transformational innovation and provide behavioral health departments with guidelines to use in evaluating the features of their innovation processes and desired outcomes
4. Offer county departments the option to train employees on the innovation process, and/or use a la carte consulting services that can aid in the process as needed
5. Create an online clearinghouse to share information across California with a community of learners comprised of county professionals, service providers, entrepreneurs, researchers, advocates and consumers. This community can access actionable data and examples that can inform the innovation process and identify gaps in the system that can be addressed.
6. Establish “Challenges and Design Competitions” where entities submit specific problems that they’re struggling to solve, inviting cross-sector collaborations across

the state to design solutions in exchange for monetary incentives, technical assistance, and prizes

These solutions form the foundation of an **Innovation Ecosystem**. The Innovation Ecosystem will leverage the resources, organizations, and partners that already exist in the field while also building additional services as needed to support behavioral health departments, service providers and stakeholders. There are three key components of an Innovation Ecosystem:

- 1) Innovation Roadmap** – providing a clear definition of what processes and capacities are essential to foster transformational innovation, and provide criteria for Commissioners to approve, reject or require additional action for counties to receive an approval to expend innovation funds
- 2) Learning Community** – building an online clearinghouse of information and a community of researchers and practitioners, issue-specific task forces, and a series of virtual and in-person events to disseminate data and stories on challenges and progress throughout the field of mental and behavioral health
- 3) Innovation Incubator** – creating an entity that will help behavioral health departments work collectively to develop partnerships within their communities and among counties, secure technical assistance and connect the incubation process with the formal community planning process, design and implement better community engagement strategies, evaluate projects and emerging practices to encourage replication and continuous improvement, and disseminate information on challenges and progress through a community of practice. The Incubator will have two key products and services:
 - a) Technical Assistance Services** – providing backbone support and a la carte training, capacity building, and consulting services to county-led collaborations and/or Learning Community members to improve innovation capacity and drive measurable outcomes
 - b) Issue-Specific Challenges and Design Competitions** – a Learning Community task force (or potentially other funders) could develop an “investment thesis” based on county-specific and statewide needs, and issues an RFP to attract local collaborations that desire incubator services and participating in a statewide and cross-sector Community of Practice

Summary of Observations and Insights

What we’ve heard, where we need to go, and how to get there

Across all five design labs, two stakeholder meetings, and dozens of interviews, we’ve heard five key problems emerge, and begun to flesh out what needs to change, and how to get there:

Stakeholders at every level expressed frustration that the current state of innovation is not meeting its promise of being a driver of transformational change. While it was noted innovation is happening in pockets across the state, it was also stated that there is not enough of it, examples are not widely visible or supported. Often pointing to the structural, regulatory, and systemic barriers of government, stakeholders across Design Labs expressed that the incentives, cultures, and workflows that exist within their organizations tend to inhibit, rather than support the experimentation and exploration that is necessary for fostering innovation. A common lack of tolerance for failure, fear of change, and comfort with the status quo, alongside minimal incentives for innovative approaches were all described as contributing factors.

Where we need to be: A cultural shift that would encourage, support and rewards experimentation and learning could benefit stakeholders at every level.

How to get there: Assemble a group of people across counties who are well-trained in innovation processes to be advocates for and drivers of innovation, responsible for “reimagining the system,” and finding better ways to approach and solve problems.

Consumers, family members, and other community members often feel disconnected from Counties’ innovation processes and that their needs are not being met. It was clear that many of the existing process that helps identify needs and proposes solutions was largely disconnected from consumers and family members. Needs are often driven by identifying areas that were costing the county the most amount of money, rather than determining the most systemic root causes. Solutions generation often happened in a vacuum, without prototyping, testing, and iterating the solution with consumers before launching it. This has resulted in programs that are often inefficient or ineffective at addressing the problem due to mismatch with true problems and/or lack of appeal to consumers.

Where we need to be: Regular and continuous engagement between behavioral health departments, consumers, and family members at every point in the innovation process, from identifying needs and data gathering to prototyping and scaling, could create better solutions and generate more positive impact.

How to get there: Establish processes for engaging with consumers and family members, including encouraging continuous data gathering and providing training in human centered design and empathy interviews. Communities should also have a team of dedicated “cultural brokers” who are especially skilled in these areas. These

brokers can be responsible for sourcing and understanding needs in the community, identifying consumers and family members to engage throughout the process, and being an active conduit between communities and the innovation teams throughout the design process.

Stakeholders at every level expressed frustration that there’s a lack of a clear definition of transformational innovation, and some county behavioral health departments find it challenging to get their innovation projects approved by the Commission. Many stakeholders are frustrated by the lack of clarity from the Commission of what transformational innovation is - both when it comes to the process required to arrive at it and the assessment of proposed projects and solutions. Many behavioral health departments and stakeholders are also frustrated by the time it takes to move a proposal through the process (both local and with MHSOAC) to get assessed and approved.

Where we need to be: Clarifying what transformational innovation looks like, how proposals are evaluated, and how the Commission prioritizes and makes final funding decisions could improve the innovation approval process.

How to get there: Offer a clear definition of transformational innovation and provide behavioral health departments with guidelines to use in evaluating the features of their innovation processes and desired outcomes

Many county behavioral health departments find it challenging to identify, implement, and robustly evaluate truly innovative projects. The processes county staff undergo when it comes to problem identification, solution design, implementation, quality improvement, and evaluation could be more thorough and systematic. This has resulted in inefficiencies in discovering true community needs, a tendency to conduct a shallow assessment, focusing on “shiny, new” challenges raised by elected and appointed leaders, and identification of “quick fix” solutions (often expanding existing programs that only address the symptoms of the problem rather than the root cause). This is often due to a lack of capacity that adversely impacts the quality and quantity of innovation.

Where we need to be: A deeper understanding of how to engage in a transformational innovation process, from identifying needs and data gathering to prototyping and scaling, could benefit behavioral health departments.

How to get there: Offer county departments the option to either train employees on the innovation process, and/or use a la carte consulting services that can aid in the process as needed.

Many county behavioral health departments find it challenging to learn from each other’s experiences and discover applicable ideas and practices from other fields and industries. Stakeholders have minimal established processes, frameworks or locations for sharing and sourcing data and “best practices” with each other. This realization has highlighted inefficiencies that arise because of constantly “reinventing the wheel.” Additionally, agencies are often disconnected from the resources and knowledge

available outside the government, specifically business and technology. It was clear across labs that they appreciated the valuable role they could play in the innovation process and were interested in engaging with them. However, there is a lack of knowledge of exactly what value they could offer, how to engage them, and how their processes and interests could align. In addition to wanting to tap into industry-specific expertise, there was also interest in finding ways to engage in democratizing the innovation process and soliciting input from the broader community.

Where we need to be: Creating a way to access data and learnings across counties to more efficiently and effectively address problems and design solutions could benefit the entire mental health ecosystem and improve outcomes. Being able to work with a cross-sectoral team (including public, private, and nonprofit sectors as well as members of multiple departments and agencies) that can help engage and leverage the necessary knowledge, skills, and resources to effectively and efficiently drive innovation could benefit local government staff and elected officials.

How to get there: Create an online clearinghouse to share information across California (e.g. reports, studies, stories, successes, failures, proposals, and relevant articles on where other counties, service providers and researchers have succeeded, failed and learned from) so they can access actionable data that can inform the innovation process. Establish a cross-sector community of leaders, where they can interact through facilitated conferences and meetings and participate on task forces about specific topic areas based on specialty and interest. Establish “Issue-Specific Challenges and Design Competitions” where entities submit a specific problem that they’re struggling to solve and invites experts and community-members across the state to design collaborative solutions.

Landscape Review and Analysisⁱⁱ

Why Incubators are Important

Incubators provide innovators and entrepreneurs access to the critical resources they need to launch scalable and sustainable products, services, and solutions. The resources provided by incubators vary broadly, but can include knowledge, training, expertise, funding, physical resources (such as space), network, and human capital.

Incubators span across sectors, areas of focus, and stage of initiative. There are incubators in for-profit, nonprofit, government and academic settings. They can focus on launching startups, building specific initiatives within an organization, teaching the principles of innovation, facilitating connections across sectors or communities, or a combination of these elements. They can work with individuals and organizations in identifying problems, designing solutions (prototyping, testing, refining), scaling an existing solution, or a combination of these stages. Incubators can also work with individuals, teams of individuals or entire organizations.

No matter the nature of the problem, stage of the solution, or context in which the innovation is being launched, without an incubator these resources and opportunities are typically otherwise unattainable by innovators and entrepreneurs due to cost, lack of expertise, and/or access constraints inherent in designing and testing a new innovation. Therefore, by gaining access to incubators and their associated benefits, innovators can more effectively and efficiently deliver and scale products and services to their target user and maximize the potential impact on the problem-to-be-solved.

What does the mental and behavioral health field stand to gain from an incubator?

Stakeholders at every level, including county behavioral health departments, stand to gain a tremendous amount from implementing an incubator that is tailored to address the unique, intricate, and complex processes inherent in implementing and scaling innovation both locally and statewide. By gathering the necessary resources (physical, monetary and human) and suite of services, counties will become empowered to more effectively and efficiently address the mental health challenges that are currently unaddressed, misaddressed, or underserved under the current solutions. If done right, and with appropriate evaluation, these solutions will not only reach more people and deliver superior results but can also do so in a more cost-efficient manner.

How do incubators work across sectors?

In order to design the most effective incubator to address the unique challenges of the counties and state, we conducted an extensive landscape review of the various incubator business models. While there are several business models not represented, the examples below represent those we believe are the most relevant within this context.

Lab@OPM (federal government hosted and funded)

The Innovation Lab at the Office of Personnel Management (Lab@OPM) is a program run by human-centered design experts from the Office of Personnel Management who partner with government organizations looking to design innovative solutions for their most

complex problems. The core function of the Lab is to build the Federal Government’s innovation capacity by training existing employees across organizations on how to effectively innovate by taking a human-centered design approach to solve problems. Depending on the project, this could include providing technical assistance to help on user experience design, service design, product design, program design, policy design, design strategy and/or design research. The Lab also offers community-building initiatives aimed to bring innovators together to share insights through an innovators network, thought leader talks, monthly education products, and publications. It also conducts and disseminates applied research around how to adapt design methodologies to address the unique processes and challenges of Federal Government organizations. Two of the notable partners that the Lab has engaged in government are 18F and the United States Digital Service (both of which are organizations that leverage private sector professionals to partner within government to build and scale solutions) to implement wide scale cultural change to better support innovation within government.

Challenge.gov (government clearinghouse)

Challenge.gov is an online platform on which agencies across the federal government can post and run various challenge and prize competitions that solicit ideas and solutions from the public in exchange for monetary rewards. The goal of the program is to engage the broader public in public sector problem solving and infuse a diversity of new ideas and approaches into problems the government lacks the knowledge, expertise and/or resources to efficiently or effectively address. The initiative was launched in 2010 after the White House’s Strategy for American Innovation urged agencies to increase their ability to promote innovation with tools such as prizes and challenges. Since its launch in 2010, over 825 challenges have been run, over \$250 million in prize money has been awarded, over 250K problem solvers from over 180 congressional districts have engaged, and over 5 million people from every state in the US (and several countries across the globe) have engaged with the website.

San Francisco’s Entrepreneurship in Residence (EIR) Program (government and for profit)

San Francisco’s EIR Program brought in teams of entrepreneurs to work alongside city officials for 16 weeks on addressing specific challenges and designing more effective public-sector initiatives. The program was started in 2013 in an effort to bring new ideas and innovative tech approaches to the city and give entrepreneurs a chance to enter the public-sector market (there was a lot of demonstrated interest, but lack of awareness of opportunities to productively engage). Teams of entrepreneurs applied and were chosen based on their demonstrated capacity to address a relevant issue, and plan to create a solution with at least \$100m worth of economic potential that could be scaled to meet the needs of other cities or municipalities. Projects of the EIRs included things like: finding ways to more efficiently leverage open data, better utilizing public assets, improving healthcare, and improving the transportation system. A similar program was started by the US Citizenship and Immigration Services Department.

Stanford d.school (academic hosted, multi-sector funded)

The Stanford “d.school” (Design School) offers a variety of courses and programs designed to teach students within and beyond the Stanford campus how to use design thinking tools

and methodologies to identify and design innovative solutions to real world problems. They take the necessary steps to build scalable and sustainable products, services, and companies. While the options are widely variable in terms of application, audience, and duration, all of them have an educational component at the core of the curriculum. Two examples of programs offered by the d.school are Hacking for Defense, and the d.School Fellowship Programs:

- Hacking for Defense: Hacking for Defense (H4D) is a Stanford course run in partnership with the Department of Defense (DoD) and Intelligence Community (IC), designed to provide students the opportunity to learn how to work with the DoD and IC to better address the nation’s emerging threats and security challenges. Students from across the graduate programs work in teams to design real solutions to real problems faced by the DoD and IC and have the potential to get follow-on funding for further refinement and development of prototypes so they can be applied in the field.
- d.School Fellowship Programs: *Project Fellowships* are granted to experts across fields who are passionate about innovating new solutions, platforms and initiatives within their respective fields. During the program, fellows use design thinking methodologies to actively conduct in-field experiments that have the potential to advance their field, or benefit the broader systems they operate, live and work within. The fellows are supported by the design thinking experts and incredible network the d.school affords. *Teaching Fellowships* are granted to people inside and outside the Stanford community looking to spend one year learning how to apply and teach the principles of design thinking. Teachers build courses, make connections, and build new design thinking methodologies.

New Ventures (international, for profit hosted, cross-sector projects, government funded)

New Ventures is an incubator based in Mexico that focuses on building and scaling social impact startups. The incubator is privately run by seasoned entrepreneurs and investors but raises funds from the Mexican government to invest in the participating startups. The Mexican government started the program because they needed more innovative solutions for government problems and wanted to support the startup ecosystem, but they didn’t know how to effectively do so themselves. Each year, the government provides the incubator with an “investment thesis” or area of focus based on the most pressing governmental needs, and the incubator recruits entrepreneurs and startups that offer solutions for that problem (for example: energy, homelessness). Teams are taken through a defined 6-month curriculum (including: business, marketing, operations, human resources), offered a suite of resources (e.g. physical space), and are granted access to mentors and relevant experts across sectors to guide them through product development, testing, and implementation. At the end of the program, startups have the opportunity to pitch their company to raise government funding and are given access to highly favorable loans from the National Bank (otherwise very hard to secure for startups in Mexico). In addition to the incubator program, New Ventures also hosts a series of Grand Challenges, which solicit ideas and solutions from entrepreneurs and innovators across society to address specific problems in exchange for a financial reward. The program has been highly successful in generating innovative solutions to real government problems and fueling the startup ecosystem in Mexico.

Y Combinator (learning community, for profit hosted and funded)

Y Combinator is a large, highly acclaimed incubator in Silicon Valley for startups. Y Combinator invests a small amount of money (\$120K) into a highly selective cohort of startups in exchange for equity (6% of the company). Y Combinator teams participate in an intensive and immersive 3-month program during which they are guided through a training program and curriculum on how to design and scale their companies. For entrepreneurs, much of the value of the incubator comes from the unique access to a network of seasoned entrepreneurs, expert investors, domain experts, and Y Combinator Alumni who can provide specific, actionable, and strategic advice on how to address challenges and capitalize on opportunities across various aspects of the business. At the end of the program, startups participate in Demo Day, during which they pitch their business to Venture Capitalists and Angel investors in an effort to raise funding. In addition to training and network access, Y Combinator also provides other resources, such as physical space, human resource support, and other perks (e.g. advertising credits, free legal counsel). Y Combinator has been one of the most successful incubators, with over 1,700 alumni startups, a community of over 3,500 founders, and a combined valuation of \$80B for participating startups. Some of the notable alumni include: Airbnb, Dropbox, Stripe, Reddit, Twitch, Coinbase, DoorDash, and InstaCart.

Proposed Innovation Ecosystem

1) Innovation Roadmap (Guidelines and Assessment)

Goal: Provide a clear definition of what processes and capacities are essential to foster transformational innovation, and provide criteria for Commissioners to approve, reject or require additional action for counties to receive an approval to expend innovation funds

- A. Published Criteria and Rubric
- B. Proposed DRAFT Categories and Standards
 - a. Capacity for Innovation
 - i. Innovation Process (sourcing needs, identifying root causes, solution generation, prototyping/experiments, going to market, learning culture/quality improvement, evaluation, scale/institutionalizing)
 - ii. Organization Capacity of County (e.g. leadership, culture, staffing, dedicated resources, mandate/buy-in)
 - iii. Community Engagement Process (beginning to end, stakeholder focus groups, consumer and family empathy interviews, engaging advocates)
 - b. Capacity for Collaboration
 - i. Capacity of Collaboration and Community of Practice (e.g. leadership, culture, staffing, dedicated resources, ability to be high performing team)
 - ii. Diversity of Local Collaborators (composition of team, multi-sector, multi-department, demographic and stakeholder categories)
 - iii. Diversity of Community of Practice (e.g. multi-county, multi-sector)
 - c. Capacity for Learning and Potential for Impact
 - i. Learning Culture and Quality Improvement (e.g. experimenting, testing, measuring, adapting, failing fast)
 - ii. Evaluation and Research (improving social determinants/outcomes, ROI)
 - iii. Systems and Process Improvement (driving systemic change)
 - iv. Potential of Innovation (move needle on outcomes or systemic change)

2) Learning Community

Goal: Build an online clearinghouse of information and a community of researchers and practitioners, issue-specific task forces, and a series of virtual and in-person events to disseminate data and stories on challenges and progress throughout the field of mental and behavioral health

- A. Membership
 - a. Diverse members (multi-sector, multi-county, multi-department, academia, business, philanthropy, service providers, stakeholders, consumers, practitioners)
 - b. Issue-specific communities
- B. Products

- a. Online Clearinghouse (well-designed repository of reports, studies, stories, successes, failures, proposals, and relevant articles)
 - b. Publications (newsletters, aggregated digests, journals, articles)
 - c. Events (conferences, webinars, award ceremonies)
 - d. Curated and robust database of partners in the ecosystem
- C. Task Forces
- a. Sponsors can create consortiums of members to focus on a specific issue area, policy, or component of the healthcare system
 - b. Findings of Task Forces could range from policy change to new Issue-Specific Challenges and Design Competitions for the incubator to explore (with pledged support from counties, foundations, and/or business)
 - c. Task Forces can also purchase Technical Assistance Services from Incubator
 - d. Policy and systems change will have a direct channel to commissioners, legislators, county superintendents and BHDs, and DHCS leadership

3) Innovation Incubator

Goal: Create an entity that will help behavioral health departments work collectively to develop partnerships within their communities and among counties, secure technical assistance and connect the incubation process with the formal community planning process, design and implement better community engagement strategies, evaluate projects and emerging practices to encourage replication and continuous improvement, and disseminate information on challenges and progress through a community of practice. The Incubator will have two key products and services:

A. Technical Assistance Services

Goal: Provide backbone support and a la carte training, capacity building, and consulting services to county-led collaborations and/or Learning Community members to improve innovation capacity and drive measurable outcomes

1. Training, Capacity Building, and Certification Services

- a. **Innovation Process**– capacity building training will teach participants how to lead a team through an innovation process including sourcing needs from communities, identifying root causes of challenges, generating solutions, prototyping and experimenting, delivering services to consumers, creating a learning culture and process for quality improvement, evaluation, and scaling and institutionalizing. Successful completion will build internal capacity through a *Certified Innovation Ambassador*
- b. **Community Engagement Process**– capacity building training will teach participants how to build an effective community engagement process from beginning to end, including assembling a diverse steering committee, conducting stakeholder focus groups, consumer and family empathy interviews, and engaging advocates. Successful completion will build internal capacity through a *Certified Engager*
- c. **Capacity of Collaboration and Community of Practice**– capacity building training will teach participants how to build an effective cross sector

collaboration and innovative community of practice, including assessing and building leadership, trust, culture, managing power dynamics, and high performing teams. Successful completion will build internal capacity through a *Certified Collaborator*

- d. **Capacity of County (or Organization)**– capacity building training will teach participants how to build an effective culture of innovation and collaboration within their organization, including assessing and building leadership and trust, changing culture, and supporting a high performing team. Successful completion will build internal capacity through a *Certified Innovator*
- e. **Learning Culture and Quality Improvement**– capacity building training will teach participants how to build a flexible and learning culture, including effective experimenting, testing, measuring, adapting, failing fast, and driving for continuous quality improvement. Successful completion will build internal capacity through a *Certified Learner*

2. Consultative and Matchmaking Services

- a. **Evaluation and Research**– this consultative service will include assessing the evaluation and research plan including its focus on social determinants, mental health service outcomes, and measuring return on investment (ROI). The consultant will identify potential evaluators (people and organizations) who could enhance the research strategy and evaluation process. This matchmaking service may include seeking advice, support and connecting with Learning Community partners.
- b. **Diversity of Local Collaborators and Diversity of Community of Practice**– this consultative service will include assessing the diversity of local collaborators and communities of practice to identify what sectors and populations are being excluded. The consultant will work with key stakeholder groups to help identify potential *Cultural Brokers* (people and organizations) who could enhance the collaboration and be more inclusive. *Cultural Brokers* could also be trained to become *Certified Collaborators*. This matchmaking service may include seeking advice, support and matchmaking with subject matter experts from MHSOAC’s stakeholder contractors.
- c. **Systems and Process Improvement and Potential of Innovation**– this consultative service will include assessing the innovation project’s hypothesis on driving systemic change and its potential for innovation. The consultant will identify potential improvements and key performance indicators to ensure the innovation project has the potential to move needle on outcomes and/or systemic change.

B. Issue-Specific Challenges and Design Competitions

Goal: A Learning Community task force (or potentially other funders) could develop an “investment thesis” based on county-specific and statewide needs, and issue an RFP to attract local collaborations that desire incubator services and participating in a statewide and cross-sector Community of Practice

1. Request for Proposals

- a. **Incentives** – some challenges will have financial rewards (and/or matching funds) for local collaborations to compete for while others will just provide facilitation support by assembling a like-minded Community of Practice connected to paid incubator services
- b. **Acceptance** – all applicants will be assessed using the Innovation Roadmap Guidelines and the incubator will invite some or all of the applicants to join the Community of Practice, while ensuring readiness to innovate and diversity of approach and county size (ability to pay for incubator services may also be a criteria)

2. Community of Practice

- a. **Innovation Fellows** – 4-6 members of each county collaborative participates in cohort with monthly video calls and quarterly in-person sessions (they become *Certified Collaborator, Innovation Ambassador, Innovator(s), Engager, and Learner*)
- b. **Collective Learning** – Fellows learn from each other throughout the challenge and test hypotheses in multiple communities to advance learning
- c. **Disseminated Findings** – final solutions, lessons learned, what’s working, and what needs additional investigation will be shared with Learning Community and can be pre-approved by MHSOAC (i.e. additional counties can get expedited approval for innovation funds so long as they follow Innovation Roadmap Guidelines and can show community interest and need)

3. Products and Services (tiered pricing based on county/population size)

- a. **Capacity Building** – Training, Coaching, Facilitation
 - i. Access to Technical Assistance Services as needed
 - ii. Every participating organization in a collaboration will need a *Certified Innovator*
 - iii. Every collaboration will need at least one *Certified Collaborator, Certified Innovation Ambassador, Certified Engager, and Certified Learner*
- b. **Collaboration Backbone**
 - i. If collaborations do not have the resources or capacity to have a dedicated, experienced *Certified Collaborator* (or would like a coach for an inexperienced *Certified Collaborator*), they can request the services of a *Collaboration Backbone* to provide backbone support
 - ii. *Collaboration Backbone*’s serve as imbedded consultants who offer support including, ensuring vision and strategy alignment, supporting aligned activities, sourcing community needs and building public will, identifying root causes, solution generation, prototyping and experimenting, mobilizing funding and take new products to market, fostering a learning culture and quality improvement, establishing shared measurement practices, and scaling results by advancing policy change. The duration of their engagement may vary depending on the needs of the initiative.

Proposed Business Model

All three of these components will be required to create an Innovation Ecosystem able to enhance and transform the mental and behavioral health field. However, each element may need a tailored business model.

1. Innovation Roadmap

The MHSOAC clearly has the authority to provide a definition of innovation and criteria for Commissioners to approve, reject or require additional action for counties to receive MHSOAC innovation funds. However, we propose that the Commission engage county behavioral health directors and staff, stakeholder and advocacy groups (local and statewide), academic and research partners, technical assistance providers, service providers, and consumers and family members in a process to develop these criteria to create understanding and ownership. This would require building on the current definition and process while being willing to adapt and change based on feedback. Specifically, we propose that the development of these criteria be the first project of the Innovation Incubator. This element has the potential of aligning stakeholders and improving innovation throughout California at a low cost.

Estimated cost: \$100,000 - \$250,000 for consultants, design labs, and stakeholder engagement and/or Innovation Incubator operator (plus MHSOAC staff time)

Proposed payer: MHSOAC

2. Learning Community

Building an online clearinghouse of information, community of researchers and practitioners, and issue-specific task forces would be a critical asset for the field of mental and behavioral health regardless of its connection to the Innovation Incubator. We propose that this component be pursued in parallel with building the Innovation Incubator, potentially in partnership with existing centers of excellence within California. We emphasize that the operator will need to both collect data and information as well as curate and foster an active cross-sector community.

Estimated cost: \$2 million - \$4 million for first three years (\$250,000-\$500,000 for startup and operations plan (identify scope of information, format of clearinghouse, community curation needs, key partners and stakeholders, and potential paid membership model); \$1 million - \$2 million for launch; \$250,000-\$500,000 annually for active curation)

Proposed payer: Seed funding from health-focused foundations with launch and ongoing operating costs from State of California and paid membership model

3. Innovation Incubator

The Innovation Incubation should support behavioral health departments in:

- working collectively to develop partnerships within communities and among counties
- securing technical assistance and connecting the incubation process with the formal community planning process
- designing and implementing better community engagement strategies
- evaluating projects and emerging practices to encourage replication and continuous improvement
- disseminating information on challenges and progress through a community of practice

The Incubator should be created by contracting with a new or existing organization that partners with existing technical assistance, research and quality improvement, and stakeholder and community engagement groups throughout California.

Beyond the technical assistance and design challenge services, the Incubator can provide coworking space where members of the Community of Practice can interact and collaborate with each other, *Collaboration Backbones*, *Imbedded Problem Solvers*, *Senior Fellows*, Learning Community members, incubator staff, and those coming into the Incubator for Technical Assistance training. This “hive” will be designed for creativity, cross-fertilization, innovation and serendipity. Membership to this coworking environment could be another revenue generating service to ensure financial sustainability.

We propose that the Incubator be launched with the \$5 million in funds set forth by the Governor’s budget in FY19-20. While we have proposed a model that is issue agnostic, the initial charge of the Incubator will be reducing the number of people deemed incompetent to stand trial (IST), as this is what is required by the source of funding. These funds will help launch the Incubator, covering startup and infrastructure costs, as well as an issue-specific challenge focused on IST. With the infrastructure built, additional issue areas can be addressed by the Incubator at a lower marginal cost.

Estimated cost: \$5 million for first two years (\$500,000 for startup costs, \$1 million annually for facilities and administration, \$1 million - \$2 million annually for technical assistance, and \$500,000-\$1 million per challenge, assuming two to three challenges in first two years)

Proposed payer: Seed funding of \$5 million provided by the State of California with a challenge focused on IST, additional funds from foundations and the State of

California could sponsor additional issue-specific challenges, and ongoing operating costs covered by county behavioral health departments (through MHSA Innovation funds and potentially other budgets) and other stakeholders paying for technical assistance services

Sustainability: All challenges are sponsored (either by State of California, foundations, and/or a consortium of county agencies), all technical assistance is paid for (either by county agencies, foundations supporting nonprofit or service provider capacity, and/or other stakeholders seeking services), and facilities and administration covered with an overhead charge on all challenges and technical assistance services

Proposed Model for Management and Operation

We identify the following three potential models for management and operation of the Incubator, and we propose that the MHSOAC pursue the Hybrid Model:

1. **Build from Scratch** – contract with an entity to build the Incubator with all of the essential services and staffing within a standalone organization
 - a. Pros – customized for specified purpose and can become a one-stop shop
 - b. Cons – most expensive model and doesn’t leverage amazing work, past investment, and current excellence already taking place in the field
2. **Connect the Dots** – contract with an existing organization that functions as a curator to connect the current service providers in the mental and behavioral health field and those in need of technical assistance and consulting services
 - a. Pros – least expensive model and leverages the best of what already exists
 - b. Cons – relies on what already exists that are not currently meeting all needs
3. **Hybrid Model** – contract with a new or existing entity that builds a lean infrastructure that connects top service providers within the field and creates products and services missing within the mental and behavioral health field (e.g. design challenges, backbone support)
 - a. Pros – reasonable cost, leverages the best of what already exists, and builds what is missing for the specified purpose
 - b. Cons – will require extra time and resources to identify, source and, coordinate with existing service providers (including potential culture conflicts)

Prototype for Executive Staffing of Hybrid Model

- CEO (Strategy and Business Development)
- CFO (or role absorbed from parent organization or fiscal sponsor)
- COO (Human Capital, Operations, Facilities)
 - Learning Community Liaison
 - Network Weaver for connecting dots and encouraging engagement and quality contributions
 - Training Faculty Lead
 - Assumes most trainings will be contracted out to approved vendors
 - Consulting Lead
 - Matchmakers (*Senior Fellows*/Learning Community members)
 - Collaboration Backbones* (potentially contracted out to approved vendors)
 - Design Challenge Lead
 - Community of Practice Facilitator
 - Community Engagement Lead
 - Quality Improvement and Evaluation Lead
 - Senior Fellows*– each challenge will assemble a select group of subject matter experts and former BHDs to support the Community of Practice
 - Infrastructure Support
 - Analyst – to capture lessons learned, synthesize and advise on program improvements
 - Software engineer(s) – implement program improvements
 - Graphic designer
 - Facilities and events manager

i List of Organizations Engaged in Stakeholder Process

7 Cups

Alameda County Behavioral Health Care Services

American Institutes for Research

Born This Way Foundation

Brainstorm: Stanford Lab for Brain Health Innovation and Entrepreneurship

Bring Change to Mind

CA Council of Community Behavioral Health Agencies

CA Pan-Ethnic Health Network

California Alliance of Child and Family Services

California Council of Community Behavioral Health Agencies

California Forward

California Health Care Foundation

California Institute for Behavioral Health Solutions

California Mental Health Services Authority

CBHDA

Center for the Vulnerable Child, UCSF Benioff Children’s Hospital Oakland

CFLC Committee Members

Children Now

CLCC Committee Members

MHSOAC Innovation Incubator – For Commissioners’ July 2018 Meeting

Updated as of 7.13.18

COMMUNITY CLINIC ASSOCIATION OF LOS ANGELES COUNTY

Consumer Advocates

Council on Criminal Justice and Behavioral Health

County of San Diego Health and Human Services Agency, Behavioral Health Services

County of Santa Clara

CPEHN

Depression & Bipolar Alliance

DHCS

DMH Los Angeles County

East Bay Agency for Children

Edegwood Center for Children and Families

former Citi Ventures

Fresno County

Health Access

Kern Behavioral Health and Recovery Services

Kern Behavioral Health and Recovery Services

Lincoln

Los Angeles County Department of Mental Health

Lucile Packard Children's Hospital Stanford

MHALA

MHSOAC

Mindstrong Health

NextGen America

NorCAL MHA

OCHA

Open Source Wellness

Orange County Health Care Agency

Peers Envisioning and Engaging in Recovery Services (PEERS)

Prevention Institute

REMHDCO

Represents schools

San Bernardino County Behavioral Health

San Francisco Behavioral Health Services

San Francisco Department of Public Health

Santa Barbara County Department of Behavioral Wellness

Santa Clara county superior court

Seneca Family of Agencies

Social Interest Solutions

Stanford Psychiatry

Stanford University

Stanislaus County/Behavioral Health and Recovery Services

Steinberg Institute

Swords to Plowshares

TeenzTalk

The Lab at OPM

Third Sector Capital Partners

Transitions Clinic Network

U.S. Department of Labor

UC Davis Dept of Psychiatry

UCSF Children's Hospital Oakland

United Parents

Uplift Family Services

Walter S Johnson Foundation, administered by Whittier Trust

Young Minds Advocacy

Youth Tech Health

ii **List of Incubator Models Researched**

Grand Central Tech
NFX
InBIA
Department of Homeland Security’s CyberApex Program
Seneca Family of Agencies
Entrepreneur First
Plug & Play
IDEO
Chobani Incubator
Tipping Point Community
Superpublic
Deloitte’s Greenhouse
Booz Allen Innovation Center
1776
City Innovate
Case Foundation
Techstars
Launchpad
Lean Launchpad
BioDesign
Omidyar Network
Emerson Collective
Presidio Institute
World Economic Forum
The Technology Suite (and 7 Cups)

Sources

- Singari Seshadri, *Associate Director, Entrepreneurial Programs Center for Entrepreneurial Studies, Stanford Graduate School of Business*
- Russell Siegelman, *Lecturer in Management, Stanford Graduate School of Business*
- Robert Chess, *Lecturer in Management, Stanford Graduate School of Business*
- Peter Reiss, *Lecturer in Management, Stanford Graduate School of Business*
- <http://www.govtech.com/local/SF-Launches-Entrepreneurship-in-Residence-EIR-Program.html>
- <https://www.challenge.gov/>
- <https://lab.opm.gov/>
- <http://www.ycombinator.com/>

AGENDA ITEM 12

Information

July 26, 2018 Commission Meeting

Technology Suite Collaborative Innovation Project Update

Summary: The Commission will hear an update from the Tech Suite Collaborative leadership representing Los Angeles County and Kern County for their Innovation Project, which was presented and approved at the Commission Meeting held on October 26, 2017. The update will address concerns raised by the Commission in April 2018 regarding procurement, evaluation and the number of counties proposing to join the collaborative.

- (A) **Technology Suite Collaborative Innovation Project Update:**
Increasing Access to Mental Health Services and Supports Utilizing a Suite of Technology-Based Mental Health Solutions

The Mental Health Services Act (MHSA) requires that an INN project does one of the following: (a) introduces a new mental health practice or approach, including but not limited to prevention and early intervention; (b) makes a change to an existing mental health practice or approach, including, but not limited to, adaptation for a new setting or community; (c) introduces to the mental health system a promising community-driven practice/approach, that has been successful in non-mental health contexts or settings; or (d) participates in a housing program designed to stabilize a person's living situation while also providing supportive services on site. The law also requires that an INN project address one of the following as its primary purpose: (1) increase access to underserved groups, (2) increase the quality of services including measurable outcomes, (3) promote interagency and community collaboration, or (4) increase access to services.

- Los Angeles and Kern Counties will be providing an update for their Innovation Project which was approved by the Commission on October 26, 2017. Upon approval, the Commission requested to receive status updates as the two counties accomplish the milestones presented in their timeline. Los Angeles and Kern proposed to work collaboratively with the Joint Powers Authority, CalMHSA, and multiple counties to develop a demonstration project to increase access to mental health services to underserved groups by implementing a group of technology-based mental health solutions that utilize peer chat rooms, virtual therapy and passive data collection to identify the early signal biomarkers for mental health symptoms and offer prompt intervention.
- Mono County was approved to join the Tech Suite Collaborative on February 22, 2018. Orange County and Modoc County were approved to join the Tech Suite Collaborative on April 26, 2018. The Commission has received an additional eleven (11) proposals to join the Tech Suite Collaborative totaling a \$104 million potential innovation investment by 16 counties. The project manager has indicated that an additional seven (7)

counties are in various stages of submitting proposals to join. The enclosed documents include a Tech Suite Dashboard outlining each county's proposed investment, selection of applications and target populations, and a Tech Suite Status Report that provides a written update from the Tech Suite Collaborative.

Presenters for Update on Technology Suite:

- Karin Kalk, Tech Suite Project Manager
- Tom Insel, Co-founder of Mindstrong Health and Advisor to 7 Cups
- Bill Walker, Director of Kern County Behavioral Health and Recovery Services
- Ronald (Ronnie) Gilbert, Operations Manager at Sunray's of Hope

Enclosures (2): (1) Biographies for Tech Suite Update Presenters, (2) Tech Suite Dashboard

Handouts (2): (1) Tech Suite Status Report; (2) A PowerPoint will be presented at the meeting

Additional Materials (1): Link to the Tech Suite Status Report is available on the MHSOAC website at the following URL:

<http://mhsaac.ca.gov/document/2018-07/tech-suite-status-report-july-5-2018>



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

Tech Suite Project Manager

Karin Kalk, Project Manager: Karin is Director for Health Care Reform with the California Institute for Behavioral Health Solutions. Since 2001, Karin has been providing consulting services throughout California in both private and public managed care and service delivery organizations; these services have included project management, quality/process improvement, and service system design. Prior to this work in the mental health field, Karin was Vice President and General Manager for ForHealth, Inc., a venture-capital funded company offering a specialized medical program for long term care residents through full and partial risk arrangements with senior health plans. Before joining ForHealth, she served as Vice President of Operations for AHI Healthcare Systems, a publicly traded managed care company serving over 200,000 members throughout the country. Karin received her Master's degree in Health Administration from Duke University, her Bachelor of Arts degree in Animal Physiology from University of California, San Diego and has additional formal training in project management and IHI's Breakthrough Series improvement methodology.

County Representative

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



Mindstrong and 7 Cups Vendor Representative

Tom Insel: Thomas R. Insel, M.D., a psychiatrist and neuroscientist, is a co-founder and President of Mindstrong Health. He is also an advisor to 7 Cups, Compass Pathways, CitiesRise, and the Steinberg Institute. From 2002-2015, Dr. Insel served as Director of the National Institute of Mental Health (NIMH), the component of the National Institutes of Health (NIH) committed to research on mental disorders. Prior to serving as NIMH Director, Dr. Insel was Professor of Psychiatry at Emory University where he was founding director of the Center for Behavioral Neuroscience in Atlanta. Most recently (2015 – 2017), he led the Mental Health Team at Verily (formerly Google Life Sciences) in South San Francisco, CA. Dr. Insel is a member of the National Academy of Medicine and has received numerous national and international awards including honorary degrees in the U.S. and Europe.

Peer Support Specialist

Ronald (Ronnie) Gilbert: Ronnie Gilbert is scheduled to complete his A.A. in Bio-Psychological Science in 2019 at Chico State University. Ronald became Operations Manager of Sunray's of Hope, Inc., in 2017 after originally starting there as Program Coordinator in 2015. He is a peer support specialist and a self-disclosed person with lived experience and family members with lived experience. He is trained in Crisis Intervention and is a member of the Modoc County Behavioral Health Advisory Board and the Modoc County Behavioral Health Cultural Competency committee. Ronnie is engaged in a three-year term as an ACCESS Ambassador for the 12-county Superior Region of Northern California beginning in December, 2017.

Tech Suite Dashboard

				Selected Applications*		
Counties Previously Approved	Budget	Duration	Commission Approval Date	Online Peer Chat and Support Groups	Virtual Therapy Using an Avatar	Digital Phenotyping/Wellness Monitoring
Los Angeles	\$33,000,000	3 Years	October	X	X	X
Kern	\$2,000,000	3 years	October	X	X	X
Mono	\$85,000	17 mos	February	X	X	X
Modoc	\$270,000	3.5 Years	April	X	X	X
Orange	\$24,000,000	5 Years	April	X	X	X
Total Approved	\$59,355,000					
Counties Proposing to Join**			Possible Commission Date	Online Peer Chat and Support Groups	Virtual Therapy Using an Avatar	Digital Phenotyping/Wellness Monitoring
Tehama	\$118,088	2 Years	September	X	X	X
Tri-City	\$1,674,755.13	4 Years	September	X	X	X
City of Berkeley	\$462,916	3 Years	September	X	X	X
Riverside	\$25,950,000	4 Years	September	X	X	X
Monterey***	\$2,526,000	3 Years	September			
San Mateo	\$3,872,167	2 Years	September	X	X	X
Santa Barbara	\$2,600,000	2 Years	September	X	X	
Marin	\$638,000	21 Months	September	X	X	X
San Francisco	\$2,273,000	5 Years	September	X	X	
Inyo	\$448,757	3 years	September			X
Santa Clara	\$4,373,886	3 years	September	Unkown	Unknown	Unknown
Total Proposed	\$44,937,569					
Total Proposed Innovation Investment	\$104,292,569					

*Selected Applications: **Online Peer Chat**-Peer chat support available 24 hours a day/7 days a week in the user's preferred language. **Virtual Therapy Using an Avatar**- Virtual manualized evidence-based interventions delivered via an avatar (e.g., mindfulness exercises, cognitive behavioral or dialectical behavior interventions). **Wellness Monitoring/Digital Phenotyping**- Utilize passive sensory data to engage, educate and suggest behavioral activation strategies to users

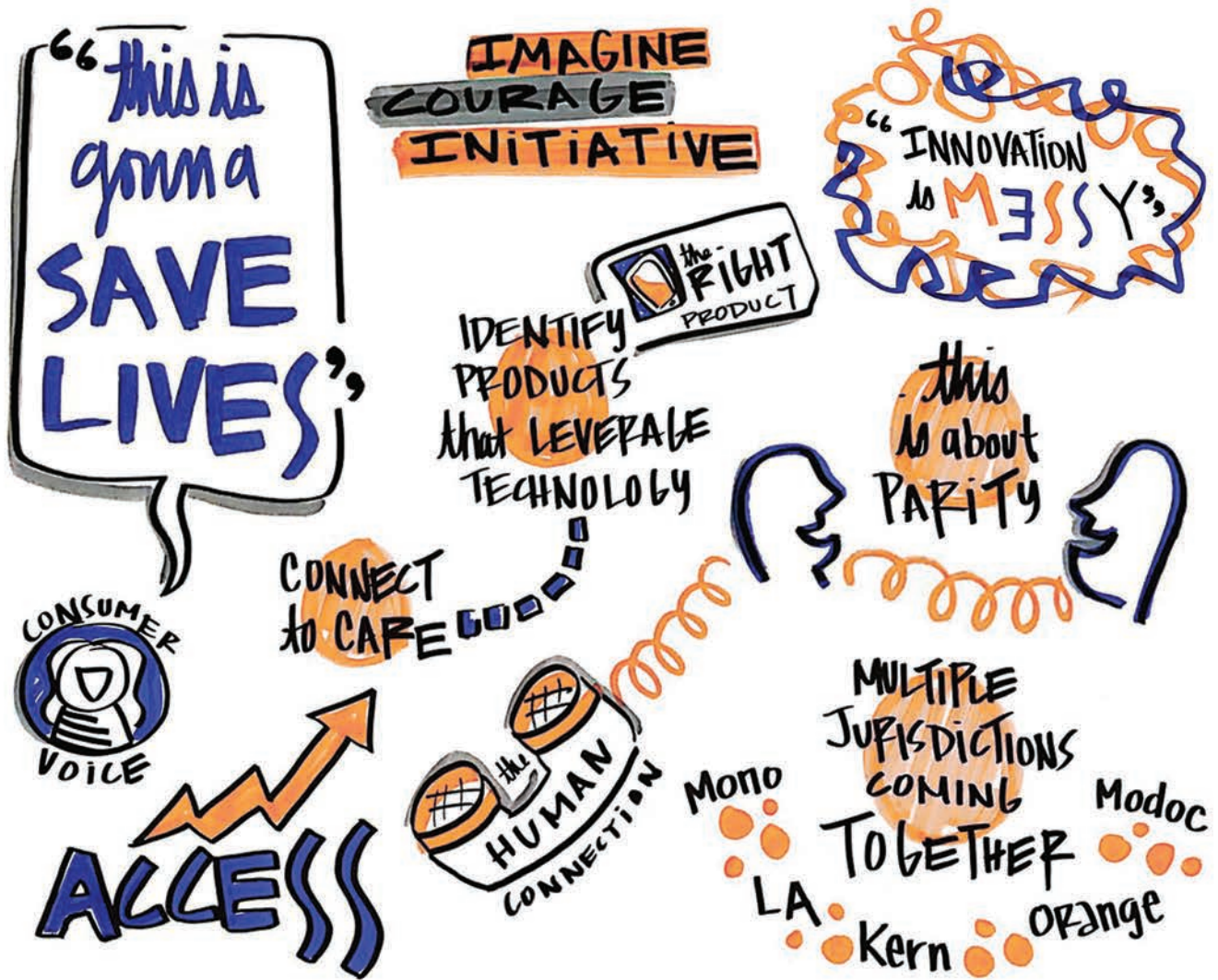
The Commission has **received eleven (11) additional proposals. The Tech Suite Project Manager indicates that seven (7) additional counties are in various stages of submitting a proposal to join the collaborative.

*** Monterey County is proposing to develop an assessment

Target Populations Include: Transitional Age Youth, Youth, Adults, Older Adults, College Students, Subclinical, Individuals At Risk of Developing Mental Health Symptoms, Adults discharged from psychiatric hospitals and/or recipients of crisis services , Individuals Who Frequently Utilize Inpatient Psychiatric Care, Isolated Individuals, Family Members, Deaf Community, Spanish Mono-lingual, Chinese Mono-lingual, Individuals in Poverty, Males at Risk of Suicide, Socially Isolated, Transgender Adults, Stigma/ Individuals Seeking Services in a Non-Traditional Setting

“THE TECHNOLOGY SUITE”

DRIVING ACCESS TO BEHAVIORAL HEALTH CARE THRU INNOVATION



MENTAL HEALTH OVERSIGHT
AND ACCOUNTABILITY COMMISSION

JULY 5, 2018

“THE TECHNOLOGY SUITE” MHSOAC STATUS REPORT

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Progress Overview

Statewide Collaborative Accomplishments & Milestones

TIMEFRAME	ACTIVITY	OUTCOME
Oct 2017	Collaborative Development: Kern and Los Angeles Counties submit proposals to the MHSOAC for a statewide collaborative Innovation project	MHSOAC Commissioners approved statewide collaborative and two inaugural counties to create the foundation for the collaboration
Nov – Dec 2017	Collaborative Development & Approach: CalMHSA engaged to provide administration of the statewide collaborative	<ul style="list-style-type: none"> • CalMHSA assigned staff to begin vendor acquisition activities
	Technology, Evaluation, Outreach & Marketing Procurement: <ul style="list-style-type: none"> • RFSQ developed and distributed for 5 tech components of the tech suite • Panel convened to review submissions to identify set of qualified vendors in each component category 	Qualified vendors selected in the following categories: <ul style="list-style-type: none"> • Digital Applications (5 vendors) • Outreach and Marketing (1 vendor) • Evaluation (2 vendors)
Jan – Feb 2018	Collaborative Development & Approach: <ul style="list-style-type: none"> • Mono County submits proposal to the MHSOAC to join the collaborative • Opportunity to join collaborative shared with CBHDA Governing Board 	MHSOAC Commissioners approved Mono County to join collaborative
	Implementation: <ul style="list-style-type: none"> • Collaborative Project Manager hired through CIBHS • Plan for collaborative infrastructure developed 	<ul style="list-style-type: none"> • Detailed infrastructure development launched (see tab 3, page 22) • Individualized county development launched (per existing plans)
Mar – Apr 2018	Technology Procurement: <ul style="list-style-type: none"> • Prequalified vendors provided a project orientation • Each vendor conducted an in-person demo and presentation of their apps for teams from initial 3 counties, including peer representatives • County staff and peers practiced with pre-qualified apps to identify initial set of apps 	<ul style="list-style-type: none"> • Initial vendors and apps selected (see tab 5, page 36) : <ul style="list-style-type: none"> • 7 Cups • Mindstrong • CalMHSA provides vendors with initial planning contracts to support readiness work
	Collaborative Development & Approach: <ul style="list-style-type: none"> • Modoc and Orange counties submitted proposal to the MHSOAC to join the collaborative 	<ul style="list-style-type: none"> • MHSOAC Commissioners approved /Modoc and Orange Counties to join collaborative • CalMHSA executed Participation Agreement with Los Angeles and Kern Counties



TIMEFRAME	ACTIVITY	OUTCOME
	<ul style="list-style-type: none"> Monthly call launched for county MHSA Coordinators across the state to support their community planning efforts and Innovation proposal development 	<ul style="list-style-type: none"> Learning from initial counties is regularly shared with interested counties to increase their understanding of the opportunity, support useful local adoption of the apps and promote greater readiness once approved
	<p>Outreach and Marketing</p> <ul style="list-style-type: none"> Based on limited respondents to initial RFSQ in Nov. 2017, a focused RFP is issued for an outreach and marketing vendor 	<p>CalMHSA's distribution of the RFP resulted in 15 letters of interest and then 5 proposal submissions.</p>
	<p>Evaluation: RAND engaged to assist with approach to evaluation, including development of over-arching approach and critical qualifications and capabilities of collaborative evaluator.</p>	<p>Collaborative determined to proceed with a follow-up Request for Qualification (RFQ) to select an evaluator to support development of evaluation plan as well as conduct the actual evaluation.</p>
	<p>Peer Roles: Participating counties begin preparation of their plan to engage peers to support individual use of apps, as well as inform needed improvements and advancements to those apps</p>	<p>County leads reach out to and engage initial peer reps into planning activities.</p>
	<p>Implementation: Budgeting and pricing methodology created to support flexible, formula driven contracts with vendors driven by size of participating county, desired level of customization and allocation of funds for shared needs as well as local supports.</p>	<ul style="list-style-type: none"> Vendors oriented to formula driven approach to pricing that enables periodic addition of counties to their contract without re-contracting for each county Initiation of new counties in their budget planning per slide fee schedule based on county size
<p>May – June 2018</p>	<p>Privacy and Security:</p> <ul style="list-style-type: none"> CalMHSA conducted search for agency with technical, legal and operational experience with data sharing and associated privacy and security concerns Intrepid Ascent worked with CalMHSA, counties and vendors to determine needs and approach to privacy and security across the elements of the project 	<ul style="list-style-type: none"> CalMHSA engages <i>Intrepid Ascent</i> (see tab 9, page 80) to support development of privacy and security guidelines, associated vendor contract requirements, contract language for data ownership and intellectual property, as well as informed consent Intrepid Ascent develops initial "Privacy and Security Guidelines" (see tab 9, page 83) and "Clinical Integration and Data Sharing Continuum" (see tab 9, page 81) to inform data sharing
	<p>Technology Procurement:</p> <ul style="list-style-type: none"> CalMHSA worked with Intrepid Ascent to develop contract for app vendors that support complexity of the project, including: 	<ul style="list-style-type: none"> App vendor contract reflecting the aims, legal complexity, and privacy/security of the collaborative developed, including a Work Order to link each county's Innovation



TIMEFRAME	ACTIVITY	OUTCOME
	<p>privacy and security issues, customization for specific county size and needs, informed consent and other unique terms and conditions</p>	<p>Proposal and Participation Agreement with the Vendor Contract (see tab 5, page 32)</p>
	<p>Peer Roles</p> <ul style="list-style-type: none"> • CalMHSA supported a shared learning process to identify the roles of peers in each county’s deployment of apps (see tab 4, page 26) • CalMHSA supported counties to evaluate opportunities for existing peers and peer network to support outreach and engagement of target populations 	<ul style="list-style-type: none"> • Individual counties appointed their lead peers for the project • Individual counties, working with 7 Cups and their local peers, develop the Tech Suite (paid) Peer role and plan recruitment • Individual counties identify existing peer network and plan to engage these individuals in marketing and support of app use
	<p>Outreach and Marketing:</p> <ul style="list-style-type: none"> • CalMHSA panel reviewed proposals received in response to RFP and identifies a recommended vendor • RSE worked with app vendors and counties to develop initial marketing outreach materials (shared and customized per county) • RSE oriented project to brand development process (see tab 8, page 74) 	<ul style="list-style-type: none"> • Leadership from initial 5 collaborating counties accepted CalMHSA panel recommendation and <u>RSE</u> (see tab 8, page 72) awarded outreach and marketing role • RSE created prototype handout cards and flyers to be customized for each county (see tab 8, page 77) • RSE developed an expedited branding process to generate collaborative brand and awareness campaign (see tab 8, page 74)
	<p>Evaluation:</p> <ul style="list-style-type: none"> • CalMHSA issued a focused RFQ to pre-qualified evaluator candidates to gain deeper understanding of each agency’s capabilities • CalMHSA convened a panel to review RFQ responses and develop recommendation for selection • Demographic reporting requirements (per MHS Innovation regs) provided to app vendors 	<ul style="list-style-type: none"> • Leadership from initial 5 collaborating counties accepts CalMHSA panel recommendation and <u>UCI</u> (see tab 10, page 88) is awarded evaluator role • App vendors developed method to gain demographic information from end-users in an engaging, person-centered way (to be tested by peers to finalize)
	<p>Implementation:</p> <ul style="list-style-type: none"> • Cohort #1 carried out detailed readiness work to support initial “soft launch” of the apps in July and then steady expansion after initial debugging • CalMHSA advanced infrastructure development to support county and vendor 	<p>Counties developed initial plans and readiness associated for their Soft Launch in July (see tab 3, page 20)</p>



TIMEFRAME	ACTIVITY	OUTCOME
	<p>contracting, budgeting and associated transactions (see tab 5, page 32)</p> <p>Collaborative Development & Approach:</p> <ul style="list-style-type: none"> • CalMHSA convened a day-long kick-off session for initial counties (cohort #1) • CalMHSA supported Innovation proposal development, including budgets aligned with vendor contracting strategy 	<ul style="list-style-type: none"> • Over 100 staff, peers and stakeholders convened in Los Angeles in a shared learning session focused on target population needs, relevant app-based solutions, and IT concerns (see tab 3, page 18) • Over 20 counties indicated interest in joining the collaborative with at least 12 planning to submit Innovation proposals to the MHSOAC in order to join as part of “Cohort #2” • CalMHSA executed Participation Agreements with Orange, Mono and Modoc Counties
<p>July – Aug 2018 (planned)</p>	<p>Implementation:</p> <ul style="list-style-type: none"> • Counties launch initial outreach and marketing efforts in association with each vendor (July 16th) • 7 Cups launches customized app in Cohort #1 counties (July 16th) • Mindstrong launches Health and Care apps in each Cohort #1 county per initial target population (launch dates are county-specific) <p>Outreach and Marketing:</p> <ul style="list-style-type: none"> • Branding and marketing campaign to be developed with county input • Counties initiate outreach and marketing efforts for soft launch and plan expanded outreach and marketing to support next phase of implementation <p>Peer Roles:</p> <ul style="list-style-type: none"> • Local paid peers to be hired, training and deployed • Local peers in existing networks to be trained to support use of apps by individuals they assist <p>Evaluation:</p> <ul style="list-style-type: none"> • UCI to develop evaluation plan and assure core data gathering and reporting capability is developed • App vendors to initiate sharing of county-level dashboards and other analytics <p>Collaborative Development & Approach:</p> <ul style="list-style-type: none"> • Counties in Cohort #2 to receive support to maximize readiness for implementation activities once approved to join the collaborative • CalMHSA to plan and prepare for an all-county, all-vendor in-person learning session in Fall 2018 to support transfer of knowledge of Cohort #1 counties to Cohort #2 counties and support all counties planning their next steps to expand (Cohort #1) or initially launch (Cohort #2) <p>Adapting to Local & Population Needs:</p> <ul style="list-style-type: none"> • App vendor to work with RSE and their partners to develop translation of their app content; initial translations will be Vietnamese and Spanish (see tab 3, page 25) <p>Technology Procurement:</p> <ul style="list-style-type: none"> • App vendor contracts to be finalized 	

Progress Overview

Individual County Accomplishments & Milestones

All of the Collaborative milestones described in the previous summary were accomplished with the deep support and involvement of these participating counties. Further, each of the above milestones reflect equivalent progress in the counties, while the items below offer insights into local level work that is assuring the unique needs and objectives of the county are central to deployment of the tech suite in their communities. As such, the following are some highlights of county-specific accomplishments.

<u>Kern County</u>	<u>Los Angeles County</u>	<u>Modoc County</u>	<u>Orange County</u>
<ul style="list-style-type: none"> • Working with two sets of Peers. <ul style="list-style-type: none"> ○ Employed Peer Navigator staff (5) have been trained in 7 cups and are ready to train others. ○ Volunteer peers (3) have been trained in 7 cups. <ul style="list-style-type: none"> - Several peers have been identified who are interested in interviewing for the Lead Peer position once it is opened in the new Fiscal year. • Customization work with 7 Cups: <ul style="list-style-type: none"> ○ Privacy protocol. Completed second tele-conference with privacy and security officers. 	<ul style="list-style-type: none"> • LA Project Team Constructed • Peer Development Activities <ul style="list-style-type: none"> ○ Recruited interim Peer Lead ○ LA county specific planning and on-boarding of a peer lead ○ Launch at the LACDMH Peer Resource Center • Outreach and Marketing <ul style="list-style-type: none"> ○ Construct digital marketing campaign ○ Participating in brand development activities ○ Coordination with LACDMH PIO for local brand development and outreach media (ongoing) • Community Planning Events: <ul style="list-style-type: none"> ○ Regular stakeholder engagement/community planning presentations to our System Leadership Team 	<ul style="list-style-type: none"> • Peer Lead team established/activated/training • Tech Suite Team established/activated • Tech Suite Implementation Planning completed • Customization with 7 cups • Customization with Mindstrong initiated • Customization with RSE completed • Quality Improvement Report/Endorsement • BH Advisory Committee Report/Oversight (audience included peers from Access California Northern Region) • Vetted materials from 7 Cups • Peer-led 7 Cups presentation to Modoc County peers • Peer-led 7 Cups presentation to Access California personnel 	<ul style="list-style-type: none"> • OC Peer Lead and local Tech Team identified and participate in collaborative and OC customization calls. <ul style="list-style-type: none"> ○ Team includes staff from INN, IT, PIO, MHSa Office and Compliance • INN staff facilitated focus groups with specific target populations to gather input on the role of the peer and marketing strategies. This information is shared during OC customization calls to discuss OC specific needs. • OC IT and Compliance staff have been working with 7 Cups and Mindstrong vendors to vet products for security and privacy requirements • OC IT, INN, MHSa and County staff have engaged in

<u>Kern County</u>	<u>Los Angeles County</u>	<u>Modoc County</u>	<u>Orange County</u>
<ul style="list-style-type: none"> ○ Updated county resources for “Neighborhood” page ○ Waiting for them to determine beneficial training dates for agency clinicians. ● Beginning to orient stakeholder groups to upcoming soft launch: <ul style="list-style-type: none"> ○ NAMI executive group ● Working with RSE, marketing group editing graphics for Kern. <ul style="list-style-type: none"> ○ Prepping for soft launch mid-July with identified team. 	<ul style="list-style-type: none"> ○ Long Beach MHC Wellness Clinic presentation for feedback ● Engagement Presentations: <ul style="list-style-type: none"> ○ Piloting and demonstration of the 7 Cups app with youth, peers, and various community members at the We Rise mental health event ○ Recruitment of LACDMH Peer Wellness Outreach Workers to assist with the technology suite ○ API Underserved cultural community meeting ● Customization of apps: <ul style="list-style-type: none"> ○ Peer planning and roll out for 7 cups peer plan ○ Mindstrong implementation and development call weekly (developing the escalation patterns) ○ 7 cups target populations identified (API, older adults, TAY, social isolated, friends/family/caregivers) 	<ul style="list-style-type: none"> ● 7 Cup webinar training for clinicians 	<p>preliminary discussions about the launch of Mindstrong clinical integration into County clinics</p> <ul style="list-style-type: none"> ● OC PIO staff has been working with RSE marketing vendor to provide input on soft launch marketing materials ● OC INN staff confirmed the soft launch location and met with the staff to prepare for the soft launch.

*Mono County has postponed its participation in the Tech Suite until Fall 2018 due to unexpected shifts in organizational priorities and demands.



“THE TECHNOLOGY SUITE”

DRIVING ACCESS TO BEHAVIORAL HEALTH CARE THROUGH INNOVATION

This California statewide collaborative project is bringing interactive technology-based mental health solutions into the public mental health system through a highly innovative set or “suite” of mobile applications. These solutions are intended to reach large populations with digital mobile applications that put choice for care in the hands of individuals and deliver individualized, person-center care.

Aim: By creating a complementary and integrated set of proven mobile applications, participating counties aim to increase access to mental health care, promote early detection of mental health symptoms, and predict the onset of mental illness.

Innovation: This project represents a new approach and service modality for the overall mental health system, including prevention and early intervention. The innovation will provide diverse populations with free access to mobile applications designed to educate users on the signs and symptoms of mental illness, improve early identification of emotional/behavioral destabilization, connect individuals seeking help in real time, and increase user access to mental health services when needed.

Objectives:

- Detect and acknowledge mental health symptoms sooner
- Reduce stigma associated with mental illness by promoting mental optimization
- Increase access to the appropriate level of support and care
- Increase purpose, belonging, and social connectedness of individuals served
- Analyze and collect data to improve mental health needs assessment and service delivery

Intended beneficiaries/users of these technology-based mental health solutions include:

Individuals with sub-acute mental health symptom presentations, including those who may not recognize that they are experiencing symptoms.

Family members with either children or adults suffering from mental illness who are seeking support.

Socially isolated individuals, including older adults at risk of depression.

Clients or potential clients in outlying or rural areas who have difficulty accessing care due to transportation limitations.

Individuals at increased risk for or in the early stages of a psychotic disorder.

Existing mental health clients seeking additional support or seeking care/support in a non-traditional mental health setting.

Individuals identified as at risk for developing mental health symptoms or who are at risk for relapsing back into mental illness.

High utilizers of inpatient psychiatric facilities.

Initial Applications Offered by the Suite

- **Mindstrong:** Mindstrong provides a digital phenotyping, artificial intelligence (AI) enabled, telemedicine network for outpatient management of behavioral health disorders that reduces resource utilization, increases access and improves patient outcomes by diagnosing behavioral comorbidities early, detecting relapse early, and intervening early.
- **7 Cups:** 7 Cups is an on-demand emotional health and well-being service. It anonymously and securely connects real people to real listeners in via one-on-one text chat. Anyone who wants to talk about whatever is on their mind can quickly reach out to a trained, compassionate listener through their network. They have hundreds of listeners who come from all walks of life and have diverse experiences.

For more information and support to join the collaborative, please contact: Karin Kalk at kkalk@cibhs.org



THE SUITE

THE "APP" COMPONENTS

Peer Chat and Digital Therapeutics: Utilize technology-based mental health solutions designed to engage, educate, assess and intervene with individuals experiencing symptoms of mental illness.

Virtual Evidence-Based Therapy Utilizing an Avatar: Virtual manualized evidence-based interventions delivered via an avatar, such as mindfulness exercises, cognitive behavioral or dialectical behavior interventions delivered in a simple, intuitive fashion.

Digital Phenotyping Using Passive Data for Early Detection and Intervention: Utilize passive sensory data to engage, educate and suggest behavioral activation strategies to users.

THE UNIVERSAL COMPONENTS

Community Engagement and Outreach Engaging Users and Promoting Use: A strategic approach to access points that will expose individuals to the technology-based mental health solutions.

Outcome Evaluation: Outcome evaluations of all elements of the project, including measuring reach and clinical outcomes.

COLLABORATIVE APPROACH

CalMHSA will serve as fiscal intermediary to facilitate contracting with technology vendors, support a shared evaluation, and maximize outreach and marketing.

Principles and aims for collaboration are:

1. Create choice and a shared learning structure for participating counties.
2. Link the technologies to support a holistic treatment approach.
3. Capitalize on shared learning to advance the scope, coverage and effectiveness of the suite.
4. Involve end users, peers and stakeholders throughout the development and operationalizing of technologies.
5. Utilize data to evaluate impact and inform services/supports for individuals and populations.
6. Maintain accountability and transparency with all stakeholders.

EVALUATION MEASURES

Experts from the University of California, Irvine are leading the evaluation of the state and county-level impacts on:

- Access to care
- Clinical outcomes
- Self-reported purpose, belonging, and social connectedness
- Consumer's ability to identify cognitive, emotional and behavioral changes and act to address them
- Utilization rates
- Stigma associated with mental illness
- Comparative analyses of population level impacts (tech users vs non-users)
- Penetration or other unmet need metrics

About the Innovation

Over-Arching Goals & Learning Questions

The Technology Suite Collaborative is being developed to leverage MHSAs Innovation funds to advance and deploy digital therapeutic technology platforms that expand the capacity and capability of the county mental health systems to serve individuals with a wide array of mental health needs. While traditional mental health services will always play an important role in supporting individuals in need, their capacity is far too small for the overall need and so new solutions are needed.

As described in the project flyer, this collaborative has set out to achieve an array of high-level goals that project participants believe are within reach based on the unique capabilities of new and emerging technology platforms. These goals are:

- Recognize and acknowledge mental health symptoms sooner
- Reduce stigma associated with mental illness as reported by users
- Increase access to the appropriate level of care
- Increase purpose, belonging and social connectedness of individuals served
- Analyze and collect data from a variety of sources to improve mental health needs assessment and service delivery

There is much to be learned in the deployment of digital applications to achieve these transformative goals. In light of this, the collaborative seeks to gain robust knowledge associated with the following 'learning questions':

- Will individuals either at risk of or who are experiencing symptoms of mental illness use virtual peer chatting accessed through a website or through a phone application?
- Will individuals who have accessed virtual peer chatting services be compelled to engage in manualized virtual therapeutic interventions?
- Will the use of virtual peer chatting and peer-based interventions result in users reporting greater social connectedness, reduced symptoms and increases in well-being?
- What virtual strategies contribute most significantly to increasing an individual's capability and willingness to seek support?
- Can passive data from mobile devices accurately detect changes in mental status and effectively prompt behavioral change in users?
- How can digital data inform the need for mental health intervention and coordination of care?
- What are effective strategies to reduce time from detection of a mental health problem to linkage to treatment?
- Can we learn the most effective engagement and treatment strategies for patients from passive mobile device data to improve outcomes and reduce readmissions?
- Can mental health clinics effectively use early indicators of mental illness risk or of relapse to enhance clinical assessment and treatment?
- Is early intervention effective in reducing relapse, reducing resource utilization and improving outcomes and does it vary by demographic, ethnographic, condition, intervention strategy and delays in receiving intervention?



County Behavioral Health
Technology Collaborative

- Can online social engagement effectively mitigate the severity of mental health symptoms?
- What are the most effective strategies or approaches in promoting the use of virtual care and support applications and for which populations?

The learning associated with these shared questions will be deepened by the unique goals each county has designated based on their stakeholder guidance and local priority needs. The following describes some of the county-specific goals and desired learning this collaborative is driving:

Los Angeles: Los Angeles will be one of the main testing grounds for the Tech Suite, with its large population and user base. They also provide a large urban population to test the effects of the intervention, unlike the smaller counties. They share many basic goals as other counties, but have the added focuses of:

- Decreasing emergency service use by high utilizers
- Comparing service utilization across populations
- Tracking how the Suite affects the larger landscape of unmet need metrics of LADMH
- Exploring promotion strategies for different populations
- Culturally adapting the Suite and making it available in all threshold languages

Kern: As one of the two inaugural counties of the Tech Suites, Kern County seeks to inform the foundation needed to support a suite of applications and answer the many questions associated with a traditional mental health system's use of such innovative technology. Specifically, Kern County plans to inform how to:

- Collaborate with those providing services to older adults at risk for social isolation, including working with senior apartment complexes, senior centers, Kern County Aging and Adult Services and faith-based organizations who outreach to seniors
- Work with mental health organizations, including the local National Alliance for Mental Illness (NAMI), peer-based community learning centers and local support groups to promote use of technology-based services
- Work with local public locations, including agencies, libraries and other resources to promote technology-based service use
- Engage school systems, including colleges and universities, to promote use of services and supports

Mono: Data from this county will not only make results more robust, but will help adapt and customize the interventions for their specific target populations. They seek to gain knowledge about how to reach young adults and other isolated adults who are reluctant to seek traditional services, but whose needs may be met through these new technologies. Additionally, Mono will be using the results from this project to inform ongoing county PEI work.

Orange: Orange, similar to Los Angeles in terms of having a large user population, is exploring many basic research questions while also working to create cultural and linguistic translations of applications that match the diversity of county's population.

Modoc: Being a small, rural county, Modoc is focused on providing services and increasing utilization among socially and/or geographically isolated individuals, as well as those concerned with confidentiality in small, close-knit communities. They are also integrating the Tech Suite project into their other Innovation projects.

About the Innovation

Target Populations

As the inaugurating counties of the Tech Suite Collaborative, Los Angeles and Kern identified the following array of target populations for the project:

- Individuals with sub-clinical mental health symptom presentations, including those who may not recognize that they are experiencing symptoms
- Individuals identified as at risk for developing mental health symptoms or who are at risk for relapsing back into mental illness
- Socially isolated individuals, including older adults at risk of depression
- Clients or potential clients in the outlying or rural areas who have difficulty accessing care due to transportation limitations
- High utilizers of inpatient psychiatric facilities
- Existing mental health clients seeking additional sources of support or seeking care/support in a non-traditional mental health setting
- Family members with either children or adults suffering from mental illness who are seeking support
- Individuals at increased risk or in the early stages of a psychotic disorder

While these are the shared target populations of the collaborative, each participating county defines specific target populations based on guidance from stakeholders during the community planning process. As peers and stakeholders will continue to be involved in this project, each county's target populations will both grow in diversity as well as in specificity (e.g. subpopulations within larger segments). In this early stage of the project development, each county's target populations are noted below:

Los Angeles:

- Individuals with sub-clinical mental health symptom presentations, including those early in the course of a mental health condition who may not recognize that they are experiencing symptoms, including college students.
- Individuals identified as at risk for developing mental health symptoms or who are at risk for relapsing back into mental illness.
- Socially isolated individuals, including older adults at risk of depression.
- High utilizers of inpatient psychiatric facilities.
- Existing mental health clients seeking additional sources of support.
- Family members with either children or adults suffering from mental illness who are seeking support.
- Individuals at increased risk or in the early stages of a psychotic disorder.

Kern:

- Those with sub-clinical mental health symptom presentation, including those who may not recognize that they are in the early course of a mental health condition.
- Those at risk for mental illness or relapse of mental illness.



County Behavioral Health
Technology Collaborative

- Socially isolated individuals, including older adults.
- Those experiencing high frequency of inpatient psychiatric care.
- Current behavioral health clients in need of additional support.
- Family members of children and adults with mental illness in need of additional support.

Mono:

- Individuals in remote, isolated areas of the county who have less access to social support and mental health services.
- Students attending Cerro Coso Community College in Mammoth Lakes (TAY).

Modoc:

- Individuals in remote, isolated areas of the county who have less access to social support and mental health services
- Transition-aged youth with first-break psychosis.
- Transition-aged youth and adults, engaged in whole-health wellness plans, who desire to track passive data for personal wellness and treatment planning.

Orange:

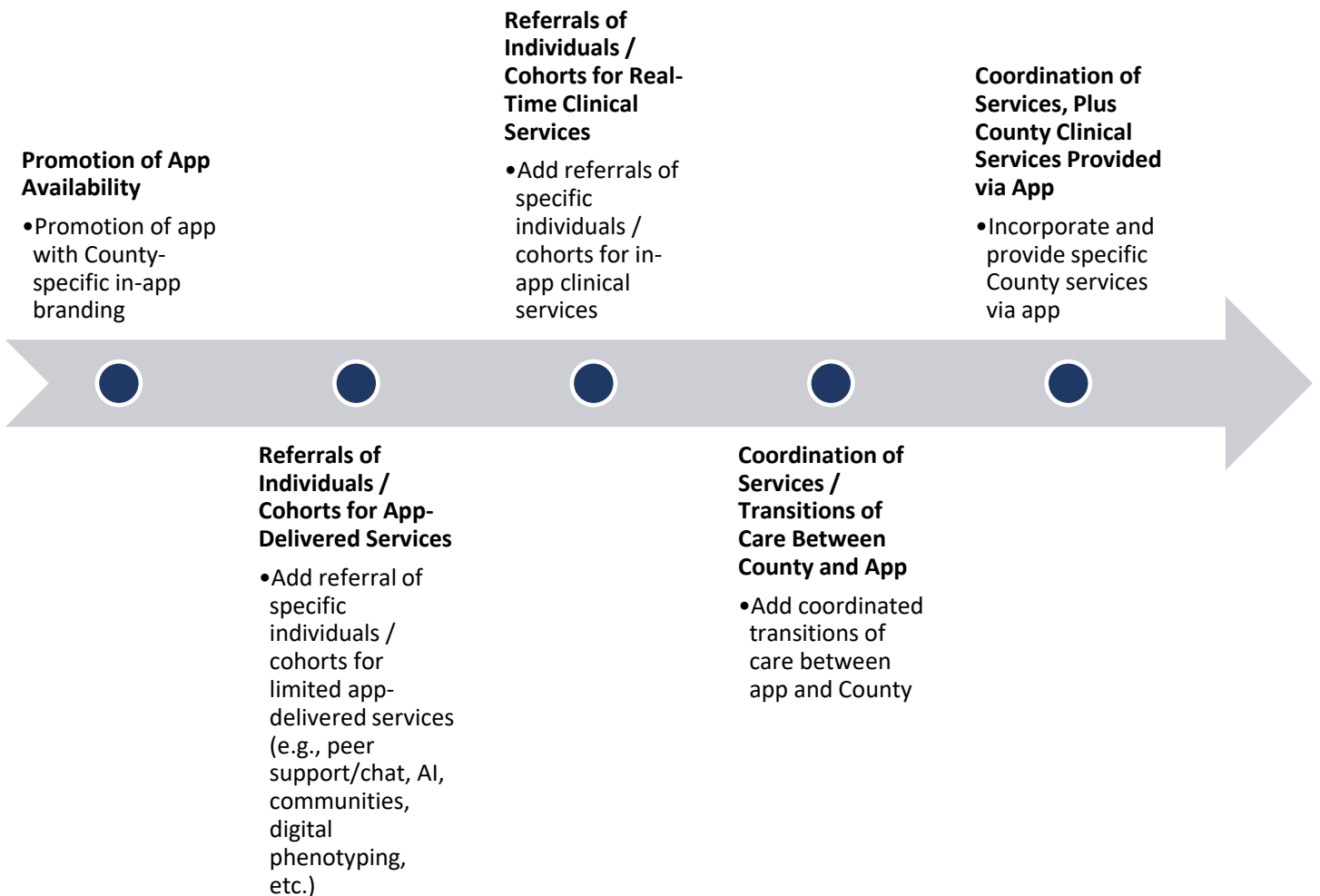
- Individuals with sub-acute mental health symptom presentations, including those who may not recognize that they are experiencing symptoms
- Family members of children or adults suffering from mental illness who are seeking support
- Socially isolated individuals, including older adults at risk of depression
- Clients or potential clients in outlying or rural areas who have difficulty accessing care due to transportation limitations
- Individuals at increased risk for or in the early stages of a psychotic disorder
- Existing mental health clients seeking additional support or seeking care/support in a nontraditional mental health setting
- Individuals identified as at risk of developing mental health symptoms or who are at risk for relapsing back into mental illness
- High utilizers of inpatient psychiatric facilities



About the Innovation

Clinical Integration Continuum – A Working Draft

The Clinical Integration Continuum (below) is a framing of the Tech Suite’s approach to service models in various levels of application integration within a County. It is intended to show a progression from limited integration (e.g., promotion of the application to Clients in the County) to full integration with County behavioral health services to support care coordination, transitions of care, and clinical services within the application. For each level of integration, the continuum also identifies the types of data to be shared and the essential privacy and security requirements. The particular service model and progression within the continuum will be determined by each County depending on their stated project goals, objectives, and capabilities.



Collaborative Approach: A Statewide Innovation Platform

The Tech Suite’s collaborative approach to the innovation creates a variety of opportunities and benefits for participating counties. Some of the most immediate benefits are:

- Increased choice for counties;
- Accelerated learning in this new modality for service delivery;
- Cost sharing for app acquisition, infrastructure and administration, and shared supports like evaluation and marketing; and
- Expanded innovation to meet the diversity of populations and needs within and across counties.

Choice: By design, the suite will create a “menu” of technology options or apps. Once pre-qualified by CalMHSA, app vendors remain on a list of available technology providers to participating counties. Over time, additional vendors can be qualified and added to the menu of technology options. As a result, counties joining, may elect to “purchase” the same array of apps as those who are part of the collaborative, or they may create their own package from the qualified vendors (including new vendors preferred and qualified through CalMHSA’s process.)

Shared Learning: To promote shared learning and manage the complement of participating counties, counties will be grouped into ‘cohorts’ based on the order of their MHSOAC approval timing. Cohort #1 consists of Kern, Los Angeles, Modoc, Mono and Orange Counties. Each cohort of counties will go through readiness and implementation together to allow learning from each other and to utilize vendor and expert supports as efficiently as possible. This will also allow newly formed cohorts to learn from those who preceded them. This spread of knowledge is expected to make app deployment increasingly simple, manageable and predictable.

Examples of current activities that advance implementation efforts while simultaneously sharing learning include:

- Weekly calls with county leaders and project leads;
- Weekly calls with county project leads;
- Weekly calls with each vendor and county project leads;
- Twice-monthly all vendor/all county calls;
- Periodic county-specific calls for specific topics (peer role, app customization, outreach, general readiness); and
- In person kick-off (May 11th)

Also, as each app vendor works with individual counties to customize their technology for the local needs, their knowledge and ability to support individual counties grows and becomes more efficient.

Finally, focused cross-county learning will also be facilitated in terms of large populations. Staff from counties with the same target populations will be organized into groups that will share their learning, successes and challenges with those populations. These groups will also work with app vendors to apply that shared learning to advance their apps’ effectiveness with these population segments.

Cost Sharing: Central to the intention of the collaborative method is cost sharing. This assists in several aspects of the project:

- Pooling funds for shared needs (procurement and contract administration, evaluation, outreach and marketing, and other technical expertise);
- Technology fees adjusted by size (making access to innovative apps affordable for small counties, among other benefits); and,
- Prevention of duplicate overhead and administration associated with local deployment of apps.

This collaborative and shared cost structure makes the development and conduct of technical infrastructure affordable for all participating counties. Each of the following functional areas are required to support deployment of mobile technology in a county and, through collaboration, does not need to be created in each county. By collaborating, cost-effective use of Innovation funds to gather the knowledge necessary to develop and maintain this functionality is possible.

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

Finally, the collaborative structure itself is a platform for innovation. As collaborative grows, so does the opportunity for innovation.

Collaborative Approach: A Statewide Innovation Platform

Driving Innovation

Innovation is possible when there exists an environment for learning and the resources (funding and talent) to act on that learning. Each instance a county joins the collaborative, both of these elements grow and there exists an opportunity to explore new possibilities and greater effectiveness for those served.

The counties in Cohort #1 are currently driving innovation on a variety of fronts, including the collaborative approach itself. However, counties seeking to join the collaborative have goals that represent additional innovative opportunities. These opportunities tend to fall into two categories: population segments and app functionality.

The following innovation areas will be come possible if the next cohort of counties is allowed to join the collaborative.

- Populations:
 - hearing impaired
 - criminal justice involved
 - older adults
 - foster youth
 - visually impaired
 - others we cannot predict!

- Capability
 - referrals
 - clinical services via mobile app
 - evidence based practices (e.g. Strengths Model)
 - others we cannot predict!

Collaborative Events

CalMHSA will periodically host in-person sessions to leverage the assets of collaboration.

Cohort #1 Kick-Off: One of these has already been held; on May 11, CalMHSA hosted Cohort #1's formal Kick-Off. This highly successful event was attended by over 100 staff, peers and stakeholders from Kern, Los Angeles, Modoc and Orange counties, statewide entities, as well as Tech Suite app vendors and experts.

Participants had the opportunity to see demonstrations of the initial apps, work in groups to understand how the apps can help specific target populations and identify issues to be addressed during readiness and implementation steps. See the next page for the agenda and specific objectives.



Learning Session #1: A similar event will be held in early October and will include teams from both cohorts #1 and #2. This two-day, in-person session will have the following objectives:

- Process and synthesize the learning to date to make it useful for all participating counties;
- Share Cohort #1 counties' learning with Cohort #2 counties;
- Support Cohort #2's readiness for launch;
- Support Cohort #1's expansion beyond the scope of initial soft launch;
- Convene population specific, cross-county groups to begin focused efforts to advance apps to better meet the needs of those populations; and
- Create an "innovation community" with a sense of its identity as a group leading a large scale change into the future.

Learning sessions such as the one target for October 2018 will be hosted every three to six months, depending on the needs of participants.



INNOVATION TECHNOLOGY SUITE KICK-OFF AND CLINICAL INTEGRATION PLANNING

Friday, May 11, 2018

9:00 – 4:00

Crowne Plaza Los Angeles Airport
5985 West Century Blvd, Los Angeles

ATTENDEES:

- Counties: LA, Kern, Mono, Orange, Modoc,
- County Representatives: Leadership, Clinical Leadership/Management, Peers, Social Media Managers
- Vendors: Mindstrong, 7 Cups, Outreach & Marketing Vendor
- Other: Intrepid Ascent, NorCal MHA, CalMHSA & CIBHS Key Staff

OBJECTIVES:

- Celebrate the Tech Suite start!
- Map applications to the continuum of care and begin planning for integration with existing clinical operations
- Plan approaches to end-user engagement to inform consent 'standards and guidelines' and readiness activities
- Begin to delineate role of peers (paid/local, volunteer/vendor) in engagement and clinical integration activities
- Inform approaches to county-specific social media strategies and methods

AGENDA

- 8:00 – 9:00** *Continental Breakfast*
- 9:00 – 9:15 Introductions & Meeting Objectives
- 9:15 – 10:00 Brief Visioning Activity & Ice-Breaker
- 10:00 – 10:15 Review of Preparation for the Soft Launch & Goals for the Day
- 10:15 – 10:45 Brief Demos by 7 Cups & Mindstrong
- 10:45 – 11:00** *Break*
- 11:00 – 12:15 Matching Apps to Need by Target Population (breakout groups)
- 12:15 – 1:15** *Lunch & Celebration*
- 1:15 – 1:45 Report Out on the Continuum of Care Mapping Results
- 1:45 – 3:00 Strategies for Engaging Target Populations (breakout groups)
- 3:00 – 3:15** *Break*
- 3:15 – 3:45 Report Out on Engagement Brainstorming Results
- 3:45 – 4:00 Wrap-Up

Implementation Phases

To manage the scope of county participation and maximize the benefit of the collaborative structure, counties will be supported in groups or “cohorts”. This is intended to facilitate both shared learning across counties within the same cohort, as well as transfer knowledge from early counties to those who join in a later phase. At this point, the first five counties (Kern, Los Angeles, Modoc, Mono and Orange) are in Cohort #1, at least 12 counties are preparing join Cohort #2 and at least seven more are looking to join in the future.

Phases: Learning to date has guided the organization of implementation into the following four phases, which Cohort #1 will apply and inform in order to improve on for future counties.

- Phase 1 - Develop the Business & Management Framework: This phase is focused on the planning and pre-work for a “soft launch” of the suite with the basics in place, including app and marketing material customization. The scope of outreach will be small and intended to allow for the shift into phase 2.
- Phase 2 - Deepen and Strengthen Clinical Integration for Wellness & Recovery: During this phase, counties will work to create linkage with their existing care processes, as appropriate, as well as support referral activity generated by app use.
- Phase 3 - Expand Marketing & Outreach: Once clinical linkages and associated data sharing is in place, the scope of the outreach and marketing will be expanded through a variety of means, including media campaigns, local outreach, etc.
- Phase 4 - Generate Sustainability & Continuous Improvement: Once outreach and marketing has reached nearly full scale, counties will shift into to assuring that capabilities developed to date can be sustained, that continuous quality improvement is part of day to day management of the applications and use of app-generated data is normed.

These phases are intended to allow the scope and complexity to grow gradually, with learning and problems solving to be sufficient to lay the ground for steady, methodical growth that assures desired results are achieved.

Phase 1 - Soft Launch: Specific readiness activities associated with Phase 1 include achieving:

- Vendor selection (through CalMHSA’s menu of apps)
- Initial county programs and target populations identified (per specific criteria for identification)
- Initial engagement strategies for each county program and/or target population delineated and ready (including role of peers)
- Initial customization of apps delineated and applied
- Program staff and peers trained and ready to support clients in use of initial apps (including clinical integration)
- Early phase of evaluation ready (related to scope of soft launch)

- Social media links and management ready
- Information security in place in each county and with each vendor
- Tracking processes ready to support daily monitoring of activities and identification of glitches, etc.

Implementation Example Tools

COUNTY:				
ITEM	PREP FOR SOFT LAUNCH	DESCRIPTION OF PLANNING OUTCOME / DECISIONS / PLANS	STATUS	TARGET DATE
1. County-specific project team	Recruit and convene representatives from: <ul style="list-style-type: none"> • Peer program • Clinical leadership/management • Social media team • Privacy/information security office 			
2. Initial county programs and target populations	Describe each target populations by: <ul style="list-style-type: none"> • Key demographics / identifiers • Need(s) to be addressed • Location(s) for engagement activities 			
3. Methodology for paid peers	Delineate approach to paid peers			
4. Initial engagement strategies for each target population delineated and ready	Develop method to outreach and engage each target population, including: <ul style="list-style-type: none"> • Role of peers, program staff, vendor staff, etc. • Materials needed to support outreach 			

COUNTY:				
ITEM	PREP FOR SOFT LAUNCH	DESCRIPTION OF PLANNING OUTCOME / DECISIONS / PLANS	STATUS	TARGET DATE
5. Initial customization of apps delineated and applied customization (continued)	<p>Work with vendors to customize their apps for county-specific needs / approaches / branding.</p> <p>Initiate planning with a “customization session” with each vendor.</p>			
6. Approach to clinical integration	<p>Work with vendors to determine approach for use of apps in care settings for each target population.</p> <p>Initiate planning with a ‘clinical integration session” with each vendor.</p>			
7. Early phase of evaluation ready	<p>Provide evaluator and vendors list of demographics for each target population.</p> <p>Provide evaluator list of desired outcomes to monitor for each target population,</p>			
8. Social media links and management are ready	<p>Create links to apps in county’s social media sites:</p> <ul style="list-style-type: none"> • Facebook • Instagram • Twitter 			

COUNTY:				
ITEM	PREP FOR SOFT LAUNCH	DESCRIPTION OF PLANNING OUTCOME / DECISIONS / PLANS	STATUS	TARGET DATE
9. Program staff and peers trained and ready to support clients in use of initial apps				
10. Information security in place in each county and with each vendor				
11. Tracking processes to support routine monitoring of activities, identification of glitches, etc.				
12. Communication strategy (internal and external, OAC)				
13. Simulations with various apps conducted and processes smoothed				

Cultural and Linguistic Adaptation

An important developmental pursuit of the Tech Suite will be the cultural and linguistic translation of our vendors apps for the diverse populations within California.

This translation work, to be conducted by the vendors, will be supported by RSE.

The RSE team, which includes Solsken PR (API Outreach Specialists), MSC Consulting (Latino Outreach Specialists) and CPEHN, share a common philosophy – that effective communication with California’s diverse populations begins with an acknowledgement that those from the community know best how to engage the community. Decades of experience have also demonstrated that even within a specific ethnicity, there will be differences based on geography and these differences must be embraced and honored. With this in mind, RSE and its team members have developed the following categories of cultural adaptation built on best practices.

1. **Language + Culture:** Cultural relevance moves beyond translation. Communities must be engaged very early on to explore historical trauma(s), where trust does or does not exist with other entities and challenges of daily life.
2. **Function + Form:** As communities develop trust and engage in the process, the RSE team recognizes not to assume the answer or solution. Rather, they embrace the fact that both the form and messaging of the campaign will evolve within each community.
3. **Community Engagement:** Sustained impact within a community is contingent on lasting relationships and trust. This is built through continued engagement throughout the campaign and materials development process to allow for input on draft documents, messages and campaign themes. Allowing for review and approval of all elements of the campaign builds ownership and greatly enhances the efficacy of their efforts.

The initial translations to be developed are Spanish and Vietnamese. Through this work, our app vendors and RSE will develop a collaborative process to assure the translations benefit from these processes and involve key constituents from each cultural group.

Peer Involvement

Peer Roles

Peers and future end users have been involved throughout the development of the Tech Suite. To date, they have participated in a variety of activities, which represents just the initial key roles and activities for peers in the Tech Suite:

- **Application Vendor Selection:**
 - Participation in vendor demo/presentations;
 - Experimentation/practice with pre-qualified apps; and
 - Providing feedback on potential apps to inform final selection.

- **Implementation:**
 - Local readiness overall;
 - Outreach and engagement strategies and networking;
 - Guidance on marketing messages and materials;
 - App design; and
 - Development of the Paid Peer role.

An early example of involvement in app design involves 7 cups, which is in need of a clinical assessment process that gathers the needed demographic information about end users per the MHSA Innovations regulations. As is described in the next section, 7 Cups is developing a Peer / End User Testing Group to guide improvements to the 7 Cups approaches, the first of which is this clinical assessment/data gathering capability. This initial testing process is supporting development of an effective design for data gathering while also creating the functionality to test future changes. Peer / end user informed change will be the norm for the Tech Suite and the pathway for it is being developed through this initial change area.

While engaging end users in early stages, the role of peers in the overall design and approach to the Tech Suite has been emerging. The learning to date has underscored the centrality of peers in every aspect of the suite. As such, peer roles are being developed in the following areas:

- **State Lead:** Assuming the collaborative expands in the coming months, the collaborative has budgeted to hire a full-time lead to support the role of peers throughout the project. If the collaborative does not expand, this will be a part-time role.
- **Local Lead:** Each county is assigning a lead peer to be part of the local project team, support the recruitment of Tech Suite Paid Peers, guide outreach to existing local peer network, and assure peer representation in all aspects of the Tech Suite and its development.
- **Tech Suite (Paid) Peers:** In conjunction with 7 Cups, each participating county will have paid peers to support the applications in their county.
- **Peers in the Local Network:** In each county, the Local Lead and Tech Suite Peers will reach out to the county's existing peer network to provide training on the apps, support these peers in their outreach and engagement of individuals they support, etc.

Below are initially identified roles and responsibilities for Tech Suite (Paid) Peers in association with the 7 Cups application. These have been developed through leadership from Sue Bergeson, a national leader in this area and now a member of the 7 Cups team, and with Cohort #1 counties. Counties included their locally appointed peer leads and peer representatives to develop these job duties; a preliminary list of these is provided below.

- Using their own lived experience perspective, the 7 Cups Peer Specialist (7CPS) will promote the Tech Suite apps to other consumers within clinics, provider organizations, drop in centers, advocacy organization meetings, during county events, at health fairs and in other places where consumers might gather. They will set up meetings, create and leverage opportunities to present to groups of consumers.
- Distribute information while persuading and engaging providers, consumer leaders and other who might connect with consumers to help promote the program and engage those consumers they serve in the Tech Suite programs.
- Provide training and education for groups of consumers to help them become comfortable with the software and the apps and reduce any fears or barriers to using the programs.
- Recruit “Super users” who love using 7 Cups and other Tech Suite apps and who are willing to volunteer to walk others through signing up and using the program, including problem solving around downloading the app and other simple tech issues. Deploy these volunteers through the 7 Cups platform to help individuals. Engage super users to teach and provide tech support at specific times and in specific locations.
- Recruit county active listeners who understand the culture, speak the languages and reflect the priority population including older adults, specific monolingual populations and college students.
- Recruit consumers who are interested in facilitating county discussion boards and facilitate online groups, especially with target populations.
- Provide specific outreach to targeted population based on specific assignments. This includes developing outreach strategies, events and being present where these populations gather, for example have a table at a church health fair, presenting information at a table during a street festival; talking to people at a food pantry.
- Solicit, categorize, track, and communicate user issues, questions, and feedback to support constant app improvement iterations.
- Identify gaps in 7 Cups listing of community resources, seek to fill gaps, add additional services that are meaningful to consumers and communicate changes in existing listing.
- Lead at least one facilitated chat specific to the county and one discussion board time slot specific to the county each week.



Peer & Underserved Cultural Community Groups User Testing

The 7 Cups community consists of millions of people. Many of these people have lived experience and have taken time and energy to help evolve 7 Cups. We listen very closely to our community because we believe it is essential to making a support system that people want to utilize and tell others about.

We will be expanding our user testing processes to incorporate a more formal peer user testing group comprised of peers across several counties. There will be different categories of peer groups that focus on specific product iterations. Broadly, the peer testing user process will work like this:

- 7 Cups team will create a beta version of a product or change to be tested.
- 7 Cups will email each peer in the peer user testing group and ask them to access this special version of the software.
- Peers in the user testing group will test the new product or enhancement.
- Peers will complete a form where they enter their name, role, county, and specific feedback on the new product change.
- 7 Cups team will collate the feedback, review, and make changes to the product.
- Peers in the user testing group will be asked to review again and make any additional comments.
- The new changes will be pushed to the live site.

In addition, 7 Cups will work closely with county Underserved Cultural Community Groups (UsCC) and will follow a similar process as outlined above. This process will start with Los Angeles. LA UsCCs include:

1. Deaf, Hard of Hearing, Blind, and Physical Disabilities
2. LGBTQI2-S
3. African/African American (AAA)
4. American Indian/Alaska Native
5. Asian Pacific Islander (API)
6. Eastern European/Middle Eastern
7. Latino

We will locate the peers by asking advocacy groups and peer run organizations in each county to nominate one or more people to serve in the testing groups. We will also seek nominations from organizations that focus on each of the seven underserved cultural community groups identified above.

Technology Procurement Selection Process

The following summarizes the steps conducted by CalMHSA to select the Suite's initial set of vendors. CalMHSA plans to conduct them at least annually to develop an evolving set of pre-qualified app vendors that result in a diverse menu of options available to participating counties.



Technology Procurement Budgeting & Pricing

Goals: The Tech Suite project budget model is designed to achieve a variety of interdependent goals representing a variety of perspectives. It is intended to serve as a planning tool and a methodology for supporting the array of transactions anticipated, as well as means to ensure the wise and fair use of each county's Innovation funds. These informing goals and perspectives are as follows:

Counties:

- Support counties' initial and ongoing budgeting for proposal development, future expansion, etc.
- Offer a fair fee structure that prorates for county size and resources.
- Create a cost sharing approach that supports "statewideness".
- Licensure at the county-level to allow participating county full access to selected vendor apps for as broad a scope of use as desired.
- Use of Innovation funds for unique county needs.

Vendors:

- Provide a formula-driven contract that flexes as counties join for different durations, scopes (e.g. array of vendors selected), etc.
- Allow easy means to calculate fees for invoicing as the collaborative grows and changes.
- Provide three categories of fees to vendors: start-up, ongoing development, and licensure.

CalMHSA:

- Minimize the volume of contracting with vendors (e.g. avoid having to amend a vendor's contract every time a new county joins).
- Easily process/adjudicate quarterly invoices from contractors as counties join the project.
- Create a means to link OAC-approved budgets and the Participation Agreement budgets with a clear fee schedule based on preferred array of technology.

The Future:

- Create a reserve to allow future technologies to be added to the suite.

Structure: The structure of the budget and budget planning tool incorporates the following categories of expenses and rationale for county-specific proration.

- Overhead: CalMHSA Overhead (5%) to cover the costs of collaborative activities, administration, expert team travel, site visits, etc.
- Direct Expenses: Direct expenses will be incurred in three areas:
 - Experts: To build the project's collaborative and integrated functionality, the following expertise will be hired/contracted:
 - Project Management: A full-time project manager to support the design, development and operation of this Innovation collaborative.
 - Start-Up Guidance: In the initial start-up phase, experts will be brought in to guide early planning and decision-making. These experts will assist in, peer engagement within

individual counties, evaluation design, legal issues for critical topics like privacy/security safeguards, intellectual property rights, etc., and recruitment of long-term expert staff and/or contractors.

- Peer / End User Expert: A lead peer/end-user expert will be recruited to work on a full-time basis to support state and county-level involvement of individuals with lived-experience. Activities will include supporting existing peers to support individual use of apps, development of local “super users”, and gather end-user feedback on improvements/advancements desired in the technology. This expert will also guide vendors in use of paid peers in each county’s local preferences.
- App/Technology Expert: An expert in health and well-being apps will be recruited to assist individual counties and the collaborative as a whole in the deployment of selected apps, as well as the specification of desired customization and additions to those apps. This expert will work with vendors to assure apps are effectively maintained as well as advanced per collaborative participant needs and goals.
- Informaticist: A behavioral health informaticist will be recruited to work in two critical areas: evaluation oversight and real-time performance monitoring. In terms of the evaluation, this informaticist will assure each vendor is appropriately engaged in the formal evaluation and the evaluation is informing the learning objectives, etc. A substantial role will be assisting each county with the regular use of data generated by the various vendors. This will include effective use of clinical data for individuals as well as targeted populations. Finally, this individual will use this data to monitor overall performance of the suite to guide the continuous improvement process.
- o Each Vendor: The cost structure planned for individual vendors will be based on the following categories of fees:
 - Start-Up Fee (year 1 only): To cover planning, customization and implementation
 - Development Fund: To cover future advancements in technology (“not to exceed”)
 - Licensure/Annual Fees: Each county pays a single licensing fee to use app(s) (for either a quarter or a year - TBD); when selecting a vendor, the county receives all apps in that vendor's platform to be used as much or as little as desired.
 - Customization: Each county may elect to purchase additional customization of the vendor apps, in terms of functionality, target populations and other changes relevant to their Innovation plan.
- o County-Specific, Local Costs: To be determined by each county for paid peers, local supports, etc.

Cost Sharing: The approach to cost sharing and payment to vendors is based on a simple formula which will assure fair and appropriate contribution by each participating county. This formula is:

$$\text{Vendor-Specific Fee Variable} \times \text{County-Specific Relative Size Unit (RSU)} = \text{Fee to Vendor per County}$$

- Relative Size Unit: Each county is assigned a relative size Unit (RSU) based on the MHSA allocation schedule published in DHCS Notice 17-041 (September 17, 2017). The RSU is calculated by dividing a county’s assigned allocation percentage in the MHSA scale and by the statewide median percentage.

Technology Procurement Contract Administration

CalMHSA Participation Agreement(s) with a County: Once a county obtains MHSOAC approval of their Innovation plan, the county has the option to join/participate in CalMHSA's Innovation Tech Suite Program. If the county elects this approach, they work with the CalMHSA JPA Administrative Manager to commence the process of seeking approval from their Board of Supervisors via a Participation Agreement. Key aspects to development and execution of these agreements are described below:

- **Participation Agreement** – In collaboration with key program staff from the county, the JPA Admin Manager will draft a Participation Agreement based on the county's MHSOAC approved Innovation Plan.
- **County Department(s) and Board of Supervisors (BOS) Approval** - Once developed, the plan is vetted internally with the county (legal counsel, finance, auditor and contracts) departments until the agreement terms have been mutually agreed upon by both the County and CalMHSA. Once mutual agreement is reached, it is scheduled to be presented to the Board of Supervisors. Upon BOS approval, the county may proceed in program participation and receive services.
- **Content of Participation Agreement** – The agreement consists of three sections: Program Description, General Terms and Conditions, County-Specific Scope and Funding.
 - **Program Description:** Describes the Innovation Tech Suite which includes the various technology based applications, marketing and outreach and evaluation.
 - **General Terms and Conditions:** Defines the responsibilities of each party (CalMHSA and County), duration and term, withdrawal/termination, fiscal provisions and indemnifying language.
 - **County Specific Scope and Funding:** This section clearly defines which components from the Innovation Tech Suite they wish to participate in, for how long, the target population, and the fiscal commitment (total funding, followed by a breakdown per fiscal year).

Vendor Contracting: Given the complexity of the project's collaborative approach, the vendor agreements are extensive. Through these agreements, CalMHSA represents its members and has a fiduciary responsibility to the California State Department of Mental Health, CalMHSA members, and the public to ensure funds are used appropriately and all shared data/information is secure and protected.

- **Content of Vendor Agreements:** The CalMHSA-app vendor agreement is extensive and includes the following 15 Exhibits: General Terms and Conditions, Statement of Work, County Work Order Template, Fees, Functional and Technical Requirements, Services Levels and Performance Standards, Maintenance and Support, CalMHSA's Administration, Contractor's Administration, Business Associates Agreement, Information Security and Privacy Requirements, Additional Terms, Terms of Use, Escrow Agreement and Work Order form.



- **Statement of Work (Exhibit B):** Will be tailored for each specific vendor with some language remaining applicable to all vendors.
 - **Fees (Exhibit D):** A fee schedule has been developed for each vendor, which specifically defines the billable fee amounts per county based on a formula that include county size, and population amongst other criteria.
 - **Work Order (Exhibit O):** This form clearly defines the scope of work, target populations, etc. for each county participating in the program. This provides clear direction to the vendors for work to be performed at each location. See example template at the end of this summary.
- **Vendor Negotiations:** CalMHSA meets with each vendor and presents the agreement to include an Exhibit O (Work Order) for each participating county. Once the parties come to mutual agreement on final terms, the vendor will commence work immediately.

Contract Management: Vendors are required to provide regular reporting to CalMHSA and counties, including monthly, quarterly and annual reporting. Given the ever-changing nature of innovative technology, these reporting requirements are important as they will ensure services are being provided as requested and needed by the participating counties.

As part of contract management, CalMHSA will ensure vendors are continuously maintaining all necessary licenses, security measures and insurance requirements. Noncompliance of these requirements could impact payments to the vendor and/or termination of the contract.

Budget Management, Invoicing and Payments: Given CalMHSA's extensive background with contract management, processes are in place that will allow for ease of tracking and issuing payments. These include:

- **Budget Management:** CalMHSA has been monitoring the overall budget and will continue to do as follows:
 - Track funds committed, received and spent by county.
 - Track funds by county by reversion year, to ensure funds subject to reversion are spent first.
 - The above steps will allow CalMHSA to easily develop annual reports of expenditures for each county, as required by the state.
- **Invoicing:** Vendors will be required to submit quarterly invoices based on the number of counties being serviced and fee schedule.
 - CalMHSA will be reviewing invoices as they are submitted for accuracy.
 - CalMHSA's program staff, project manager and accounting team will meet regularly to discuss any issues that may arise with a given vendor.
- **Payments:** Payments will be made within 30 days of receipt of invoice unless issues are encountered, at which time they will be addressed prior to issuing payment.

County Work Order Template

County			
Project Summary <i>[Summary of the project explaining services, timeline, where Services will be performed, and other general requirements.]</i>			
County Goals and Objectives <i>[Specific goals and objectives, including learning lessons, as outlined in the County's OAC proposal.]</i>			
Funding Timeframe <i>[Commencement and termination dates for this Work Order.]</i>	Start Date	End Date	Total # of Months
Detail of Services Required <i>[Describe Services to be completed by Vendors, including requested apps and applicable fees:</i>			
<i>(1) Start-up – initial County customization</i>			
<i>(2) Development</i>			
<i>(3) Licensure</i>			
<i>(4) Customization – additional county-specific application development and/or services]</i>			
<i>(5) Networking and Collaboration</i>			
<i>(6) Contract Management</i>			



Tasks			
<i>[Tasks necessary to support the project, including (a) a description of all subtasks and deliverables; (b) scheduled beginning and end dates; and (c) reporting timeframe and frequency].</i>			
	<u>Description of all Subtasks and Deliverables</u>	<u>Beginning and End Dates</u>	<u>Reporting Frequency</u>
Deliverable No. 1:			Upon completion of start-up phase
Start-Up			
Deliverable No. 2:			Quarterly
Development			
Deliverable No. 3: Licensure			Quarterly
Deliverable No. 4:			Quarterly
Customization			
Deliverable No. 5: Networking and Collaboration			Quarterly
Deliverable No. 6: Contract Management			
6.1	Participation in regular and ongoing contract management meetings as determined with Contract Manager.		Quarterly
6.2	Submit Quarterly Status of Deliverables Reports to CalMHSA.		Quarterly
6.3	Submit additional program/activity reports and data as determined by CalMHSA.		As requested
6.4	Submit Annual Report to CalMHSA at the end of each year addressing the following:		
(a)	Describe the accomplishments of each deliverable within the contract.		Annually
(b)	Describe the external resources that were leveraged to complete activities.		Annually

Technology Procurement

Initial Vendors: 7 Cups and Mindstrong

The Tech Suite has selected two initial digital technologies; these are:

- **Mindstrong:** Mindstrong provides a digital phenotyping, artificial intelligence (AI) enabled, telemedicine network for outpatient management of behavioral health disorders that reduces resource utilization, increases access and improves patient outcomes by diagnosing behavioral comorbidities early, detecting relapse early, and intervening early.

Website: <https://mindstronghealth.com/>

- **7 Cups:** 7 Cups is an on-demand emotional health and well-being service. It utilizes anonymous bridging technology to securely connect real people to real listeners in one-on-one chat. Anyone who wants to talk about whatever is on their mind can quickly reach out to a trained, compassionate listener through their network. They have hundreds of listeners who come from all walks of life and have diverse experiences.

Website: <https://www.7cups.com/>

Brief video: <https://www.7cups.com/demo/member/>

Sections 6 and 7 have the following information for 7 Cups and Mindstrong, respectively:

- Overview of their organization;
- Descriptions of their applications;
- Evidence basis for their applications;
- Frequently Asked Questions about their applications;
- A Glossary of Terms related to their applications.

See the Outreach and Marketing section for initial descriptions of their applications.



History

7 Cups started at a kitchen table. The founder, a licensed psychologist, was talking to his wife, a therapist, about a problem. She listened to him and he immediately felt better. He asked himself, "What do people do when they don't have a therapist for a partner?" It occurred to him that everyone should have access to a great listener.

He started with an ambitious vision: to build the emotional support system for the Internet. Anyone should be able to open an app or go online to share what is on their mind. 7 Cups was born and launched in June 2013 through the support of Y Combinator (YC), the startup accelerator behind massively successful companies like Dropbox and AirBnB. The person that created Gmail and the Facebook feed, Paul Buchheit, was the YC partner that focused on 7 Cups.

7 Cups is now helping millions of people a month. Early on they had a small, dedicated team of 20 listeners. Now they have over 260,000 listeners providing support in 140 languages across 189 countries. The site was very basic to start, but now has robust training, growth paths, sub-communities, licensed professionals, and iPhone and Android apps. Additionally, 7 Cups has won the Stanford MedX Award for Health System Innovation and serves dozens of organizations like MIT and Harvard.

7 Cups has the infrastructure, the technology, and the know-how to expand its reach to include entire counties as it presently reaches 1-3% of the population in any given region. Today's adults and teenagers, beset with ever-increasing levels of stress, are struggling to thrive more than ever. Fortunately, 7 Cups is an ideal source of emotional support, as more and more of our society looks online for emotional wellness options. Health systems can easily integrate 7 Cups' member support system into their already existing systems, thereby encouraging a culture of awareness and support across the membership body. By increasing emotional support and referring people in need of enhanced care to mental health services, 7 Cups can help increase access and reduce costs.

7 Cups is well on its way to realizing its ambitious starting vision. The team at 7 Cups firmly believes in collaboration and wants to help you further support your members so that they can thrive right along with you.

Founder

Glen Moriarty is the founder and CEO of 7 Cups, a web and mobile peer to peer emotional support platform. He is a psychologist passionate about the Internet's power to help people lead better lives. He has been involved in a number of services and organizations that support people in need. 7 Cups of Tea is his most recent endeavor, marrying his background in psychology with his love for technology.

Advisory Board

Tom Insel

Chair of Advisory Board

Amy Kennedy

Education Director for the Kennedy Forum

Linda Rosenberg

CEO of National Council

Ken Duckworth

CMO of NAMI, Harvard, BC/BS Head of Behavioral Health

Henry Harbin

Former CEO of Magellan

Values

Your work saves lives

Work with purpose, step up to help others.

Grow through the path of problems

Face problems head on to continually develop, solve the most critical ones in the way.

High expectations and high warmth

Deliver quality work supported through learning, safety, and candor.

Accountability

Own your work and hold others to theirs, speak up and act.

Grit

Drive yourself, mental agility to push past barriers.

Believe in equality

Value equally everyone's background, work, and ideas; collaborate across teams and levels.

Have fun and keep full

Enjoy the experience, take care of yourself in order to give back.

Mission

7 Cups is for anyone who wants to live in a world where the human experience is free from stigma and stereotypes and rich with love and support. A world where all 7 billion of us can grow and feel like we truly belong.

We believe that each one of us is inherently valuable. We do not measure people based on where they are from, what they look like, or what position they hold. We recognize that people make sense in the larger story of their lives. We understand that people are complicated and that life is not simple or easy.

We are all on the same path. Some of us are just starting out. Others are further down the road. No matter where we are, being kind, compassionate, and accepting of one another enables us all to grow.

We do not tolerate people being mean, harmful, or rejecting of others. We do not judge or look down on people.

Although there are forces that tend to disempower and create division, we stand together as we compassionately care for and champion one another. We see our differences as a strength. We are united in our shared goal of creating a place where all can find acceptance and be welcomed to a home where we all belong.



7Cups.com



7 CUPS in California

7 Cups is an on-demand emotional health and well-being service. Our bridging technology anonymously and securely connects real people to real listeners in one-on-one chat.

7 CUPS AT A GLANCE



7 CUPS BY THE NUMBERS

58,270,696 messages sent

2,041,724 people helped*

20,846 listeners

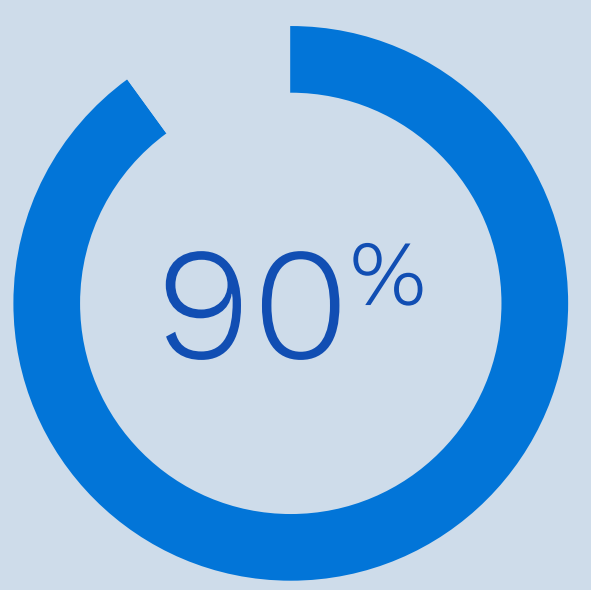
* since 2014

used in
58 Counties

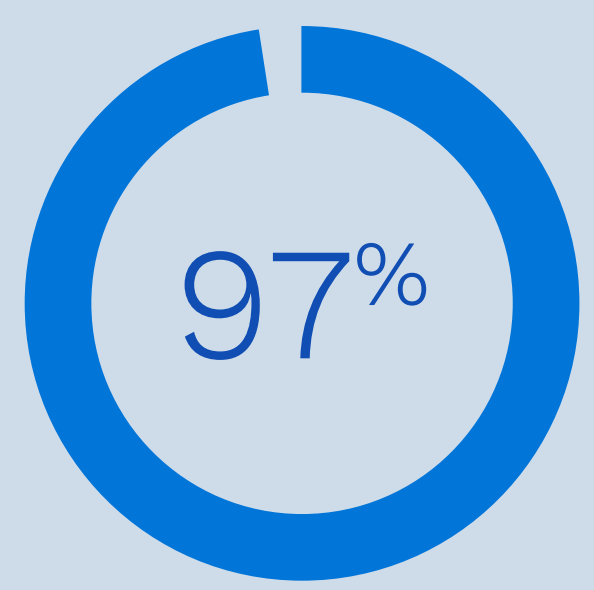


county with the largest number of people helped
LA 413,555

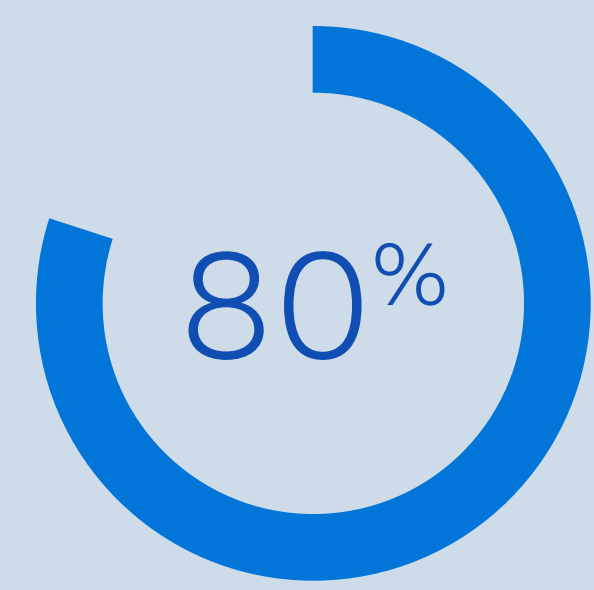
7 Cups makes a positive impact in people's lives



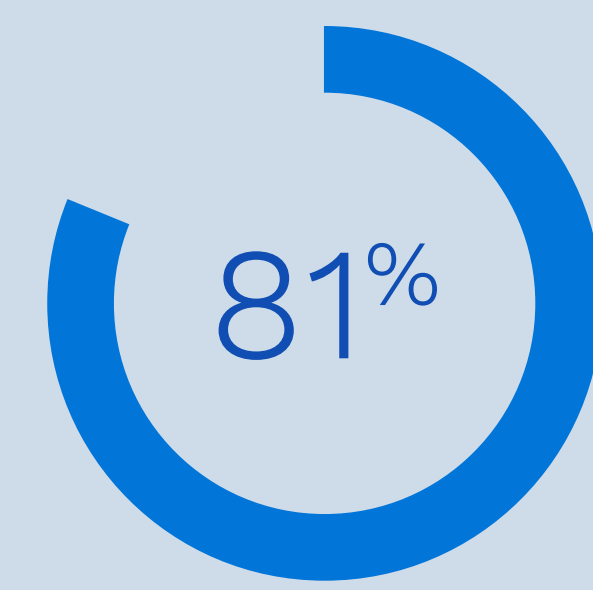
90%
people feel better after talking to listeners



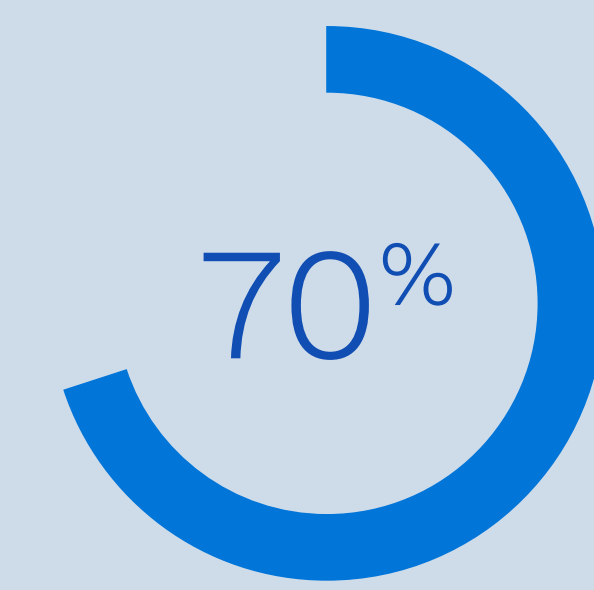
97%
people view their listener positively



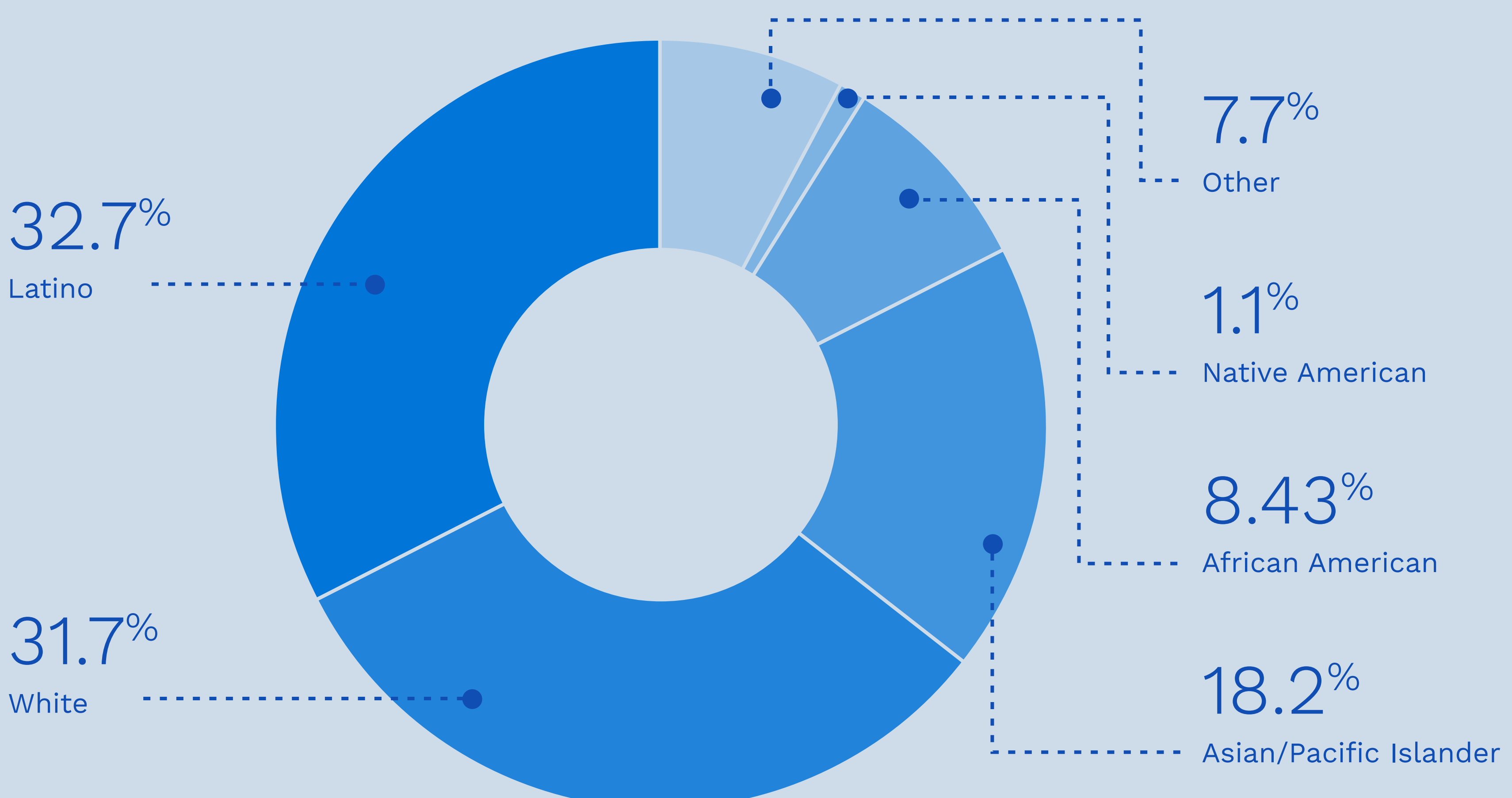
80%
people believe listeners can help people with mental health issues



81%
users consider 7 Cups as a helpful service



70%
people feel support provided by 7 Cups listeners is just as or more helpful than that provided by psychotherapy



Find the 7 Cups research here:
<https://www.7cups.com/about/research-stats.php>

F.A.Q.

What is 7 Cups of Tea?

7 Cups of Tea is an online emotional support service. Through a secure, anonymous bridging technology, we connect those in need of emotional support with our network of Active Listeners, individuals from all walks of life who want to provide compassionate care. Connections to Listeners are private, one-on-one conversations initiated on demand.

What is Active Listening?

Active Listening is a set of communication skills that demonstrate empathy, compassion, understanding, and respect. Active Listening is different from the normal listening we do in our everyday conversations. Instead of just “waiting to talk” or thinking about what we’re going to say once our conversation partner stops speaking, active listening requires that the listener completely focus on absorbing, comprehending, and reflecting what the speaker is saying.

Active listening is a great technique to help people feel better when they are going through hard times, dealing with loss, struggling with health issues, or just need to vent. Because active listening directs all focus towards the speaker, it removes potential sources of stress, conflict and discomfort that can happen in a regular conversation.

How does 7 Cups of Tea connect Active Listeners with people in need of support?

Since all connections are on demand, our service is run like a marketplace. When an individual reaches out to connect, we notify our available Listeners that a request has come in. The first Listener to respond can then begin a conversation with the individual in need of support. If an individual wants to connect to a specific Listener, they can request a direct connection by visiting that Listener’s profile.

Is 7 Cups of Tea really anonymous?

Yes. 7 Cups of Tea is really anonymous. Listeners only know what is disclosed to them by the person they are helping. Contact information is kept strictly confidential.

Do Active Listeners receive training?

Yes. Listeners are required to complete an online course which helps develop Active Listening skills. The course also goes over certain scenarios in which a Listener may need to refer the person with whom they are speaking to a professional licensed therapist, counselor, or emergency contact. While many of our Active Listeners happen to be licensed professional counselors and therapists, they do not give medical or psychological advice during conversations.

Can I become a listener?

We'd love to have you! Anyone can sign up to become an Active Listener. All Listeners must successfully complete our online course, which includes a mock chat. [Sign up here to begin!](#)

What's the story behind 7 Cups of Tea?

It's pretty simple. The founder, Glen, was sitting at his kitchen table talking to his wife about a problem he was having. Her close listening made him feel a lot better, and it occurred to him that he was incredibly lucky. For one, he is married to a Licensed Counselor. Furthermore, she was available when he needed to talk. Glen realized that many people do not have this same opportunity.

Not everyone has a friend or family member to talk to at all times, nor do they always feel comfortable doing so if they can. The only other real option is therapy, but that can be expensive and carries an unfortunate stigma, plus it involves scheduling. Glen envisioned 7 Cups of Tea as a third space to fill the gap in between the two current options.

Where does the name "7 Cups of Tea" come from?

7 Cups of Tea is actually the name of a famous Chinese poem. The suggestion is that each cup provides a different level of healing. It's important that our community feels that 7 Cups of Tea is a place where you can sit down and have several cups of tea with a friend. It isn't just a one-time meeting. You can touch base as much as you like.

7 Cups of Tea, by Lu Tong (795 - 835 CE)

The first cup kisses away my thirst,
and my loneliness is quelled by the second.
The third gives insight worthy of ancient scrolls,

and the fourth exiles my troubles.
My body becomes lighter with the fifth,
and the sixth sends word from immortals.
But the seventh—oh the seventh cup—
if I drink you, a wind will hurry my wings
toward the sacred island.
Translated by Christopher Nelson

How does 7 Cups of Tea ensure that listeners are high quality?

Our application to become a listener includes many steps. Listeners must complete the Active Listening Training Course and receive a perfect score on the accompanying quiz. Additionally, every listener is reviewed and may be subject to a background check to ensure they are friendly, considerate, and competent. Anyone can see how well a listener is doing simply by looking at their reviews' cumulative score, and by checking out the badges that they have earned.

How do I contact 7 Cups for subscription support?

For any billing issues, contact billing@7cups.com or (844) 755-8757

7 CUPS

Research-Backed, Evidence-Based Online Emotional Support



Four peer-reviewed publications support the efficacy of 7 Cups for a broad spectrum of mental health populations including perinatal mood disorders, postpartum depression, anxiety, and schizophrenia spectrum disorders



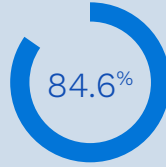
7 Cups demonstrates real clinical outcomes including a mean score reduction of approximately 2.5pts on each of the depression, anxiety and stress subscale of the Depression Anxiety Stress Scales (DASS) for our members experiencing the most emotional distress (members in the 10th percentile severity group)



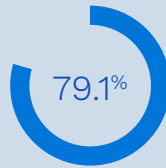
7 Cups listeners reach similar therapeutic alliance levels in 19-minute message-based conversations as licensed therapists in face-to-face settings



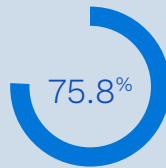
100% of research participants would recommend 7 Cups to people who suffer from perinatal mood disorder



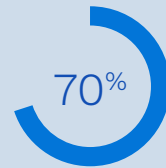
84.6% of participants indicated that the listener is a good supporter



79.1% of participants indicated that they would like to chat with the listener again



75.8% of participants indicated that they feel much better after chatting with a listener



70% of research participants rate support from volunteer listeners on 7 Cups as equally, or more, effective than traditional psychotherapy

On a scale of 0 to 100, after chatting with a listener, 7 Cups users rated:

85 Feeling heard and understood by the listeners

84 Being able to talk about what they wanted

81 Being satisfied with the listener's approach

77 Overall rating of the session

44

The 7 Cups platform includes 32 evidence-based therapy protocols based on the best empirically validated treatment techniques to reduce symptoms in clinical studies

CBT

Cognitive-behavioral therapy

MBCT

Mindfulness-based cognitive therapy

DBT

Dialectic behavioral therapy

ACT

Acceptance and Commitment therapy



7 Cups administers three different empirical diagnostics:

- > DASS
- > PHQ-9
- > GAD-7



7 Cups offers a continuing education program of 50 topic-specific trainings for listeners based on microcounseling skills



The Wellness Engagement Engine - the core of the 7 Cups platform - is built on Prochaska and DiClemente's (1983) stage of change model to pace movement toward wellness based on predictable tasks necessary within each stage



7 Cups has been recognized with the Stanford MedX Prize for Health System Innovation

We have strategic research partnerships with organizations at the intersection of clinical psychology, computer science, and computational linguistics, including:

- ✓ University of Oregon Center for Digital Mental Health
- ✓ Harvard Medical School
- ✓ Harvard School of Global Health and Social Medicine
- ✓ Qntfy

We are actively pursuing research on our platform with experts in the following areas:



Psychological aspects of natural language use



Digital phenotyping, i.e., passively collecting behavioral data via monitoring naturalistic language and smartphones/wearable usage



Mental health analysis via natural language processing (e.g. language markers of depression, anxiety online)



Mobile social support in college students with depression and anxiety



Effectiveness of novel treatment strategies to improve access to mental health care for adult and adolescent populations



Chatbot/ Avatar perceptions and efficacy in providing emotional support



Adolescent emotional development



Neuropsychology of mental illness

7 Cups Glossary

for California Counties Tech Suite Initiative

User Types

Term	Definition
Guest	someone exploring the site who has not made or signed into an account yet
Member	a person coming to seek help/support on 7 Cups (loosely synonymous with client) who has signed up for an account
User	any participant on 7 Cups - could be a member, a listener, or a therapist
Listener	aa volunteer support provider on 7 Cups, trained in active listening. Can be thought of as a peer counselor
Therapist	a licensed, professional therapist who provides online therapy via text on 7 Cups
Moderator (or “Mod”)	a member or listener designated as having a special role in supporting the community, and having powers to enforce rules.
Community Mentor	someone who combines leading discussions with moderating forums in a subcommunity
Community Mentor Leader	someone responsible for overseeing a subcommunity
Ambassador	the highest level of leadership role in the community
Verified Listener	a listener who has met an experience requirement and has been recommended by a more experienced listener following a mock chat is granted a Verified Listener badge that enables them to show up in filtered searches for more experienced listeners
Admin	a user term for staff members or high level volunteers who can solve problems
Noni	A chatbot that engages in limited conversation with guests and members who are waiting in the general request queue, and that can also take part

in 1-to-1 chats, guide users through scripted interventions, or lead a chatroom discussion.

Noni is usually referred to as she or her, as if female.

She uses artificial intelligence and machine learning to offer empathy and support, based upon outcome-driven data. (In the tech suite specifications, she would be called an “avatar”).

Noni can also offer to send users reminders and will check in with them from time to time unless asked not to

Features

Term	Definition
Forum	an online written discussion where individuals can anonymously post questions or comments, and others can respond. All responses are published to be viewed by others
Thread	a discussion about a particular topic in a forum.
Chat	a system that connects people so that they may send messages to each other with very little delay, so that the effect is quite like a real life conversation
Chatroom	a system that connects multiple people to chat with each other at the same time. 7 Cups contains many chatrooms, each of them intended for particular topics or groups of participants.
Group support	a chatroom-based place for a group of people to connect over shared experience.
Discussion	A scheduled and often somewhat formal session in a chatroom, led by one or more designated people and with a focus on a particular topic. Also, a discussion in a forum.
1-on-1	A conversation, held via text/chat between two users. At least one of the people in a 1-to-1 chat must be a listener, a therapist, or a bot, because and members cannot chat 1-to-1 with other members on 7 Cups.
PM	“Private message”. This is a message sent directly from one user to another, and cannot be seen by anyone else.

Community	The area on 7 Cups that contains all group interactions, such as forums and chatrooms. It is where users can connect with one another. This also includes Q&A and wiki sections. Sometimes referred to as <i>the</i> community as opposed to any one particular (sub-)community.
Subcommunity	An issue specific community where one can find relevant resources, such as specialized listeners, chatrooms, and forums. Also sometimes referred to as a community.
Feed	A sequence of posts, which are personal statements by the owner of the feed. Members, listeners and therapists can have feeds. This is similar to a Facebook feed, where a user's feed will display posts made by anyone they are following.
Repost	To copy a post from a feed into your own feed, which brings it to the attention of people who follow your feed.
Follow	A way to read all the future posts in someone's feed. The posts of all the people you follow appear in your own feed.
Upvote	A sign of approval for a post in a forum thread.
@-sign, or "@ mention"	In a feed post or forum post, a prefix that turns the name of a member, listener or therapist into a tag (sometimes called tagging or mentioning someone).. For example, @Boris tags the account named Boris. The account tagged will receive a notification containing a link to the feed or thread.
Growth Path	a series of interactive written or video exercises, based on evidence-based protocols. You can think of each as a self-help treatment plan. 7 Cups currently has growth paths on 32 different mental health topics, but new ones can be developed at any time.
General Request	when a help seeker submits a request to be connected to any available listener
Personal Request	when a help seeker submits a request to be connected to a specific listener
EARS	"Effortless Assessment of Risk States". This is a separate app by which passive data is collected for the purpose of providing users with additional information about their behavior and symptoms.

Bot/Chatbot	A computer program that behaves in some way like a person. The only bots on 7 Cups are Noni and Sophia (the therapy intake bot). (Originally short for robot.)
AMA	Ask Me Anything” A forum thread in which someone invites questions and answers them.
Status	An indicator that shows whether an account is online, offline or (only for listeners) busy.
Offline	A status setting indicating that a listener is not necessarily available to respond to messages. Listeners who are logged in can respond while offline at their discretion, but they are not required to. For members, it indicates that the person is logged out.
Online	A status setting indicating that a listener is active on 7 Cups and available for new chats. For guests, members and therapists it indicates that the account is logged in.
Onboarding	The process of welcoming people “on board” 7 Cups, or the parts of the website designed to introduce new members. (The current 7 Cups onboarding design is codenamed “Campfire.”)
Wiki	Part of the website containing a linked library of articles maintained by the community
My Impact -	A private page giving information about a listener’s activity on 7 Cups (as opposed to the public information in the listener’s profile).
My Progress	a private page given a member details about their ongoing progress.

Moderation & Reputation

Term	Definition
Badge	A displayed award, earned through the 7 Cups reputation system - such as by gathering hearts and cheers (see below), and engaging in other useful ways on the site. A badge usually unlocks various privileges within the site. It can also be used to group users of a certain type together--for instance, all NAMI listeners will have taken the NAMI training, and earned the NAMI badge
Hearts	There are little heart icons next to all messages on 7 Cups. If a user feels that something said by another user (in a chatroom, forum, or 1:1

messaging) was particularly helpful or empathetic, the user can click on the heart icon, giving the other user a point toward earning badges and improved reputation. It is also just another way of showing support and appreciation.

Cheer	A point awarded for activity on 7 Cups. Cheers accumulate and form part of the system of reputation. Some people have accumulated more than a million cheers. <i>Also sometimes referred to as compassion heart</i>
Reputation	A cumulative record of an account's activity at 7 Cups, particularly the number of cheers, which the system represents as a level.
Ratings	A system for evaluating 1-to-1 chats based on the qualities helpfulness, professionalism, empathy and response time, with up to five stars being awarded for each. The system includes an optional written review.
Ban	A setting that prevents an account from using 7 Cups. Used to protect the community after some rule has been broken.
Block	A setting that prevents a pair of accounts from having any contact with each other. Used to protect people from unwanted chats or messages.
Mute	A setting that prevents someone from participating in a chatroom. Used to protect the room after some rule has been broken.
Flag	A reporting system for inappropriate content in forum posts, feed posts, or profiles.

Technology

Term	Definition
Badge	App or mobile app - for 7 Cups, the downloadable apps for Android or iOS, as distinguished from the website.
Website , or "browser" experience	for 7 Cups, the website as accessed via a web browser, whether on a desktop/laptop device or a mobile device. The 7 Cups website is designed in a "progressive" framework that provides a good mobile experience even for devices that do not support or users who do not wish to install the mobile app.
UX , or user experience	the overall experience a user has interacting with the product or service (website or app), the sum of all the various interactions and the

relationships that is formed between the user and the service. Distinguished from UI or User Interface, which deals with the details of interactions on each screen or interactive experience.

UI, or user interface, also just interface

the details of the screen or other interactive elements, such as boxes, buttons, links, animations, scrolling, tapping, clicking, dragging, etc.

Artificial intelligence (AI)

Various ways to automate and speed up logical insight, inference, pattern recognition, and other forms of “intelligent” processing.

Machine Learning (ML)

an algorithmic approach to artificial intelligence somewhat analogous to expert systems but trained on as large as possible a set of examples rather than by feeding in a set of a priori rules. Allows for a feedback loop of learning from data, while simultaneously integrating what has been learned.

SEO

or Search Engine Optimization - techniques intended to ensure that our content and services rank high in searches (like google) for relevant topics, so that we can be discovered by and ultimately enroll and support as many people as possible.

New Message Notifications

notifications of new messages that may be sent via email or push notification and that accumulate in the header of the website until read.

Notifications

General notifications of mentions in forums and feed sites, or of updates in subscribed communities or forum threads, may also be delivered via email or push notification.

Push Notifications

in a mobile app, a notification that may come directly to your device even if the app is not currently running.

Alerts

on 7 Cups, messages that go out to the entire community or to targeted subsets of the community (such as listeners, or teens).



mindstrong

About Mindstrong Health

Mindstrong is a healthcare innovation company transforming brain health through pioneering work in measurement science and new models of care delivery. Mindstrong's health platform connects patients and providers with continuous, objective measures of cognition and mood giving patients agency in their care and providers confidence that they will be alerted to early signs of mental health deterioration. For overburdened mental health clinics, Mindstrong *Health Services*, a California professional corporation, provides wrap-around health services using the health platform to increase patient tenure in the community using high touch escalating levels of care. These escalating levels move from care management services, to psychologist provided therapies to psychiatrist delivered psychopharmacology. For populations at high risk of a mental illness, Mindstrong's health platform increases patient self-awareness, and its health services provides immediate access to care.

The Mindstrong Solution, Including *Health Services*

The Mindstrong Solution

The Mindstrong Solution consists of *Health* by Mindstrong, *Care* by Mindstrong, and Mindstrong *Health Services*.

Health by Mindstrong is a smartphone application downloaded onto patients' smartphones. The app comprises: 1) measurement through passive capture of human-computer interaction (HCI) data; and 2) management through communication and engagement functionality. *Health* by Mindstrong enables providers to remotely manage patients and allows patients to access their providers.

Care by Mindstrong is a portal provided as a smartphone or tablet application and web portal and utilized by Mindstrong *Health Services*. *Care* by Mindstrong enables Mindstrong *Health Services* to: 1) review and triage patients who are exhibiting high risk of relapse; 2) review trend history; and 3) facilitate communication between Mindstrong *Health Services* and partner clinical staff.

Mindstrong *Health Services* comprises certified care professionals that deliver evidence-based assessment and intervention via *Care*. Mindstrong *Health Services* will review patients' *Health* by Mindstrong data daily. If it appears that a patient is demonstrating a risk signal, Mindstrong *Health Services* will contact the patient. During this contact, Mindstrong *Health Services* will conduct a brief assessment and determine the appropriate course of action, including brief intervention, referral back to the patient's existing clinical providers, or refer to immediate crisis response.

Mindstrong Care Delivery Models

The Mindstrong program demonstrates the improvement in patient functioning and reduction in rates of relapse, transition to higher levels of care, and clinical service utilization that are achievable with the Mindstrong Solution, which includes *Health* by Mindstrong, *Care* by Mindstrong, and Mindstrong *Health Services*.

The program offers patient enrollment into two care models: Self-Referred Care and Clinician-Referred Care. These two models span the continuum of care. Individuals that are healthy but at a high-risk for a mental illness such as depression, schizophrenia, perinatal mood disorder, or post-traumatic stress disorder will self-select into the Self-Referred Care enrollment. In contrast, individuals that have been diagnosed with a mental illness will be sent to Clinician-Referred Care enrollment during clinic visit or discharge from a County facility. The steps in the two care models are summarized below.

Self-Referred Care

- User self-enrolls following public awareness campaign, back-to-school night at a high-school, registration at a community college or word-of-mouth
- User installs *Health* by Mindstrong application and is greeted by Mindstrong *Health Services* during onboarding
- Mindstrong *Health Services* provides psychoeducation and care assistance
- Mindstrong *Health Services* may recommend additional County services
- User can request higher levels of care provided by Mindstrong *Health Services* to discuss any concerning thoughts, emotions, or behaviors

Clinician-Referred Care

- Patient is referred to Mindstrong on discharge from a County facility or clinic
- Patient installs the *Health* by Mindstrong application
- Patient is greeted by Mindstrong *Health Services* during onboarding
- Following installation of the *Health* by Mindstrong application, the *Care* by Mindstrong application synchronizes the patient's medical data with the County medical records
- The patient now appears in the *Care* by Mindstrong application to the Mindstrong *Health Services* team that will be responsible for delivering continuity of care between clinic visits and strengths model based care including telehealth psychoeducation, motivational interviewing, tele psychiatric care and wrap-around service referral
- Mindstrong *Health Services* schedules an outpatient clinic appointment that appears in the patient's *Health* by Mindstrong app directing the patient to a county or community clinic for clinic-based care

Both self-referred and clinician-referred users will have access to Mindstrong *Health Services* 24 hours a day, 7 days a week. Self-referred users accessing the services for the first time will go through an intake process that is triaged to their level of acuity. Established patients under care that initiate contact with Mindstrong *Health Services*, will undergo a brief assessment and, in partnership with partner clinical staff and/or according to agreed upon protocol, will follow an appropriate course of action.

Mindstrong Healthcare Model

The implementation of the services partnership will leverage staff from Mindstrong *Health Services* and the County. A typical model for roles, responsibilities, and communication is outlined below and can be customized based upon the County's specific needs and structure.

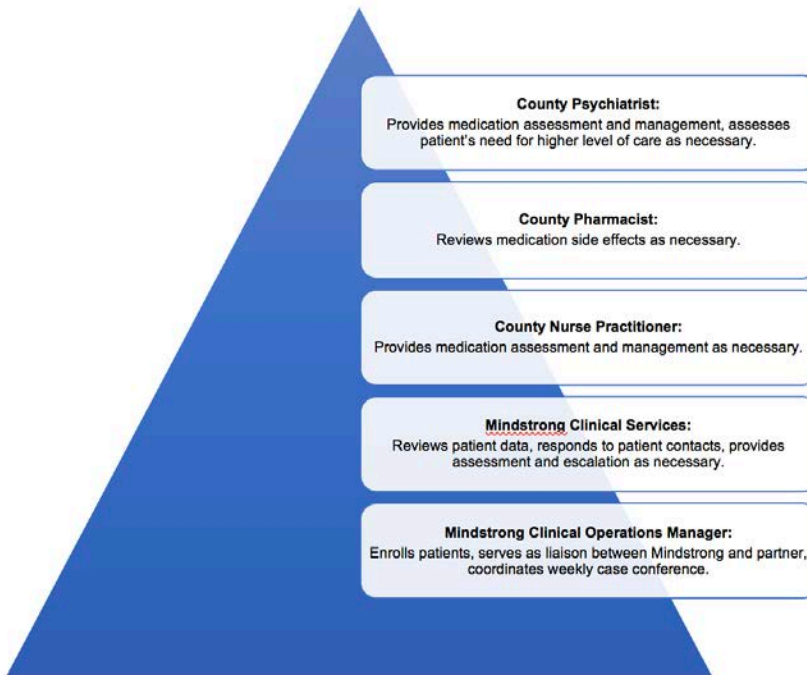
Full Service Model

In this model, Mindstrong *Health Services* provides full psychopharmacology and psychological care management of patients between clinic visits, maintains care plan adherence and clinic follow up appointments, and provides 24 x 7 access. The *Care* by Mindstrong application enables care coordination across the various levels of care from clinical operations manager to psychiatrist. The patient receives the care interactively through the *Health* by Mindstrong application.



Hybrid Model

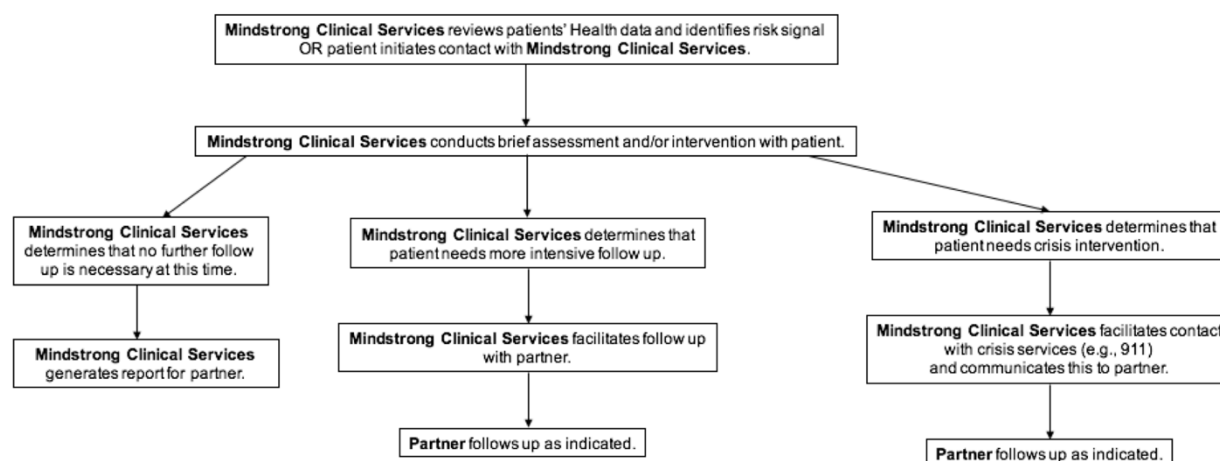
In this hybrid model, continuity of care between clinic visits is shared by Mindstrong and the County. Mindstrong supports the lower two tiers of disease interception and care management and the County provisions the upper three tiers of care. As in the first model, the *Care* by Mindstrong application is used across all tiers of care for care coordination and care interaction with the patient that is received through the *Health* by Mindstrong application.



Real-Time Needs Assessment, Stabilization and Escalation

Mindstrong coordinates closely with County/partner mental health providers to deliver continuity of patient care. Mindstrong *Health Services* escalation pathways ensure each patient receives the appropriate level of care referral without delay that results in improved outcomes at reduced total cost of care. A patient case summary accompanies an escalation referral by a Mindstrong referring clinician to a County/partner clinician.

Escalation Pathway



Assessment and Intervention

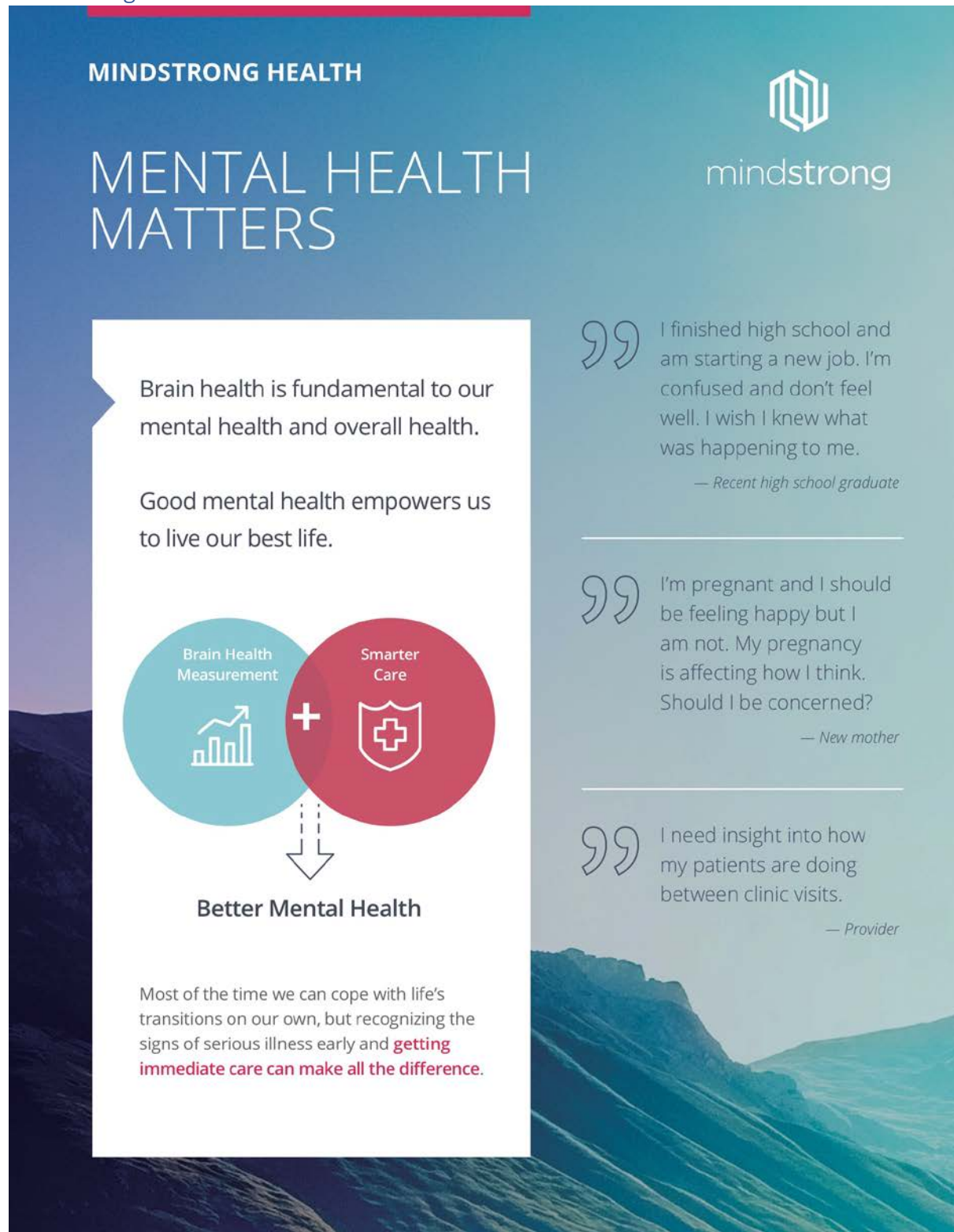
Mindstrong *Health Services* utilizes an evidence-based assessment and intervention workflow to provide care to patients via *Care* by Mindstrong. The clinical assessment and intervention workflow includes general areas that are applicable to all patients (e.g. safety risk, medication compliance) and specific areas that are relevant to specific patient populations (e.g. substance use disorder, mood/anxiety disorders, psychosis). The assessment and intervention workflow is designed to allow clinicians to flexibly move between areas of assessment and intervention that are most relevant to the individual patient's needs. For a full schematic of the assessment and intervention workflow see the Assessment and Intervention Decision Tree.

Structurally, the assessment determines the intervention needs. For example, if a patient reports non-adherence to medication, a medication adherence intervention is initiated. If the patient reports adherence to his or her medication regimen, a prompt to positively reinforce this behavior is initiated.

Areas of assessment and intervention are hierarchically structured from most important to least necessary. Clinicians are prompted to opt out of assessment and intervention modules that are deemed to be unnecessary. Whenever appropriate, the clinician is prompted to provide positive reinforcement of treatment-consistent behavior and to provide motivation in response to treatment-inconsistent behavior. Finally, upon completion, a patient contact report is generated from the assessment and/or intervention encounter to fully document the interaction for the patient's full clinical team.

Marketing Collateral Examples

Mindstrong Flier



The flier features a blue and teal background with a mountain range at the bottom. At the top left, it says "MINDSTRONG HEALTH". In the top right is the Mindstrong logo, a stylized white 'M' icon above the word "mindstrong". The main headline is "MENTAL HEALTH MATTERS".

Brain health is fundamental to our mental health and overall health.

Good mental health empowers us to live our best life.

The central graphic consists of two overlapping circles. The left circle is teal and labeled "Brain Health Measurement" with a bar chart icon. The right circle is red and labeled "Smarter Care" with a shield and cross icon. A white plus sign is between them. A dashed arrow points down from the circles to the text "Better Mental Health".

Most of the time we can cope with life's transitions on our own, but recognizing the signs of serious illness early and **getting immediate care can make all the difference.**

Three testimonials are on the right, each preceded by a double quote icon and followed by a horizontal line:

- “ I finished high school and am starting a new job. I'm confused and don't feel well. I wish I knew what was happening to me. — Recent high school graduate
- “ I'm pregnant and I should be feeling happy but I am not. My pregnancy is affecting how I think. Should I be concerned? — New mother
- “ I need insight into how my patients are doing between clinic visits. — Provider

Digital Biomarkers of Brain Health

Mindstrong Health scientifically validated a way to measure brain health on a daily basis. It's like a weight scale or vital signs, but for your brain.

Patterns of touchscreen interactions like taps and swipes on your smartphone are used to recreate gold-standard measurements of brain health, including cognition and mood.

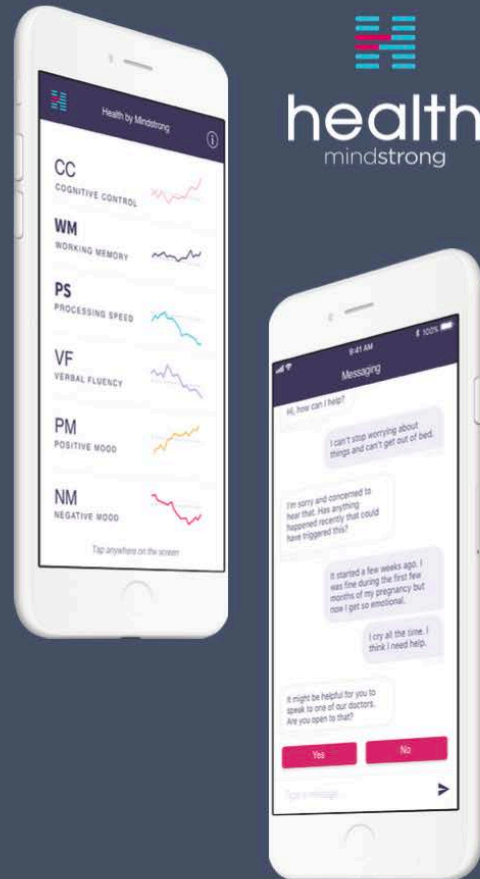
Mindstrong doesn't capture any content, like what you type or who you talk to, your location, passwords or browser searches.

The Solution: Health by Mindstrong

Health by Mindstrong provides daily measurements about your brain health and how it is affected by your mood, sleep, and worries.

Through Health by Mindstrong, you can access licensed counselors, therapists, and doctors through text messaging, live chat and telehealth. Mindstrong augments and extends existing provider care team capabilities.

You can sign up through a referral from a participating healthcare provider, or through an in-network health plan.



WWW.MINDSTRONGHEALTH.COM

Mindstrong Health: Brain Health for Life.

Mindstrong Health Clinical Evidence: 2013-2018

Mindstrong has a five-year history of clinical research in developing and bringing to market digital biomarker measures of cognition and mood. Mindstrong's unique approach is based on creating digital signals from human-computer interaction patterns. Mindstrong's clinical research has focused largely on touchscreen interactions from a user's smartphone. By capturing the patterns and the timing of these events, and not their content, Mindstrong has shown in repeated sponsored clinical studies and partnerships with leading academic centers that its digital biomarkers reproduce the major gold standard measures of cognition and mood in use clinically today.

Prior attempts to create digital phenotypes have relied on GPS signals, search terms, websites visited, Facebook postings, and other expressions of behavior and personal preferences. These approaches are beleaguered with ethical and privacy concerns. They also do not demonstrate strong and consistent signals with clinical outcomes that limit their clinical use. Distinct from these approaches, Mindstrong's science uses millisecond variability in reaction times from repeated multi-step touchscreen activities to create digital biomarkers proven in repeated clinical trials to have very high validity and reliability with gold standard neuropsychological assessments [1,2].

Mindstrong has been awarded five US Patents for its discovery that led to digital biomarkers of neuropsychological and neurocognitive function from human-computer interaction patterns [3-7]. Mindstrong's strong patent portfolio enables the company to freely publish its clinical results in prestigious peer-review journals and to include its clinical data and algorithms for public review of reproducibility [8]. Mindstrong promotes open science and collaboration to further the field of digital biomarkers for measuring mental health and illness. It has sponsored clinical studies that use its digital biomarker platform in the US, UK and Asia [9], and it has directly sponsored collaborators in the field [10].

Mindstrong's biomarkers have been licensed by pharmaceutical companies as sensitive functional endpoints in the development of new drugs for major depression and schizophrenia [11,12]. They are also in use for patient stratification of response for companion diagnostics and companion therapeutics [13,14].

In clinical practice, Mindstrong's digital biomarkers are used in patient care for severe mental illnesses and for substance-use disorders in private clinics in the US. They have demonstrated high sensitivity and specificity in detecting early changes in deterioration and improvement with an ROC exceeding 80% in clinical programs [15] and in quality improvement programs. Clinics receive regular consult notes from Mindstrong *Health Services* with the following information:

- Mindstrong's digital biomarker evaluation reports six NIMH gold-standard, trans-diagnostic criteria of cognition and mood. The report contains trend (stable, increasing, decreasing), volatility (stable, increasing, decreasing), peak and trough performance relative to the patient's targets and percentile rank normed to age, education and gender.
- Mindstrong assessment of the effectiveness of the current care plan and persistent gaps in care and adherence that relies on the objective digital biomarker evidence.

For counties that opt in for a higher level of service by Mindstrong *Health Services*, referring clinics benefit from 24x7 coverage of their patients between clinic visits to predict and pre-empt deterioration and illness early. By delivery of escalating levels of care through the Mindstrong health platform, Mindstrong *Health*

Services increases patient tenure in the community. For these counties, scheduled progress notes additionally include the following:

- Subjective information acquired through the patient’s engagement with Mindstrong *Health Services* through the *Health* by Mindstrong and *Care* by Mindstrong applications. This includes a summary of care plan changes since the last consult note and changes in patient symptomatology and functional impairment as reported by the patient during structured interviews and objectively observed in the digital biomarker chart.
- Care plan recommendations including psychopharmacology, CBT, DBT, psychoeducation, family and peer involvement, digital therapeutics, other.

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4. [U.S. Pat. No. 9,474,481](#)
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14. <https://clinicaltrials.gov/ct2/show/NCT03429361?term=mindstrong&rank=1>

Frequently Asked Questions

About the Mindstrong App

How does the Mindstrong app work?

Mindstrong developed the first continuous measurement system of cognition and mood. Brain functions such as memory and attention are reflected in the way you use your phone. Using swipes, taps and other touchscreen events on your smartphone, Mindstrong measures biomarkers of cognition and emotion that provide information about your brain health.

Mindstrong does not collect the content of your typing, or any personally identifiable, credit card, and other sensitive information such as voice calls, locations, passwords, or browser searches.

What data is collected by the Mindstrong application?

We collect data about the patterns in your smartphone use such as swipes, taps, and other touchscreen activities, and the timing of those patterns.

Mindstrong does not collect any personal information, including what you type or who you talk to, your location, passwords or browser searches. More information can be found in Mindstrong's Privacy Policy, see here: <https://mindstronghealth.com/privacy/>

What data is collected from other applications?

We don't collect data from other applications.

Will the app affect how my phone works or cause overage of my data plan?

The Mindstrong app does not interfere with your phone's normal functionality. It has no noticeable effect on battery consumption or data usage.

Where can I find a copy of the web address/URL for the website's authentication portal?

Mindstrong end users access the applications through a download from the Apple App and Google Play stores.

What is the consent process for the app?

Users will be provided the terms of service and consent information after initial login. Upon acceptance of the login and consent by clicking "I agree", they will be able to access the application content and features.

Data Storage & Security

How safe is my data?

Your data is encrypted at all times using gold standard industry security standards. The data are deleted from the phone when they are uploaded to a secure server.

Are the data from my phone collected and stored securely?

Your data is encrypted at all times using gold standard industry security standards. This applies to data in-transit and at rest.

Could the app be "hacked", and my data be accessed by unauthorized individuals?

The data collected by the app and stored in Mindstrong's HIPAA-compliant servers are secured using gold standard industry standard encryption technologies. The data that the app collects does not include personally identifiable information.

How long is information stored on the vendor servers? (chats, phenotype etc.)

Historical information will be retained on Mindstrong's servers for a period of at least 8 years following the end of active enrollment for a user as required by state law.

What happens if someone loses their device and someone else accesses the information on the device?

Mindstrong's application requires PIN or biometric security to be enabled on the phone, and offers additional security at the application level. In addition, Mindstrong requires that the user be authenticated with username and password to the Mindstrong account. A user may change his/her password which will disable access from any device which was previously logged in.

iOS Questions

Is there a way to remove predictive text from the keyboard?

This feature can be turned on or off. You can find it in the "Settings" tab in the Mindstrong App.

Is there a way to disable keyboard click sounds?

This feature can be turned on or off. You can find it in the "Settings" tab in the Mindstrong App.

Can I switch languages with the Mindstrong keyboard?

Currently the Mindstrong keyboard supports American English. Additional languages will be available in August 2018.

Do I need to use the Mindstrong keyboard for everything or can I use the default iOS keyboard?

On iPhones, data about brain health are only collected when the keyboard is installed and in use. As a result, you should use the Mindstrong keyboard. On Android phones you can use any keyboard.

Troubleshooting and Technical Questions

I tried logging in several times, but after many failed attempts I was locked out of the system.

Please let your clinician or a Mindstrong team member know that you have been locked out. They will work with the Mindstrong technical team to unlock your account.

Do I need to do anything to stay enrolled in the Mindstrong App if I get a new phone?

If you get a new phone, please re-download the Mindstrong Health App from the App store. You can log in with the same information you used on your old phone.

Peer Chat

Are the peer chats encrypted?

All Mindstrong communications are encrypted. Chats between Health Users and between Health and Care users are stored in a database and are encrypted on the device, during transmission, and when stored. All communications are sent through a HIPAA compliant messaging channel.

Are the chats recorded?

Chat message content is stored in a database. Access to the content is only provided to the user with an active account. Any user will only see his/her chat history and the chat history of any peer connection where the peer has given informed consent for the sharing.

Authentication, Data Storage & Security

Where can I find a copy of the web address/URL for the website's authentication portal?

Mindstrong end users access the applications through a download from the Apple App and Google Play stores.

How is information stored on individual devices and the vendor's servers? How long is information stored for?

Information is stored on vendor devices only while the user is logged into the application in an authenticated state. Historical information will be retained on Mindstrong's servers for a period of at least 8 years following the end of active enrollment for a user as required by state law.

How long is information stored on the vendor servers? (chats, phenotype, etc.)

Historical information will be retained on Mindstrong's servers for a period of at least 8 years following the end of active enrollment for a user as required by state law.

What happens if someone loses their device and someone else accesses the information on the device?

Mindstrong's application requires PIN or biometric security to be enabled on the phone, and offers additional security at the application level. In addition, Mindstrong requires that the user be authenticated with username and password to the Mindstrong account. A user may change his/her password which will disable access from any device which was previously logged in.

Glossary for INN Tech Suite Project

Brain health is fundamental to our mental health and overall health. Mindstrong Health developed and validated a new ability to measure brain health on a daily basis, much like we measure weight and blood pressure as basic health metrics.

Patterns generated from touchscreen interactions like swipes and taps on your smartphone reflect the way your brain processes and responds to the world around you. Modern neuroscience shows that millisecond-scale touchscreen interactions reflect the function and integrity of neural circuits that drive cognition and mood, and can give insight into the interplay between brain health, and overall health and disease.

The Mindstrong Health App provides daily measurements about your brain health and how it might be affected by your environment, sleep, and illness.

These signals allow for the early detection of brain health deterioration, and the opportunity for early interception and early intervention, in order to improve clinical and health outcomes.

See below for useful terminology:

Terminology	Definition
Algorithm	An algorithm is a procedural set of steps that a computer follows to solve a problem. Mindstrong generates digital biomarkers through proprietary algorithms that convert patterns of gestures on a smartphone into meaningful signals related to brain function.
Amazon Web Services (AWS)	AWS is Amazon.com’s HIPAA-compliant cloud computing platform. Cloud computing enables scalable data storage and computing. All data that Mindstrong collects is securely stored and processed in AWS.
Artificial Intelligence	Artificial Intelligence is an umbrella term for the concept of machines being able to carry out tasks in a way that humans would consider “smart”, i.e. the capability of a machine being able to imitate intelligent human behavior. ¹
Attention	Attention is the cognitive process that your brain uses to select and prioritize sensory information. This cognitive process filters information so you don’t get overwhelmed.
Augmented Intelligence	An alternative to “artificial intelligence” that focuses on AI’s assistive role, emphasizing the fact that it is designed to enhance human intelligence rather than replace it. ²

¹<https://www.forbes.com/sites/bernardmarr/2018/02/14/the-key-definitions-of-artificial-intelligence-ai-that-explain-its-importance/#a0e937f4f5d8>

² <https://whatis.techtarget.com/definition/augmented-intelligence>

Terminology	Definition
Cognitive Control	Cognitive control is the ability to control your thoughts and actions. It allows you to override an impulse and instead make a decision based on your goals, rather than habit. Cognitive control helps you concentrate, and to stay on a diet, as examples. It can be impacted by mood.
De-identified data	Data that is anonymous, and disconnected from a person’s personal information. It can’t be used to trace back to an individual.
Digital Biomarkers	<p>Digital biomarkers are user-generated physiological and behavioral measures collected through connected digital tools.</p> <p>Mindstrong discovered and patented digital brain biomarkers in psychiatric and neurologic disorders³. These biomarkers are generated via machine learning techniques from patterns in smartphone use such as swipes, taps, and other touchscreen activities, and are scientifically validated to provide measurements of cognition and mood. For an introductory overview of Mindstrong’s digital biomarkers see this overview from Rock Health.</p> <p>Mindstrong’s digital biomarkers are collected passively, continuously, objectively and quantitatively through smartphone use. The analysis of these biomarkers enable the monitoring of brain health, and makes timely medical interventions possible.</p> <p>Mindstrong’s digital biomarkers do not rely on the content of typing, any personally identifiable, credit card, or other sensitive information such as voice calls, locations, passwords, or browser searches. Instead, they are based on patterns like “delete-delete” or “scroll-scroll-click”.</p>
Digital Phenotype	Digital phenotypes are patterns of digital biomarkers.
Encryption	Security measures that protect the privacy of personal data, and other data. All data collected by Mindstrong is encrypted at all times.
Executive Functions	Executive functions refer to a set of cognitive processes responsible for the cognitive control of behavior. This includes functions such as attentional control, cognitive inhibition, inhibitory control, working memory, and cognitive flexibility. Executive functions gradually develop and change as we age.

³ Dagum, npj Digital Medicine; 1:10 (2018)

Terminology	Definition
HIPAA	Health Insurance Portability and Accountability Act of 1996 is United States legislation that provides data privacy and security provisions for safeguarding medical information. As a healthcare company, Mindstrong Health is HIPAA compliant and abides by all state and federal regulations in how data is managed and accessed.
HIPAA covered entity	Your physician and health insurance plan are HIPAA covered entities, as well as their partners who provide care or services on their behalf. They have access to medical and other personal information, and are required to protect it under HIPAA Privacy and Security rules. ⁴ Mindstrong is a HIPAA covered entity and operates under gold standard encryption and security practices.
Human Computer Interactions (HCI)	The design and use of computer technology, focused on the interfaces between people and computers. Mindstrong has demonstrated that swipes, taps and other activities on the smartphone touchscreen can be used to create digital biomarkers that measure brain health and cognitive processing. Mindstrong is also investigating other modalities of human computer interactions, including augmented reality.
ISO 27001	An internationally recognized cyber security best practice specification for information security management system. This framework of policies and procedures includes all legal, physical and technical controls validates that patient and user data is secure. Mindstrong complies with ISO 27001 regulations.
Machine Learning	Machine learning is a subset of artificial intelligence (AI) in the field of computer science that uses statistical techniques to give computers the ability to "learn" (i.e., progressively improve performance on a specific task) with data, without being explicitly programmed.
Memory	Psychologists consider many different types of memory, such as short-term memory, long-term memory and working memory. Short-term memory is often defined as information that is currently held 'in mind' and has limited capacity, whereas long-term memory refers to information that is stored in the brain. See Working Memory below.
Mindstrong Solution (<i>Health, Care, and Health Services</i>)	Mindstrong's solution includes a patient-facing app (<i>Health</i> by Mindstrong), a provider-facing product (<i>Care</i> by Mindstrong), and Mindstrong <i>Health Services</i> that leverage its telehealth enabled measurement science and engagement platform. The solution augments existing care capabilities and infrastructure.

⁴ https://privacyruleandresearch.nih.gov/pr_06.asp

Terminology	Definition
Negative mood	<p>Negative mood is similar to negative valence, but refers specifically to a negative emotional state, such as anger, frustration, sadness, and fear.</p> <p>Long term disturbances of mood can sometimes indicate a mood disorder. Someone with clinical depression may experience a state of abnormally low mood and aversion to activity for a prolonged period of time.</p>
Negative valence	<p>Negative valence is how you respond to negative events or situations. It sounds like negative mood, but it's a little different. The word valence means the direction of the response: anger and fear are emotions with a negative valence.</p> <p>Behaviors can also have a negative valence such as avoiding a situation due to fear. If you've experienced loss or grief, you might avoid places, people or activities that bring back difficult memories.</p> <p>Negative valence can affect your cognitive control, verbal fluency and working memory. Think about how hard it is to concentrate when you're feeling anxious or sad.</p>
Personally Identifiable Information (PII)	<p>PII is any data that can be used to identify a specific individual.</p>
Positive mood	<p>Positive mood is similar to positive valence, but refers specifically to a positive emotional state, such as contentment, elation or excitement.</p>
Positive valence	<p>Positive valence is how you respond to positive situations or events. Positive valence is similar to mood, but not quite the same. The word valence describes the direction of the emotion or behavior: joy and pride are emotions that have a positive valence. These kinds of emotions are brought about by positive events, objects, or situations.</p> <p>Behaviors can have a valence too. Think about a time you threw yourself into a new project with enthusiasm. A person with high positive valence takes on new challenges, is eager to engage with the world and takes active care of themselves.</p> <p>When you have low positive valence, you stop enjoying doing the things that usually make you happy, like being with friends and family or taking care of your health.</p>
Processing speed	<p>Processing speed is the time it takes your brain to understand, process and react to new information.</p>

Terminology	Definition
	<p>Your processing speed varies from day to day. Think about a time when you felt sluggish, and it took you longer to do a task or an assignment than usual. Too much alcohol or not enough sleep slows your processing speed.</p> <p>It also varies over the course of our lives. Processing speed increases from childhood to adolescence, remains relatively stable until adulthood and then declines slowly from middle age.</p> <p>This rate of decline varies from person to person, and can be affected by physical health or chronic conditions.</p>
Protected Health Information (PHI)	<p>PHI refers to all data that a healthcare professional collects to identify an individual and determine appropriate care. This can include demographic information, electronic healthcare records, medical tests, insurance information or information about health conditions.⁵ PHI is protected under HIPAA laws.</p> <p>Mindstrong is HIPAA compliant and operates under gold standard encryption and security practices. We have strict policies on privacy, informed consent, transparency and accountability.</p>
Verbal fluency	<p>Verbal fluency involves accessing your mental vocabulary and selecting the appropriate words when speaking or writing. Think about a time when you failed to recall a word “on the tip of your tongue,” which might indicate lowered verbal fluency.</p> <p>Stress and anxiety can impact verbal fluency. Age and experience are also important: children perform less well on tests of verbal fluency compared to adults.</p>
Working memory	<p>Working memory is how you temporarily store and actively manipulate information. You use working memory to think through problems, make decisions or do mental arithmetic, and to carry on a conversation since you need to remember the last thing a person said to appropriately respond.</p> <p>Your mood can impact your working memory. Think about a time you were deeply preoccupied. This can make it hard to concentrate, problem solve or engage in conversation.</p>

⁵ <https://searchhealthit.techtarget.com/definition/personal-health-information>

Founder Biographies

Paul Dagum, MD PhD

Founder & Chief Executive Officer

Paul Dagum, MD PhD is a computer scientist, physician and entrepreneur with a track record of creating and launching products in three successful venture-backed companies. Dr. Dagum's early pioneering research in AI is in use in many modern-day applications. He further developed and patented massively parallel algorithms for big data science in use by the world's largest data companies, and created and patented the first ever digital measures of central nervous system function based on human-computer interaction patterns. Dr. Dagum led NSF and NIH grants while at Stanford University, published over 75 peer-review articles and book chapters in computer science and medicine, and was awarded over 25 patents. Dr. Dagum received an MSc in theoretical physics, PhD in theoretical computer science both from the University of Toronto and an MD from Stanford University.

Tom Insel, MD

Co-Founder & President

Thomas R. Insel, MD, a psychiatrist and neuroscientist, is a co-founder and President of Mindstrong Health. From 2002-2015, Dr. Insel served as Director of the National Institute of Mental Health (NIMH), the component of the National Institutes of Health (NIH) committed to research on mental disorders. Prior to serving as NIMH Director, Dr. Insel was Professor of Psychiatry at Emory University where he was founding director of the Center for Behavioral Neuroscience in Atlanta. Most recently (2015 – 2017), he led the Mental Health Team at Verily (formerly Google Life Sciences) in South San Francisco, CA. Dr. Insel is a member of the National Academy of Medicine and has received numerous national and international awards including honorary degrees in the U.S. and Europe.

Richard Klausner, MD

Co-Founder & Executive Chairman

Richard D. Klausner, MD is founder and Director of Juno Therapeutics and founder and Director of GRAIL. He is the former Senior Vice President, Chief Medical Officer and Chief Opportunity Officer of Illumina. He currently chairs the Grand Challenges in Cancer program of Cancer Research UK. Previously, he has served as the Executive Director for Global Health of the Bill and Melinda Gates Foundation. Dr. Klausner was appointed by Presidents Clinton and Bush as the eleventh Director of the U.S. National Cancer Institute between 1995 and 2001. Dr. Klausner served as chief of the Cell Biology and Metabolism Branch of the National Institute of Child Health and Human Development, as well as a past president of the American Society of Clinical Investigation. He is a member of the National Academy of Sciences, the Institute of Medicine and the American Academy of Arts and Sciences.

Management Biographies

Pravene Nath, MD

Chief Product Officer

Pravene A. Nath, MD previously served as Chief Information Officer and Chief Digital Officer of Stanford Health Care, where he led technology strategy and operations and launched the industry-leading Stanford MyHealth digital platform for patient and consumer engagement. Before Stanford, Dr. Nath was Chief

Medical Information Officer at NYU Langone Medical Center in New York City. Dr. Nath has served on the boards of for-profit and not-for-profit health systems and has practiced emergency medicine as a member of the Stanford University and New York University medical school teaching faculty. He received his BSE in biomedical engineering from Duke University, his MD and MSE in biomedical engineering from The University of Michigan, and his residency training from NYU Langone and Bellevue Hospitals in New York City.

[Greg Ryslik, PhD, FCAS](#)

[Vice President, Data Science](#)

Greg Ryslik, PhD, FCAS, MAAA is a statistician, researcher and AI expert who has worked across a variety of industries including biotech, actuarial science and automotive. Greg led the Data Science team for Service at Tesla Motors and the Data Science & Analytics team at Faraday Future. Previously, Greg performed non-clinical machine learning and bioinformatics research at Genentech as well as actuarial analysis at PricewaterhouseCoopers. His research into cancer genomics, bioinformatics and structural biology has been published in journals ranging from Nature to BMC Bioinformatics and his textbook on actuarial science has been used to teach courses at several universities. He is a member of the American Academy of Actuaries, a Fellow of the Casualty Actuarial Society and has degrees from Yale, Columbia and Rutgers. He also holds an adjunct assistant professorship with the statistics department at Pennsylvania State University.

[Leo Dagum, PhD](#)

[Vice President, Engineering](#)

Prior to Mindstrong, Leo held executive positions in technology at a variety of privately held companies working on, amongst other things, IoT management and optimization solutions, vertical search, online marketing, and demand and supply chain optimization. Earlier in his career he worked on Linux kernel development, performance engineering and parallelization/performance tuning of commercial scientific applications. He is one of the architects of the OpenMP language standard and original authors of the NAS Parallel Benchmarks. Leo has over 30 peer-reviewed publications in computer science, mathematics and rocket science and is inventor on 5 patents. He received his BSc in Engineering Physics from Queen's University, and MSc and PhD in Aeronautics/Astronautics from Stanford University.

[Elaine Cheung, MS](#)

[Vice President, Marketing](#)

Elaine was previously Head of Business Development at GRAIL, Inc. where she was a founding employee and implemented the strategy/transactions to execute the business plan, and strategic collaborations with pharma companies involved in its Series B \$900M+ financing. Formerly, she was Director of Strategic Partnerships at Illumina. There, she led BD for the Oncology Business Unit, and also executed strategy and transactions/M&A in the fields of Non-Invasive Prenatal Testing and Transplant Medicine. Elaine spent 6 years at Genomic Health, where she focused on product pipeline and global commercial expansion. Elaine has a BS in Biological Sciences and an MS in Management Science & Engineering, both from Stanford University, where she was also a Mayfield Fund Fellow.

[Robert Dougherty, PhD](#)

[Head, Translational Science](#)

Bob is a scientist and engineer with expertise in measuring human behavior and the neural basis of cognitive function. Prior to joining Mindstrong, Bob was the Research Director of the Stanford Center for Neurobiological Imaging and has published over 50 peer-reviewed articles in the fields of psychology, neuroscience, and magnetic resonance technology. Bob completed his PhD in Experimental Psychology at the University of California at Santa Cruz, and postdoctoral fellowships at the University of British Columbia and Stanford.

Boards

Board of Directors

- Rick Klausner, MD, Co-Founder and Executive Chairman, Mindstrong Health
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- Paul Gionfriddo, President & CEO, Mental Health America
- Brandon Staglin, Director, One Mind
- Nev Jones, PhD, Director of Research, Felton Institute
- Nicole Martinez, PhD, JD, Postdoctoral Fellow, Stanford Bioethics
- Sharon Terry, MA, President & CEO, Genetic Alliance
- Katherine Switz, MBA, Founder & Executive Director, The Stability Network
- Monica Luke, Executive Director, Living Assistance Fund

RSE and Team

Runyon Saltzman, Inc. (RSE) is a leading communications firm known for its innovation and exceptional strength in the use of online outreach and traditional offline techniques to create positive social impact. Comprehensive array of services includes strategic planning, advertising, branding, digital marketing, public relations, community engagement and evidence-based social marketing — work that has taken us to all California counties and to other states.

After a public review process, RSE was selected based on their outstanding service, knowledge of mental health outreach, creativity, passion, enthusiasm and ability to quickly support counties launching the Innovation and Technology Suite.

RSE's 52 staffers are well versed in and deeply committed to CalMHSA's goals, having worked on many ground-breaking mental health efforts over the last six plus years. For CalMHSA's mental health stigma and discrimination reduction initiative, having created and launched Each Mind Matters: California's Mental Health Movement (SanaMente, Movimiento de Salud Mental de California.) RSE introduced the ReachOut Here/Busca Apoyo Forums in California that uniquely suit them to handle the branding and roll out of the Innovation and Technology Suite. These peer-guided online forums served California's 14-24-year-olds and provided an online community of support. ReachOut Here was visited by 423,266 young people who left more than 55,000 posts.

Other relevant work includes social impact campaigns to reduce childhood obesity, reduce teen pregnancy rates, reduce infant mortality rates in the African American community (Sacramento County), boost college attendance among key ethnic populations and reduce rates of suicide among gun owners in isolated rural communities (Oregon). RSE also developed and introduced CityLinkLA, an initiative sponsored by the City of Los Angeles to provide gig-speed broadband access to all city residents.

Equally impressive were the team members that RSE included to support counties in the development and introduction of the Innovation and Technology Suite, including:

Solsken Public Relations & Marketing has worked with RSE team on the Each Mind Matters campaign to develop and implement materials to reach Hmong, Cambodian, Laotian, Korean, Chinese, Vietnamese and Mien audiences. Capitalizing on their success, Solsken PR specialists will continue to reach critically important API audiences and contribute to developing strategy for this target group.

California Pan-Ethnic Health Network, which was established in 1992 as a forum for multicultural health advocacy in the wake of riots in South Central Los Angeles to advance health care needs of communities of color. It is the only statewide multicultural health advocacy organization dedicated to improving the health of communities of color through advocacy, research, communications, and community outreach and engagement. In 2010, CPEHN was awarded the contract from the Department of Mental Health Office of Multicultural Services to facilitate the process to create the strategic plan for the California Reducing Disparities Project (CRDP). Building on this critical CRDP work, they developed the Behavioral Health Equity

Collaborative which includes representatives from education, foster youth, immigrant and refugee, and organizations serving people of color in order to reach unserved and underserved populations. CPEHN has completed numerous mental health related projects for several southern California counties include Los Angeles and Kern and has access to networks that will prove invaluable to the successful roll out of the INN Tech Suite.

RTBIQ specializes in data-driven digital advertising utilizing vast amounts of consumer data to tailor messaging to the right audience at the right time. RTBIQ's partnerships with cutting edge technology partners result in 90%+ match rates of digital ads via IP address to household addresses allowing seamless digital advertising delivery against specific data targets. In addition, RTBIQ can leverage location data from top GPS data providers to measure where mobile users consistently spend their time, and can match this to US census block data to further determine ethnicity, income levels, and other pertinent data points to precisely target populations that will likely benefit from the Innovation and Technology Suite.

iHeart Amplify Division brings radio broadcast partnerships, Clear Channel Outdoor and partner agreements with Outfront, Lamar, Regency Outdoor companies. This network helps penetrate key neighborhoods to deliver Innovation and Technology Suite messaging. They can also deploy a team of grass roots activation specialists and two customizable Mobile Marketing Pavilions to travel the state to deliver Innovation and Technology Suite programs to the people and counties of California.

Evaluation of RSE communications programs will be conducted by **National Opinion Research Center (NORC)** at the University of Chicago, under the leadership of long-time RSE partner, Larry Bye. He and his team have provided invaluable formative and evaluation studies that guided many key decisions about CalMHSA's Each Mind Matters campaign and other RSE social impact campaigns.



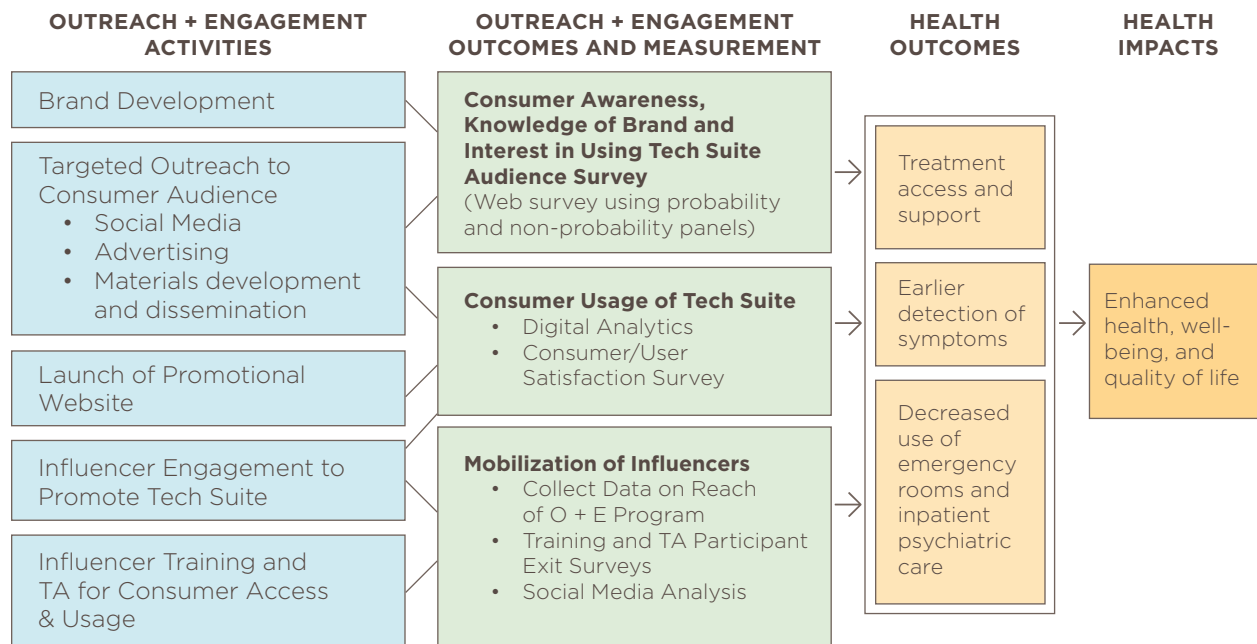
RSE Approach

The Innovation and Technology Suite is intended to be accessed via a wide range of mediums and devices by even wider and more diverse audiences. County behavioral health departments have intimate and insightful knowledge about the populations they serve and the delivery of mental health. However, these departments are not focused on cutting-edge technology or communications innovation. The RSE team is prepared to help fill this gap. They bring a wealth of data regarding technology adoption and usage in specific audiences, within a rapidly evolving landscape. In addition to resources such as Pew Research Center, American Community Survey and CHIS, RSE has access to multiple data source and tools, including Scarborough, Nielsen, Strata SBMS and View, Media Audit, SQAD, Keyword Planner, Radiant 6, Eleven and Google Analytics that will inform and influence the campaign to promote the Innovation and Technology Suite.

RSE has assembled a team drawn from the most successful and forward-thinking organizations working on mental health and disparity reduction to connect and engage communities with the Innovation and Technology Suite. Their campaign aims include: increasing access to care needed and desired; reducing time between recognition and acknowledgement that a symptom needs to be addressed and the time to receiving appropriate care; increase purpose, belonging and social connectedness for users; and reducing the stigma associated with mental illness by promoting wellness. Ultimately, the campaign will break down barriers and provide a path for people to receive the mental health care and support they deserve when they need it and where they need it. This pathway is best illustrated by the Logic Model developed by RSE for the campaign (See exhibit below).

Logic Model

CalMHSA Innovation Technology Outreach + Engagement



One of the reasons RSE was selected through the competitive public bid process was their demonstrated ability to mobilize team resources quickly to actualize the Logic Model and meet aggressive county timelines. Their immediate work has fallen into three objectives, to:

- Create a universal and person-centered brand for the campaign that will appeal to multiple audiences;
- Prepare and support the soft introduction of the Innovation and Technology Suite for the first five counties, and;
- Plan for the official hard launch of the brand and campaign which will include capacity to support added counties once approved by the MHSOAC.

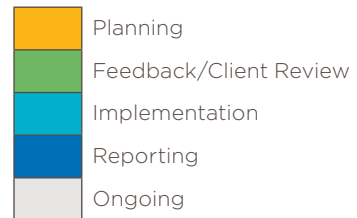
In order to meet these objectives, the RSE team has deployed to complete a number of activities and deliverables in direct support of the counties and Innovation and Technology vendors. Highlights include:

- Identified Innovation and Technology Suite benefits, key supports and core benefits to create a Message Map to guide consistent communication with counties, vendors, peer navigators and others. The final Message Map will be vetted with peer groups and cultural ambassadors to ensure relevancy.
- Applied findings of the Message Map process to begin the exploration of a brand platform for the Innovation and Technology Suite that will guide the development of the name, logo, color pallet, style guide, language and tonality.
- Begun the development of a campaign website including development of wireframes and identification of key website functionalities. Suite vendors have been involved in this process.
- Informed the linguistic and cultural adaptation of the Innovation and Technology Suite for California's diverse audiences.
- Engaged directly with the initial counties to provide customized and direct support for their individual soft roll out needs.
 - Created initial collateral materials for the soft launch including tent cards explaining the component apps of the Innovations and Technology Suite and flyers customized for each county.
 - Development of a paid social media campaign to support LA County
 - TA available for each county as requested/needed for planning and logistics of soft launch events. Customized collateral materials to each county as requested/needed.
 - Development of an API specific outreach plan for Orange County.
 - Development of an API specific outreach plan for LA County.

See below for an approximate timing of activities.

Campaign Timeline

	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
ACTIVITY												
Onboarding	Planning											
Strategic Council	Planning	Feedback/Client Review	Ongoing	Ongoing	Ongoing	Ongoing	Ongoing	Ongoing	Ongoing	Ongoing	Ongoing	Ongoing
Brand Development	Planning	Planning	Implementation	Feedback/Client Review	Reporting	Reporting	Ongoing	Ongoing	Ongoing	Ongoing	Ongoing	Ongoing
Stakeholder Meetings	Planning	Planning	Feedback/Client Review	Feedback/Client Review	Ongoing	Ongoing	Ongoing	Ongoing	Ongoing	Ongoing	Ongoing	Ongoing
Outreach Materials/Website	Implementation	Feedback/Client Review	Planning	Implementation	Feedback/Client Review	Ongoing	Ongoing	Ongoing	Ongoing	Ongoing	Ongoing	Reporting
Paid Advertising	Ongoing	Ongoing	Planning	Implementation	Implementation	Feedback/Client Review	Feedback/Client Review	Feedback/Client Review	Reporting	Ongoing	Ongoing	Ongoing
Technical Assistance	Feedback/Client Review	Ongoing	Ongoing	Ongoing	Ongoing	Ongoing	Ongoing	Ongoing	Ongoing	Ongoing	Ongoing	Ongoing
Mini-Grant Program	Planning	Planning	Planning	Feedback/Client Review	Feedback/Client Review	Feedback/Client Review	Feedback/Client Review	Feedback/Client Review	Feedback/Client Review	Feedback/Client Review	Reporting	Reporting
Systems Outreach	Planning	Planning	Planning	Implementation	Implementation	Feedback/Client Review	Ongoing	Ongoing	Ongoing	Ongoing	Ongoing	Reporting
Media Relations	Ongoing	Ongoing	Ongoing	Planning	Planning	Feedback/Client Review	Ongoing	Ongoing	Ongoing	Ongoing	Ongoing	Reporting



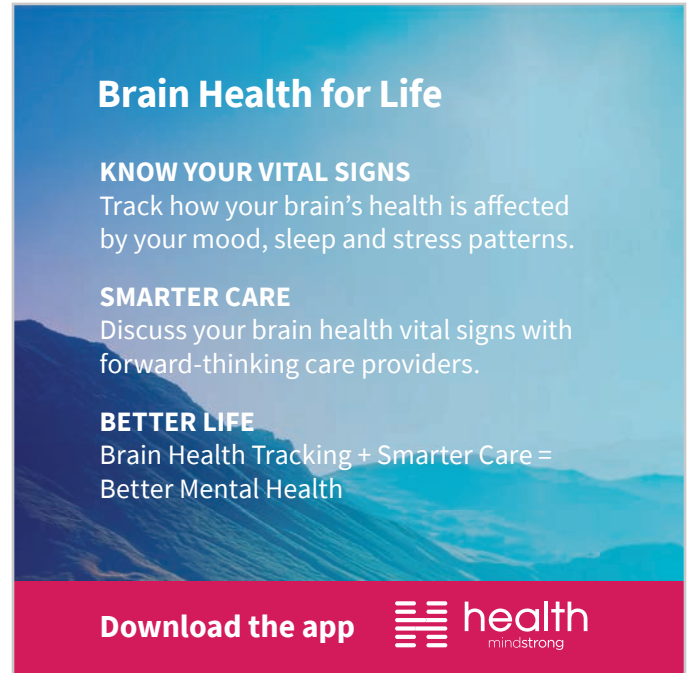
Tech Suite Draft Materials

Tent Cards

Front



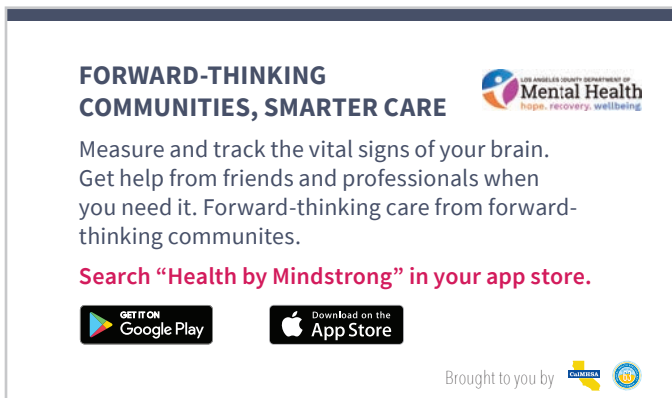
Interior



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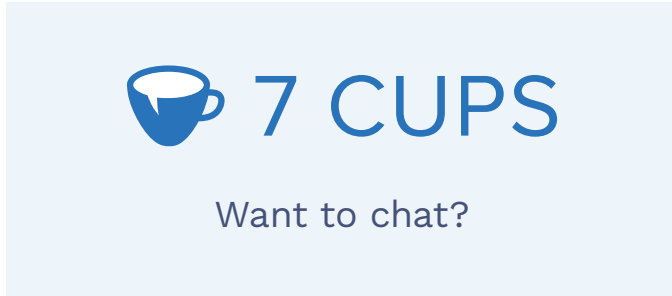
Alternate Attribution Statement



Tech Suite Draft Materials

Tent Cards

Front



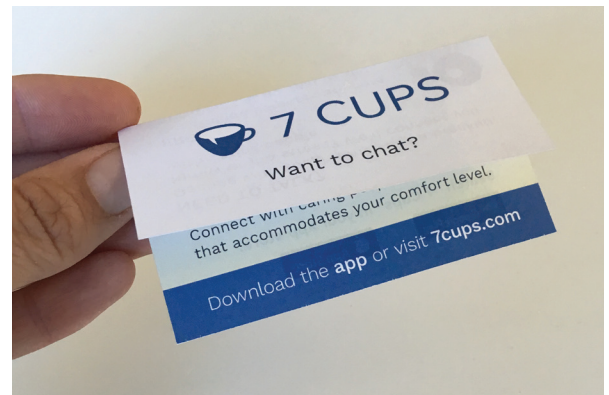
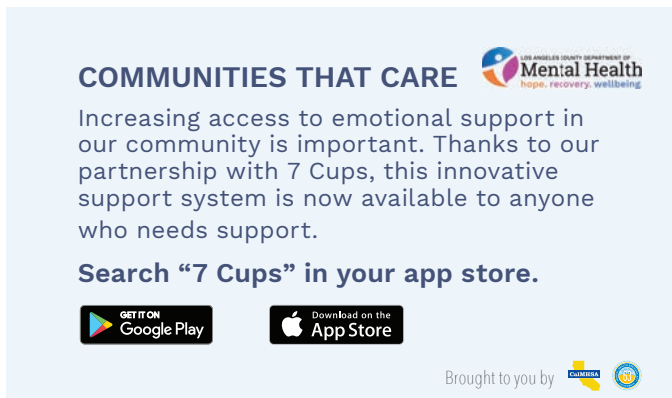
Interior



Back



Alternate Attribution Statement



YOUR MENTAL HEALTH ON YOUR TERMS



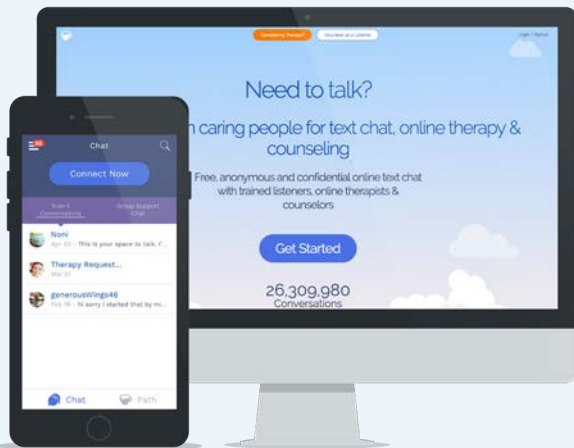
Through a statewide innovation effort, we're using technology to bring forward-thinking mental health services to our community. Get customized support, when you need it, on your terms. With a variety of **free, convenient and confidential** mobile services available, you now have access to a 24/7 support system.

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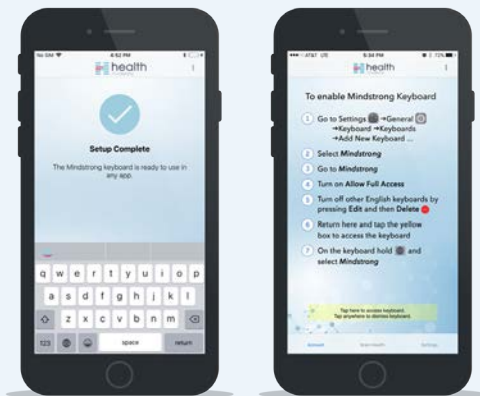
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How Intrepid Ascent Offers Value

Intrepid Ascent guides organizations through the data management demands of value-based care, with extensive experience orchestrating large-scale collaborative initiatives. We equip clients with the knowledge to make informed decisions, the tools to execute their plans effectively, and the momentum to sustain change. We offer a broad spectrum of professional services including health IT assessments, strategic planning, stakeholder engagement, governance and policy development, vendor selection, workflow redesign, implementation, and outcomes monitoring.



Our team combines expertise in the following areas to lead our clients to success:

- Health Information Exchange (HIE) – Intrepid Ascent’s team has led HIE planning and implementation projects in California and nationwide, guiding organizations to efficiently and appropriately share data to meet clinical, program, and business needs. We consider priority use cases, technical and operational infrastructure, and data protections to help organizations **establish successful connectivity** with key partners using national interoperability standards. Our team is skilled in convening stakeholders across sectors for HIE consensus-building in support of community-wide care integration projects.

Population Health Management – With the health care system transitioning to a focus on health outcomes, thriving in this landscape requires proactive care of specific populations and the data infrastructure to support it. Through comprehensive services from needs assessments to systems selection to implementation and change management, **we help clients optimize analytics and care management tools** within and across organizations to deliver high-value care.

- Patient-Centered Systems – Our team **enables clients to implement strategies that put individuals and their families at the center of coordinated care systems**, with transparent access to their health information, clear communication with their providers, and integration of consumer-facing apps with health care IT infrastructure.
- Data Quality – Trustworthy data is critical for clinical, program, and financial performance. Intrepid Ascent’s data quality services **leverage groundbreaking tools and techniques that assist in identifying and addressing data quality issues**. Our team combines expertise in workflow analysis, quality assessments, and data extraction to address immediate gaps and ongoing processes.
- Clinical Quality Reporting & Improvement – Smart approaches to data management form a foundation for clinical quality improvement. **We assist organizations with demonstrating data-driven improvement to meet the needs of clinical programs and changing funding structures**. Our team works closely with health care organizations on selecting measures for reporting and meaningful quality improvement over time.
- Privacy & Security – Intrepid Ascent provides guidance on the development and implementation of robust frameworks for health information privacy and security. Our approach goes **beyond focusing on technical infrastructure, addressing the relationships between organizational culture, information governance, and policy** to build a culture of compliance. We conduct assessments on privacy and security risks and organizational behavior; identify the privacy impacts of planned systems and services; and support the development of appropriate policies, governance, and technical infrastructure.



Our 2018 Clients Include:

California Department of Health Care Services • California Department of Public Health • California HealthCare Foundation • California Mental Health Services Authority • California Health Care Safety Net Institute • Marin County • Merced County • Placer County • San Joaquin County • Sacramento County • Sacramento Covered • San Joaquin Community Health Information Exchange • Santa Cruz Community Health Centers • Redwood Community Health Coalition • North Coast Health Improvement and Information Network • COPE Health Solutions • Object Health • Simi Group • Transform Health

Privacy and Security

Informed Consent & Data Sharing

Clinical Integration and Data Sharing Continuum – A Working Draft

Overview: This Clinical Integration and Data Sharing Continuum describes the service models to support various levels of application integration within a County. It is intended to show a progression from limited integration (e.g. promotion of the application to Clients in the County) to full integration with County behavioral health services to support care coordination, transitions of care, and clinical services within the application. For each level of integration, the continuum also identifies the types of data to be shared and the essential privacy and security requirements. The particular service model and progression within the continuum will be determined by each County depending on their stated project goals, objectives, and capabilities.

Informed Consent: The Technology Suite Integration Project Guiding Principles describe the overarching framework that governs the project to ensure the goals, objectives, and outcomes are met. A critical principle is Individual Choice, providing Clients the opportunity and the means to make informed decisions about their participation in the program and how their data is collected, used, and disclosed to other Project participants. It is the intent of all Project Participants to protect the confidentiality and security of Client information through the implementation of policies and procedures, including specifying when permission from the Client is required to share Personally Identifiable (PII) and Protected Health Information (PHI). The approach to informed consent is intended to maintain the confidentiality of Client information, while conforming to applicable State and Federal laws and integrating with County policies and workflows.

For the initial service model – limited integration through promotion of application availability – the informed consent process includes notification to the Client upon initial use of the application on the vendor’s terms of service and how data may be shared with the County. Client acceptance of the terms of service and use of the application serves as consent to sharing aggregate data only, with no PII or PHI being shared outside of the application. Counties have the option of providing additional education on the privacy practices within their existing workflows. As integration with County services progresses along the continuum, explicit consent from the Client is required, in addition to the terms of service and user acceptance. Detailed functional requirements and workflows for consent management will be determined in advance of a County adopting a more integrated service model to ensure policies and procedures are in place for all Project Participants.

Level of App Integration: Activity/Role:	Promotion of App Availability	Referrals of Individuals / Cohorts for App-Delivered Services	Referrals of Individuals / Cohorts for Real-Time Clinical Services	Coordination of Services / Transitions of Care Between County and App	Coordination of Services, Plus County Clinical Services Provided via App
Service Model	Promotion of app with County-specific in-app branding	Promotion + referral of specific individuals / cohorts for app-delivered services (e.g., peer support/chat, AI, communities, digital phenotyping, etc.)	Same + referral of specific individuals / cohorts for clinical services	Same + referrals + coordinated transitions of care between app and County	Same + referrals + coordinated transitions + some County services provided in-app
Current App Vendors	7 Cups (Mindstrong eventually)	7 Cups Mindstrong	7 Cups Mindstrong	Mindstrong	Mindstrong
Data Sharing Model	Aggregate reporting only, no Personally Identifiable Information/ Protected Health Information	Aggregate reporting; PII in referrals	Aggregate reporting; PII in referrals	Aggregate reporting; PII in referrals; bi-directional sharing of PHI	Aggregate reporting; PII in referrals; bi-directional sharing of PHI
Privacy & Security Requirements	<ul style="list-style-type: none"> • Terms of Service with language on data sharing with Counties • Informed consent: User acceptance • Business Associate Agreement between CalMHSA/County and Vendors 	<ul style="list-style-type: none"> • Terms of Service with language on data sharing with Counties • Informed consent: User acceptance + Authorization + County policies and Notice of Privacy Practices • Business Associate Agreement between CalMHSA/County and Vendors • Security controls (e.g. encryption, audit logs, secure file sharing, access controls, etc.) 	<ul style="list-style-type: none"> • Terms of Service with language on data sharing with Counties • Informed consent: User acceptance + Authorization + County policies and NPP • BAA between CalMHSA/County and Vendors • Security controls (e.g. encryption, audit logs, secure file sharing, access controls, etc.) 	<ul style="list-style-type: none"> • Terms of Service with language on data sharing with Counties • Informed consent: User acceptance + Authorization + County policies and NPP • Data Sharing Agreement between CalMHSA, Counties, and Vendors • Security controls (e.g. encryption, audit logs, secure file sharing, access controls, etc.) 	<ul style="list-style-type: none"> • Terms of Service with language on data sharing with Counties • Informed consent: User acceptance + authorization + County policies and NPP • DSA between CalMHSA, Counties, and Vendors • Security controls (e.g. encryption, audit logs, secure file sharing, access controls, etc.)

Privacy and Security Guiding Principles

Purpose

The Technology Suite Innovation Project is a multi-county, multi-vendor collaborative to increase access to mental health care and support and promote early detection of mental health symptoms that predict the onset of mental illness. The project includes offering a suite of virtual mental health care applications (Technology Suite) to counties, conducting outreach and marketing to increase access to care through Client use of the applications, and evaluating outcomes. The purpose of these Guiding Principles is to describe the framework for accomplishing project goals and objectives, as it relates to privacy and security of user data. These Guiding Principles are based on industry best practices, such as the Fair Information Practices, as well as approaches identified by CalMHSA and the Mental Health Services Oversight and Accountability Commission (MHSOAC).

The Guiding Principles are applicable across all Project Participants, which include:

- **Application Vendors** – Organizations contracted with CalMHSA to provide the suite of technology components to Counties
- **Counties** – Approved by the MHSOAC to implement Innovation projects
- **CalMHSA** – Joint Powers Authority providing oversight and management of the Technology Suite
- **Experts** – Organizations contracted with CalMHSA to provide technical assistance and subject matter expertise in carrying out the Project

Guiding Principles

Shared Services – Leverage economies of scale through the pooling of resources while ensuring flexibility to meet specific County needs.

Sustainability – Implement Innovation projects to meet intended goals and objectives while establishing a framework for long-term sustainability and growth.

Innovation – Promote and support Innovation to find new ways to improve access to mental health services, leverage new technologies, and improve client outcomes.

Communication and Collaboration – Promote open, timely communication with Project Participants and stakeholders and work collaboratively to support the goals and objectives of the Project.

Oversight and Accountability – Report and resolve issues in a timely manner; monitor overall program to ensure goals and outcomes are met; and provide regular reporting to stakeholders, including MHSOAC.

Shared Governance and Policies – Maintain a well-documented governance framework with clear policies supported and endorsed by all stakeholders that allows for the guiding principles to be

implemented, and that can be easily accessed by and shared with other Project Participants and stakeholders.

Compliance – Ensure compliance with relevant federal and state laws, regulations, and contractual obligations, including taking all necessary steps to implement or modify policies and procedures to ensure ongoing compliance.

Health Information Technology Standards – Wherever possible, utilize widely accepted healthcare information technology standards for data content and transport.

Data Quality & Integrity – Ensure the accuracy, completeness, and timeliness of all data and facilitate the sharing of meaningful information across all Project Participants to improve care.

Security Safeguards & Controls – Protect the confidentiality of Client information through alignment with national best practices by implementing, or modifying as appropriate, all administrative, technical, and physical safeguards and preventing unauthorized or inappropriate access, use, or disclosure.

Openness and Transparency – Be open and transparent about policies, procedures, and technologies, particularly as it relates to how data is used, stored, and shared with and among Project participants. Use every opportunity to inform Clients about what information has collected about them, the purpose of its use, who can access and use it, where it resides, and how they may obtain access to and control who has access to their information.

Individual Choice – Provide the opportunity and the means for Clients to make informed decisions about their participation in the program and how their data is collected, used, and disclosed to other Project participants.

The following table further delineates the roles of each type of entity to assure these principles are applied and adhered to throughout the design and conduct of the project.

	App Vendors	Counties	CalMHSA	Experts
Shared Services	Work to standardize service offerings, integration deployments, and product customizations across Counties	Work to co-develop and keep each other informed of special projects, services, and app service offerings	Coordinate sharing of information on services between Vendors and Counties, helping all to stay informed on innovative and/or successful strategies	Assist Participants in adopting successful strategies for shared services and evaluating effectiveness
Sustainability	Develop customizations and service offerings that	Develop sustainability plans and allocate resources at	Develop sustainability plan for shared services in alignment	Evaluate sustainability plans to ensure success and support the cross-



	App Vendors	Counties	CalMHSA	Experts
	fit into sustainability plans	appropriate level to succeed	with individual County plans	pollination of promising approaches between Counties
Innovation	Suggest innovative approaches that have worked in other environments and implement innovative solutions developed by Counties	Develop innovative approaches to services and technologies that fit local use-cases and target populations	Coordinate among Participants to drive real tests of change and share outcomes	Determine how innovations can be expanded and/or improved, and evaluate innovations to ensure they fit into overall Project framework
Collaboration	Collaborate with Participants and communicate in a clear and timely manner	Collaborate with Vendors and internal County stakeholders and communicate in a clear and timely manner	Foster collaboration among counties and between counties and vendors and establish a mechanism for reporting issues	Find new ways for Participants to collaborate, building on past successes and fostering open communication
Oversight and Accountability	Work with Counties and CalMHSA to develop standardized methods for reporting	Submit reports to CalMHSA	Design reporting requirements and provide project oversight	Assist participants in using standardized technologies and processes for reporting, working to ensure limited burden on participants
Shared Governance & Policies	Adopt standard policies and governance developed by Counties	Work to co-develop and keep each other informed of governance and policies	Coordinate governance for shared decision-making and develop associated policies	Assist CalMHSA and Participants in adopting successful strategies for shared governance and decision-making
Compliance	Follow relevant laws, regulations, and policies	Evaluate customizations and innovations for compliance with statutes, share information between counties on strategies for compliance	Develop Project policies; share information between counties on strategies for compliance	Evaluate customizations and innovations for compliance with applicable laws, regulations, and policies
Health Information Technology Standards	Implement customizations and new services using common Health IT	Suggest uses of common Health IT standards by Vendors; support standards-based	Evaluate and, as appropriate, require use of Health IT standards by app	Evaluate proposals for use of Health IT standards, suggest innovative



	App Vendors	Counties	CalMHSA	Experts
	standards whenever possible	data-sharing capabilities in County systems if integrating with apps	vendors and/or Counties	approaches that leverage standards
Data Quality & Integrity	Implement safeguards to ensure data quality and integrity	Manage data quality and integrity, especially where local county IT systems are sharing information with Vendors	Help Counties and Vendors share strategies for managing data quality and integrity, evaluate integrity of reporting data	Assist Participants in identifying strategies for data quality and integrity management, assist in evaluation processes
Security Safeguards & Controls	Implement customizations and new services using common Health IT standards for security whenever possible	Suggest use of common Health IT standards for security by vendors whenever possible	Evaluate and, as appropriate, require use of Health IT standards by app vendors and/or Counties	Evaluate proposals for use of Health IT standards for security, suggest innovative approaches that leverage standards
Openness & Transparency	Adopt standard terms of service and privacy policy to inform Clients about how their data is used and with whom their data will be shared	Establish clear policies and procedures to inform Clients how County is integrating with applications and how data will be used	Help Counties and Vendors share strategies for managing policies and procedures	Assist Participants in finding strategies for implementing policies and procedures
Individual Choice	Implement an informed consent process within the app consistent with standard terms of service and privacy policies	Provide notification to Clients about how their data will be shared with Vendors	Identify minimum requirements for informed consent; Assist Vendors and Counties with implementing an informed consent process	Assist Participants with implementing an informed consent process and evaluate effectiveness

Evaluation and Performance Monitoring

Selected Evaluator

Based on qualification criteria delineated in the next section, **University of California, Irvine** was selected as the evaluator, as they exhibited competence and excellence in the following areas:

- **Applicable Experience and Staffing:** UCI's staff includes a diversity of personnel with a wide array of experience and subject matter expertise including clinical, informatics, and program evaluation. Additionally, their staff has previously been involved in participatory research grounded in cultural anthropology.
- **Previous Evaluation Projects:** In their proposal, UCI detailed a history of very relevant mental health projects including innovate mobile and web-based technologies, digital products and apps, and digital phenotyping. Projects included extensive development and evaluation of self-developed projects as well as those developed by others.
- **Proposed Evaluation Framework:** UCI demonstrated an impressive depth and breadth of thinking related to frameworks involved in the project; they did not just mention appropriate frameworks, they advanced and applied frameworks with obvious care and forethought. The suggested implementation strategy utilizing the frameworks demonstrated similarly careful consideration.
- **Data Collection:** In applying the above frameworks, UCI provided a wide range of interesting questions and ideas for evaluation. They convey an understanding of and willingness to adapt to the program's evolving needs, identifying and anticipating several potentially important challenges.

Evaluation

Overview & Approach

The Tech Suite Collaborative Innovation Project has selected a single qualified vendor (University of California, Irvine) to conduct formative evaluations of the statewide implementation of the suite, as well as for each participating county.

A formative evaluation is the chosen approach as it is a “rigorous assessment process designed to identify potential and actual influences on the progress and effectiveness of implementation efforts.” The goals of the formative evaluation approach which match the needs of the Tech Suite evaluation include:

- **Developmental**: plan for successful uptake of an intervention by clearly defining the problem and understanding its context, designing or adapting an intervention to address a problem and utilizing an implementation framework to anticipate negative unintended consequences, and understanding the organizational context (e.g. readiness) and stakeholder perspectives on a planned intervention;
- **Implementation**: help ensure a project is successfully implemented by monitoring key indicators, work with stakeholders to pivot/change/adapt as need arises to respond to both internal and external factors;
- **Interpretation**: create generalizable knowledge for how to successfully implement the intervention in other settings.

Tech Suite Outcomes to be Evaluated: The health and clinical outcomes to be assessed through the Tech Suite evaluation include:

- Adherence to a treatment protocol (which may be pre-programmed into an app, such as daily maintenance exercises; or developed by a professional, such as medication adherence).
- Improving safety (e.g. reduce adverse events)
- Increasing quality (e.g. on patient-reported outcome measures)
- Increasing access (to technology products, or to traditional medical services)
- Increasing treatment-seeking behaviors (e.g. utilizing previously unused services)
- Reducing utilization (e.g. ED visits, hospitalization, frequency of in-person visits)
- Improving recognition of and treatment outcomes for vulnerable or at-risk patients
- Increasing community engagement and target population(s) reach

Evaluator Selection: The evaluator selection process had two phases: pre-qualification and competitive selection.

1. **Pre-Qualification**: Through an RFSQ solicitation, CalMHSA received from a variety of organizations their qualifications to evaluate the three-year innovation Tech Suite project. An independent panel reviewed these organizations’ proven ability to evaluate the following impacts:

- Changes in user’s utilization of inpatient and emergency service.
- Changes in the duration of untreated or under-treated mental illness.
- Changes in ability for users to identify cognitive, emotional and behavioral changes and act to address them.
- Changes in quality of life, as measured objectively and subjectively (by user and by indicators such as activity level, employment, school involvement, grades, etc.).
- Measurement and evaluation of user wellbeing and social connectedness.
- Comparative analyses of population level utilization data in participating counties over the life of the project to determine impact on various types of service utilization.
- Changes in how users with particular biomarkers (characteristics identified either through history or digital phenotyping analysis) respond to treatment options identified through this project.

In addition, they assessed their capabilities to:

- Analyze how the technology suite is used as a source of information and is guiding interventions provided by mental health professionals.
- Conduct an analysis of retrospective and prospective utilization of hospital resources from claims data and medical records data. The analysis shall incorporate disease risk stratification, digital phenotype and digital biomarker measurement, type of intervention, and delay in receiving care. Quality of like impact will include, where applicable, school grades, graduation rates, job retention, and absenteeism.
- Track and report number of users, including ethnicity, gender and preferred language.

Review of the qualifications of respondents led to the selection of two “pre-qualified” evaluator candidates.

2. Competitive Selection: The second step leading to final selection of the innovation evaluator was a competitive comparison of the pre-qualified agencies based on:

- Applicable Experience and Staffing: Experience with formative evaluation methods, including qualitative interviewing, participant observation, surveys, analysis of secondary data, and integrating data collected using mixed methods;
- Previous Evaluation Projects: Description of actual projects involving formative evaluations, with emphasis on those involving mental health interventions, health IT/informatics interventions, and interventions involving participatory research
- Proposed Evaluation Framework: Conceptual frameworks for implementation research and formative evaluation used in previous work and description of how they were applied to address the research question(s).
- Data Collection: Types of research questions, conceptual frameworks, data needed to be

collected, formative evaluation approaches, clinical and health outcomes (from list above), and anticipated challenges that might be relevant to the Tech Suite Innovation project.

Evaluation Panel Credentials

A panel of highly experienced professionals convened to evaluate the proposals of the two ‘pre-qualified’ vendor candidates using the above criteria. This panel represented or had lived experience with/in:

- County and State behavioral health planning, advocacy, and evaluation (executive level)
- CBO and CBO board experience
- Health IT Innovation design, development, and research
- African American Perspectives
- Lived experience; have received mental health treatment
- Rural counties: implementing and evaluating behavioral health programs
- Large (urban) counties: implementing and evaluating behavioral health programs
- Engaging diverse communities in mental health or other social causes
- Completed graduate degree

MHSA Evaluation Requirements

In order to adhere to MHSA regulations (per Section 3580.010) and assure a thorough evaluation of the innovation’s impact on target populations, each application vendor is required to gather the demographic information (listed below) about end users. In turn, the selected evaluator will aggregate, analyze and report on impacts to individuals served in the following attributes:

- Age
- Race
- Ethnicity
- Primary language used by threshold languages for the individual county
- Sexual orientation
- Disability
- Veteran status
- Gender

GENERAL

Dashboard

REPORTS

Overview

Traffic

Users

Time

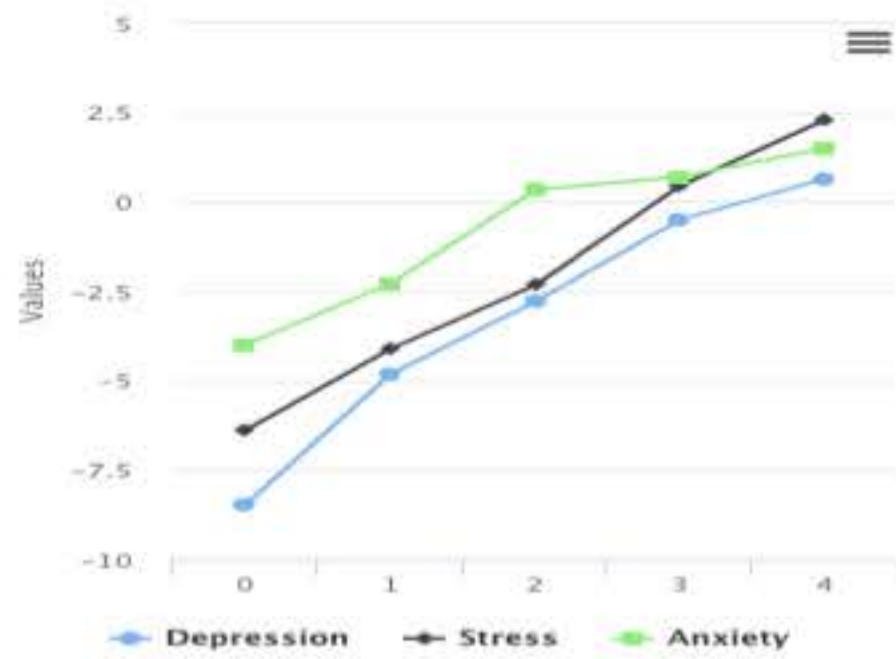
Location

Sources

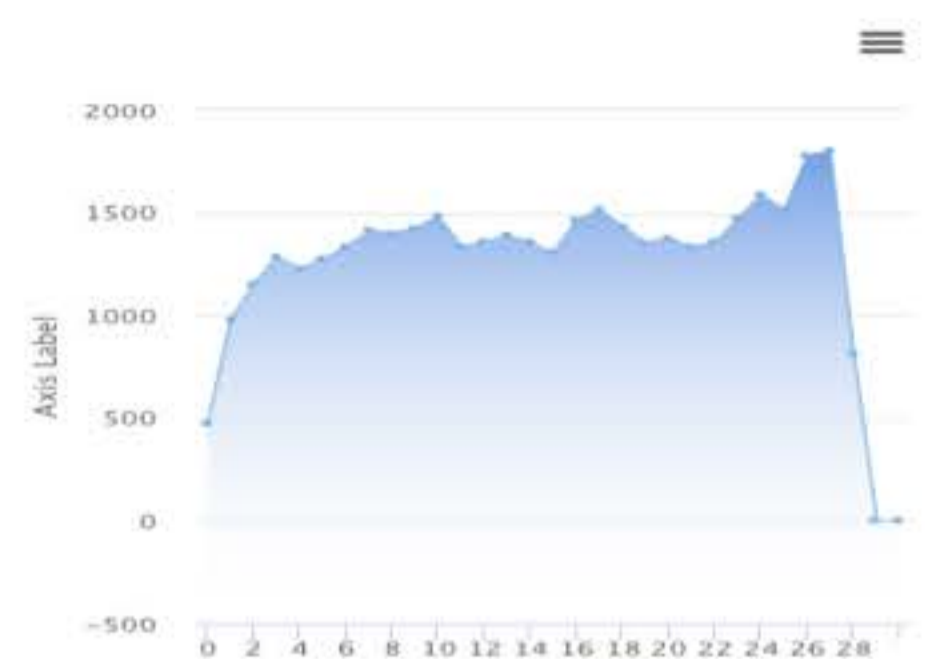
Language

Home / Dashboard / Report

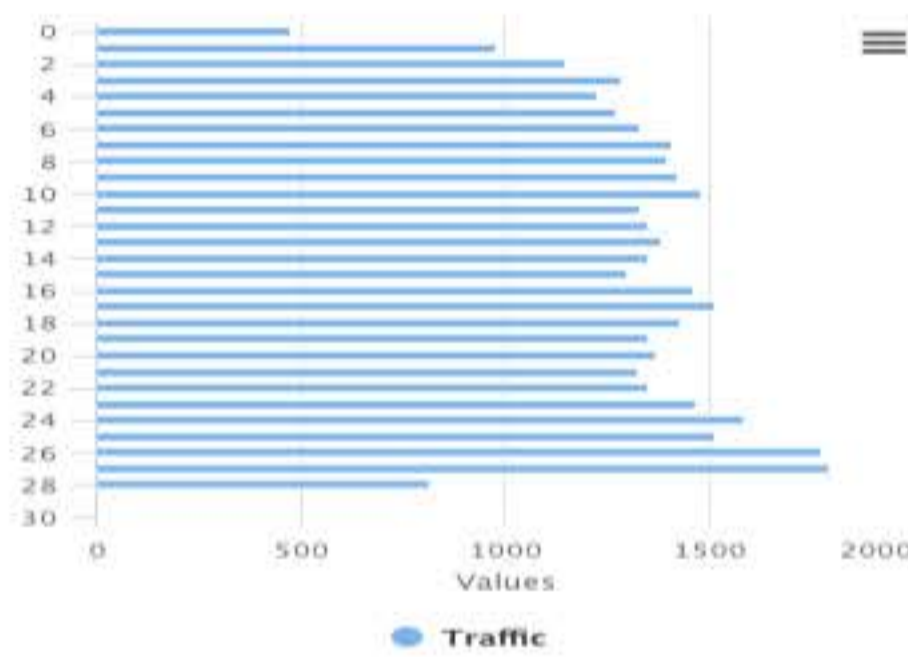
Wellness Test Results (Outcomes)



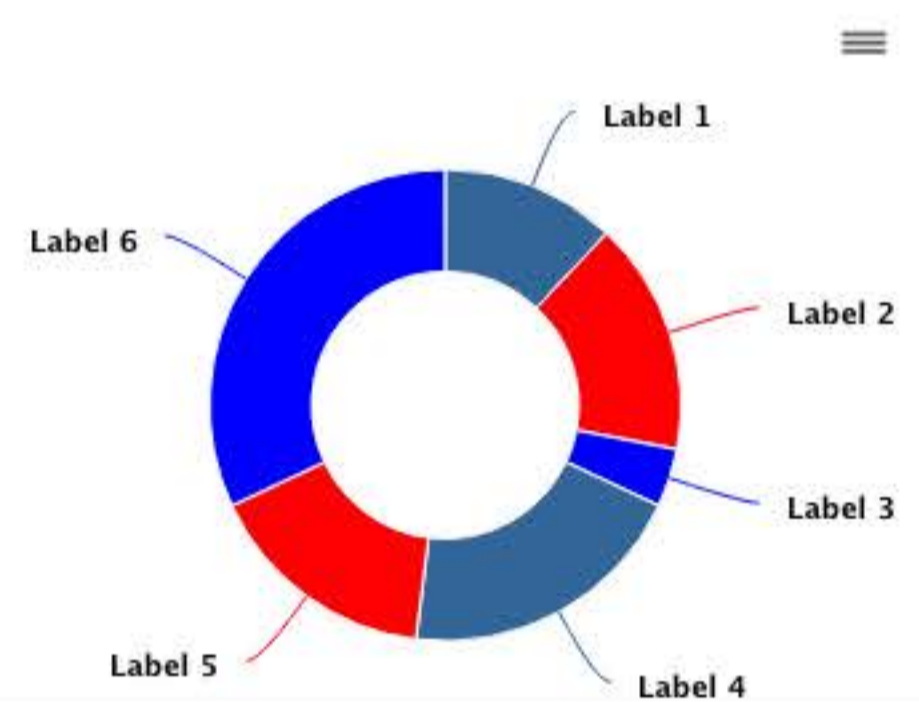
Active Users in LA County



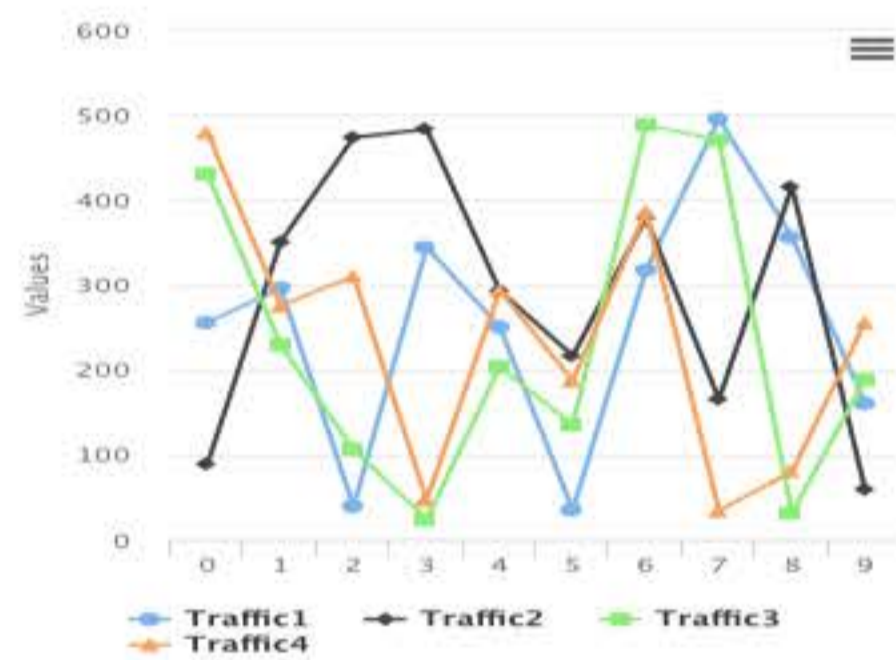
Top Locations in LA County



Top Languages in LA County



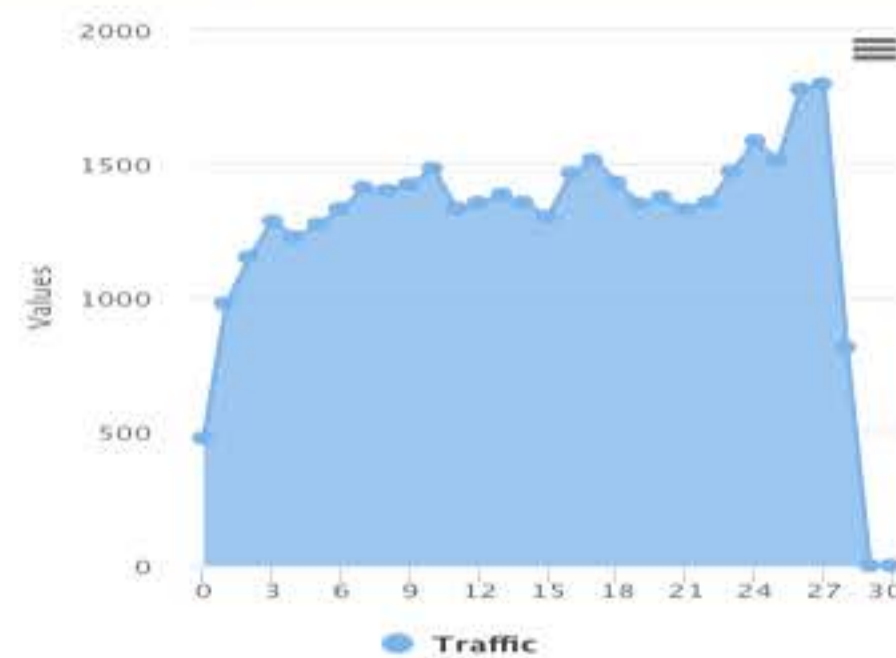
Traffic by Referral Source



All Traffic



Session Length / Time on Site



Percentage of Users in Treatment Before

