August 23, 2018
PowerPoint Presentations and Handouts

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To Who It May Concern

Subject: MHSA FUNDS FOR Marin County

In my family, growing up, we were taught some basic principles. One stands out and serves as a beacon to show the way. In a time of economic prosperity there is enough to go around anccommodate those in need.

Marin is a county rapidly growing older with 1 out of 4 aged 60 + and in short time there will be 1 out of 3 aged 60+. Surveys have shown older adults being worried about losing their memory, cognitive deficits and feeling lonely and isolated. It is estimated that better than 20% of people 55 or older have mental health issues having to do with mood disorder and/or cognitive decline. The American Psychiatric Association and UCLA studies document the fact that older adults with mental health needs remain undiagnosed and untreated.

The passage of MHSA created immense opportunities to address the mental health needs of Californias. However, disparities in access to mental health services for older adults in Marin County still exists.

There is a system of care in Marin County offering full range services to children and young adults. The older adult population is not yet benefiting from a system of care. A recently published UCLA study of MHSA State programs reported that as of 2014, the MHSA of 2004 generated $13 BILLION to fund delivery of services in the public mental health sector They found that NO MONEY IS SPECIFICALLY EARMARKED TO DEVELOP A SYSTEM OF CARE FOR OLDER ADULTS! In contrast, children's mental health programs do receive earmarked funding. In Marin County, the budgetary figures for mental health and prevention services amount to about 50% of the total funds available.

The authors of the UCLA study report that more information is needed about older adults who develop late-onset mental health problems and how they find their way to public health services. Their findings indicate that less than one third of older adults who need mental health services are receiving that care.

Chrisula Asimos PhD. Marin COA Volunteer, Mari Villages & FAST

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Assembly Member Lorena S. Gonzalez Fletcher
Chair, Appropriations Committee
State Capitol, Room 2114
Sacramento CA 95814

RE SB 1004: Support if amended

Dear Honorable Gonzalez Fletcher

The California Association of Mental Health Peer Run Organizations (CAMHPRO) is a statewide consumer run organization with the mission to empower, support and ensure the rights of consumers, eliminate stigma, and advance self-determination

Although CAMHPRO appreciates the positive changes that have been made in SB 1004 in response to feedback, **CAMHPRO cannot support the bill without revisions.** We understand that amendments are being developed to address some of our ongoing concerns. For example, we have been advised that older adults will be added as a special population prioritized for Prevention and Early Intervention (PEI) funding. The exclusion of older adults was a major concern of ours.

Our remaining areas of concern include:

- The bill seems to supplant local stakeholders' developing PEI plans that fit the needs of their specific communities. This local stakeholder planning process is the basis of the MHSA. The legislature setting statewide priorities for all of California violates the local and stakeholder mandate of the MHSA.
- The bill is too restrictive, excluding the large population of adults. Adding "across the life span in 5840.7 (a) (2) and 5840.6 (g) (3) isn't enough emphasis to include people of all ages. Emerging emotional crises can occur for individuals across any time span across the life span. The bill discriminates against age groups other than children, youth and older adults – the largest age group within the life span. Adults in addition to transitional age youth need to be prioritized in outreach and engagement programs, whether these are wellness centers which empower individuals and thus can prevent serious mental health issues to rise, or stigma reduction activities which promote individuals to live fully integrated lives in the community.
- Within the transitional age group, college students are prioritized. Many youth do not go to college after high school, youth whose emotional difficulties may make it difficult for them to continue school and youth from under privileged communities, especially youth of color.

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- The legislature may be the wrong place to define in detail what PEI funds can be used for. Legislation is written in stone. The priorities may change with time. The bill has the appearance of a strategic plan to address current problems. But current problems and thus strategic plans change with time.
- What will happen to services that are currently funded under PEI that do not meet the more restrictive focus for PEI funds? Can there be a grandfathering in of these programs? Otherwise, counties (and more importantly, the people whom these programs are serving) will lose excellent programs that are benefiting individuals' lives.

For these reasons, CAMHPRO cannot support SB 1004 at this time.

Sincerely,

Sally Zinman

Sally Zinman
Executive Director, California Association of Mental Health Peer Run Organizations (CAMHPRO)

Cc:
Senator Scott Wiener
Senator John Moorach
Senator Anthony J. Portantino
Adrienne Shilton, Government Affairs Director, the Steinberg Institute
Assembly Appropriations Committee members

AMENDED IN ASSEMBLY AUGUST 20, 2018

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 ⅔ 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 authorize counties to act jointly to meet specified requirements.* 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: ⅔. Appropriation: no. Fiscal committee: yes. State-mandated local program: yes.

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

SECTION 1. The Legislature finds and declares all of the following:

(a) Mental illness affects one in four people in the United States and is the leading cause of disability worldwide.

(b) Every year, 100,000 young adults in the United States experience their first psychotic episode, frequently involving debilitating hallucinations and delusions.

(c) The average delay in receiving appropriate diagnosis and treatment is an astonishing 18.5 months after the illness takes root and the patient suffers their first psychotic break.

(d) The longer a mental illness goes untreated, the more likely it is that a young person will spiral down a damaging course and find themselves unable to graduate, form relationships, or hold a job.

(e) Fifty percent of all mental illness begins by 14 years of age and 75 percent by 24 years of age, yet young people are often reluctant and afraid to seek help.

(f) One in 10 college students has considered suicide. Suicide is the second leading cause of death among college students, claiming more than 1,100 lives nationally every year.

(g) The Adverse Childhood Experiences Study, an observational study of the relationship between trauma in early childhood and morbidity, disability, and mortality in the United States, demonstrated that trauma and other adverse experiences are associated with lifelong problems in mental health, addiction, and general health.

(h) Toxic stress, which is the result of frequent or prolonged biological responses to adversity, can damage a developing brain and increase the likelihood of significant mental illness and problems that may emerge immediately or in years to come.

(i) In California, nearly ~~one~~ *1* in 7 children have experienced abuse or neglect.

(j) In the United States, more than 6 in 10 young people have been exposed to violence within the past year, including witnessing

violence, assault with a weapon, sexual victimization, child maltreatment, and dating violence. Nearly ~~one~~ *1* in 10 was injured.

~~(k) Older adults face a significant risk of mental health conditions due to failing health, isolation, economic insecurity, and vulnerability to exploitation, often leading to depression, anxiety, and psychological traumas.~~

~~(l)~~

(k) Early intervention in mental illness comes with a measurable cost benefit. A joint analysis by the National Academies of Sciences, Engineering, and Medicine determined that every $1 invested in prevention and early intervention for mental illness and addiction programs yields $2 to $10 in savings related to health costs, criminal and juvenile justice costs, and low productivity.

~~(m)~~

(l) A multiyear review by the National Institute of Mental Health found that patients with first episode psychosis who received early intervention, with coordinated specialty care, experienced greater improvement in their symptoms, relationships, and quality of life. They were also more involved in work or school compared with patients who did not receive these services.

~~(n)~~

(m) A report conducted by the University of California at Los Angeles Center for Health Policy Research in 2015 states that more than 70 percent of behavioral health conditions are diagnosed and treated within the primary care setting, underscoring the critical role of primary care in linking clients to care across their lifespans.

~~(o)~~

(n) As documented in "Mental Health: A Report of the Surgeon General" and its supplement, "Mental Health: Culture, Race, and Ethnicity," racial and ethnic minorities have less access to mental health services, are less likely to receive needed care, and are more likely to receive poor quality care when treated.

(o) A report, entitled "Mental Health Services for Older Adults: Creating a System that Tells the Story," conducted by the University of California at Los Angeles Center for Health Policy Research in January 2018, states that services provided under the Mental Health Services Act are insufficient. The report identifies the need to further involve and include older adults in the Prevention and Early Intervention programs, including the planning process and outreach efforts, and improve the

coordination and administration of the older adult system of care at the statewide level.

(p) Older adults face a significant risk of mental health conditions due to failing health, isolation, economic insecurity, and vulnerability to exploitation, often leading to depression, anxiety, and psychological traumas.

(q) The average age for onset of a major depressive disorder is 32.5 years.

(r) Older adults consist of 13 percent of the population. However, this population has the highest suicide rate of any age group, and older adults account for 20 percent of the people who commit suicide.

SEC. 2. The heading of Chapter 1 (commencing with Section 5840) is added to Part 3.6 of Division 5 of the Welfare and Institutions Code, to read:

CHAPTER 1. PREVENTION AND EARLY INTERVENTION PROGRAMS

SEC. 3. Chapter 2 (commencing with Section 5840.5) is added to Part 3.6 of Division 5 of the Welfare and Institutions Code, to read:

CHAPTER 2. PREVENTION AND EARLY INTERVENTION PROGRAM PLANNING

5840.5. It is the intent of the Legislature that this chapter achieve all of the following:

(a) Expand the provision of high quality Mental Health Services Act (MHSA) Prevention and Early Intervention (PEI) programs at the county level in California.

(b) Increase the number of PEI programs and systems, including those utilizing community-defined practices, that focus on reducing disparities for unserved, underserved, and inappropriately served racial, ethnic, and cultural communities.

(c) Reduce unnecessary hospitalizations, homelessness, suicides, and inpatient days by appropriately utilizing community-based services and improving timely access to prevention and early intervention services.

(d) Increase participation in community activities, school attendance, social interactions, physical and primary health care

services, personal bonding relationships, and rehabilitation, including employment and daily living function development for clients.

(e) Increase collaboration and coordination among primary care, mental health, and aging service providers, and reduce hesitance to seek treatment and services due to mental health stigma.

~~(e)~~

(f) Create a more focused approach for PEI requirements.

~~(f)~~

(g) Increase programmatic and fiscal oversight of county MHSA-funded PEI programs.

~~(g)~~

(h) Encourage counties to coordinate and blend funding streams and initiatives to ensure services are integrated across systems.

~~(h) Leverage~~

(i) Encourage counties to leverage innovative technology platforms.

~~(i)~~

(j) Reflect the stated goals as outlined in the PEI component of the MHSA, as stated in Section 5840.

5840.6. For purposes of this chapter, the following definitions shall apply:

(a) "Commission" means the Mental Health Services Oversight and Accountability Commission established pursuant to Section 5845.

(b) "County" also includes a city receiving funds pursuant to Section 5701.5.

(c) "Prevention and early intervention funds" means funds from the Mental Health Services Fund allocated for prevention and early intervention programs pursuant to paragraph (3) of subdivision (a) of Section 5892.

(d) "Childhood trauma prevention and early intervention" refers to a program that targets children exposed to, or who are at risk of exposure to, adverse and traumatic childhood events and prolonged toxic stress in order to deal with the early origins of mental health needs and prevent long-term mental health concerns. This may include, but is not limited to, all of the following:

(1) Focused outreach and early intervention to at-risk and in-need populations.

(2) Implementation of appropriate trauma and developmental screening and assessment tools with linkages to early intervention ~~services.~~ *services to children that qualify for these services.*

(3) Collaborative, strengths-based approaches that appreciate the resilience of trauma survivors and support their ~~roles as~~ parents and caregivers when appropriate.

(4) Support from ~~peers~~ *peer support specialists* and community health workers trained to provide mental health services.

(5) ~~Two-generational~~ *Multigenerational* family engagement, education, and support for navigation and service referrals across systems that aid the healthy development of children and families.

(6) Linkages to primary care health settings, ~~including~~ *including, but not limited to,* federally qualified health centers, rural health centers, ~~and~~ *community-based providers,* school-based health ~~centers and~~ *centers, and school-based* programs.

(7) 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.

(8) Coordinated and blended funding streams to ensure individuals and families experiencing toxic stress have comprehensive and integrated supports across systems.

(e) "Early psychosis and mood disorder detection and intervention" has the same meaning as set forth in paragraph (2) of subdivision (b) of Section 5835 and may include programming across the age span.

(f) ~~"Outreach~~ "*Youth 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. Outreach and engagement may include, but is not limited to, all of the following:

(1) Meeting the mental health needs of students that cannot be met through existing education funds.

(2) Establishing direct linkages for students to community-based mental health services.

(3) Addressing direct services, including, but not limited to, increasing college mental health staff-to-student ratios and decreasing wait times.

(4) Participating in evidence-based and community-defined best practice programs for mental health services.

(5) 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.

(6) Establishing direct linkages for students to community-based mental health services for which reimbursement is available through the students' health coverage.

(7) Reducing racial disparities in access to mental health services.

(8) Funding mental health stigma reduction training and activities.

(9) Providing college employees and students with education and training in early identification, intervention, and referral of students with mental health needs.

(10) 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.

(11) Integrated youth mental health programming.

(12) Suicide prevention programming.

(g) "Culturally competent and linguistically appropriate prevention and intervention" refers to a program that creates critical linkages with community-based organizations, including, but not limited to, clinics licensed or operated under subdivision (a) of Section 1204 of the Health and Safety Code, or clinics exempt from clinic licensure pursuant to subdivision (c) of Section 1206 of the Health and Safety Code.

(1) "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.

(2) "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.

(h) "Strategies targeting the mental health needs of older adults" means, but is not limited to, all of the following:

(1) Outreach and engagement strategies that target caregivers, victims of elder abuse, and individuals who live alone.

(2) Suicide prevention programming.

(3) Outreach to older adults who are isolated.

(4) Early identification programming of mental health symptoms and disorders, including, but not limited to, anxiety, depression, and psychosis.

5840.7. (a) On or before January 1, 2020, the commission shall establish priorities for the use of prevention and early intervention funds. These priorities shall include, but are not limited to, the following:

(1) Childhood trauma prevention and early intervention to deal with the early origins of mental health needs.

(2) Early psychosis and mood disorder detection and ~~intervention, including mood disorder~~ *intervention, and mood disorder and suicide prevention* programming that occurs across the lifespan.

(3) ~~Outreach~~ *Youth outreach* and engagement strategies that target secondary school and transition age youth, with a priority on partnership with college mental health programs.

(4) Culturally competent and linguistically appropriate prevention and intervention.

(5) Strategies targeting the mental health needs of older adults.

~~(5)~~

(6) Other programs the commission identifies, with stakeholder participation, that are proven effective in achieving, and are reflective of, the goals stated in Section 5840.

(b) On or before January 1, 2020, the commission shall develop a statewide strategy for monitoring implementation of this part, 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 commission shall analyze and monitor the established metrics using existing data, if available, and shall propose new data collection and reporting strategies, if necessary.

(c) The commission shall establish a strategy for technical assistance, support, and evaluation to support the successful implementation of the objectives, metrics, data collection, and reporting strategy.

(d) *(1)* The portion of funds in the county plan relating to prevention and early intervention shall focus on the ~~priorities established by the commission.~~ *established priorities, and shall be allocated, as determined by the county, with stakeholder input.* A county may 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 plan shall include a description of why those programs are included and metrics by which the effectiveness of those programs is to be measured.

(2) Counties may act jointly to meet the requirements of this section.

(e) If the commission requires additional resources for these purposes, it may prepare a proposal for consideration by the appropriate policy committees of the Legislature.

5840.8. Notwithstanding the rulemaking provisions of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code), the commission may implement this chapter without taking regulatory action until regulations are adopted. The commission may use information notices or related communications to implement this chapter.

SEC. 4. The Legislature finds and declares that this act furthers the intent of the Mental Health Services Act, enacted by Proposition 63 at the November 2, 2004, statewide general election.

SEC. 5. If the Commission on State Mandates determines that this act contains costs mandated by the state, reimbursement to local agencies and school districts for those costs shall be made pursuant to Part 7 (commencing with Section 17500) of Division 4 of Title 2 of the Government Code.

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MONTEREY COUNTY BEHAVIORAL HEALTH

Avanzando Juntos
Forward Together

Monterey County Innovations:

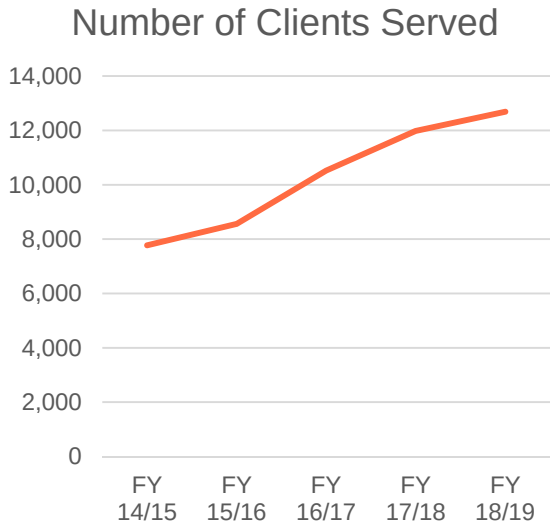
Micro-Innovation Grant Activities for Increasing Latino Engagement

Presented by Amie Miller, Psy.D, MFT
Behavioral Health Director

Micro-Innovation Grant Activities for Increasing Latino Engagement

Problem: Persistent gap in services to our Latino population.

- **75%** of Medi-Cal eligible population in Monterey County is Latino.
- For the past five years, only **54%** of our clients were Latino, despite the fact that the overall number of clients served by County-operated programs and our network of contractors has increased by **63%**.
- Achieving Health Equity is our number one priority. Our Behavioral Health Commission and Board of Supervisors have endorsed our goal of increasing Latino engagement in services by **7%** by 2020.



Micro-Innovation Grant Activities for Increasing Latino Engagement

Proposed Innovation: Create a competitive process to offer mini-grants for innovative projects aimed at increasing Latino engagement in our local mental health system. This will create an opportunity to test small scale community-driven innovation.

- Time-Limited: one-time or continuous (1 year maximum)
- $1,000 - $50,000
- Payment conditional on achievement of deliverables
- Micro-Innovation Grant Review Board to be assembled of MCBH staff, consumers and community stakeholders to review proposals and award mini-grants
- Proposals required to include a “Plan, Do, Study, Act” evaluation strategy

Innovative Component: Support network of small-scale client and community-driven projects to foster rapid learning on effective strategies for Latino community engagement.

Micro-Innovation Grant Activities for Increasing Latino Engagement

Community Planning Process:

- 13 focus groups (n=232)
- Underserved Latino communities survey (n=214)
- 4 planning workshops (n=114)

Identified Barriers to Receiving Care:

- Language / Cultural barriers
- Gang violence
- Political climate / Fear and distrust of government
- Lacking knowledge of mental health conditions / resources
- Transportation

Lessons Learned:

- Plenty of interest in small group activities (zumba, soccer, parent groups, etc.)
- Interest in using local communal areas to convene services in innovative locations.

Micro-Innovation Grant Activities for Increasing Latino Engagement

Learning Goals:

- Does supporting small-scale efforts contribute to rapid learning and increased engagement of Latino populations?
  - *Evaluation*: Review EHR data for increase in Latino demographics
- For each micro-innovation:
  - How many new Latino individuals engaged in services without prior engagement?
  - How many successful referrals were made?
  - To which type of service were referrals made?
  - Which activities demonstrated successful engagement and referral strategies?
  - Which cultural or other barriers were identified and/or addressed?
    - *Evaluation:* Assessment of individual micro-innovation evaluation tools (surveys, sign-in sheets, etc.) in conjunction with EHR data, if applicable. Evaluation strategies to be refined and/or approved as part of proposal review process
- Exit Summit with all grantees to be held to showcase activities and outcomes/learning.

Micro-Innovation Grant Activities for Increasing Latino Engagement

Timeline: 3 years

Total Budget: $1,240,000

- County Personnel: $201,000
  - 0.3 FTE Management Analyst (Project Coordination)
  - 0.2 FTE Epidemiologist (Evaluation)
  - 0.18 FTE Chronic Disease Prevention Specialist (Community Outreach)
- Consultant Costs / Contracts: $1,039,000
  - Micro-Innovation Grant Review Board
  - Fiscal Agent (15% administrative fee per grant)
  - Grantees
  - Translation Services

Sustainability: Promising practices may be integrated into PEI and CSS programming or supported with non-MHSA funds.

Micro-Innovation Grant Activities for Increasing Latino Engagement

Questions?

Amie Miller, Psy.D, MFT: MillerAS@co.monterey.ca.us

Wesley Schweikhard, MPP: Schweikhardw@monterey.ca.us

Micro-Innovation Grant Activities for Increasing Latino Engagement

- **Proposed Motion:** The MHSOAC approves Monterey County's Innovation Projects, as follows:

- **Name:** Micro-Innovation Grant Activities for Increasing Latino Engagement
- **Amount:** $1,240,000
- **Project Length:** Three (3) Years

MONTEREY COUNTY BEHAVIORAL HEALTH

Avanzando Juntos
Forward Together

Monterey County Innovations:

Transportation Coaching by Wellness Navigators

Presented by Amie Miller, Psy.D, MFT
Behavioral Health Director

Transportation Coaching by Wellness Navigators

Community Need: Transportation consistently identified by Monterey County residents as a significant barrier to receiving care. This input was received when developing:

- MCBH Strategic Plan
- FY18-20 MHSA 3-Year Program and Expenditure Plan
- MHSA Annual Updates

Two-fold concern:

1. Community members not receiving necessary care; and
2. MCBH staff allotting time to provide transportation for an average of 150 consumers per week; time would be better spent providing direct treatment services.

Transportation Coaching by Wellness Navigators

Proposed Innovation: Develop and pilot a Transportation Needs Assessment Tool (TNAT) that screens for client capabilities and concerns related to transportation. Peer Wellness Navigators to facilitate transportation coaching activities for addressing levels of expressed need/concern.

Implementation Phases:

1. Develop TNAT and identify coaching activities in collaboration with local Consumer Advisory Task Force
2. Contract with local vendor to hire and train Wellness Navigators
3. Administer TNAT to Adult System of Care consumers [n=2,096], and enlist volunteers to receive transportation coaching services.
4. Wellness Navigators perform transportation coaching services, re-administering TNAT every three months.
5. Evaluating impact of TNAT and coaching services; identify promising practices.

Transportation Coaching by Wellness Navigators

Learning goals:

1. Does the TNAT demonstrate value in prescribing coaching activities that lead to greater levels of independence and recovery?
   - *Evaluation*: Compare aggregate TNAT scores over time
2. Which transportation coaching activities correspond to improved levels of independence and recovery?
   - *Evaluation*: Qualitatively assess activities associated with highest rates of improved TNAT scoring
3. What investment is required to “step-down” clients to a lower level of need/towards greater independence?
   - *Evaluation*: Quantify staff time/cost associated with activities linked with improvements in TNAT scoring
4. Do project participants demonstrate improved levels of independence over time when compared to non-participants?
   - *Evaluation*: Compare aggregate TNAT scores across voluntary participants and non-participants

Transportation Coaching by Wellness Navigators

Timeline: 3 years

Total Budget: $1,234,000

- MCBH Personnel: $195,000
  - 0.3 FTE Management Analyst for project coordination and evaluation/reporting
  - 0.2 FTE Epidemiologist for evaluation
- Contractor(s): $1,039,000
  - Facilitate development of TNAT and identify coaching activities
  - Hire and Train peer Wellness Navigators
  - Administer TNAT and enlist project participants
  - Implementation of transportation coaching services
  - Translation services

Sustainability: Integrate use of TNAT and promising transportation coaching activities into CSS-funded programming or supported with non-MHSA funds.

Transportation Coaching by Wellness Navigators

Questions?

Amie Miller, Psy.D, MFT: MillerAS@co.monterey.ca.us

Wesley Schweikhard, MPP: Schweikhardw@monterey.ca.us

Transportation Coaching by Wellness Navigators

- **Proposed Motion:** The MHSOAC approves Monterey County's Innovation Project, as follows:

- **Name:** Transportation Coaching by Wellness Navigators
- **Amount:** $1,234,000
- **Project Length:** Three (3) Years

SANTA CLARA COUNTY
Behavioral Health Services

PROPOSED MHSA INNOVATIONS PROJECT: *headspace*

MENTAL HEALTH SERVICES OVERSIGHT AND ACCOUNTABILITY COMMISSION (MHSOAC)

AUGUST 23, 2018

PROBLEM STATEMENT

- In Santa Clara County, only 8,122 youth are using mental health services, while data suggests that over 30,000 youth should be accessing service[1].
- Young people often do not seek health, social service, or justice systems until their mental health problems have become more severe and often more difficult and costly to treat[2].
- Young people with emerging mental health issues have difficulty finding timely, appropriate treatment and a service system that can respond to their needs[2].
- Currently, there is no integrated public mental health early intervention structure in place for young people in the US[2].

Sources

[1] http://www.nccp.org/

[2] Adelsheim, S., Tanti, C., Harrison, V., and King, R., (2015). *headspace*: US Feasibility Report.

SANTA CLARA COUNTY
Behavioral Health Services
Supporting Wellness and Recovery

PROJECT OVERVIEW: INNOVATION COMPONENTS

- Integrated "one-stop shop" service – behavioral health, primary care, employment support and education support - for young people between 12 and 25.
- Promote peer leaders through diverse Youth Advisory Group at each site that will help to promote headspace and inform services.
- Community building and mobilization to create a public mental health continuum of care.
- Create a new model for public/private billing, thus providing a new service model for other counties and states.
- Eliminate stigma through youth-informed sites, service integration, and service promotion.
- Foster community partnership in service delivery: Partnership between Santa Clara County, Stanford University and Community-Based Organizations.

RECENT DEVELOPMENTS DURING RAMP-UP

- Developed an integrated service model.
- Formed two Youth Advisory Groups (YAG) representing the County's diverse population.
- Identified potential sites at both locations (i.e., San Jose and North County) in partnership with YAG members.
- Developed site design concept and branding in partnership with YAG members, ideo.org as well as other youth, families and members of the community)
- Implementation of initial process evaluation, development of evaluation plan and data system development is underway.
- County team visit to Foundry sites in Vancouver, British Columbia, Canada scheduled for October 3-4 2018.
- The Release for Proposal (RFP) for the CBO contractor is scheduled to be released upon OAC approval of implementation phase.

LEARNING GOALS

The learning goals of the project are as follows (The goals and outcomes are being refined in partnership with the evaluation planning team and the YAG):

1. Understand the efficacy of integrating multiple service components to increase youth access and engagement in behavioral health services.
2. Identify best approaches to include youth, family members, and community stakeholders in the development, implementation and evaluation of an integrated care model intended for young people.
3. Distinguish the barriers and facilitators to access *headspace* sites among youth who are currently engaged and not engaged in the integrated care model.
4. Understand how to effectively and successfully adopt a financial model that allows all youth to access integrated care services regardless of their ability to pay and insurance coverage.
5. Learn the effects of the integrated model on clients' social-emotional and physical wellbeing, as well as life functioning.

PROPOSED BUDGET AND SUSTAINABILITY

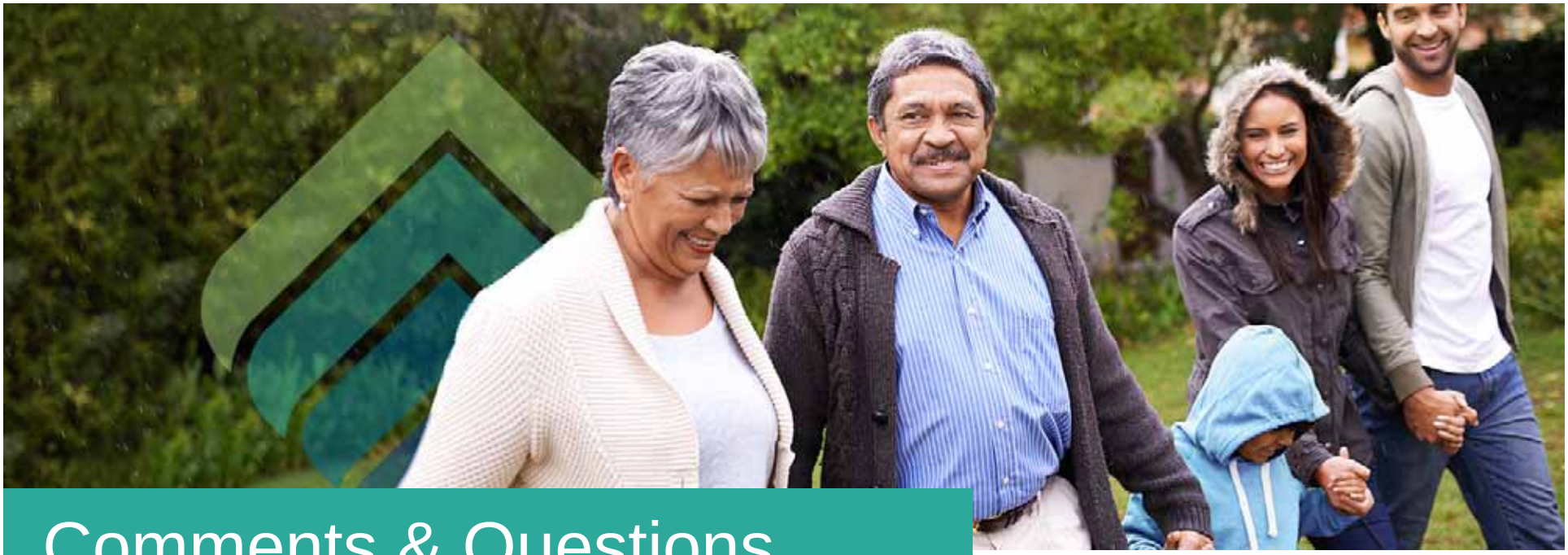
Approximately $16.5 million* for two sites over the span of four years.
Main budget components:

- **BHSD**: Approximately $8.7 million for 6.40 FTE for both sites, as well as the leasing expense and evaluation.
- **Community Based Organization**: Approximately $3.2 million for 8.0 FTE for both sites to provide direct services.
- **Stanford University**: Approximately $3 million for technical assistance team from the SCYMHW ($1.4 million for 2.25 FTE) and the clinical staff from Stanford Medicine ($1.6 million for 1.2 FTE).

*The remainder of the expense mainly pertains to facility improvement ($940,000) and the one-time County General Fund investment through a Board Inventory Item ($564,379). BHSD will utilize unspent CFTN dollars ($470,000 for FY19 and $470,000 for FY20) to renovate the two sites. $1,822,772 of the $16.5 million will be from the INN reversion funds.

Sustainability Plan

There is high potential for future public/private partnerships as well as MHSA Community Services and Supports and medi-cal revenue, to sustain the *headspace* project.



Comments & Questions

SANTA CLARA COUNTY
Behavioral Health Services

THANK YOU

Toni Tullys, MPA
Director, Behavioral Health Services

Steve Adelsheim, MD
Director, Stanford Center for Youth Mental Health and Wellbeing

Cha See, PhD
Program Manager, School Linked Services

SANTA CLARA COUNTY
Behavioral Health Services
Supporting Wellness and Recovery

PROPOSED MOTION

MHSOAC approves Santa Clara County's Innovation Projects as follows:

Name:	headspace
Amount:	$14,960,943
Project Length:	Four (4) Years

SANTA CLARA COUNTY
Behavioral Health Services
Supporting Wellness and Recovery

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STEINBERG INSTITUTE

ADVANCING BRAIN HEALTH POLICY & INSPIRING LEADERSHIP

August 21, 2018

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

Dear Honorable Commissioners,

The Steinberg Institute is in strong support of Santa Clara County's *headspace* Innovation Proposal. We know that the *headspace* program supports young people who are experiencing mental health issues and we applaud Santa Clara County's leadership for bringing this model to the United States.

Headspace is an early intervention program that improves the lives of young people, and their families, who are affected by brain health challenges. Developed in Australia, it is a core component of an international effort to build a culture of health for adolescents by emphasizing *early* mental health *intervention* while breaking down the stigma of accessing care *early*.

We have learned a lot over the course of the past 14 years since the inception of the Mental Health Services Act and we are convinced that we will never catch our own tail if we don't do all we can to ensure that people receive high quality care as early as possible. As with all other health issues, life changing impacts are made most effectively during the early stages of an illness. Nearly 50% of all mental health conditions have their onset by the age of 14 and 75% by the age of 24. Half of adolescents meet the criteria for having a mental health issue at some point in their early lives and we find it startling that 79% of these youth and young adults do not access care. *Headspace* will go a long way to change this unacceptable fact.

Unfortunately, California lacks a comprehensive, reliable system of care for adolescents that is easy to access and is provided in an environment that meets their unique developmental and cultural needs. This lack is creating tragic and expensive consequences in communities across the country. As a result, young people often do not reach our health, social service, or justice systems until their mental health problems have become more severe and often more difficult and costly to treat.

Please do consider supporting this innovation project. The *headspace* model takes us in an incredibly positive direction and, we believe, will prove to be a model that should be replicated throughout California.

Thank you very much.

In Partnership,

M. Merritt

Maggie Merritt
Executive Director

CC: Toby Ewing, Mental Health Services Oversight and Accountability Commission
Toni Tullys, Santa Clara County Department of Behavioral Health
Steven Adelsheim, Stanford University

COUNTY OF SAN DIEGO
BEHAVIORAL HEALTH SERVICES

ACCESSIBLE DEPRESSION AND ANXIETY PERIPARTUM TREATMENT (ADAPT)

MHSA CYCLE 4 INNOVATION PROGRAM

Alfredo Aguirre, LCSW, Director

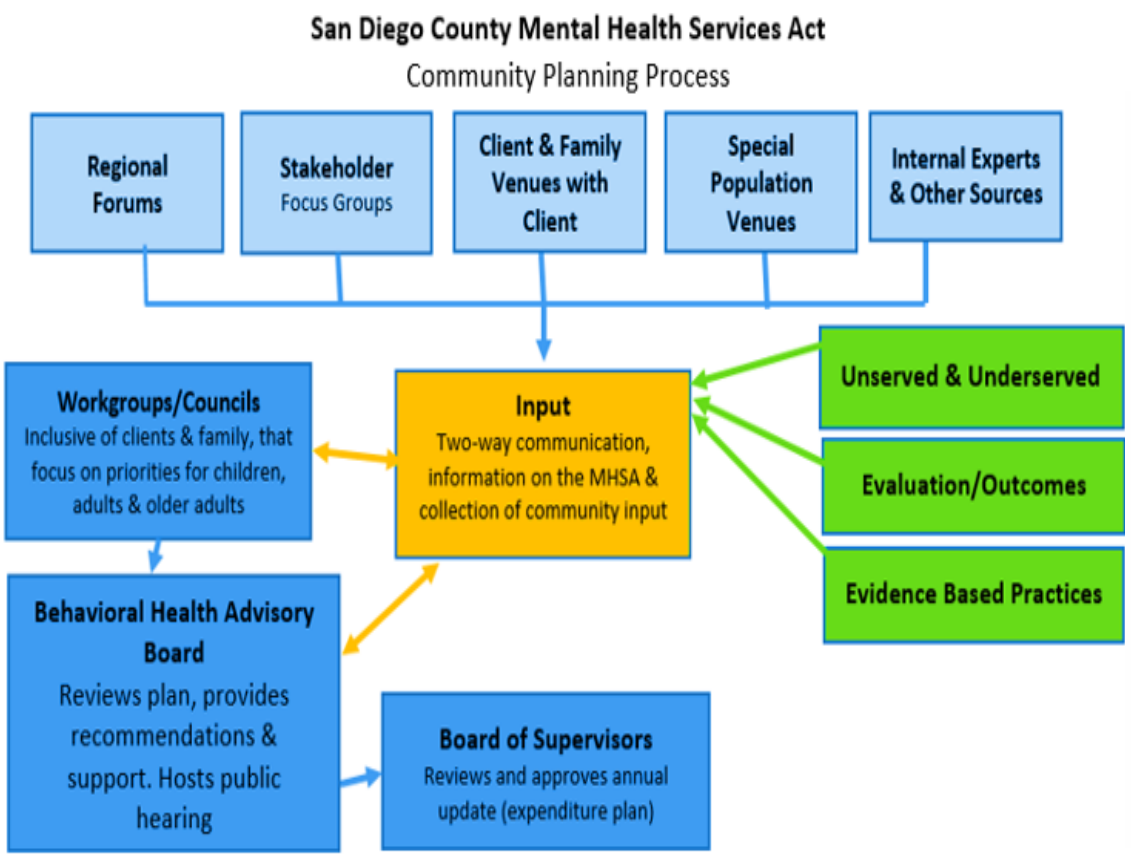
Dean E. Sidelinger, MD, MSEd, Child Health Medical Officer

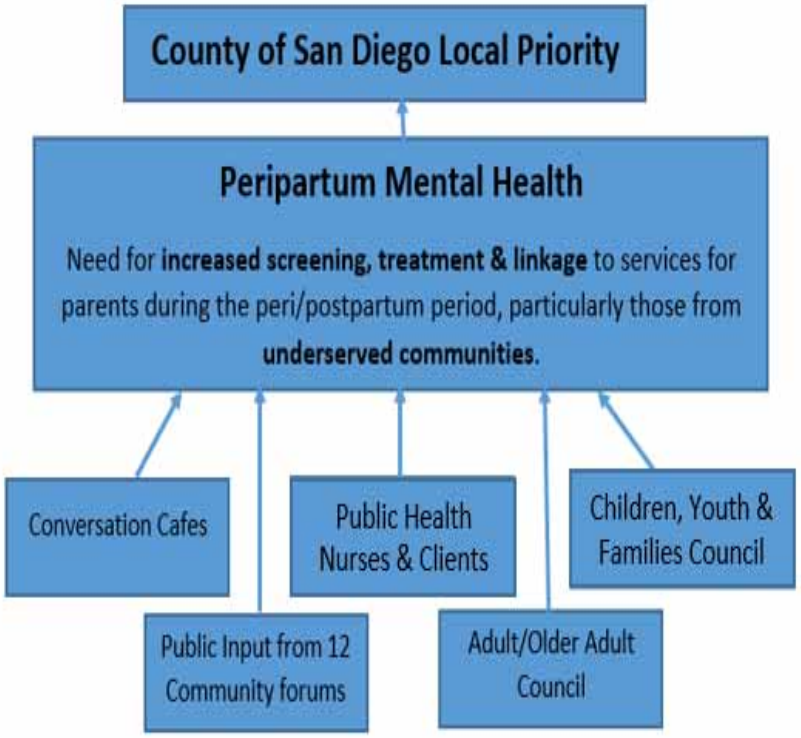
Yael Koenig, LCSW, Deputy Director

08/23/2018

LIVE WELL SAN DIEGO

BHS COMMUNITY PROGRAM PLANNING PROCESS





Impact of Peripartum Depression and Anxiety

Maternal and Infant Health Assessment showed **14% of women giving birth in San Diego** were diagnosed with Postpartum Depression (PPD). Worldwide, approximately 15% of mothers experience PPD and Postpartum Anxiety (PPA).

New parents from **underserved communities are disproportionately impacted** by PPD and PPA due to increased risk factors, barriers to accessing treatment, and inadequate social support.

PPD and PPA are associated with **delays in language development, increased crying, behavioral problems, bonding difficulties, insecure attachment, and increased parental conflict.**

Failure to screen and treat parents for PPD and PPA has **long term consequences for children, families, and the communities** in which they live.

Emerging research estimates **around 10% of fathers experience PPD and PPA**, and that parental and partner postpartum mental health symptoms are interrelated.

Public Health In-Home Visiting Nurse Programs

Nurse Family Partnership

- **Population:** Low-income, first-time mothers. Enrollment prior to 28th week of pregnancy and continues until child's second birthday.
- **Services:** Support, education and counseling on issues including health, behavioral issues, and self-sufficiency.
- **Provides:** Referrals to healthcare, childcare, behavioral health services, job training and other support services available in their community.

Maternal Child Health

- **Population:** Low-income, at-risk pregnant and postpartum women and their children ages 0-5.
- **Goal:** Improve birth outcomes, access to health care, and promote the health and well-being of women and their children.
- **Services:** Support and education on issues which include health, parenting, and bonding.
- **Provides:** Case management and referrals to healthcare and support services.

The Challenge: Linking Clients to MH Services

Despite success in outcomes related to health and parenting, **PHNs have difficulty connecting clients to MH services.**

- PHNs may need additional **support and training** to identify behavioral health needs.
- **Lack of referral resources** providing treatment to parents with PPD and PPA.
- **Stigma** related to mental health which prevents parents from following through.
- **Barriers to accessing services** including transportation and lack of financial resources.

Parents are not accessing mental health services during a critical timeframe

Many Parents and Partners with PPD or PPA are not being diagnosed and treated in a timely manner.

Parents from underserved communities have additional risk factors and barriers which prevent them from accessing treatment.

Limited availability and options for timely and appropriate diagnosis and treatment.

ADAPT PROGRAM COMPONENTS

Proposed Innovation

Co-Location
- Co-locate Mental Health Clinicians at Nurse Family Partnership & Maternal, Child Health sites

Training
- Provide routine training to PHNs on MH issues and participate in Case Conferences with PHNs

Holistic Approach
- Provide services collaboratively with PHNs to treat the family as a whole

Evidence-Informed
- Utilize Motivational Interviewing, Normed Screening Tools, Peer Partners

Underserved Communities
- African-Americans, Latinos, Refugee and Immigrant families will be prioritized through the referral process

Community-Based
- Provide services at a location most convenient for the family, including in the home or community

Stepped Care
- Level 1: 200 clients/FY
- Level 2: 100 clients/FY

Peer Partner
- Education, Advocacy, Stigma Reduction, Engagement, Culturally Competent, Supportive Relationships

Learning Questions

- Will a collaboration with the PHN Home Visiting programs be effective in engaging mothers and fathers / partners in treatment for peripartum depression and anxiety?
- What is the best way to equip the PHNs to effectively connect parents to services for PPD and PPA?
- Can ADAPT provide effective, short term treatment services that meet the needs of ADAPT clients?
- What are the barriers to engaging new parents in treatment for PPD and PPA?
- What are the characteristics of paternal / partner symptomology?
- How to effectively engage and treat clients in a culturally competent manner?
- What percentage of ADAPT clients are linked to existing resources and what are the remaining system gaps?

Outcome Objectives

- Increase access to screening and treatment for parents.
- Decrease negative consequences of untreated PPD and PPA.
- Improve cross-sector competencies of PHNs to support parents.
- Increase advocacy and awareness of Peripartum mood and anxiety disorders across Systems of Care.

ADAPT BUDGET

ADAPT PROGRAM PROJECTED COST

Total Project Cost:	$4,773,040		Project Duration: 5 Years				
	FY 18/19 (Half year only)	FY 19/20	FY 20/21	FY 21/22	FY 22/23	FY 23/24	Total
Salaries & Benefits	$ 370,555	$ 741,111	$ 741,111	$ 741,111	$ 741,111	$ -	$ 3,334,999
Operating Cost	$ 57,815	$ 114,270	$ 114,270	$ 114,270	$ 114,270	$ -	$ 514,895
Indirect Cost	$ 65,668	$ 154,944	$ 154,944	$ 154,944	$ 154,944	$ -	$ 685,444
Subtotal							
Annual Program Budget	$ 494,038	$ 1,010,325	$ 1,010,325	$ 1,010,325	$ 1,010,325	$ -	$ 4,535,338
Annual Evaluation Cost	$ 23,771	$ 47,540	$ 47,540	$ 47,540	$ 47,540	$ 23,771	$ 237,702
Total Project Budget	$ 517,809	$ 1,057,865	$ 1,057,865	$ 1,057,865	$ 1,057,865	$ 23,771	$ 4,773,040
S&B Rate to Annual Budget	75%	73%	73%	73%	73%	0%	74%
Operating Cost Rate to Annual Budget	12%	11%	11%	11%	11%	0%	11%
Indirect Rate based on Annual Budget	13%	15%	15%	15%	15%	0%	15%

QUESTIONS?

PROPOSED MOTION

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

Name: Accessible Depression and Anxiety Postpartum Treatment (ADAPT)

Amount: $4,773,040

Project Length: Five (5) Years

COUNTY of SAN LUIS OBISPO

SAN LUIS OBISPO COUNTY
BEHAVIORAL HEALTH DEPARTMENT

MENTAL HEALTH SERVICES ACT · PROPOSITION 63 · CALIFORNIA

WELLNESS • RECOVERY • RESILIENCE

INNOVATION

County of San Luis Obispo Behavioral Health Department

Proposal for the Innovation Component of the Three-Year Program and Expenditure Plan

3-by-3: Developmental Screening Partnership between Parents and Pediatric Practices

Presenting Problem/Need

- Lack of comprehensive and recurring behavioral health screenings for children.
- County does not have data or programs solely dedicated to measure and capture data for children 0-3.

Proposed Solution

- Tests three methods to administer Ages & Stages Questionnaire: Social Emotional for children 0-3:
  - Health Educator:
    - 30-minute in-clinic education encounter
  - Parent Self-Administration:
    - 30-minute self-administered assessment
  - Child-care Provider:
    - Completed and collected at child-care provider

Evaluation Components

- 3 testing methods
  - What are the best practices that will most likely increase behavioral health screenings in early childhood?
  - What are the best practices/methods that will most likely increase knowledge/conversation about mental health?
  - What are the best practices/methods that will most likely increase referrals?

  - Increase parent/primary caregiver:
    - Knowledge of age-appropriate social emotional development
    - Mental health knowledge
  - Increase pediatric setting mental health knowledge
  - Increase appropriate referrals for behavioral health needs

Innovation Budget

- Total Project Cost = $859,998

Fiscal Year (July-June)	AB114 MHSA	FY 2017-18 MHSA	FY 2018-19 MHSA	FY 2019-20 MHSA	Total
FY 2018-19	$184,860				$184,860
FY 2019-20		$215,428			$215,428
FY 2020-21			$223,184		$223,184
FY 2021-22				$236,526	$236,526
Total	$184,860	$215,428	$223,184	$236,526	$859,998

Sustainability

- Through evaluation determine which method(s) is cost-saving and effective based on the goals;
- Continue the partnership with established Community Health Centers and child care providers; and
- Establish the best public and private funding sources to continue the service.

Affirming Cultural Competence Education & Provider Training: SLO ACCEPTance

Presenting Problem/Need

- San Luis Obispo County lacks qualified culturally competent and LGBTQ-affirming providers;
- Many LGBTQ community members travel outside of the county to find the support of trained affirming therapists;
- Insufficient services for transgender clients and LGBTQ youth in the community; and
- Supportive mental health services and youth services as two of the most important service needs in the county.

Proposed Solution

- LGBTQ mental health care training – 9 month learning process:
  - Phase I: Cultural Sensitivity: Language and Becoming Aware
  - Phase II: Clinical Issues for Client
  - Phase III: Potential Provider Issues

  - Comprehensive and empirically-based training program delivered across 2-3 day trainings.
  - Professional consultation meetings
  - Network development

Evaluation Components

- Testing a new training curriculum
  - What is the best training approach for training/teaching therapist to work with LGBTQ clients?
  - What is the best method to increase the number of mental health professionals and peers who can provide LGBTQ affirming services?
  - What is the best method that allows increase access for the LGBTQ community to mental health services?

  - Increase:
    - Therapist knowledge, awareness, and skills
    - Level of LGBTQ competency and attendees' learning outcomes
    - Number of services that engage LGBTQ-identified clients
    - Number of LGBTQ-identified clients in the community

Innovation Budget

- Total Project Cost = $554,729

Fiscal Year (July-June)	AB114 MHSA	FY 2017-18 MHSA	FY 2018-19 MHSA	FY 2019-20 MHSA	Total
FY 2018-19	$107,461				$107,461
FY 2019-20		$177,108			$177,108
FY 2020-21			$177,108		$177,108
FY 2021-22				$93,052	$93,052
Total	$107,461	$177,108	$177,108	$93,052	$554,729

Sustainability

- Through evaluation determine the effectiveness of the new curriculum, and make changes if necessary;
- If possible, continue partnership with established community based organizations to leverage resources; and
- Establish the best public and private funding sources to continue the service

Questions?

Proposed Motion

The MHSOAC approves San Luis Obispo County's two (2) Innovation Projects, as follows:

- **Name:** 3-by-3 Developmental Screening Partnership Parents & Pediatric Practices
- **Amount:** $859,998
- **Project Length:** Four (4) Years

- **Name:** Affirming Cultural Competence Education & Provider Training: Offering Innovative Solutions to Increase LGBTQ Mental Health Care Access (SLO ACCEPTance)
- **Amount:** $554,729
- **Project Length:** Four (4) Years