WELLNESS • RECOVERY • RESILIENCE

Mental Health Services
Oversight & Accountability Commission

Commission Packet

Commission Meeting
October 25, 2018

The Marina Inn
68 Monarch Bay Drive
San Leandro, CA 94577

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

Mental Health Services
Oversight & Accountability Commission

WELLNESS • RECOVERY • RESILIENCE

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

1325 J Street, Suite 1700
Sacramento, California 95814

Commission Meeting Agenda

October 25, 2018
9:00 AM – 5:00 PM

The Marina Inn
68 Monarch Bay Dr.
San Leandro, CA 94577

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
October 25, 2018

Khatera Aslami-Tamplen
Vice Chair

Approximate Times

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

9:05 AM **Announcements**

9:25 AM **Action**
1: Approve September 26-27, 2018 MHSOAC Meeting Minutes
The Commission will consider approval of the meeting minutes from the September 26-27, 2018 meeting.

- Public Comment
- Vote

9:30 AM **Information**
2: Suicide Prevention Project
Subject matter experts and stakeholders have been invited to participate in the three panels to support the Commission's understanding of opportunities to prevent suicide and improve outcomes for suicide attempt survivors and their loved ones.

Panel I: Working Upstream to Prevent Suicide
Invited panelists will share opportunities to empower people, families, and communities to address underlying determinants of health before the development of suicide ideation and behavior, including strategies to reduce risk and promote healing after a suicide death.

Panelists:

- Lisa Firestone, Ph.D., Director of Research and Education, The Glendon Association, Member of the Santa Barbara County Response Network
- Janet King, MSW, Program Manager of Policy and Advocacy, Native American Health Center

Panel II: Intervention through Crisis Care and the Health Care System
Invited panelists will present opportunities for improving crisis care and response for people at-risk or in crisis, and opportunities to prevent suicide for people coming into contact with the health care and behavioral health care systems.

Panelists:

- David Camplin, LMFT, Director of Behavioral Health, San Bernardino County Service Area, Kaiser Permanente
- David Covington, LPC, MBA, CEO and President of RI International
- Katherine Jones, RN, MS, MSN, Director, Adult/Older Adult System of Care, Alameda County Behavioral Health Care Services

Panel III: Building Infrastructure, Leadership, and Sustainability
Invited panelists will present opportunities for fostering multi-disciplinary suicide prevention leadership with private and public partners, strengthening state infrastructure and connections between partners, and ensuring sustainability of suicide prevention efforts over time.

Panelists:

- Colleen Carr, MPH, Director of the National Action Alliance for Suicide Prevention
- Peter Manzo, President and CEO, United Ways of California

Public Comment on All Panels

12:00 PM **Lunch Break**

1:00 PM **Action**
3: Election of the Chair and Vice-Chair for 2019
Facilitator: Filomena Yeroshek, Chief Counsel

Nominations for Chair and Vice-Chair for 2019 will be entertained and the Commission will vote on the nominations and elect the Chair and Vice-Chair.

- Public Comment
- Vote

1:30 PM **Sally Zinman and Rusty Selix MHSOAC Fellowship Programs**
Sally Zinman and Rusty Selix will be presented with a Resolution to commemorate the naming of the MHSOAC Fellowship Programs in their honor.

2:00 PM **Action**

4: Alameda County Innovation Plans (3)

Presenters for Introducing Neuroplasticity to Mental Health Services for Children:

- Catherine Franck, LCSW, Behavioral Health Clinical Manager for Child and Young Adult System of Care
- Jeff Rackmil, LCSW, BHCS Child and Young Adult System of Care Director
- Sindy Wilkinson, MEd, LMFT, Behavioral Health Clinician for Child and Young Adult System of Care

Presenters for the Community Assessment and Transport Team (CATT):

- Stephanie Lewis, MS, LMFT, Interim Crisis Services Division Director
- Karl A. Sporer, MD, Emergency Medical Services Medical Director
- Melissa Vallas, MD, Alameda County Care Connect Crisis Liaison/ Lead Psychiatrist for Children's System of Care

Presenters for the Emotional Emancipation Circles for Young Adults:

- Lisa Carlisle, MA, Med, Medi-Cal Specialty Mental Health Coordinator for Child and Young Adult System of Care
- Shannon Singleton-Banks, MPH, Senior Program Specialist for Alameda County's Public Health Department

The Commission will consider approval of (1) $2,054,534 to support the Introducing Neuroplasticity to Mental Health Services for Children; (2) $9,878,082 to support the Community Assessment and Transport Team (CATT); and (3) $501,808 for the Emotional Emancipation Circles for Young Adults Innovation Plans.

- Public Comment
- Vote

3:30 PM **Action**

5: San Francisco County Innovation Plan

Presenters for Wellness in the Streets:

- Stephanie Felder, M.S., Director, Comprehensive Crisis Services, San Francisco Department of Public Health
- Amber Gray, Health Worker III, Peer Specialist, San Francisco Department of Public Health
- Charlie Mayer-Twomey, LCSW, Project Administrator, Hathuel Tabernik and Associates

The Commission will consider approval of $1,750,000 to support the San Francisco County Wellness in the Streets Innovation Plan.

- Public Comment
- Vote

4:00 PM **Information**

6: 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. The Commission will discuss the Executive Director's report out.

Enclosures (6): (1) The Motions Summary from the September 26-27, 2018 Meeting; (2) Evaluation Dashboard; (3) Innovation Dashboard (4) Presentation Guidelines; (5) Calendar of Commission Meeting Draft Agenda Items; (6) Department of Health Care Services Revenue and Expenditure Reports status update; (7) Legislative Report to the Commission.

- Public Comment

4:45 PM **General Public Comment**

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

5:00 PM **Adjourn**

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AGENDA ITEM 1

Action

October 25, 2018 Commission Meeting

Approve September 26-27, 2018 MHSOAC Meeting Minutes

Summary: The Mental Health Services Oversight and Accountability Commission will review the minutes from the September 26-27, 2018 Commission meeting. Any edits to the minutes will be made and the minutes will be amended to reflect the changes and posted to the Commission Web site after the meeting. If an amendment is not necessary, the Commission will approve the minutes as presented.

Presenter: None.

Enclosures (1): (1) September 26-27, 2018 Meeting Minutes.

Handouts: None.

Proposed Motion: The Commission approves the September 26-27, 2018 Meeting Minutes.

Mental Health Services
Oversight and Accountability Commission

STATE OF CALIFORNIA
EDMUND G. BROWN
Governor

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
STRATEGIC PLANNING SESSION

Minutes of Meeting
September 26, 2018

MHSOAC
Hyatt Regency Los Angeles
6225 West Century Blvd
Los Angeles, CA 90045

Members Participating:

John Boyd, Psy.D., Chair
Khatera Aslami-Tamplen, Vice Chair
Mayra Alvarez
Reneeta Anthony
Lynne Ashbeck
Sheriff Bill Brown
Keyondria Bunch, Ph.D.
Itai Danovitch, M.D.
David Gordon
Mara Madrigal-Weiss
Tina Wooton

Members Absent:

Senator Jim Beall
Assemblymember Wendy Carrillo
Gladys Mitchell

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

DAY 1: September 26, 2018

CONVENE AND WELCOME

Chair John Boyd called the meeting of the Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission) Strategic Planning Session to order at 9:27 a.m. and welcomed everyone. He asked Vice Chair Aslami-Tamplen to share her opening comments.

Vice Chair Aslami-Tamplen provided a brief overview of her background and experiences on the Commission over the past six years and the recent projects undertaken by the Commission.

Chair Boyd reviewed the agenda for the next two days. He stated the work of the Commission could not be more important. He stated general society appears to be more at a state of disease than ever before. He stated uncertainty that the Commission is living up to the expectations of the voters in California for Proposition 63, the Mental Health Services Act (MHSA), which established this Commission. He stated he was not confident in the direction of the Commission, if left unchecked.

Chair Boyd stated the Innovation plan approval process does not work. It does not serve the counties or the stakeholder consumer voices who are trying to work with a broken process. It is not meaningful; it does not make a difference. The Commission puts out white papers but he questioned whether counties are using them. He asked if the Commission is driving the behind-the-scenes advocacy to effect change. The Commission spends a lot of time, but he asked if it meets needs and leverages more stakeholder voice.

Chair Boyd stated the Commission's role is to advise the Governor and the Legislature and yet has done that only once in five years. He asked if the Commission is responsible for connecting to local mental health boards and ensuring that their voice and the voice of local stakeholders are heard. He asked if it should be the Commission's role to make them more successful – to listen and ask them what tools they need to do their jobs more effectively at the local level. He asked for a raise of hands of participants who are representatives of a local mental health board. One individual from Napa raised their hand.

Chair Boyd stated we need to closely listen to those local county board voices. What do they need to be successful? How does the Commission empower the stakeholder voice at that level? How does the Commission ensure it gives voice in the Commission meetings and in the Commission's work to those voices? That must be asked as strategies are designed.

Chair Boyd stated, at the end of the day, the Commission can pull the Department of Health Care Services (DHCS), stakeholders, Commissioners, peers, consumers, and county directors together and set standards, mandate those standards, and hold individuals accountable. That is oversight and accountability. He stated he wanted to see the Commission put together structures to ensure it is able to do that. He stated the need to clearly define what successful outcomes are, mandate those, and ensure that they are informed truly by the collective voice of stakeholders and consumers at every level of the state along with the expertise of the Commissioners.

Chair Boyd stated today's focus is to determine the strategy for the next two to three years to ensure that California is a good steward of its incredible responsibility to the MHSA. He thanked everyone for their willingness to participate in the process.

Roll Call

Chair Boyd asked for the roll call.

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

Ms. Yeroshek announced that the telephone is on listen only for the morning session and individuals will be unable to listen in to the afternoon break-out session because participants will be divided into groups for discussion. The telephone will be back on for the reporting out of those break-out groups.

STRATEGIC PLANNING SESSION OVERVIEW

Presenters:

- Toby Ewing, Ph.D., Executive Director
- Filomena Yeroshek, Chief Counsel
- Lynne Ashbeck, Commissioner

Bagley-Keene Presentation

Ms. Yeroshek provided an overview, with a slide presentation, of the requirements of the Bagley-Keene Open Meeting Act. She stated staff will be taking photographs and making videos throughout today's meeting to be used in publications and on the website. She asked anyone who would not like their photograph taken to contact staff.

Questions and Discussion

Commissioner Ashbeck asked how the Brown Act compares to the Bagley-Keene Act for individuals in local government, and if the Bagley-Keene Act contains language about what constitutes a quorum.

Ms. Yeroshek stated the Commission's Rules of Procedure discusses the definition of a quorum. One of the biggest differences between the Brown Act and the Bagley-Keene Act is the amount of public notice that is required. There is only a 72-hour public notice requirement in the Brown Act versus the Bagley-Keene's 10-day requirement. The Brown Act has many details that are not specified in the Bagley-Keene Act such as the agenda having to be posted at the site of the meeting.

Lynne Ashbeck

Commissioner Ashbeck stated the comments of the chair and vice chair reflect the spirit of today, which is to achieve the highest and best use of this Commission for those it serves, the counties, and the taxpayer funding. She stated all the answers will not be found today but hopefully ways can be found to elevate the work to serve the needs of Californians.

Due to the fact that there are many newer Commissioners, Commissioner Ashbeck suggested a review on how Commissioners should behave collectively in the interest of those the Commissioners are trying to serve.

Executive Director Ewing

Executive Director Ewing reviewed the direction of the Commission and projects that have been conducted over the past year. He stated the Commission wanted to step back and revisit the foundation that should guide and shape the work it does. In addition to having new Commissioners, the Commission has had new opportunities and new obligations.

Executive Director Ewing stated there are areas where the Commission is successful and areas where it struggles. These areas will be put on the table today and Commissioners will be engaged through a process that extends well beyond today. He stated the need to step back and remind Commissioners of why they are here, of what the opportunity is, and of the challenge of ensuring that the obligation of the Commission - which is to promote transformational change – is met.

Executive Director Ewing stated the value and structure of the Commission that brings stakeholders together is an opportunity to leverage the political capital that must be leveraged to

improve the mental health system in dramatic ways. The MHSA is unusual to have a policy vision in that California has a mental health system that is heavily driven by prevention and early intervention opportunities. It is rare to have a mandate for prevention and the money to go with it.

Executive Director Ewing stated the other unusual piece of the MHSA is that every county is required to take risks to try new things. It is a built-in mechanism for continuous improvement. He noted the difference in the Commission workload of two years ago where the Commission reviewed 11 plans in the calendar year versus the 80 to 90 plans that are currently in the queue.

Executive Director Ewing stated today is an opportunity to step back and to hear where the Commission is developmentally, where it needs to be, the aspects of the work that should be prioritized, the aspects of the work that there is no time for and are not effective, and the aspects that need to be enhanced collectively. He stated, over the course of a year and with the guidance of the Applied Survey Research Team, staff wants to ensure that their time and energies are dedicated to Commissioners' priorities to be as effective as possible.

STRATEGIC PLANNING SESSION

Presenters:

- Susan Brutschy, President, Applied Survey Research (ASR)
- Lisa Colvig-Niclai, Vice President of Evaluation, ASR
- Samantha Green, Project Manager, ASR
- Kendra Fisher, Research and Administrative Assistant, ASR

Executive Director Ewing introduced Susan Brutschy, who will facilitate today's strategic planning session.

Susan Brutschy, President, ASR, introduced the members of her team and reviewed the agenda, plan, and goals for the day. She gave a brief overview of the background of the ASR. She asked Commissioners to introduce themselves and share their passion and drive for this work.

<u>Commissioner Introduction</u>

Commissioner Gordon, Sacramento County Superintendent of Schools, stated his passion is a focus on early intervention. What is typically considered as early intervention is, in fact, far too late.

Commissioner Danovitch, Chair, Department of Psychiatry, Cedars-Sinai Medical Center, stated his passion is a focus on early intervention. He stated he also is interested in the fragmentation in the system as a barrier to providing care to individuals. California has rich resources but those resources often do not communicate or coordinate. He stated he would like to see the Commission help promote a system in California that touches individuals and helps catch them in the areas where they tend to slip through the cracks.

Commissioner Danovitch stated it is important during today's strategic planning session to take the opportunity to discuss how the Commission does what it does.

Commissioner Ashbeck, Senior Vice President, Community Engagement and Population Health, Valley Children's Healthcare, and Elected Councilmember, City of Clovis, stated her

passion is to build stronger local capacity and strong systems of care where people live and give people a voice in the places where they call home.

Vice Chair Aslami-Tamplen, Consumer Empowerment Manager, Alameda County Behavioral Health Care Services, stated her passion is the people the Commission serves, the system being focused on wellness and recovery, and the underserved, unserved, and inappropriately served communities. Vice Chair state she also is passionate about ensuring that everyone in those communities has a voice, that the system is guided through their leadership, and peer specialist certification.

Chair Boyd, Chief Executive Officer of Mental Health Services, Sutter Health, stated his passion is that California does a phenomenal job to ensure that anyone suffering from a mental health challenge in the workplace, school setting, community setting, or streets is able to navigate that easily without the effort that happens today that becomes a barrier to care, and to change the narrative for mental health in California so social prejudice and stigma are no longer barriers to accessing care.

Chair Boyd stated he also is passionate about handing off the leadership of this Commission to drive the Commission forward to lead the public and to strengthen the dialogue around how California can be effective for everyone.

Commissioner Anthony, Executive Director, A3 Concepts, LLC, stated her passion is persons who are considered seriously mentally ill and their family members. It is important to stay focused on illness, wellness, and recovery in all aspects of the work the Commission does.

Commissioner Bunch, Clinical Psychologist, Emergency Outreach Bureau, Los Angeles County Department of Mental Health, stated her passion is to advocate for more programs that will make a difference for underserved communities.

Commissioner Alvarez, President, Children's Partnership, stated her passion is to ensure that low-income, particularly marginalized communities, have access to the services that they need. Health is a social justice issue that is connected to every aspect of life. She stated she is particularly motivated by today's environment and what it is doing to the mental health and wellbeing of children and families.

Commissioner Madrigal-Weiss, Director, Wellness and Student Achievement, San Diego County Office of Education, stated her passion is prevention and building capacity of school communities. She stated she is also an advocate for building capacity of youth and teaching youth how to do things for themselves.

Commissioner Brown, Sheriff and Coroner for Santa Barbara County and immediate past president of the State Sheriffs' Association, stated his passion is for keeping individuals with mental health issues out of the criminal justice system as much as possible, and doing a better job of treating individuals with mental health issues who have to be in the system due to other circumstances.

Strategic Planning Overview

Ms. Brutschy provided an overview, with a slide presentation, of the strategic planning process. She stated the ASR will not necessarily do a traditional strategic plan but will approach it with a results-based focus. She stated one of the most important purposes of today's session is to establish a common language about the Commission's goals, priorities, and results so that Commissioners can carry it with them to their jobs, when advocating, when speaking about the connection they have to the MHSA, the difference the MHSA makes, and how they know that the Commission is making that difference. She stated the ASR's primary role is to help tell the

story of how the Commission knows it is doing what it strives to do and that it is being done together. She reviewed the other purposes listed on the Results-Based Strategic Plan presentation slide.

Ms. Brutschy stated much will be accomplished quickly today by starting large and then going deeper and deeper. She asked Commissioners to keep their eyes on the results to ensure everyone is at the same level and that there is agreement.

Ms. Brutschy stated Lisa Colvig-Niclai will be listening today for ideas, patterns, and commonalities. She turned the microphone over to Lisa Colvig-Niclai to discuss how today's goals will be accomplished.

The Plan

Lisa Colvig-Niclai, Vice President of Evaluation, ASR, stated Chair Boyd's description of what drove him was getting to a place of a clear definition of successful outcomes. She asked what that looks like, what the metrics look like, and how to know that the Commission is doing the work that it was charged with. She reviewed the Our Understanding of Results logic model presentation slide that showed the most important buckets of the work, how to know it is working well, and to what end.

Ms. Colvig-Niclai stated the green Strategy bubbles graphic represents the buckets of the most important work, and the yellow Short-Term Result bubbles represent the operational results – in other words, how to know if the Commission is doing that work well. She stated it is not yet about the outcomes that are achieved for clients or the population – those are represented by the orange Longer-Term Result bubbles – but it is about the measures of effectiveness, if the Commission is doing that work well. The yellow bubble column will answer the questions of when the Commission will look at what it is doing and how well it is doing.

Ms. Colvig-Niclai stated the orange Longer-Term Result bubbles graphic is the big "so what?" She stated the Commission could be doing its work well, but to what end? The orange bubbles will contain the client and population measures that will be the beacon that all this work is aiming toward. Some of those are called out in the MHSA, such as a focus on school, criminal justice involvement, employment, homelessness, or suicide. She stated the need to create consensus around the community-level indicators to aim toward and monitor to ensure that they are moving gradually in California in the right direction.

Ms. Colvig-Niclai stated the ASR has an intensive nine-month process to fill in the Our Understanding of Results logic model framework. She turned the microphone over to Samantha Green to walk Commissioners through that process.

The Process

Samantha Green, Project Manager, ASR, reviewed the Strategic Plan Process Map Summary (Process Map) presentation slide, which denoted four phases laid out for this nine-month process. She stated hard copies of the Process Map are on each of the discussion tables.

Ms. Green reviewed each of the four phases of the Process Map:

- Phase 1 is the organizational roadmap. It will define who the Commission is. It will include personal interviews, the workshop later today, and an online survey to help the ASR identify themes and collect data.
    - Defines who the Commission is and identifies those buckets of most important work

  - Clarifies the role, goals, and priorities of the Commission and develops that shared understanding that Commission Danovitch requested of why the Commission does what it does
  - Considers the activities with the greatest potential to meet the goals and outcomes identified

- Phase 2 is the framework for success. These are operational measures.
  - Identifies how well the Commission is doing
  - Identifies how to know that the Commissioners' work is effective and moving toward the intended outcomes
  - Sets up a framework for understanding how success will be measured
- Phase 3 is the populated framework for success with baseline data to understand the starting point. It will ensure continued success. It will include another community survey, more discussions, and collecting additional information to understand the baseline of where the Commission is now based on those measures.
- Phase 4 is the final report. It will tell the story. It will bring all the gathered information together.
  - Identifies the shared priorities
  - Identifies a way of communicating that to individuals effectively
  - Includes the results and activities done to date
  - Sets the framework for the Commission to tell its story effectively from here on out
  - Allows the framework to be updated on a regular basis

Opportunities for Feedback

Ms. Brutschy stated the Commission information has already been inputted on a Tableau database and is ready to go. The icons on the Process Map let the ASR know if they met their markers for participation, check-in, relook, and organization. Commissioners will continue to see the Process Map throughout the strategic planning process.

Ms. Brutschy stated there are discussion questions on the back of the Process Map for Commissioners to make a note of their ideas so they will be ready for the afternoon break-out session. There are also note cards for comments to the ASR, and sticky notes for Commissioners to stick their comments to the beautiful charts at the back of the room that they feel strongly about.

Ms. Brutschy stated personal interviews will be conducted over the next two weeks. She asked Commissioners to sign up for personal interviews on the sign-up sheet. Also, an online survey with the same questions that are on the back of the Process Map will be posted online for additional feedback.

Commissioner Comments and Suggestions for the ASR to Consider

Chair Boyd welcomed Commissioner Brown and introduced him to Ms. Brutschy.

Ms. Brutschy provided a brief summary for Commissioner Brown on items he had missed including the Commissioner Introduction activity where Commissioners introduced themselves and shared their passion area.

[See Commissioner Brown's contribution in the Commissioner Introduction section, above.]

Ms. Brutschy asked Commissioners for comments and suggestions to consider as the ASR launches this process.

Commissioner Alvarez asked the ASR to consider individuals who may not be as familiar with the Commission but could benefit from the Commission's activities, and how to reach out to nontraditional partners in getting that input and ensuring that they can become engaged in the future.

Commissioner Anthony asked the ASR to include a statement about the Commission's purpose and what Commissioners see as that purpose.

Commissioner Brown stated his hope that the Commission can collectively come up with ideas and thoughts in terms of the direction of the Commission and the Commission's approach to this awesome responsibility that it has been entrusted with, and to work together to try to craft the best possible use of the considerable amount of funding that can do a considerable amount of good if done the right way.

Commissioner Gordon asked the ASR to consider that California is in an inflection point now. He suggested considering top-line things that Commissioners can agree on to get across to a new governor or individuals in the new administration when it is timely to do so, such as the top four things that need to be worked on, not exactly what to do but what should be paid attention to.

MHSOAC Framework

Executive Director Ewing provided an overview, with a slide presentation, of the mission statement, the components of the MHSA, the Commission's current portfolio, Commission activities, and the connection of those activities to each other. He also discussed missed opportunities within these activities. He noted that the Commission activities have been placed on posters in the back for reference throughout the day. He asked Commissioners to put concerns onto sticky notes and stick them to the appropriate posters.

Executive Director Ewing stated he wanted to put on the table all the functions that the staff do every day to remind Commissioners how they connect in some ways but also show where connections have been missed, and to remind Commissioners of functions that have not been revisited for some time such as plan review, which is a potentially important opportunity that the Commission has not discussed publicly.

Executive Director Ewing stated the strategic planning session was a good place to give Commissioners the full perspective of what is on staff's plate, to support Commissioner discussion around which of those functions staff needs to double down on and which of those functions might need to be transformed and reshaped. This is important so at the end of the strategic planning process, staff will have clear direction and guidance to be thoughtful with resources.

Commissioner Questions and Discussion

Commissioner Ashbeck stated it is important to underline the process of the work in all the activities that the Commission does. How the Commission does the work it does is the underlying piece of all the activities. She asked staff to help Commissioners have a better understanding of the Rules of Procedure.

Executive Director agreed that the Rules of Procedure need to be updated.

Chair Boyd agreed that Commissioners should better understand those rules to comply until a better process is put in place.

Commissioner Anthony stated she would like to be made aware of opportunities for Commissioners to participate within the Committee structure and which Commissioners are not participating in the Committee structure.

Chair Boyd stated Executive Director Ewing is the best person to try to meet the Commissioner's needs and sometimes that means taking on too much. The idea of creating a calendar and sending it out monthly to all Commissioners to identify points of engagement was identified at the beginning of this year but staff has been unable to get to it due to the workload of the Commission. He asked Commissioners to be sensitive to the workload of staff as objectives and priorities are set.

ASR Questions for Commissioners

Ms. Brutschy asked Commissioners to share their thoughts and ideas about the following questions in preparation for the group discussion later in the day.

Question #1: Given your broad view of mental health around the state of California, what is the unique role of the Commission in helping meet community mental health needs?

Commissioner Gordon stated the Commission is doing a lot of routine functions which are not unimportant but should not be the signature activities of the Commission. He stated the Commission is behind the MHSA when it was first passed in the following bulleted items:

- A unique role of the Commission is prompting innovation. Funding is given to counties but counties have no incentive to cooperate, collaborate, or share good practices – how do we get to a system which is doing things differently?
- The Commission does not know the results of its activities due to the lack of data. There are different agencies and they have different databases. They are reluctant to share data or cooperate in terms of how data gets put together and reported so the Commission is always scrambling to find out how activities are doing. It is the same thing in education and it is worse in health care.
- Leadership Development – is the Commission investing in leaders who will be innovative, who will be disrupters?
- The notion of wellness – how to get away from the notion of focusing on weakness or disability.

Commissioner Brown:

- The magnitude of what this small Commission is tasked with doing and is currently doing is overwhelming. The reality is that, without the proper structure and staff, it is almost an impossible task to do all of that and to do it well. The Commissioners need to ask in their role how to lead counties, consumers, and community-based organizations in figuring out a way to collaborate and work together on this very complex, longstanding, difficult issue of mental health in the communities.
- The Commission should be focused on shaping how counties spend their own dollars including their MHSA dollars and incentivize them to augment them with other funding. He suggested that a way to do that is to develop a report, similar to what the Criminal Justice Committee did. The report was a mechanism to get the attention of the governor and the Legislature to get some action in terms of additional funding.

- Although it is time-consuming and difficult, there is a need to look at these projects and come up with a written deliverable that can be given to those groups that ultimately will be responsible for the funding at the state level. These also will serve as a mechanism for policymakers at the local and county levels to see where there have been successes where individuals have come together and shared everything, including their budgets.

Commissioner Danovitch:

- He agreed with Chair Boyd's opening comments about timing around these issues.
- The MHSA is a unique Act inasmuch as it did something remarkable.
- It recognized that there were major problems across California in the way that mental health is provided and the way conditions are prevented.
- It established an audacious and bold aspiration to transform the mental health system – not just to make incremental improvements but to transform it.
- It created pathways, processes, the five broad strategies, and mechanisms such as innovation.
- The challenge is to work within that construct and to overcome some of the limitations of that construct to be true to that intent, and to do so in a state that is the sixth biggest national economy.
- The important subject of how to coordinate and integrate services is critical.

Commissioner Ashbeck:

- A unique role of the Commission is to do things that counties cannot do by themselves. What is the highest common denominator that the Commission can operate in?
- A unique role of the Commission is to build incentives and/or limit barriers to implementation of local programs.

Vice Chair Aslami-Tamplen stated the consumer movement has the five key concepts of recovery. She stated she was going to tie that to what the Commission can do in its unique role.

- Hope. Providing hope that recovery is possible, that people do get well, and that ways toward recovery can be found.
- Personal responsibility. What is the Commission's responsibility? Always be looking at that in terms of accountability and oversight. How is the Commission doing that with the projects, regulations, and innovations that are presented to Commissioners that do not seem innovative?
- Education. What kind of technical assistance is needed for counties and stakeholders around what is working and what is not working?
- Advocacy. This is critical. The Commission needs to continue to advocate with the governor, legislators, and amongst each other around the paths towards recovery. Many counties come to the Commission with great ideas and then they experience stigma and discrimination in their own local communities, specifically NIMBYism, or Not in My Backyard. Housing is a huge crisis in California but programs cannot be opened in communities because of the NIMBYism issue.

- Support. Supporting the Commission's vision, the work, and the counties to be successful, and the legislators to better understand the MHSA so that recovery is possible for mental health consumers and family members.

Chair Boyd stated he especially liked Commissioner Danovitch's frame, which is how to fully realize the opportunities, challenges, and limitations while staying true to the MHSA.

- What is needed at the local level for success where a lot of this work happens before it gets to the Commission – peers, elected officials, mental health board members, etc.
- The Commission can be a political cover. The Commission works in an environment where the County Board of Supervisors is able to exercise oversight around state funding and move dollars around and that inhibits counties at the local level from being as successful as they desire. The Commission can look at the county level. How this is done is essential in addressing the political issues.

Commissioner Anthony:

- Ensure that the Commission does not focus on the individual silos of each seat on the Commission. The focus should be on how the Commission can ensure positive outcomes for the individual and their family members who are living in the communities in counties and living with severe mental illnesses. That cannot be forgotten.

Commissioner Bunch:

- The Commission has a push to look for programs that are innovative, but should move more toward what communities and clients need versus what sounds cool. Individuals in skid row need housing. This is not innovative but it is needed.
- It is important for Commissioners to receive updates of the outcomes and impacts of approved plans. There is no visible evidence in the field of the millions of dollars that have been allocated.

Commissioner Alvarez:

- Think about the Commission's responsibility statewide to identify lessons learned from innovation projects, to not reinvent the wheel every time, and to continually ask what more can be done.
- Navigate the web of state agencies in order to not only be good stewards of the public dollar but also collectively as state agencies and Commissioners prioritize the mental health and wellbeing of families. The Commission is putting resources where other state agencies put resources but the entities do not communicate with each other. This does a disservice to the families that need the services in the first place.

Commissioner Madrigal-Weiss:

- One of the purposes of the MHSA is to decrease school failure due to the unmet mental health needs of children. The Commission is in a unique position to help define common language, standards, and metrics. What does the language used in mental health, schools, and juvenile justice look like? Agencies work for common goals but come at it differently.
- It is important for Commissioners to receive updates of the outcomes and impacts of approved plans for themselves and also so they can share examples with other states and entities of the results of the funding the Commission has allocated and the impact that Proposition 63 has made in the state of California.

Ms. Brutschy stated there is so much commonality among the Commissioners and agreement about the possibilities. She noted that amplification, elevation, and collaboration seem to be coming through. She asked Commissioners to share their thoughts and ideas on the second question in preparation for the group discussion later in the day.

Question #2: How would you know if the Commission is successful in fulfilling this role?

Commissioner Madrigal-Weiss:

- Intentionality. The systems would align with language, standards, and metrics. If the Commission worked toward this in mental health disciplines and schools, resources and funding could be leveraged to do something meaningful. Right now, it is hit and miss. Doing it with intention and having common metric standards to address prevention and intervention would lead to success.

Commissioner Alvarez:

- Impact of investment. Having data that demonstrates the effectiveness of the investments the Commission makes is a standard the Commission should hold itself to.
- Seeing a change in the numbers, particularly when it comes to access to services for underserved communities.
- Coordination. Having discussions and intentional strategic planning with the other agencies in this space to coordinate efforts and ensure the most impact.

Commissioner Bunch:

- More access and less unserved and underserved communities.

Commissioner Anthony:

- Coordination, wellbeing, and happiness. A way of measuring that persons who are diagnosed with serious mental illnesses are receiving coordinated services, living in recovery, living independently, and experiencing some level of happiness.

Chair Boyd:

- Alignment – and fast. Alignment with the governor's office, the DHCS, and counties that are supported by strong public engagement and driven in a rapid timeline that matches the urgency of the situation.

Vice Chair Aslami-Tamplen:

- Continuous improvement and an ability to adapt to changing environment and changing needs. Success does not just happen once; it requires an ongoing commitment. There are successes in one area but then another area will require attention and further strategic planning processes. Involvement of stakeholders in the process is imperative.

Commissioner Ashbeck:

- Alignment. If any one sector could have figured this out, they would have, but they cannot. The eight children's hospitals are meeting on Monday to discuss what they can collectively do. The power of that is amazing.
- Counties saying it is easier to do their work and it is making a difference. That is where the work is done. If counties describe that the process is easier and more individuals are being served, that would be a huge success.

Commissioner Danovitch:

- Dashboard. Achieve a state-level dashboard that reflects the mental health and health of California residents. It is difficult to change what cannot be measured. The Commission's work begins and ends with measurement.

Commissioner Brown:

- Facilitate enlightenment about mental illness and challenges and paths to solutions with legislators, communities, state county officials, CEOs, and communities.
- Quality of life. Assist counties to identify how they can best allocate resources, coordinate efforts, reduce stigma, and increase quality of life to mentally ill individuals, families, and the community at large.

Commissioner Gordon:

- Leadership. Importance of grooming leaders. The Commission can take a major role in prompting investment in grooming leaders locally and statewide because that is where sustainability of all of this will come from.
- Consumer representation. Success means that individuals do not have to pound on the Commission to ask to be listened to, but that the consumer voice is routinely included and valued as part of the way the Commission operates and does business.

Morning Session Closing Remarks

Ms. Brutschy stated the afternoon session will be dynamic. Participants will be in mixed groups to think more deeply about some of the questions and the solutions just offered.

Executive Director Ewing stated staff thinks about these issues every day. He agreed with Commissioner Brown about the way the criminal justice project drew attention. He stated it also is a way to get Commissioners in alignment on a topic. Rather than bringing bills before the Commission that someone else has written for debate, a lot of the work staff is trying to do is to give Commissioners a common framework for understanding what is in place today, what is working and not working, and hearing the Commissioners' common voice through the vote to adopt a report. This is important because staff is trying to do that today – to create shared understanding of where the Commission is in terms of how time and resources are used. The most important thing that staff has is Commissioners' time.

Executive Director Ewing stated he was delighted that the Commissioners were beginning to focus on big pieces but the hard part is how to do it. Many issues that were brought up are tough, enduring kinds of challenges around leadership, data, siloing of dollars, and responsibility, the fiscal incentives, and competitive cost avoidance – county agencies that are working hard not to have to care for that really expensive child or family but hoping someone else does it because of the expense. In the meantime, that child or family struggles, suffers, and loses. It is the examples of young children who are struggling with mental health needs in schools or the child welfare system or the juvenile justice system. The connections often are lost from the view of the public agency, but it is the parents, families, colleagues, and neighbors who have to try to help that child to integrate those services and, oftentimes, particularly for disenfranchised communities, they are the least equipped to do that.

Executive Director Ewing dismissed everyone for the lunch break.

LUNCH BREAK

STRATEGIC PLANNING WORKSHOP

Chair Boyd asked Ms. Brutschy to guide the Commission through the strategic planning workshop process.

Ms. Brutschy stated the participants will be randomly assigned to tables with two Commissioners and a scribe at each of five tables for the afternoon workshop of facilitated conversations. She asked for a show of hands of individuals in the audience who represent a county program, community-based program, consumer or family member, another type of stakeholder, Commission staff, or veterans to get an idea of who the participants were who would be joining in the workshop.

Ms. Brutschy stated each table will discuss the same two questions that the Commissioners were asked during the morning session: the unique role of the Commission and what success looks like for the Commission. She asked everyone to count off from one to five to divide up into five tables for the workshop discussions.

Ms. Brutschy dismissed everyone to go to their respective tables.

Strategic Planning Workshop Report-Out

Commissioners reconvened and Ms. Brutschy asked the table captains to summarize the feedback received during the workshop discussions. She stated her team will be looking for patterns.

Question #1

Table 1

Noah Hampton-Asmus, ACCESS California, Mental Health America of Northern California (NorCal MHA), summarized the group's comments and suggestions for Question #1 – the unique role of the Commission:

- Transparency and visibility between the Commission and the counties, between counties, and between counties and residents that would spread the work of the Commission and make it more visible
    - To promote the work in mental health
    - To build relationships in communities that might not know what everyone is doing between the different elements and areas.
- Inclusion and empowerment
    - To be a steward of the mission of the MHSA
    - To further the mission of the MHSA as a state role model of client and family-driven services and client and family-driven advocacy

Table 2

Richard Van Horn, Former Commissioner, Mental Health America of Los Angeles, summarized the group's comments and suggestions for Question #1 – the unique role of the Commission:

- Describe the vision for mental health systems
- Megaphone for the most disenfranchised groups around the state

- Provide a statewide leadership role
- Tell the story
    - Be a serious presence in the media and the public voice

Table 3

Sharon Yates, National Alliance on Mental Illness (NAMI), LACC, & CFLC Committees, summarized the group's comments and suggestions for Question #1 – the unique role of the Commission:

- Legislation
- Data Outcomes
- Broad Standards

Table 4

Theresa Comstock, President, California Association of Local Behavioral Health Boards and Commissions, summarized the group's comments and suggestions for Question #1 – the unique role of the Commission:

- Be a change agent for transformational change
    - Encourage collaboration both within local communities and among state agencies
    - Identify best practices

Table 5

Jane Adcock, California Behavioral Health Planning Council, summarized the group's comments and suggestions for Question #1 – the unique role of the Commission:

- Accountability should be at both the local and the system level
    - It is important for the Commission to communicate out and to provide transparency
- Scope of authority and limited resources to fulfill the scope
    - Since the Commission is spread thin, a review of the mandated versus discretionary activities would be useful
- Serve as a model for stakeholder engagement and collaboration
- Serve as a leader in innovation
    - Provide coordination, resources, and technical assistance
    - Bring expertise to bear
- Serve as a leader in promoting systems collaboration, coordination, and sharing of resources of behavioral health system with other systems such as physical health care, child welfare, juvenile criminal justice, and education

Question #2

Table 1

Noah Hampton-Asmus, ACCESS California, Mental Health America of Northern California (NorCal MHA), summarized the group's comments and suggestions for Question #2 – what would real success look like for the Commission?

- Accountability
  - Tracking attendance and engagement
  - Recognizing community voices
  - Attributing that this idea was heard in several different counties and we want to reinforce the positivity that had been received
- Oversight
  - Quality improvement process that is based on evaluations and the dissemination of learning and information that will lead to advocacy

Table 2

Richard Van Horn, Former Commissioner, Mental Health America of Los Angeles, summarized the group's comments and suggestions for Question #2 – what would real success look like for the Commission?

- Transformation and disruption – collaborative efforts are transforming and disrupting the old system
- People know who the Commission is in the communities around the state
- Define the successful steps toward the north star or are successfully moving north in the northbound train

Table 3

Sharon Yates, National Alliance on Mental Illness (NAMI), LACC, & CFLC Committees, summarized the group's comments and suggestions for Question #2 – what would real success look like for the Commission?

- Growth in the mental health workforce
- Getting the legislative bill signed
- Increasing accessibility of quality-appropriate services to all

Table 4

Theresa Comstock, President, California Association of Local Behavioral Health Boards and Commissions, summarized the group's comments and suggestions for Question #2 – what would real success look like for the Commission?

- Transformation and outcomes – the Commission would be using data and performance measures to drive transformation change and inform programs and planning
- Stakeholders would be involved in community planning processes

- The Commission would understand good innovations from counties and from other states and countries
- The Commission would be able to identify best practices, which would be characteristics of programs that have best outcomes and could be implemented with good fidelity

Table 5

Jane Adcock, California Behavioral Health Planning Council, summarized the group's comments and suggestions for Question #2 – what would real success look like for the Commission?

- California would continue to be the leader for the nation
- Persons with serious mental illness are receiving coordinated services
- They are in recovery
- They are safely housed
- Policymakers are informed, resulting in well-designed programs and effective use of resources
- The public is educated and it reaches a level of enlightenment regarding stigma and NIMBY or Not In My Backyard
- The Commission helps the systems to truly work together, combining resources to increase success and using data to track the reductions in hospitalizations, suicides, school dropout, child welfare, engagement, etc.
- Stakeholders would be satisfied and happy and would feel that they were heard and the processes would reflect their input
- Data, information, and reports would be available to inform all regarding the funding, who was served, successful programs, and unmet needs, gaps, and services, etc.

Bundling Report-Out

Ms. Brutschy stated there was a lot of commonality, not only in what the role could be, particularly about Commissioners knowing what their role was and being able to communicate. With success, the focus on oversight and accountability was key. Ms. Brutschy turned the microphone over to Ms. Colvig-Niclai to provide a bundling report of the feedback gathered from the strategic planning workshop discussions.

Bundling of Question #1 Responses

Ms. Colvig-Niclai stated there were several things related to accountability:

- Collecting data
- Setting standards
- Monitoring standards
- Helping tell the story
- Being a model for stakeholder engagement
- Modeling inclusion and empowerment
- Being a visionary

- Being a leader in innovation
- Being a change agent for transformational change
- Being a leader
- Focusing on priorities
- Being a convener
- Helping to stimulate systems collaboration and coordination
- Minding legislation
- Being an advocate or being a megaphone
- Promoting transparency and visibility between partners and families, partners and the Commission, etc.

Bundling of Question #2 Responses

Ms. Colvig-Niclai stated there were many things that came out as markers of success:

- Legislative bills are signed
- California is a leader in mental health
- Informed policymakers
- People around the state would know who the Commission is
- The public is educated around mental health
    - Social awareness around the work of the Commission and the importance of mental health and mental wellness
- Service Delivery
    - Accessibility to services
    - Better coordinated services
    - Increased wellness
    - Increased mental health workforce
- Collaboration between partners
- Being a part of transformation and disruptive change
- Using data to track outcomes and change and share that story
- Stakeholder satisfaction, engagement, happiness, and being involved in the work
- Oversight and advocacy
    - Information being available or promoting information, sharing it out in terms of best practices
    - Keeping eyes on what is happening and being learned, and sharing, promoting, and advocating for the practices that work

Ms. Brutschy added that she heard groups discussing as a marker of success that the Commission would be visible so that people would really know and see a difference in the

communities and the neighborhoods that they lived and worked in. That is powerful. She stated happiness and wellbeing as a marker of success is important. Wellbeing for all is attainable in the state of California.

Closing Statements

Ms. Brutschy thanked everyone for their participation. She stated this process was very helpful to the ASR team. She stated there will be many opportunities to further explore these issues. She stated the ASR will be coming back to the Commission to try the bundling and narrowing on for size at the November Commission meeting. The online survey will be posted on the website and through the LISTSERV. It is important now to go broad. Some of these same themes and questions will be included in the first online survey.

Ms. Brutschy thanked Commissioners in advance for participating in personal interviews. She suggested that Commissioners go out and collect information to funnel to the ASR about the role that is unique to this Commission and how the Commission can tell the story of its success. She stated the goal of completing the communication, roadmap, and data portions of the strategic planning process by May of 2019.

Commissioner Ashbeck and Vice Chair Aslami-Tamplen thanked the ASR team for their help and thanked everyone for their participation.

On behalf of the Commission, Executive Director Ewing thanked everyone for their participation. He stated much of the process has been built in through this meeting, the November Commission meeting, personal interviews, the survey, and public engagement opportunities. He asked everyone to let staff know if there are additional ways to capture more voices and vision in terms of the role of the Commission. The more robust this process is, the more likely staff can put in front of Commissioners the grist that they need to frame out opportunities that the Commission has and how to move forward. He reiterated the importance of letting staff know if there is a piece of the process that can be enhanced.

GENERAL PUBLIC COMMENT

Mandy Taylor, Health Access, California LGBT Health and Human Services Network, stated appreciation of beginning the meeting with Commissioner introductions. It is helpful for the community to understand the perspective each Commissioner comes to the table with.

Poshi Walker, LGBTQ Program Director, NorCal MHA, Co-Director, Out 4 Mental Health, loved the Commissioner introductions and thought the whole day was fabulous. The speaker noted that many staff members are starting to put preferred pronouns on emails, which is fabulous, but there are a number of people who are still uncomfortable and unsure what to do with that. The speaker offered that Out 4 Mental Health has a quick training on pronouns that also is followed up with a fact sheet. The speaker suggested presenting this information at a future Commission meeting so individuals can better understand, get used to saying their pronouns, and make a safe space for queer and trans people.

Steve Leoni, consumer and advocate, stated this was a wonderful day. The Commission is the embodiment of the MHSA in terms of moving forward. Individuals, including the speaker, who worked on the original MHSA had hopes and dreams about a better mental health community in the state. The Commission is the carrier of that vision. One of the things that many of the stakeholders who identify with that idea always wanted was a meeting where the boundaries were down, where the Commission and the community members could talk in a large group –

and, for the most part, they did not get it. Today was a fulfillment of part of that role of being the custodians of the vision of the MHSA. He thanked the Commission.

Noah Hampton-Asmus, ACCESS California, NorCal MHA, stated today's afternoon session provided the opportunity to do something that was lost in reporting and evaluation – to take qualitative information. Moving forward with evaluation, the qualitative aspects of mental health are measured because it is about feeling better and about making people feel independent and resilient. This was a foundational principal of how to get qualitative information and how important it is to the process moving forward. It was well done.

RECESS

Vice Chair Aslami-Tamplen recessed the meeting at 3:16 p.m. and invited everyone to join the Commission for Day 2 of the meeting tomorrow morning at 9:00 a.m.

Mental Health Services
Oversight and Accountability Commission

STATE OF CALIFORNIA
EDMUND G. BROWN
Governor

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
September 27, 2018

MHSOAC
Hyatt Regency Los Angeles
6225 West Century Blvd
Los Angeles, CA 90045

Members Participating:

John Boyd, Psy.D., Chair
Khatera Aslami-Tamplen, Vice Chair
Mayra Alvarez
Reneeta Anthony
Lynne Ashbeck
Sheriff Bill Brown
Keyondria Bunch, Ph.D.
Assemblymember Wendy Carrillo
Itai Danovitch, M.D.
David Gordon
Mara Madrigal-Weiss
Gladys Mitchell
Tina Wooton

Members Absent:

Senator Jim Beall

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

DAY 2: September 27, 2018

RECONVENE AND WELCOME

Chair John Boyd reconvened the meeting of the Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission) to order at 9:16 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 and stated he moved a few agenda items up. He gave a brief summary of yesterday's Strategic Planning Session.

Chair Boyd welcomed Assemblymember Wendy Carrillo to the Commission. Commissioner Carrillo introduced herself.

Youth Participation

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. Amanda Southworth introduced herself.

Consumer/Family Voice

Chair Boyd stated the scheduled speaker was unable to be in attendance. He stated the next Commission meeting will begin with an individual with lived experience sharing their story.

Chair's Remarks

Chair Boyd asked Ms. Yeroshek to direct the public where to access the expenditures for all levels of the Commission for the last two years. Ms. Yeroshek stated the Commission's expenditures are on the website for the State Controller's Office.

Chair Boyd asked about the process for next month's nominations for chair and vice chair for 2019. Ms. Yeroshek stated there will be nominations at the next Commission meeting. The individuals nominated will be given an opportunity to say a few words.

Chair Boyd paused for a moment to acknowledge suicide prevention month and all the young people who have been impacted by suicide. He also acknowledged the role that sexual assault has in the area of trauma, post-traumatic stress, and suicide.

ACTION

1: Approve August 23, 2018, MHSOAC Meeting Minutes

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

The Commission approves the August 23, 2018, Meeting Minutes.

Motion carried 10 yes, 0 no, and 3 abstain, per roll call vote as follows:

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

The following Commissioners abstained: Commissioners Ashbeck, Brown, and Bunch.

ACTION

2: Kings County Innovation Plan

Presenters:

- Ahmad Bahrami, MBA, Program Manager, Kings County
- Unchong Parry, MPA, Deputy Director, Kings County
- Katie Arnst, MA, Deputy Director, Kings County

Ahmad Bahrami, Program Manager, Kings County Behavioral Health, provided an overview, with a slide presentation, of the problem, innovative components, learning goals, evaluation, and sustainability of the proposed Multiple Organization Shared Telepsychiatry Innovation project.

Commissioner Questions and Discussion

Commissioner Alvarez asked how the county planned to introduce this concept to patients, families, and peer support teams to ensure success of the project.

Mr. Bahrami stated county residents are already familiar with telepsychiatry services. The project will shorten the length between appointments from approximately five weeks to five to seven days.

Commissioner Danovitch asked what the current barriers are to implementing this program.

Mr. Bahrami stated the startup cost is a barrier because most providers are small. Current telepsychiatry services are with one provider. Having an approved plan would also increase support from the county administration.

Commissioner Danovitch stated his concern about whether the learnings from the proposed project are predicated on being able to compare this intervention to another comparison group. That would require a level of study that is sophisticated and challenging to do and it may be difficult at the end of this to make a comparison that allows an informed decision about whether to continue it. He asked if there were other learnings from this that inform decisions about whether to sustain it.

Vice Chair Aslami-Tamplen stated she would have liked to have seen full-time peer positions since that is the driving force of this Innovation. She asked if the peers will be trained in things that are developed by consumers, such as the Wellness Recovery Action Plan (WRAP). She stated she hoped the collaborations between the psychiatrists and peers will decrease stigma.

Mr. Bahrami stated the first phase will allow the county to do the necessary classification and position studies for the new peer positions while peers can get started in the projects by doing contract work. Peers will go through trainings that other staff already go through on wellness and recovery and the WRAP program.

Commissioner Anthony suggested that the county consider agency perceptions and predisposed biases when doing the study and if changes can be made to improve those.

Commissioner Bunch stated the amount requested is below the projected cost of the program. She asked why the county did not ask for more funding.

Mr. Bahrami stated that is the way Innovation funding is set up with each county receiving a certain amount. Funding will also be leveraged through Medi-Cal and Community Services and Supports (CSS).

Commissioner Wooton stated her concern that the county is relying on Senate Bill (AB) 906, peer support specialist certification, for peers. She encouraged the county to look at other counties and their peer certification curriculum.

Public Comment

Stacie Hiramoto, Director, Racial and Ethnic Mental Health Disparities Coalition (REMHDCO), spoke in support of the proposed project.

Ken Baird spoke in support of the proposed project.

Poshi Walker, LGBTQ Program Director, Mental Health American of Northern California (NorCal MHA), Co-Director, Out 4 Mental Health, spoke in support of the proposed project. The speaker agreed with Vice Chair Aslami-Tamplen that the peer support specialists should be full-time, that there should be more than two, that they should have a supervisor who is also a peer, and that they should be in a safe environment. The speaker stated the need to look for

happiness, not just to reduce symptoms, and for medications that not only reduce symptoms but that cause the least amount of harm. The speaker supported the comments that would be made by the next speaker, Mandy Taylor.

Mandy Taylor, Health Access, California LGBT Health and Human Services Network, spoke in support of the proposed project. The speaker encouraged the county to ensure that their providers are trained in providing clinical care to their transgender and LGB clients so that more harm is not being done by their psychiatry then help.

Max Geide, County Behavioral Health Directors Association (CBHDA), spoke in support of the proposed project.

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

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

Name: Multiple Organization Shared Telepsychiatry (MOST) Project

Amount: $1,663,631

Project Length: Three (3) years

Motion carried 11 yes, 0 no, and 0 abstain, per roll call vote as follows:

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

ACTION

3: <u>Los Angeles County Innovation Plans (2)</u>

Presenters for Conservatees Living in the Community Project:

- Debbie Innes-Gomberg, Ph.D., Deputy Director, Los Angeles County
- Maurnie Edwards, Health Program Analyst, Los Angeles County
- Connie Draxler, Los Angeles Public Guardian
- Evelio Franco, Team Supervisor, Los Angeles County

Presenters for Therapeutic Transport Project:

- Debbie Innes-Gomberg; Ph.D., Deputy Director, Los Angeles County
- Anthony Ruffin, Outreach Worker, Los Angeles County
- Paul Stansbury, Family Member

Commissioner Bunch recused herself from the discussion and decision-making with regard to this agenda item pursuant to Commission policy.

<u>Conservatees Living in the Community Project</u>

Debbie Innes-Gomberg, Deputy Director, Los Angeles County, provided an overview, with a slide presentation, of the problem, innovative components, and learning questions and outcomes of the proposed Conservatees Living in the Community Innovation project.

Maurnie Edwards, Health Program Analyst, Los Angeles County, spoke about the need for and benefits from the peer support component of the proposed Innovation project.

Evelio Franco, Team Supervisor, Los Angeles County, discussed how consumers and family members will benefit from the proposed Innovation project.

Connie Draxler, Los Angeles Public Guardian, discussed the innovative team environment component of the proposed Innovation project.

Commissioner Questions and Discussion

Commissioner Wooton asked the county to return to share the findings of this project. Peer support is an evidence-based practice but it is not done much in California.

Commissioner Danovitch questioned the sustainability of the proposed project. A significant portion of durable goods will depreciate over the length of the project. He asked about the number of clients who will be served by the proposed project.

Dr. Innes-Gomberg stated each of the 16 teams will serve approximately 50 clients at any one particular time. She stated, if the project is successful and the county learns the best practices associated with the skill-building, increasing decisional capacity, the role of the peers in that process, and how it is tied to the outpatient mental health program, it will be funded with a combination of CSS Systems Development and Full Service Partnership (FSP) funding.

Vice Chair Aslami-Tamplen asked if the proposed project will help with the individuals whom the public guardians have already served or if it will add more individuals.

Ms. Draxler stated it will be both. Individuals who do not qualify for an FSP program will be eligible for this enhanced service. Individuals will be brought out of Institutions for Mental Disease (IMDs) or other higher levels of care to lower levels of care because of this enhanced service.

Vice Chair Aslami-Tamplen stated her concern that the peers may be coopted into doing what the conservators are doing instead of doing the peer work.

Dr. Innes-Gomberg stated recovery-oriented services must be provided in order to increase conservatorship capacity and peers are critically important to that.

Commissioner Mitchell asked about the phrase “increase conservatorship capacity” and if it refers to the number of individuals served.

Dr. Innes-Gomberg stated there is a parallel to increasing access to mental health services and providing the optimal frequency and intensity of services so individuals get better and can exit the system.

Commissioner Mitchell asked how many individuals in the county are conserved and how many have become un-conserved.

Ms. Drexler stated there is an average of approximately 2,700 conservatees on any given day. The county receives approximately 100 referrals per month from acute psychiatric facilities and 60 to 70 percent are placed in a conservatorship. Getting off conservatorship varies from month to month.

<u>Therapeutic Transport Project</u>

Dr. Innes-Gomberg provided an overview, with a slide presentation, of the problem and innovative components of the proposed Therapeutic Transport Innovation project.

Anthony Ruffin, Outreach Worker, Los Angeles County, discussed the current process and how the proposed Innovation project will improve the process to better support consumers.

Paul Stansbury, Family Member, shared his experience of noise, chaos, and confusion of the current process during his son's psychotic episode that added stress for his son and disturbed his neighbors. He stated the need for a more dignified, humane treatment during this traumatic moment in his son's life. He stated law enforcement is doing better, but a peer would have provided calm understanding and would have better communicated to his son the steps being taken to help him.

Miriam Brown, Mental Health Clinical Program Manager, Los Angeles County Department of Mental Health, discussed the advantages of implementing the proposed project.

Commissioner Questions and Discussion

Vice Chair Aslami-Tamplen stated, if the peer is driving, they are not really connecting.

Dr. Innes-Gomberg stated the county does not envision the peer driving.

Commissioner Wooton suggested something on the side of the van other than Los Angeles Mental Health to reduce stigma. She stated her concern about the wage amount for peers and whether they can live on that in Los Angeles County.

Dr. Innes-Gomberg stated the Department is currently in negotiations on that issue.

Commissioner Gordon asked about the phrase "those deemed safe for transport." He asked how that decision is made and what the backup is if there is an unanticipated problem in one of the vans.

Ms. Brown stated there is a policy in place in terms of whom to transport. Eventually there will also be protocols on how to make the decision of when a person will be safe to be transported. In an emergency, the clinicians on the scene would decide whether an alternative van is called or if an individual requires restraining.

Amanda Southworth asked if the county is going to scale to address the issue of transporting combative individuals or individuals who may be agitated or violent.

Dr. Innes-Gomberg stated the Department's goal is to use the proposed approach where possible.

Commissioner Anthony asked if the response time for the van will be included in the learning outcomes. She asked for more detail on how service delivery for the van will be evaluated.

Dr. Innes-Gomberg stated response time will be added to the metrics. In response to the question on service delivery, Dr. Innes-Gomberg stated that question is part of the learning questions and evaluation. She reviewed the presentation slide she had yet to discuss about the learning questions and evaluation.

Commissioner Anthony asked how often the manager and team will debrief and discuss the activities and services being provided.

Ms. Brown stated the teams will meet twice a day in the beginning, to discuss the plan for the day in the morning and the lessons learned and how to improve at the end of the day.

Commissioner Mitchell asked how the vans will answer emergency calls quicker than the historical emergency response vehicles in the same Los Angeles traffic.

Ms. Brown stated the vans will be located in specific areas throughout the county such as the county hospitals. She stated the team will collaborate with other emergency response teams to determine the quickest response during high-traffic situations.

Commissioner Alvarez asked about the differences between the proposed Innovation project and the references to other initiatives in Los Angeles that do similar work to minimize law enforcement involvement and to support the community.

Ms. Brown stated there is a collaborative with 39 of the 46 police departments in Los Angeles County to provide 40-hour training for all incoming law enforcement officers. The goal is for law enforcement and clinicians to work together. A 16-hour training has been developed for small police departments that cannot afford to put their officers through the 40-hour training. Over 5,000 law enforcement officers have been trained about law enforcement and mental health. Also, clinicians receive training about the policies and procedures of law enforcement.

Commissioner Alvarez asked if the team is expected to work on the back end when a call is received to determine which team is deployed to be more responsive and accurately respond to the needs of the individual. Ms. Brown stated they do.

Commissioner Alvarez asked about the key difference between their project and Alameda County's project.

Dr. Innes-Gomberg stated Alameda County does not have a peer component and they had a second component that was very different. She stated her team felt it was significantly different in terms of its goals and the overall approach.

Commissioner Madrigal-Weiss stated there is a statewide concern about how to address the issue with students not wanting to receive help because schools often do not respond immediately but only call 911 when all else fails. She asked if schools were part of the community planning process and, if so, if there was consideration to approach this to schools, if there already was a program in place, and, if so, how to learn more about it.

Dr. Innes-Gomberg stated the Department is working with LAUSD in a broad way to increase the Department's presence on campus. She stated the Innovation Pipeline Work Group was part of the community planning process but she was unsure if schools were a part of that.

Ms. Brown stated the Department works closely with schools. Schools call the Department directly. The only time they use 911 is when there is high need.

Public Comment

Max Geide spoke in support of both proposed projects.

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

Carmen Diaz, former Commissioner, spoke in support of both proposed projects.

Steve Leoni, consumer and advocate, spoke in support of both proposed projects but was concerned about how they would be implemented. He stated concern about the language for resources for the conservatees that would be marshalled "in the best interest of the client." He stated many sins have been committed under those words. He asked who determines what is in the best interest. He asked when someone will look at how to fix the 5150 process so that clients are no longer traumatized and retraumatized and so that clients can go to a place to feel better rather than a place they have to fear.

Noah Hampton-Asmus, ACCESS California, NorCal MHA, spoke in support of both proposed projects.

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

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

Name: Ongoing Focused Support to Improve Recovery Rates for Conservatees Living in the Community

Amount: $16,282,502

Project Length: Five (5) years

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

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

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

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

Name: Therapeutic Transportation

Amount: $18,342,400

Project Length: Three (3) years

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

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

Commissioner Bunch rejoined the Commissioners at the dais.

[Note: Agenda Item 4 was moved from after the lunch break to before the lunch break.]

Commissioner Gordon stated he needed to leave prior to Agenda Item 7, the naming of the fellowships. He went on record to give his support of naming the fellowships in honor of the two nominated individuals.

INFORMATION

4: Executive Director Report Out

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

Executive Director Ewing presented his report as follows:

Fiscal Oversight

Four to six counties seem to have spent Innovation funds without Commission approval. In some instances, it looks as if these were projects that were approved by the counties during a point in time when the Commission's approval was not required. The spending patterns were not consistent with the Commission's rules at certain points in time. We are still investigating this issue and will know more as counties submit their fiscal reports.

Innovation Incubator

An additional public forum is planned to discuss the consultant's report. The consultant has advised the Commission to clarify expectations for county Innovation plans. This will create an opportunity for a consent calendar, to explore opportunities to form an information clearinghouse and a learning community to support all aspects of the mental health system. The Innovation Incubator can serve as a venue for engaging counties in strategic opportunities for innovation, provide technical assistance, support evaluation, and disseminate the results.

Legislation

The Governor has signed the following bills:

- SB 192 (Beall) Mental Health Services Fund
- SB 688 (Moorlach) Mental Health Services Act: revenue and expenditure reports
- SB 1113 (Monning) Mental Health in the Workplace: voluntary standards

The Commission needs to consider the kinds of proposals it has already supported through policy recommendations and how to make those happen through legislation and budget change opportunities. Executive Director Ewing asked if there were legislative priorities or budget issues that Commissioners would like to bring up because this is the time that the legislative process will start to engage on that.

Commissioner Feedback

Vice Chair Aslami-Tamplen suggested cleaning up the stigmatizing language in the statutes, such as "mentally disordered offender."

Executive Director Ewing stated staff will work with the Chair and Vice Chair to work on this, possibly through one of the Committees, to consider the need for a historical update of the statutory references and the way individuals with mental health needs are characterized and spoken of.

Commissioner Anthony cautioned that changing the language may lessen the intent of those that the funding was intended to serve. A clinical definition of a service group should not be watered down so that it is no longer focused on who the law was intended to serve.

Commissioner Alvarez stated Assembly Bill (AB) 2315, pupil health: mental and behavioral health services was also signed by the Governor. She suggested exploring how mental health services can be more accessible to children in schools. Commission Gordon echoed this idea.

Vice Chair Aslami-Tamplen suggested legislation on the NIMBYism or Not in My Backyard issue specifically to increase peer respites.

Commissioner Wooton stated sometimes referrals are not made to peer respites because there is not a clinician onboard. She stated the hope that there will be training to the staff on the value of peer respites and programs being led by peers.

Commissioner Mitchell stated there is an issue with transition age youth (TAY) with mental health issues who are adults but do not function as adults. This is a parental concern.

Commissioner Alvarez stated there is a direct link between mental health and civic engagement. She asked the Commission to explore that moving forward.

Mental Health Policy Fellowship

An application has been posted on the website for individuals who want to serve on the advisory committee to help frame out the fellowship.

Stakeholder Contracts

Community meetings were held in San Diego and Los Angeles to look at how to allocate stakeholder advocacy dollars for the immigrant and refugee populations.

Staff has been in discussions with the Council on Criminal Justice and Behavioral Health about how to support them in their use of the criminal justice stakeholder advocacy dollars.

Triage Grants

The triage funds were reduced by 71 percent over what was initially proposed. Twenty-two of the twenty-four contracts have gone out to counties.

Butte County rejected the funds because they could not make up the shortfall. Those funds were reallocated to a different project that had been partially funded with the intent of fully spending the dollars that were allocated based on the scoring that was done through the application process.

Workplace Mental Health

Staff is in the process of bringing together advisors to help frame this project out.

Youth Innovation Project

Youth engagement meetings were convened in Northern California and the Central Valley to get feedback and input on the proposal. Staff is working to engage a consultant to help inform the youth leadership advisory body, to support youth engagement efforts, and to identify key challenges.

Commission Meeting Calendar

The October 25th meeting will be at the Marina Inn in Alameda County.

The November 14-15 (2-day) meeting will be at the Mission Inn in Riverside. The Commission meeting will be on Wednesday, November 14th and the strategic planning session will be on Thursday, November 15th.

There will be no Commission meeting in December.

Commissioner Questions and Discussion

Commissioner Alvarez asked staff to send Commissioners a weekly calendar of events so Commissioners can be part of the ongoing discussions.

Commissioner Alvarez stated she received positive feedback about the listening session in Los Angeles but the negative feedback was that no Commissioners were present. Commissioners add value to the conversation because they are part of discussions that no one else is part of and can share what they learn out in the community with staff and each other. Commissioners and staff would be more aligned with the needs of communities by sharing information.

Chair Boyd suggested adding a permanent 30-minute block in Commission meetings following the Executive Director Report Out for Commissioners to have dialogue amongst themselves on strategy, the direction of the Commission, and other priorities that are important to the Commission.

Commissioner Anthony agreed.

Commissioner Gordon agreed with the caveat to be respectful to staff because there is already a lot on their plate. He suggested figuring out how to complete current projects in a more coordinated way.

Chair Boyd asked staff to send the last three years' Commission meeting attendance sheets to Commissioners.

Chair Boyd reminded Commissioners that staff will be sending out the protocols on nominating and electing the chair and vice chair of the Commission for 2019 for next month's meeting.

Vice Chair Aslami-Tamplen stated Commissioner Ashbeck had expressed an interest in running for vice chair.

Commissioner Anthony asked about the nomination process. Ms. Yeroshek reviewed the process.

Public Comment

Stacie Hiramoto spoke in support of Chair Boyd's recommendation for a permanent 30-minute block for Commissioner discussion following the Executive Director Report Out. She reminded the Commission of a letter sent from many organizations encouraging the Commission to create a Legislative Committee so the public can have a more thoughtful, planned discussion on legislation.

Stacie Hiramoto requested two General Public Comment sections in the meeting agenda. She stated REMHDCO supports Sally Zinman as the name for the consumer fellowship and strongly recommends Rusty Selix for the professional fellowship name.

LUNCH BREAK

ACTION

5: <u>Santa Barbara County Innovation Plan Extension</u>

Presenters:

- Lindsay Walter, J.D., Deputy Director of Operations and Administration, Santa Barbara County
- Lisa Conn Akoni, MA, Marriage and Family Therapist, Santa Barbara County
- Carissa Phelps, J.D., Santa Barbara County

Commissioners Brown and Wooton recused themselves from the discussion and decision-making with regard to this agenda item and left the room pursuant to Commission policy.

Lindsay Walter, J.D., Deputy Director of Operations and Administration, Santa Barbara County, requested a two-year extension on the Resiliency Interventions for Sexual Exploitation (RISE) Innovation project, which the Commission approved three years ago. She provided an overview of the background of the RISE Project.

Lisa Conn Akoni, MA, Marriage and Family Therapist, Santa Barbara County, discussed the need for the RISE Project in Santa Barbara County.

Carissa Phelps, J.D., CEO of Runaway Girl, Inc. provided an overview, with a slide presentation, of the status, goals met to date, and goals yet to be realized from the RISE Project. She stated the first three years were about collaboration and building the infrastructure.

Commissioner Questions and Discussion

Commissioner Danovitch asked about the achievements the program has been able to register in the first phase to understand the barriers. He asked what was successful in the first phase to help the success of the second phase.

Commissioner Bunch asked how the county partners with law enforcement.

Ms. Akoni reviewed the goals met to date on the goals met/goals yet to be realized presentation slide.

Commissioner Danovitch asked what would happen to the project if the extension was not funded.

Ms. Walter stated the county is trying to figure out how to develop this special population treatment into the TAY FSP and how to leverage Medi-Cal using the FSP model. The county now has leveraging partners – the Junior League has raised money to develop a safe house and the Good Samaritans received a grant last week to house individuals.

Commissioner Mitchell asked for a description of what a typical day's work is like.

Ms. Akoni stated she typically has 180 emails asking for support on a myriad of issues. There may be a schedule and then something else comes in. It is all day, every day. She stated the county is flying the plane while building it. The majority of her work is about the multidisciplinary treatment team.

Ms. Phelps provided the Commissioners with a survivor's perspective of the project and that the project feels warm, welcoming, accessible, and safe.

Public Comment

Max Geide spoke in support of the proposed project extension.

Poshi Walker spoke in support of the proposed project extension and suggested that housing discussions consider gender identity.

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

The MHSOAC approves Santa Barbara County's innovation project extension as follows:

Name: Resiliency Interventions for Sexual Exploitation (RISE)

Amount: $2,600,000 for a total INN project budget of $5,107,749

Project Length: Two (2) years for a total project duration of five (5) years

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

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

Commissioners Brown and Wooton rejoined the Commissioners at the dais.

ACTION

6: Technology Suite Collaborative Innovation Project

Presenters:

- Karin Kalk, Tech Suite Project Manager
- Gloria Moriarty, Advocate Specialist, Center of Deafness Inland Empire
- Imo Momoh, M.P.A., Director, Mental Health Services Act, San Francisco County Department of Public Health
- Sharon Ishikawa, Ph.D., MHSA Coordinator, Orange County Health Care Agency Behavioral Health Services
- Dara H. Sorkin, Ph.D., Associate Professor, Department of Medicine, University of California, Irvine

Commissioner Wooton recused herself from the discussion and decision-making with regard to this agenda item and left the room pursuant to Commission policy.

Karin Kalk, Tech Suite Project Manager, provided an overview, with a slide presentation, of the Tech Suite Project and lessons learned and introduced the Cohort #2 counties and their proposals. She played videos showcasing stakeholders who were involved in the community planning process speaking in support of the proposed project.

Sharon Ishikawa, Ph.D., MHSA Coordinator, Orange County Health Care Agency Behavioral Health Services, continued the slide presentation and discussed the Cohort #1 progress.

Dara H. Sorkin, Ph.D., Associate Professor, Department of Medicine, University of California, Irvine, continued the slide presentation and discussed the evaluation approach.

Imo Momoh, M.P.A., Director, Mental Health Services Act, San Francisco County Department of Public Health, continued the slide presentation and discussed the Cohort #2 San Francisco County Project.

Gloria Moriarty, Advocate Specialist, Center of Deafness Inland Empire, continued the slide presentation and discussed the Cohort #2 Riverside County Project.

Ms. Kalk, continued the slide presentation and discussed the remaining counties in Cohort #2.

Commissioner Questions

Commissioner Danovitch asked if there is an execution risk and if the project can be harmed by the scaling before there is readiness to scale.

Dr. Ishikawa stated it is framed more that, instead of ten buildings being built simultaneously, additional individuals are coming to help construct the building that already has a set foundation. These individuals can bring added focus, perspective, and expertise to help make it more functional.

Ms. Kalk stated the collaborative process is one that fosters parallel learning. She gave the example of two counties working hard on one issue. It does not burden the other counties, but, as that learning emerges, it can be rapidly disseminated throughout the other counties to make them more effective. Collaborative learning is a structure that allows parallel learning where there is a common aim but distinction within each entity.

Commissioner Danovitch asked if 7 Cups and Mindstrong are for profit and, if so, how to ensure that there is alignment of interests of the individuals that are intended to be serve and the companies involved helping to provide the services.

Ms. Kalk stated there is a contract monitoring process that clearly describes the services and requirements of the project in the procurement and contractual process to ensure that every county's interests are translated into work orders to those vendors to ensure that there is delivery of those orders.

Commissioner Danovitch stated there will be repositories of incredibly sensitive information for large cohorts of individuals. There are a lot of unknowns in the positive sense but also in the risk sense in terms of how interaction with these applications will develop over time and where this is all going to go.

Ms. Kalk introduced Ann Collentine, Deputy Director of Programs, California Mental Health Services Authority (CalMHSA), and asked her to address Commissioner Danovitch's concern. Ms. Collentine stated technology and legal experts have been engaged to protect the rights of counties moving forward. These experts will continue to be engaged throughout the process.

Vice Chair Aslami-Tamplen stated concern about security, where collected information will be kept, and the $59 million that has already been invested in this collaborative with nothing yet to show for it.

Dr. Sorkin stated what happens to that data is critically important. Issues of privacy and security of the data are taken seriously. One of the key innovations that is happening here is that it is not likely that counties will ever be able to develop mobile apps within their county systems and counties will always need to reach out to private companies or universities. That process of bringing those apps into county mental health services is the innovation of this time. Working out the details of who gets access to what data and who is responsible for securing that is a large part of the work being done with the proposed project.

Mark Elson, Ph.D., Principal, Intrepid Ascent, stated Intrepid Ascent works with CalMHSA on privacy and security. Trust is the greatest asset for the organizations collaborating on this project and maintaining the trust of stakeholders. As with health care, there has been a shift to different cloud-hosted applications.

Dr. Elson stated Intrepid Ascent did a review of the initial two vendors, which informed the contracting process between CalMHSA and those vendors. Requirements from CalMHSA and specific county concerns are in those contracts. The collaborative not only has more collective expertise for this group contracting but also more leverage with these technology companies than if a county was individually contracting with an app vendor.

Dr. Elson stated the two vendors have been responsive and made changes to their privacy policy, are making movements toward greater transparency, and are working with counties on specific processes for informed consent.

Amanda Southworth stated everything that these counties are coming up with can be found outside the counties. The proposed project is not innovative enough to be considered groundbreaking. She stated she wished there was more brevity, security, and detail about what is happening with the proposed project and what the county wants to see from the results. It needs to be accessible to more individuals.

Commissioner Anthony stated she was involved in the California Work Opportunity and Responsibility to Kids Information Network (CalWIN), the social services benefit-issuance system for 18 counties. She stated it was a monster when looking at implementation within each

of the counties. She asked about the dedication in each county for staff to meet and collaborate on a regular basis. She also asked about the methodology for distributing the information back to general county employees. Information going back for implementation and referral is the critical mass issue.

Ms. Kalk spoke about how the work is done across counties. There are mechanisms for routine shared learning, for example, telephone and online meetings and regular convenings. The intention of the collaborative is to overcome challenges more quickly and robustly because of the different perspectives. One-on-one support with counties is also maintained to keep the focus on local conditions.

Dr. Ishikawa spoke about how the work is done within counties. She stated Orange County has a team within the Innovation Office that interfaces with the collaborative multiple times a day, three to four days per week, tackling issues related to the development and implementation of the proposed project.

Commissioner Anthony asked about the full-time equivalent (FTE) staff who are contributing to this process on a monthly basis.

Dr. Ishikawa approximated a minimum of four FTE.

Chair Boyd asked Tom Insel, who presented at the July Commission meeting, to comment.

Tom Insel, M.D., Co-founder, Mindstrong Health, Advisor, 7 Cups, introduced himself and gave a brief overview of the background of Mindstrong Health. He responded to Commissioner Danovitch's questions about execution costs and whether this is the right time. He likened the project to CalMHSA's building a restaurant where Mindstrong and 7 Cups are the cooks to build things that can go onto a menu. He stated the questions are what is on that menu and how long and how big the menu should be. He stated the proposed project has been a spectacular opportunity for Mindstrong and 7 Cups to align with what the counties need. He stated this is a chance to create tools for the public good.

Commissioner Mitchell stated sometimes counties do not know what they want. She stated it would help Commissioners feel more comfortable if counties would demonstrate how the project is moving and growing each time expansion is requested. She stated it is difficult to approve additional funding when Commissioners do not know what was done with the first set of funds.

Betsy Gowan, Director, Tehama County Mental Health, stated the proposed project makes county mental health relevant to consumers in the community. Having county behavioral health associated with the project is huge. She also stated she has not seen as much excitement as when this idea was first broached, and the excitement continues to today. This gives county mental health an opportunity to provide input.

David Schoelen, Mental Health Services Act Administrator, Riverside County, asked the Commission to consider not only the technological innovation that these applications provide, but also the process innovations of county collaboration and reaching individuals who otherwise would not come to the table.

Commissioner Madrigal-Weiss stated the greatest struggle she is having is that the $59 million has already been invested but the proposed project is still at the learning level. It is important to show the Commission something that has been learned before asking for another $43 million. She asked if more counties are anticipated to come onboard after this group.

Ms. Kalk stated there is interest but it has not been entertained at this stage.

Commissioner Alvarez stated there is no question that the Commission is excited and believes in the promise of technology to do better by individuals with mental illness in order to promote mental health and wellbeing. She stated Commissioners want to ensure that the public dollars are best utilized, are tracked appropriately, and provide the return on the investment that is expected, that there is a sustainability plan, that there are lessons learned that are lifted up, and that there is ethical practice and privacy. That is the concern. She stated she has heard presentations on the Tech Suite project three times but still does not know what it does, what the impacts will be, and how these tools are identified to best meet the needs of priority populations in the counties.

Commissioner Brown addressed concerns of his fellow Commissioners:

Funding Concerns

- Much of the prior approval amount of $59 million was for two counties – Los Angeles County and Orange County. Those counties will get the larger chunks of innovation funding anyway. It is their money that has been allocated towards them.
- In the first cohort, there were three smaller counties that have piggybacked on those two larger counties and been able to get innovative technology that they would have had no chance of getting on their own for the amounts that they would have been allocated.
- The additional $42,868,480 involves eight additional counties and four cities. One of the eight additional counties is Riverside, which is another one of the four big counties in California. Of the $42 million, $25 million belongs to Riverside County.

Security Concerns

- Law enforcement has lots of very sensitive digital information, which is stored and used on the cloud and is in the custody of private companies that are contracted with. The same is true for the banking and medical industries. It is a currently-accepted practice to do that.

Innovative Collaboration

- The bottom line is, by having three of California's four largest counties involved in this consortium, the leveraging of that funding is providing the opportunity for the smaller counties. There are another seven smaller counties in this next batch that would get this technology that would not otherwise be able to do it.
- The innovation in these counties collaboratively coming together to do this is the basis of what the Commission is supposed to be looking to approve.

Commissioner Mitchell agreed but asked if there was something the Commission can see about where the counties are in the process.

Chair Boyd paused the Technology Suite presentation. He asked Ms. Kalk to get together with her team and put together a five-minute demonstration to resolve Commissioner concerns.

[Chair Boyd moved the Commission on to Agenda Item 7, the naming of the fellowship programs, while the Technology Suite Collaborative Innovation Project team worked on Chair Boyd's request. See below for discussion f Agenda Item 7.]

[After the completion of business for Agenda Item 7, the Commission resumed discussion on the Technology Suite Collaborative Innovation Project.]

Ms. Kalk stated appreciation for the opportunity to show the progress to date on the proposed project. She referred to the Technology Suite Implementation Timeline presentation slide and noted the milestones that have been achieved to date. She stated the core venders are in place.

Ms. Kalk stated the first application, Mindstrong, has been deployed in Kern and Modoc Counties. Orange County is in the process of deploying Mindstrong in several of their clinics and Los Angeles County is preparing to deploy Mindstrong in their DVT clinic.

Paul Dagum, M.D., Ph.D., Founder and CEO, Mindstrong Health, showed a demonstration of the Mindstrong app and new innovation that they have done on the collaborative's behalf for Los Angeles County. He showed an aspirational video about the Mindstrong app and a series of slides to give additional information about Mindstrong.

Glen Moriarty, Founder and CEO, 7 Cups, walked Commissioners through the 7 Cups landing pages for the participating counites to demonstrate the customization capability that has been accomplished for Cohort #1.

Ms. Kalk stated they would be happy to return to provide further detail at a future Commission meeting.

Public Comment

Poshi Walker spoke in opposition to the proposed project. The speaker stated ACCESS California and Out for Mental Health have provided written and public comment voicing concerns about the Technology Suite throughout the process. It is not innovative because there are already five counties trying this and there is already a cohort. If this is approved, the Commission will be spending over $100 million on an unproven modality.

Mandy Taylor referred to the sample policies and particularly highlighted number two, ensuring culturally accurate and affirming information, support, and resources. The speaker stated the Technology Suite should be moderated by qualified community members who are compensated for their time and labor. Individuals who know what they are talking about should be the ones providing support.

Mandy Taylor pointed out policy recommendation number ten, that counties or cities prioritize community outreach and in-person engagement using the integrated service model that is required by the Mental Health Services Act. The speaker stated a warm handoff is one of the only value-added components of this project that cannot be found by another application that can be downloaded. The only thing that is being added here is the county connection.

Max Geide spoke in support of the proposed project.

Alexis Stokes-Shaw, MHSA Coordinator, Kern Behavioral Health and Recovery Services, spoke in support of the proposed project.

Adrienne Shilton spoke in support of the proposed project.

Ann Collentine spoke in support of the proposed project.

Carmen Diaz stated she is neither for nor against the proposed project. She stated her concern that children have access to apps. She asked about the protection for children and the parents of these children.

Commissioner Discussion

Commissioner Anthony made a motion in support of the additional 10 county Innovation plans and the request that the overall project be moved for involvement by the Subcommittee on

Innovation and Technology and that counties will allow Subcommittee members to participate at a high level in any Technology Suite processes and report back regularly to the Commission.

Commissioner Danovitch asked for clarification on the motion and whether the motion is to approve and to have the Subcommittee on Innovation oversee this project given the size of it and to develop a regular monitoring process.

Commissioner Anthony agreed with the statement and added that it would be not only monitoring but providing information to the Commission.

Commissioner Brown asked to vote separately on Santa Barbara County.

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

The MHSOAC approves each of the following county Innovation plans and directs Subcommittee on Innovation to provide oversight of the Tech Suite Collaboration Innovation project and provide regular updates to the Commission.

Name	Amount	Project Length
City of Berkeley	$462,916	3 Years
Inyo	$448,757	3 Years
Marin	$1,580,000	3 Years
Monterey	$2,526,000	3 Years
Riverside	$25,000,000	3 Years
San Francisco	$2,273,000	3 Years
San Mateo	$3,872,167	3 Years
Tehama	$118,088	2 Years
Tri-City	$1,674,700	3 Years

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

The following Commissioners voted “Yes”: Commissioners Anthony, Brown, Danovitch, Madrigal-Weiss, and Mitchell, and Chair Boyd.

Commissioner Brown recused himself from the discussion and decision-making with regard to Santa Barbara County’s request and left the room pursuant to Commission policy.

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

The MHSOAC approves Santa Barbara County’s Innovation plan and directs Subcommittee on Innovation to provide oversight of the Tech Suite Collaboration Innovation project and provide regular updates to the Commission as follows:

Amount: $4,912,852

Project Length: Five (5) years

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

The following Commissioners voted “Yes”: Commissioners Anthony, Danovitch, Madrigal-Weiss, and Mitchell, and Chair Boyd.

Commissioner Brown rejoined the Commissioners at the dais.

ACTION

7: Naming of the Fellowship Programs

Presenter:

- Rebecca Herzog, MHSOAC Associate Governmental Program Analyst

Rebecca Herzog, MHSOAC, provided an overview, with a slide presentation, of the background, goals, advisory committee role, and nominations for the honorary naming of the Mental Health Policy Fellowship Programs.

Ms. Herzog stated the Commission received a letter from the Steinberg Institute suggesting to name the mental health consumer fellowship after Sally Zinman, Executive Director, California Association of Mental Health Peer-Run Organizations (CAMHPRO), and Program Director, Client Stakeholder Project (CSP), and the mental health professional fellowship after Rusty Selix, Executive Director, California Council of Community Behavioral Health Agencies (CCCBHA) and Mental Health America of California (MHAC) in recognition of their many years of leadership in mental health.

Ms. Herzog stated the Commission received two additional letters this week in support of the nominees.

Commissioner Questions and Discussion

Vice Chair Aslami-Tamplen shared the backgrounds and reasons why it was important to her to name the two fellowships after the nominees.

Chair Boyd thanked Sally Zinman and Rusty Selix for sharing their hearts, minds, and spirits so generously.

Public Comment

Max Geide spoke in support of honoring Sally Zinman and Rusty Selix.

Adrienne Shilton spoke in support of honoring Sally Zinman and Rusty Selix.

Poshi Walker spoke in support of honoring Sally Zinman and Rusty Selix.

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

The MHSOAC names the Mental Health Policy Consumer Fellowship in honor of Sally Zinman and the Mental Health Policy Practitioner Fellowship in honor of Rusty Selix.

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

The following Commissioners voted “Yes”: Commissioners Anthony, Brown, Danovitch, Madrigal-Weiss, and Mitchell, Vice Chair Aslami-Tamplen, and Chair Boyd.

GENERAL PUBLIC COMMENT

Jonathan Sherin, M.D., Ph.D., Director, Los Angeles County Department of Mental Health, stated there are visiting leaders in the mental health field from around the world learning from Los Angeles. He invited them to share their experience.

Daniele Piccione stated he is from Trieste, Italy, and is here to study the mental health system in the County of Los Angeles. He stated it has been an intensive four days as he has been gathering as much information as possible to try to combine the Los Angeles mental health

system with the European system. He stated his guidelines are extremely peculiar because they come from an experience which is particular in Europe because the system is based on social community services.

Roberto Mezzina, Director, Mental Services, Trieste, Italy, stated Trieste was the first city in Italy to close the Catholic hospitals in 1980 and transformed them into a network of community-based services. The mental health system in Los Angeles has a lot of good points and good innovative practices but is still difficult to navigate in such a large county. He stated treatment gaps should be better addressed in Los Angeles. He stated the need to create a system that is person-centered and rights-based. Los Angeles and Trieste are working together to achieve that goal.

James Bianco, Judge, Mental Health Court, Los Angeles, stated he was part of the contingent from Los Angeles to visit Trieste last November and participate in a conference with representatives from 36 countries. He stated it is difficult to explain how different the system in Trieste is from the mental health system in the United States and particularly Los Angeles. Individuals in the US system try hard to deliver care to individuals who need it but so much time is spent getting bogged down in different pathways. The US mental health system is so fragmented and so much time is spent grappling with that. Of the many amazing things about the mental health system in Trieste, the one that appeals to him the most as a mental health judge is that it is so simple. If someone needs care, they go to the community mental health center. If they need slightly more structure, they go to the community mental health center. If they need someone to come to their home and help them, it is the community mental health center that goes. It is a one-stop-shop for mental health.

Professor Sashi Sashidharan, a psychiatrist based in Glasgow, Scotland, stated he has been closely involved with mental health services for the past 20 years. He stated he is privileged to be here as part of the visiting team. He shared his impressions of the mental health system in Los Angeles. There are some good people, some good innovative practices, and individuals trying to make a difference, but overarching that is the perception of a very complex system that is mostly opaque or impervious to individuals with severe mental health difficulties to negotiate. As a result of that, there is an experience of fragmentation of the services reported by individuals who use the services. It is a system almost in a vacuum without any serious consideration for the welfare or wellbeing of the people the system is supposed to help.

Professor Sashidharan stated, for outcomes of the services, he had only four words: skid row and Twin Towers. He stated the team visited those facilities and it was an extremely moving experience. He stated it is not that the team is not used to failures in their systems, but they have not seen anything like this anywhere else. The experience really got to the team members not only as professionals and psychiatrists but also as human beings. The degree of suffering that the team witnessed will stay with them for a long time. He stated this must not be allowed to happen – not in the richest city in the world. Something ought to be done about it.

Professor Sashidharan stated there are two options available. One is to scale up services, meaning more of the same, or to accept change and make a qualitative difference to the services currently provided. That is what the team hopes to bring to the table with colleagues at all levels from top to bottom who remain committed to changing things, putting the person with mental health problems at the center of it. He stated that is what the teams hopes will happen here – an exemplary practice, which will have an impact not only in Los Angeles, but right across the country, and right across the world.

Chair Boyd asked to hear and see more of the visiting team's work.

Poshi Walker requested a second General Public Comment period earlier in the day. NorCal MHA has heard that CCJDH, formerly COMIO, has been sole-sourced for the criminal justice stakeholder contract, not just to oversee it but to perform it. NorCal MHA is wondering if that is true and whether the immigrant/refugee stakeholder contract will also be sole-sourced. That rumor has been heard, as well.

Dr. Sherin stated he was sorry he was unable to attend yesterday's strategic planning session.

Chair Boyd asked him to share his comments today.

Dr. Sherin stated one of the things he has tried to understand is the different roles of the different entities: the counties, DHCS, CBHDA, MHSOAC, and advocacy groups across the board including consumers. He stated the MHSOAC has an incredibly important role – to transform mental health in this state. He stated the need for help to serve people. If the Commission is positioned such that the ear of the consumers can connect up with the mental health boards across the state to find out what is going on, it can distill that voice and identify needs locally and across the state. And then, with that, in collaboration with all stakeholders including the DHCS, the counties, and other stakeholders, it can identify outcomes. He recommended identifying the outcomes the Commission wants and agreeing on what those outcomes look like, and then holding everyone to that.

Dr. Sherin stated, in order to go after those goals, there needs to be less focus on funding. To succeed, California needs the DHCS to facilitate the work, not to audit everyone to death. Mental health workers do not want to take care of medical charts, they want to take care of human beings. Half the time in the trenches is taking care of auditors, not people.

Dr. Sherin stated he also wanted county governments and boards of supervisors to understand that the state is giving money to the counties and that the counties have their own process for approving activities. Setting the goals and then allowing the counties the flexibility to use the money to take care of people and not bureaucracy will transform the system.

Dr. Sherin asked the Commission to think about things in that manner – collect the voice through the Commission, identify the outcomes that matter, and then help counties with the state to succeed.

ADJOURN

There being no further business, the meeting was adjourned at 5:17 p.m.

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AGENDA ITEM 2

Information

October 25, 2018 Commission Meeting

Suicide Prevention Project

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

The effort is led by the Suicide Prevention Subcommittee:

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

Subject matter experts have been invited to participate in the Commission's second public hearing on suicide prevention during the October 25th Commission Meeting. The hearing will focus on opportunities for preventing suicide and suicide attempt. Panel presentations are designed to support the Commission's understanding of opportunities for suicide prevention, crisis intervention, and sustainability of suicide prevention efforts.

Panel 1: Working Upstream to Prevent Suicide

- Lisa Firestone, Ph.D., Director of Research and Education, The Glendon Association, and Member of the Santa Barbara County Response Network
- Janet King, MSW, Program Manager of Policy and Advocacy, Native American Health Center

Panel 2: Intervention through Crisis Care and the Health Care System

- David Camplin, LMFT, Director of Behavioral Health, San Bernardino County Service Area, Kaiser Permanente
- David Covington, LPC, MBA, CEO and President of RI International
- Katherine Jones, RN, MS, MSN, Director, Adult/Older Adult System of Care, Alameda County Behavioral Health Care Services

Panel 3: Building Infrastructure, Leadership, and Sustainability

- Colleen Carr, MPH, Director of the National Action Alliance for Suicide Prevention
- Peter Manzo, President and CEO, United Ways of California

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Enclosures:
(1) Panel presentations brief
(2) Panelist biographies

COVER PAGE: Panel 1: Working Upstream to Prevent Suicide

(3) Firestone: Invitation letter
(4) Firestone: Written presentation
(5) King: Invitation letter
(6) King: Written presentation
(7) King: One supporting document

COVER PAGE: Panel 2: Intervention through Crisis Care and the Health Care System

(8) Camplin: Invitation letter
(9) Camplin: PowerPoint Presentation
(10) Covington: Invitation letter
(11-13) Covington: Three supporting documents
(14) Jones: Invitation letter

COVER PAGE: Panel 3: Building Infrastructure, Leadership, and Sustainability

(15) Carr: Invitation letter
(16) Carr: Written response
(17) Manzo: Invitation letter
(18) Manzo: PowerPoint Presentation
(19) Manzo: Written response

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

Suicide Prevention Project

October 25, 2018 Public Hearing Brief

PURPOSE

The purpose of this document is to provide background and rationale for the public hearing on suicide prevention during the Mental Health Services Oversight and Accountability Commission's October 25, 2018 meeting. Panel presentations were organized to support the Commission's effort to develop a statewide strategic plan for suicide prevention.

This document will first provide an overview of the Commission, and the Commission's project to develop a statewide strategic suicide prevention plan, including some data to demonstrate the need for a strategic plan to guide policy, practice, and investment to prevent suicide in California. The brief will then provide a short description of each panel organized for the Commission's second public hearing on suicide prevention. The document concludes by highlighting some key questions for the Commissioners to consider to support the development of a suicide prevention plan.

INTRODUCTION

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

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

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

BACKGROUND

Suicide and suicide attempts affect every demographic group in California. More than twice as many Californians die annually by suicide as from homicide.[1] Rates vary in significant ways, however. Some three-quarters of Californians who die by suicide each year are male.[2] Adults aged 20-59 account for more than 70 percent of suicides in the state, while the highest suicide death rates are among middle aged and older adults.[3] The largest numbers of suicides occur in southern California, with Los Angeles County accounting for about 20 percent of statewide suicide deaths annually. In contrast, suicide death rates are highest in rural northern California, with rates in the Superior region close to twice the national average. Additional at-risk populations include people involved with the criminal justice system, people experiencing homelessness, immigrants and refugees, veterans and military personnel, and LGBTQ – particularly transition aged youth.[4] As is true nationally, Californians are most likely to die by suicide

using firearms (42 percent) compared to other means, such as suffocation (27 percent) and poisoning (19 percent).[5]

In addition to the devastating human impacts on survivors of suicide loss, suicides and suicide attempts also significantly affect the economy. The American Foundation for Suicide Prevention reports that in 2010 suicides cost California over $4 billion in combined medical expenses and lost productivity.[6] Another report suggest that suicide and suicide attempts nationally cost anywhere between $58 billion and $94 billion in 2013.[7]

PROCESS

The Commission's effort to develop a suicide prevention plan is led by the Suicide Prevention Subcommittee, a subcommittee of Commissioners including Tina Wooton (Chair), Khatera Aslami-Tamplen, and Mara Madrigal-Weiss. Guided by the leadership of the subcommittee, the Commission's process is designed to develop a suicide prevention plan informed by best practice and in collaboration with community members and other stakeholders.

Public Meetings

The Commission has organized a series of public hearings, meetings, and site visits to identify challenges and opportunities to prevent suicide. These events, held throughout the State, are designed to ensure that the plan reflects California's cultural, ethnic, linguistic, and economic diversity, all of which shape the need for a broad perspective on addressing suicide.

The Subcommittee began its work with a meeting in Redding, a rural community in Shasta County, which has one of the highest rates of suicide in California. This meeting included a site visit to a health center serving local Tribal communities to better understand the causes behind high rates of suicide, particularly among Native youth. The subcommittee then met in Sacramento to explore opportunities to address barriers identified during the Redding meeting, including challenges to addressing risk factors for suicide, such as isolation, feelings of rejection, and perceived burdensomeness.

The Subcommittee met in two California counties with established or recently developed local suicide prevention plans—San Diego and Fresno. Community discussions highlighted opportunities for the State's plan to promote local suicide prevention efforts—including county plans and school-based suicide prevention plans as required by Assembly Bill 2246 (Chapter 642, Statutes 2016). Meeting attendees also shared their ideas for building robust community coalitions to prevent suicide and suggested the state could support local efforts by offering guidance on how to start suicide prevention efforts and obtain buy-in from multisector partners.

In addition to its subcommittee meetings, the Commission held a public hearing on May 24, 2018 in Sacramento focused on barriers and challenges to preventing suicide and suicide attempt. Panelists included survivors of suicide loss and attempt, clinicians, researchers, and representatives of the Department of Health Care Services and the Department of Public Health. California Public Health Officer Dr. Karen Smith presented an opportunity to address suicide within a violence prevention framework, recognizing the interconnectedness between suicidal behavior and various forms of violence and trauma. Additional recommendations from panelists included increasing meaningful inclusion and

support of parents in interventions for youth, strategies to restrict lethal means, and expanding community connections for socially isolated older adults.

Research and Technical Support

Commission staff have met - and continue to meet - with local and national leaders in suicide prevention. Staff are working with representatives of departments under the California Health and Human Services Agency, in addition to state and local public partners, including behavioral health, public health, law enforcement, and education and private partners, including health care, foundations and nonprofits, and business.

The Commission also will use the latest research on suicide and information gathered through local, national, and international efforts, including the 2012 National Strategy for Suicide Prevention developed by the U.S. Surgeon General and the National Action Alliance for Suicide Prevention, to shape potential opportunities for suicide prevention.[8] The Commission has contracted with experts on suicide at Stanford University as technical advisors to provide additional guidance on research and best practice.

OCTOBER 24th EVENTS

Commissioners will have the opportunity to visit sites and attend a community forum on October 24, 2018 to support the development of the statewide strategic suicide prevention plan. The site visits and community forum are described below.

Site Visits

Commissioners have the opportunity to visit UCSF Benioff Children's Hospital in Oakland in the morning of October 24, 2018. The Commission heard testimony during its first public hearing about challenges to meeting the needs of people in crisis, particularly children for which resources are often unavailable or inappropriate. The Commission will explore evidence-based treatment for suicidal children in acute care and in crisis, opportunities for safely transitioning children and youth out of hospital care and back into the community, and school-based services to prevent suicidal behavior and other negative health outcomes for transition-age youth.

Community Forum

Commissioners have the opportunity to participate in a community forum in San Leandro in the afternoon of October 24, 2018. The Commission heard testimony during its first public hearing that suicide and suicide attempt is often underreported in communities of color and LGBT communities for many reasons, including cultural-based or religious-based stigma about suicide. The community forum will focus on small group activities to better understand opportunities for culturally competent approaches that could potentially prevent suicide, strategies for connecting people with services they need, and methods of promoting safety and wellness.

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PUBLIC HEARING ON SUICIDE PREVENTION

The second public hearing on suicide prevention will focus on opportunities for preventing suicide and suicide attempt. Panel presentations are designed to support the Commission's understanding of opportunities for suicide prevention, crisis intervention, and sustainability and leadership. Panels also are designed to follow-up on statements made by panelists and questions posed by Commissioners during the May 24, 2018 public hearing. A description of each panel and questions Commissioners may wish to consider are outlined below.

Overall Considerations

Below are some questions Commissioners may wish to consider overall as they listen to the panel presentations and consider how the Commission could support suicide prevention efforts. The MHSA was designed to support consumer-driven, transformational change of the public mental health system. The Commission has at its disposal a number of tools for helping consumers, counties and providers to drive change in meaningful ways, including its policy advisory role to the Governor and Legislature, regulatory authority, SB 82 Triage Grant program, approval role over county Innovative Program projects, policy research projects, technical assistance and learning community efforts, statewide prevention and early intervention prioritization responsibilities under SB 1004, and research and evaluation efforts.

- STATEWIDE LEADERSHIP. A statewide strategic plan for suicide prevention may encompass a broad array of agency-specific initiatives and programs. How can or should these disparate efforts be coordinated?
- INNOVATION. Should the Commission encourage Counties to prioritize suicide prevention through their Innovative Project proposals?
- SB 82 TRIAGE GRANTS. The Commission directly administers a $60 million competitive grant program to improve mental health crisis responses in communities. What opportunities does this program present to the Commission to identify, promote and evaluate potentially transformative initiatives to improve system responses to mental health crises that may lead to suicide or suicide attempts?
- PREVENTION AND EARLY INTERVENTION. SB 1004 (Wiener, Chapter 843, Statutes of 2018) directs the Commission to establish statewide priorities for PEI funding and strategies for monitoring and reporting on outcomes. Additionally, the Commission has authority to promulgate regulations regarding the State's $350 million annual MHSA investment in prevention and early intervention, which includes the goal of reducing suicide among people with mental health needs. Currently, counties have discretion to use PEI to fund suicide prevention programs in a variety of ways.[9] How can the Commission best prioritize its use of its tools and capacity to strengthen suicide prevention using this investment?

Panel 1: Working Upstream to Prevent Suicide

During the Commission's May 24, 2018 public hearing, panelists called for a greater focus on "upstream" strategies to prevent suicide and intentional self-harm, including those that have community-defined evidence and empirical research support. In response, panelists have been invited to present on both community-defined and evidence-based methods to prevent the further development of self-harm risk, suicide attempt, and death by suicide.

Ms. King will discuss community-defined practices to deliver programs and services to prevent suicide among Native American community members. She also will share opportunities for the state to consider to expand the use of community-defined practices, and how the state can work with Native American communities to meet needs and restore cultural healing practices. Dr. Firestone will then present evidence-based strategies for preventing risk factors for suicide from developing and will offer the Commission guidance on how the state can support the expansion of evidence-based approaches.

Some Considerations:

- Should the Commission encourage broader utilization of statewide or multi-county collaborative efforts to specifically address systemic root causes of elevated suicide risk?
- How can communities be supported or incentivized to work together to address community trauma, including a death by suicide in the community?
- What barriers impede the spread of culturally-competent best practices in suicide prevention?
- What role should the state play in supporting education and training for professionals and community members most likely to come into contact with a person at risk for suicide?

Panel 2: Intervention through Crisis Care and the Health Care System

The *Zero Suicide Initiative* is a national initiative that recognizes the critical role health and behavioral health systems play in preventing suicide. This initiative prioritizes the broader use of screening tools for suicide risk, including in primary care settings. For example, the majority of people who die by suicide had contact with a primary care provider within a month prior to death.[10] Health care systems across the country – and including in California – are following the initiative's programmatic approach to identify and intervene with people at risk.

Despite prevention efforts, some people will need a variety of crisis services, which could range from use of crisis hotlines, crisis stabilization, and short-term crisis residential care.[11] Often crisis services – if available - are uncoordinated, resulting in potential inefficiencies and over use of costly law enforcement and emergency departments.[12] Panelists have been invited to present before the Commission suicide prevention opportunities that strengthen crisis care and care delivered through health and behavioral health systems, nationally and in California.

Mr. Covington, co-creator of the Crisis Now Model and the Zero Suicide Initiative, will present challenges and opportunities for the state to pursue to strengthen crisis care, health care, and behavioral health care delivery systems and incentivize such approaches to prevent suicide. Ms. Jones will present how Alameda County Behavioral Health Care Services delivers a crisis care continuum, and how the state can support strengthening crisis services to improve coordination and timely connection of people to services, reducing outcomes such as hospitalization, suicide, and suicide attempt. Mr. Camplin will present challenges and barriers to implementing approaches to prevent suicide by people utilizing services in health and behavioral health care systems, and opportunities to incentivize suicide prevention strategies, including collaborative care, for private health and behavioral health care systems.

Some Considerations:

- What policy and practice barriers most challenge effective intervention when people are in crisis?
- How can the health care system more effectively prevent suicide, especially among people known to be at high risk such as attempt survivors or people with a history of suicidal behavior in their families?
- How can California's crisis services, health care, and behavioral health care delivery systems be better aligned to support identification of suicidal people and intervene more effectively and efficiently?

Panel 3: Building Infrastructure, Leadership, and Sustainability

Suicide prevention cannot be accomplished through one person or a single agency. The federal Substance Abuse and Mental Health Services Administration's guidance to states developing suicide prevention plans is to collaborate with multiple public and private organizations, establishing leadership and building commitment and ownership.[13] SAMHSA's guidance is illustrated at the national level through the work of the National Action Alliance for Suicide Prevention, a public-private partnership changed with advancing the National Strategy for Suicide Prevention.[14] The final panel of the Commission's public hearing on suicide prevention will explore opportunities to strengthen leadership for suicide prevention through meaningful engagement with public and private sectors, incentivizing suicide prevention in diverse settings, and creating a sustainable strategic suicide prevention plan.

Ms. Carr will present how the National Action Alliance for Suicide Prevention utilizes a private-public partnership to advance the national suicide prevention strategy and how this approach is working in other states. She also will present how the state could support and incentivize expansion of suicide prevention efforts in private industry settings, including the workplace, private health care, and private senior living communities. Mr. Manzo will present on the activities of United Ways of California and its network of affiliates, opportunities for integrating services delivered by nonprofits into the health and behavioral health care systems. Both presenters will present how public-private partnerships could help advance California's suicide prevention strategy.

Some Considerations:

- Who are the public and private partners most necessary to implementing and sustaining momentum over time for an effective statewide suicide prevention strategy? How could the Commission support public-private partnerships and create sustainable funding streams to support suicide prevention?
- How should the Commission make the case for a multi-sector approach to including suicide prevention strategies in policies and practices throughout California's private and public sectors?

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NOTES

[1] American Foundation for Suicide Prevention. Suicide: California 2017 Facts & Figures. Accessed January 12, 2018 at http://chapterland.org/wp-content/uploads/sites/10/2016/03/California-Facts-2017.pdf.

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[4] U.S. Department of Health and Human Services, Office of the Surgeon General and National Action Alliance for Suicide Prevention. *2012 National Strategy for Suicide Prevention: Goals and Objectives for Action*. 2012. Accessed on January 11, 2018 at https://www.surgeongeneral.gov/library/reports/national-strategy-suicide-prevention/full-report.pdf.

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[8] Office of the Surgeon General and National Action Alliance for Suicide Prevention (2012). National Strategy for Suicide Prevention: Goals and objectives for action. Washington, DC: US Department of Health & Human Services.

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[10] Mann, J. J., Apter, A., Bertolote, J., Beautrais, A., Currier, D., & Haas, et al. (2005). Suicide prevention strategies: A systematic review. *Journal of the American Medical Association, 294(16)*, 2064- 2074.

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[12] Ibid.

[13] *Guidance for State Suicide Prevention Leadership and Plans*, SAMHSA

[14] For more information, please visit http://actionallianceforsuicideprevention.org/home.

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LISA FIRESTONE, Ph.D., Director of Research and Education, The Glendon Association, and Member of the Santa Barbara County Response Network

Lisa Firestone, Ph.D. is the Director of Research and Education at the Glendon Association and Senior Editor for www.psychalive.org. She has been involved in clinical training and research in the areas of suicide and violence which resulted in the development of the assessments Firestone Assessment of Self-destructive Thoughts (FAST)and (FASI) and the Firestone Assessment of Violent Thoughts (FAVT), for adults and adolescents. Dr. Firestone is the author of numerous articles, chapters and books including: Conquer Your Critical Inner Voice, Creating a Life of Meaning and Compassion and The Self under Siege. Lisa is a clinical psychologist in private practice and consultant on the management of high risk clients. Dr. Firestone is a regular blogger on Psychology Today and PsychAlive.org

JANET KING, MSW, Program Manager of Policy and Advocacy, Native American Health Center

Janet King, MSW has been a long-time advocate of mental health transformation. She has testified at many speaking engagements and in many publications that the best mental health practices for Native Americans are those rooted in culture and those that promote the collective healing of Native Americans by acknowledging and giving context to the collective traumatization of Native Americans. The untold story needs to be told to promote healing from trauma. This approach not only promotes healing but reduces stigma from having mental health challenges. Ms. King is a founding member of Racial Ethnic Mental Health Disparities Coalition of California. She has been vocal at many Community Forums to explain why the current mental health system leaves many cultural groups unserved, underserved or inappropriately served. She was on the 8-member team of the Native American Strategic Planning Workgroup that conducted research with Native American Communities in California to determine Native mental health needs and the solutions to meeting those needs as part of the California Reducing Disparities Project (CRDP) phase 1. The findings of this two-year research and 22 Native American best practices are listed in Native Vision (the Native American population report of the CRDP Phase 1). Ms. King also advocates for evaluation of best practices be done from the perspectives of the community implementing the best practice and people being served by the best practice. She is an enrolled member of the Lumbee tribe of North Carolina.

DAVID R. CAMPLIN, LMFT, Director of Behavioral Health for Kaiser Permanente San Bernardino Service Area

Dave Camplin LMFT is Director of Behavioral Health for Kaiser Permanente San Bernardino Service Area. He graduated from Hope International University with his masters in Marriage and Family Therapy in 1996. His behavioral health career began in 1995 working in inpatient mental health. He has worked at SED Schools for children with Serious Emotional Disturbance as well as working in the public sector for the Department of Public Social Services, and the Department of Mental Health supervising for Quality Improvement and Behavioral Health and Child Development integrated services. Additionally, he has been in private practice in the Inland Empire for over 20 years serving a broad range of patients,

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specializing in adolescents and crisis care. He transitioned to Kaiser Permanente in 2008 working in the Inpatient Unit in Moreno Valley and then managing the Euclid clinic in Orange County.

In 2016 Dave moved to the Director position for Kaiser Permanente in San Bernardino County. He currently oversees programming and providers at 16 locations in the San Bernardino service area, including nine main psychiatry and addiction medicine clinics, integrated services in Obstetrician and Primary Care, Consultation and Liaison Psychiatry in two emergency departments and integrated staff at two contracted psychiatric inpatient units. The San Bernardino County Behavioral Health appointment center also houses the Therapist Now and Teen Now programs designed for routine and crisis virtual care for adult and adolescent patients. He is part of the Regional Director Leadership committee and serves on multiple regional committees focused on improving patient care and outcomes. He serves as the Director Representative for the Regional Feedback Informed care workgroup focused on improving quality and outcomes and serves as the Director Representative on the development of the regional Zero Suicide initiatives. The San Bernardino County area has been the part of the pilot sites for implementation and rollout of program and was the first area to go forward with full implementation of the regional Zero Suicide initiative. In his spare time he enjoys concerts and comedy shows and spending time with his wife and six kids.

DAVID COVINGTON, LPC, MBA, CEO and President of RI International

David Covington, LPC, MBA serves as Chief Executive Officer and President of RI International (formerly Recovery Innovations), is a partner in Behavioral Health Link, co-founder of CrisisTech 360 and leads the international initiatives “Zero Suicide,” “Crisis Now” and “Peer 2.0.” A licensed professional counselor, Mr. Covington received an MBA from Kennesaw State and an MS from the University of Memphis. He previously served as Vice President at Magellan Health responsible for the executive and clinical operations. He is a member of the Department of Health & Human Services Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC) established in 2017 in accordance with the 21st Century Cures Act to report to Congress on advances in behavioral health. A recognized health care innovations entrepreneur, global speaker and blogger, Mr. Covington is a two-time national winner of the Council of State Governments Innovations Award. He also competed as a finalist in Harvard’s Innovations in American Government in 2009 for the Georgia Crisis & Access Line, and the program was featured in Business Week magazine. Mr. Covington is the President-Elect of the American Association of Suicidology and has served on the National Action Alliance for Suicide Prevention Executive Committee since 2010. He is also the Chair of the National Suicide Prevention Lifeline SAMHSA Steering Committee. He has served on numerous committees and task forces on clinical care and crisis services, including the National Council for Behavioral Health Board of Directors.

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KATHERINE JONES, RN, MS, MSN, is the Director of Adult and Older Adults Service for Alameda County Behavioral Health Care Services

Kate Jones, RN, MS, MSN, is the Director of Adult and Older Adults Service for Alameda County Behavioral Health Care Services. Kate possesses a Masters in Nursing and Health Care Leadership from UCSF. Kate was the previous Division Director of Crisis Services for BHCS. Kate's previous work experience includes Administrator of Villa Fairmont MHRC (sub-acute 97-bed facility); Director of Saint Mary's Medical Center Adolescent Acute Psychiatric Inpatient Program; Psychiatric Nurse at San Francisco General Hospital and Heritage PHF. The adult and older adult system of care is currently developing a crisis continuum of care and focusing on creating a system of care that serves the whole person and provides excellent care coordination.

COLLEEN CARR, MPH, Director of the National Action Alliance for Suicide Prevention

Colleen serves as the Director of the National Action Alliance for Suicide Prevention's (Action Alliance) Secretariat at the Education Development Center (EDC). Launched in 2010, the Action Alliance is the nation's public-private partnership for suicide prevention, charged with uniting the public and private sectors to coordinate a comprehensive national suicide prevention response in the U.S. Working with more than 250 partner organizations, the Action Alliance works to advance the National Strategy for Suicide Prevention (NSSP) and reduce the annual suicide rate 20 percent by 2025. As the Director, Colleen is responsible for providing strategic leadership to the Action Alliance's leadership, including its 40-member Executive Committee, cultivating new partnerships with key public and private sector partners, delivering technical assistance focused on policy analysis and system change; developing high-level public and private-sector leadership communications and briefings, and advancing Action Alliance priority initiatives such as, transforming health systems, transforming communities, and changing the public conversation about suicide. Colleen has more than 15 years of experience working in public health. She started her career serving in AmeriCorps *VISTA and has experience in state and nation-level policy, poisoning prevention, clinical research, and state public health. Colleen has spent the last decade focused on suicide prevention, including seven years at the national level with the Action Alliance. She received her undergraduate degree in public policy analysis from the University of North Carolina at Chapel Hill and her master's degree in public health from Boston University.

PETER MANZO, President and CEO, United Ways of California

Pete Manzo is President & CEO of United Ways of California, which improves health, education and financial results for low-income children and families by enhancing and coordinating the community impact and advocacy work of California's United Ways. Previously, Pete was Director of Strategic Initiatives for The Advancement Project, a civil rights "action tank" that advances equity and expands opportunity for low income and vulnerable people, Executive Director and General Counsel of the Center for Nonprofit Management, where he directed the expansion of the Center's information, training, consulting, technology and search and compensation services to nonprofits; and Directing Attorney of Community Development Programs for Public Counsel. Mr. Manzo is a graduate of Boalt Hall School of Law at the University of California, Berkeley; he also is a graduate of the London School of Economics, where he received a Master's degree in Political Sociology, and the University of Notre Dame, where he received a Bachelor's degree in Government.

Mental Health Services
Oversight & Accountability Commission

Suicide Prevention Public Hearing
October 25, 2018

Panel 1: Working Upstream to Prevent Suicide

- Firestone: Invitation letter
- Firestone: Written presentation
- King: Invitation letter
- King: Written presentation
- King: One supporting document

STATE OF CALIFORNIA
EDMUND G. BROWN JR., Governor

Mental Health Services
Oversight & Accountability Commission

September 14, 2018

Lisa Firestone, Ph.D.
The Glendon Association
115 W. Canon Perdido
Santa Barbara, CA 93101

Dear Dr. Firestone:

Thank you for agreeing to participate in the Commission's public hearing on suicide prevention on Thursday, October 25, 2018 at the Marina Inn on San Francisco Bay, 68 Monarch Bay Drive, San Leandro, California. The Commission's meeting will include three panels to support the Commission's understanding of opportunities to prevent suicide and suicide attempt, and support the Commission's efforts to develop a strategic statewide suicide prevention plan, as authorized by the California Legislature.

Your panel will highlight best practices, including community-defined and evidence-based practices, to prevent the development of risk factors for suicide, and is scheduled to begin at approximately 9:30 a.m. Please plan to present for 10 to 15 minutes to leave time for discussion with Commissioners. Please organize your presentation to respond to the following:

- How the Glendon Association is delivering evidence-based programs and services to prevent suicide and address self-destructive behavior
- Opportunities for the state to pursue to support or incentivize the expansion or implementation of evidence-based practices which may prevent the development of factors that put people at risk for suicidal thoughts and behaviors
- Opportunities for the state to pursue to support and expand coordinated community responses following a suicide, including how the Santa Barbara Response Network assists community members after traumatic events

Please send a brief biography and written response or background materials to the items above by Wednesday, October 3, 2018 to Ashley Mills at ashley.mills@mhsoac.ca.gov. Your written responses will allow Commissioners attending the meeting the opportunity to prepare questions for you after your presentation, and will be available for Commissioners unable to attend the meeting. Please note that your written responses and biography will be shared as public documents.

Should you have any questions, I can be reached at toby.ewing@mhsoac.ca.gov or 916.445-8696. Thank you again for your willingness to participate in this important meeting.

Respectfully,

Toby Ewing

Toby Ewing, Ph.D.
Executive Director

Lisa Firestone
October 25, 2018

How the Glendon Association is delivering evidence based programs and services to prevent suicide and address self-destructive behavior

At the Glendon Association we provide research, education and training in suicide prevention. Our research has led to the development of a measure to assess risk, and track changes over time in monitoring risk. To provide education to mental health professionals and first responders: we do live trainings as well as webinars and training films with experts in the field of suicidology, and have developed an e-course designed to familiarize professional with the latest research on empirically validated crises management and effective treatments for suicidality. Through our sister website, Psychalive.org we have valuable suicide prevention information available to the general public, (concerned family member, friends and the suicidal person themselves). This includes blogs, articles, and webinars public on suicide awareness, and prevention. These materials reflect current research and national research informed, efforts to prevent suicide, through educating the public about suicide prevention.

Opportunities for the state to pursue to support or incentive the expansion or implementation of evidence based practices which may prevent the development of factors that put people at risk for suicidal thoughts and behaviors

The state could require Suicide prevention training for all who will be providing mental health services during their various training programs, graduate education etc., including: social workers, alcohol drug treatment counselors, MFT's, Psychologists, and Psychiatrists. The state could also encourage the use of programs that teach emotional literacy to children such as the Ruller program, developed and researched through the Yale Child Studies program, to be implemented in the schools. This program has demonstrated an improvement in children's ability to identify and deal with their emotions and reduce the risk of problem behaviors as well as increase academic performance. Another program that schools could adopt is DBT Steps-A, DBT skills for every teen. This program was developed by Dr. James Mazza, and it can be implemented in 9th grade health class. It provides teens with essential emotional regulation skills which research has demonstrated have been effective in reducing suicidality.

Opportunities for the state to pursue to support and expand coordinated community responses following a suicide, including how the Santa Barbara response Network assists community members after traumatic events

The Santa Barbara Response Network (SBRN) has trained volunteers in Psychological First Aid (PFA) an evidence-informed modular approach to help children, adolescents, adults, and families in the immediate aftermath of disaster and trauma https://www.nctsn.org/treatments-and-practices/psychological-first-aid-and-skills-for-psychological-recovery/about-pfa
They work closely with schools, mental health clinics, hospitals and agencies offering support in the aftermath of trauma. SBRN responded to the recent Thomas Fire and debris flow disasters in our county. They established compassion centers in the schools and public places offered ongoing support to individuals and families directly impacted. SBRN is a member of the Community Mental Team, a collection of mental health agencies formed after the Thomas fire Debris Flow and they continue to offer mental health recovery in the aftermath of the disasters. SBRN volunteers also responded to the increase of youth suicides and attempts in the local schools and community. They worked with SB Behavioral Wellness and the School Board and other mental health agencies to bring in Dr Robert Macy to provide additional PFA and

Gatekeeper training and support to the schools and community. They went on to bring in the Signs of Suicide Program (SOS) https://mentalhealthscreening.org/programs/youth to assess students for depression and suicide and provided support to the counsellors and teachers for students who identified to be at risk. SBRN volunteers are bilingual and bicultural and continue to provide support in the Latino community as it deals to immigration and deportation issues. SBRN continues to offer PFA trainings in local schools, mental health centers and to agencies wanting to form their own PFA teams to respond to traumatic events in their own settings.

STATE OF CALIFORNIA
EDMUND G. BROWN JR., Governor

Mental Health Services
Oversight & Accountability Commission

September 14, 2018

Janet King, MSW
Sent via email to janetk@nativehealth.org

Dear Ms. King:

Thank you for agreeing to participate in the Commission's public hearing on suicide prevention on Thursday, October 25, 2018 at the Marina Inn on San Francisco Bay, 68 Monarch Bay Drive, San Leandro, California. The Commission's meeting will include three panels to support the Commission's understanding of opportunities to prevent suicide and suicide attempt, and support the Commission's efforts to develop a strategic statewide suicide prevention plan, as authorized by the California Legislature.

Your panel will highlight best practices, including community-defined and evidence-based practices, to prevent the development of risk factors for suicide, and is scheduled to begin at approximately 9:30 a.m. Please plan to present for 10 to 15 minutes to leave time for discussion with Commissioners. Please organize your presentation to respond to the following:

- How the Native American Health Center is delivering programs and services to prevent suicide, restore culture, and build resiliency, particularly for Native American youth
- Opportunities for the state to pursue to support or incentivize the expansion or implementation of community-defined practices which may prevent the development of factors that put people at risk for suicidal thoughts and behaviors
- How the state can work with tribes and other Native American communities to prevent suicide and increase community-defined protective factors

Please send a brief biography and written response or background materials to the items above by Wednesday, October 3, 2018 to Ashley Mills at ashley.mills@mhsoac.ca.gov. Your written responses will allow Commissioners attending the meeting the opportunity to prepare questions for you after your presentation, and will be available for Commissioners unable to attend the meeting. Please note that your written responses and biography will be shared as public documents.

Should you have any questions, I can be reached at toby.ewing@mhsoac.ca.gov or 916.445-8696. Thank you again for your willingness to participate in this important meeting.

Respectfully,

Toby Ewing

Toby Ewing, Ph.D.
Executive Director

Janet King – Written Response for Presentation to the Commission on October 25, 2018

How the Native American Health Center is delivering programs and services to prevent suicide, restore culture, and build resiliency, particularly for Native American youth.

Native American Health Center (NAHC) provides many programs addressing the wellness needs of Native American Youth. Two programs, Native Connections and Native Wellness Youth Initiative, specifically address suicide prevention. NAHC is also one of the Implementation Pilot Projects (IPP) of the California Reducing Disparities Project (CRDP) phase 2 grants to show evidence of a community defined evidence practice (CDEP). The CDEP that NAHC is showing evidence for is called Gathering of Native Americans or GONA for short. NAHC has done this CDEP for 18 consecutive summers for teenage Native American youth ages 13-18. It is a 4 day experience to relearn culture, build resiliency with the manualized GONA curriculum developed by Native Americans for Native Americans. The location for GONA is preferably in a natural setting away from the inner cities where youth are concerned about their safety.

GONA addresses historical trauma in the curriculum lesson What Broke Apart the Native American World and addresses solutions in the curriculum lesson What will Restore the Native American World. The curriculum is interactive with short lectures and many creative art activities and expressions among the youth. Youth are organized into clans to remember the Native American value of Belonging. The other three Native American values in the curriculum are Mastery-a time when youth become aware of their gifts and start to develop them, Interdependence- a time of adulthood and cooperation with others to raise healthy children and communities and Generosity-a time of being an Elder and giving back.

The GONA curriculum has been known by Native American communities across the nation for 25 years to prevent mental health challenges and to reduce the severity of mental health challenges. NAHC is grateful to have this opportunity to show evidence of the effectiveness of GONA by being one of the 7 IPPs in the CRDP phase 2 grants. This showing of evidence of the effectiveness of GONA is in collaboration with 3 other Native American agencies in San Diego, Fresno and Sacramento. The youth participants of GONA often come back to help staff later GONAs so we have seen the effectiveness of GONA in generating community leaders.

There are many other best practices at NAHC where youth and adults are connected to their peers, to Elders, to culture and traditional healing. Some of the groups and events are:

- Young Women's Group
- Young Men's Group
- Summer Youth Internship Program
- Beading Circle
- Elders Group
- Drumming Circle
- Circle of Healing for HIV positive people
- Water Walk
- Gathering of the Lodges

- Positive Indian Parenting

The main goal of all of these programs and events is to let people know that they are not alone and have a community's support and guidance to live a healthy lifestyle.

Opportunities for the state to pursue to support or incentivize the expansion or implementation of community-defined practices which may prevent the development of factors that put people at risk for suicidal thoughts and behaviors.

The lack of continuation of services was identified in one of the focus groups to write Native Vision the Native American Population Report of CRDP phase 1 as one of the barriers for wellness. When good services that have a positive impact on the community end because funding cycles end then protective factors decrease and risk factors increase. One young person from one of the focus groups stated "If I had someone to talk to I would not have gone to jail"

All of the above programs at NAHC are dependent on money to avoid a lapse in services. As money to run these programs fluctuate so do the strength of these programs and the ability to reach more people. The youth internship program was only able to serve 4 youth in its first year and today is able to serve 10. More youth apply than we have openings. Keeping prevention money protected is important to continue wellness programs for youth.

While Prevention and Early Intervention (PEI) is an important component of the MHSA and could be a good resource to help with youth development programs it seems often to be under scrutiny with prescriptions that poses barriers to reach those most at need.

While PEI is an expressed component of the MHSA, precedent still seems to go to western psychological treatments that many underserved communities will not engage in. Even though the MHSA is critical of a broken system that costs a lot of money and serves few effectively, CDEPs are struggling to get sustainable funding. There is no plan that I am aware of what happens after the 5 year cycle of CRDP phase 2 is done. What will the hard work of showing evidence of the effectiveness of CDEPs result in? Structural changes are needed so CDEPs are regarded in the same status of funding as psychological services. CDEPs cost less money to administrate than psychological services, employs peers from the community being served, and are more effective with more people served. There is less stigma when mental health challenges are put in the context of the social determinants of health which is a common feature of CDEPs. There is plenty of rationale for CDEPs as it meets many of the transformation criteria listed in the MHSA. CDEPs keeps families together in the least restricted environments, reduces prolonged suffering, are culturally competent and community and recovery based.

How the state can work with tribes and other Native American communities to prevent suicide and increase community-defined protective factors.

Help to increase awareness that CDEPs are more effective than western practices. Increase awareness that while psychological services are preferred by some; cultural interventions are preferred by many. Psychological services addresses the individual but not the whole community like CDEPs do. Protect PEI money and make sure communities in need are eligible for PEI funds. Make sure that tribes and Native communities know of PEI funds in their counties and have the criteria and capacity to apply for them. Not all counties communicate their MHSA money to all of their county constituents.

Native American
California Reducing Disparities Project Report
Executive Summary

Introduction

Through support from the Mental Health Services Act (MHSA), the California Reducing Disparities Project (CRDP) initiative focuses on reducing mental health disparities in historically underserved populations across California. The former California Department of Mental Health launched a statewide Prevention and Early Intervention (PEI) effort in five populations, one of which is Native Americans. Through a statewide effort, the Native American Health Center, Inc. gathered strengths, issues, and specific recommendations on behalf of Native people in California with regard to mental health disparities. Native American behavioral health issues in California vary by community and stretch beyond Prevention and Early Intervention (PEI) services. We must also consider mental health treatment and socioeconomic factors and how it all intertwines with traditional cultural practices and beliefs. This report includes Native American community member recommendations to address disparities as well as strategies for creating culturally competent PEI to promote mental wellness of Native people throughout the state.

Methodology

The Native American Reducing Disparities Project involved extensive engagement of the diverse tribal, rural, and urban communities, individuals, and experts from across the state through an 8 member Native American Strategic Planning Workgroup Advisory Committee. Regional gatherings were held in 11 communities, drawing over 300 people during the project to gather input on mental health issues from Native American community members, including youth, families, and behavioral health workers. One-on-one feedback and follow-up, semi-structured interviews and site visits were also conducted to garner input for this report. The workgroup advisory committee guided the direction and gave valuable input to the project. The dialogue from community gatherings was analyzed using a qualitative data analysis. Inferences were drawn from queries which identify intersections between discussion topics and statements. Notable statements from gathering sessions are interspersed throughout this report.

Findings

The report findings show the diversity of the Native American population, and the difficulties its members experience with respect to accessing and receiving culturally appropriate behavioral health wellness. The report highlights 22 community defined practices identified by our Native American population. However, there are dozens if not hundreds of past and present practices that improve our Native behavioral health wellness. The identified activities include varying levels of intervention. For example, there are structured curriculums such as the Gathering of Native Americans which was developed by Native American professional educators and supported by the Substance Abuse and Mental Health Services Administration. Other activities support the individual, such as talking circles, while annual wellness gatherings are community-based. The general key findings in the Native American CRDP report are listed below.

Key Findings to the Native American CRDP Report:

→ Non-Native American entities need to understand the Native American population's diversity, historical and current disparity, and challenges specific to mental health.
→ Restoration and continuation of cultural practices, tribal traditions, and tribal values are essential to Native American behavioral wellness.
→ Elders, spiritual healers, traditional medicine men/women, and natural helpers are important within Native American communities to guide and maintain wellness.
→ Native American communities have incorporated grassroots community defined culturally based mental health PEI practices that have proven to be adaptable to tribal, rural, and urban programs.
→ Native American communities do not have a "one size fits all" for each individual PEI practice.
→ PEI for Native American communities are varied and fluid. There are many differences between and within Native communities.
→ Native American communities need to be empowered with regard to implementation, evaluation, support, and funding to

reduce mental health disparities and appropriate access to culturally-based services.

Recommendations

Tribal sovereignty is an important issue to take into consideration when addressing American Indian mental health and well-being. For delivery of services to be culturally competent, it is important that outside entities have clarity about objectives and expectations within tribal and urban American Indian health policy. Tribal sovereignty is a unique legal relationship between the Federal government and federally recognized American Indian tribes. Strategic directions and core principles for alleviating the mental health disparities of Native Americans in California must directly correlate to community empowerment. The general key recommendations in the Native American CRDP report are listed below.

Key Recommendations to the Native American CRDP Report:

→ Native American communities need to be included on all levels of the CRDP.
→ Support cultural revival for tribal, rural, and urban communities and encourage Native American practices as a way to recover from federal policies that disallowed these practices.
→ Support the communities receiving the funds, which include technical assistance, training, and direct funding from the MHSA to the communities.
→ Distribute next phase funds through a grant mechanism.
→ Ensure accountability and oversight of services to the community and ensure culturally competent PEI practices for Native Americans.
→ Reduction or elimination of county-level oversight of programming during the implementation and evaluation next phase.
→ Use community driven participatory evaluation strategies for the next phase of the CRDP.

The **Native American California Reducing Disparities Report** is now available for website viewing and PDF download. Visit the following web-link: http://www.nativehealth.org/content/publications

Next Steps & Conclusion

The need for culturally competent mental health services is imperative to improve Native American wellness. This report should not be intended as a "how to" manual but a resource and to connect with Native Vision staff, the Native American Strategic Planning Workgroup Advisory Committee, and with the PEI community projects referenced in the catalogue section of this manuscript as well as Native American communities across California. This report should be considered an on-going process and not a definitive "final" report of PEI Native American practices in California.

In order to effectively address mental health issues, it is essential that implementation and evaluation of the next phase of the CRDP be centered in the community and not rely upon a top-down approach. It order to provide our Native community with the maximum chances of successful intervention, the ideal is to work transparently and closely with all interested partners at the Mental Health Services Oversight and Accountability Commission (MHSOAC), and the California Mental Health Directors Association (CMHDA) and any other entities associated with the MHSA project. We strongly recommend maintaining the Native American workgroup as the state moves forward to ensure sustainability and effectiveness of program implementation. This is a landmark project for California – one where voters chose to take a momentous step towards rectifying serious and sustained mental health disparities – and the recommendations made herein are essential to transforming mental health in Native California. If the CRDP implementation phase is business as usual – funds channeled through the counties and/or lacking strong oversight from and accountability to Native communities – this project will undoubtedly fail.

Lastly, a very heartfelt expression of gratitude and thanks go out to the Native Vision 8 member advisory workgroup, the various Native American communities and individuals in which information gatherings took place, staff with the Office of Multicultural Services at the California Department of Mental Health, the fellow CRDP population groups, coalition and facilitator, and staff at the Native American Health Center. As a whole, they have guided the Native American California Reducing Disparities Project and report in "a good way."

Mental Health Services
Oversight & Accountability Commission

Suicide Prevention Public Hearing
October 25, 2018

Panel 2: Intervention through Crisis Care and the Health Care System

- Camplin: Invitation letter
- Camplin: PowerPoint Presentation
- Covington: Invitation letter
- Covington: Three supporting documents
- Jones: Invitation letter

STATE OF CALIFORNIA
EDMUND G. BROWN JR., Governor

Mental Health Services
Oversight & Accountability Commission

WELLNESS • RECOVERY • RESILIENCE

September 24, 2018

David Camplin, LMFT
Director of Behavioral Health
17046 Marygold Ave.
Fontana, CA 92335

Dear Mr. Camplin:

Thank you for agreeing to participate in the Commission's public hearing on suicide prevention on Thursday, October 25, 2018 at the Marina Inn on San Francisco Bay, 68 Monarch Bay Drive, San Leandro, California. The Commission's meeting will include three panels to support the Commission's understanding of opportunities to prevent suicide and suicide attempt, and support the Commission's efforts to develop a strategic statewide suicide prevention plan, as authorized by the California Legislature.

Your panel will highlight opportunities for suicide prevention in crisis care and health care and behavioral health care settings, and is scheduled to begin at approximately 10:30 a.m. Please plan to present for 10 to 15 minutes to leave time for discussion with Commissioners. Please organize your presentation to respond to the following:

- How Kaiser Permanente is implementing the Zero Suicide Initiative, including challenges to implementation
- How the state can reduce challenges and barriers to implementing approaches to prevent suicide by people utilizing services in health and behavioral health care systems, such as those proposed by the Zero Suicide Initiative, including capacity, training, and coordination challenges
- Opportunities for the state to pursue to incentivize suicide prevention strategies, including collaborative care, for private health and behavioral health care systems

Please send a brief biography and written response or background materials to the items above by Wednesday, October 3, 2018 to Ashley Mills at ashley.mills@mhsoac.ca.gov. Your written responses will allow Commissioners attending the meeting the opportunity to prepare questions for you after your presentation, and will be available for Commissioners unable to attend the meeting. Please note that your written responses and biography will be shared as public documents.

Should you have any questions, I can be reached at toby.ewing@mhsoac.ca.gov or 916.445-8696. Thank you again for your willingness to participate in this important meeting.

Respectfully,

Toby Ewing

Toby Ewing, Ph.D.
Executive Director

Mental Health and Wellness

A Kaiser Permanente Zero Suicide Overview

David R. Camplin LMFT, Director of Behavioral Health| October 25, 2018

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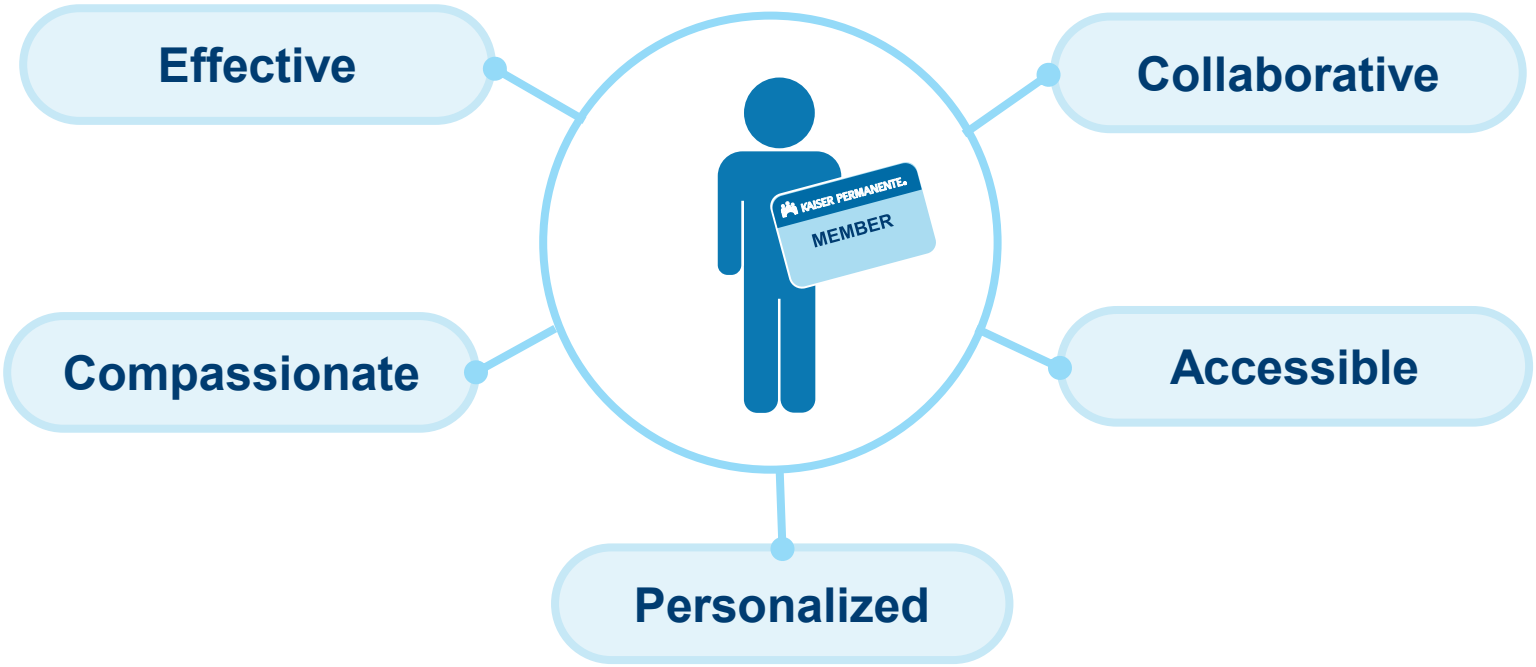
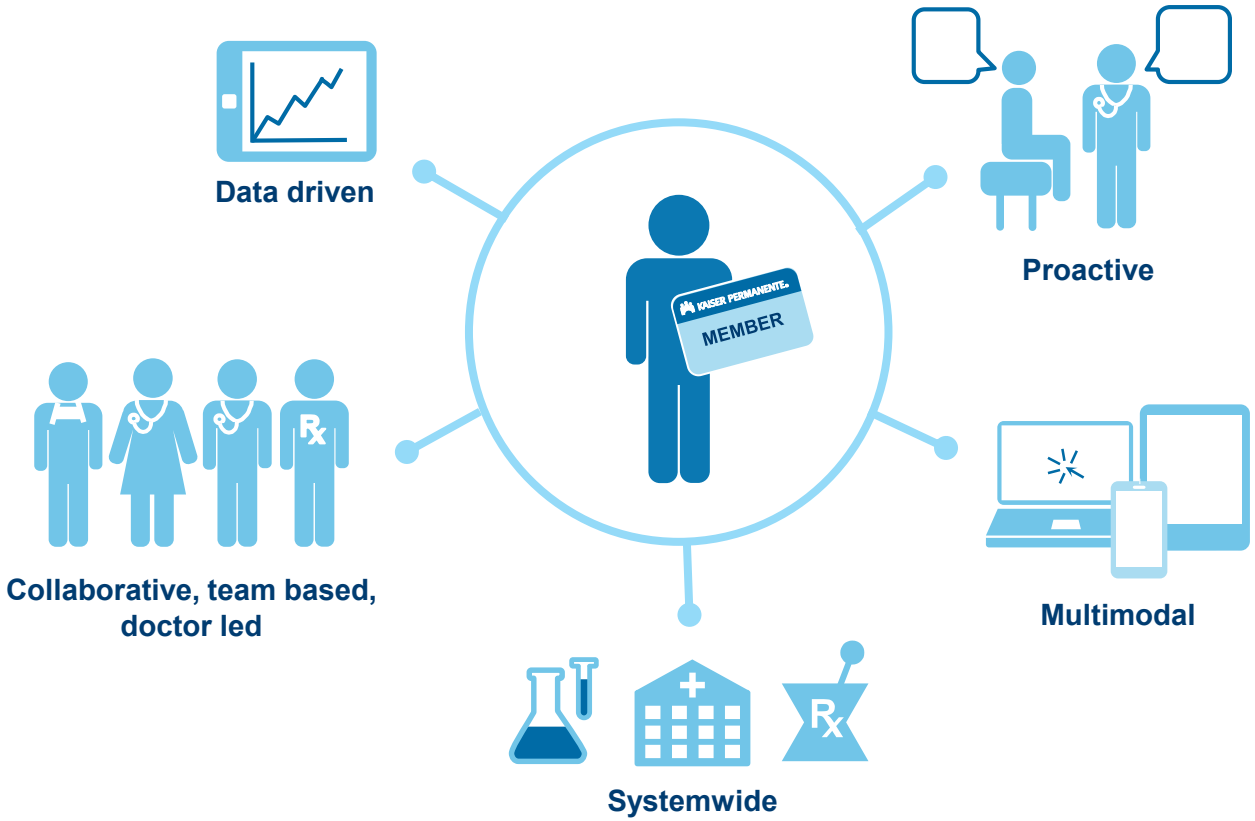
Characteristics of our mental health and wellness care



Our integrated approach to mental health and wellness benefits members



National Suicide Prevention Vision

- Nationally, KP has committed to **reduce and eliminate suicide** through the incorporation of **system-wide, person-centered, evidence-based care practices**, and to bring hope to those affected by suicide.
- The program focuses on *increasing the reliability of the care processes for at risk members* via the following critical components:

Identify: All health system patients are screened for suicide upon their first visit, and annually thereafter if negative or every visit if positive.

Engage: All individuals identified as 'at-risk' are engaged in a Care Management Plan available to all health team members across KP.

Treat: Clients with suicide risk receive evidence-based specialty treatment to address suicidal thoughts and behaviors directly.

Transition: Access to specialty care, uninterrupted care transitions, and continuity of specialty treatment after first receipt – information available and accessible across the continuum of care

Leadership- KP and SCAL

- 2015 Regional Leaders attended a forum in Oakland focused on Suicide Prevention and the Zero Suicide Initiative
- KP Care Management Institute and Risk Management along with regional leaders decide to lead an effort to reduce patient risk and improve outcomes focused on Zero Suicide
- November 2015 an Inter-Regional Learning Collaborative formed to develop the national strategy
- 2016 Don Mordecai MD Moved into the physician leadership role for Mental Health and Wellness and developed the National MHW Strategy
- 2016 SCAL Leaders Paul Castaldo MSW, Assoc. Med Group Administrator and Bridget Wilcox PHD Director of Clinical Outcomes initiate Zero Suicide vision in SCAL

Leadership Vision and Strategy

SCPMG Mental Health Vision Statement

Achieve the highest quality outcomes and reduce the stigma of receiving mental health care to improve the lives of all Southern California members and their families.

Strategic Pillars	***Strategic Imperatives***
High-Quality, High-Reliability	Mental Health Quality Management (MHQM), Clear Pathways, Care Coordination
Outcomes	Feedback Informed Care, Suicide Prevention, Evidence Based Practices
Optimized Infrastructure	Access, Technology, Convenience
Supportive Professional Culture	Wellness, Collaboration, Shared Goals

National/SCAL Tool Development

As part of the Interregional Learning Collaborative, the Columbia Suicide Severity Rating Scale was identified as a leading, evidenced based tool for identifying patients at risk

The CSSRS nationally adopted to help Identify patients at risk

Research based, Standardized Safety Plan developed with input from multiple areas, to include lethal means restriction

COLUMBIA-SUICIDE SEVERITY RATING SCALE

Emergency Department Screen Version with Triage Points

SUICIDE IDEATION DEFINITIONS AND PROMPTS:	Past month	
Ask questions that are in bold and underlined.	YES	NO
Ask Questions 1 and 2		
1) Wish to be Dead: Person endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up? ***Have you wished you were dead or wished you could go to sleep and not wake up?***		
2) Suicidal Thoughts: General non-specific thoughts of wanting to end one's life/commit suicide, "*I've thought about killing myself*" *without general thoughts of ways to kill oneself/associated methods, intent, or plan.*" ***Have you had any actual thoughts of killing yourself?***		
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.		
3) Suicidal Thoughts with Method (without Specific Plan or Intent to Act): Person endorses thoughts of suicide and has thought of a least one method during the assessment period. This is different than a specific plan with time, place or method details worked out. "*I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it....and I would never go through with it.*" ***Have you been thinking about how you might do this?***		
4) Suicidal Intent (without Specific Plan): Active suicidal thoughts of killing oneself and patient reports having some intent to act on such thoughts, as oppose to "*I have the thoughts but I definitely will not do anything about them.*" ***Have you had these thoughts and had some intention of acting on them?***		
5) Suicide Intent with Specific Plan: Thoughts of killing oneself with details of plan fully or partially worked out and person has some intent to carry it out. ***Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?***		
6) Suicide Behavior Question ***Have you ever done anything, started to do anything, or prepared to do anything to end your life?*** Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.	Lifetime	
If YES, ask: *Was this within the past 3 months?*	Past 3 Months	

KAISER PERMANENTE®

SCAL Strategic Imperatives

SCAL Strategies Developed to meet the Zero Suicide Initiatives

Identify

- Columbia
- Every Initial visit for new patients 10+
- Implementation at First Call for Appointment
- Emergency Department Implementation
- Social Services, Outside Network
- Expansion Plans

Engage

- Clinical evaluation
- Crisis intervention
- Individual psychotherapy
- Group psychotherapy
- Condition education classes
- Case management
- Psychopharmacological treatment
- Dual-diagnosis programs

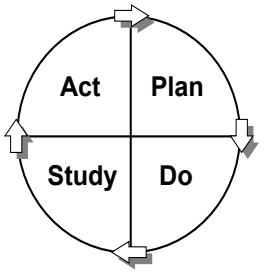
Treat

- Follow Up Protocol Developed
- IOP/ Partial hospitalization
- Chemical dependency intensive recovery programs
- Intensive case management
- Consultation — emergency department and hospital liaison services

Transition

- EMR Documentation and Coding
- Readily Accessible Safety Plan by Providers
- Real time reporting and follow up strategies for fallout
- Follow Up after ED and Urgent Care Visits
- Safety Planning Post Inpatient Discharge
- 24/7 Behavioral Health Crisis Line

SCAL Implementation



Area Director Assessment

- Plan Development
- Area Readiness
- Leadership Buy-In

Clinic Pilot

- Clinic Training
- Online Tools
- Digital Training
- Model Improvement
- MD/Therapist Collaborative Feedback

Area/Regional Rollout

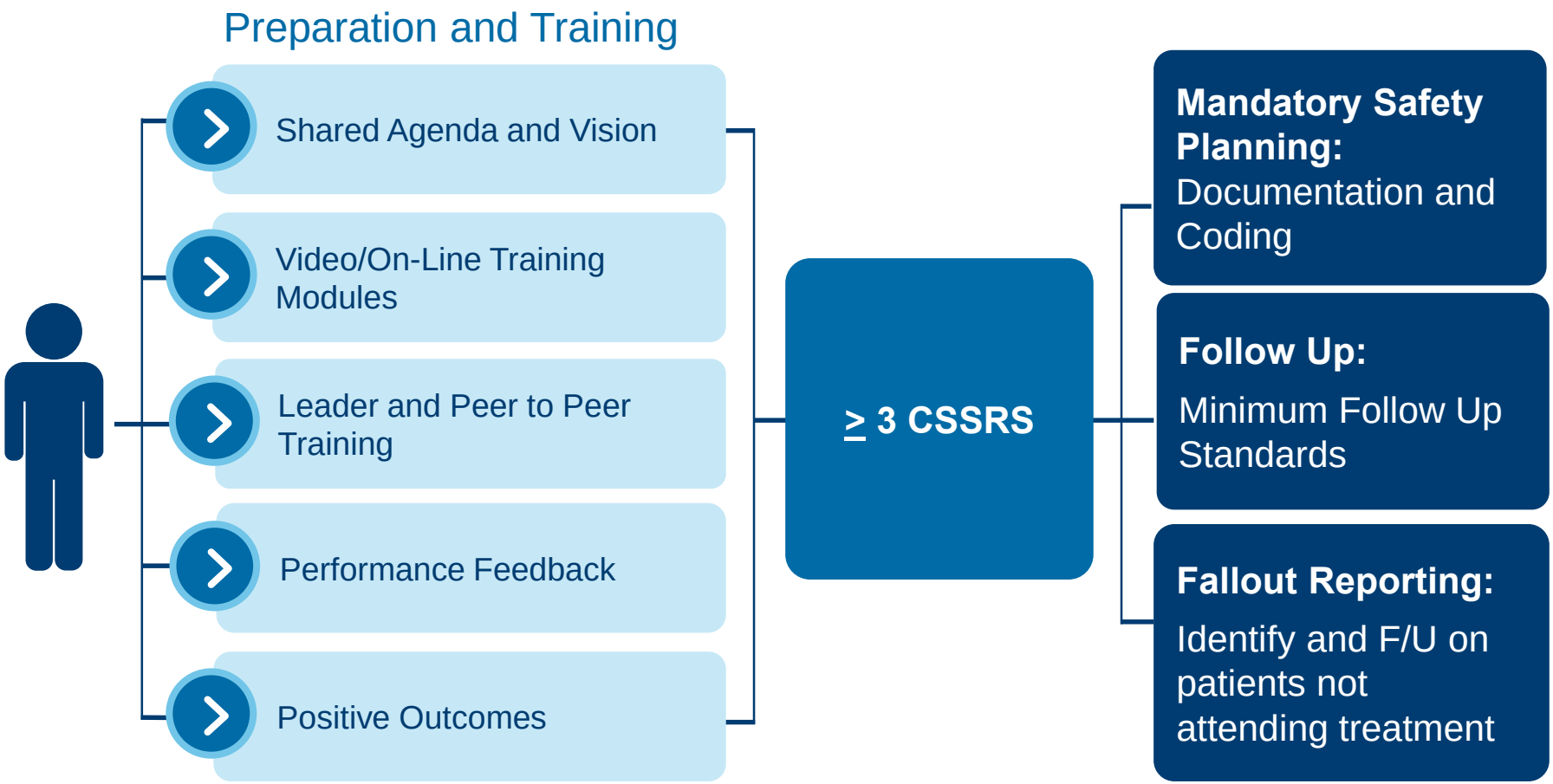
- In-Person Training
- Leadership Communication and feedback
- Continuous Improvement
- Therapist Champions
- Large and Small group training
- Ongoing Refresher
- New Therapist Onboarding

Spread

- Appointment Center
- ED
- Social Services
- Outside Contracting
- Depression Care Management
- Other Primary and Specialty Services

KAISER PERMANENTE®

Provider Training



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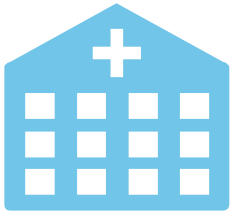
In Person and Telephonic Screening



In Person Screening

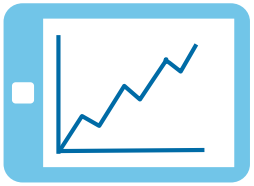
- Incorporated into EMR
- Screening at every appointment as part of Feedback Informed Care/Treatment Progress Indicator
- Incorporated into Intensive Services

Telephone Screening

- All First Appointments Screened at initial call
- Therapist Now- On-the-Spot Telehealth Screening
- Teen Now- Telephone and Video Visits
- OD/Crisis Intervention for critical care

Future Casting- On the Horizon

Data Driven Identification:

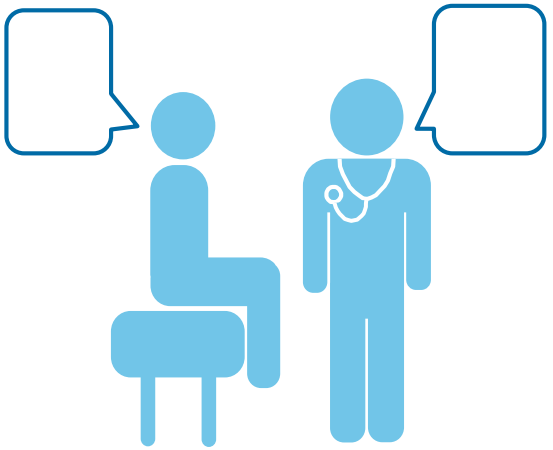


Data driven

Predictive Analytics to identify and outreach to at risk populations

Universal Screening:

- Integrated Behavioral Health – Primary Care and Pediatrics, OB and other Specialties
- Universal Screening tools available to multiple disciplines in patient care environment
- Telehealth presence for high risk patients in medical environment



NIMH Grant for Continuous Improvement

Funded NIMH grant (5 year) to evaluate suicide prevention efforts in large healthcare systems. Research funding brings additional resources to:

- Collaborate with regional clinical and quality leaders to precisely specify improvement targets and care processes
- Develop and implement metrics to continuous assess quality/fidelity of care process implementation
- Develop and implement metrics to assess impact of care improvements on ultimate outcomes (suicide attempts and suicide deaths)
- Support data capabilities and investigator time in each participating region's research center/department as well as central support at KPWA and Henry Ford Health System

Thank You !

STATE OF CALIFORNIA
EDMUND G. BROWN JR., Governor

Mental Health Services
Oversight & Accountability Commission

September 14, 2018

David W. Covington, LPC, MBA
RI International
2701 N. 16th Street, Suite 316
Phoenix, AZ 85006

Dear Mr. Covington:

Thank you for agreeing to participate in the Commission's public hearing on suicide prevention on Thursday, October 25, 2018 at the Marina Inn on San Francisco Bay, 68 Monarch Bay Drive, San Leandro, California. The Commission's meeting will include three panels to support the Commission's understanding of opportunities to prevent suicide and suicide attempt, and support the Commission's efforts to develop a strategic statewide suicide prevention plan, as authorized by the California Legislature.

Your panel will highlight opportunities for suicide prevention in crisis care and health care and behavioral health care settings, and is scheduled to begin at approximately 10:30 a.m. Please plan to present for 10 to 15 minutes to leave time for discussion with Commissioners. Please organize your presentation to respond to the following:

- How the Crisis Now Model and the Zero Suicide Initiative efforts have the potential to prevent suicide and suicide attempt
- How the state can reduce challenges and barriers to implementing the Crisis Now Model and the Zero Suicide Initiative, including capacity, training, and coordination challenges
- Short-term and long-term opportunities for the state to pursue to strengthen crisis care, health care, and behavioral health care delivery systems using approaches identified in the Crisis Now Model and the Zero Suicide Initiative and incentivize such approaches

Please send a brief biography and written response or background materials to the items above by Wednesday, October 3, 2018 to Ashley Mills at ashley.mills@mhsoac.ca.gov. Your written responses will allow Commissioners attending the meeting the opportunity to prepare questions for you after your presentation, and will be available for Commissioners unable to attend the meeting. Please note that your written responses and biography will be shared as public documents.

Should you have any questions, I can be reached at toby.ewing@mhsoac.ca.gov or 916.445-8696. Thank you again for your willingness to participate in this important meeting.

Respectfully,

Toby Ewing

Toby Ewing, Ph.D.
Executive Director

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CRISIS NOW
Transforming Crisis Services

Business Case

The Crisis Now Model

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This business case builds on the foundational model:
Covington D, Hogan, M, et al. Crisis Now: Transforming services is within our reach. National Action Alliance for Suicide Prevention: Crisis services task force; 2016.

Prepared by Crisis Tech 360, a joint venture of RI International and Behavioral Health Link, national leaders in crisis to recovery programs (2018).

Key informants to the assumptions in this report:

Dr. Michael Hogan, NYS Mental Health Commissioner (2007-2012); Detective Nick Margiotta, Retired Phoenix PD, CIT International Board of Directors; Dr. Michael Allen, Professor Psychiatry and Emergency Medicine; Wendy Farmer, LPC, MBA, CEO, Behavioral Health Link; and RI International crisis facility directors Sarah Blanka, Rivers Carpenter, Purcell Dye, Jodie Leer, Tammy Margeson, Joy Brunson Nsubiga, Arneice Ritchie, and Peggy Wiley.

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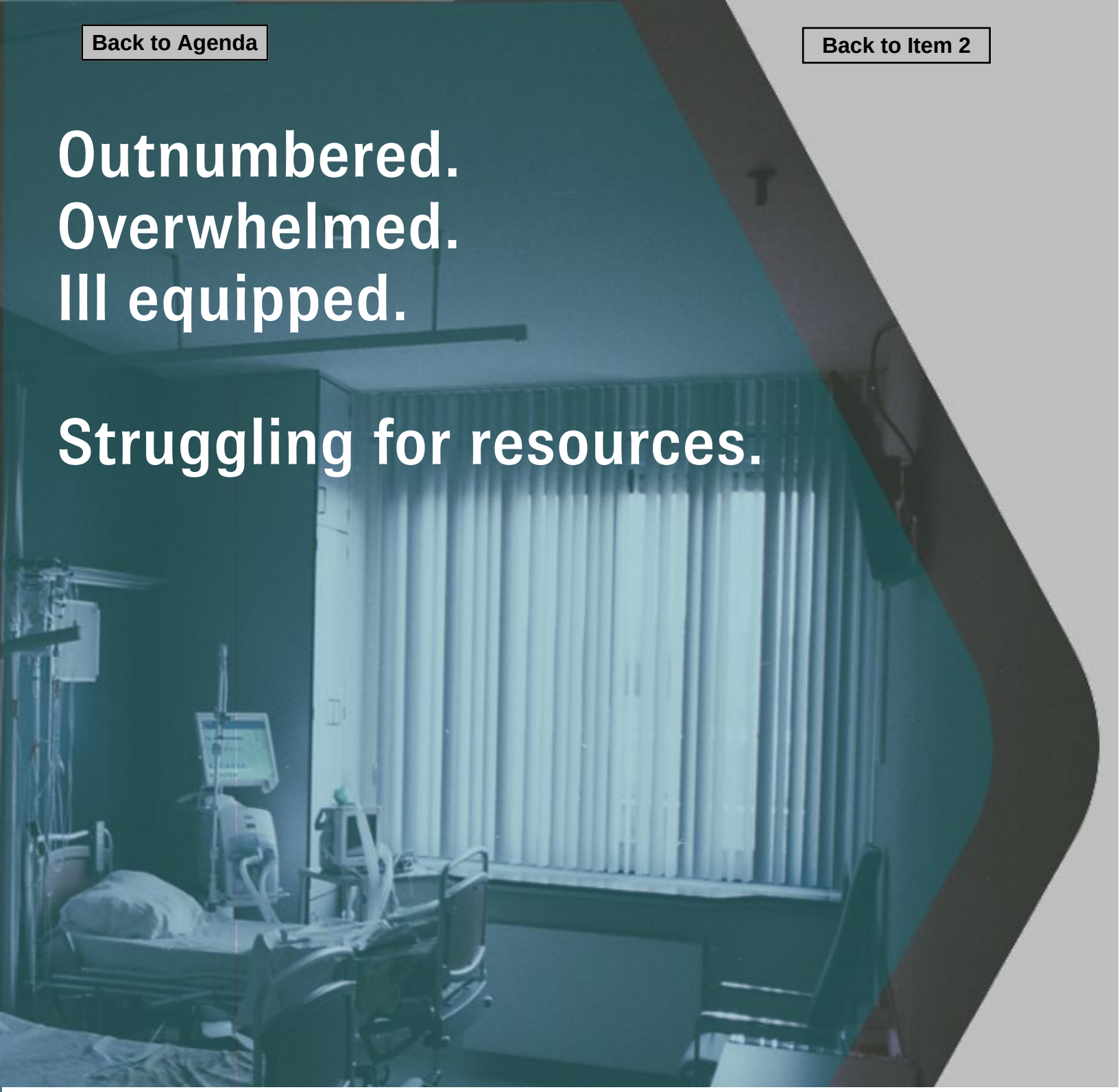
Outnumbered.
Overwhelmed.
Ill equipped.

Struggling for resources.



Evidence suggests that your community's emergency departments are losing the battle of mental health access and care.

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“8 in 10 ED Doctors Say Mental Health System Is Not Working for Patients.”

Survey by the American College of Emergency Physicians (ACEP) of 32,000 physicians, residents, and medical students working in hospital emergency departments.

Is it any different in your community?

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Traditional Community Crisis Flow

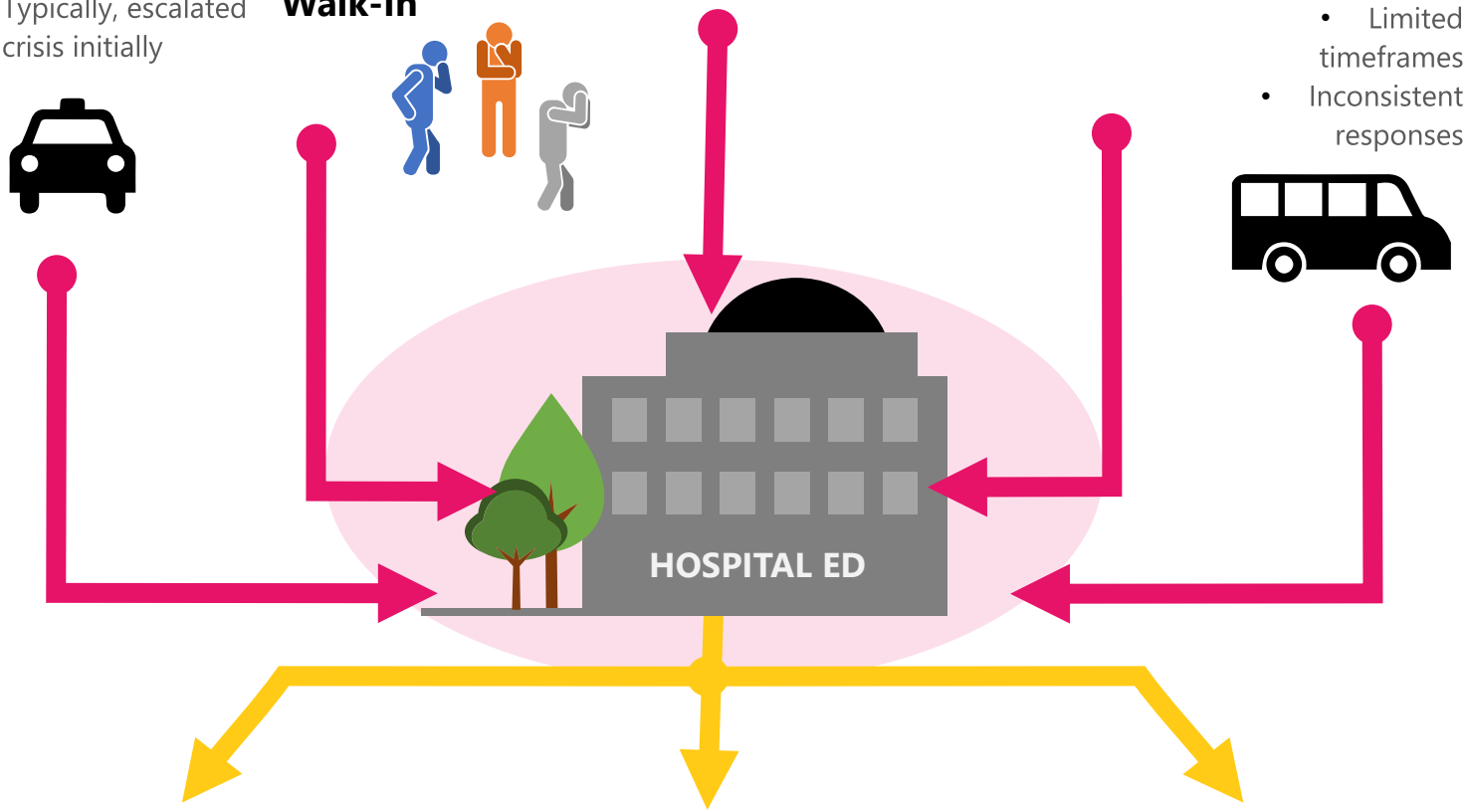
Police
- The untrained MH workforce.
- Typically, escalated crisis initially

Individuals, Friends, Family Walk-In

Primary Care & Social Services

Crisis Call Lines

Mobile Outreach
- Few locations
- Limited timeframes
- Inconsistent responses



ACUTE SERVICES
- Extreme cases only where capacity exists
- Interminable waits common

REFERRED ELSEWHERE
- Outpatient Mental Health
- Community Resources
- Detoxification/Substance Abuse Services

SERVICES DECLINED
- Referred back to community/ natural supports
- No therapeutic support
- Incarceration/Relocation

Where's the Choke Point in the Usual Approach?

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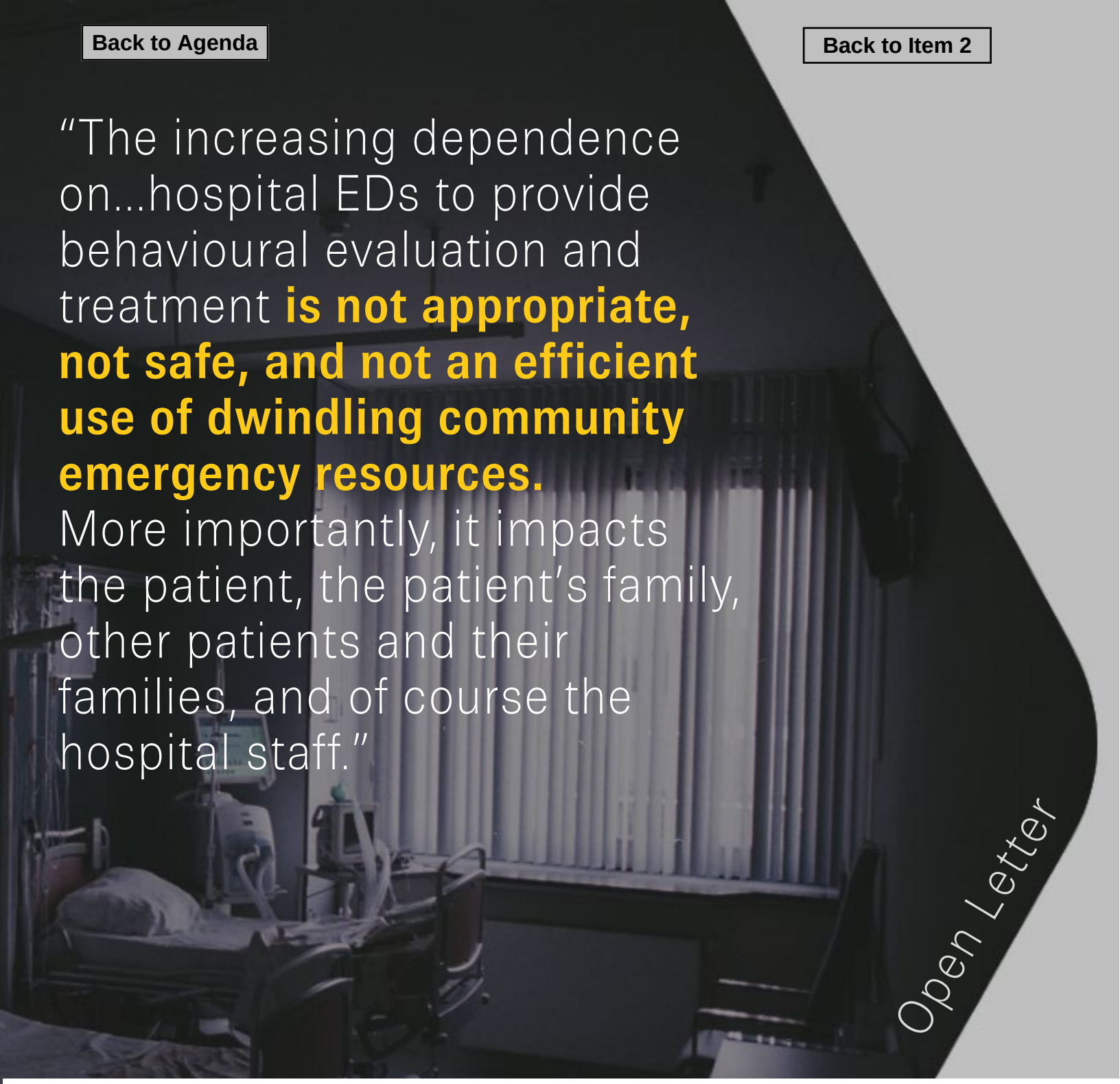

"The increasing dependence on...hospital EDs to provide behavioural evaluation and treatment **is not appropriate, not safe, and not an efficient use of dwindling community emergency resources.** More importantly, it impacts the patient, the patient's family, other patients and their families, and of course the hospital staff."

Open Letter

Sheree (Kruckenberg) Lowe, VP of Behavioral Health for the California Hospital Association, representing 400 hospitals and health systems

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Seattle Times 2013.

Lack of space forced those involuntarily detained in EDs to wait on average 3 days.

Every time such an inhumane psychiatric boarding occurs, the hospital experiences a cost/loss of $2,264

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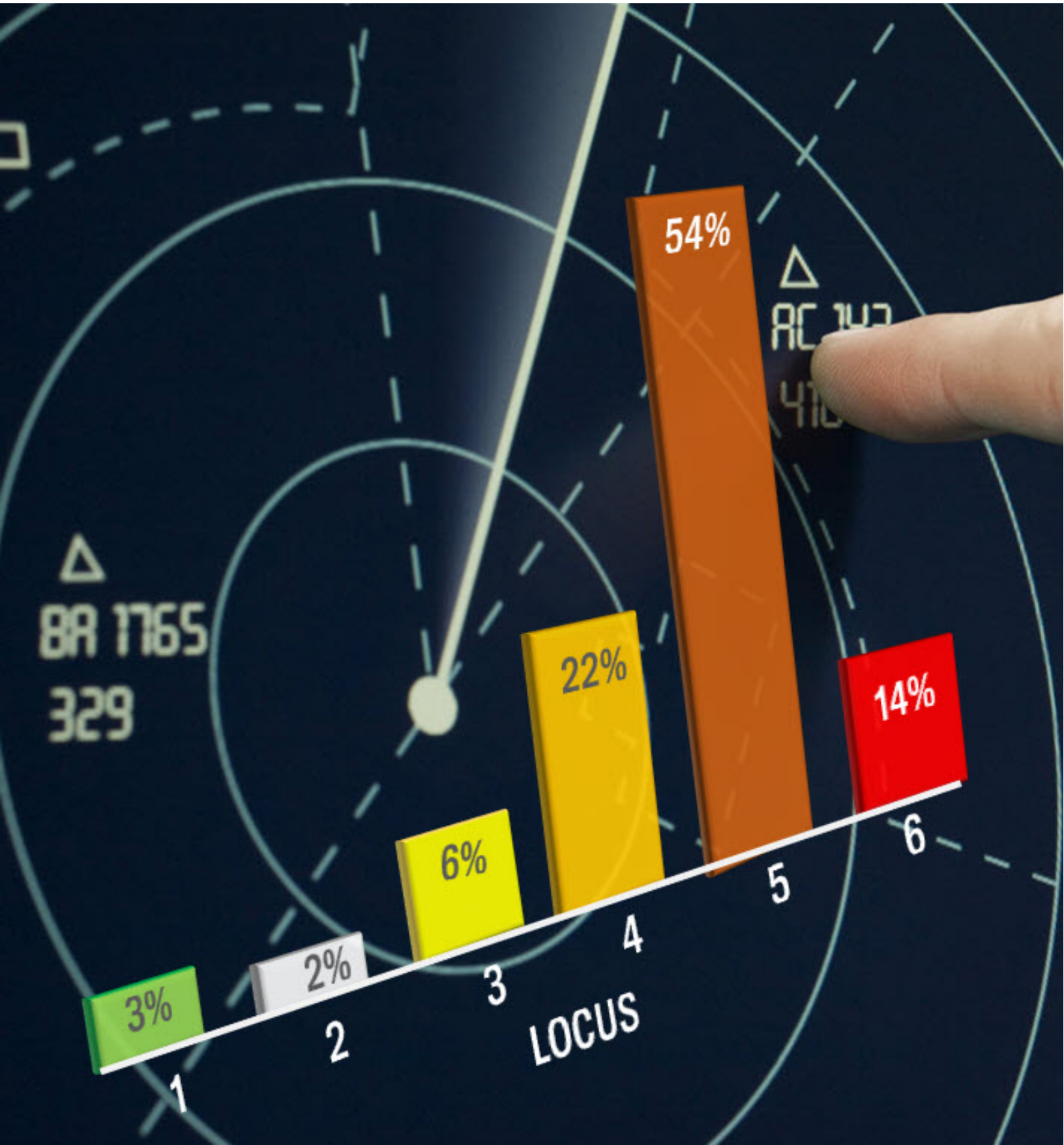
Radically transforming mental health

Good crisis care prevents suicide and provides help for those in distress. It cuts the cost of care, reduces the need for psychiatric acute care, hospital ED visits and police overuse.

CRISIS NOW

Transforming Crisis Services

We utilized more than a decade of statewide crisis data to produce the analysis in this report.



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What is the Crisis Now model?

Three core services in a crisis continuum deployed as full partners with law enforcement, hospitals and first responders.

CRISIS NOW
Transforming Crisis Services

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Law Enforcement By-passes the Emergency Room and Proceeds Directly to Crisis

Mobile Crisis

Crisis Facilities

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5 to 7 Minute Turn-Around Police Drop Off. No Call. No Referral. No Rejection. Simple.

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“Air Traffic Control” Crisis Call Center Hub Connects and Ensures Timely Access and Data

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What difference does Crisis Now make?

In the 4-million-person community of Maricopa County (Phoenix, Arizona) the continuum of crisis services has had the following outcomes compared with a community without them.

CRISIS NOW
Transforming Crisis Services

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37 FTE Police Officers Engaged in Public Safety Instead of Mental Health Transportation/Security

Resource savings for fire fighters also exist but not yet quantified.

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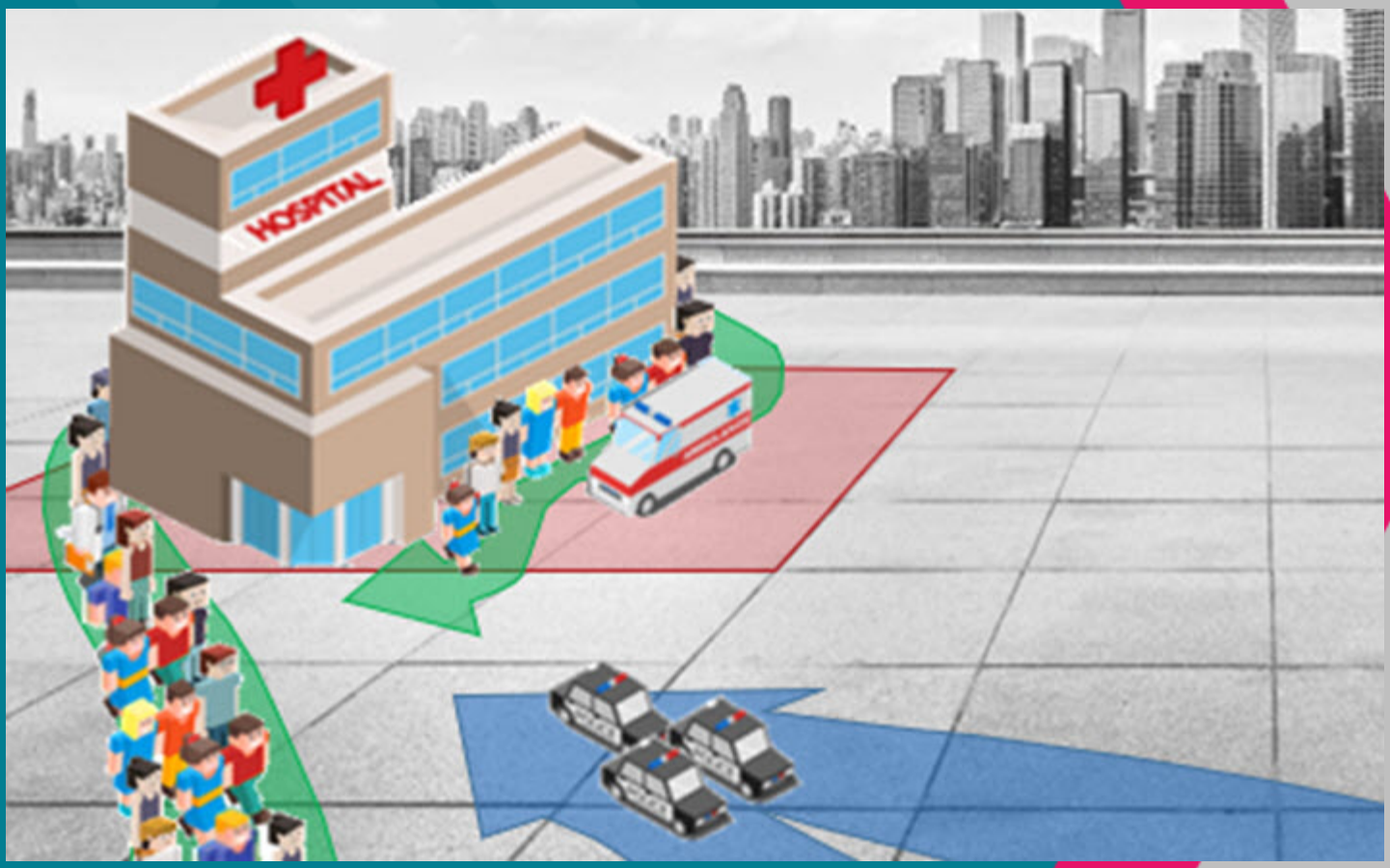
A Staggering Reduction of 45 Cumulative Years of Psychiatric Boarding (aka Waiting in the ED)



Creating a savings to hospitals of **$37 million** in avoided costs/losses

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Reduced Potential State Acute Care Inpatient Expense by $260 million

The cost avoidance represents the net savings of a $100 million investment in a full, integrated crisis continuum

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Key references to the mathematics in this report:

"The Impact of Psychiatric Patient Boarding in Emergency Departments" (2012) (Nicks and Manthey):

- 35% of those consulted to psychiatry required inpatient care
- The average hospital ED length of stay was 1,089 minutes (just over 18 hours)
- The hospital psychiatric patient boarding cost was $2,264 per person

"Amazing Results of Team Work: 2016 Diversions" (2017) (Mercy Maricopa Integrated Care RBHA, Arizona):

- In 2016, 21,943 individuals with mental health and addiction challenges were handed off from Phoenix area police departments directly to crisis
- Reportedly, approximately 1,000 individuals received a direct connection through fire fighters, but these relationships are newer and the full potential is yet unknown.

"Psychiatric Bed Supply Per Capita" (2016) Treatment Advocacy Center:

- The consensus opinion of an expert panel on psychiatric care estimated the need as around 50 public psychiatric beds per 100,000 population

"Georgia Crisis & Access Line LOCUS" (2006-2017) Behavioral Health Link

- 1.2 million caller episodes of care were evaluated for higher intensity cases in which emergency department, law enforcement or mobile crisis were involved
- 54% were LOCUS Level 5, which warrants non-secure sub-acute crisis levels of care

"Crisis Now Business Case" (2017) David Covington presentation at the National Dialogues on Behavioral Health Conference (New Orleans)

- Crisis Now model improves "Crisis Clinical Fit to Need (CCFN)" by 6x (meaning that the LOCUS assessment matches the connected service description)
- Psychiatric inpatient expense reduced from a potential $485 million to $125 million (savings of $260 million after adding the $100 million investment in crisis continuum)
- Seattle Times reported avg. psychiatric boarding time in Washington State 3 days (2013)
- Carolinas Healthcare reported baseline psychiatric boarding 40 hours on average (Dr. John Santopietro presentation at the National Council for Behavioral Health)
- Average hospital ED waiting time for person without SMI 2 to 3 hours

"Law Enforcement and Mental Health" (2017) Ruby Qazilbash Bureau Justice Assistance to Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC)

- In Madison, WI, law enforcement BH calls 3 hours versus 1.5-hour average contact
- By contrast, in the Arizona model BH calls 45 minutes to 1 hour (direct transport to sub-acute crisis urgent care with 5 to 7-minute turnaround, per Nick Margiotta)


LEAVE THE DRY ERASE MARKERS TO THE BRAINSTORMING SESSIONS
Is your crisis bed board electronic?
CrisisTech 360

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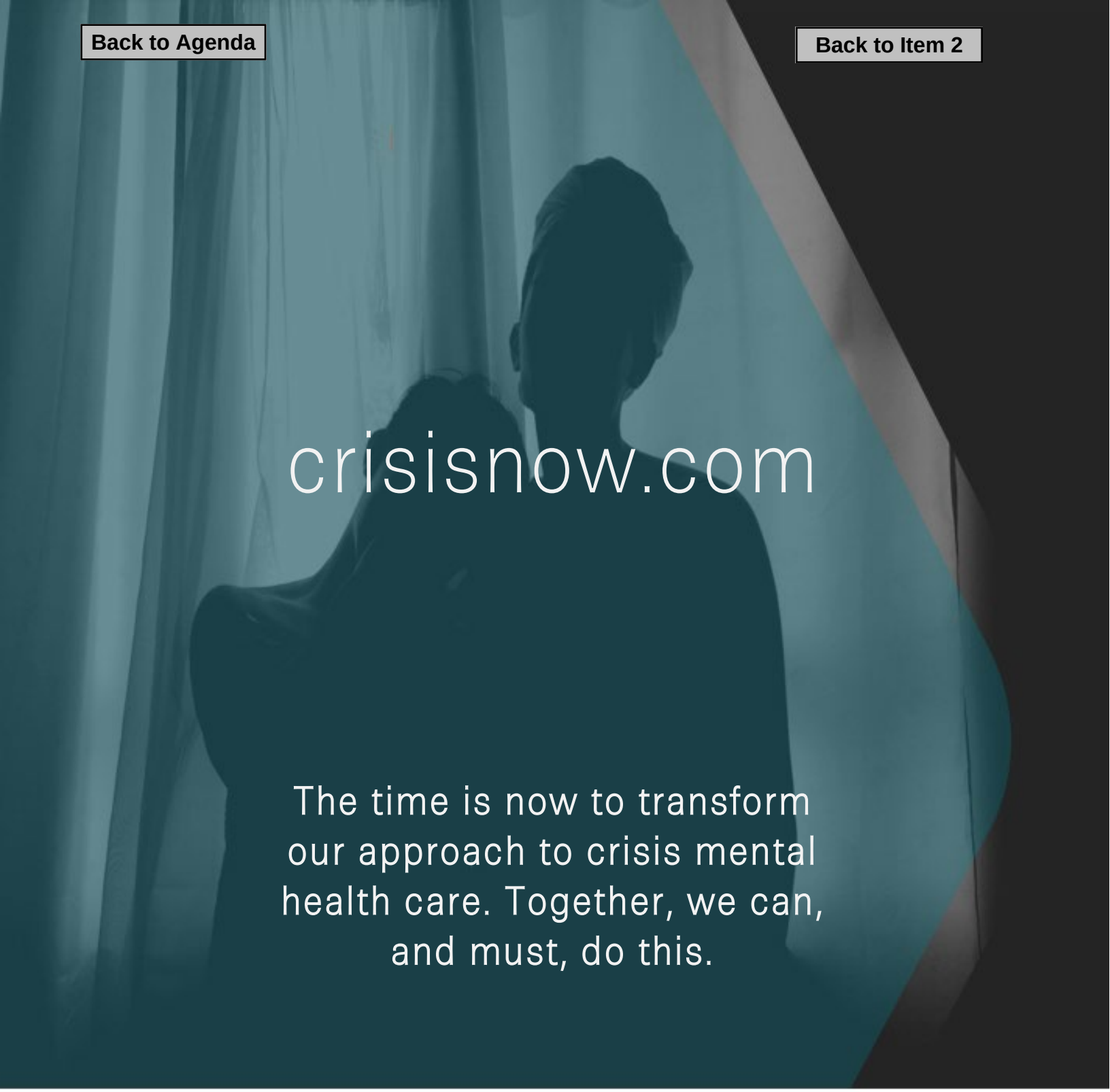

crisisnow.com

The time is now to transform our approach to crisis mental health care. Together, we can, and must, do this.

CRISIS NOW
Transforming Crisis Services

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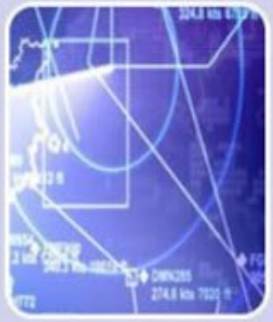
How Does Your Crisis System Rate?

NATIONAL ACTION ALLIANCE FOR SUICIDE PREVENTION

A Framework for State/Regional Self-Assessment

For more info see http://crisisnow.com



What makes Level 5 different?	① Call Center Hub Real Time Access Valve Mgmt	② Mobile Outreach Meets Person at Home/Apt/Street	③ Sub-acute Stabilization Direct LE Drop Off <10 Min	Crisis Now System Equal Partners 1st Responders	Level 5 System Also Conforms to 4 Modern Principles
Level 5: FULLY INTEGRATED	Air Traffic Control Connectivity	Adequate Access Statewide	Adequate Access Statewide	Adequate Access Statewide Plus →	① Priority Focus on Safety/Security
Level 4: CLOSE	Data Sharing (Not 24/7 or Real Time)	Statewide Access but Reliant on ED	Statewide Access but Reliant on ED	Integrated System w/ Diversion Power	② **Suicide Care Best Practices**, e.g. Systematic Screening, Safety Planning and Follow-up
Level 3: PROGRESSING	Formal Partnerships	Adequate Access **<1 Hr Response**	Adequate Access **>50% Bed Available**	Adequate Access Major Payers Included	
Level 2: BASIC	Shared MOU/ Protocols	Some Availability Limited to Urban	Some Availability Limited to Urban	Limited State/ County Support	③ Trauma-Informed, Recovery Model
Level 1: MINIMAL	Agency Relationships	None or Very Limited Availability	None or Very Limited Availability	Fragmented Status Quo	④ Significant Role for Peers

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NATIONAL ACTION ALLIANCE FOR SUICIDE PREVENTION

How Does Your Crisis System Flow?

% whose assessed need matched their linked crisis service

Individual, Friends, Family Walk-In | Primary Care & Social Services | Police | Crisis Line & Mobile

Most all community crisis referrals flow through the hospital ED.

Compute your crisis system flow.

STEP 1

Community Crisis Flow

Hospital ED

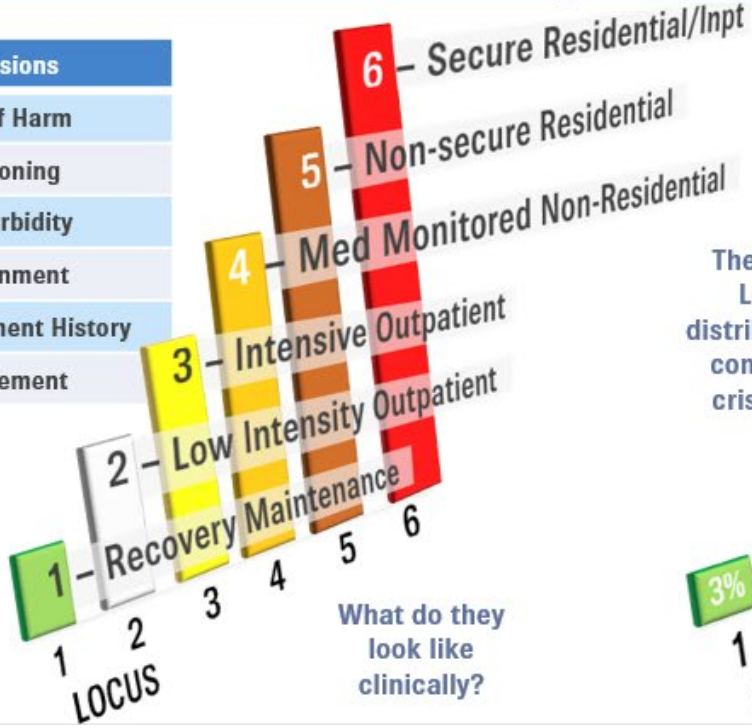
200 persons in crisis per 100,000 persons in your community on a monthly basis.

Greater Phoenix	4m	Divide by 100k and multiply by 200	8,000	What do they look like clinically?
Community	Total Pop.		Monthly Crisis Flow	

STEP 2

LOCUS Levels of Care

Dimensions
Risk of Harm
Functioning
Co-Morbidity
Environment
Treatment History
Engagement

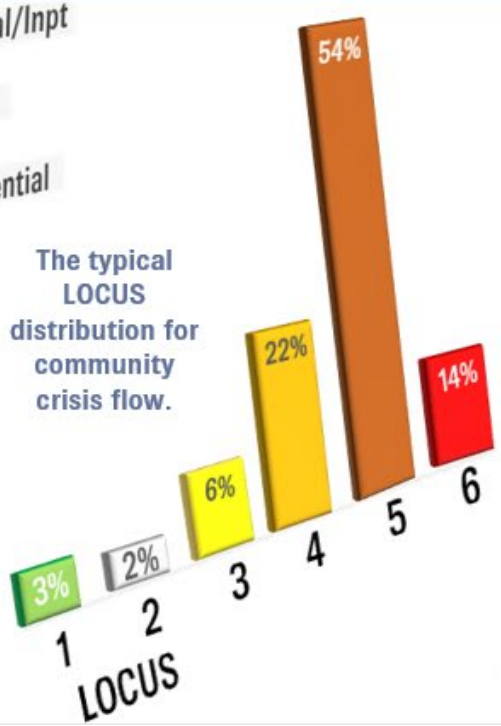


What do they look like clinically?

STEP 3

Stratified Crisis Need

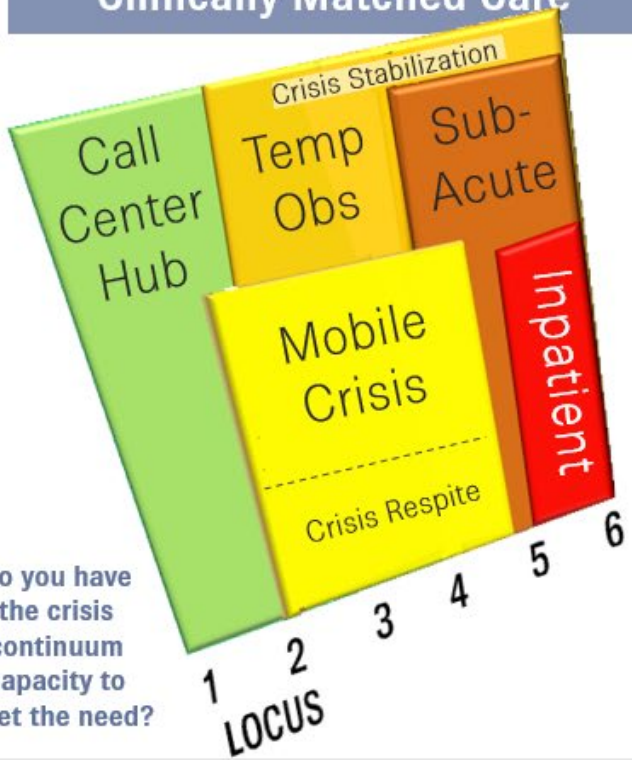
The typical LOCUS distribution for community crisis flow.



STEP 4

Clinically Matched Care

Do you have the crisis continuum capacity to meet the need?



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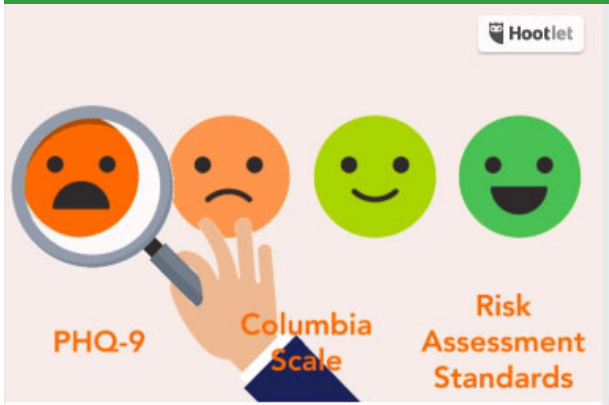
Zero Suicide

Healthcare that believes no one should die alone and in despair. Healthcare that's safer.



Screening & Assessment

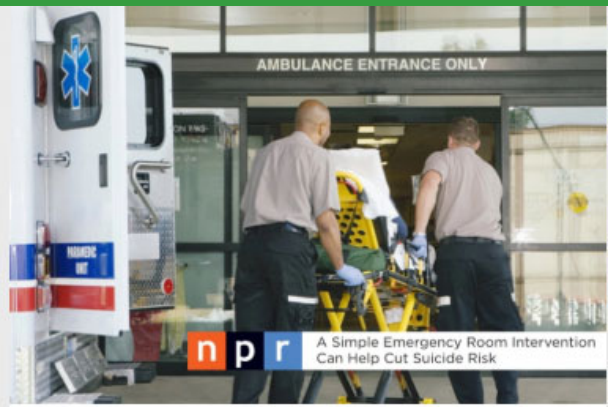
The interventions that make up the primary elements of Zero Suicide are known to work. They all have research-based efficacy. Routine screening and assessment for suicide risk is a core component. In 2015, Dr. Greg Simon and team concluded in Psychiatric Services that the PHQ-9 question 9 "identifies outpatients at increased risk for suicide attempt or death." ...

Read more

Direct Treatment & Follow-Up

The interventions that make up the primary elements of Zero Suicide are known to work. They all have research-based efficacy. Direct treatment of suicide risk is a core component. Usual care is disastrous. Dr. Mark Olfson in the July 2017 JAMA Psychiatry carefully describes the very significant suicide risks for individuals in the immediate aftermath of a ...

Read more



Collaborative Safety Planning

Until 2018, there were few studies of safety planning. Craig Bryan's findings in The Journal of Affective Disorders were promising ("Effect of crisis response planning vs. contracts for safety on suicide risk in U.S. Army Soldiers," January 2017). However, in 2018, Health News from NPR highlighted a study by Dr. Barbara Stanley and Dr. Greg Brown, "A ...

Read more

For decades, individual clinicians made heroic efforts to save lives… but systems of care did very little. Henry Ford Health System proved a large healthcare system could do far better and that Zero Suicide is not just a possibility, but a reality when leadership, high reliability performance improvement and patient engagement are connected and evidence-based clinical practices are fully scaled.

ZeroSuicide.org for global learning community. **ZeroSuicide.com** for fidelity toolkit/resources.

Crisis Now

Transforming Services is Within Our Reach

Suggested Citation Format: National Action Alliance for Suicide Prevention: Crisis Services Task Force. (2016). *Crisis now: Transforming services is within our reach*. Washington, DC: Education Development Center, Inc.

The National Action Alliance for Suicide Prevention (Action Alliance) is the public-private partnership advancing the *National Strategy for Suicide Prevention* by championing suicide prevention as a national priority, catalyzing efforts to implement high-priority objectives of the National Strategy for Suicide Prevention (NSSP), and cultivating the resources needed to sustain progress. Launched in 2010 by Health and Human Services Secretary Kathleen Sebelius and former Defense Secretary Robert Gates, the Action Alliance envisions a nation free from the tragic event of suicide. Education Development Center, Inc. (EDC), operates the Secretariat for the Action Alliance through the Suicide Prevention Resource Center.

Learn more at http://actionallianceforsuicideprevention.org

Contents

Foreword: Message from Co-leads

Vastly outnumbered. Ill equipped. Foraging for resources. The nation's emergency departments are the Alamo of mental health access and care.

The recent headline was not surprising: "8 in 10 ER Docs Say Mental Health System Is Not Working for Patients." The survey by the American College of Emergency Physicians (ACEP) of 32,000 physicians, residents, and medical students working in hospital emergency departments concluded that "boarding" wait times for psychiatric inpatient needed to be reduced and more training and education of staff about psychiatric emergencies was required (http://prn.to/1VIKuU4).

Sheree Kruckenberg is Vice President of Behavioral Health for the California Hospital Association, which represents 400 hospitals and health systems. Her April 2015 open letter drew similar conclusions:

> *The increasing dependence on…hospital EDs to provide behavioral evaluation and treatment is not appropriate, not safe, and not an efficient use of dwindling community emergency resources. This includes not only hospitals, but emergency transportation providers and law enforcement. More importantly, it impacts the patient, the patient's family, other patients and their families, and of course the hospital staff (http://bit.ly/1PxFqSq).*

Everyone seems to agree with the problem.

While efforts to improve suicide care in emergency departments (e.g., as suggested by the recent Joint Commission Sentinel Event Alert #56) are necessary, we must also work toward more fundamental improvements in crisis care.

Several pioneering states have already shown us a path.

The vision of the National Action Alliance for Suicide Prevention is a nation free from the tragic experience of suicide. The members of the Crisis Services Task Force hope that this report, *Crisis Now: Transforming Services is Within Our Reach*, will lead to expedited and substantive changes in behavioral health crisis care.

The time is now. Together, we can, and must, do this.

David W. Covington, LPC, MBA
CEO & President
RI International

Michael F. Hogan, PhD
Principal
Hogan Health Solutions

Introduction and Overview

Summary of the Problem

Crisis mental health care in the United States is inconsistent and inadequate. This is tragic in that good crisis care is a known effective strategy for suicide prevention, a preferred strategy for the person in distress, a key element to reduce psychiatric hospital bed overuse, and crucial to reducing the fragmentation of mental health care.

Short-term, inadequate crisis care is shortsighted. Imagine establishing emergency services in a town by purchasing a 40-year-old fire engine and turning the town's old service shop into the fire station. It will work until there is a crisis.

With non-existent or inadequate crisis care, costs go up because of hospital readmissions, overuse of law enforcement, and human tragedies. In too many communities, the "crisis system" has been unofficially handed over to law enforcement, sometimes with devastating outcomes. Our current approach to crisis care is patchwork, delivering minimal care for some people while others (often those who have not been engaged in care) fall through the cracks—resulting in multiple readmissions, life in the criminal justice system, or death by suicide.

Our country's approach to crisis mental health care must be transformed. Crisis care is the most basic element of mental health care, yet in many states and communities, it is taken for granted. Limited. An afterthought. A work-around. Even non-existent. In many communities, the current crisis services model depends primarily upon after-hours work by on-call therapists or space set aside in a crowded emergency department (ED). These limited and fragmented approaches are akin to plugging a hole in a dike with a finger.

Include Crisis in Mental Health Reforms

Foundational elements of an improved mental health system are in place with mental health parity, coverage expansion, the launch of the Certified Community Behavioral Health Clinics and the Excellence in Mental Health Act, and the national implementation of first episode psychosis programs. Our nation's political leaders recognize the work is not done, and for the first time in many years, there are several robust legislative proposals that focus on "fixing the broken mental health system." Now is the time to get it right. Therefore, comprehensive crisis care must be included in mental health reform. Yet systematic improvements in crisis care, which could save lives and reduce fragmentation, are not included in current leading reform proposals.

Now is the time to establish comprehensive crisis care as a foundational, transformative, life-saving core element of behavioral health care and of suicide prevention.

A Time for Change

After reviewing approaches to crisis care across the United States, the Crisis Services Task Force (hereafter "Task Force") of the National Action Alliance for Suicide Prevention (Action Alliance) believes now is the time for crisis care to change. The Task Force, established to advance objective 8.2 of the *National Strategy for Suicide Prevention* (NSSP), comprises many experts (see Task Force and Support Team Participants in the Appendix), including leaders who have built and who operate many of the most acclaimed crisis programs in the nation.

After reviewing the literature and model programs, we offer this report to suggest what can be done, galvanize interest, and provide a road map for change. Our comprehensive review finds that now is the time for crisis services to expand because of a confluence of factors and forces, including:

- Crisis care often being the preferred and most efficient care for people in crisis
- The absence of core elements of successful crisis care in many communities
- Mental health reform proposals that are on the table but fail to seize the opportunity to improve crisis care
- Mental health parity legislation and coverage expansion

The challenge EDs face addressing behavioral emergencies

The Task Force has studied elements of successful programs and reviewed their effectiveness. While some communities are crisis-ready, there are very few communities where all key elements of crisis care are in place, and many where even the "parts" of crisis care that exist are inadequate.

In short, core elements of crisis care include:

1. Regional or statewide crisis call centers coordinating in real time
2. Centrally deployed, 24/7 mobile crisis
3. Short-term, "sub-acute" residential crisis stabilization programs
4. Essential crisis care principles and practices

These elements are discussed in more detail later in this report. Effective crisis care that saves lives and dollars requires a systemic approach, and these key elements must be in place. In this report we will review the proven key components of good crisis care and demonstrate that piecemeal solutions are unacceptable.

Crisis Care as a Part of Mental Health Infrastructure

The tragedies and problems associated with inadequate crisis care have produced wounds in our national identity and revealed unacceptable chasms in care. These chasms are longstanding, having been made worse by deinstitutionalization and never filled in the 50+ years since President Kennedy's Community Mental Health initiative. Growth of some mental health services has undeniably occurred as

a result of parity legislation and coverage expansion. However, expanded coverage has not led to adequate crisis care, because crisis care must be built and paid for as part of mental health infrastructure.

Preventable Tragedies

An adequate crisis network is the first line of defense in preventing tragedies of public and patient safety, civil rights, extraordinary and unacceptable loss of lives, and the waste of resources. Tragedies like:

- Thousands of Americans dying alone and in desperation from suicide: In 2014, 42,773 people ended their life by suicide. Over the last 15 years, the rate of increase in suicide deaths exceeds the increase in every other leading form of death except Alzheimer's disease. In July 2015, the Action Alliance launched the Task Force, with the goal to provide stronger 24/7 supports to the 9 million Americans at risk each year. Over 115 people per day in the United States die alone and in despair.
- Unspeakable family pain: In November 2013, Virginia State Senator Creigh Deeds told CNN that he was alive for just one reason: to work for change in mental health. A week earlier, he was stabbed 10 times by his son, Austin "Gus" Deeds, who then ended his life by suicide. The incident happened hours after a mental health evaluation determined that Gus needed more intensive services. Unfortunately, he was released before the appropriate services could be found (http://bit.ly/cbs-deeds).
- Psychiatric "boarding": In October 2013, the *Seattle Times* concluded its investigation of the experience for individuals with mental health needs in EDs. "The patients wait on average three days—and in some cases months—in chaotic hospital EDs and ill-equipped medical rooms. They are frequently parked in hallways or bound to beds, usually given medication, but otherwise no psychiatric care (http://bit.ly/ST-boarding)." In 2014, the Washington State Supreme Court ruled the practice of "psychiatric boarding" unconstitutional (http://bit.ly/Forbes-SupremeCourt).
- The wrong care in the wrong place, delivered in a way that compromises other medical urgent care: In April 2014, California approved $75 million for residential and crisis stabilization and mobile support teams. This investment was based on the belief that 3 out of 4 visits to hospital EDs for mental health and addiction issues could be avoided with adequate community-based care (http://bit.ly/CA-crisiscare).
- Law enforcement working as "mobile crisis": Law enforcement resources in many communities are tied up delivering "substitute crisis care" because mental health crisis care is inadequate. The results have sometimes been tragic, have added to the stigma associated with mental illness, and have drawn police resources away from other priorities. A January 13, 2015, *New York Times* Op-Ed piece described the recent death of 19-year-old Quintonio LeGrier, who was shot and killed by a Chicago police officer a month earlier. The author links the death with recent substantial cutbacks in Illinois's troubled mental health system (including the closure of half of Chicago's mental health centers) and recommends that "we need to invest more broadly in a mental health crisis system to work in conjunction with the police" (http://bit.ly/OpEd-LeGrier).

Five compelling reasons for change. In this document, the Task Force will present solutions that work to address one of our most stubborn human problems.

Some States Are Making Progress

In a few states and communities across the United States, solutions are in place. *But until now we did not have the vision or will to approach crisis care with national resolve and energy.*

Systematic reform of crisis care has been or is being implemented in a number of states like California, Colorado, Georgia, and Washington State. These states were driven to new approaches for different reasons; however, their approaches share the four core, common elements presented earlier and are explained in further detail below:

1. **Regional or Statewide Crisis Call Centers**. These programs use technology for real-time coordination across a system of care and leverage big data for performance improvement and accountability across systems. At the same time, they provide high-touch support to individuals and families in crisis that adheres to National Suicide Prevention Lifeline (NSPL) standards.
2. **Centrally Deployed Mobile Crisis on a 24/7 Basis**. Mobile crisis offers outreach and support where people in crisis are. Programs should include contractually required response times and medical backup.
3. **Residential Crisis Stabilization Programs**. These programs offer short-term "sub-acute" care for individuals who need support and observation, but not ED holds or medical inpatient stay, at lower costs and without the overhead of hospital-based acute care.
4. **Essential Crisis Care Principles and Practices**. These must include a recovery orientation, trauma-informed care, significant use of peer staff, a commitment to Zero Suicide/Suicide Safer Care, strong commitments to safety for consumers and staff, and collaboration with law enforcement.

These core elements of comprehensive crisis care are drawn from well-established principles for emergency services, as well as new developments in technology and mental health care. Historically, the essential nature of crisis/emergency services was established when emergency services were designated one of five categories of "essential services" required to be offered by community mental health centers (CMHCs). These centers resulted from President Kennedy's 1963 Mental Retardation Facilities and Community Mental Health Centers Construction Act (Public Law 88-164).

The central mission of crisis services and the core elements described above are not new. In 1979, Massachusetts's Brewster v. Dukakis Consent Decree (76-4423, D. Mass., 1979) defined the *crisis intervention unit* required for each area as "a program designed to provide crisis intervention on a 24 hour a day, 7 days a week basis for up to five days, 24 hours a day to clients both new to the [mental health] system and those already receiving services" (p. 151). The program was intended to serve "clients who are acutely and severely disturbed, including those who may be dangerous to themselves

or others, extremely psychotic, intoxicated, or experiencing some severe life crises" and was to act as a gatekeeper for hospital care "for highly assaultive persons or those needing medical attention" (p. 151–152).

In addition to these long-established principles, the evolution of information and communications technology and of best practices in mental health care has led to newer elements of comprehensive crisis care that we can now define as essential:

- Harnessing Data and Technology. The Georgia Crisis and Access Line utilizes technology and secure Web interfaces to provide a kind of "air traffic control" (ATC) that brings big data to crisis care and provides the ability of real-time coordination. This essential capability could not have been envisioned a generation ago.
- Power of Peer Staff. PEOPLe, Inc.'s Living Room model, peer staffing, and the retreat model provide safety, relief, and recovery in an environment more like a home than an institution. The paradigm of recovery and the value of peers, highlighted in the Surgeon General's report on mental health (DHHS, 1999) and the report of the President's New Freedom Commission on Mental Health (DHHS, 2003), are now cornerstones of modern mental health care.
- Power of Going to the Person. Colorado mobile crisis teams do not wait for law enforcement to transport a person in need to the hospital. They go to the person. Colorado is the first state to prove this can be done everywhere, and in *any* area: urban, rural, and even frontier. Combining modern technology with the long-established value of care close to home, this approach is essential in modern crisis care (also, see the Action Alliance's *The Way Forward* report).
- Evidence-based Suicide Prevention. The effectiveness of high-quality crisis lines in suicide prevention has been well established (e.g., Gould et al., 2007). The nation has a national crisis line in the NSPL, but crisis care in many communities is lacking. Since the NSPL's network of qualified local crisis lines depends on state and local resources to fund participating centers, many parts of the United States do not have a local crisis line. Thus, many calls to the NSPL's 1-800-273-TALK (8255) number are answered in their regions or in a national call center, not in a local center where both crisis calls and in-person crisis support can be most effectively delivered.

These approaches to modern crisis care must be developed in every state. The systems blend both long established principles (regional or statewide 24/7 functioning, focus on urgent care for an entire population, use of structured alternatives to hospitalization) with new approaches that were not available or proven during President Kennedy's time (sophisticated communications, real-time data, and the proven power of peers to facilitate engagement and recovery). Table 1 demonstrates this.

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Big data and basic principles of coordination lead to an extraordinary level of safety for air travelers.

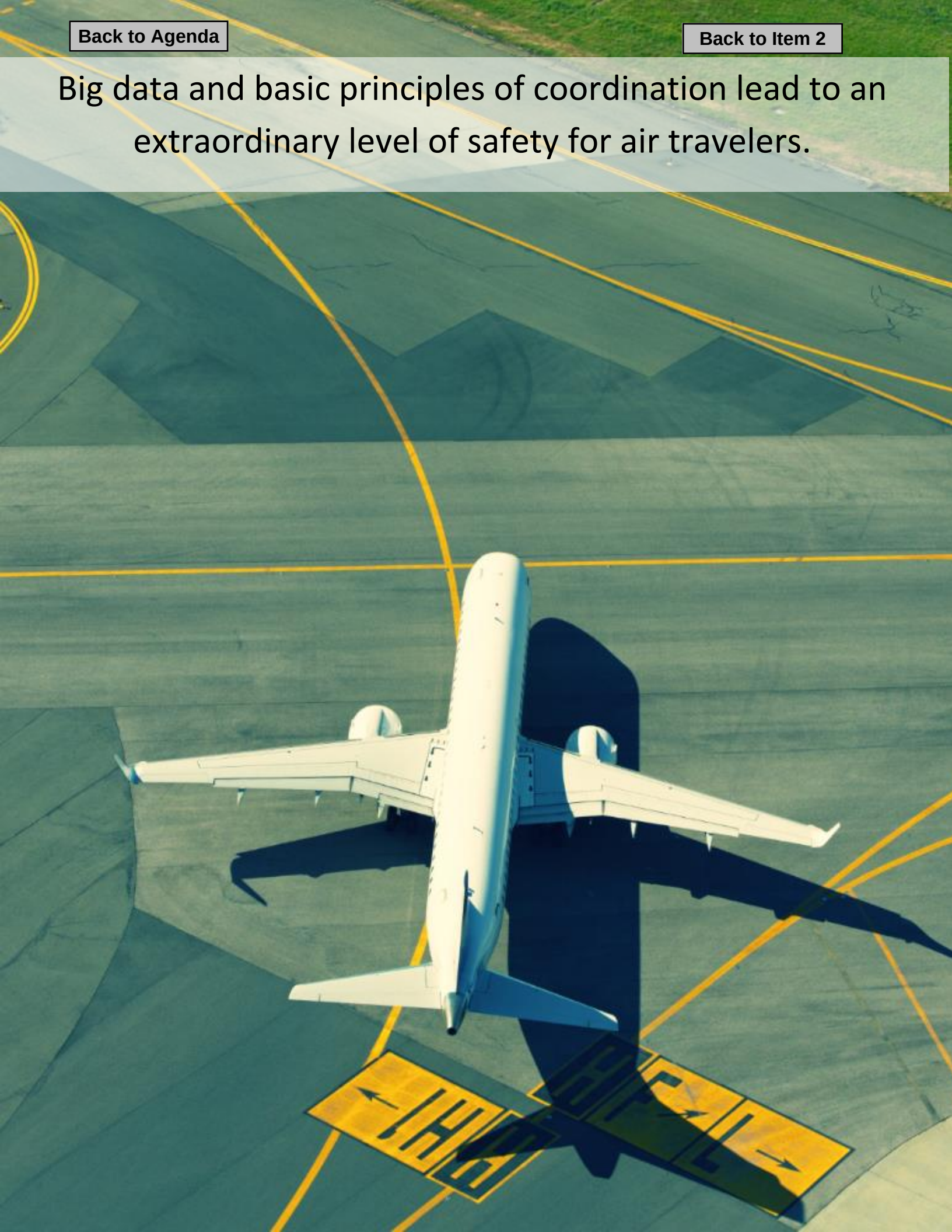

Table 1: Modern Crisis Care Changes the Paradigm

FROM	TO
Absence of data and coordination on ED wait times, access, crisis bed availability, and outcomes	Publically available data in real-time dashboards
"Cold" referrals to mental health care are rarely followed up, and people slip through the cracks	Direct connections and 24/7 real-time scheduling
EDs are the default mental health crisis center	Mobile crisis provides a response that often avoids ED visits and institutionalization
Crisis service settings have more in common with jails; police transport to distant hospitals takes law enforcement off the beat and is unpleasant and stigmatizing for people in crisis	Crisis service settings—the urgent care units for mental health—look more like home settings and also provide a reliable partner for law enforcement
Despair and isolation worsened by trying to navigate the mental health system maze	Crisis care with support and trust: what the person wants and needs, where the person wants and needs it

Our society takes for granted a national emergency medical response system. 911 centers use advanced technology to ensure individuals with *other medical problems* do not fall through the cracks. For example, using mobile scanners for immediate assessment that supports timely administration of clot-busting medications has transformed stroke and heart attack care. With emergency medical services in nearly every area of the country, ambulance services go to the person directly to ensure life-saving care for acute heart disease. If this can be done for heart disease and stroke—a brain condition—we can, and must, also do it for mental health crises.

This brings us to our first recommendation:

> *Recommendation 1: We recommend national-and state-level recognition that effective crisis care must be comprehensive and include the core elements listed above.*

Overview of the Report

In the sections that follow we summarize findings about the essential elements of effective, modern, and comprehensive crisis care, and the actions needed to bring it to communities across the United States. The following is an overview of the report.

- **Section 1:** Regional 24/7 clinically staffed hub/crisis call center that provides crisis intervention capabilities (telephonic, text, chat), meeting the standards of the NSPL and also providing ATC-quality coordination of crisis care, with real-time data management of:
    - Clients in crisis
    - Availability of outpatient and inpatient services in the area
    - Mobile crisis teams
    - Crisis stabilization programs
- **Section 2:** Mobile crisis teams available to reach any person in the service area in his or her home, workplace, or other convenient and appropriate setting
- **Section 3:** Crisis stabilization facilities providing short-term observation and support in a home-like, non-hospital environment
- **Section 4:** The essential qualities that must be "baked into" comprehensive crisis systems, including:
    - Embracing recovery, significant use of peers, and trauma-informed care
    - Suicide safer care, providing comprehensive crisis services that include all core elements described in this report
    - Safety and security for staff and consumers
    - Law enforcement and crisis response training and coordination
- **Section 5:** Financing crisis care, including a discussion of current payment/financing models, as well as opportunities and threats in the current environment
- **Section 6:** Strategic directions for crisis care

About the Task Force

This report, prepared by the Task Force of the Action Alliance, summarizes the status, needs, and opportunities for mental health crisis care. The Task Force was launched in July 2015 by the Action Alliance and was composed of 31 leaders in the field of crisis services (list of members is included at the end of this document). In preparing this report, which was reviewed by all members, the Task Force also considered a recent national review of key issues in crisis care, *Crisis Services: Effectiveness, Cost Effectiveness, and Funding Strategies* (Substance Abuse and Mental Health Service Administration, SAMHSA, 2014) for evidence of effectiveness and as a basis for recommendations on funding.

Our review has taught us that all the elements of excellent crisis care are proven and have been demonstrated as feasible in some communities. However, many essential elements are not available in most communities. Sadly, this gap is both fatal and expensive. It will only be filled by the efforts of both a united mental health community and leadership by elected and appointed officials.

In all the states that have achieved or are advancing comprehensive crisis care, the involvement of elected/appointed officials was crucial. Change was achieved with activating legislation in California and Colorado, engagement of governors in Colorado and Georgia, and prodding by the judicial branch (Department of Justice, Supreme Court) in Georgia and Washington State.

Section 1: Air Traffic Control (ATC) Capabilities with Crisis Line Expertise

As mentioned in the introduction, State Senator Creigh Deeds was stabbed by his son, Gus, who then took his own life by suicide. Shortly before, Gus had been assessed at a local hospital and a magistrate had ordered an involuntary commitment, but no beds were available at any nearby inpatient psychiatric hospitals, so Gus was sent home (Gabriel, 2013). Sadly, it is common for individuals in mental health crisis to initially be assessed, but then later be released, only to "fall through the cracks" (http://bit.ly/CNN-Deeds).

The cracks occur because of interminable delays for services deemed essential based on professional assessments and are often attributable to two critical gaps, including the absence of:

1. Real-time coordination of crisis and outgoing services
2. Linked, flexible services specific to crisis response, namely mobile teams and crisis stabilization facilities

Because of these gaps, individuals walk out of an ED often "against medical advice" and disappear until the next crisis occurs.

Making the Case for a Close and Fully Integrated Crisis Services Collaboration

Prior to 2000, there were several hundred local crisis call centers across the country, underfunded, fragmented, and lacking in credibility with policymakers and funders. Staffed with dedicated volunteers, these poorly funded programs lacked the technology, data-tracking tools, and consistent protocols needed to effectively perform their work. In some larger communities with strong community mental health programs, crisis call centers were part of or strongly linked to mental health crisis care programs. But many communities lacked comprehensive crisis services, and advocates questioned the value and effectiveness of crisis call centers.

The nation's approach to crisis call centers received a significant upgrade starting in 2004 with creation of the NSPL. Over time, the NSPL has demonstrated its effectiveness and raised the performance bar for crisis call centers.

Comprehensive crisis systems are necessary to prevent avoidable tragedies and to orchestrate effective care. It is time to establish crisis systems as essential in a system of care, and to raise the bar on their functioning, to achieve a different set of results.

> *Recommendation 2: Crisis call services should participate in and meet the standards of the NSPL, and crisis intervention systems should adopt and implement Zero Suicide/Suicide Safer Care across all program elements.*

However, two critical problems remain. First, in many parts of the United States, there is no qualified crisis call center, thus calls roll over to a regional or national center, which may be in a different state. Second, in most communities there is not a comprehensive crisis care system that includes or is linked with ATC-like capabilities to the local call center.

ATC systems provide a meaningful point of reference for the necessity of national availability of service, with consistent standards and functioning. The ATC analogy teaches us important lessons in the value of real-time, technology-driven coordination and collaboration. Adopting an ATC model for crisis services could significantly reduce the incidence of suicide by individuals in crisis.

Learning from ATC Safety

ATC works to ensure the safety of nearly 30,000 U.S. commercial flights per day. In the United States this occurs with a very high success rate. ATC makes it remarkably safe to fly today.

But it can be very unsafe for an individual experiencing a mental health crisis.

The advancements in ATC that have helped transform aviation safety are two vitally important objectives, and without them it is nearly impossible to avoid tragedy:

- Objective #1: Always know where the aircraft is (in time and space) and never lose contact.
- Objective #2: Verify the hand-off has occurred and the airplane is safely in the hands of another controller.

These objectives easily translate to behavioral health and to a crisis system of care in particular. Always knowing where an individual in crisis is and verifying that the hand-off has occurred to the next service provider seem like relatively easy objectives to fulfill, yet they are missing from most of the U.S. behavioral health and crisis systems. Individuals and families attempting to navigate the behavioral health system, typically in the midst of a mental health or addiction crisis, should have the same diligent standard of care that ATC provides.

The ATC Model for Crisis Services

This model used within integrated crisis call centers creates a professional framework for all levels of crisis services. It provides a hub for effective deployment of mobile crisis and for ensuring timely, appropriate access to facility services like crisis stabilization and crisis respite, and ultimately psychiatric hospitalization. Furthermore, this model is considered a part of the whole, integrated crisis system of care. It identifies the next generation of integrated crisis systems and the essential components that are required, including:

- Qualified crisis call centers that meet the standards of and participate in the NSPL
- 24/7 clinical coverage with an identifiable single contact point covering a defined region

- The ability to deploy mobile crisis services, with control over access to a sufficient range and diversity of sub-acute alternatives (respite, etc.), and the ability to secure same-day/next-day outpatient clinical services
- Clinically sufficient personnel to make triage decisions, preferably including control of acute inpatient access
- Clear expectations for outpatient clinical providers that interface with crisis care of routine emergent care

> *Note: The ATC approach does not imply a belief that human beings can be routed like objects, nor is it an effort to force a one-size-fits-all approach on unique geographies, demographics, funding streams, and behavioral health care systems. Rather, it ensures no individual gets "lost" in the system.*

Required Core Elements of an ATC Model Crisis System of Care

The "front door" of a modern crisis system is a crisis call center that meets NSPL standards and participates in the national network. Since 2005, SAMHSA has funded multiple research projects to evaluate the critical role of crisis call centers as indispensable resources for suicide prevention. Nationally more than 160 call centers meet the standards of and participate in the NSPL.

However, in many regions of the country—just as other crisis intervention programs like mobile teams are absent—there is no qualified call center, and calls from distressed people are routed to centers in other states. The Veterans Administration (VA) system, with its own national call center and national network of facilities, is a partial exception to this rule, although travel times to VA facilities in many parts of the country are excessive.

It is no longer acceptable for there to be no local access to a competent call center. Ideally, each call center is embedded in a comprehensive crisis system with ATC capabilities.

The system should provide electronic interconnectedness in the form of secure HIPAA-compliant, easy-to-navigate, Web-based interfaces and community partner portals to support communication between support agencies (including EDs, social service agencies, and community mental health providers) with intensive service providers (such as acute care psychiatric inpatient, community-based crisis stabilization, inpatient detoxification, and mobile crisis response services).

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Ubiquitous and inexpensive technology is changing nearly every other industry. It’s time for the same in crisis services.

Interfaces should also include Web-based submission forms for use by collaborating agencies to support mobile crisis dispatch, electronically scheduled referrals by hospitals as a part of discharge planning, and managed care and/or authorization requirements.

An ideal system would provide functionality described in the following sub-sections.

Status Disposition for Intensive Referrals
There must be shared tracking of the status and disposition of linkage/referrals for individuals needing intensive service levels, including requirements for service approval and transport, shared protocols for medical clearance algorithms, and data on speed of accessibility (average minutes until disposition). The program should take advantage of sophisticated software to help crisis professionals assess and engage those at risk and track individuals throughout the process, including where they are, how long they have been waiting, and what specifically is needed to advance them to service linkage. Some systems display names on a pending linkage status board, highlighted in green, white, yellow, or red, depending on how long they have been waiting.

24/7 Outpatient Scheduling
Crisis staff should be able to schedule intake and outpatient appointments for individuals in crisis with providers across the state while providing data on speed of accessibility (average business days until appointment).

Shared Bed Inventory Tracking
An intensive services bed census is required, showing the availability of beds in crisis stabilization programs and 23-hour observation beds, as well as in private psychiatric hospitals, with interactive two-way exchange (individual referral editor, inventory/through-put status board).

High-tech, GPS-enabled Mobile Crisis Dispatch
Mobile crisis teams should use GPS-enabled tablets or smart phones to quickly and efficiently determine the closest available teams, track response times, and ensure clinician safety (time at site, real-time communication, safe driving, etc.).

Real-time Performance Outcomes Dashboards
These are outwardly facing performance reports measuring a variety of metrics such as call volume, number of referrals, time-to-answer, abandonment rates, and service accessibility performance. When implemented in real time, the public transparency provides an extra layer of urgency and accountability.

Recommendation 3. State and national authorities should review the core elements of Air Traffic Control qualified crisis systems, apply them to crisis care in their jurisdictions, and commit to achieving these capabilities within 5 years, so that each region of the United States has a qualified hub for crisis care.

A Continuum of Care

In 2010, the Milbank Memorial Fund published the landmark *Evolving Models of Behavioral Health Integration in Primary Care*, which included a continuum from "minimal" to "close and fully integrated" that would establish the gold standard for effective planned care models and change the views of acceptable community partnership and collaboration (http://bit.ly/MilbankContinuum). Prior to this, coordination among behavioral health and primary care providers had frequently been minimal or non-existent, and it would have been easy to accept any improvement as praiseworthy.

The Milbank report portrayed close agency-to-agency collaboration (evidenced by personal relationships of leaders, Memorandums of Understanding (MOUs), shared protocols, etc.) at the lowest levels of the continuum and insufficient. It described these community partnerships and their coordination as minimal or basic, citing only sporadic or periodic communication and inconsistent strategies for care management and coordination. Even organizations with numerous close relationships can be extremely inefficient and ineffective when clinical care relies on telephonic coordination of care (voicemails, phone tag, etc.). It called for frame-breaking change to the existing systems of care, and its report continues to reverberate throughout the implementation of integrated care.

A modification of the Milbank collaboration continuum provides a standard for evaluating crisis system community coordination and collaboration, as shown in Table 2 (http://bit.ly/crisiscontinuum).

Table 2: Continuum to Evaluate Crisis Systems and Collaboration

← CRISIS SYSTEM COMMUNITY COORDINATION & COLLABORATION CONTINUUM→				
Level 1 **MINIMAL** *Agency Relationships*	*Level 2* **BASIC** *Shared MOU Protocols*	*Level 3* **BASIC** *Formal Partnerships*	*Level 4* **CLOSE** *Data Sharing (Not 24/7 or Real-Time)*	*Level 5* **CLOSE** *"ATC Connectivity"*

In this model, the highest level requires shared protocols for coordination and care management that are supported in real time by electronic processes. For a crisis service system to provide Level 5 close and fully integrated care, it must implement an integrated suite of software applications that employ online, real-time, and 24/7 ability to communicate about, update, and monitor available resources in a network of provider agencies.

Given the now-established value of high-quality crisis call centers to support many individuals who may be suicidal or distressed, but who do not need or may not prefer face-to-face care, integration of crisis call centers as the telephonic hub of crisis care is a powerful and effective approach.

Section 1 Conclusion

Statewide community collaboration for Level 5 crisis systems of care is needed. The approaches described above are not theoretical or hypothetical; they have been employed on a statewide basis for nearly eight years in Georgia. New Mexico and Idaho added statewide crisis and access lines in 2013; Colorado launched its statewide system in 2014.

In most U.S. locations, the crisis system is not able to properly track individuals receiving services, from their entry into the system—whether via an ED, a mobile crisis team, a crisis hotline, or a walk-in clinic—to their discharge. It is typical for hand-offs to occur throughout an individual's experience in the crisis system. In a system without close, full integration supported by electronic communication, updates, and monitoring, individuals are too likely to fall through the cracks. The consequences of losing track of people who are in a crisis situation can be disastrous, including potential harm to self and to others.

Section 2: Community-Based Mobile Crisis Teams

Since the 1970s, community-based mobile crisis services have been a core component of crisis care systems. These services emerged in response to the mental health center movement of the 1960s and comprised significant changes in the treatment of people with mental illness (Ruiz et al., 1973).

What is Mobile Crisis?

Community-based mobile crisis services use face-to-face professional and peer intervention, deployed in real time to the location of a person in crisis, in order to achieve the needed and best outcomes for that individual. Since the mid-2000s many metropolitan area mobile crisis programs have used GPS programming for dispatch in a fashion similar to Uber, identifying the location of teams by GPS signal and then determining which team can arrive at the location of an individual in crisis the quickest.

Most community-based mobile crisis programs utilize teams that include both professional and paraprofessional staff, for example, a Master's- or Bachelor's-level clinician with a peer support specialist and the backup of psychiatrists or other Master's-level clinicians. Peer support workers often take the lead on engagement and may also assist with continuity of care by providing support that continues past the crisis period.

Goals of Community-based Mobile Crisis Programs

According to SAMHSA's recent report on crisis care (2014, p. 10):

> *The main objectives of mobile crisis services are to provide rapid response, assess the individual, and resolve crisis situations that involve children and adults who are presumed or known to have a behavioral health disorder (Allen et al., 2002; Fisher, Geller, and Wirth-Cauchon, 1990; Geller, Fisher, and McDermeit, 1995). Additional objectives may include linking people to needed services and finding hard-to-reach individuals (Gillig, 1995). The main outcome objective of mobile crisis teams is to reduce psychiatric hospitalizations, including hospitalizations that follow psychiatric ED admission.*

Community-based mobile crisis programs exist in the majority of states, but few have statewide coverage. While terms describing mobile crisis care differ, these programs share common goals to:

1. Help individuals experiencing a crisis event to experience relief quickly and to resolve the crisis situation when possible
2. Meet individuals in an environment where they are comfortable
3. Provide appropriate care/support while avoiding unnecessary law enforcement involvement, ED use, and hospitalization

Evidence of Mobile Crisis Team Effectiveness and Cost-Effectiveness

SAMHSA's same report confirmed previous evidence on the effectiveness of mobile crisis service:

> *Four studies were identified with empirical evidence on the effectiveness of mobile crisis services: one randomized controlled trial (Currier et al., 2010) and three that used quasi-experimental designs (Guo, Biegel, Johnsen, and Dyches, 2001; Hugo, Smout, and Bannister, 2002; Scott, 2000; Dyches, Biegel, Johnsen, Guo, and Min, 2002). The studies suggest that mobile crisis services are effective at diverting people in crisis from psychiatric hospitalization, effective at linking suicidal individuals discharged from the emergency department to services, and better than hospitalization at linking people in crisis to outpatient services.*

SAMHSA (p. 15) summarized the cost-effectiveness of mobile crisis, as well:

> *Scott (2000) analyzed the effectiveness and efficiency of a mobile crisis program by comparing it to regular police intervention. The average cost per case was $1,520 for mobile crisis program services, which included $455 for program costs and $1,065 for psychiatric hospitalization. For regular police intervention, the average cost per case was $1,963, which consisted of $73 for police services and $1,890 for psychiatric hospitalization. In this study, mobile crisis services resulted in a 23 percent lower average cost per case. In another study analyzing the cost impact of mobile crisis intervention, Bengelsdorf et al., (1987) found that mobile crisis intervention services can reduce costs associated with inpatient hospitalization by approximately 79 percent in a six-month follow-up period after the crisis episode.*

Task Force Findings on Mobile Crisis Services

After reviewing previous reports and research on mobile crisis programs and considering model programs, the Task Force finds mobile crisis services accomplish a wide range of tasks and are a necessary, core component of a well-integrated crisis system of care. To maximize effectiveness, the availability of mobile crisis services should match needs in the area/region they serve on a 24/7/365 basis and should be deployed and monitored by an ATC-capable regional call center.

Further, the Task Force recommends that essential functions of mobile crisis services should include triage/screening, including explicit screening for suicidality; assessment; de-escalation/resolution; peer support; coordination with medical and behavioral health services; and crisis planning and follow-up.

Triage/Screening

As most mobile crisis responses are initiated via phone call to a hotline or provider, the initial step in providing community-based mobile crisis services is to determine the level of risk faced by the individual in crisis and the most appropriate mobile crisis team. In discussing the situation with the caller, the mobile crisis staff must decide if emergency responders should be involved.

For example, if the person describes a serious medical condition or indicates that he or she poses an imminent threat of harm, the mobile crisis team should coordinate with emergency responders. The mobile crisis team can meet emergency responders at the site of the crisis and work together to resolve

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It’s time for a national ***mental health*** Emergency Medical Services (EMS) system.

the situation. Explicit attention to screening for suicidality using an accepted, standardized suicide screening tool should be a part of triage.

Assessment

The behavioral health professional (BHP) on the mobile crisis team is responsible for completing an assessment. Specifically, the BHP should address:

- Causes leading to the crisis event, including psychiatric, substance abuse, social, familial, and legal factors
- Safety and risk for the individual and others involved, including an explicit assessment of suicide risk
- Strengths and resources of the person experiencing the crisis, as well as those of family members and other natural supports
- Recent inpatient hospitalizations and/or current relationship with a mental health provider
- Medications and adherence
- Medical history

Task Force Spotlight

Becky Stoll, LCSW, VP for Crisis & Disaster Management

Centerstone offers a comprehensive crisis system in 20 counties of Middle Tennessee. The entryway is via a 24/7 virtual Crisis Call Center. Staff work from home with telephonic crisis intervention and follow-up, silent monitoring, call recording, and supervision. Centerstone operates three Mobile Crisis Outreach Teams (MCOT) that respond to any location where an individual is experiencing a behavioral health crisis, regardless of payer status. Many assessments occur in local EDs. In partnership with the Healthcare Corporation of America and the Tennessee Department of Mental Health and Substance Abuse Services, Centerstone provides crisis assessments in many locations via telehealth.

De-escalation and Resolution

Community-based mobile crisis teams engage individuals in counseling throughout the encounter and intervene to de-escalate the crisis. The goal is not just to determine a needed level of care to which the individual should be referred, but to resolve the situation so a higher level of care is not necessary.

Peer Support

According to SAMHSA (2009, p. 8), mental health crisis services "should afford opportunities for contact with others whose personal experiences with mental illness and past mental health crises allow them to convey a sense of hopefulness first-hand. In addition, peers can offer opportunities for the individual to connect with a supportive circle of people who have shared experiences—an option that may have particular relevance given feelings of isolation and fear that may accompany a mental health crisis" (see Significant Role for Peers in Section 4).

For community-based mobile crisis programs, including peers can add complementary qualifications to the team so that individuals in crisis are more likely to see someone they can relate to while they are receiving services. Peers should not reduplicate the role of BHPs but instead should establish rapport, share experiences, and strengthen engagement with individuals experiencing crisis. They may also

engage with the family members of (or other persons significant to) those in crisis to educate them about self-care and ways to provide support.

Coordination with Medical and Behavioral Health Services

Community-based mobile crisis programs, as part of an integrated crisis system of care, should focus on linking individuals in crisis to all necessary medical and behavioral health services that can help resolve the situation and prevent future crises. These services may include crisis stabilization or acute inpatient hospitalization, treatment in the community (e.g., CMHCs, in-home therapy, family support services, crisis respite services, and therapeutic mentoring).

Crisis Planning and Follow-Up

SAMHSA's essential values for responding to mental health crisis include prevention. "Appropriate crisis response works to ensure that crises will not be recurrent by evaluating and considering factors that contributed to the current episode and that will prevent future relapse. *Hence, an adequate crisis response requires measures that address the person's unmet needs, both through individualized planning and by promoting systemic improvements*" (SAMHSA, 2009: p. 7, emphasis in the original). During a mobile crisis intervention, the BHP and peer support professional should engage the individual in a crisis planning process, which can result in the creation or update of a range of planning tools including a safety plan.

When indicated, they should then follow up with individuals to determine if the service or services to which they were referred was provided in a timely manner and is meeting their needs. For example, Behavioral Health Response (BHR) in St. Louis has a follow-up program in which eligible crisis callers receive a follow-up call within 48 hours by a follow-up coordinator who continues to ensure support, safety, assistance with referrals and/or follow-up until the crisis is resolved or the individual is linked to other services.

Section 2 Conclusion

Community-based mobile crisis is an integral part of a crisis system of care. Mobile crisis interventions provide individuals with less restrictive care in a more comfortable environment that is likely to produce more effective results than hospitalization or ED utilization. When collaboration exists with hospitals, medical and behavioral health providers, law enforcement, and other social services, community-based mobile crisis is an effective and efficient way of resolving mental health crisis and preventing future crisis situations.

> *Recommendation 4: State and national authorities should work to ensure that mobile crisis teams capable of providing the functions we cite are available to each part of every state.*

Section 3: Crisis Stabilization Facilities/Settings

Many individuals in crisis brought to hospital EDs for stabilization report experiencing increased distress and worsening symptoms due to noise and crowding, limited privacy in the triage area, and being attended to by staff who had little experience with psychiatric disorders. All of this increases frustration and agitation (Clarke et al., 2007). Agar-Jacomb and Read (2009) found individuals who had received crisis services preferred going to a safe place, speaking with peers and trained professionals who could understand what they were experiencing, and interacting with people who offered respect and dignity to them as individuals, an experience they did not have at the hospital. In such an alternative setting, psychiatric crises could be de-escalated.

What are Crisis Stabilization Facilities?

In its recent review of crisis services, SAMHSA (2014) defined crisis stabilization as:

> *A direct service that assists with deescalating the severity of a person's level of distress and/or need for urgent care associated with a substance use or mental health disorder. Crisis stabilization services are designed to prevent or ameliorate a behavioral health crisis and/or reduce acute symptoms of mental illness by providing continuous 24-hour observation and supervision for persons who do not require inpatient services. Short-term crisis residential stabilization services include a range of community-based resources that can meet the needs of an individual with an acute psychiatric crisis and provide a safe environment for care and recovery" (page 9).*

Crisis residential facilities are usually small (e.g., 6–16 beds), and often more home-like than institutional. They are staffed with a mix of professionals and paraprofessionals. They may operate as part of a community mental health center or in affiliation with a hospital. The Task Force recommends crisis stabilization facility function is maximized when the facilities:

- Function as an integral part of a regional crisis system serving a whole population rather than as an offering of a single provider
- Operate in a home-like environment
- Utilize peers as integral staff members
- Have 24/7 access to psychiatrists or Master's-level mental health clinicians

Evidence on Effectiveness and Cost-Effectiveness of Crisis Stabilization Facilities

In general, the evidence suggests a high proportion of people in crisis who are evaluated for hospitalization can safely be cared for in a crisis facility, the outcomes for these individuals are at least

as good as hospital care, and the cost of crisis care is substantially less than the costs of inpatient care. In its recent review, SAMHSA (2014) summarizes evidence on crisis stabilization facilities as follows:

> *The current literature generally supports that crisis residential care is as effective as other longer psychiatric inpatient care at improving symptoms and functioning. It also demonstrates that the satisfaction of these services is strong, and the overall costs for residential crisis services are less than traditional inpatient care. For the studies examined in this review, the populations range from late adolescence (aged 16–18 years) through adulthood. Regarding mental health and crisis residential, a recent systematic review examined the effectiveness of residential alternatives to hospital inpatient services for acute psychiatric conditions (Lloyd-Evans, et al., 2009). This review included randomized control trials or studies that provided specific quantitative comparisons of effectiveness of alternatives to standard acute inpatient care. The authors concluded that there is preliminary evidence to suggest that residential alternatives may be as effective and potentially less costly than standard inpatient units (pages 9–10).*

Task Force Findings on Crisis Residential Facilities

After reviewing prior reports and research and considering presentations on model programs, the Task Force recommends that small, home-like crisis residential facilities are a necessary, core element of a crisis system of care.

To maximize their usefulness, crisis residential facilities should function as part of an integrated regional approach within a state serving a defined population (as with mobile crisis teams). Access to the program should be facilitated through the ATC-capable hub of the regional system.

The Task Force also notes two of the most exciting new approaches to crisis residential services: the "living room" and peer-operated respite.

The "Living Room" Model

Ashcraft (2006) and Heyland et al. (2013) describe an alternative crisis setting called "the living room," which uses a different recovery model to support an individual's stabilization and return to active participation in the community. Key elements include a welcoming and accepting environment, which conveys hope, empowerment, choice, and higher purpose.

Individuals in crisis are admitted as "guests" into a pleasant, home-like environment designed to promote a sense of safety and privacy. A team of "crisis competent" professionals, including peers with lived experience (individuals with first-person knowledge of receiving services and/or experiencing mental health, suicidal and/or addiction experiences), engages with the guest. Risk assessment and management, treatment planning, and discharge goals are set. A peer counselor is assigned to each guest to discuss any crisis and coping skills that can be used to reduce distress and empower the guest on his or her recovery journey.

In some communities, “living rooms”/crisis respite facilities are available for direct drop-off by trained law enforcement teams (see discussion below). This advanced practice can avoid both criminalization of crisis-induced behavior and the costs and potential trauma associated with hospitalization. If it is determined a guest continues to pose a safety threat to self or others, he or she may be transferred to a more intensive level of care.

Peer-Operated Respite

The second new and very promising model of crisis facilities is peer-operated respite. Peer-operated/governed respite programs function at the intersection of the consumer/independent living movement and the professional behavioral health system. They provide restful, voluntary sanctuary for people in crisis, which is preferred by guests and increasingly valued in service systems. A 2013 survey by Ostrow found 13 such facilities around the country, with others planned in 12 states. In some cases, these facilities are part of a local array of peer-operated support activities. At Rose House (2 facilities in New York State), analysis showed costs of peer respite stays were 30% the cost of inpatient care. The Task Force finds that peer-operated respite facilities are a valuable alternative. Ideally, there should be one respite alternative in every crisis care system.

> *Recommendation 5: After reviewing the findings about effectiveness and the cost-sensitive nature of crisis respite care, the Task Force recommends that these alternatives to hospitalization be made available as a core component of comprehensive crisis systems in every state.*

Section 3 Conclusion

Many communities have only two basic options available to those in crisis, and they represent the lowest and highest end of the continuum. But for those individuals whose crisis represents the middle of the ladder, outpatient services are not intensive enough to meet their needs, and acute care inpatient services are unnecessary. Crisis stabilization facilities offer an alternative that is less costly, less intrusive, and more easily designed to feel like home.

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Carolinas HealthCare’s Charlotte crisis facility was designed with safety, privacy, and trauma-informed care principles.

Section 4: Core Principles and Practices of Modern Crisis Care

The Task Force recommends several additional elements that must be systematically "baked in" to excellent crisis systems in addition to the core structural elements that we find essential for modern crisis systems (ATC capabilities, mobile crisis teams, and crisis residential facilities). These essential principles and practices are:

- Embracing recovery
- Significant role for peers
- Trauma-informed care
- Suicide safer care
- Safety/security for staff and consumers
- Crisis response partnerships with law enforcement

Embracing Recovery

The fact that recovery is possible—and the realization that recovery means not just absence of symptoms, but also development of meaning and purpose in life—has begun to transform mental health care (Anthony, 1993). The President's New Freedom Commission on Mental Health (Hogan, 2003) recommended that mental health care be "recovery-oriented" and enriched by person-centered approaches, a hopeful and empowering style, and increased availability of support by individuals with lived experience.

The Task Force found that the significance of a recovery-oriented approach is elevated for individuals in crisis, and thus for crisis settings. In an outmoded, traditional model, crises reflect "something wrong" with the individual. Risk is seen as something to be contained, often through involuntary commitment to an inpatient setting. In worst-case situations, this obsolete approach interacts with inadequate care alternatives, resulting in people restrained on emergency room gurneys or transferred to jails because of their behavior.

In a recovery-oriented approach to crisis care, the risks of harm to self or others are recognized, but the basic approach is fundamentally different. Crises are viewed as challenges that may present opportunities for growth. When crises are managed in comfortable and familiar settings, people feel less alone and isolated with their feelings of anxiety, panic, depression, and frustration. This creates a sense of empowerment and belief in one's own recovery and ability to respond effectively to future crises. The Task Force finds that a recovery-oriented approach to crisis care is integral to transforming a broken system. Not only must we expand crisis care, but we must forge a better approach to crisis care.

Significant Role for Peers

One specific, transformative element of recovery-oriented care is to fully engage the experience, capabilities, and compassion of people who have experienced mental health crises. Including peers as

core members of the crisis team and in all elements of the crisis system recognizes that individuals with lived experience could "take all of [their] experiences, regardless of the pain, and use them to transform [their] life into 'living hope' for others who want to recover" (Ashcraft, Zeeb, & Martin, 2007).

Analyses investigating peer services and supports have found support for a range of peer support models. Benefits include strengthened hope, relationship, recovery, and self-advocacy skills and improved community living skills (Landers & Zhou, 2011).

Using peers—especially people who have experienced suicidality and suicide attempts and learned from these experiences—can be a safe and effective program mechanism for assessing and reducing suicide risk for persons in crisis. Peer intervention in the crisis setting with suicidal individuals is particularly potent in light of the reported 11%–50% range of attempters who refuse outpatient treatment or abandon outpatient treatment quickly following ED referral (Kessler et al., 2005). Peers can relate without judgment, can communicate hope in a time of great distress, and can model the fact that improvement and success are possible. This increases engagement while reducing distress.

The role of peers—specifically survivors of suicide attempts as well as survivors of suicide loss—was bolstered when the Action Alliance's Suicide Attempt Survivors Task Force released its groundbreaking report, *The Way Forward: Pathways to hope, recovery, and wellness with insights from lived experience*, in July 2014 (http://bit.ly/AA-wayforward). The report describes the many ways in which learning from and capitalizing on lived experience can be accomplished. This Task Force endorses recommendations of *The Way Forward* and finds that including individuals with lived experience in many roles in crisis care settings is effective. Further, taking this step will result in improved risk management and support for people with suicidal thoughts and feelings.

Task Force Spotlight

Shannon Jaccard, MBA, CEO

The San Diego affiliate of NAMI began in the early 1970s as a group called "Parents of Adult Schizophrenics." Over the decades, it has found that a Family Support Specialist is an invaluable resource to those whose family member is in crisis, and adjunct to peer support. It is designing a program with coaches to help family members navigate next steps immediately following an involuntary commitment in which the loved one is forcibly removed from the home by law enforcement. These services are especially important if it is the first experience with psychosis.

Trauma-Informed Care

The great majority of individuals served in mental health and substance use services have experienced significant interpersonal trauma. The adverse effects of child trauma may present well into adulthood, increasing the risk for post-traumatic stress disorder (PTSD), mental illness, substance abuse, and poor medical health in these individuals (Finkelhor et al., 2005). Persons with history of trauma or trauma exposure were more likely to engage in self-harm and suicide attempts as well, and their trauma experiences make them very sensitive to how care is provided.

A first implication is that mental health crises and suicidality often are rooted in trauma. These crises are compounded when crisis care involves loss of freedom, noisy and crowded environments, and/or the use of force. These situations can actually re-traumatize individuals at the worst possible time, leading to worsened symptoms and a genuine reluctance to seek help in the future.

On the other hand, environments and treatment approaches that are safe and calm can facilitate healing. Thus, the Task Force finds that trauma-informed care is an essential element of crisis treatment. In 2014, SAMHSA posited five guiding principles for trauma-informed care:

1. Safety
2. Trustworthiness and transparency
3. Peer Support and mutual self-help
4. Collaboration and mutuality
5. Empowerment, voice and choice
6. Cultural, historical and gender issues

These principles should inform treatment and recovery services. If such principles and their practice are evident in the experiences of staff as well as consumers, the program's culture is trauma-informed and will screen for trauma exposure in all clients served, as well as examine the impact of trauma on mental and physical well-being. Addressing the trauma that family and significant others have experienced is also a critical component that assists stabilization and reduces the possibility for further trauma or crisis.

Trauma-informed systems of care ensure these practices are integrated into service delivery. Developing and maintaining a healthy environment of care also requires support for staff, who may have experienced trauma themselves. An established resource for further understanding trauma-informed care is provided by SAMHSA (2014): *Trauma-Informed Care in Behavioral Health Services* (TIP 57).

The Task Force finds that trauma-informed care is urgently important in crisis settings because of the links between trauma and crisis, and the vulnerability of people in crisis (especially those with trauma histories).

Zero Suicide/Suicide Safer Care

Crisis intervention programs have *always* focused on suicide prevention. This stands in contrast to other health care and even mental health service, where suicide prevention was not always positioned as a core responsibility. This has begun to change, largely through the efforts of the Action Alliance.

One of the first task forces of the Action Alliance was the Clinical Care and Intervention (CCI) Task Force. Its report, *Suicide Care in Systems Framework* (2012), suggested transformational change in health care on two dimensions: adopting suicide prevention as a core responsibility, and committing to dramatic reductions in suicide among people under care. These changes were adopted and advanced in the

revised *National Strategy for Suicide Prevention* (2012), specifically via a new Goal 8: "Promote suicide prevention as a core component of health care services" (p. 51).

The recommendations of the CCI Task Force have now been translated into a set of evidence-based actions (together known as Zero Suicide or Suicide Safer Care) that health care organizations can implement to work more systematically on this goal. An implementation toolkit for health care organizations has been developed (see http://zerosuicide.sprc.org/toolkit) by the Suicide Prevention Resource Center (SPRC) at Education Development Center, Inc. (EDC), and several hundred health and behavioral health organizations are implementing the approach.

The seven key elements of Zero Suicide or Suicide Safer Care are all applicable to crisis care:

- Leadership-driven, safety-oriented culture committed to dramatically reducing suicide among people under care, which includes survivors of suicide attempts and suicide loss in leadership and planning roles
- Develop a competent, confident, and caring work force
- Systematically identify and assess suicide risk among people receiving care
- Ensure every individual has a pathway to care that is both timely and adequate to meet his or her needs and that includes collaborative safety planning and reducing access to lethal means
- Use effective, evidence-based treatments that directly target suicidal thoughts and behaviors
- Provide continuous contact and support, especially after acute care
- Apply a data-driven quality improvement approach to inform system changes that will lead to improved patient outcomes and better care for those at risk

See more at http://zerosuicide.sprc.org/about

It should be noted that the elements of zero suicide closely mirror the standards and guidelines of the NSPL, which has established suicide risk assessment standards, guidelines for callers at imminent risk, protocols for follow-up contact after the crisis encounter, and has promoted collaborative safety planning, reducing access to lethal means, and incorporating the feedback of suicide loss and suicide attempt survivors.

Given that crisis intervention programs have always focused on suicide prevention, how do these developments affect crisis intervention services? The Task Force has made two findings related to this question.

First, since comprehensive crisis intervention systems are the most urgently important clinical service for suicide prevention, and since this report confirms most parts of the country do not have adequate crisis care, we find a national- and state-level commitment to implementing comprehensive crisis services as defined in this report is foundational to suicide prevention. Comprehensive crisis

intervention systems must include all of the core elements and core principles and practices that we discuss.

Second, although suicide prevention is central to crisis services, the Task Force finds best practices in suicide care (for clinical settings, "Zero Suicide") have not been implemented uniformly in all crisis settings. Additionally, these best practices in suicide care are not yet required by health authorities (i.e., payers, plans, state agencies, Medicaid and Medicare).

Safety/Security for Consumers and Staff

Safety for both consumers and staff is a foundational element for all crisis service settings. Crisis settings are also on the front lines of assessing and managing suicidality, an issue with life and death consequences. And while ensuring safety for people *using* crisis services is paramount, the safety for staff cannot be compromised.

People in crisis may have experienced violence or acted in violent ways, they may be intoxicated or delusional, and/or they may have been brought in by law enforcement, and thus may present an elevated risk for violence.

Trauma-informed and recovery-oriented care is safe care. But much more than philosophy is involved. DHHS's Mental Health Crisis Service Standards (2006) begin to address this issue, setting parameters for crisis services that are flexible and delivered in the least restrictive available setting while attending to intervention, de-escalation, and stabilization.

The keys to safety and security in crisis delivery settings include:

- Evidence-based crisis training for all staff.
- Role-specific staff training and appropriate staffing ratios to number of clients being served.
- A non-institutional and welcoming physical space and environment for persons in crisis, rather than Plexiglas "fishbowl" observation rooms and keypad-locked doors. This space must also be anti-ligature sensitive and contain safe rooms for people for whom violence may be imminent.
- Established policies and procedures emphasizing "no force first" prior to implementation of safe physical restraint or seclusion procedures.
- Pre-established criteria for crisis system entry.
- Strong relationships with law enforcement and first responders.

Ongoing staff training is critical for maintaining both staff competence and confidence, and promotes improved outcomes for persons served and decreased risk for staff (Technical Assistance Collaborative, 2005). Nationally recognized best practices in crisis intervention such as CPI (Crisis Prevention Institute, Nonviolent Crisis Intervention Training) and Therapeutic Options (Therapeutic Options, Inc.) are highly effective and instrumental in their utilization of positive practices to minimize the need for physical

interventions and re-traumatization of persons in crisis. Such approaches have contributed to a culture of safety for staff and clients in the crisis setting.

Adequate staffing for the number and clinical needs of consumers under care is foundational to safety. Access to a sufficient number of qualified staff (clinicians, nurses, providers, peer support professionals) promotes timely crisis intervention and risk management for persons in crisis who are potentially dangerous to self or others (DHHS, 2006).

In some crisis facilities that are licensed or certified to provide intensive services, seclusion and/or restraint may be permitted. Though some practitioners view physical and/or pharmacological restraint and seclusion as safe interventions, they are often associated with increased injury to both clients and staff and may re-traumatize individuals who have experienced physical trauma. Therefore, restraint and seclusion are now considered safety measures of last resort, not to be used as a threat of punishment, alternative to appropriate staffing of crisis programs, as a technique for behavior management, or a substitute for active treatment (Technical Assistance Collaborative, 2005).

The National Association of State Mental Health Program Directors (NASMHPD) (2006) discussed core strategies for mitigating the use of seclusion and restraint. These included leadership that sets seclusion and restraint reduction as a goal, oversight of all seclusion/restraint for performance improvement, and staff development and training in crisis intervention.

Person-centered treatment and use of assessment instruments to identify risk for violence were also critical in developing de-escalation and safety plans. Other recommendations include partnering with the consumer and his or her family in service planning, as well as debriefing staff and consumers after a seclusion/restraint event, to inform policies, procedures, and practices to reduce the probability of repeat use of such interventions.

Following the tragic death of Washington State social worker Marty Smith in 2006, the Mental Health Division of the Department of Social and Health Services sponsored two safety summits. The legislature passed into law a bill (SHB 1456) relating to home visits by mental health professionals.

According to SHB 1456, the keys to safety and security for home visits by mental health staff include:

- No mental health crisis outreach worker will be required to conduct home visits alone.
- Employers will equip mental health workers who engage in home visits with a communication device.
- Mental health workers dispatched on crisis outreach visits will have prompt access to any history of dangerousness or potential dangerousness on the client they are visiting, if available.

The Task Force finds that ensuring safety for both consumers and staff is the very foundation of effective crisis care. While safety is urgently important in all health care, in crisis care, the *perception of safety* is

also essential. The prominence and damaging effects of trauma and the fear that usually accompanies psychological crisis make safety truly "Job One" in all crisis settings.

Law Enforcement and Crisis Response—An Essential Partnership

Law enforcement agencies have reported a significant increase in police contacts with people with mental illness in recent years. Some involvement with mental health crises is inevitable for police. As first responders, they are often the principal point of entry into emergency mental health services for individuals experiencing a mental health or substance use crisis.

Police officers are critical to mobile crisis services as well, often providing support in potentially dangerous situations (Geller, Fisher, & McDermeit, 1995). Research investigating law enforcement response to individuals with mental illness (Reuland, Schwarzfeld, & Draper, 2009) found police officers frequently:

- Encounter persons with mental illness at risk of harming themselves
- Often spend a greater amount of time attempting to resolve situations involving people exhibiting mental health concerns
- Address many incidents informally by talking to the individuals with mental illness
- Encounter a small subset of "repeat players"
- Often transport individuals to an emergency medical facility where they may wait for extended periods of time for medical clearance or admission

Task Force Spotlight

Barbara Dawson, MEd, Deputy Director, Comprehensive Psychiatric Emergency Program Division

The Harris Center for Mental Health and IDD, formerly known as "MHMRA of Harris County," has partnered with Houston Police Department (PD) and the Emergency Communications 9-1-1 Center to co-locate and integrate its mental health crisis line team members, with the purpose of diverting appropriate calls from law enforcement interaction. Houston PD received more than 30,000 mental health calls in 2014.

However, in many communities across the United States, the absence of sufficient and well-integrated mental health crisis care has made local law enforcement the *de facto* mental health crisis system. This is unacceptable and unsafe. The Task Force finds that the role of local law enforcement in mental health crisis response is essential and important. However, the absence of adequate mental health crisis care, which has led to this function being dumped on law enforcement, is deplorable. Adequate mental health crisis systems must be built. With good mental health crisis care in place, good collaboration with law enforcement can proceed in a fashion that will improve both public safety and mental health outcomes.

We now know a good deal about crisis care/law enforcement collaboration. Deane et al. (1999), reporting on partnerships between mental health and law enforcement, found the alliance between first responders and mental health professionals helped to reduce unnecessary hospitalization or incarceration. Specialized responses to mental health crisis included police-based specialized police

response, police-based specialized mental health response, and mental health-based specialized mental health response. These forms of collaboration share the common goal of diverting people with mental health crises from criminal justice settings into mental health treatment settings and were rated as "moderately effective" or "very effective" in addressing the needs of persons in crisis.

Specialized police responses involve police training by mental health professionals in order to provide crisis intervention and act as liaisons to the mental health system. The Memphis Crisis Intervention Team (CIT) model pioneered this approach. In CIT, training for law enforcement includes educating officers about mental illness, substance use and abuse, psychiatric medications, and strategies for identifying and responding to a crisis (Tucker et al., 2008). Lord et al. (2011) found most officers involved volunteered to participate in the training.

Consistent with the findings above, CIT necessitates a strong partnership and close collaboration between the police officers and mental health programs (e.g., availability of a crisis setting where police can drop off people experiencing a mental health crisis). CIT has been cited as a "Best Practice" model for law enforcement (Thompson & Borum, 2006).

With a second type of law enforcement-based response program, police-based specialized mental health response, mental health professionals are partnered with law enforcement officers at the scene to provide strategic consultation/intervention and to support persons in accessing treatment. Outcome studies comparing models of police response to individuals in mental health crisis found that officers in a police-based response were more likely than other officers to transport individuals to mental health services. As discussed above, availability of a central crisis drop-off center for individuals with mental illness that had a no-refusal policy for police cases increased the number of police calls that implemented a specialized response (Steadman et al., 2000).

Specialized law enforcement responses to mental health crises have shown improved safety outcomes for persons served. Studies examining CIT have found significantly less use of force in situations rated as high violence risk (Skeem & Bibeau, 2008), and Morabito et al. (2012) found CIT-trained officers used less force as person's resistance increased compared to resistance experienced by officers who lacked CIT training. In a qualitative study, Hanafi et al. (2008) noted that officers reported the application of their CIT skills served to decrease the risk of injury to officers and individuals with mental illness.

In many cases, officers receive a call that is not presented as a suicidal crisis, but rather as a public disturbance, domestic violence, or other dangerous situation. The CIT officers identify people at risk for suicide, address safety issues for all present, and offer support and hope to the person who is suicidal. In conjunction with other mental health service providers and/or Emergency Medical Services (EMS) personnel, they may directly transport or arrange transport for the person who is potentially suicidal to be brought to an ED or mental health center for an evaluation (Suicide Prevention Resource Center, 2013).

In addition, as first responders for persons with mental illness in crisis, the officers can assess individuals and provide transport to alternative levels of care to divert hospitalization. Further support for the model is provided by police officers' reports of improved confidence in identifying and responding to persons with mental illness and enhanced confidence in their department's response to mental health-related calls (Wells & Schafer, 2006).

The Task Force finds that strong partnerships between crisis care systems and law enforcement are essential for public safety, including suicide prevention. We also find that the absence of comprehensive crisis systems has been the major "front line" cause of the criminalization of mental illness, and a root cause of shootings and other incidents that have left people with mental illness and officers dead.

> *Recommendation 6. The Task Force recommends that national and state authorities (and where relevant, accrediting organizations and payers such as health plans) commit to ensuring that the core principles and practices covered here are addressed in existing and to-be-developed comprehensive crisis systems.*

Section 4 Conclusion

It is easy to fall into the trap of attempting to guarantee safety in community-based crisis programs with the use of Plexiglas-walled rooms and security keypads that separate staff and guests. Other programs work to ensure that law enforcement has sent a consumer through a lengthy ED visit prior to admission to the program. However, the most effective community-based crisis care occurs in welcoming and trauma-informed care environments that serve individuals whose mental health and/or addiction crisis has resulted in interactions with law enforcement. The critical component to making these approaches work is the integration of trained and certified peer support staff and law enforcement.

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Section 5: Financing Crisis Care

The method of financing crisis mental health services varies from state to state. In many cases, it is cobbled together. Inconsistently supported. Inadequate.

The federal government provides a very small SAMHSA investment (just over $6 million annually) in the NSPL; however, that investment only provides for a national call infrastructure and does not cover the state/local costs of either crisis lines or crisis intervention systems. Aside from this minimal investment, there is no dedicated national funding source, nor is there a national infrastructure for a service that is perhaps the most important single element of community mental health care, and which provides the most important elements of acute suicide care.

Crisis Care Funding vs. Emergency Care Funding

It is revealing to compare mental health crisis care to other first responder systems like firefighting or EMS. There are striking similarities:

- The service is essential.
- The need for it is predictable over time, but the timing of crises is not predictable.
- Effective crisis response is lifesaving, yet it is also much less expensive than the consequences of inadequate approaches.

For EMS, we might measure its effectiveness in lives saved because of timely intervention for individuals with acute heart disease. For mental health crisis response, we can see the impact of comprehensive approaches in lives saved from suicide and people cared for effectively and more efficiently via mobile crisis visits or brief crisis respite stays at about $300/day vs. inpatient rates of $1000/day.

It is also useful to think about financing of core crisis services. It would be unthinkable for any community except frontier or very small ones to go without a fire department. Because this is known to be an essential public expenditure, fire stations and fire trucks are always provided. Sometimes users may pay a fee for service calls, but the station and the equipment are provided. A frequent scenario for mental health crisis services is the opposite approach. Health coverage (e.g., Medicaid) will pay for the visit, but often no one will pay for the infrastructure: phone and computer systems, 24/7 coverage, or crisis facilities.

This will not work.

A Financial Crisis for Crisis Care

SAMHSA's (2014) report on crisis service effectiveness and funding discusses "funding strategies" for this care. The report includes important information about funding *approaches,* but provides no analysis of funding *levels.* Given the absence of any national expectations for establishing or maintaining crisis

infrastructure (excepting the NSPL network) and the absence of national funding for crisis care, the general absence of comprehensive crisis services is not surprising.

Partial data on the financing of crisis care have been complied by NASMHPD. In his presentation to the Task Force, Brian Hepburn, MD, NASMHPD Executive Director, shared data at both the provider and state levels that illustrate the problem. NASMHPD's analysis of funding patterns for one typical crisis care provider demonstrates how financing is cobbled together from multiple sources:

- State grant funding: 41% (includes hotline/mobile crisis team/detoxification)
- Federal funding: 10% (includes portion of hotline costs paid through mobile crisis team payments)
- Fee for service: 45% (33% of this is Medicaid; 67% State general funds)
- Private organizations & miscellaneous: 4%
- TOTAL: 100%

The Problem with Typical Funding Patterns

What is wrong with this typical pattern of crisis care funding? First, there is no overall, reliable source of funding. Resources are cobbled together from multiple sources, including private fund raising. It is as if we had a fire department with no fire station and the fire fighters must use their own vehicles. The Task Force finds that the absence of national expectations for crisis care infrastructure, as well as lack of funding for such infrastructure, is the primary cause of inadequate crisis services.

Second, less than half of all funding in this typical example comes from a dedicated/reliable source (in this case, the State Mental Health Authority). This is problematic, since dedicated state mental health funding is threatened by the transition of services paid by Medicaid, which is typically delivered per unit-of-care (i.e., the visit), not for the 24/7 infrastructure essential for crisis care.

According to NASMHPD surveys, over $4 billion, or about 10%, in state mental health funding was cut/eliminated in the 2007–2009 recession; however, funding has been restored through Medicaid Expansion. Therefore, there needs to be a method for covering crisis services through changes to the State Medicaid Plan.

To put this cut into perspective, NASMHPD reports that *total* funding through state mental health agencies is only $39 billion. Additionally, as Medicaid has become a more reliable way to pay for many mental health services, state budget offices have been reducing general state mental health funding, which is currently the major source for crisis funding. While this works well in terms of overall investments in mental health, which have improved, it is a problem for crisis care.

Third, and reinforcing this point, the biggest single source of funding in this example is Medicaid billings. This is both an expensive/cumbersome way to bill for crisis care (a claim must be submitted for every contact), and it also reveals the overall lack of program funding for the core elements of crisis care.

Finally, in this example one sees no payment from Medicare and commercial/private health insurers. This means that the nation's crisis care infrastructure has essentially no support from mainstream health payers. In more sophisticated crisis systems, there is some billing to health insurers.

In his presentation to the Task Force, NASMHPD Executive Director Brian Hepburn reported that a survey of states reveals great variability in patterns of crisis funding.

Table 3: Examples of State Funding for Crisis Care

STATES	MOST STATES	MAINE	RHODE ISLAND	PENNSYLVANIA	OHIO
Sources of Crisis Funding					
State Mental Health	Primary	70%	50%	--	16.5%
State/Federal/ Other	--	--	—	--	5%
Medicaid	Limited	30%	50%	54%	29.5%
Block Grant	--	--	--	46%	4%
Local/County	--	--	--	--	45%

The NASMHPD survey data reinforce the conclusions about crisis care funding, namely the lack of consistent, reliable, and robust national support for the 24/7 infrastructure of crisis care, and the virtual absence of payment by health insurance programs except for Medicaid.

Patchwork Medicaid Funding

The NASMHPD data complement SAMHSA's 2014 report, which also illustrates the patchwork nature of crisis service funding. To complete the SAMHSA report, Truven Health Analytics examined patterns of Medicaid funding of crisis care in all 50 states. Examining Medicaid is particularly important because it is the largest payer for community mental health care. The SAMHSA report notes that its survey methodology—that is, review of Medicaid State Plans and other official documents—was thorough, but limited. The review also included in-depth case study interviews with officials from eight states. SAMHSA

did note that in some states, authorities have worked through their managed care partners to support comprehensive crisis care. The Task Force examined the Truven/SAMHSA findings with reference to the three core structural elements of comprehensive crisis care that we identified.

The SAMHSA report finds:

- *No* states are using Medicaid to pay for the central, ATC-capable infrastructure that is needed as the hub of comprehensive crisis care, including the crisis call center.
- A dozen states are using Medicaid to pay for mobile crisis services.
- Ten states are using Medicaid to pay for crisis residential services and/or observation beds.

The Task Force finds that the absence of consistent expectations for crisis care functioning and funding is problematic given Medicaid's key role as a payer. It is perhaps likely to become more problematic as Medicaid managed care responsibilities are increasingly integrated with/scattered to competing mainstream health plans that are less likely to support an integrated, statewide crisis care solution.

An Emerging Opportunity: New Legislation

The Comprehensive Community Behavioral Health Centers (CCBHC) legislation (Section 223 of the Protecting Access to Medicare Act, also referred to as "Section 223") represents perhaps the most significant national effort to build community mental health capacity in the past several decades. The legislation authorizes demonstration grants to eight states that agree to raise standards for and implement a statewide network of CCBHCs. Currently in 2016, 24 states have received planning grants totaling $22.9 million to develop an infrastructure that will allow them to compete to become one of the eight demonstration states. Legislative advocacy to expand the number of pilot states is also occurring.

The Section 223 initiative is relevant and helpful to crisis care and suicide prevention in several ways. As we referenced early in this report, crisis care was one of five "essential services" in CMHCs funded under President Kennedy's legislation. However, CMHC grants were time-limited, most areas of the country never received one, and CMHC requirements were all but eliminated when the CMHC program was converted to a block grant in President Reagan's first budget.

The Section 223 requirements for CCBHC crisis care are robust and include requirements for 24/7 availability, a continuum of crisis care options, and individuals in crisis to be seen within 3 hours. Section 223 also elevates requirements for suicide care, including additional training, protocols for risk assessment, the expectation that all consumers are informed about crisis lines, and finally a mandate to measure suicide deaths for people in care.

To date, the Section 223 requirements are perhaps the most concrete and useful federal steps to improve access to crisis care. The Task Force finds that this is a very promising development and urges that Section 223 be made permanent and extended to all states. These would be very substantial and

helpful steps. They would not, however, accomplish all the actions we recommend here to make comprehensive crisis care available across the United States.

Recommendation 7: This recommendation follows directly from the Task Force's conclusion that crisis calls should always be answered by an NSPL-qualified and participating center in the caller's area. Federal support for crisis call centers is necessary to allow for, at a minimum, the development of crisis call centers in areas where one does not exist. Ideally, funding would come from an expansion of the Mental Health Block Grant, coupled with a requirement that states ensure the presence of qualified call centers covering their population. Call centers should be part of comprehensive crisis systems that have all the core requirements we have discussed: 24/7 clinical coverage with ATC capabilities, adequate mobile crisis teams, and sufficient crisis respite alternatives.

Recommendation 8: All major health payers should recognize and reimburse crisis services provided to their members by comprehensive crisis systems. An analogy for this is payment for EMT by health providers. This step is necessary in order to have adequate capacity for crisis care and for efficiency. In order to achieve this step, leadership will be needed from CMS (Medicare/Medicaid), the Department of Labor, and state Insurance Commissioners.

Section 5 Conclusion

In order to achieve the kind of EMS response in mental health crises described above, payers must prioritize these services and programs. The piecemeal approach currently utilized by states has been inconsistent with the original tenets of the community mental health movement. Funding of a primary community capacity for mental health crisis response is also consistent with current mental health parity, coverage expansion, and the launch of the Comprehensive Community Behavioral Health Center initiative.

Report Conclusion

The Task Force has outlined five compelling reasons for change. These include:

- Thousands of Americans dying alone and in desperation from suicide
- Unspeakable family pain for those whose children have serious mental illness
- Inhuman treatment of individuals who sometimes wait for days in EDs
- The wrong care in the wrong place, compromising other medical urgent care
- Tying up valuable law enforcement resources to substitute as “mobile crisis”

We have presented the solutions, and they are accessible now, summarized below.

The problem with delaying is…crises are happening now.

Summary of Task Force Recommendations

Recommendation 1: We recommend national-and state-level recognition that effective crisis care must be comprehensive and include these core elements and practices: a) ATC-capable central coordination, using technology for real-time care coordination while providing high-touch support meeting NSPL standards; b) availability of centrally deployed Mobile Crisis Services on a 24/7 basis; c) residential crisis stabilization programs; and d) conformance with essential crisis care principles and practices.

Recommendation 2: Crisis call services should participate in and meet the standards of the NSPL, and crisis intervention systems should adopt and implement Zero Suicide/Suicide Safer Care across all program elements.

Recommendation 3: State and national authorities should review elements of ATC-qualified crisis systems, apply them to crisis care in their jurisdictions, and commit to achieving these capabilities within 5 years, so that each region of the United States has a qualified hub for crisis care.

Recommendation 4: State and national authorities should work to ensure that mobile crisis teams are available to each part of every state.

Recommendation 5: Residential crisis stabilization alternatives to hospitalization should be made available as a core component of comprehensive crisis systems in every state.

Recommendation 6: The Task Force recommends that national and state authorities (and where relevant, accrediting organizations and payers such as health plans) commit to ensuring that the core principles and practices discussed in this report are addressed in existing and to-be-developed comprehensive crisis systems.

Recommendation 7: This recommendation follows directly from the Task Force's conclusion that crisis calls should always be answered by an NSPL-qualified and participating center in the caller's area. Federal support for crisis call centers is necessary to allow for, at a minimum, the development of crisis call centers in areas where one does not exist. Ideally, funding would come from an expansion of the Mental Health Block Grant, coupled with a requirement that states ensure the presence of qualified call centers covering their population. Call centers should be part of comprehensive crisis systems that have all the core requirements we have discussed: 24/7 clinical coverage with ATC capabilities, adequate mobile crisis teams, and sufficient crisis respite alternatives.

Recommendation 8: All major health payers should recognize and reimburse crisis services provided to their members by comprehensive crisis systems. An analogy for this is payment for EMT by health providers. This step is necessary in order to have adequate capacity for crisis care and for efficiency. In order to achieve this step, leadership will be needed from CMS (Medicare/Medicaid), the Department of Labor, and state Insurance Commissioners.

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Making the crisis center welcoming and comfortable is an important first step (RI Crisis in Peoria, Arizona).

Appendix

Task Force and Support Team Participants

A group of consensus national experts were invited to participate in the Task Force and associated Support Team. They include government and health plan administrators, provider executive leaders, people with lived experience, and family members of those with serious mental illness:

David Covington, LPC, MBA, Task Force Co-lead; EXCOM member; RI International; Behavioral Health Link

Michael Hogan, PhD, Task Force Co-lead; EXCOM member; Hogan Health Solutions

Jason H. Padgett, MPA, MSM, Deputy Secretary, National Action Alliance for Suicide Prevention; Suicide Prevention Resource Center; Education Development Center, Inc. (EDC)

Bart Andrews, PhD, Behavioral Health Response

Leon Boyko, MBA, MSW, LCSW, RI Crisis (RI International)

Lisa Capoccia, MPH, Suicide Prevention Resource Center, EDC

Lynn Copeland, Georgia Department of Behavioral Health and Developmental Disabilities

Barbara Dawson, MEd, The Harris Center for Mental Health and IDD

Susan Dess, RN, MS, Crestline Advisors

Steven Dettwyler, PhD, Community Mental Health and Addiction Services Delaware DHSS/DSAMH

Bea Dixon, BSN, PhD, Optum WA Pierce RSN

John Draper, PhD, Link2Health Solutions; National Suicide Prevention Lifeline

Phil Evans, ProtoCall Services

Gerald Fishman, PhD, RI Crisis (RI International, Inc.)

Vijay Ganju, PhD, Behavioral Health Knowledge Management

Larry Goldman, DMD, Beacon Health Options

Gabriella Guerra, MSW, Mercy Maricopa Integrated Care

Brian Hepburn, MD, National Association of State Mental Health Program Directors (NASMHPD)

Shannon Jaccard, MBA, NAMI San Diego

Helen Lann, MD, Beacon Health Options

Nick Margiotta, Phoenix Police Department

Richard McKeon, PhD, Substance Abuse and Mental Health Services Administration (SAMHSA)

Tim Mechlinski, PhD, Crestline Advisors

Steve Miccio, PEOPLe, Inc.

Heather Rae, MA, LLP, Common Ground

John Santopietro, MD, DFAPA, Carolinas HealthCare System

Wendy Schneider, LPC, Behavioral Health Link

Cheryl Sharp, MSW, ALWF, National Council for Behavioral Health

Becky Stoll, LCSW, Centerstone

Eduardo Vega, MA – EXCOM member; MHA of San Francisco

James Wright, LCPC, SAMHSA

Task Force Schedule

The Crisis Services Task Force worked a sprint schedule meeting twice monthly by WebEx Video Conferencing from September to December 2015:

- Introductions & Task Force Sponsors (September 4, 2015) – Co-chairs David Covington and Mike Hogan launch the Action Alliance Crisis Services Task Force
- The Framework & Agenda (September 18) – Introductory comments from the Action Alliance (Jason Padgett) and SAMHSA (Richard McKeon), and description of the Task Force roadmap
- Topic 1: Peers & Recovery (October 2) – Living Rooms, peers, and new models for crisis alternatives (Steve Miccio) and trauma-informed care (Cheryl Sharp)
- Topic 2: Air Traffic Control (October 16) – Adaptation of the Milbank integration continuum (David Covington) and Georgia Crisis & Access Line (Wendy Schneider)
- Topic 3: Integration with First Responders (November 6) – Harris County 9-1-1 co-location (Barbara Dawson) and Crisis Intervention Team Training (CIT) - International Board Member and Phoenix Police Department (Nick Margiotta)
- Topic 4: Community-based Mobile Crisis (November 20) – St. Louis-area Behavioral Health Response model (Bart Andrews) and Centerstone (Becky Stoll)
- Topic 5: Safety/Security for Consumers and Staff (December 4) – State of Washington Safety Summit Clinical Training (Bea Dixon) and RI Crisis utilization of peer staffing and healing spaces (Leon Boyko)
- Topic 6: Pay for Value, Financing, and ROI (December 18) – Shift to value-based care/financing (Larry Goldman) and NASMHPD/public-sector (Brian Hepburn)

Timeline of Crisis Innovations

1958

First Free, 24-Hour Crisis Hotline – In 1958, Edwin Shneidman founded the Los Angeles Suicide Prevention Center, which was the nation's first crisis hotline and later consolidated into Didi Hirsch Mental Health Services. Ten years later, Shneidman would form the American Association of Suicidology (http://www.didihirsch.org/History).

1995

Hi-tech, Professionally Staffed – Behavioral Health Response was formed by the Missouri legislation after the shooting deaths of prominent family members by a person with serious mental illness. It was first with advanced software, clinical staffing, mobile crisis, and a Board of Directors comprised of local CMHCs (http://bhrstl.org/).

2003

Full Continuum of Crisis Services – Harris County MHMRA developed a groundbreaking array of integrated crisis services for the greater Houston metropolitan area, one of the largest in the United States, with a psychiatric emergency room, crisis residential services, mobile crisis outreach team, homeless services, and crisis help line (http://www.mhmraharris.org/Crisis-And-Emergency-Services.asp).

2006

Statewide Crisis & Access Line – After Hurricane Katrina, the Georgia Department of Behavioral Health and Developmental Disabilities expanded its Single Point of Entry into a statewide program for all 159 counties with 24/7 scheduling, online dashboards, and advanced analytics (recognized as innovation by *Business Week*) (http://behavioralhealthlink.com/).

2010

Big Box Full Continuum – The Regional Behavioral Health Authority for Tucson and University Physicians Hospital partnered on a $54 million community bond to launch a mega-crisis center with co-located call center, crisis stabilization (adults and teens), law enforcement sally port, and more (http://bit.ly/TucsonCRC).

Americans with Disabilities Act & Olmstead – The Department of Justice entered into a Settlement Agreement with Georgia over complaints of unnecessarily institutionalization. The agreement included

new crisis stabilization programs, mobile crisis teams, crisis apartments, expanded crisis hotline, etc. (http://www.ada.gov/olmstead/olmstead_cases_list2.htm).

2012

24/7 Outpatient & Short-term Residential – The Regional Behavioral Health Authority for Phoenix, Arizona, expanded its robust crisis continuum with two new Access Point/Transition Point facilities for individuals with after-hours presentations but whose needs did not require sub-acute stabilization (http://bit.ly/CBAccessPoint).

A Plan to Safeguard All Coloradans – In response to the Aurora theater tragedy, Governor Hickenlooper and the Colorado legislature introduced over $100 million in state funds for a five-year contract to expand crisis stabilization, crisis respite, mobile crisis, crisis call center, warm line, and marketing. (http://bit.ly/CO-Crisis).

2013

Investment in Mental Health Wellness Act – California legislation SB 82 provided nearly $150 million to improve access to and capacity for crisis services, believing that 70% of ED presentations for psychiatric evaluation could be avoided with improved crisis stabilization, mobile crisis, and crisis triage (http://bit.ly/CAimhwa).

2014

Air Traffic Control Level 5 System –Milbank collaboration continuum modified (original citation: Doherty, 1995) for evaluating crisis system community coordination and collaboration. The model suggests five required elements, including electronic crisis bed inventories (http://bit.ly/crisiscontinuum).

National Council Leadership – Linda Rosenberg and the National Council for Behavioral Health launched the first-ever specialized track for crisis service at the spring Washington, DC, conference, including a pre-conference, town hall, and multiple sessions on crisis services, and one of its most actively subscribed list serves ever (http://bit.ly/1KVp54i).

"Psychiatric Boarding" Ruled Illegal – In 2013, ten persons filed a suit in Pierce County contesting their petitions due to long waits. A year later, the Washington State Supreme Court said holding an individual in an ED until an appropriate bed is available is unconstitutional and therefore unlawful (http://onforb.es/1P4pXaX).

2015

Effective Inpatient Interventions & Alternatives – NIMH, NIDA, SAMHSA, and AFSP release Request for Information (RFI): Building an Evidence Base for Effective Psychiatric Inpatient Care and Alternative Services for Suicide Prevention. “While a number of interventions… have been effective and even replicated, the effectiveness of inpatient care… remains a question” (http://1.usa.gov/1JWouEH).

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Now is the time for crisis care to change.

NATIONAL Action Alliance FOR SUICIDE PREVENTION

Crisis Services Task Force

STATE OF CALIFORNIA
EDMUND G. BROWN JR., Governor

Mental Health Services
Oversight & Accountability Commission

September 14, 2018

Kate Jones, RN, MS, MSN
Alameda County Behavioral Health Care Services
2000 Embarcadero Cove, Suite 400
Oakland, CA 94606

Dear Ms. Jones:

Thank you for agreeing to participate in the Commission's public hearing on suicide prevention on Thursday, October 25, 2018 at the Marina Inn on San Francisco Bay, 68 Monarch Bay Drive, San Leandro, California. The Commission's meeting will include three panels to support the Commission's understanding of opportunities to prevent suicide and suicide attempt, and support the Commission's efforts to develop a strategic statewide suicide prevention plan, as authorized by the California Legislature.

Your panel will highlight opportunities for suicide prevention in crisis care and health care and behavioral health care settings, and is scheduled to begin at approximately 10:30 a.m. Please plan to present for 10 to 15 minutes to leave time for discussion with Commissioners. Please organize your presentation to respond to the following:

- How Alameda County Behavioral Health Care Services delivers a crisis care continuum, including crisis hotline, mobile crisis, and crisis residential
- How the state can support local efforts to strengthen crisis services to improve coordination and timely connection of people to services, reducing outcomes such as hospitalization, suicide, and suicide attempt
- How Alameda County plans to implement the Zero Suicide Initiative, including challenges and barriers to implementation

Please send a brief biography and written response or background materials to the items above by Wednesday, October 3, 2018 to Ashley Mills at ashley.mills@mhsoac.ca.gov. Your written responses will allow Commissioners attending the meeting the opportunity to prepare questions for you after your presentation, and will be available for Commissioners unable to attend the meeting. Please note that your written responses and biography will be shared as public documents.

Should you have any questions, I can be reached at toby.ewing@mhsoac.ca.gov or 916.445-8696. Thank you again for your willingness to participate in this important meeting.

Respectfully,

Toby Ewing

Toby Ewing, Ph.D.
Executive Director

Mental Health Services
Oversight & Accountability Commission

Suicide Prevention Public Hearing
October 25, 2018

Panel 3: Building Infrastructure, Leadership, and Sustainability

- Carr: Invitation letter
- Carr Written presentation
- Manzo: Invitation letter
- Manzo: PowerPoint Presentation
- Manzo: Written presentation

STATE OF CALIFORNIA
EDMUND G. BROWN JR., Governor

Mental Health Services
Oversight & Accountability Commission

September 14, 2018

Colleen L. Carr, MPH
National Action Alliance for Suicide Prevention
1025 Thomas Jefferson St, NW St.700W
Washington, DC 20007

Dear Ms. Carr:

Thank you for agreeing to participate in the Commission's public hearing on suicide prevention on Thursday, October 25, 2018 at the Marina Inn on San Francisco Bay, 68 Monarch Bay Drive, San Leandro, California. The Commission's meeting will include three panels to support the Commission's understanding of opportunities to prevent suicide and suicide attempt, and support the Commission's efforts to develop a strategic statewide suicide prevention plan, as authorized by the California Legislature.

Your panel will highlight opportunities for private-public partnership and sustaining suicide prevention efforts over time, and is scheduled to begin at approximately 11:30 a.m. Please plan to present for 10 to 15 minutes to leave time for discussion with Commissioners. Please organize your presentation to respond to the following:

- How the National Action Alliance for Suicide Prevention utilizes a private-public partnership to advance the national suicide prevention strategy
- Opportunities for the state to pursue private-public partnerships as a possible method to advance its own suicide prevention strategy, including examples from other states
- How the state could support and incentivize expansion of suicide prevention efforts in private industry settings, including the workplace, private health care, and private senior living communities, such as nursing homes and assisted living facilities

Please send a brief biography and written response or background materials to the items above by Wednesday, October 3, 2018 to Ashley Mills at ashley.mills@mhsoac.ca.gov. Your written responses will allow Commissioners attending the meeting the opportunity to prepare questions for you after your presentation, and will be available for Commissioners unable to attend the meeting. Please note that your written responses and biography will be shared as public documents.

Should you have any questions, I can be reached at toby.ewing@mhsoac.ca.gov or 916.445-8696. Thank you again for your willingness to participate in this important meeting.

Respectfully,

Toby Ewing

Toby Ewing, Ph.D.
Executive Director

NATIONAL ACTION ALLIANCE FOR SUICIDE PREVENTION

THE NATION'S PUBLIC-PRIVATE PARTNERSHIP FOR SUICIDE PREVENTION

California Mental Health Services Oversight Commission
October Hearing

October 3, 2018
Mental Health Services Oversight and Accountability Commission
1325 J Street, Suite 1700
Sacramento, CA 95814

Dear Commissioners,

The National Action Alliance for Suicide Prevention (Action Alliance) is the nation's public-private partnership for suicide prevention. Launched in 2010 by a former Secretary of the U.S. Department of Defense and the Secretary of the U.S. Department of Health and Human Services in collaboration with the private sector, the Action Alliance is charged with advancing the National Strategy for Suicide Prevention (National Strategy). Because suicide prevention requires a multi-sectoral approach, the Action Alliance brings together federal agencies with key private sector stakeholders to align and scale up suicide prevention at the national level.

One of the Action Alliance's first tasks was to revise the National Strategy to ensure the nation had an updated roadmap, informed by the best available science, for advancing suicide prevention. Released in 2012 by the Action Alliance and U.S. Surgeon General's Office, this strategy informs the Action Alliance's approach, priorities, and partnerships.

We applaud California's current effort to revise its suicide prevention strategy and encourage the Commission to use this opportunity to identify a comprehensive approach to suicide prevention informed by data and the best available research on how to reduce the impact of suicide on communities across the state.

BACKGROUND- THE NATION'S PUBLIC-PRIVATE PARTNERSHIP FOR SUICIDE PREVENTION

The Action Alliance serves as a convener and catalyst for U.S. suicide prevention efforts. The Action Alliance assembles senior leaders from the nation's public sector, including federal agencies (e.g., U.S. Department of Health and Human Services, U.S. Department of Defense, U.S. Department of Veterans Affairs, U.S. Department of Justice, U.S. Department of Education) and the private sector (e.g., social media, health care, transportation, construction, entertainment, business, faith, behavioral health) to play a collective role in suicide prevention. The Action Alliance intentionally engages senior leaders, decision-makers, and key influencers who can both take action within a specific organization they lead and use their leverage and influence to be a change agent within their sector.

Operational support for the Action Alliance is provided by a Secretariat team housed at the Education Development Center (EDC), an independent 501(c)(3) organization. The Secretariat – the core infrastructure for all of the Action Alliance's work – is responsible for providing strategic direction, suicide prevention content, technical expertise, meeting planning and logistics, communication (e.g., media, social media, websites, e-newsletters, branding), and supports the 40+ Executive Committee members and the public sector and private sector chairs. For more information about the Action Alliance, please see our video.

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Priority Initiatives

The Action Alliance has three priority initiatives, based on high-priority objectives found in the National Strategy. Action Alliance leadership selected these priorities based both on their potential to significantly reduce the burden of suicide in the nation and on the need for public and private sector collaboration, thus positioning the Action Alliance as uniquely suited to provide leadership. We encourage stakeholders, states, and communities to consider how these national-level priorities can support and align with their efforts.

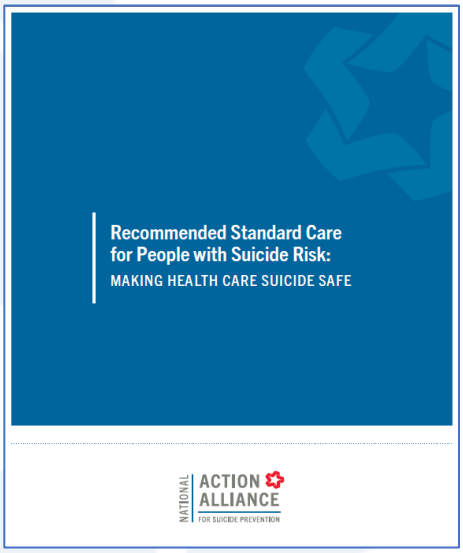
Priority initiatives:

- Transforming Health Systems
- Transforming Communities
- Changing the Public Conversation about Suicide and Suicide Prevention

Transforming Health Systems

National Strategy Goal 8: Promote suicide prevention as a core component of health care services.
National Strategy Goal 9: Promote and implement effective clinical and professional practices for assessing and treating those identified as being at risk for suicidal behaviors.

The Action Alliance selected Transforming Health Systems as a key priority because the majority of individuals who die by suicide engaged the health care system in the months and days leading up to their death.



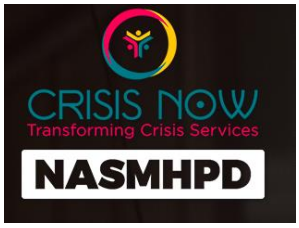
Efforts include scaling up implementation of Zero Suicide, improving the clinical workforce's capacity to treat individuals at risk for suicide, improving financing for suicide care, improving care transition for patients, elevating the standard of care, and transforming the crisis care system. In addition to developing the recently released "Recommended Standard Care for People with Suicide Risk," which can serve as a roadmap for health care policymakers regarding what the expectation for standard care should be, the Action Alliance catalyzed two other initiatives beneficial to the people of California:

- The ***Zero Suicide*** initiative
- The ***Crisis Now*** initiative

Crisis Now

Source: www.CrisisNow.org

Catalyzed by the Action Alliance and now led by the National Association of State Mental Health Program Directors (NASMHPD), *Crisis Now* is a framework for fundamentally transforming the delivery of crisis care in states across the country. This model, based on early adopter states that are implementing comprehensive crisis care today, can be utilized as a blueprint for California, as the delivery of crisis care across the state is re-envisioned. In addition to NASMHPD and the Action Alliance, leadership is provided by RI International, the National Suicide Prevention Lifeline, and the National Council for Behavioral Health.



Source: www.zerosuicide.com

A systematic approach to quality improvement in health care settings is both available and necessary. In 2012, the Action Alliance launched Zero Suicide, a quality improvement approach to fundamentally transform the delivery of suicide care within health systems, on the foundational belief that suicide deaths for individuals under care within health and behavioral health systems are preventable. It presents both a bold goal and an aspirational challenge.

For health care systems, this approach represents commitments to:

- Patient safety, the most fundamental responsibility of health care; and
- The safety and support of clinical staff, who do the demanding work of treating and supporting suicidal patients.

Recognizing that suicidal individuals often fall through the cracks in a fragmented health care system, Zero Suicide requires a system-wide approach to improve outcomes and close gaps, and does not rely solely on practitioners providing clinical care.

Potential impact: With a focus on suicide care using rigorous quality improvement processes (such as those now included in the Zero Suicide model), the Henry Ford Health System demonstrated stunning results—a 75% reduction in the suicide rate among their health plan members (Coffey, 2007). Centerstone, one of the nation's largest not-for-profit CMHCs, saw a reduction in suicide deaths from a baseline of 35 per 100,000 to 13 per 100,000 after implementing Zero Suicide for 3 years.

Source: http://zerosuicide.sprc.org/sites/zerosuicide.actionallianceforsuicideprevention.org/files/What%20is%20Zero%20Suicide.pdf

Transforming Communities

National Strategy Goal 1: Integrate and coordinate suicide prevention activities across multiple sectors and settings.

While many individuals who die by suicide interact with our health care system, we also know that a significant number of individuals who die are not seen in a health care setting leading up to their death. Therefore, it is critical that entire communities are engaged in suicide prevention efforts. The Action Alliance is leading several national efforts to engage community leaders and partners in suicide prevention, a number of which can inform California's strategy.

In June 2018, the Centers for Disease Control and Prevention (CDC) released data which underscored that suicide is not explained by any single cause, but instead by a range of factors. Beyond mental health conditions, relationship, substance use, physical health, job, financial, and legal problems, all contribute to suicide as well and need to be part of prevention efforts. The findings further reinforce the need to address suicide prevention through a robust, coordinated, multi-sector approach that combines health care system efforts with a strong community response. Below are two examples of how the Action Alliance is engaging new partners from the business/employer community and the faith community.

Workplace Suicide Prevention

As a public-private partnership, there is a real opportunity to engage the private sector employer community through suicide prevention in the workplace. Promoting mental health and wellness in the workplace not only supports suicide prevention, it increases productivity and well-being among workers. Just as suicide prevention in health care requires a comprehensive approach, so do workplace efforts. Workplace suicide prevention requires an organizational response encompassing education, training, policy/practice, resources, services, and culture change. Resources available through the Action Alliance to support engagement of employers in California include:

- *Comprehensive Blueprint for Workplace Suicide Prevention*, an online guide for workplaces on how to develop a comprehensive suicide prevention program.
- *A Manager's Guide to Suicide Postvention in the Workplace*, a guide that presents 10 action steps for addressing the aftermath of a suicide.

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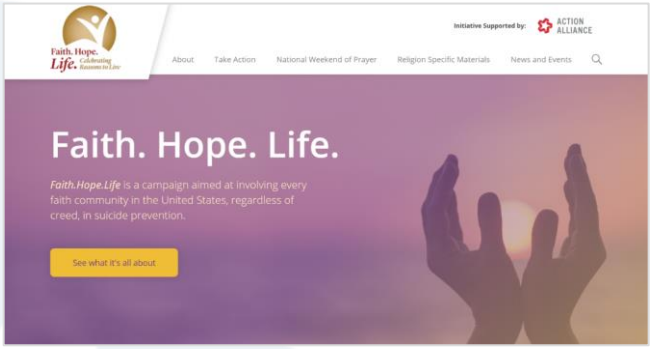
Fait

Source: https://theactionalliance.org/faith-hope-life

The Action Alliance initiated the national Faith.Hope.Life campaign, which is an opportunity for every faith community in the United States, regardless of creed, to support individuals and families in their community who are struggling or in crisis. This campaign includes 4 key components: 1) Learn – understand how specific faith traditions celebrate reasons for living; 2) Pray and Worship – share resources with faith leaders and faith communities (e.g., communication materials, sermon starters, sample prayers) to help faith leaders and faith communities get started; 3) Care and Comfort – provide care and comfort to those who are struggling with thoughts of suicide (and their loved ones) and those grieving the death of a loved one; and 4) Build Community – build positive connections that support mental health and increase connectedness (a protective factor to prevent suicide).

To date, the Faith.Hope.Life campaign contains resources for Christian, Jewish, Muslim, Buddhist, Hindu, American Indian/Alaska Native and Interfaith communities. As part of the Faith.Hope.Life campaign, the Action Alliance supports the National Weekend of Prayer for Faith, Hope, & Life, an annual event around World Suicide Prevention Day. On this weekend, faith communities all around the country pledge to join in prayer for those who have been touched by suicide, those who are facing mental health concerns and feelings of hopelessness, and for the people who love and care for them.



*Watch a short 2-minute **video** for faith leaders about the Action Alliance's Weekend of Prayer (featuring a number of prominent California faith leaders.)*

There are a number of strategies to leverage the connections and influence of the Commission to engage California's faith communities in suicide prevention, including formal support from the Governor's office (see example to the right from Utah) in the form of a formal communication and press event, to other promotional efforts to ensure that faith communities across the state are encouraged by political and community leaders to be a key partner in community suicide prevention efforts.

STATE OF UTAH

GARY R. HERBERT, GOVERNOR

OFFICE OF THE GOVERNOR
SALT LAKE CITY, UTAH
84114-2220

SPENCER J. COX, LIEUTENANT GOVERNOR

August 23, 2018

Dear Faith Leaders,

You and I recognize that each individual is precious in the eyes of God. It is very concerning when community members suffer emotional crises. It is especially tragic when they die by suicide. Because many of you have experienced the devastation that comes with a loved one's death by suicide, you know that any suicide death is one too many. The fact that suicide death has become a leading cause of death, particularly among our youth, is a national and state public health crisis with suicide as a leading cause of death among our youth.

Changing the Conversation

National Strategy Goal 4: Promote responsible media reporting of suicide, accurate portrayals of suicide and mental illnesses in the entertainment industry, and the safety of online content related to suicide.

Evidence shows that public messaging about suicide can impact suicidal behavior at the population level. Suicide-related messages must be conveyed in ways that support safety, help-seeking, and healing. Toward this goal, the Action Alliance leads efforts focusing on three key groups: the news media, the entertainment media, and other organizations that regularly disseminate messages related to suicide (i.e., public messengers).

News media

Media efforts include training journalists and newsrooms on ethical and accurate reporting (building off California's early efforts in this area). In addition, the Action Alliance works to promote positive stories of recovery in the media and ensure the suicide prevention field's contributions to media coverage promotes prevention and healing when appropriate.

Entertainment

Entertainment efforts include encouraging accurate depictions of suicide in entertainment content. The Action Alliance encourages the dissemination of messaging guidance to content creators and the promotion of prevention resources when there is a depiction of a suicide attempt or suicide loss in a program.

STATE-LEVEL PUBLIC-PRIVATE PARTNERSHIPS

When considering applying the national model for an executive level public-private partnership to advance suicide prevention for states, the following are important to consider:

- Bringing senior executives from the public and private sector (particularly non-tradition sectors) to the table, not with the responsibility to be suicide prevention expert with the responsibility to leverage their influence to champion suicide prevention as a priority within their sector.
- Building an infrastructure that includes sector-specific and strategy-specific task forces/advisory groups that bring content experts and stakeholders together.
- Ensuring there is consistent, predictable, and adequate infrastructure support (similar to the national-level Secretariat model described above) to provide technical assistance, strategic leadership, communications, logistical support, and more.
- Adopting a data-informed approach guided by state and community level data to select strategies that are most likely to be impactful, culturally competent, and geographically relevant.

At least two states, Colorado and Washington, launched state-level initiatives based on the national model. Both initiatives were launched following policymaker leadership – an Executive Order in Washington state and legislation in Colorado.

Washington State Action Alliance

Source: https://www.doh.wa.gov/YouandYourFamily/InjuryandViolencePrevention/SuicidePrevention/StateActions/ActionAlliance

The Washington State Action Alliance for Suicide Prevention (AASP) launched in 2016. The goal of the Action Alliance is "to use strategy, momentum, and input to guide policy, financial, legislative, and programmatic change in accordance with Governor Jay Inslee's January 2016 Executive Order (EO 16-02) and the Washington State Suicide Prevention Plan. Members share their multidisciplinary expertise, perspectives, and networks to improve suicide prevention implementation efforts across Washington State".

Contact: Neetha Mony- neetha.mony@doh.wa.gov

Colorado Suicide Prevention Commission

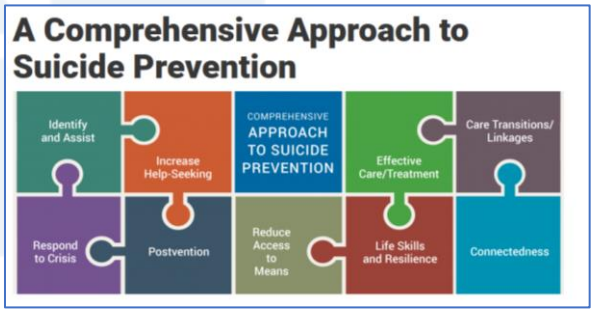
Source: https://www.colorado.gov/pacific/cdphe/suicide-prevention-commission

The Colorado Suicide Prevention Commission "serves as the interface between the public and private sectors in establishing statewide suicide prevention priorities that are data-driven and evidence-based. By focusing on current resources and expanding the network of partnerships across the state, the commission boosts the efforts of Colorado's Office of Suicide Prevention and submits annual reports to the governor and the General Assembly".

Contact: Sarah Brummett- sarah.brummett@state.co.us

Additional resources for states:

The majority of states, including California, have active suicide prevention coalitions that already bring together state and local leaders and key community partners. The Suicide Prevention Resource Center (SPRC) is a valuable resource that connects state leaders who are doing similar work across states.



In addition, SPRC has *A Comprehensive Approach to Suicide Prevention*, a framework useful for states and communities. In addition to this model, SPRC has resources available to communities (e.g., implementation tools, virtual events).

Source: www.sprc.org

One lesson learned at the national level, is the key role that consistent and adequate state infrastructure plays in supporting community efforts. When investing in data-driven best practices, it is also important to have consistent and high-quality technical assistance to strengthen efforts in both the public and private sector, access to and interpretation of ongoing data to inform prevention efforts, economies of scale around resources and support (to avoid duplication of efforts), and sharing successes and best practices. Supports for tracking and evaluating implementation of the state's infrastructure is also important so course corrections can be made to focus on strategies with the most potential for impact.

OPPORTUNITIES FOR ENGAGING THE PRIVATE SECTOR

In most cases, innovation in new non-traditional sectors is driven by leadership willing to adopt suicide prevention as a priority and translate interventions so they are relevant to the sector's risk factors and culture. For an example of how the construction industry has galvanized around the issue of suicide prevention and made it unique to their industry's needs and culture, please see the Construction Industry Alliance for Suicide Prevention. There are similar efforts related to engaging public safety professionals in suicide prevention.

There are a number of opportunities to engage the private sector to advance state-level suicide prevention efforts. The Action Alliance model includes bringing together key leadership from the sector to develop a strategic implementation plan specific to that industry, for example:

- Workplace:
  - Provide a platform for larger employers to serve as leaders and promote their work to integrate mental wellness and suicide prevention into workplace violence prevention, risk management, and wellness efforts.
  - Support adoption of a comprehensive approach to suicide prevention among larger employers.
- Healthcare:
  - Ensure that communities and organizations in responding to new training requirements (Board of Psychology) have access to evidence-informed training opportunities, increasing the capacity of the private sector clinical workforce to treat those at risk for suicide.
  - Support implementation of Zero Suicide in private sector health care by hosting statewide Zero Suicide Academies and creating other opportunities to unite state health care leaders around statewide adoption of Zero Suicide.

CONCLUSION

We look forward to continuing to work with the Commission in whatever way is helpful to support efforts to develop a revised California state suicide prevention plan and encourage consideration of the critically important role the private sector plays in scaling up suicide prevention within the state.

A recent report from the U.S Substance Abuse and Mental Health Services Administration found that while there are more suicide prevention activities in states than ever before – there is still no one state implementing a comprehensive approach to suicide. This is critically important to note because the evidence for successful suicide prevention efforts at the population level, all require a bundled, comprehensive approach. We encourage California to use this opportunity to put in place a scalable comprehensive state response to suicide.

NATIONAL ACTION ALLIANCE FOR SUICIDE PREVENTION

The nation's public-private partnership for suicide prevention

The National Action Alliance for Suicide Prevention is working with more than **250** national partners to advance the nation's goal of reducing the annual suicide rate 20 percent by **2025** by:

Engage key stakeholders to improve and strengthen suicide care in our nation's health systems.

PRIORITY: Scale up implementation of Zero Suicide in health care, enhance follow-up care, train health care workforce, improve the financing of suicide care, and ensure care is available during a crisis to treat individuals at risk.

Support community-based efforts to implement effective suicide prevention strategies.

PRIORITY: Support the development of comprehensive community-based suicide prevention resources for states and communities, and improve the effectiveness of existing community-based suicide prevention efforts.

Leverage news media, entertainment industry representatives, and suicide prevention messengers to change the national narrative around suicide.

PRIORITY: Engage with key audiences, who play a role in educating the public about suicide and suicide prevention, to transform national narrative from ones of despair to ones of hope and recovery.

ActionAllianceforSuicidePrevention.org | Info@ActionAllianceforSuicidePrevention.org | FOLLOW US:

The nation's public-private partnership for **suicide prevention**

Our Background

Launched on World Suicide Prevention Day (September 10) in 2010, the Action Alliance is the nation's public-private partnership for suicide prevention. The Action Alliance is an influential and productive public-private partnership charged with championing suicide prevention as a national priority, catalyzing efforts to implement high priority objectives of the *National Strategy for Suicide Prevention (NSSP)*, and cultivating the resources needed to sustain progress.

Our Leadership

We are guided by a distinguished group of leaders from the public and private sectors who provide leverage and influence to prioritize suicide prevention at the national level.

Sectors represented include automobile, construction, defense, education, entertainment, faith, forestry, health, insurance, justice, law enforcement, mental health, military, news media, professional sporting, railroad, technology, and veteran services.

Our Commitment

The Action Alliance is committed to:

- Developing, disseminating, and supporting the implementation of suicide prevention efforts in clinical and community settings (e.g., health care systems, faith communities, workplaces)
- Reaching at-risk populations (e.g., American Indian/Alaska Native, service members, suicide attempt survivors, survivors of suicide loss, veterans and military)
- Ensuring public messaging about suicide and suicide prevention is accurate, safe, helpful, and effective
- Engaging individuals with lived experience to inform and enhance future prevention strategies
- Improving national data systems for public health surveillance of suicide-related behavior
- Advancing implementation of the Action Alliance's *A Prioritized Research Agenda for Suicide Prevention*

NATIONAL ACTION ALLIANCE FOR SUICIDE PREVENTION

ZEROSuicide IN HEALTH AND BEHAVIORAL HEALTH CARE

Faith. Hope. Life.

Support for Action Alliance initiatives comes from the public and private sectors. The Substance Abuse and Mental Health Services Administration (SAMHSA) provides funding to Education Development Center, Inc. (EDC), to operate and manage the Secretariat for the Action Alliance, which was launched in 2010. Initiatives catalyzed by the Action Alliance include the Faith. Hope. Life Campaign and the Zero Suicide Initiative.

ActionAllianceforSuicidePrevention.org | Info@ActionAllianceforSuicidePrevention.org | FOLLOW US:

ZEROSuicide

IN HEALTH AND BEHAVIORAL HEALTH CARE

www.zerosuicide.com

Transforming Systems for Safer Care

Suicide deaths for patients at risk of suicide in health and behavioral health systems are preventable. For systems dedicated to improving patient care and outcomes, the Zero Suicide framework presents both an aspirational challenge and a way forward.

Zero Suicide Approach

People who die by suicide are touching the health care system: 83% of those who die by suicide have seen a health care provider in the year before their death (Ahmedani et al., 2014). Only 29% of those who died in the past year were seen in outpatient behavioral health (Luoma et al., 2002).

Across health and behavioral health care settings, there are many opportunities to identify and provide care to those at risk for suicide. Before that can happen, suicide prevention must first be seen as a core responsibility of health care.

The Zero Suicide framework is defined by a system-wide, organizational commitment to safer suicide care in health and behavioral health care systems.

It is a culture shift away from fragmented suicide care toward a holistic and comprehensive approach to patient safety and quality improvement—the most fundamental responsibility of health care—and to the safety and support of the staff who do the demanding work of treating and caring for suicidal patients.

Elements of Zero Suicide

1. **Lead** system-wide culture change committed to reducing suicides
2. **Train** a competent, confident, and caring workforce
3. **Identify** patients with suicide risk via comprehensive screenings
4. **Engage** all individuals at-risk of suicide using a suicide care management plan
5. **Treat** suicidal thoughts and behaviors using evidence-based treatments
6. **Transition** individuals through care with warm hand-offs and supportive contacts
7. **Improve** policies and procedures through continuous quality improvement

EDC Education Development Center

SPRC

ZEROSuicide

IN HEALTH AND BEHAVIORAL HEALTH CARE

www.zerosuicide.com

Zero Suicide Results

Zero Suicide fills the gaps that patients at risk for suicide often fall through using evidence-based tools, systematic practices, training, and embedded workflows. Continuous process improvement drives this framework to ensure organizations deliver quality care, routinely examine outcomes, and remain committed to fidelity. The Zero Suicide approach builds on successes supported by data in health care organizations, including Henry Ford Health System and Centerstone.

With a focus on suicide care using such rigorous quality improvement processes, Henry Ford Health System demonstrated stunning results—a 75% reduction in the suicide rate among their health plan members (Coffey 2007). Centerstone, one of the nation's largest not-for-profit CMHCs, saw a reduction in suicide deaths from a baseline of 35 per 100,000 to 13 per 100,000 after implementing Zero Suicide for 3 years.

> *It is critically important to design for zero even when it may not be theoretically possible. When you design for zero, you surface different ideas and approaches that if you're only designing for 90 percent may not materialize. It is about purposefully aiming for a higher level of performance.*

Thomas Priselac, CEO
Cedars Sinai Medical Center

Visit the Zero Suicide Toolkit

To assist health and behavioral health organizations in their adoption of the Zero Suicide framework, the Suicide Prevention Resource Center (SPRC), federally funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), offers a free and publicly available evolving online toolkit that includes modules and resources to address each of the elements of Zero Suicide.

www.zerosuicide.com/toolkit

For more information, please contact us at:

zerosuicide@edc.org

@ZSInstitute

Information on SAMHSA's Zero Suicide Grants can be found at https://go.edc.org/samhsazsgrants.

Ahmedani, B. K., et al. (2014) Health care contacts in the year before suicide death. Journal of General Internal Medicine 29(5):870-7.

Luoma, et al. (2002) Contacts with mental health and primary care providers before suicide: a review of the evidence. American Journal of Psychiatry 159(6): 909-916.

Coffey, C.E. (2007). Building a system of perfect depression care in behavioral health. Joint Commission Journal on Quality and Patient Safety 33(4):199-6.

Getting Started with Zero Suicide

Ready to join the growing number of health and behavioral health care organizations who have already begun implementing Zero Suicide? Follow the link below for access to:

- The Quick Guide to Getting Started
- The Zero Suicide e-list
- Training and consultation

www.zerosuicide.sprc.org/how-do-i-get-started

STATE OF CALIFORNIA
EDMUND G. BROWN JR., Governor

Mental Health Services
Oversight & Accountability Commission

September 14, 2018

Pete Manzo, President and CEO
United Ways of California
1107 Fair Oaks Avenue, #12
South Pasadena, CA 91030

Dear Mr. Manzo:

Thank you for agreeing to participate in the Commission's public hearing on suicide prevention on Thursday, October 25, 2018 at the Marina Inn on San Francisco Bay, 68 Monarch Bay Drive, San Leandro, California. The Commission's meeting will include three panels to support the Commission's understanding of opportunities to prevent suicide and suicide attempt, and support the Commission's efforts to develop a strategic statewide suicide prevention plan, as authorized by the California Legislature.

Your panel will highlight opportunities for private-public partnership and sustaining suicide prevention efforts over time, and is scheduled to begin at approximately 11:30 a.m. Please plan to present for 10 to 15 minutes to leave time for discussion with Commissioners. Please organize your presentation to respond to the following:

- How United Ways of California and its network of affiliates are delivering services that prevent suicide and promote protective factors
- How programs and services delivered by nonprofits, such as United Ways, can be integrated with other health care and behavioral health care systems to prevent the development of factors that put people at risk for suicidal thoughts and behaviors
- Opportunities for the state to pursue private-public partnerships as a possible method to advance its suicide prevention strategy, including the role of nonprofits in such a partnership

Please send a brief biography and written response or background materials to the items above by Wednesday, October 3, 2018 to Ashley Mills at ashley.mills@mhsoac.ca.gov. Your written responses will allow Commissioners attending the meeting the opportunity to prepare questions for you after your presentation, and will be available for Commissioners unable to attend the meeting. Please note that your written responses and biography will be shared as public documents.

Should you have any questions, I can be reached at toby.ewing@mhsoac.ca.gov or 916.445-8696. Thank you again for your willingness to participate in this important meeting.

Respectfully,

Toby Ewing

Toby Ewing, Ph.D.
Executive Director

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United Ways of California

Opportunities for Private-Public Partnership and Sustaining Suicide Prevention Efforts

Pete Manzo, CEO, United Ways of California

October 25th, 2018

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Topics

United Ways of California

- Overview of UWCA Statewide Network, Mission, Goals
- 2-1-1 in California
- Suicide Prevention Efforts of Local United Ways
- Resiliency & Protective Factors
- Community Strengthening
- Private-Public Partnerships & Opportunities

UWCA Statewide Network

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United Ways of California

01 Arrowhead United Way
02 Central County United Way
03 Corona-Norco United Way
04 Inland Empire United Way
05 Kings United Way
06 Orange County United Way
07 United Way California Capitol Region
08 United Way Fresno and Madera Counties
09 United Way of Greater Los Angeles
10 United Way of Imperial County
11 United Way of Kern County
12 United Way of Merced County
13 United Way of Mojave Valley
14 United Way of Monterey County
15 United Way of Nevada County
16 United Way of Northern California
17 United Way of Northern Santa Barbara County
18 United Way of San Diego County
19 United Way of San Joaquin Valley
20 United Way of San Luis Obispo
21 United Way of Santa Barbara County
22 United Way of Santa Cruz County
23 United Way of Stanislaus County
24 United Way of the Bay Area
25 United Way of the Desert
26 United Way of the Inland Valleys
27 United Way of the Wine Country
28 United Way of Tulare Couunty
29 United Way of Ventura County
30 United Ways of California
31 Woodland United Way
32 Yuba-Sutter United Way

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What We Do: Community Impact

United Ways of California

- UWCA advances the health, education and financial stability of all Californians by enhancing and coordinating the advocacy and community impact work of our United Way network .
- UWCA is the nonpartisan state association for the 31 local United Ways.
- We believe the involvement of all sectors are required to make progress on vital challenges facing children and families.
- Advancing the common good is less about helping one person at a time and more about changing systems to help all of us

California 2-1-1
Get Connected. Get Answers.

United Way
United Ways of California

- Currently serving 1.4 million callers of all income levels, languages and cultural backgrounds each year, and many more people through the internet, 2-1-1 programs in California are an essential part of the state's social service infrastructure.
- 2-1-1 services are available to 97% of Californians, residing in 38 of 58 California counties.
- California United Ways collectively either operate or provide financial support for 2-1-1 services in 29 counties.

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Suicide Prevention

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United Way
United Ways of California

Suicide Prevention and Crisis Services of Yolo County

Our Programs

Suicide Prevention of Yolo County is a non-profit organization with the mission of providing crisis prevention and intervention, education, and community outreach services to the residents of Yolo County. Click the menu button above to find out more about our programs, agency information, and how you can get involved.

Crisis Lines

Suicide Prevention provides 24-hour crisis lines where you can reach out for help, 365 days a year. We are American Association of Suicidology (AAS) accredited and a National Suicide Prevention Lifeline certified center.

SOS-Signs of Suicide® School Program

SOS Signs of Suicide® programs are depression awareness and suicide prevention programs that can be implemented in one class period by our School Presenter.

Friends & Families of Suicide Loss Support Group

This once a month group in Davis provides a place for people who have lost someone to suicide. With the aid of a professional facilitator, group members help each other through the painful grief associated with a suicidal death.

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Suicide Prevention: The HELPline of Community Connect for Riverside County

United Ways of California

211 Community Connect

Home | What We Do | Get Involved | Events | News | About Us | Contact Us | Donate

HELPline

How Does HELPline at (951) 686-4357 Work?

The HELPline of Community Connect offers a confidential 24/7 Suicide/Crisis Intervention hotline service. When you dial (951) 686-4357, you are put in touch with someone who cares, who will listen and support you in your time of crisis. Counselors who have successfully completed 58 hours of crisis/suicide training answer the HELPline phones 24-hours a day. Bilingual counselors are also available. The hotline number serves as a lifeline to those who may be feeling overwhelmed, in need of emotional assistance and possibly considering suicide.Together you explore alternatives to help stabilize your situation. It is important to remember "you are not alone" when a crisis occurs. You may remain anonymous when you call HELPline, all conversations are confidential.

There Is Hope

Community Education

Volunteer

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Resiliency & Protective Factors

United Ways of California

The effect that a sense of belonging can have on an individual and community is a powerful tool in preventing isolation, building confidence, and accessing services that improve the quality of life.

United Way of Kern County

Raising A Reader

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Community Strengthening

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United Ways of California

UWCA has a unwavering commitment to “horizontal integration.”

- The building blocks – health, education and financial stability - of a good life are interconnected.
- We believe the services that support positive outcomes for children and families should be as well.

United Way
California Capital Region

SQUARE ONE PROJECT

Private-Public Partnerships

United Ways of California

Our role is to bring diverse and unlikely, and seemingly incompatible stakeholders together to solve problems.

In addition to our nonprofit and public sectors partners, California United Ways are proud to work with the following regional and corporate partners:

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THANK YOU

FOR GETTING INVOLVED.

CHANGING LIVES.

LIVING UNITED.

MHSOAC Suicide Prevention Panel Background

Your panel will highlight opportunities for private-public partnership and sustaining suicide prevention efforts over time, and is scheduled to begin at approximately 11:30 a.m. Please plan to present for 10 to 15 minutes to leave time for discussion with Commissioners. Please organize your presentation to respond to the following:

- **How United Ways of California and its network of affiliates are delivering services that prevent suicide and promote protective factors?**

    - United Ways of California advances the health, education and financial stability goals of the 31 local United Ways through education and advocacy. As a nonpartisan state association, we believe the involvement of all sectors—business, nonprofits, philanthropy, government, and an engaged citizenry—are required to make progress on vital challenges facing children and families. We see our role as bringing diverse (and sometimes unlikely) groupings of stakeholders together to address common social problems and work closely with local United Ways to create innovative opportunities to address them.

      We have the benefit of a statewide and national network with a trusted brand AND the ability to be hyper-local in our activities and programs. One of the most compelling elements of this work is the inherent protective factors that come with our local initiatives and opportunities for communities to come together to address various social determinants of health. Family strengthening, volunteer opportunities, crisis and disaster response, cross-generational and cross-cultural exchanges, you name it we are building connections that are profound.

      The effect that a sense of belonging can have on an individual and community is a powerful tool in preventing isolation, building confidence, and accessing services that improve the quality of life for millions.

    - Millions of people rely on 2-1-1 information and referral services for support and assistance during a mental health crisis or when seeking advice and connections to resources on behalf of a loved one. While there are a number of local and regional crisis lines - many of which our members support and promote in our communities, 2-1-1 also acts as a safe starting point for a wide range of services that inherently have protective factors. *It is important to note that 2-1-1 services (hours of operation, linked services) may vary by county and region.*

    - Some specific suicide prevention efforts that our local member United Ways' support are:
        - United Way – California Capitol Region supports the Suicide Prevention and Crisis Services serving Amador, El Dorado, Sacramento, and Yolo Counties. These services include:
            - 24-hour/365-day telephone crisis services for teens and adults,
            - "SOS – Signs of Suicide" school prevention and education program,
            - and survivor support groups.

- United Ways of the Inland Valleys supports The HELPline of Community Connect for Riverside County which offers a confidential 24/7 Suicide/Crisis Intervention hotline service.
    - Counselors have successfully completed 58 hours of crisis/suicide training answer the HELPline phones 24-hours a day. Bilingual counselors are available.
    - The hotline number serves as a lifeline to those who may be feeling overwhelmed, in need of emotional assistance and possibly considering suicide.

- **How programs and services delivered by nonprofits, such as United Ways, can be integrated with other health care and behavioral health care systems to prevent the development of factors that put people at risk for suicidal thoughts and behaviors**

    - The simple first step is taking place here today, by actively inviting the non-profit sector to the table and conversation we are able to open up the state and local public services to a whole new network of community-based impact work that is underway. And for United Ways' we are all committed to a unique approach that integrates all elements of wellness, from health, education, and financial security. It is built into our service delivery approach that these important factors are thoughtfully tied into all we do. We believe in the integration of services and programs to address the whole person, family and community.

    - Nonprofits, especially local United Ways, are all independent 501(c)3s and this allows great flexibility and the ability to respond to specific local issues and needs. It also means having differing roles from county to county or region to region. Our collective success relies greatly on our relationships and commitment to breaking down silos in a highly segmented service delivery system. This is where nonprofits as a neutral convener and backbone entities as part of a collective impact model really demonstrates our strengths and value, even beyond direct services and programming.

      Additionally, we build and promote opportunities for volunteerism, which is at its core an expression of human relationships. It is about people's need to participate in their societies and to feel that they matter to others. We strongly believe that the social relationships intrinsic to volunteer work are critical to individual and community well-being and therefore something as critical as mental health and suicide prevention.

- **Opportunities for the state to pursue private-public partnerships as a possible method to advance its suicide prevention strategy, including the role of nonprofits in such a partnership**

    - We know that to achieve our shared goals, a broad range of stakeholders must assume responsibility for child and youth success. Systems and settings should be organized to ensure the all young people have ongoing access to and participate in high quality services. This is where our community and collective impact approach truly shows how much we can accomplish together. It is grounded in the belief that no single policy, government department, organization

or program can tackle or solve the increasingly complex social problems we face as a society. This approach calls for multiple organizations or entities from different sectors to set aside their own agendas in favor of a common agenda, shared measurement and alignment of effort. United Ways as a trusted brand and partner across the state of California, working on a myriad of public-private partnerships including outreach and enrollment into healthcare, volunteer tax assistance and the expansion of the California Earned Income Tax Credit, and outreach and enrollment into affordable high speed internet, to name just a few.

- The State has a number of opportunities to engage and collaborate with private entities, including nonprofits. One opportunity that stands out is including nonprofits as key informants in the statewide suicide prevention planning process and tasking them with providing robust and meaningful feedback on existing relationships and efforts at the local and state level. Additionally, these partners can discuss the challenges that may exist in ensuring that Californians are in fact receiving the services and supports, both public and private, that encourages protective factors and ensures lives filled with meaning and connection.

- Nonprofits often have robust relationships with the private sector. A cornerstone of local United Way's impact is grounded in the trust and engagement we have with small and large corporate partnerships, such as UPS, Target, and Microsoft, among many others. These connections are powerful opportunities to imbue the broader conversation of wellness with how we as a community support one another experiencing mental health challenges. Additionally, these connections to private sector companies and philanthropic giving allows us to leverage engagement and potentially greater investments in prevention focused systems of care.

- We have lots of places to give back, and as we say at United Way – Live United, so the more we are talking with our public entity partners, both locally and statewide, the more connections we are able to build.

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AGENDA ITEM 3

Action

October 25, 2018 Commission Meeting

Election of the Chair and Vice-Chair for 2019

Summary: Elections for the Mental Health Services Oversight and Accountability Commission Chair and Vice-Chair for 2019 will be conducted. The MHSOAC Rules of Procedure state that the Chair and the Vice-Chair shall be elected at a meeting held preferably in September but no later than during the last quarter of the calendar year by a majority of the voting members of the Commission. The term is for one year and starts January 2019.

This agenda item will be facilitated by Chief Counsel, Filomena Yeroshek.

Enclosures: Commissioner Biographies

Handout: None

Mental Health Services
Oversight & Accountability Commission

Commissioner Biographies

Reneeta Anthony, Fresno
Joined the Commission: January 2016
Reneeta Anthony has been executive director at A3 Concepts LLC since 2013. She was principal staff analyst at the Fresno County Department of Social Services from 2005-2012, at the Fresno County Department of Behavioral Health from 2004-2005 and at the Fresno County Human Services System from 2001-2004. Anthony was principal staff analyst at the Fresno County Department of Children and Family Services from 2000-2001, where she was senior staff analyst from 1999-2000. Commissioner Anthony fills the seat of a family member of an adult child with a severe mental illness.

Mayra Alvarez, Los Angeles
Joined the Commission: December 2017
Mayra Alvarez is the President of the Children's Partnership, a nonprofit children's advocacy organization. She served in the U.S. Department of Health and Human Services (HHS), most recently as Director of the State Exchange Group for the Center for Consumer Information and Insurance Oversight at the Centers for Medicare and Medicaid Services. She also served as the Associate Director for the HHS Office of Minority Health and was Director of Public Health Policy in the Office of Health Reform at HHS. Alvarez received her graduate degree from the University of North Carolina at Chapel Hill and her undergraduate degree from University of California Berkeley. Commissioner Alvarez fills the seat of the Attorney General/designee.

Lynne Ashbeck, Clovis
Joined the Commission: February 2016
Lynne Ayers Ashbeck is the senior vice president of community engagement and population wellness for Valley Children's Healthcare. She has also served as vice president at Community Medical Centers; regional vice president at the Hospital Council of Northern and Central California; director of Continuing and Global Education at California State University, Fresno; and director of education at Valley Children's Hospital. She is an elected Councilmember in the City of Clovis, first elected in 2001. She is also a member of the California Partnership for the San Joaquin Valley Board of Director and the Maddy Institute Board of Directors. She received her Master of Arts degree from Fresno Pacific University and a Master of Science degree from California State University, Fresno. Commissioner Ashbeck fills the seat of a representative of a health care service plan or insurer.

Khatera Aslami-Tamplen, Pleasant Hill
MHSOAC Vice Chair
Joined the Commission: June 2013
Khatera Aslami-Tamplen has been consumer empowerment manager at Alameda County Behavioral Health Care Services since 2012. She was executive director at Peers Envisioning and Engaging in Recovery Services from 2007-2012 and served in multiple positions at the Telecare Corporation Villa Fairmont Mental Health Rehabilitation Center from 2002-2007, including director of rehabilitation. Aslami-Tamplen is a founding member of the California Association of Mental Health Peer Run Organizations and on the Board of Directors of the National Coalition for Mental Health Recovery. Commissioner Aslami-Tamplen represents clients and consumers.

Senator Jim Beall, San Jose
Joined the Commission: February 2015
Jim Beall was elected to the California State Senate in 2012 and represents the 15th Senate District. He was elected to the State Assembly in November 2006, representing District 24. He is the chairman of the Senate Transportation and Housing Committee, in addition to serving on several other committees. He has spent three decades in public service as a San Jose City Councilman, a Santa Clara County Supervisor and an Assembly member. On the Commission, Senator Beall represents the member of the Senate selected by the President pro Tempore of the Senate.

John Boyd, Psy.D, Folsom
MHSOAC Chair
Joined the Commission: June 2013
John Boyd is Sutter Health's Chief Executive Officer of Mental Health Services. He has an extensive background in healthcare administration and mental health. Prior to joining Sutter in 2008, he served as Assistant Administrator for Kaiser Permanente Sacramento Medical Center and has worked as both an inpatient and outpatient therapist in several organizations. He is a Board Member of National Mental Health America; he has also served in other appointed capacities, including City of Sacramento Planning Commissioner. Boyd is a Fellow with the American College of Healthcare Executives. He earned his doctorate in psychology at California School of Professional Psychology and his MHA from University of Southern California. Commissioner Boyd represents an employer with more than 500 employees.

Bill Brown, Lompoc
Joined the Commission: December 2010
Bill Brown was first elected as sheriff and coroner for Santa Barbara County in 2006. He had previously served as chief of police for the city of Lompoc from 1995-2007, and chief of police for the city of Moscow, Idaho from 1992-1995. He was a police officer, supervisor and manager for the city of Inglewood Police Department from 1980-1992, and a police officer for the city of Pacifica from 1977-1980. Prior to his law enforcement career, Sheriff Brown served as a paramedic and emergency medical technician in the Los Angeles area from 1974-1977. Sheriff Brown holds a master's degree in public administration from the University of Southern California and is a graduate of the FBI National Academy and the Delinquency Control Institute. Commissioner Brown fills the seat of the county sheriff.

Keyondria Bunch, Ph.D., Los Angeles
Joined the Commission: August 2017
Keyondria Bunch works as a Clinical Psychologist for the Los Angeles County Department of Mental Health in the Assisted Outpatient Treatment program where she collaborates with hospitals, community mental health agencies, and court officials to provide services to chronically mentally ill individuals. Bunch also serves as an SEIU 721 Union Steward and initiated the Los Angeles County Department of Mental Health Psychologist Joint Labor Management Meeting. She is certified in evidenced-based treatment interventions and has served on the DMH committee for national training on African American mental health. Bunch also has a private practice where she provides Post Traumatic Stress Disorder and Military Sexual Assault assessments for Veterans as well as Court Appointed Competency evaluations. She has held numerous adjunct professor positions at various colleges and universities. Bunch earned a B.A. in Psychology from San Diego State University and a Masters Degree in Education from Harvard University as well as a Ph.D. in Counseling Psychology from the University of Southern California. Commissioner Bunch fills the seat of a labor representative.

Assemblymember Wendy Carrillo, Los Angeles
Joined the Commission: February 2018
Wendy Carrillo was elected to represent California's 51st Assembly District in December 2017. Assemblymember Carrillo has advocated for educational opportunity, access to quality healthcare, living wage jobs, and social justice. She was host and executive producer of community-based radio program "Knowledge is Power" in Los Angeles. Her previous work with Service Employees International Union (SEIU) Local 2015 included better working conditions for caregivers. She arrived to the United States as an undocumented immigrant from El Salvador and became a U.S. citizen in her early 20s. Assemblymember Carrillo represents the member of the Assembly selected by the Speaker of the Assembly.

Itai Danovitch, M.D., Los Angeles
Joined the Commission: February 2016
Itai Danovitch has been chair of the Psychiatry Department at Cedars-Sinai Medical Center since 2012, where he has held several positions since 2008, including director of addiction psychiatry clinical services and associate director of the Addiction Psychiatry Fellowship. He is a member of the American Society of Addiction Medicine and the American Psychiatric Association and past president of the California Society of Addiction Medicine. Danovitch earned a Doctor of Medicine degree from the University of California, Los Angeles School of Medicine and a Master of Business Administration degree from the University of California, Los Angeles School of Management. Commissioner Danovitch fills the seat of a physician specializing in alcohol and drug treatment.

David Gordon, Sacramento
Joined the Commission: January 2013
David Gordon has been county superintendent at the Sacramento County Office of Education since 2004. He served at the Elk Grove Unified School District as superintendent from 1995-2004. He worked at the California Department of Education as deputy superintendent from 1985-1991. He earned a Master of Education degree from Harvard University. Commissioner Gordon holds a seat as superintendent of a school district.

Mara Madrigal-Weiss, San Diego
Joined the Commission: September 2017
Mara Madrigal-Weiss is the Director of Wellness and Student Achievement with the San Diego County Office of Education. Her experience includes working with school communities as a Family Case Manager, Protective Services Worker and Family Resource Center Director. Madrigal-Weiss received her M.A. in Human Behavior from National University; a M.Ed. in counseling and a M.Ed. in Educational Leadership from Point Loma Nazarene University. She was part of the California Department of Education's Student Mental Health Policy Workgroup that supported recently-passed AB 2246 requiring all school districts in California to adopt a suicide prevention policy. Commissioner Madrigal-Weiss fills the seat of designee of the State Superintendent of Public Instruction.

Gladys Mitchell, Sacramento
Joined the Commission: January 2016
Gladys Mitchell served as a staff services manager at the California Department of Health Care Services from 2013-2014 and at the California Department of Alcohol and Drug Programs from 2010-2013 and from 2007-2009. She was a health program specialist at California Correctional Health Care Services from 2009-2010 and a staff mental health specialist at the California Department of Mental Health from 2006-2007. She was interim executive officer at the California Board of Occupational Therapy in 2005 and an enforcement coordinator at the California Board of Registered Nursing from 1996-1998 and at the Board of Behavioral Science Examiners from 1989-1993. She is a member of the St. Hope Public School Board of Directors. Mitchell earned a Master of Social Work degree from California State University, Sacramento. Commissioner Mitchell fills the seat of a family member of a child who has or has had a severe mental illness.

Tina Wooton, Santa Barbara
Joined the Commission: December 2010
Tina Wooton has worked in the mental health system for 23 years, advocating for the employment of consumers and family members at the local, state and federal levels. Since 2009 she has served as the Consumer Empowerment Manager for the Santa Barbara County Department of Alcohol, Drug, and Mental Health Services. From 2005 through 2009 she worked as the Consumer and Family member liaison for the California State Department of Mental Health and was staff to the state Mental Health Services Act Implementation Team. Between 1997 and 2005 she served as Consumer Liaison for the Mental Health Association / County Mental Health of Sacramento and as service coordinator for Human Resources Consultants from 1994 through 1997. Wooton is Vice President of AMP (Arts Mentorship Program) for Santa Barbara Dance Arts and a Santa Barbara Elks member. Commissioner Wooton represents clients and consumers.

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AGENDA ITEM 4

Action

October 25, 2018 Commission Meeting

Alameda County Innovation Plans

Summary: The Mental Health Services Oversight and Accountability Commission will consider approval of Alameda County's request to fund the following three new Innovative projects for a total amount of $12,434,424 (see below for project breakdown).

(A) **Introducing Neuroplasticity to Mental Health Services for Children - $2,054,534**

(B) **Community Assessment and Transport Team (CATT) - $9,878,082**

(C) **Emotional Emancipation Circles for Young Adults - $501,808**

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.

- Alameda County would like to incorporate neurodevelopmental interventions into participating elementary schools within their school district by bringing Holistic Approach to Neuro-Developmental and Learning Efficiency (HANDLE) training for clinical and non-clinical providers to provide assessment and interventions with the hopes that incorporating HANDLE will improve outcomes for youth experiencing mental health challenges by changing the brain's plasticity.

- Alameda County proposes to design and implement a mobile crisis response system that requires collaboration among several county agencies in an effort to reduce the high rates of 5150 holds in their County.

- Alameda County proposes to take a community defined practice (Emotional Emancipation Circles, ECC) and "tailor" it to better reach African American young adults. The County reports that in its current format, the community practice is geared more towards older participants and that there is an identified sense of isolation and community disconnectedness expressed by younger African American mental health consumers.

Presenters for Introducing Neuroplasticity to Mental Health Services for Children Project:

- Catherine Franck, LCSW; Behavioral Health Clinical Manager for Child and Young Adult System of Care
- Jeff Rackmil, LCSW; BHCS Child and Young Adult System of Care Director
- Sindy Wilkinson, MEd, LMFT, Behavioral Health Clinician for Child and Young Adult System of Care

Presenters for Community Assessment and Transport Team Project:

- Stephanie Lewis, MS, LMFT, Interim Crisis Services Division Director
- Karl A. Sporer, MD, Emergency Medical Services Medical Director
- Melissa Vallas, MD, Alameda County Care Connect Crisis Liaison/ Lead Psychiatrist for Children's System of Care

Presenters for Emotional Emancipation Circles for Young Adults Project:

- Lisa Carlisle, MA, MEd, Medi-Cal Specialty Mental Health Coordinator for Child and Young Adult System of Care
- Shannon Singleton-Banks, MPH, Senior Program Specialist for Alameda County's Public Health Department

Enclosures (7): (1) Biographies for Alameda County's Innovation Presenters; (2) Staff Analysis: Introducing Neuroplasticity to Mental Health Services for Children Project; (3) Project Brief: Introducing Neuroplasticity to Mental Health Services for Children; (4) Staff Analysis: Community Assessment and Transport Team Project; (5) Project Brief: Community Assessment and Transport Team; (6) Staff Analysis: Emotional Emancipation Circles for Young Adults Project; (7) Project Brief: Emotional Emancipation Circles for Young Adults.

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

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

http://mhsoac.ca.gov/sites/default/files/documents/2018-10/Alameda%20County_INN%20PLAN_%20Neuroplasticity%20for%20Children_8.6.2018_Final.pdf

http://mhsoac.ca.gov/document/2018-10/alameda-county-community-assessment-and-transport-team-catt-innovation-plan-october

http://mhsoac.ca.gov/sites/default/files/documents/2018-10/Alameda_INN%20Draft_Transitional%20%20Age%20Youth%20Emotional%20Emancipation%20Circles_8.6.2018_Final.pdf

Proposed Motion: The MHSOAC approves Alameda County's Innovation Projects, as follows:

Name:	Introducing Neuroplasticity to Mental Health Services for Children
Amount:	$2,054,534
Project Length:	4 years

Name:	Community Assessment and Transportation Team (CATT)
Amount:	$9,878,082
Project Length:	5 years

Name:	Emotional Emancipation Circles for Young Adults
Amount:	$501,808
Project Length:	2 years, 6 months

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Biographies for Alameda County Presenters

INN Project #1: Introducing Neuroplasticity to Mental Health Services for Children

Catherine Franck, LCSW
Behavioral Health Clinical Manager for Child and Young Adult System of Care
Ms. Franck has been working with children and families as a social worker for over thirty years. For the past twenty years she has been working at Alameda County Behavioral Health Care services as a therapist and manager. In 2009 she was certified as a HANDLE Screener.

Jeff Rackmil, LCSW
BHCS Children and Young Adult System of Care Director
Mr. Rackmil has been with Alameda County Behavioral Health Care Services (BHCS) since 1998, implementing his belief that effectively helping children and families requires collaboration among agencies. He has played an instrumental role in developing an integrated System of Care approach, partnering with child-serving agencies including Social Services, Juvenile Probation, School Districts, Public Defender, District Attorney, Regional Center and many others.

Sindy Wilkinson, MEd, LMFT
Behavioral Health Clinician for Child and Young Adult System of Care
Ms. Wilkinson has worked for 38 years with youth with mental health issues, including 17 years as a certified HANDLE Practitioner and 8 years as a public school teacher. She uses her training in HANDLE with BHCS and private practice clients, as well as in providing training for other practitioners.

INN Project #2: Community Assessment and Transport Team (CATT)

Stephanie Lewis, MS, LMFT
Interim Crisis Services Division Director
Ms. Lewis has nearly 20 years of experience providing crisis mental health services in collaboration with law enforcement and EMS. Beyond the day to day oversight of crisis services, she is responsible for development of the Crisis Continuum of Care, with the goal of providing right matched care and reducing the use of the most restrictive psychiatric services.

Karl A. Sporer, MD
Emergency Medical Services Medical Director
Dr. Sporer is a board certified emergency physician with over 30 years of experience in public emergency departments. He has worked as the Medical Director for multiple EMS organizations over the past 20 years including San Mateo EMS Agency, San Francisco 911 Dispatch Center, and the San Francisco Fire Department.

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Melissa Vallas, MD
Alameda County Care Connect Crisis Liaison/ Lead Psychiatrist for Children's System of Care
Dr. Vallas' experience covers a wide range of psychiatric service delivery models including: office based out-patient psychiatry services, program development, and psychiatric emergency services. She has worked in community psychiatry serving safety net populations since the completion of her training.

INN Project #3: Emotional Emancipation Circles for Young Adults

Lisa Carlisle, MA, MEd
Medi-Cal Specialty Mental Health Coordinator for Child and Young Adult System of Care
Ms. Carlisle has been working in education and mental health since 1999, with extensive experience providing direct support services to youth as well as overseeing various school and community based mental health programs. She holds a Master's Degree in Ethnic Studies and in Educational Administration and has been working in Alameda County Behavioral Health Care Services for nearly 8 years.

Shannon Singleton-Banks, MPH
Senior Program Specialist for Alameda County's Public Health Department
Ms. Singleton-Banks brings a wealth of experience in public and behavioral health, including community programming, health promotion, administration, and 25 years of working with specialty populations. She was the Transitional Age Youth program lead for BHCS for 12 years, including implementing an Emotional Emancipation Circles pilot project in 2017.

Mental Health Services
Oversight & Accountability Commission

STAFF ANALYSIS - ALAMEDA COUNTY

Name of Innovative (INN) Project:	**Introducing Neuroplasticity to Mental Health Services for Children**
Total INN Funding Requested for Project:	**$2,054,534**
Duration of Innovative Project:	**Four (4) Years**

Review History:

Approved by the County Board of Supervisors:	July 24, 2018
County submitted Innovation (INN Project):	August 6, 2018
MHSOAC consideration of INN Project:	October 25, 2018

Project Introduction:

Research shows that early trauma, also known as adverse childhood experiences (ACEs), can severely impact the neurodevelopment of a child. Neurodevelopmental disorders are disabilities in the functioning of the brain that affect a child's behavior, memory or ability to learn well beyond childhood years. Neuroplasticity is defined as the brain's ability to reorganize and change throughout an individual's life.

Alameda County would like to incorporate neurodevelopmental interventions into participating elementary schools within their school district. The County proposes to do this by bringing Holistic Approach to Neuro-Developmental and Learning Efficiency (HANDLE) training for clinical and non-clinical providers to provide assessment and interventions in the participating elementary schools with the hopes that incorporating HANDLE will improve outcomes for youth experiencing mental health challenges by changing the brain's plasticity.

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. Alameda County asserts this innovation project meets the primary purpose of increasing the quality of mental health services, including measurable outcomes.

The Need

Alameda County states there is research regarding neurodevelopmental differences in children who experience traumatic events early in life. Childhood trauma, known as Adverse Childhood Experiences (ACEs), can disrupt the brain's development which may result in physical, cognitive, and behavioral issues. ACEs may include events such as experiencing various types of abuse, neglect, growing up in a domestic violence environment, living in a household where mental illness is present, and parental separation and/or divorce. When children are exposed to stressful events, their development can become disrupted and as a result, develop negative coping mechanisms.

Additionally, there is existing correlation that indicates children who possess behavioral and emotional issues may also have underlying neurodevelopmental differences. It is Alameda's assertion that addressing these differences may result in improvement in emotional and behavioral issues.

Specific to the County, Alameda claims that in 2016, the Lucile Packard Foundation for Children's Health provided specialized educational services for the treatment of emotional disturbances for a total of 6,510 children (4.2%) between the ages of 5-12. Additionally, approximately 15% of students (n=23,250) in the County have been referred by school staff to Prevention and Early Intervention funded programs due to the child exhibiting behavioral and emotional issues.

Research performed for the writing of this analysis supports the County's findings that both positive and negative childhood experiences have significant impact on future violence victimization, perpetration, and overall health and well-being. According to the Substance Abuse and Mental Health Services Administration (SAMHSA), approximately 46% of youth have reported experiencing at least one trauma by the time they turn 17 years of age and this can lead to serious health and social consequences as an adult. If the number of traumatic events experienced by children increase, this typically results in an increase of various risk factors. For example, higher ACE scores could mean an individual is more at risk to attempt suicide, become an alcoholic or abuse substances.

With this project, the County proposes to adopt neurodevelopmental interventions as a school pilot project for children who may exhibit emotional and behavioral issues and determine if those symptoms are reduced with the incorporation of these interventions.

One of the examples the County provided was that of a child who may have skipped the crawling stage as an infant/toddler and as a result, will likely exhibit higher levels of anxiety, frustration and an ability to focus due to the underdevelopment between the left and right hemispheres of the brain. An activity to recreate this neural connection would be to bounce a ball in "an intentionally rhythmic and repetitive manner". This activity will create a new neural connection that would have originally been developed during the child's crawling stage as an infant/toddler. **The County may wish to provide additional examples of some of the interventions that may be used to reduce neurodevelopmental issues in the school setting.**

The Response

Alameda County proposes to incorporate a practice based on the neuroplasticity of the brain which effects learning, mood and behavior. This practice, called HANDLE (**H**olistic **A**pproach to **N**euro-**D**evelopmental and **L**earning **E**fficiency), has become a promising practice demonstrated to reduce underlying neurodevelopmental issues that can ultimately contribute to behavioral issues.

The research between neurodevelopmental disruption and childhood trauma is still being explored and there are studies to support that children diagnosed with ADHD experience functional improvements after being introduced to the HANDLE model. The County states there are HANDLE practitioners dispersed worldwide, with 12 HANDLE practitioners located in California. It is important to note that HANDLE does not teach coping skills; it is intended to improve brain function which can assist in reducing fundamental neurodevelopmental issues that can contribute to behavioral and emotional issues. Alameda County states this innovation project will address students who exhibit emotional and/or behavioral health issues and that HANDLE has not been previously evaluated regarding behavioral health issues. The HANDLE model is comprised of an initial assessment which helps to discover interruptions in the communication between the body and the brain which may add to functional difficulties.

For this project, the County states this innovation project will include the following steps **(see pages 103-104 for full details of steps below)**:

1. Participating schools and staff who will receive HANDLE training will be identified. HANDLE practitioners will then train approximately 150 individuals consisting of youth services staff from Alameda Behavioral Health Care Services (BHCS), staff from the participating elementary schools, parents of BHCS clients or students attending the participating elementary schools.
2. Training and certification for those who will be providing the neurodevelopmental interventions for students at the participating schools. It is anticipated that two full time equivalent (2.0 FTE), and up to six (6) part time positions, will be needed for this project.
   Additionally, approximately 12 staff (6 school staff and 6 BHCS staff) will attend a 14-day training to learn how to conduct assessment and apply more specific interventions. Later during the project, six (6) of the HANDLE practitioners will take

a more advanced assessment and intervention training. That training will be a total of 25 days and will take place over a several month period.

3. Lastly will come the three (3) part process of the implementation and application of HANDLE:
    a. Identification: School personnel will identify students who may be exhibiting signs of emotional and/or behavioral problems. Both the child's parent/guardian and child's teacher will be asking to complete a brief questionnaire along with a completing a checklist of possible concerns. Questionnaires and the checklist will be provided by HANDLE. Parent permission will be required in order for identified students to continue in this project. Additionally, parent involvement is also welcome. **The County may wish to explain the criteria that will be utilized when identifying children who may benefit from the HANDLE model.**
    b. Assessment: Depending on the results of the questionnaire, children who meet the established criteria will be assessed by a HANDLE practitioner who has already received previous training and certification.
    c. Intervention: Based upon the assessment, HANDLE practitioners will develop an intervention plan to address any identified neurological weaknesses. Once the intervention plan has been created, the HANDLE practitioner will review the intervention plan with the student's parent/guardian and the child's assigned Parent Aide. The Parent Aide will then provide neurodevelopmental interventions every day at school for a four (4) month period. Students receiving an assessment that identifies and requires more significant needs will be provided a more intensive six (6) month intervention. These interventions will occur in years two (2) and three (3) of the project. **The County may wish to discuss how this daily intervention may impact the child's curriculum or if it will cause child to fall behind in academics.**

One of the lead staff in this innovation project is a HANDLE trainer and will continue providing ongoing clinical support as needed throughout the duration of this project.

Alameda County states this is innovative because the integration of neurodevelopmental assessments and interventions may lead to improved outcomes for youth who may be experiencing a wide variety of mental health issues. Because neurodevelopmental research is still an evolving arena, mental health therapists are unlikely to have received formal training in this area as part of their academia. The treatment of underlying neurodevelopmental issues may ultimately also address any emotional and behavioral symptoms as a result. The County asserts that the provision of HANDLE services is a feasible way to provide non-clinical services for children who may be experiencing emotional and/or behavioral issues.

The Community Planning Process

Alameda County states their community planning process for this innovation project began in June 2017 and allowed for community feedback and input while developing this project. Five (5) separate community forums were held in each of the supervisory districts; 18 focus groups representing the various diverse populations were conducted in

the County; and a total of 550 surveys were completed and submitted in various languages to solicit feedback and input from the community. Alameda County asserts that school staff, parents, and providers will be culturally diverse and representative of the community. Additionally, schools participating in this project have been selected to ensure diversity in terms of culture, race, ethnicity, and socio-economic status and are represented in order to ensure underserved populations have access to these types of services.

Based on the needs identified during the CPP process, feedback from stakeholders revealed that behavioral issues and trauma in school settings were of primary concern. Public comment period at the County level began April 13, 2018 and concluded with a public hearing on May 14 2018. Alameda County submitted, as part of the innovation project, the substantive feedback that was received during the public comment period. Additionally, the County responded back to the public comments that were made (**see pgs 20-21 of plan**). The County also included letters of support along with their innovation project.

The link to this innovation project was also shared with stakeholders on April 18, 2018 while the County was in the middle of their county-level public comment period. Although the County received and responded to feedback, no letters of support or opposition were received at MHSOAC.

Learning Objectives and Evaluation

Alameda County plans on implementing a project to provide neurodevelopmental interventions in a non-clinical setting with the overall goal of reducing symptoms and improving functioning among students experiencing emotional and behavioral disorders. The County will target students in the County between the ages of 5 and 12 exhibiting emotional and behavioral disorders. It is the hope that approximately 70 students will be served each year, with a total of approximately 200 students receiving intervention services over the span of the three-year project. To guide their project, the County has identified two main learning goals, as well as short, medium, and long term outcomes (**See pg. 99 of County plan for logic model**):

1. Determine if implementing a neurodevelopmental approach to mental health changes the way educators and mental health providers understand children with emotional and behavioral disorders
    a. *Short-term outcome*: increase knowledge and skills on neurodevelopment, framework, assessment, and interventions by 75%
    b. *Medium-term outcome*: Increase neurodevelopment-informed responses to students by 50%
    c. *Long-term outcome*: Increase understanding of student behavior by 70%
2. Determine if neurodevelopmental interventions, using the HANDLE model among youth in the target population, reduces their emotional and behavioral symptoms and increases academic outcomes

a. *Short-term outcome*: students receiving interventions experience improved neuro-development, improved emotional or behavioral symptoms, and improved school performance
b. *Medium-term outcome*: students continue to show improvement over the year post-intervention
c. *Long-term outcome*: students experience long-term improved mental health and functional outcomes

In order to determine the effect that the HANDLE approach has on increasing neurodevelopment knowledge, the County will track trainings, provide surveys to participants after each training, track referral patterns, and hold focus groups at the conclusion of the project. In order to understand the impact that the interventions have on students' emotional and behavioral symptoms, and academic outcomes, the County will track HANDLE assessments, treatment plans and interventions, use a standardized tool to track changes in mental health symptoms and emotional regulation, as well as track school performance (**see pgs. 106-107 of County plan**). The County states that evaluators will review individual education plans (IEPs) for HANDLE participants one year after services have been provided in order to determine if any trends can be discerned.

Alameda County will contract out for evaluative purposes. An outside evaluator will assist the County in finalizing the evaluation plan, gathering and analyzing the data, and completing the final evaluation report. At the conclusion of the project, results and findings will be shared among other schools, stakeholders, and among other counties. Additionally, findings will be presented at various meetings with the MHSA Stakeholder Group, the Cultural Competency Advisory Board (CCAB), the Whole Person Care consumer group, NAMI, and others.

The Budget

Total proposed expenditures for this innovation project is $2,538,071; however, Alameda County is seeking approval for MHSA innovation funds in the amount of $2,054,534 for a total project length of four (4) years. The County anticipates in-kind funding (staff time and resources) in the amount of $483,537 (19%) in order for the Behavioral Health Clinician II's to attend training, complete assessments, and creating intervention plans. Alameda states this in-kind funding will come from the County General Fund, Early and Periodic Screening, Diagnostic and Treatment (EPSDT), and/or realignment funds.

The County will expend a total of $943,631 (37%) on employee salaries and staff will consist of a Behavioral Health Clinical Supervisor and a Clinician II.

Operating costs total $80,200 (3%) and will be used for office supplies, resource manuals, snacks, incentives, and paying for substitute teachers while the teacher's attend training. Indirect costs total $267,983 (11%) and will cover employee benefits, information technology, contract management, rent, utilities, and other various expenditures to facilitate the administration of this project.

A total of $762,720 (30%) has been allotted for the evaluation and associated consultant costs. Of this amount, $120,000 will be for the evaluation itself and will be contracted out; $135,000 will be provided for the HANDLE trainers for Fiscal Years (FY) 19/20 and FY 20/21; and the remaining $507,720 will pay for the parent aides. The County anticipates the parent aides will be filled with a total of six (6) part time aides to ensure adequate student coverage. These six (6) part time positions will be the equivalent of two (2) full time positions.

In regards to sustainability, the County states the continuation of this project will depend upon the overall evaluation results, the success, and available funding, recommendations from stakeholders, and support from the Children's system of care. If this project will be continued, the County may consider Prevention and Early Intervention or Community Service and Supports funding. Subject to Assembly Bill 114 (AB-14), the County will be using funds deemed reverted from FY 10/11 to cover expenses incurred during FY 18/19 and 19/20.

Additional Regulatory Requirements

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

References

https://sharpbrains.com/blog/2008/02/26/brain-plasticity-how-learning-changes-your-brain/

https://stepwellboulder.com/how-trauma-early-in-life-affects-neurodevelopment/

https://www.samhsa.gov/sites/default/files/brief_report_natl_childrens_mh_awareness_day.pdf

Anda, R.F & Felitti, V.J. (2003), ACE Reporter: *Origins and Essence of the Study,* v.1(1), pgs 1-2

Full project proposal can be accessed here:

http://mhsoac.ca.gov/sites/default/files/documents/2018-10/Alameda%20County_INN%20PLAN_%20Neuroplasticity%20for%20Children_8.6.2018_Final.pdf

Project Summary

County: **Alameda County**
Date submitted: 4/13/2018
Project Title: **Introducing Neuroplasticity to Mental Health Services for Children**
Total amount requested: $2,054,534
Duration of project: 4 years

General Requirement	Applies a promising community driven practice or approach that has been successful in a non-mental health context or setting to the mental health system
Primary Purpose	Increases the quality of mental health services, including measured outcomes

Problem

Many children with emotional and behavioral disorders have underlying neurodevelopmental differences that exacerbate the emotional and behavioral disorders. For example, childhood trauma and related stress may result in a delay in organized neurodevelopment due to prioritizing safety (fight/fright/freeze). This frequently results in functional issues such as hypersensitivity to touch, an inability to know where one is in space or a need to move constantly, as well as other behaviors that result in discipline, interrupted learning, and mental health services. Unfortunately, mental health practitioners are not trained to identify, nor treat, the neurodevelopmental disorders that may be contributing to the emotional and behavioral symptoms.

Data is not available to estimate the number of youth with emotional/behavioral issues who also have neurodevelopmental issues, but based on rates of emotional/behavioral symptoms and trauma among children, we can estimate that 67-90% (19,939 to 26,784) of students aged 5-12 in Alameda schools who exhibit emotional/behavioral symptoms have experienced trauma, a leading cause of neurodevelopmental issues.

In Alameda's recent Community Planning Process (CPP) for the MHSA Three Year Plan, 71% of respondents identified violence and trauma as a priority issue for youth. While MHSA Prevention, Education, and Innovation (PEI) provides some trauma related training and services in schools, the community requested that Innovation try to find additional ways to address behavioral and emotional issues – whether related to trauma or not – in schools.

Project

Brain research has helped us to understand the link between neurodevelopment and mental health. This has led to inter-disciplinary efforts and well developed assessments, but limited specific interventions. Most of these efforts are only available to clients in specialty centers and clinical settings. In addition, while the existing research supports the effectiveness of these efforts in regards to mental health outcomes, the research focusing on mental health is limited.

This Innovation project aims to provide neurodevelopmental interventions for youth experiencing moderate and serious mental health issues in an accessible manner. Trained HANDLE® (Holistic Approach to Neuro-Development and Learning Efficiency) instructors provide training for clinical and non-clinical providers in unique assessment procedures and specific interventions. In addition, this project would evaluate the impact on mental health symptoms. This project proposes to:

- Train school and BHCS staff in the HANDLE model
- Have school staff refer students (K-5) exhibiting emotional/behavioral symptoms
- Conduct eligibility screening, gain parent permission
- Assess students, including a neurodevelopment assessment, in order to develop an intervention plan
- Provide 4-6 months of services each day in school by trained HANDLE practitioners

Evaluation

Integrating neurodevelopmental assessments and interventions into mental health services is a significant change to existing practice that may lead to improved outcomes for youth experiencing a wide variety of mental health issues. Alameda County aims to learn:

Can neurodevelopmental interventions provided in a non-clinical setting for youth with emotional and behavioral disorders reduce their symptoms and improve their functioning?

Learning Goals

1. Determine if implementing a neurodevelopmental approach to mental health changes the way educators and mental health providers understand children with emotional and behavioral disorders.
2. Determine if neurodevelopmental interventions, using the HANDLE model, with youth with emotional and behavioral disorders reduces their emotional and behavioral symptoms and improves academic outcomes.

The project could provide a model for improving underlying neurodevelopmental issues that contribute to emotional and behavioral symptoms for a wide range of youth. The results will be shared statewide with mental health divisions, as well as regionally with schools, and further.

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B. New Innovative Project Budget By FISCAL YEAR (FY)*						
EXPENDITURES						
	PERSONNEL COSTs (salaries, wages, benefits)	**FY2018-19 9 months**	**FY2019-20**	**FY2020-21**	**FY2021-22**	**Total**
1	Salaries	$ 129,493	$ 257,276	$ 278,431	$ 278,431	**$ 943,631**
2	Direct Costs					**$ -**
3	Indirect Costs	$ 19,424	$ 38,591	$ 41,765	$ 41,765	**$ 141,545**
4	Total Personnel Costs	**$ 148,917**	**$ 295,867**	**$ 320,196**	**$ 320,196**	**$ 1,085,176**
	OPERATING COSTs	**FY2018-19 9 months**	**FY2019-20**	**FY2020-21**	**FY2021-22**	**Total**
5	Direct Costs		$ 38,350	$ 36,850	$ 5,000	**$ 80,200**
6	Indirect Costs	$ -	$ 5,753	$ 5,528	$ 750	**$ 12,030**
7	Total Operating Costs	**$ -**	**$ 44,103**	**$ 42,378**	**$ 5,750**	**$ 92,230**
	NON RECURRING COSTS (equipment, technology)	**FY2018-19 9 months**	**FY2019-20**	**FY2020-21**	**FY2021-22**	**Total**
8						**$ -**
9						**$ -**
10	Total Non-recurring costs	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
	CONSULTANT COSTS/CONTRACTS (clinical, training, facilitator, evaluation)	**FY2018-19 9 months**	**FY2019-20**	**FY2020-21**	**FY2021-22**	**Total**
11	Direct Costs	$ 30,000	$ 244,240	$ 289,240	$ 199,240	**$ 762,720**
12	Indirect Costs	$ 4,500	$ 36,636	$ 43,386	$ 29,886	**$ 114,408**
13	Total Consultant Costs	**$ 34,500**	**$ 280,876**	**$ 332,626**	**$ 229,126**	**$ 877,128**
	OTHER EXPENDITURES (please explain in budget narrative)	**FY2018-19 9 months**	**FY2019-20**	**FY2020-21**	**FY2021-22**	**Total**
14						**$ -**
15						**$ -**
16	Total Other expenditures	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
	BUDGET TOTALS					
	Personnel (line 1)	**$ 129,493**	**$ 257,276**	**$ 278,431**	**$ 278,431**	**$ 943,631**
	Direct Costs (add lines 2, 5 and 11 from above)	**$ 30,000**	**$ 282,590**	**$ 326,090**	**$ 204,240**	**$ 842,920**
	Indirect Costs (add lines 3, 6 and 12 from above)	**$ 23,924**	**$ 80,980**	**$ 90,678**	**$ 72,401**	**$ 267,983**
	Non-recurring costs (line 10)	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
	Other Expenditures (line 16)	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
	TOTAL INNOVATION BUDGET	**$ 183,417**	**$ 620,846**	**$ 695,199**	**$ 555,072**	**$ 2,054,534**

Response to MHSOAC Staff Analysis

In addition to the example provided in the Staff Analysis, this one may be helpful:

A child diagnosed with PTSD due to physical abuse may be over-sensitive to touch. This trauma expresses itself in learning difficulties and problematic behavior driven by the system's overreaction to physical contact. The child's brain has formed neural connections that interpret tactile sensation as a threat. A HANDLE treatment plan may include rolling a softball-sized ball along the child's arms in an organized rhythm to allow him to efficiently integrate sensory information from the tactile stimulation. By intentionally and repetitively creating appropriate stimuli in a safe environment, neural connections are formed, and the tactile sensation is reinterpreted by the brain as non-threatening.

Criteria for identifying children who may benefit from HANDLE:

Students exhibiting emotional and behavioral problems not explained by intellectual or development disability will be identified by the school personnel. Students with a primary diagnosis of intellectual or developmental disability are eligible for other services more appropriate for their needs. The parent(s) and teacher will be asked to complete a brief questionnaire and mark a checklist of concerns provided by HANDLE. Parent(s) would also complete a consent for participation. Based on the results of the initial surveys, the children who meet criteria will be assessed by a trained HANDLE Practitioner to determine eligibility.

In addition to emotional and behavioral issues identified by school staff, the child must exhibit signs that there are neurodevelopmental issues. These may include issues with focus, attention, clumsiness, bowel/bladder, sleeping, putting thoughts into words, touch, sound, handwriting, and other common signs related to neurodevelopment.

Impact of intervention services on child's regular academic curriculum:

It is expected that interventions would take 15-20 minutes each day plus transition to/from the classroom, for a total of 30 minutes out of regularly scheduled activities. School staff and Parent Aides will coordinate to minimize the loss of instruction time, as well as to consider the optimal time for the student. For example, if the student consistently struggles during a certain part of the day, that's often the best time to remove them from the classroom. They are often not benefitting from the instruction and disrupting others from benefitting. Once the interventions have better prepared the student to learn, they will get more benefit from time in class.

Mental Health Services
Oversight & Accountability Commission

STAFF ANALYSIS - ALAMEDA COUNTY

Name of Innovative (INN) Project:	**Community Assessment and Transport Team (CATT)**
Total INN Funding Requested for Project:	**$9,878,082**
Duration of Innovative Project:	**Five (5) Years**

Review History:

Approved by the County Board of Supervisors:	July 24, 2018
County submitted Innovation (INN Project):	August 6, 2018
MHSOAC consideration of INN Project:	October 25, 2018

Project Introduction:

Alameda County proposes to design and implement a mobile crisis response system that requires collaboration among several county agencies in an effort to reduce the high rates of 5150 holds in their County. As defined in the Welfare and Institutions Code, a 5150 is an involuntary 72-hour hold in a psychiatric facility, for evaluation. A peace officer, registered nurse, medical doctor, or any specifically-designated county clinician may place the hold. Three criteria apply to this section: a danger to themselves, a danger to others, or gravely disabled. The County hopes to learn if a collaborative and technological approach brings services to those in need more efficiently, effectively, and rapidly.

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. Alameda County asserts this innovation project meets the primary purpose of promoting interagency collaboration.

The Need

Alameda County is proposing this innovation project to address the substantial number of individuals placed on 5150 holds by collaborating with other agencies and resources within the County along with the use of technological services.

The County claims they have the highest rate of 5150 holds in California. In 2016, Alameda County transported via ambulance a total of 13,143 individuals placed on psychiatric holds which can become quite costly for the County. Of those placed on psychiatric holds, a total of 56% required medical clearance in an emergency room prior to being admitted into a psychiatric hospital. The County states those requiring medical clearance can sometimes wait 12 hours or more. Figures in 2017 show that Alameda County transported 7,847 individuals placed on 5150 holds solely from three (3) cities: Oakland, Hayward, and San Leandro.

Typically, Alameda County attempts to transport 5150 holds via ambulance, rather than law enforcement vehicles, in an effort to reduce stigma; however, medical emergencies take precedence so ambulances may not always be available to transport 5150 holds. For those individuals who do not meet the criteria of admittance into a psychiatric hospital, linkages to services are not provided. Alameda states this results in the person in crisis requiring emergency services.

As part of the research for this innovation project, the County researched and gathered information on how other counties in California transport 5150 holds along with staffing structures that work best in terms of addressing those in crisis situations. The County learned that crisis teams that are staffed with a mental health clinician and an Emergency Medical Technician (EMT) are suggested because EMTs have less licensing restrictions in terms of the various locations they can transport clients. For example, EMTs can transport clients who do not meet 5150 criteria to crisis residential centers, sobering centers, and other behavioral health services that are non-emergency in nature.

The County found that other counties have addressed mobile crisis services, typically funded with triaged SB82 funds. San Diego contains crisis teams with a paramedic and behavioral health staff; however, that project was specific to clients on 5150 holds and did not utilize EMTs. In contrast, Alameda County's proposal will utilize EMTs and will be inclusive of clients who are on holds and those who are not on holds. Additionally, San Mateo County created a program to train paramedics to assess patients in mental health crisis although that program only consists of a single paramedic (not an EMT) and does not include a behavioral health clinician as part of the team.

The County states that although they were granted funding from the Whole Person Care effort, it does not consist of crisis service mechanisms, although funding from Whole Person Care may assist in supporting aspects of this innovation project while working in

conjunction with Alameda County Emergency Medical Services. Previous efforts to address crisis services in Alameda County have been made with the use of SB82 funds; however, the County asserts that none of the programs created for crisis services incorporate or provide transportation. Additionally, the County states other programs may include limited collaboration in regards to the crisis response system; however, none of them focus on multi-agency collaboration to develop, implement, and enhance the crisis response system.

The Response

In order to reduce the rates of 5150 holds and provide linkages and resources for those who do not meet the criteria for 5150 holds, Alameda County seeks to collaborate with a variety of agencies to design and implement a crisis response system with the use of an appropriately designed staffing model and the use of technology.

The following agencies will be working collaboratively on this project:

- Alameda County Health Care Programs
  - Behavioral Health Care Services
  - Emergency Medical Services
  - Alameda Care Connect (Whole Persons Care)
- 911 Dispatch Center
- Alameda County Sheriff's Department
- City Police Departments
- City Health and Human Services

As the research conducted by the County indicates the best staffing model includes an EMT, the County chooses to utilize an EMT and a behavioral health provider to respond to crisis services in a non-emergency vehicle. The use of an EMT, compared with paramedics, allows for a broader range of disposition options beyond transporting clients to a psychiatric hospital. The availability of a behavioral health provider allows for immediate assessment of clients in order to properly determine the appropriate service that is needed. For those clients who do not meet the criteria of a 5150 hold, the Community Assessment and Transport Team (CATT) will be able to still transport the client for needed services (sobering center, crisis residential sites, and detox centers). **The County may wish to describe inclusion and exclusion criteria for those they will be transporting (i.e. will the County transport clients who may be showing signs of aggression or noncooperation?).**

The technological component of this project involves ReddiNet which is a web-based emergency communications system, utilized in the County since 2008. Historically, this system has assisted the County in tracking the availability of emergency room beds after multi-casualty events. With this innovation project, the County hopes to expand the current use of ReddiNet to allow the most up-to-date availability of beds and appointments in crisis stabilization units, crisis residential centers, and sobering centers. This will allow clients, regardless of 5150 hold, to receive immediate and appropriate behavioral health services. For those clients who need translation services, the County states a video translation service will be part of this innovation project and available when needed. **The**

County may wish to discuss the different types of language translation services that will be available.

The CATT teams will provide services between 7:00am-12:00am, seven (7) days per week and will be in unmarked vehicles. Vehicles will include safety features including but not limited to: a barrier between the driver and passenger seats, locking storage cabinets and modified locks and windows. All behavioral health calls will be dispatched to the CATT team by the 911 system; however, law enforcement will arrive first to assess safety. Once the behavioral health provider and EMT makes a determination in regards to a 5150 hold, CATT will make the appropriate transport that best serves the client's needs. The utilization of an EMT on the CATT allows clients placed on 5150 hold to be medically cleared by the EMT, thereby eliminating the need for clients to be taken to the emergency room. The clients on holds will be able to be transported directly to a psychiatric hospital. For those clients not on holds, the CATT will be able also transport individuals to programs such as peer respite, sobering centers, and crisis stabilization units.

San Leandro and Hayward will be the first two cities in Alameda County that will be served by CATT and will have two (2) vehicles to assist these communities. These areas were selected because San Leandro and Hayward both have a large number of 5150 holds within the County, and do not have crisis response systems in place. Once the CATT team has been deployed in these two (2) cities and has been able to vet out the functionality of the process, the CATT team will then expand to include Oakland which has the largest number of 5150 holds. Two (2) additional vehicles will be deployed to serve the Oakland area. In contrast with San Leandro and Hayward, Oakland does have a crisis response program; however, it does not provide transportation.

In addition to providing services to individuals in crisis, the County collaboration hopes to establish criteria to assist in determining how to appropriately transport clients; understanding and addressing why certain clients to not meet criteria to receive certain services; and ensuring the client records are available and maintained with up-to-date information. Beginning in 2019, the County claims that behavioral health clinicians will be able to access client records through Alameda's Care Connect. As a result, the EMT staff on the mobile crisis team will be able to access existing electronic patient records that is currently utilized in the 911 dispatch system. **The County may wish to discuss how they will maintain confidentiality of client records to ensure HIPAA compliance.**

The County states this project is innovative because the research performed by the County indicated that interagency collaborations were best in terms of improving crisis systems. Although the goal is to ultimately reduce the number of 5150 holds and provide resources for those who are not on holds, the County wants to make the collaborative element the primary focus of this project so that appropriate time and energy can be devoted towards the design and implementation of a system that can hopefully be transformed into a model to be shared statewide. The County claims the combination of staffing, agency collaboration, and technological components provides the innovative components.

The Community Planning Process

Alameda County states their community planning process for this innovation project began in June 2017 and allowed for community feedback and input while developing this project. Five (5) separate community forums were held in each of the supervisory districts; 18 focus groups representing the various diverse populations were conducted in the County; and a total of 550 surveys were completed and submitted in various languages to solicit feedback and input from the community. Alameda County asserts that staff hired for this innovation project will receive cultural competency training and the County will try to ensure that employed staff reflect the diversity of the areas they will serve.

Based on repeated feedback from stakeholders, the lack of resources available for consumers experiencing a crisis was the second highest concern within the County. The largest need surrounds homelessness and it is the County's hopes that this innovation project will also assist the homeless.

Public comment period at the County level began April 13, 2018 and concluded with a public hearing on May 14 2018. Alameda County submitted, as part of the innovation project, the substantive feedback that was received during the public comment period. Additionally, the County responded back to the public comments that were made (**see pgs 20-21 of plan**). Feedback received from a stakeholder expressed concern regarding the lack of resources available in the County and anticipates that the lack of resources will increase as the housing market continues to rise. The County also included letters of support along with their innovation project. **In the event that crisis beds are at maximum capacity within the County, the County may wish to discuss and provide any contingency plans for finding resources when crisis beds are full.**

The link to this innovation project was also shared with stakeholders on April 18, 2018 while the County was in the middle of their county-level public comment period. Although the County received and responded to feedback, no letters of support or opposition were received at MHSOAC.

Learning Objectives and Evaluation

Alameda County plans on implementing a collaborative project that will employ a crisis transport staffing model to improve the effectiveness and efficiency of the crisis response system in the county. The project will target individuals in the county experiencing a behavioral health crisis resulting in a 9-11 response, but not necessitating emergency medical services. Based on the number of 5150 holds in the County, the project has the potential to serve upwards of 3,000+ individuals annually (**see pg. 22 of County plan**).To guide their project, the County has identified two main learning goals:

1. Determine if and how collaboration among agencies responding to the mental health crises can contribute to developing an effective and efficient crisis response system, and

2. Determine if and how the changes in the crisis response system result in community and county priorities, including better client services and more efficiency in the system.

Alameda County has identified several intended outcomes from the CATT project, including: (1) reducing unnecessary 5150 holds; (2) getting clients that are not on a hold into services; (3) increasing client engagement with services; (4) reduce time spent by clients waiting to be transitioned to a service; and (5) reduce time spent by law enforcement and ambulatory services on psychiatric crises.

In order to better understand the effect of the collaboration on the crisis response system, the County will track participation in collaborative meetings, develop survey instruments, hold focus groups. Additionally, the County will use electronic health records to establish baseline information and track the number of assessments, 5150 status and final disposition, and services in which clients are enrolled. To gauge client satisfaction with services and their perceptions of stigma, post-crisis survey calls will be made to clients by a peer provider (**see pgs. 16-18 of County plan for specific measures**).

Alameda County will contract out for evaluative purposes. An outside evaluator will assist the County in finalizing the evaluation plan, gathering and analyzing the data, and completing the final evaluation report. At the conclusion of the CATT collaborative project, results and findings will be shared across agencies, among stakeholders, and among other counties. Additionally, findings will be presented at various meetings with the MHSA Stakeholder Group, the Cultural Competency Advisory Board (CCAB), the Whole Person Care consumer group, NAMI, and others.

The Budget

Total proposed expenditures for this innovation project is $14,812,932; however, Alameda County is seeking approval for MHSA innovation funds in the amount of $9,878,082 for a total project length of five (5) years. The County anticipates reimbursements from Medi-Cal in the amount of $3,450,000 and reimbursements from Measure A in the amount of $1,484,850.

The County will expend a total of $7,435,761 (50%) on employee salaries. Initially, staff will be comprised of 7.2 FTE Behavioral Health clinicians, 7.2 FTE Emergency Medical Technicians (EMTs); 1 FTE Clinical Supervisor, and 1 FTE Program Specialist. Beginning Fiscal Year 19/20 and for the duration of the project, staffing for the Behavioral Health clinicians and EMTs will increase to 14.4 FTE in order to provide services for the Oakland area. The Clinical Supervisor and Program Specialist will remain and will oversee the project in the County regardless of service area.

Operating costs total $403,875 (2.7%) and will be used for service plans associated with mobile phones, tablets, and vehicle fuel/maintenance. The County anticipates that funding will be leveraged from Measure A to cover all operating costs for FY 18/19.

Indirect costs total $1,288,446 (8.7%) and will cover employee benefits, rent, utilities, and other various expenditures to facilitate the administration of this project. The County

anticipates that all non-recurring costs for the purchase of vehicles, tables, phones, laptops, and staff training will be covered by Measure A for the life of the project.

A total of $750,000 (5.1%) has been allotted for the evaluation and associated consultant costs. Of this amount, $700,000 will be for the evaluation itself and will be contracted out. The remaining $50,000 will be stipends for peers and family to conduct client satisfaction surveys and assistance with the evaluation and data analysis.

The County indicates that although SB82 triage funds have been previously granted to expand crisis services in Alameda County, those triage-funded programs do not offer crisis transportation and also does not allow for the level of collaboration that is entailed within this innovation project.

In regards to sustainability, the County states the continuation of this project will depend upon the overall evaluation results and support from clients and law enforcement. If successful, the project will be funded thru Medi-Cal reimbursement along with MHSA Community Services and Supports funding. Subject to Assembly Bill 114 (AB-14), the County will be using funds deemed reverted from fiscal years 08/09, 09/10, and 10/11.

Additional Regulatory Requirements

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

References

https://en.wikipedia.org/wiki/Lanterman%E2%80%93Petris%E2%80%93Short_Act

Full project proposal can be accessed here:

http://mhsoac.ca.gov/document/2018-10/alameda-county-community-assessment-and-transport-team-catt-innovation-plan-october

Project Summary

County:	**Alameda County**
Date submitted:	4/13/2018
Project Title:	**Community Assessment and Transport Team (CATT)**
Total amount requested:	$9,878,082
Duration of project:	5 years

General Requirement	Makes a change to an existing practice in the field of mental health, including but not limited to, application to a different population
Primary Purpose	Promotes interagency and community collaboration related to Mental Health Services or supports or outcomes

Problem

Many counties and cities struggle with developing a crisis response system that is efficient and effective – getting clients to the right services at the right time, without unnecessary use of first responder and client time, and in a respectful and non-stigmatizing manner. In Alameda, there have been a various efforts made to improve crisis response, but the impact has been limited:

- Alameda has the highest rate of 5150 holds in California;
- Of those on a 5150 hold transferred to the psychiatric emergency services unit (PES), 75-78% did not meet medical necessity criteria for inpatient acute psychiatric services;
- People who do not qualify for 5150 holds are not linked to planned services and continue to over-use emergency services;
- First responders spend many hours addressing behavioral health related 911 calls that would be better served in a different manner;
- While Alameda's practice of having ambulances transport individuals on a 5150 hold has many benefits, it is an expensive approach to transport; diverts resources from life threatening emergencies; and leads to clients, law enforcement, and other responders experiencing lengthy wait times for ambulances.

There are many agencies that play a role in crisis response. This project hypothesizes that in order to effectively change the Alameda County crisis response system from one with the highest rates of 5150 holds to a model of efficient and effective response, a collaborative effort to support creative solutions is required. (Winters, S. Inter-professional collaboration in mental health crisis response systems: a scoping review. *Perspectives in Rehabilitation.* Jan 14, 2015).

Project

Alameda County proposes to test two primary strategies to improve the crisis response system:

1) A collaboration among core Alameda County Health Care Services Agency programs - *Behavioral Health Care Services, Emergency Medical Services, and Alameda Care Connect (Whole Person Care)* – as well as other partners – *911 dispatch, the County Sheriff's Office,*

city police departments, city health and human services, and other relevant services – to ensure the crisis response system is effective and efficient. For example:

- Participating partners will provide the staff time, training, and support to ensure that in-the-moment client services are responsive, such as keeping records up to date so the mobile crisis teams have current information about the client and available services.
- Conduct ongoing Continuous Quality Improvement process to ensure that system improvements are made in a timely manner, resulting in better outcomes, such as understanding why clients in crisis continue to be routed to services they do not meet eligibility criteria for and developing systemic solutions to get them routed correctly.

2) Combining a unique crisis transport staffing model with current technology supports to enable them to connect clients to a wider array of services in the moment.
   a. A mental health provider and an Emergency Medical Technician in a van to provide mental and physical assessment and transport to a wide range of services.
   b. Technological support, such as ReddiNet to provide current availability of beds and Community Health Records to provide up-to-date information about the client's physical and mental health history. This assists with connecting a client to the most appropriate service in the moment, especially if they are not on a 5150 hold.

This project proposes to make the collaborative process a focus of the project and evaluation, recognizing that this is essential to making the level of systems change that is needed. This will allow Alameda to put the necessary time and resources behind working together to design the system improvements, monitoring the results, and making timely course corrections.

Evaluation

Alameda County has two primary learning goals:

1. Determine if and how collaboration among agencies responding to mental health crises can contribute to developing an effective and efficient crisis response system.
   - Actions taken to improve the crisis response system, and the results
   - Collaborative members perception of the effectiveness of the collaboration
2. Determine if and how the changes in the crisis response system result in community and county priorities: better client services and more efficiency in the system.
   - Number of clients served
   - Number of clients not on 5150 hold that are transported to services

This project is beyond adding a discrete service to a challenged system, it is a *test of concept for how to improve the system* through a focused collaborative approach and innovative change in staffing model paired with technological support. If successful, it will contribute to increased efficiency for the emergency system, more appropriate services for the client, and a model that other counties can adopt or adapt to significantly improve their crisis response system.

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B. New Innovative Project Budget By FISCAL YEAR (FY)*							
EXPENDITURES							
PERSONNEL COSTs (salaries, wages, benefits)		**FY 18-19 9 months**	**FY 19-20**	**FY 20-21**	**FY 21-22**	**FY 22-23**	**Total**
1	Salaries	$820,047	$1,775,301	$1,613,471	$1,613,471	$1,613,471	$7,435,761
2	Direct Costs						$0
3	Indirect Costs	$ 123,007	$ 266,295	$ 242,021	$ 242,021	$ 242,021	$ 1,115,365
4	Total Personnel Costs	$ 943,054	$ 2,041,596	$ 1,855,492	$ 1,855,492	$ 1,855,492	$ 8,551,126
OPERATING COSTs		**FY 18-19**	**FY 19-20**	**FY 20-21**	**FY 21-22**	**FY 22-23**	**Total**
5	Direct Costs	$ -	$ 80,775	$ 107,700	$ 107,700	$ 107,700	$ 403,875
6	Indirect Costs	$ -	$ 12,116	$ 16,155	$ 16,155	$ 16,155	$ 60,581
7	Total Operating Costs	$ -	$ 92,891	$ 123,855	$ 123,855	$ 123,855	$ 464,456
NON RECURRING COSTS (equipment, technology)		**FY 18-19 9 months**	**FY 19-20**	**FY 20-21**	**FY 21-22**	**FY 22-23**	**Total**
8	**Vehicles and Equipment**	$0					$0
9	**Training**	$0					$0
10	Total Non-recurring costs	$0	$0	$0	$0	$0	$0
CONSULTANT COSTS/CONTRACTS (clinical, training, facilitator, evaluation)		**FY 18-19 9 months**	**FY 19-20**	**FY 20-21**	**FY 21-22**	**FY 22-23**	**Total**
11	Direct Costs	$135,000	$135,000	$135,000	$210,000	$135,000	$750,000
12	Indirect Costs	$20,250	$20,250	$20,250	$31,500	$20,250	$112,500
13	Total Consultant Costs	$155,250	$155,250	$155,250	$241,500	$155,250	$862,500
OTHER EXPENDITURES (please explain in budget narrative)		**FY 18-19 9 months**	**FY 19-20**	**FY 20-21**	**FY 21-22**	**FY 22-23**	**Total**
14							$0
15							$0
16	Total Other expenditures	$0	$0	$0	$0	$0	$0
BUDGET TOTALS							
Personnel (line 1)		$820,047	$1,775,301	$1,613,471	$1,613,471	$1,613,471	$7,435,761
Direct Costs (add lines 2, 5 and 11 from above)		$135,000	$215,775	$242,700	$317,700	$242,700	$1,153,875
Indirect Costs (add lines 3, 6 and 12 from above)		$143,257	$298,661	$278,426	$289,676	$278,426	$1,288,446
Non-recurring costs (line 10)		$0	$0	$0	$0	$0	$0
Other Expenditures (line 16)		$0	$0	$0	$0	$0	$0
TOTAL INNOVATION BUDGET		$1,098,304	$2,289,737	$2,134,597	$2,220,847	$2,134,597	$9,878,082

Response to MHSOAC Staff Analysis

Criteria for determining who would be served by CATT

This project serves people experiencing a behavioral health crisis in the community that results in a 911 response. Eligibility includes:

- Services are required in a location and during a time CATT is in service
- The situation must be assessed as safe by a law enforcement officer
- The individual cannot be in need of emergency medical services

BHCS and EMS will develop specific eligibility criteria in the initial phase of this project. For example, individuals who are non-cooperative will continue to be served by law enforcement and a paramedic ambulance, rather than the CATT team.

Language translation services

Alameda County Behavioral Health Care Services has a contract with an agency, called Lionbridge, to provide on-demand interpretation in essentially all languages. CATT will have access to these services via video on an iPad.

Ensuring HIPAA compliance

Community Health Records are being developed through Alameda's Care Connect (Whole Person Care). These shared physical and mental health records will be available to CATT for reference and to enter data. Care Connect will ensure that all access and use of records is HIPAA complaint. CATT will be trained in HIPAA procedures in regards to these records.

Contingency plans for when crisis beds are full

In the event that certain services, such as a Crisis Stabilization Unit, is at capacity, ReddiNet will inform CATT, enabling CATT to efficiently transport a client to another service. For individuals in crisis, the Psychiatric Emergency Services is required to accept CATT transports, even if they are considered at capacity, due to EMTALA (Emergency Medical Treatment And Labor Act) and the PES census management plan. For individuals not in crisis, every effort will be made to transport them to the most appropriate service.

Mental Health Services
Oversight & Accountability Commission

STAFF ANALYSIS – ALAMEDA COUNTY

Name of Innovation (INN) Project:	**Emotional Emancipation Circles for Youth**
Total INN Funding Requested:	**$501,808**
Duration of Innovation Project:	**Two (2) Years, Six (6) Months**

Review History:

Approved by the County Board of Supervisors:	July 24, 2018
County submitted INN Project:	August 6, 2018
MHSOAC consideration of INN Project:	October 25, 2018

Project Introduction:

For this Innovation project, Alameda County proposes to take a community defined practice, Emotional Emancipation Circles, (EEC) and "tailor" it to better reach African American young adults. EEC's are a community defined practice developed by the Community Healing Network (CHN and the Association of Black Psychologists (ABPsi) to engage African Americans, (p. 71). The County reports that in its current format, the community practice is geared more towards older participants (p. 78) and that there is an identified sense of isolation and community disconnectedness expressed by younger African American mental health consumers. Additionally, the County proposes that it will evaluate the functional outcomes of program participants, as opposed to the current evaluation system, which only reports participant satisfaction.

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 Need

Alameda County reports that in FY 2016-17, 32% of the 6,188 young adults between the ages of 18 and 30 served were African Americans. The County also reports that despite an increased penetration rate and receiving more outpatient services hours in 2016, African American young adults showed less improvement in their overall mental health. African American crisis services were reduced 17% while crisis services for white young adults were reduced 37%. Similarly, hospitalizations of African American young adults was reduced by 12% while there was a reduction in hospitalizations of 37% for white young adults.

Other feedback received by the County, including the California Reducing Disparities Project, an African American Utilization study, 2011 and a Results Based Accountability process, contributes to the County's need for identifying this particular community of young adults. These documents and processes have identified that the African American young adult community not only feels discrimination and social isolation, but also a lack of trust in mental health services, identifies a lack of cultural diversity among service providers, a sense of not being valued or connected to an inclusive community and an inability to achieve independence and self-sufficiency.

The Response

After looking at various programs related to addressing the needs of cultural specific youth populations, including San Diego's Urban Beats, the City of Richmond's Rising Youth for Social Equity (RYSE) Center and Substance Abuse and Mental Health Services Association (SAMHSA) programs, the County determined that these programs did not address the specific needs of young African Americans and/or did not include the measurement tool/capability they wanted to create. Currently the County has 6-8 previously certified EEC facilitators. The County anticipates updating the certificates of these facilitators and will ask two of the facilitators to host six (6) informational sessions throughout the county to recruit program participants.

The current EEC program will be tailored by:

- Initially having trained facilitators working with young adults through a co-facilitated EEC program;
- Developing a method of delivery that is relevant to the young adult audience;
- Incorporating modules such as housing, education, employment into the adapted EEC programs;
- Developing a marketing structure that addresses the young adult audience;

- Offering sessions at age appropriate times and venues, supplying food and transportation assistance, and
- Developing an evaluation tool(s).

Because the EEC program is a community based practice and because its format has been codified, the County intends to ensure fidelity to the essential curriculum but believes that the participants and facilitators can influence how the Seven Keys are introduced into the sessions. The Seven Keys are critical to the program and are defined as:

The Seven Keys to Emotional Emancipation are affirmations of the work required to free ourselves as Black people from the psychological and emotional bondage of centuries of racism. These keys serve as conscious reminders of what we must understand, what we must tell ourselves, what we must seek out, and what we must do in order to free ourselves. They can serve as sources of support in moments of stress, challenge, strain, and whenever we are at risk of slipping into old habits, outdated thinking, and unhelpful patterns. The EEC keys unlock the potential for action in the service of emotional emancipation. https://blackculturalarchives.org/events/2018/emanicipation-circles-bca

The County reports that all staff related to this Innovation; the Project Administrator, Peer Project Coordinators and trained facilitators/peers will be African American.

The Community Planning Process

The County reports that during its most recent Community Program Planning (CPP) process for the MHSA Three Year program and Expenditure plan, 60% of young adult respondents reported feeling social isolation or feeling alone. Further, 44% of respondents identified as belonging to an underserved population. This CPP process was conducted from June through October 2017. The County conducted five (5) community forums, eighteen (18) focus groups throughout the County and received community input from 550 surveys.

Proposals were submitted and reviewed by County MHSA staff for Innovation criteria and community priority. This proposal was posted for public comment April 13 through May 13, 2018 and the County received comments about the positive effects of peer run services, the need for measurable outcomes, what will be done to address/reduce attrition and increase support for the project.

The link to this innovation project was also shared with stakeholders on April 18, 2018 while the County was in the middle of their county-level public comment period. The County received and responded to feedback, and a number of letters of support were included with the proposal, but no letters of support or opposition were received at MHSOAC from stakeholders.

Learning Objectives and Evaluation

Alameda County seeks to implement a project that will make use of Emotional Emancipation Circles (EEC) to meet the needs of young adults, contributing to increased independence and self-sufficiency. The County will target young adults between the ages of 18 and 30 who identify as African American/African descent that experience or are at risk for mental illness. It is estimated that approximately 120 individuals will be served over the span of the project. To guide their project, the County has identified two main learning goals, as well as short, medium, and long term outcomes (**See pg. 73 of County plan for logic model**):

Goals:

1. How can EECs be tailored to effectively engage young adults?
2. Will participants in young adult EECs experience improved mental health and functional outcomes, specifically independence and self-sufficiency?

Outcomes:

- *Short-term outcome*s: EECs reach full registration; participants complete the series (75% of series); participants are satisfied with the EEC experience during the series.
- *Medium-term outcome*: Participants report improved mental health upon conclusion of participation; average participant satisfaction with EEC experience increases between first and final series.
- *Long-term outcome* (3-months post-participation): participants report improved functional outcomes; appropriate use of planned services increases for participants; BHCS clients that participate show better outcomes than non-participating clients.

In order to determine the effect that EECs have on engaging young adults, the County will track participation, develop surveys, and hold focus groups to gather feedback and family member perspectives. In order to determine if EECs improved independence and self-sufficiency among young adults, the County will create surveys and hold focus groups to establish changes in mental health (i.e. measuring well-being, self-worth, connectedness), changes in functioning (i.e. education, employment,), changes in services engagement (changes in services use and patterns), and examine assessments and outcomes to evaluate outcomes for BHCS clients (**see pgs. 80-81 of County plan**).

Alameda County will contract out for evaluative purposes. An outside evaluator will assist the County in finalizing the evaluation plan, gathering and analyzing the data, and completing the final evaluation report. At the conclusion of the project, results and findings will be shared among stakeholders, mental health directors, and among Ethnic Services Managers. Additionally, findings will be presented at various meetings with the MHSA Stakeholder Group, the Cultural Competency Advisory Board (CCAB), NAMI, and the Alameda County African American Health and Wellness Steering Committee.

The Budget

The County is requesting $501,808 in MHSA funds for this Innovation over 2.5 years. The County expects to use the funds for salaries, wages and benefits, at $102,374 for a Project Administrator at 0.3 FTE. This represents 20% of the total budget. Operating costs for the program are anticipated to be 11% of the budget. Non-recurring expenses are anticipated to be $5,000, representing less than 1% of the budget, County administrative costs at $64,801 represent 13% of the total budget and Consultant/ Contractor ($184,553 and $90,000, respectively), costs in the amount of $274,553 represent 55% of the budget.

The County reports that they will use AB 114 deemed reverted funds from FY 10/11. The County will continue to support this program, based on evaluation results, buy-in from its Children/Youth/TAY and Adult systems of care, the recommendations of the various stakeholder committees and constituencies and funding. It is anticipated that if the program is continued it will be funded with PEI and CSS funds.

Additional Regulatory Requirements

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

References

https://blackculturalarchives.org/events/2018/emanicipation-circles-bca

www.ACHSA.org

http://www.cablackhealthnetwork.org/wp-content/uploads/2017/03/health-report.pdf

Full project proposal can be accessed here:

http://mhsoac.ca.gov/sites/default/files/documents/2018-10/Alameda_INN%20Draft_Transitional%20%20Age%20Youth%20Emotional%20Emancipation%20Circles_8.6.2018_Final.pdf

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Project Summary

County: **Alameda County**
Date submitted: 4/13/2018
Project Title: **Emotional Emancipation Circles for Young Adults**
Total amount requested: $501,808
Duration of project: 2 years 6 months

General Requirement	Makes a change to an existing practice in the field of mental health, including but not limited to, application to a different population
Primary Purpose	Increases the quality of mental health services, including measured outcomes

Problem

African Americans are a historically inappropriately served population. The Mental Health Services Act (MHSA) California Reducing Disparities (CRDP) report on African Americans found that many of the key issues revolve around racism, stigma, marginalization, and isolation – in society and within mental health services. Fundamentally, African Americans feel that their experiences and perspectives are not heard, respected or acted upon by the mental health system.

In Alameda County, after receiving on average more hours of mental health outpatient services, African American young adults (18-30) showed significantly less improvement than White young adults. Focusing time, energy and funding on developing new services that respond to the needs African Americans have identified and take into account the complexity of their experience – poverty, trauma, racism, etc. – is essential to reduce disparities.

Local African American young adults have identified the need to address isolation and to value one another, culturally and ethnically, despite the negative images communicated by the media or community. Alameda County Behavioral Health Care Services (BHCS) aims to address this need as a pathway to fostering independence and self-sufficiency.

Project

BHCS worked with African American young adults to pilot Emotional Emancipation Circles (EEC) to address the needs they identified. EECs are a community-defined practice developed by the Community Healing Network (CHN) and Association of Black Psychologists (ABPsi). The participants felt the EECs were valuable but needed to be tailored to better engage young adults. This project will:

- Work with young adult EEC facilitators to conduct outreach, tailor them to young adult needs, and provide 6 EEC series
- Conduct evaluations of each series to contribute to tailoring of the model

Evaluation

This Innovation Project aims to tailor the EEC model, a community-defined practice within the mental health field, to answer:

Can Emotional Emancipation Circles that are tailored for young adults result in participants feeling valued and connected to an inclusive community, contributing to independence and self-sufficiency?

1. How can EECs be tailored to effectively engage young adults?
   - In what way were EECs tailored? (program records)
   - Did young adults engage with and complete the series? (participation records)
   - Were young adults satisfied with their experience? (surveys, focus groups)
2. Will participants in young adult EECs experience improved mental health and functional outcomes, specifically independence and self-sufficiency?
   - Do they experience changes in well-being, connectedness and self-worth?
   - Do they experience changes in education and/or employment activities?
   - Do they experience changes in their use of planned services? (surveys, focus groups)
   - Do BHCS clients who participate have better outcomes than non-participants? (compare BHCS client records)

The learnings from this project will help counties address common challenges regarding serving the African American young adults by providing data on whether EECs improve mental health and functioning and by providing a version of EECs that is well-adapted for young adults. The learnings will be shared with behavioral health divisions throughout the state, as well as through the CHN and ABPsi networks. Alameda County will use the learnings to determine what aspects to continue under MHSA PEI or CSS funding.

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B. New Innovative Project Budget By FISCAL YEAR (FY)*					
EXPENDITURES					
PERSONNEL COSTs (salari		**FY2018-19 9 months**	**FY2019-20 12 months**	**FY2020-21 9 months**	**Total**
1	Salaries	$ 30,712	$ 40,950	$	**$ 102,374**
2	Direct Costs				**$ -**
3	Indirect Costs	$ 4,607	$ 6,143	$ 4,607	**$ 15,357**
4	Total Personnel Costs	**$ 35,319**	**$ 47,093**	**$ 35,319**	**$ 117,731**
OPERATING COSTs		**FY2018-19 9 months**	**FY2019-20 12 months**	**FY2020-21 9 months**	**Total**
5	Direct Costs	$ 9,180	$ 32,130	$	**$ 55,080**
6	Indirect Costs	$ 1,377	$ 4,820	$ 2,066	**$ 8,262**
7	Total Operating Costs	**$ 10,557**	**$ 36,950**	**$ 15,836**	**$ 63,342**
NON RECURRING COSTS (equipment, technology)		**FY2018-19 9 months**	**FY2019-20 12 months**	**FY2020-21 9 months**	**Total**
8	Workshop materials	$ 5,000			**$ 5,000**
9					**$ -**
1	Total Non-recurring costs	**$ 5,000**	**$ -**	**$ -**	**$ 5,000**
CONSULTANT COSTS/CONTRACTS (clinical, training, facilitator, evaluation)		**FY2018-19 9 months**	**FY2019-20 12 months**	**FY2020-21 9 months**	**Total**
1	Direct Costs	$	$	$	**$**
1	Indirect Costs	$	$	$	**$**
1	Total Consultant Costs	**$**	**$**	**$**	**$**
OTHER EXPENDITURES (please explain in budget narrative)		**FY2018-19 9 months**	**FY2019-20 12 months**	**FY2020-21 9 months**	**Total**
1					**$ -**
1					**$ -**
1	Total Other expenditures	**$ -**	**$ -**	**$ -**	**$ -**
BUDGET TOTALS					
Personnel (line 1)		**$ 30,712**	**$ 40,950**	**$ 30,712**	**$ 102,374**
Direct Costs (add lines 2, 5 and 11 from above)		**$ 91,953**	**$ 135,290**	**$ 102,390**	**$ 329,633**
Indirect Costs(add lines 3, 6 and 12 from above)		**$ 18,400**	**$ 26,436**	**$ 19,965**	**$ 64,801**
Non-recurring costs (line 10)		**$ 5,000**	**$ -**	**$ -**	**$ 5,000**
Other Expenditures (line 16)		**$ -**	**$ -**	**$ -**	**$ -**
TOTAL INNOVATION BUDGET		**$ 146,065**	**$ 202,676**	**$ 153,067**	**$ 501,808**

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AGENDA ITEM 5

Action

October 25, 2018 Commission Meeting

San Francisco County Innovation Project

Summary: The Mental Health Services Oversight and Accountability Commission will consider approval of San Francisco County's request to fund a new Innovative project:

(A) **Wellness in the Streets (WITS)- $1,750,000**

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.

- Wellness in the Streets (WITS) is proposed as a five-year, peer-run and peer-led project based on the concept that lack of housing should not be a barrier to improving mental health. WITS will test new ways of peer-to-peer service delivery and engagement with unhoused San Francisco residents by meeting them where they are and supporting participants through the stages of change until they are able to engage in services.

Presenters for San Francisco County's Innovation Project:

- Stephanie Felder, MS, Director, Comprehensive Crisis Services Behavioral Health Services, San Francisco Department of Public Health
- Amber Gray, Health Worker III/Peer Specialist, Behavioral Health Services, San Francisco Department of Public Health
- Charlie Mayer-Twomey, LCSW, Project Administrator Hatchuel Tabernik & Associates

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Enclosures (3): (1) Biographies for San Francisco County Innovation Presenters; (2) Staff Analysis, Wellness in the Streets; (3) Wellness in the Streets Innovation Plan

Handout (1): PowerPoint Presentation

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

http://mhsoac.ca.gov/document/2018-09/san-francisco-county-innovation-project-wellness-streets-october-2018

Proposed Motion: The MHSOAC approves San Francisco County's Innovation plan as follows:

Name: Wellness in the Streets
Amount: $1,750,000
Project Length: Five (5) Years

San Francisco Health Network

SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

Wellness in the Streets (WITS) Innovations Project
Presenter Biographies

1. **Stephanie Felder, MS**
   Director, Comprehensive Crisis Services
   Behavioral Health Services, San Francisco Department of Public Health

   Stephanie Felder, MS has been the Director of Comprehensive Crisis Services for the San Francisco Department of Public Health for the past 6 years. Comprehensive Crisis Services is a 24-7 day/week mobile multi-disciplinary, culturally diverse team that provides service to individuals who are experiencing an acute mental health crisis and or have experienced community violence. She works in the community directly on the streets, frequently interacting with the unhoused population of San Francisco. Ms. Felder is also a member of the Crisis Response System (CRS) which is a partnership between many city departments and local organizations. The CRS ensures that people affected by a violent incident on the streets receives the services they need immediately.

2. **Amber Gray**
   Health Worker III/Peer Specialist
   Behavioral Health Services, San Francisco Department of Public Health

   Amber Gray is currently a Health Worker III with the City and County of San Francisco working as a Case Manager at the Treatment Access Program. She is a certified WRAP facilitator and completed her Drug and Alcohol Studies at San Francisco City College. Ms. Gray is a former peer supervisor at a mental health respite called the Hummingbird located in the Behavioral Health Services department of San Francisco General Hospital. She currently serves as a community stakeholder on the Taja Coalition that focuses on prevention services for trans woman of color. She has served as a group facilitator for Suicide Prevention/Community Behavioral Health Services. Lastly, Ms. Gray has spent the past 18 years providing HIV Education and Prevention services to high risk youth and the transgender community.

3. **Charlie Mayer-Twomey, LCSW**
   Project Administrator
   Hatchuel Tabernik & Associates

   Charles Mayer-Twomey, LCSW was employed with the San Francisco Department of Public Health's (SF-DPH) Behavioral Health Services for almost eight (8) years. He worked as a clinical social worker in both the Child, Youth and Families System of Care and the Adult/Older Adult System of Care before advancing to a management position overseeing various vocational, peer-to-peer and mental health programs. Within his time at SF-DPH, Mr. Mayer-Twomey most recently held the position of Acting Director of Mental Health Services Act for San Francisco. He oversaw 85 mental health programs including all areas of program design, implementation, policy development, budget planning and program evaluation. Charles moved into a consulting role in March of 2016 and continued to provide support to the SF-DPH, primarily working with the SF-MHSA team. Today, Mr. Mayer-Twomey frequently works as a project administrator coordinating behavioral health activities, providing strategic planning efforts and creating comprehensive state reports with statistical outcomes.

Mental Health Services
Oversight & Accountability Commission

STAFF ANALYSIS— San Francisco COUNTY

Innovation (INN) Project Name:	**Wellness in the Streets (WITS)**
Total INN Funding Requested:	**$1,750,000**
Duration of Innovative Project:	**Five (5) Years**

Review History:

Approved by the County Board of Supervisors:	October, 2018*
County submitted INN Project:	September 14, 2018
MHSOAC consideration of INN Project:	October 25, 2018

Project Introduction:

Wellness in the Streets (WITS) is proposed as a five-year, peer-run and peer-led project based on the concept that lack of housing should not be a barrier to improving mental health. WITS will test new ways of service delivery and engagement with unhoused San Francisco residents by meeting them where they are and supporting participants through the stages of change until they are able to engage in services.

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 Need

The San Francisco 2017 Homeless Count and Survey identified 7,499 homeless individuals with sixty-three percent (63%) of chronically homeless survey respondents reporting a psychiatric or emotional condition; forty-five percent (45%) reporting Post Traumatic Stress Disorder (PTSD); and sixty-five percent (65%) reporting alcohol or substance use (San Francisco, 2017).

In mid-2017, a diverse group of peers from San Francisco's' Department of Public Health and Behavioral Health Services conducted a Community Needs Assessment regarding the needs of unhoused individuals experiencing barriers to accessing services. The overarching theme reported from the assessment was the need to have contact with someone willing to connect with individuals at their current location. The County states that homeless participants described very little contact with social services.

As a result of both the Community Needs Assessment and the most recent Community Program Planning process, a recommendation was made to create a peer-based mental health team that would work directly with unhoused individuals in their environment, in order to support the individual to be successful in their personal recovery.

The Response

The County states that the Wellness in the Streets project will make a change to an existing mental health practice by utilizing peer-to-peer interventions targeting all San Franciscans who are unhoused.

The County Acknowledges that there are many current programs which conduct outreach to unhoused individuals on the streets but assert that existing programs attempt to link individuals to programs at a physical location and that this approach is missing opportunities to provide interventions to many unhoused individuals in need.

One such program is Los Angeles' Mobile Triage Team that meets individuals where they are, provides supplies such as food and helps coordinate services with the hope that individuals will engage in treatment (Abram 2018). San Francisco County is proposing something different. They seek to test if bringing evidence-based treatment directly to the unhoused individuals through peer-peer delivery will result in individuals moving through the stages of change.

It is important to note the robust peer specialist-training component of this plan. The County is proposing to go above and beyond their already established 12-week Peer Specialist Mental Health Certificate Program, Advanced Peer Certificate Program and the Leadership Academy's monthly training seminars by providing additional trainings in: Wellness Recovery Action Plan, harm reduction, psychological education on mental health, coping skills and socialization skills, de-escalation strategies, CPR/First Aid, personal safety training, Seeking Safety, and Motivational Interviewing.

Of particular note is the training of Peer Specialists in the Seeking Safety treatment model. Seeking Safety is an evidence-based, adaptable practice that is designed to treat Post Traumatic Stress Disorder and substance abuse at the same time in any environment.

This treatment model is adapted from cognitive-behavioral therapy and is designed for use when time is short and demands are high. Seeking Safety has been implemented by various programs, including community-based, criminal justice involved, veteran/military, adolescent, schools, and medical settings for more than 18 years (Najavits 2002).

Commission staff are unaware of any county program that is fully training a peer team in this treatment modality and then providing the modules directly where unhoused individuals live.

In addition, the County explains that a strength of their innovation proposal is that they plan to collaborate with the following organizations/programs:

- The Peer Wellness Center
- Mental Health Association San Francisco
- The Peer Employment Program
- Central City Hospitability House
- Transgender Pilot Project
- The Department of Homelessness and Supported Housing
- Law Enforcement Assisted Diversion (LEAD) Program
- San Francisco Homeless Outreach Team (HOT Team)
- Multiple other behavioral health and community programs

Recognizing that counties are increasingly investing in mobile peer teams, the Commission may wish to raise the issue of identifying opportunities to strengthen cross-county information sharing of best practices for forming, training and supporting mobile peer teams to provide street based interventions.

The Community Planning Process

San Francisco County's Mental Health Services Act team reports hosting eighteen (18) community engagement meetings with attendees representing: mental health and other service providers, consumers of mental health services and their families, representatives from local public agencies, community and faith-based organizations, residents of San Francisco, and other community stakeholders. In order to collect community member feedback and better understand the needs of the community all materials were translated into Spanish, Mandarin, and other languages, and interpretation was provided at all public community meetings, as needed. The County reports that they also provided a training regarding the specific purposes of gathering input and Mental Health Services Act requirements for innovation projects. The Commission may wish to encourage all counties to provide training regarding gathering input for innovation projects to support a robust community planning process.

Community feedback identified the need to provide support to unhoused individuals who are experiencing difficulty accessing services. This feedback led to an in-depth Community Needs Assessment that supported the need. The County reports that in two cases, respondents were within two blocks of identified service providers but were unsure where to go for support.

The community input gathered from the community planning and the needs assessment helped to shape the Innovations Proposal for this project.

This proposal was shared with MHSOAC stakeholders on September 17, 2018. In response, MHSOAC staff received one (1) email in support of the proposal.

Learning Objectives and Evaluation

San Francisco County is proposing a peer-run, peer-led project that seeks to test strategies in engaging with and delivering services with unhoused residents in the county. The County will target adult and older adult residents that are homeless, and do not typically access behavioral health services—despite experiencing behavioral health needs. It is the hope that approximately 465 clients will be served each year, with approximately 2,090 served over the span of the project.

San Francisco County has developed a thorough evaluation plan with clearly identified goals, questions, outcomes, and measurements. To guide their project, the County has identified three main learning questions:

1. Do street-based mental health peer-to-peer activities that address the immediate needs and wants of unhoused individuals help to increase their personal wellness (i.e. social connectedness, better quality of life, etc.)?
2. What components of the peer-based interventions and tools are most positively received by San Francisco residents who are homeless?
3. What engagement strategies work best to facilitate collaboration and communication between mental health peer specialists and homeless residents on the streets?

In addition to these learning questions, the County has identified several intended outcomes from the project (**see pgs. 16-17 of County plan**). To determine if outcomes are met, the County will assess a number of measures relative to social connectedness, social isolation, quality of life, satisfaction with intervention strategies, increased knowledge, among others (**for complete list of measures, see logic model on pg. 19 of County plan**). To collect the data necessary for evaluation, the County will track outreach/engagement, interview unhoused residents, survey peer staff and clients, as well as hold focus groups. Peers will also participate in the evaluation of the project by providing participants with a feedback tool at the end of each interaction.

The San Francisco Mental Health Services Act team will work with the San Francisco Department of Quality Management to evaluate the program, develop the tools necessary, and complete the final evaluation plan. At the conclusion of the WITS program, results and lessons learned will be shared with the San Francisco Mental Health Board, Board of Supervisors, among others. Additionally, findings will be shared statewide and among other counties that are serving similar populations and implementing similar projects.

The Budget

The County is requesting $350,000 in innovation dollars annually, for a total budget of $1,750,000 over five (5) years.

The majority of spending, $1,425,015, will go toward hiring personnel who identify as peers. Specifically, the County will hire 3.0 FTE County Contracted Peer Counselors at $20/hr. and a 1.0 FTE County Contracted Peer Supervisor who identifies as a consumer at $22/hr. The County reports that peer counselor rates of pay were determined by using the Behavioral Health Services' Peer Pay Rate Structure and that all peers who work at least 20 hours per week will be eligible for health insurance.

Evaluation is budgeted at $200,000 (11% of total budget) and will be completed by County personnel or contracted consultants.

Operating expenses total $91,985 and training expenses total $33,000.

The County states that they are leveraging existing funds allocated to the Peer Specialist Mental Health Certificate program in order to provide training for the peer counselors and peer supervisor hired for this project.

The County is not using funds subject to reversion or deemed reverted for this project.

Additional Regulatory Requirements

The proposed project appears to meet the minimum requirements listed under MHSA Innovation regulations; however, if Innovation Project is approved, the MHSOAC must receive and inform the MHSOAC of this certification of approval from the San Francisco County Board of Supervisors before any Innovation Funds can be spent.

References

Abram, Susan (2018, March 1) For LA County's mobile mental-health teams, persistence is key to leading homeless to help. *Los Angeles Daily News* Retrieved from: https://www.dailynews.com/2018/02/27/for-la-countys-mobile-mental-health-teams-persistence-is-key-to-leading-homeless-to-help/

Najavits, L.M. (2002) Seeking Safety A Treatment Manual for PTSD and Substance Abuse

San Francisco Homeless Count & Survey (2017) Retrieved from: http://hsh.sfgov.org/wp-content/uploads/2017/06/2017-SF-Point-in-Time-Count-General-FINAL-6.21.17.pdf

Full project proposal can be accessed here:

http://mhsoac.ca.gov/document/2018-09/san-francisco-county-innovation-project-wellness-streets-october-2018

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SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

Innovations Learning Project Proposal: Wellness in the Streets (WITS)

San Francisco Mental Health Services Act

2018

San Francisco Health Network

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Wellness in the Streets (WITS) Innovations Proposal

Local Review

The recent San Francisco Community Planning Process (CPP) involved various opportunities for community members and stakeholders to share input in the development of our Wellness in the Streets (WITS) Innovations Project. Please see the CPP meetings section below for details.

In fulfillment of the provisions of the Welfare and Institutions (W&I) Code Section 5848, a 30-day public review and comment of the Wellness in the Streets Innovations Project was posted on the San Francisco Mental Health Services Act (SF-MHSA) website at www.sfdph.org/dph and www.sfmhsa.org. This **plan was posted for a period of 30 days from 7/2/18 to 8/1/2018** as an appendix to the FY18/19 Annual Update. Members of the public were requested to submit their comments either by email or by regular mail. We received no comments regarding this project.

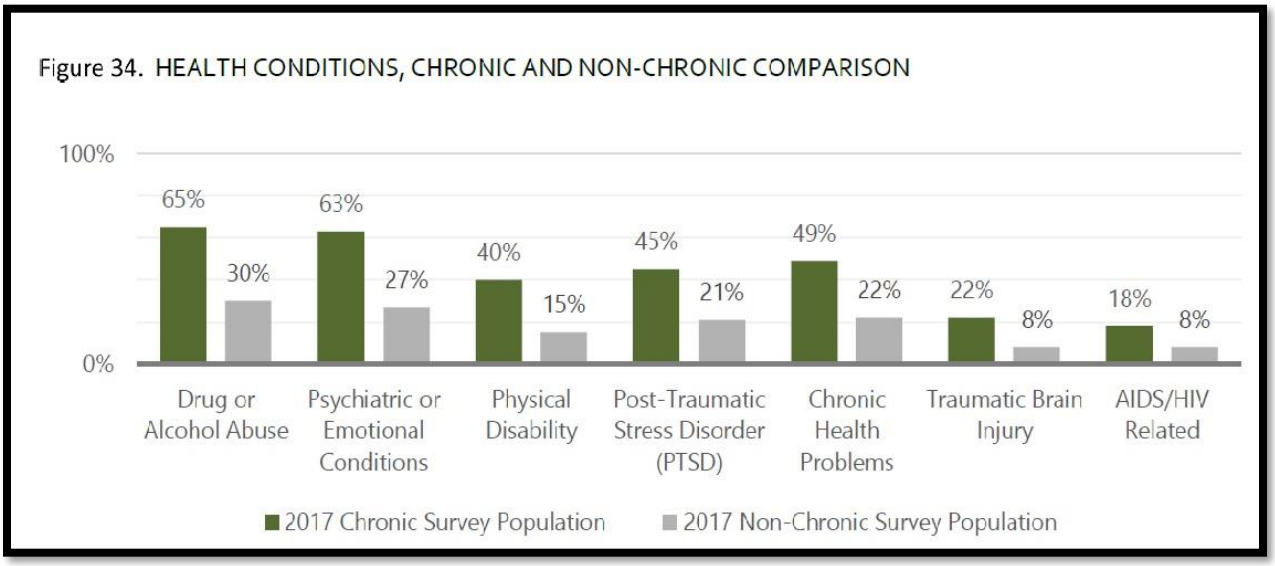
Following the 30-day public comment and review period, **a public hearing was conducted by the Mental Health Board of San Francisco on 8/1/18**. We anticipate that this Innovations project plan and Annual Update will be adopted by the San Francisco Board of Supervisors in October 2018.

Project Background

San Francisco is part of the 9-county Northern Californian Bay Area, containing four of the ten most expensive counties in the United States. With a population exceeding 7 million, the San Francisco Bay Area has an increasingly expensive housing market that is difficult for many to afford. In addition, it has been a destination for individuals who are homeless. As many as 39% of those surveyed have reported they first became homeless in a city outside of San Francisco *(San Francisco's Ten Year Plan to End Chronic Homelessness: Anniversary Report Covering 2004 to 2014)*. According to the last homeless count conducted by the City and County of San Francisco, the city has 7,499 homeless individuals with a large percentage living with severe mental illness or at risk of experiencing mental health issues.

The homeless population is an especially vulnerable population, particularly those who are chronically homeless, which includes those who have been homeless over a year or homeless four times in the last three years, and have a condition keeping them from work or housing. *San Francisco's Ten Year Plan to End Chronic Homelessness: Anniversary Report Covering 2004 to 2014* reports that the chronically homeless population has "high rates of behavioral health needs, including severe mental illness and substance abuse disorders, conditions often exacerbated by physical illness, injury or trauma."

According to the San Francisco 2017 Homeless Count and Survey, **sixty-three percent (63%) of chronically homeless survey respondents reported a psychiatric or emotional condition. Forty-five percent (45%) reported Post Traumatic Stress Disorder (PTSD). Sixty-five percent (65%) reported alcohol or substance use.**



Community Planning Process

The San Francisco Department of Public Health (SF-DPH) has strengthened its Mental Health Service Act program planning by collaborating with mental and behavioral health consumers, their families, peers, and service providers to identify the most pressing mental and behavioral health-related needs of the community and develop strategies to meet these needs. In late 2017 and early 2018, San Francisco Mental Health Services Act (SF-MHSA) hosted eighteen (18) community engagement meetings inviting participants from all over the city to collect community member feedback to better understand the needs of the community. Attendees included mental health and other service providers, consumers of mental health services and their families, representatives from local public agencies, community and faith-based organizations, residents of San Francisco, and other community stakeholders.

All meetings were advertised on the SF-DPH website and via word-of-mouth and email notifications to service providers. Printed and electronic materials were translated into Spanish, Mandarin, and other languages, and interpretation was provided at all public community meetings, as needed. A brief training was provided to the Community Program Planning participants regarding the specific purposes of gathering input and MHSA requirements for Innovations Projects. The community input gathered from these meetings helped to shape the Innovations Proposal for this project.

The eighteen (18) community engagement meetings are listed in the following table:

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Community Program Planning (CPP) Meetings	
Date	**CPP Location**
November 8, 2017	The Village Visitacion Valley Service Providers 1099 Sunnydale Avenue San Francisco, CA 94134
November 28, 2017	Sunset Mental Health Center Service Providers & Community Advisory Board Members 1990 41st Avenue, Suite 207 San Francisco, CA 94116
January 24, 2018	Excelsior Family Connections: Chinese families & Excelsior Family Connections staff 60 Ocean Avenue San Francisco, CA 94112
January 29, 2018	SF LGBT Center Population Focused Engagement 1800 Market Street San Francisco, CA 94102
February 5, 2018	Curry Senior Center MHSA Advisory Committee meeting 315 Turk Street – John Stanley Room San Francisco, CA 94102
February 7, 2018	TAY Full Service Partnership Meeting 755 South Van Ness San Francisco, CA 94110
February 15, 2018	Richmond District Neighborhood Center Service Providers Meeting 4301 Geary Boulevard San Francisco, CA 94118
February 26, 2018	Department of Rehabilitation (DOR-BHS) Co-op Administration Meeting (Vocational Programs) 455 Golden Gate Avenue, #7727 San Francisco, CA 94102
February 28, 2018	San Francisco Veterans Town Hall Meeting Veterans & Service Providers Meeting 401 Van Ness Avenue San Francisco, CA 94102
March 2, 2018	Excelsior Family Connections Spanish Speaking Families & Staff Meeting 60 Ocean Avenue San Francisco, CA 94112
March 2, 2018	SFDPH BHS Adult/Older Adult Service Providers Meeting 1 South Van Ness San Francisco, CA 94103

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Community Program Planning (CPP) Meetings	
Date	**CPP Location**
March 9, 2018	API Wellness Center Transgender Program Community Members & Service Providers 730 Polk Street San Francisco, CA 94109
March 13, 2018	Rafiki Coalition Black/African American Community 601 Cesar Chavez Street San Francisco, CA 94124
March 14, 2018	Huckleberry Youth Programs TAY Service Providers Meeting 555 Cole Street San Francisco, CA 94117
March 14, 2018	Crisis Intervention Training Meeting Workgroup – Law Enforcement, Peers & Service Providers 870 Market Street #785 San Francisco, CA 94102
April 18, 2018	SF Behavioral Health Services MHSA Advisory Committee Meeting 1380 Howard Street San Francisco, CA 94103
June 13, 2018	San Francisco Public Library Combined MHSA Provider and Advisory Committee Meeting 100 Larkin Street San Francisco, CA 94102
June 13, 2018	City College of San Francisco - Health Education Dept. Workforce Development Networking Session 50 Phelan Avenue San Francisco, CA 94112

Stakeholders from the Community Program Planning efforts requested more peer-to-peer services, additional programming for the homeless populations and more programs that increase access to clients currently not being served.

Community Needs Assessment

As a result of the feedback we received from our Community Program Planning (CPP) efforts regarding the need to provide support to unhoused individuals who are experiencing difficulty accessing services, we decided to conduct a more thorough and specific Community Needs Assessment targeting this population.

From April 1- July 14 2017, a diverse group of peers from various SF-DPH/BHS programs began the collection of information from homeless and marginally housed individuals. These information collection sessions occurred in multiple San Francisco neighborhoods including: *South of Market, Castro, Bayview/Hunters Point, Tenderloin, Mid-Market, Mission, and the*

Haight Ashbury District. The information collection efforts were conducted in both English and Spanish. Peer specialists were selected to support this needs assessment based on personal lived experience with homelessness, previous history in the BHS Peer Certificate program or previous experience working with the San Francisco homeless population.

Peer Specialists who conducted the Community Assessment

Peer counselors traveled in teams or pairs to various areas of the city with high concentration of unhoused individuals with the goal of engaging them in conversations related to mental health services in San Francisco. The peers provided outreach bags containing socks, snacks, and toiletries as an engagement strategy. The overarching goal was to collect statements related to both engagement and retention in services provided at BHS clinics. Conversations could be as brief as a few sentences or as long as the interaction felt comfortable to gain some insight into the needs of the population. Counselors were advised to create an open ended dialogue as opposed to any promises of services. After the encounters, summary notes were developed to capture the main points of the conversations and the primary needs of this specific population.

Primary Problem and Community Needs

The re-occurring themes to arise from the Community Planning Process and the Community Needs Assessment were feelings of isolation and disconnectedness for the City's homeless population. Homeless participants described **very little contact with social services**. A few respondents had the experience of **falling out of services because of their inability to keep track of appointments within their current living situation**.

The overarching theme was the need to **have contact with someone willing to connect with individuals at their current location**. "No one talks to us…" was repeated frequently during the Needs Assessment as well as, **"you are the only people that have come to speak with us."** In addition, surveyed individuals were confused as to where to obtain mental health services. In two cases, **respondents were within two blocks of identified service providers but were unsure where to go for support.** Calling to ask information for services with no live receptionist to answer questions was also identified as a barrier.

In a Wellness and Recovery-oriented system, a grounding principle is that recovery is a "possible and expected outcome of treatment, and that the full range of comprehensive services and supports that an individual needs to meet his or her recovery goals be **accessible, flexible, individualized, and coordinated**." (Felton et al, 2010, p. 441)

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As a result of the Community Program Planning input and the Community Needs Assessment**, a recommendation was formulated to create a peer-based mental health team that would work directly with unhoused individuals on the streets, in their environment, in order for the individual to be successful in their personal recovery.**

"The community is asking for this project!"

- ***SF-MHSA Peer Specialist***

Review of Existing Practices and Evidenced-Based Models

An extensive literature review of categories including homeless engagement strategies, evidence-based treatment modalities when working with the homeless population, patient navigation, peer programs, and housing reveals the following:

- Street based mental health services are generally conducted as an extension of an Assertive Community Treatment (ACT) program, a street based medical program, or a program that encourages individuals who are homeless to come into a physical program.
- Individuals who are homeless may wait until symptoms become so severe that they need to be treated at psychiatric hospitals or inpatient facilities.
- Teaching about wellness tools and crisis planning can be implemented by peers and is proven to be effective with homeless individuals.
- We could not identify any other counties or states that have extensive research on implementing street-based peer-to-peer interventions for the unhoused community.

Innovative Component

The Wellness in the Streets (WITS) project will implement **changes to existing mental health practices that have not yet been demonstrated to be effective, including, but not limited to, adaptation for a new setting and population.** This project is unique to San Francisco since we will utilize peer-to-peer interventions among San Francisco's diverse communities, targeting all San Franciscans who are unhoused.

The California Mental Health Services Act has done incredible work promoting Wellness and Recovery principles among the consumers that have accessed services since the implementation in 2005. The WITS project will be taking a fresh approach to peer support services. As rising housing costs and other exacerbating factors have pushed more and more communities to confront the needs of displaced residents, WITS aims to bring the concepts of Wellness and Recovery to many of San Francisco's most vulnerable residents.

Based on our literature review and extensive research of programming in other counties, the WITS model, which is described in the following section '*Proposed Project*', has not been attempted anywhere else in the State. Outreach and engagement services of unhoused

individuals has been a key aspect of numerous public health programs, yet the WITS model plans to bring something new to the community. Many current programs conduct outreach to unhoused individuals on the streets with the goal of linking to programs at a physical location but many individuals are not able to follow-through to gain access to mental health support, however, this project will bring the peer mental health interventions directly to the clients wherever they may be in the community.

San Francisco's Chinatown District

We feel this project is innovative due to the following:

- Peer-to-Peer Counseling and peer interventions provided to unhoused individuals directly where they are at and directly on the streets have rarely been tested, especially in a support group setting in a local park.
- Interventions directly on the streets have never been tested in San Francisco with San Francisco's unique and diverse communities.
- Peer interventions that include manual-based and evidence-based peer modalities including WRAP, Seeking Safety, crisis planning, wellness planning, coping skills development, etc. have rarely been tested directly on the streets.

Another unique feature of WITS would be the incorporation of real time feedback to evaluate what can be done to improve upon the service. Peers with lived experience with homelessness will be providing participants with a feedback tool at the end of each interaction. Instead of waiting days, weeks or months to gather information regarding what elements of the program are perceived as being valuable, the feedback tool will allow for immediate adaptation according to the needs of the people the program serves. SF-MHSA will also partner with the Quality Management (QM) department to frequently monitor and evaluate the success of our engagement and implementation strategies so we can fine-tune and adjust as needed.

We feel it is important to examine these aspects of the project so we can determine if our approach of providing peer interventions directly on the streets where unhoused individuals are located demonstrates positive health outcomes. We believe it is important to test and determine what specific engagement strategies and what specific peer interventions are most useful for participants on the streets.

Proposed Project / Response to Community Needs

Wellness in the Streets, otherwise known as WITS, will be a five-year peer-run, peer-led project that will test new ways of service delivery and engaging with unhoused San Francisco residents. The SF Bay Area is in the middle of a housing crisis that disproportionately impacts low income

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individuals suffering with or at-risk of severe mental illness. With shelters full to capacity every single night, individuals and organizations are facing the reality that services must meet people "where they are at" in new ways. This includes outdoor settings including street corners, encampments, and public parks. Peers would be leading interested individuals in activities such as one-to-one support, crisis planning, and support groups.

"No one ever talks to us!"

-Unhoused San Francisco Resident who expressed the need for support

The ultimate goal of WITS is moving participants along the stages of change until they are able to engage in services. Peers will gage the interactions through short feedback tools that will be filled out on the spot to evaluate what can be changed or added to improve the service quality and delivery.

WITS is a project that is fully invested in the concept that lack of housing should not be a barrier to creating improvements in mental health. While WITS staff will certainly do their best to refer and/or link participants to any and all available housing opportunities, housing linkage is not the main goal. The overarching concept is that the unhoused community should be able to utilize the benefits of peer services where ever they are located in the community.

Program Design

The purpose of this Innovations Learning Project will be to increase access to underserved populations, with **our target population being San Francisco adult and older adult residents who are homeless that do not typically access behavioral health services despite experiencing behavioral health needs.** The proposed project would involve a roving support team of **4.0 Full-Time Equivalent (FTE) formerly homeless peer counselors** that would engage in peer counseling directly on the streets of San Francisco in areas where individuals are unhoused.

Teams of 2-3 peers will go out to the various neighborhoods of San Francisco in search of or to follow-up with unhoused residents who are at-risk or currently in need of peer-based mental health services. The initial meetings with participants will involve building rapport and documenting the general geographic areas where individuals can be found for future encounters. In the pool of the long-term homeless, many have a particular habit of returning to a coffee shop, a street corner, or block where they feel safe while developing relationships with neighborhood regulars. The hours of operations for the WITS project will be more flexible than traditional clinics, with available times earlier in the day and later into the night depending on the weather, the seasons and the needs of the community.

Peer Roles

A peer is defined as an individual with personal lived experience who is a current or former client of behavioral health services, or a family member of a current or former client. Peer-to-Peer services encourage peers to utilize their lived experience, when appropriate and at the discretion of the peer, to benefit the wellness and recovery of the clients being served. Each peer working with this project will be trained as a peer specialist with experience in a mental health work place, personal experience with homelessness and a vast understanding of the mental health system.

The peers will be a vital component to designing the program details, developing the policies, implementing the scope of work, monitoring the progress and evaluating the desired outcomes. The peer specialists will be a driving force through all phases of this project from beginning to end and will act as leaders for the communities being served.

Our peer staff will also help provide outreach and education about this program to San Francisco residents among various community settings including the San Francisco Library system, wellness centers, homeless shelters and behavioral health programs to promote WITS. Peer staff will provide education about San Francisco mental health resources and linkage to services. As participants utilize the support of WITS, they will be offered alternative and appropriate services within Behavioral Health Services, as needed.

One of the peers will be assigned as a peer supervisor leading the peer team. This peer supervisor will be a key individual on the team designing and driving the peer engagement/intervention efforts and providing feedback. This peer supervisor will help us determine how to best train our system of peers for outreach, engagement, and supporting the use of these street-based peer interventions. We plan to hire this position as soon as we are approved by the MHSOAC since this is such a vital role.

Training and Supervision for Peer Specialists

Peer specialists will be trained using the current 12-week BHS Peer Specialist Mental Health Certificate Program, the Advanced Peer Certificate Program and the Leadership Academy monthly training seminars for peers. Additional training will be offered including, but not limited to:

- Wellness Recovery Action Plan (WRAP)
- Harm Reduction
- Psycho-education on mental health, coping skills and socialization skills
- De-escalation strategies
- CPR/First Aid
- Personal safety training
- Seeking Safety
- Motivational Interviewing

Peer Program Team Huddle

A SF-DPH Manager will be available to supervise the project and peers. There will also be clinical supervision available on an as needed basis and quarterly debriefings with the clinical supervisor to provide clinical support.

Assessment and Engagement Strategies

WITS will seek to build rapport with unhoused individuals over time through a process of mapping out “hang-out spots” and resources that have value to potential program participants. A brief community assessment and research will be conducted to determine what areas of San Francisco have the greatest number of unhoused individuals and the greatest level of need. These areas will then be prioritized and targeted.

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Engagement will be made based on building a relationship between the peer and the participant, verses a traditional quick triage of what a caseworker perceives the needs of the person in front of them to be. A diverse team of peer counselors will go out in the community in pairs to engage unhoused San Francisco residents in meaningful connections, based on the needs of the residents. Peer workers will distinguish themselves by wearing a sweatshirt or other garment with a visible project logo.

The first 3 months of the implementation stage of this project will be primarily focused on engaging and building a relationship with unhoused community members Small items will be used as engagement tools such as coffee, snacks, clothing, blankets and other items. Peer counselors will engage unhoused individuals by explaining their role and asking initial questions such as, “how are you doing today?” and, “are you interested in talking?”. Most of this stage will be focused on listening to community members tell their story and relationship building. **We will also use this engagement period to better assess their needs and gather information about what unhoused individuals think we should do to best provide support.** It is important to develop a process of best practice to determine what will best motivate unhoused individuals to move through the stages of change. We believe that this population should lead the interventions, not the project staff.

After the first 3 months, it is believed that a trusting relationship should be developed with several community members at which point more concrete peer interventions will be offered. These interventions will be introduced based on the feedback we received and based on what individuals told us they would prefer. These may include evidenced-based peer interventions that can take place in a park, on a sidewalk or in a nearby coffee shop.

Peer Interventions

Peer counselors will spend time listening to personal stories, discussing wellness and recovery, and modeling hope. Peers will provide **brief peer counseling activities** including behavioral health education activities, wellness planning, crisis planning and other activities. Peer counselors will also distribute a one-page resource sheet to educate unhoused individuals regarding behavioral health services, housing resources and alternate peer counselling programs. Education regarding the array of behavioral health services that San Francisco has to offer will be provided.

Longer-term interventions will be provided including weekly support groups in a park or café based on the preferences of the participants. These interventions may include, but not limited to:

- Wellness planning group – help individuals develop a wellness toolbox directly on the street that can be used on a daily basis to promote recovery
- Motivational Interviewing - meet up with unhoused individuals at coffee shops for one-on-one social connection while using motivational interviewing and other evidenced-based peer interventions for support
- Crisis planning group – help create a self-developed crisis plan to provide participants coping tools and a concrete plan to follow when feeling distressed or in crisis
- Support system development – develop a list of support people when needs arise and help create a plan to stay organized

- Mental health psycho-education groups - teach early warning signs of mental health problems, teach what to do when problems arise and provide education on resources
- Seeking safety support groups – teach coping skills and healthy strategies regarding trauma and substance use
- Socialization skills development – teach conflict resolution and communication skills that are specific to the individuals' needs
- Harm reduction skills training – teach safe and alternative practices to reduce harm
- Coping skills development – teach healthy new ways to deal with stressors
- Support managing appointments & medications – teach organizational strategies and provide organizational tools
- Reconnection with friends or family members support – provide emotional support and help individuals access their support system
- Stages of Change Model and education – teach the stages of change model and help the individual strategize ways to reach their goal

Participants will be able to set up appointments to meet with a peer. In addition, a 4-hour block of time will be available for community meet-ups with the peers. Programming will be entirely street-based and peer specialists will be setting up activities on street corners, in coffee shops or cafes based on the preferences of the participants.

SF-MHSA Peer Specialists

Peer counselors will provide linkage to services as needed and assist with escorting individuals to such programs. For example, if an unhoused individual is found to be in need of medical care, they will be supported and escorted to the SF Hot Street Medicine team to address their needs in an appropriate setting.

Estimate of Clients Served

According to the last homeless count conducted by the City and County of San Francisco, the city has 7,499 homeless individuals with a large percentage with high-risk situations or at-risk of experiencing mental health issues. This data demonstrates a high need for this population.

We conducted research on various low-threshold, outreach and peer-to-peer programs that are similar in nature to analyze the number of clients being served. We determined that this program should invest about $600-$900 per client per year, and on average we should invest $750 per client per year. With our requested annual budget of $350,000, we should serve about 465 clients per year. Of these clients being served, 50 of them will receive longer term interventions.

Over the 5-year project, we will need approximately 3 months to ramp up the project and 3 months to tapper down the project. Therefore we will be serving participants over the span of 4.5 years. If we **serve 465 clients per year,** and serve these clients for 4.5 years, then we will **serve an estimated total of 2,090 participants over the entire 5 year project.**

Safety

Safety is critical for both the participant and the WITS team. In the program development stage, the peer staff will receive training on Harm Reduction, De-escalation, Overdose Prevention, and other safety and risk related training seminars. The peers will spend weeks shadowing existing Health Department staff who currently are working in the field to get a baseline understanding on how to conduct operations in a safe fashion. In addition, the peers will carry Narcan; a non-prescription nasal spray that can be administered in case of an overdose.

SF-MHSA CPP Meeting

Self-Care

There will be a heavy emphasis on self-care and wellness for the WITS staff and preserving the wellness of the WITS team of peers will be critical to the functions of the project. There is a core understanding that working with humans in such substandard environments can be taxing on the mental health of community outreach specialists.

Regular supervision and team stress reduction activities will be provided for all peer staff members. Accommodations will also be provided for those in need of additional breaks or increased wellness/support activities in order to prevent burn-out. Lastly, the pay-rate for the WITS peers will be a starting salary comparable to the City and County of San Francisco's civil service Health Workers to demonstrate that this team is valued.

San Francisco Partnerships

SF-MHSA will partner with several local and county programs to best implement this project. We envision collaborating with the following organizations/programs:

- The Peer Wellness Center
- Mental Health Association San Francisco
- The Peer Employment Program
- Central City Hospitability House
- Transgender Pilot Project
- The Department of Homelessness and Supported Housing
- Law Enforcement Assisted Diversion (LEAD) Program
- San Francisco Homeless Outreach Team (HOT Team)
- Multiple other behavioral health and community programs

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Language Capacity and Cultural Considerations

The City and County of San Francisco has five threshold languages that include Spanish, Vietnamese, Cantonese, Russian and Tagalog. SF-MHSA will work in collaboration with the San Francisco Department of Public Health's Cultural Competency department to implement these services in the threshold languages and engage these specific populations.

In addition, we will aim to hire a peer who identifies as lesbian, gay, bi-sexual, transgender, queer, questioning and/or intersex (LGBTQQI+) and a Spanish speaking peer to assist with reaching these communities.

Confidentiality

All elements of this project will adhere to HIPAA (Health Insurance Portability and Accountability Act of 1996) regulations, and we will only implement HIPAA compliant protocol with a high concern to safe-guarding participant confidentiality.

The process of informed consent will lie with the peer specialists and verbal consent will be required before working with the peer team. This will serve as the informed consent outlining the nature of the relationship, parameters of this project, confidentiality, data collection, etc.

Contribution to Learning

This project will center on the development of a highly skilled peer specialist team to help support San Francisco homeless residents advance in their wellness and recovery using a peer-to-peer counseling approach directly on the streets. The primary goals of the project would be to increase social connectedness of homeless individuals; increase awareness of mental health resources; and increase feelings of wellness and the overall quality of life of individuals who are homeless by using peer-to-peer interventions on the street. These goals will be achieved by taking a unique approach of learning from unhoused residents in the moment regarding their presenting needs and then strategize as an interdisciplinary team (including peers and consumers) on how to best work together to meet those needs.

Key Learning Questions

1. Do street-based mental health peer-to-peer activities that address the immediate needs and wants of unhoused individuals help to increase their personal wellness (i.e. social connectedness, better quality of life, etc.)?

2. What components of the peer-based interventions and tools are most positively received by San Francisco residents who are homeless?

3. What engagement strategies work best to facilitate collaboration and communication between mental health peer specialists and homeless residents living on the street?

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Evaluation / Learning Plan

SF-MHSA will work in close partnership with SF-DPH Quality Management (QM) to implement a comprehensive evaluation plan with tools to measure immediate outcomes and longer term impact of the project. The evaluation plan includes a logic model to guide the design and implementation of the Innovations Learning Project. An ethnically diverse group of consumers and community members will be involved in the design of the evaluation tools, particularly people with lived experience with homelessness. The use of surveys and key informant interviews will be used. The number and quality of the peer staff interactions with homeless residents will be measured by survey questions, with some questions to measure the satisfaction of the interaction and some to identify what community members suggest for near future efforts and activities. SF-MHSA and QM will compile evaluation reports summarizing the program design, results, outcomes, lessons learned, and ways to continuously improve program services based on stakeholder feedback.

Based on evidence available in the existing literature for effective interventions with homeless individuals (Altena, Brilleslijper-Kater, & Wolf, 2010; Karabanow & Clement, 2004), it is better for rapport development to begin with asking what the unhoused residents needs and wants are in the moment, rather than approaching this community with the assumption that we know what works best already. We anticipate that this approach will be more effective for rapport development as a first step towards increasing knowledge and willingness to engage with the larger, institutional, behavioral health system of care.

In addition, the peer staff will begin by engaging unhoused residents with evidence-based intervention strategies, such as developing trust, facilitating positive interpersonal relationships, and increasing access to information and community-based social services. While doing so, we will gather real-time information from the unhoused residents about what intervention strategies may be more effective in achieving one or more of our program goals such as increasing knowledge of community resources, and increasing both motivation and willingness to engage in the available community-based social services. As the new intervention strategies are developed based on the input from the unhoused residents, the peer staff will begin to implement these new strategies and get new ratings of efficacy on these new strategies. The evaluation staff may then recommend implementation or ongoing use of the intervention strategies that have higher positive ratings.

Based on the lessons learned from the above activities, best practice protocols will be developed for both engagement and intervention activities when working with unhoused residents in San Francisco. The expectation is to expand the existing knowledge base of known effective intervention strategies.

The specific outcomes that we may measure include:

1. Qualitative assessment of presenting need(s) of users (e.g., what are your immediate needs? What can I help you with today?)
2. Increased social connectedness for users
3. Decreased social isolation for users
4. Increased quality of life
5. Increased feelings of personal value or self-worth

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6. Satisfaction with intervention strategies
7. Satisfaction with outreach/engagement strategies
8. Qualitative assessment of other strategies for outreach, engagement, and intervention (e.g., What are your interests? What do you need information about? What are some things that you want to get help with today?)
9. Increased knowledge of activities and/or resources (including services) available to users
10. Increased motivation to engage in harm reduction and/or social service activities
11. Increased willingness to engage in harm reduction and/or social service activities.

Social connectedness is defined as the measure of how people come together and interact with others such as friends, family and acquaintances, whether one on one or in groups. It can be structured or scheduled activities or unstructured visiting and conversation. It measures a person's comfort and trust with others such that they can ask for help when they need it.

Wellness is defined as the presence of purpose in life, active involvement in satisfying work and/or play, joyful relationships, a healthy body and living environment, and happiness. Wellness is often evident when individuals have "a reason to get out of bed in the morning," something to do, somewhere they want to be, along with the emotional and physical capacity to do it. It is often linked to purpose and optimism.

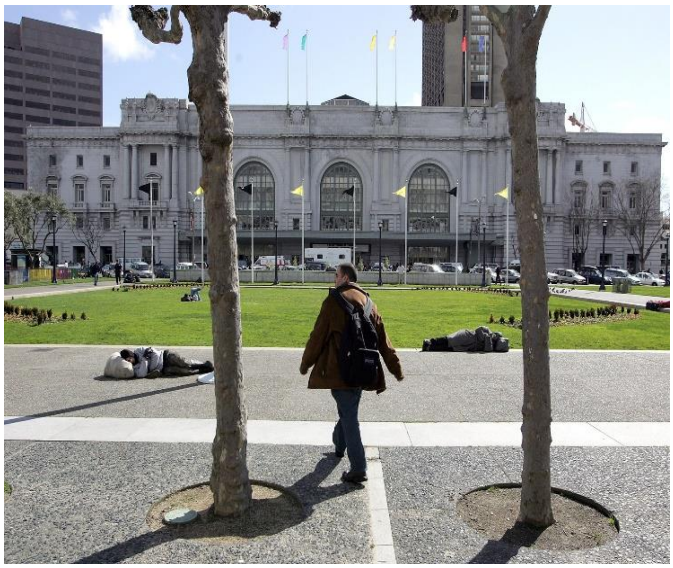
Learning Question	Sources of Data	Data Collection Strategy
1) Do street-based mental health peer-to-peer activities that address the immediate needs and wants of unhoused individuals help to increase their personal wellness (i.e. social connectedness, better quality of life, etc.)?	Peer Staff Unhoused residents	Interviews with Users on the streets Client feedback survey forms Focus groups
2) What components of the peer-based interventions and tools are most positively received by San Francisco residents who are homeless?	Peer Staff Unhoused residents	Interviews with Users on the streets Client feedback survey forms Focus groups
3) What engagement strategies work best to facilitate collaboration and communication between mental health peer specialists and homeless residents living on the street?	Peer Staff Unhoused residents	Interviews with Users on the streets Client feedback survey forms Focus groups

Data collection tools include, but not limited to:

- Brief client feedback survey to be used for the short-term peer interventions to evaluate activities provided in the moment to individuals that are more transient
- Surveys to assess the longer-term peer interventions (i.e. weekly support groups in the park) to evaluate individuals engaged in ongoing activities
- Staff checklists that include a list of evidence-based effective peer interventions that also include blank spaces for new interventions suggested or implemented in real time to track the peer activities being used.

In addition, process measures may be gathered to track the progress of outreach/engagement, rapport development, and the implementation of the peer-based street interventions. For example,

- Number of interactions with unhoused residents on the streets (administrative)
- Number of resources shared with unhoused residents on the streets (administrative)
- Number of peer-led groups hosted for unhoused residents off the streets (administrative)
- Number of repeat interactions



It is proposed as part of this project that we explore and test different strategies for outreach, engagement, and intervention with unhoused residents as a PDSA (Plan-Do-Study-Act) in the early stages of implementation and review its value. The PDSA cycles will focus on community-informed recommendations for improving engagement and intervention strategies. Qualitative information gathered will inform the longer term outcome objectives of forming best-practice models for increasing motivation and willingness to engage with behavioral health and harm reduction social services in San Francisco. Data will be analyzed in aggregate quarterly to identify and improve our engagement and intervention activities. The PDSA cycle is expected to contribute to ongoing improvements, as based on the lessons learned from the activities used most successfully. Best practice protocols will be developed for both engagement and intervention activities when working with unhoused residents in San Francisco. The expectation is to expand the existing knowledge base of known effective intervention strategies.

- Satisfaction with outreach/engagement strategies (quantitative data collection)
- Satisfaction with intervention strategies (quantitative data collection)
- Recommendations for improving engagement strategies (qualitative data collection)
- Recommendations for improving intervention strategies (qualitative data collection)

Please see the below logic model to describe the evaluation efforts and desired outcomes.

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Identified Concern:	Contributing Risk Factors:	Learning Questions:
There are 7,000 + unhoused SF residents currently experiencing emotional distress Unhoused residents report feelings of isolation and disconnectedness Limited access to services Limited access to social support	Poverty, personal history of trauma, substance use, low inventory of stable affordable housing, prevalence of street drugs and alcohol, disability, stigma, and open hostility related to those who are unhoused	1) Do street-based mental health peer-to-peer activities that address the immediate needs and wants of unhoused individuals help to increase their personal wellness (i.e. social connectedness, better quality of life, etc.)? 2) What components of the peer-based interventions and tools are most positively received by San Francisco residents who are homeless? **3)** What engagement strategies work best to facilitate collaboration and communication between mental health peer specialists and homeless residents living on the street?

Resources	Strategies/ Activities	Expected Outcomes			Suggested Measurements
		Short Term	Intermediate	Long Term	
◊ MHSA funding ◊ Peers with lived experience of homelessness from the community ◊ Peers trained and certified in engagement modalities (stages of change, motivational interviewing, harm reduction, seeking safety, Certified Wellness Recovery Action Plan (WRAP), etc.) ◊ Program Manager ◊ Knowledge of the SF neighborhoods, service provider landscape, and homeless engagement services. ◊ City Partnerships (e.g., coffee shops, SF public library, SF police department) ◊ Materials (e.g., log books, Narcan)	◊ Peer led trainings, outreach, and engagement ◊ Peer-based services ▪ 1:1 counseling ▪ Groups (e.g., seeking safety) ▪ Resource planning ▪ Crisis planning ▪ Social support ▪ Skill building (socialization, harm reduction, coping) ▪ Appointment management ▪ Asset mapping ◊ System navigation or linkage as needed, where appropriate ◊ Interventions occur on location with unhoused residents (not in clinics). ◊ Meetings (staff, stakeholder, supervision, evaluation) ◊ Partnership coordination ◊ Protocol development	◊ Connect unhoused individual with a peer to establish trust & rapport ◊ Identification of presenting needs of unhoused individual ◊ Increase knowledge of peer-led wellness activities available for unhoused residents ◊ Increase knowledge of harm reduction supports for isolated and/or high risk unhoused individuals ◊ Increase participant knowledge of additional available services & mental health and/or wellness resources ◊ Linkage to behavioral health services as needed	◊ Decrease feelings of social isolation among unhoused SF residents ◊ Identify factors that increase motivation to access services ◊ Identify factors that are feasible for serving unhoused residents on the streets ◊ Increase willingness of unhoused residents to engage in peer-led wellness activities ◊ Increase willingness of unhoused residents to engage with harm reduction supports ◊ Increase willingness of unhoused residents to engage with behavioral health and/or wellness resources ◊ Increase knowledge among unhoused residents of a wellness toolbox for support	◊ Develop best practice peer-engagement strategies with unhoused residents. ◊ Develop best practice peer-led interventions that increase motivation to engage with behavioral health services ◊ Increase quality of life among unhoused residents ◊ Increase feelings of personal value among unhoused residents ◊ Better service delivery to unhoused residents in SF that is directly informed by homeless needs ◊ Improve experiences among unhoused residents with behavioral health and/or wellness resources ◊ Improve understanding of behavioral health service needs among unhoused individuals experiencing/at risk for trauma, substance use disorder, mental health conditions	**Outcome indicators**: ◊ Assessment of presenting need ◊ Satisfaction with intervention strategies ◊ Satisfaction with outreach and engagement strategies **Real-time survey that as a direct result of working with the peer staff assesses measures of:** 1. Social connectedness 2. Social isolation 3. Quality of life 4. Self-worth (personal value) 5. Resource knowledge gained 6. Motivation to engage in services 7. Most positively received interventions 8. Engagement strategies that facilitate collaboration 9. Willingness to engage in services 10. Knowledge of mental health services

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Project Evaluation, Cultural Competence and Meaningful Stakeholder Involvement

The evaluation of the Wellness in the Streets project will be conducted with sensitivity and awareness of our users' diverse experiences related to age, disabilities, as well as cultural, language, ethnic, sexual and gender identities. We seek to generate relevant and useful evaluation results by consulting with key stakeholders who help us ensure that any data collection reflect the values and diverse experiences of our behavioral health community.

We have already established a group of stakeholders that includes community members, behavioral health leaders and peer advocates. As the Innovations program is established and the Peer Team identified and trained, the stakeholder group will expand to include members of the Peer Team as well as clients/users.

The stakeholder group will be consulted on Innovations project learning goals, data collection tools, methods and language for data collection, and how best to summarize and communicate findings to suit diverse audiences. San Francisco also has an active Mental Health Board that meets monthly and a Behavioral Health Services Client Council, where issues important to client representatives, including Innovations project findings, are presented and discussed. Both the Client Council and the Mental Health Board will be integral partners in designing the evaluation, interpreting and reporting the findings, and making recommendations for client-focused program improvement.

MHSA General Standards

Our Innovations Project reflects and is consistent with all potentially applicable MHSA General Standards set forth in Title 9 California Code of Regulations, Section 3320.

a) Community Collaboration
The project will be a collaboration between peer specialists, Behavioral Health Services, community-based organizations, and San Francisco community members.

b) Cultural Competency
The Peer Specialists will receive cultural humility training and they will reflect the diversity of the community they are serving.

c) Client-Driven/ Family-Driven
This project places peers who have lived experience and who have been involved in the mental health system at the center of programming. The peer specialists will be a highly skilled team who will use their expertise to meet each client where they are at.

d) Wellness, Recovery, and Resilience-Focused

This project design will be consistent with the philosophy, principles, and practices of Wellness and Recovery for mental health consumers. It will promote concepts key to the recovery for mental illness such as: hope, personal empowerment, respect, social connections, self-responsibility, and self-determination.

e) Integrated Service Experience for Clients and Families

This project focuses on increasing access to mental health resources for underserved communities throughout San Francisco by utilizing the peer interventions integrated throughout the existing San Francisco mental health system and implementing these interventions directly where participants are located.

Plan after the Innovations Learning Project Ends

San Francisco Behavioral Health Services will utilize several strategies to secure continuation funding for the proposed Innovations Learning Project, if the entire project or components of the project are found to be effective in meeting our proposed outcomes.

The team will utilize data reports to identify successful interventions, population needs and opportunities. The Program Manager and Quality Management will analyze project data to determine the efficacious components of this project. These findings will be used to construct a rationale for the ongoing continuation of funding based both on the positive impact of the community being served.

Another approach involves an ongoing process of improving and enhancing citywide collaborations as a way to both expand services reimbursements and identify potential points of interaction or resource sharing that could create opportunities for alternate forms of continuation support.

Continuity of Care for Individuals with Serious Mental Illness

Within the broader system of care, there is a network of peer providers that provide services for clients with severe mental illness. In addition, a segment of peer services exists within a wide variety of MHSA providers. These contractors are funded by MHSA to provide peer services for any BHS clients. The existing menu of services includes support groups; individual and group counseling; wellness activities including outings and family to family classes; linkage; Dual Recovery Anonymous groups, Wellness Recovery Action Plan (WRAP) planning; cultural specific activities; services to those with hoarding and cluttering issues; and support for those interested in vocational activities.

Some of the ongoing goals for the peer specialists involved with this project will be to educate participants about existing resources and link into relevant services in the community, as needed. When the project ends, the participants involved in the project will have received an introduction to these services and be able to access them as part of their care plans.

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Communication and Dissemination Plan

Feedback from participants will be shared regarding the successes and lessons learned from this project. The peer specialists will be invited to co-present with other project staff on progress, findings, and their experience of the project to stakeholders.

Project learnings and newly demonstrated successful practices will be shared within our county and to stakeholders. Successful elements of this project can be applied to other areas of the behavioral health system of care. Shared practices could change service delivery and the peer employment infrastructure, possibly expanding the focus areas of future peer programs to involve more street-based interventions.

Successful practices and lessons learned will be shared with the San Francisco Mental Health Board and San Francisco Board of Supervisors, as well as with the BHS Executive Team. SF-MHSA team members will present findings at the MHSA Advisory Committee and MHSA Provider Meetings, which include peer-based organizations and community-based agencies. Project successes and challenges will be presented at the Client Council, a committee of consumers that perform an advisory role on BHS affairs. The findings will be disseminated to stakeholders via the SF-MHSA website, the email distribution system, and through the monthly BHS Director's Newsletter. Lastly, the results will be disseminated on a state-level to the MHSOAC and these findings may provide insight to other counties working on similar projects.

Timeline

The City and County of San Francisco is proposing a five-year timeline that will begin upon MHSOAC approval.

Phase I- Start Up and Planning (11/1/2018-12/31/2019)

Program staff and consumers will spend the first two months of this project selecting community partners that employ peers that can engage and serve San Francisco residents who experience homelessness. The program will also fine-tune the scope of work, hire needed staff, and establish the necessary infrastructure to operate the program.

Phase II- Implementation (1/1/2019-6/30/2023)

In this phase, the project will be fully operational and engaging with San Francisco residents who experience homelessness directly on the streets by considering their social and behavioral health needs, and implementing mutually-agreed upon peer activities. The evaluation plan will be refined and implemented throughout this phase.

Phase III – Reflection, Evaluation, and Dissemination (7/1/2023-10/31/2023)

In this phase, the project will be wrapping up and the implementation phase will be tapering down. The evaluation data gathered in the implementation phase will be analyzed and we will work with stakeholders to determine best practices, lessons learned and the overall impact of the project. We will also assess the success of the community partnerships and the added value of their collaborative efforts. In partnership with consumers and stakeholders, we will determine whether and how to continue the successful components of this project. We will disseminate the results.

Budget Narrative

The total requested budget is $350,000 annually, for a total budget of $1,750,000 over five (5) years. If approved by the MHSOAC, SF-MHSA will utilize FY18/19 Innovations Funding for the first year and will not utilize reversion funds.

The majority of spending for this project will go toward hiring 3.0 FTE County Contracted Peer Counselors at $20/hr to staff the project. There will also be a 1.0 FTE County Contracted Peer Supervisor who identifies as a consumer at $22/hr. The peer counselor rates of pay were determined by using the Behavioral Health Services' Peer Pay Rate Structure based on the specific peer activities being conducted and the skill-level required. All peers that work at least 20 hours per week will be eligible for health insurance, and all peers will be eligible for fringe benefits including workers compensation and access to a health services account. All benefits/fringe is estimated to be at 29.74% of the total salaries budget.

There will be a 0.25 FTE SF-DPH Manager of the overall project who self-identifies as a consumer. This manager will be responsible for implementing the work plan for this project.

We are requesting $18,397 annually for operating expenditures to engage participants and operate the program including food, coffee, clothing materials, blankets, travel, art supplies, office supplies and other items.

Lastly, we will place a strong emphasis on evaluation. Therefore we are requesting an annual budget of $40,000 to implement the evaluation activities. These efforts may be carried out by SF-DPH personnel and/or county contracted professional consultants.

Leveraged Funding

The training for the peer counselors and the peer supervisor will be leveraged through existing funds allocated to the BHS Peer Specialist Mental Health Certificate program, the Advanced

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Peer Certificate Program and the Leadership Academy's monthly training seminars for peers. The additional annual training expenditures for this project are estimated at $6,600.

Please refer to the Innovations Project Budget below for more details.

Innovations Budget

WITS BUDGET	Year One	Year Two	Year Three	Year Four	Year Five	Innovations Total
Personnel Expenses						
County Manager	$ 39,133	$ 39,133	$ 39,133	$ 39,133	$ 39,133	$ 195,665
County Contracted Peers	$ 245,870	$ 245,870	$ 245,870	$ 245,870	$ 245,870	$ 1,229,350
Evaluation	$ 40,000	$ 40,000	$ 40,000	$ 40,000	$ 40,000	$ 200,000
Operating Expenses	$ 18,397	$ 18,397	$ 18,397	$ 18,397	$ 18,397	$ 91,985
Training Expenses	$ 6,600	$ 6,600	$ 6,600	$ 6,600	$ 6,600	$ 33,000
TOTAL EXPENSES	**$ 350,000**	**$ 350,000**	**$ 350,000**	**$ 350,000**	**$ 350,000**	**$ 1,750,000**

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AGENDA ITEM 6

Information

October 25, 2018 Commission Meeting

Executive Director Report Out

Summary: Executive Director Ewing will report out on projects underway and other matters relating to the ongoing work of the Commission. The Commission will discuss the Executive Director's report out.

Presenter: Toby Ewing, Executive Director

Enclosures:
(1) The Motions Summary from the September 27, 2018 Meeting; (2) Evaluation Dashboard; (3) Innovation Dashboard (4) Presentation Guidelines; (5) Calendar of Commission Meeting Draft Agenda Items; (6) Department of Health Care Services Revenue and Expenditure Reports status update; (7) Legislative Report to the Commission

Handouts: None.

Mental Health Services
Oversight & Accountability Commission

WELLNESS • RECOVERY • RESILIENCE

Motions Summary
Commission Meeting
September 27, 2018

Motion #: 1

Date: September 27, 2018 **Time:** 9:32 AM

Motion:

The Commission approves the August 23, 2018 Meeting Minutes.

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

Motion carried 10 yes, 0 no, and 3 abstain, per roll call vote as follows:

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

Motion #: 2

Date: September 27, 2018 **Time:** 10:21 AM

Motion:

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

Name: Multiple Organization Shared Telepsychiatry (MOST) Project

Amount: $1,663,631

Project Length: Three (3) Years

Commissioner making motion: Commissioner Anthony
Commissioner seconding motion: Commissioner Wooton

Motion carried 11 yes, 0 no, and 0 abstain, per roll call vote as follows:

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

Motion #: 3

Date: September 27, 2018 **Time:** 11:44 AM

Motion:

The MHSOAC approves Los Angeles County's Innovation Projects, as follows:

Name: Ongoing Focused Support to Improve Recovery Rates for Conservatees Living in the Community

Amount: $16,282,502

Project Length: Five (5) Years

Commissioner making motion: Commissioner Brown

Commissioner seconding motion: Commissioner Alvarez

Commissioner Bunch recused herself.
Motion carried 10 yes, 0 no, and 0 abstain, per roll call vote as follows:

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

Motion #: 4

Date: September 27, 2018 **Time:** 11:45 AM

Motion:

The MHSOAC approves Los Angeles County's Innovation Projects, as follows:

Name: Therapeutic Transportation

Amount: $18,342,400

Project Length: Three (3) Years

Commissioner making motion: Commissioner Madrigal-Weiss

Commissioner seconding motion: Commissioner Gordon

Commissioner Bunch recused herself.
Motion carried 10 yes, 0 no, and 0 abstain, per roll call vote as follows:

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

Motion #: 5

Date: September 27, 2018 **Time:** 2:21 PM

Motion:

The MHSOAC approves Santa Barbara County's request for $2,600,000 additional funding and extension of time for its Resiliency Interventions for Sexual Exploitation (RISE) previously approved by the Commission on May 28, 2015 as follows:

Name:	Resiliency Interventions for Sexual Exploitation (RISE)
Additional Amount:	$2,600,000 for a total INN project budget of $5,107,749
Additional Project Length:	Two (2) years for a total project duration of (5) five years.

Commissioner making motion: Commissioner Anthony

Commissioner seconding motion: Vice-Chair Aslami-Tamplen

Commissioners Brown and Wotton recused themselves.

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

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

Motion: 6

Date: September 27, 2018 **Time:** 4:20 PM

Motion:

The MHSOAC names the Mental Health Policy Consumer Fellowship in honor of Sally Zinman and the Mental Health Policy Practitioner Fellowship in honor of Rusty Selix.

Commissioner making motion: Vice-Chair Aslami-Tamplen

Commissioner seconding motion: Commissioner Danovitch

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

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

Motion #: 7

Date: September 27, 2018 **Time:** 4:58 PM

Motion: The MHSOAC approves each of the following County's Tech Suite Collaboration Innovation plans, and directs the Subcommittee on Innovation to provide oversight of the Tech Suite Collaboration project and provide regular updates to the Commission:

Name	Amount	Project Length
City of Berkeley	$462,916	3 Years
Inyo	$448,757	3 Years
Marin	$1,580,000	3 Years
Monterey	$2,526,000	3 Years
Riverside	$25,000,000	3 Years
San Francisco	$2,273,000	3 Years
San Mateo	$3,872,167	3 Years
Tehama	$118,088	2 Years
Tri-City	$1,674,700	3 Years

Commissioner making motion: Commissioner Anthony

Commissioner seconding motion: Commissioner Danovitch

Commissioner Wooton recused herself.

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

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

Motion #: 8

Date: September 27, 2018 **Time:** 4:59 PM

Motion:

The MHSOAC approves Santa Barbara County's Tech Suite Collaborative Innovation plan, as follows:

Amount: $4,912,852
Project Length: Five (5) Years

Commissioner making motion: Commissioner Anthony
Commissioner seconding motion: Commissioner Madrigal-Weiss
Commissioners Brown and Wotton recused themselves.

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

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

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MHSOAC
Mental Health Services
Oversight & Accountability Commission

MHSOAC Evaluation Dashboard Month September 2018
(Updated October 4th, 2018)

Summary of Updates

Contracts

No Changes

Total Contracts: 4

Funds Spent in September 2018

16MHSOAC021	$90,000
17MHSOAC024	$12,880
17MHSOAC081	$0
17MHSOAC085	$0
Total	**$102,880**

Contracts with Deliverable Changes

17MHSOAC081

MHSOAC Evaluation Dashboard Month September 2018
(Updated October 4th, 2018)

The iFish Group: Visualization Configuration & Publication Support Services (16MHSOAC021)

MHSOAC Staff	Brandon McMillen & Rachel Heffley
Active Dates	10/31/16 – 7/27/2019
Total Contract Amount	$1,000,000
Total Spent	$775,000

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 & statistics to various stakeholders. Resources will be provided to allow MHSOAC staff to evaluate, merge, clean, & link all relevant datasets; develop processes & standards for data management; identify & configure analytics & visualizations for publication on the MHSOAC public website; & manage the publication of data to the open data platform.

Deliverables	Due Date	Status	Change
Fiscal Transparency Tool 1.0- (Design specs, Configuration & Related Datasets, Test Results, Visualization & Dataset Deployed)	10/31/16	Complete	No
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)	05/30/18	In Progress	No
Fiscal Transparency Tool 2.0- (Design specs, Configuration & Related Datasets, Test Results, Visualization & Dataset Deployed)	07/28/18	Complete	No

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MHSOAC Evaluation Dashboard Month September 2018

(Updated September 6th, 2018)

Mental Health Services
Oversight & Accountability Commission

The iFish Group: Hosting & Managed Services (17MHSOAC024)

MHSOAC Staff	Pu Peng & Brandon McMillen
Active Dates	12/28/17 - 12/31/18
Total Contract Amount	$423,923
Total Spent	$286,823

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

Deliverable	Status	Due Date	Change
Secure Data Management Platform	Complete	12/28/17	No
Visualization Portal	Complete	12/28/17	No
Data Management Support Services	In Progress	12/31/18	No

MHSOAC Evaluation Dashboard Month September 2018

(Updated September 6th, 2018)

Mental Health Services
Oversight & Accountability Commission

Regents of University of California, Los Angeles: Population Level Outcome Measures (17MHSOAC081)

MHSOAC Staff	Michelle Adams
Active Dates	7/1/20185-7/31/2020
Total Contract Amount	$1,200,000
Total Spent	$0

The purpose of this project is to develop, through an extensive public engagement effort and background research process, support for datasets of preferred (recommended) & feasible (delivered) measures relating to

1) negative outcomes of mental illness
2) prevalence rates of mental illness by major demographic categories suitable for supporting the evaluation of disparities in mental health service delivery & outcomes
3) the impact(s) of mental health & substance use disorder conditions (e.g., disease burden),
4) capacity of the service delivery system to provide treatment and support,
5) successful delivery of mental health services
6) population health measures for mental health program client populations.

Deliverable	Status	Due Date	Change
Work Plan	Under Review	09/30/19	Yes
Outcomes Reporting Draft Report	Not Started	12/31/19	No
Outcomes Reporting Final Report	Not Started	06/01/20	No
Outcomes Reporting Data Library & Data Management Plan	Not Started	06/01/20	No
Data Fact Sheets and Data Briefs	Not Started	06/01/20	No

MHSOAC Evaluation Dashboard Month September 2018
(Updated September 6th, 2018)

Mental Health Services
Oversight & Accountability Commission

Mental Health Data Alliance: FSP Pilot Classification & Analysis Project (17MHSOAC085)

MHSOAC Staff	Rachel Heffley & Pu Peng
Active Dates	07/01/18 - 09/30/19
Total Contract Amount	$234,279
Total Spent	$0

The intention of this pilot program is to work with a three-county sample (Amador, Los Angeles, & Orange) to collect FSP program profile data, link program profiles to the FSP clients they serve, & model a key outcome (early exit from an FSP) as a function of program characteristics, service characteristics, & client characteristics

Deliverable	Status	Due Date	Change
FSP Program Data Sets	Not Started	1/25/19	No
FSP Formatted Data Sets	Not Started	5/06/19	No
FSP Draft Report	Not Started	6/28/19	No
FSP Final Report	Not Started	8/30/19	No

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MHSOAC
Mental Health Services
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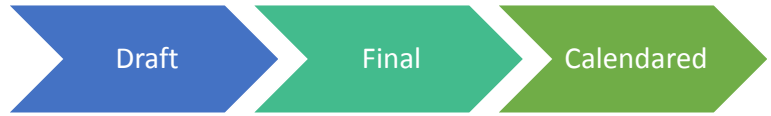
INNOVATION DASHBOARD - OCTOBER 2018
(Current)

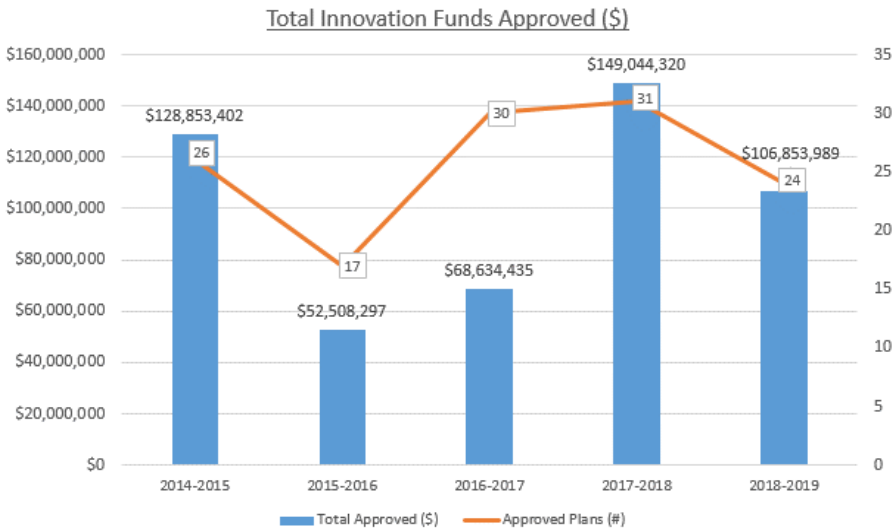
	NUMBER OF PLANS	COUNTIES	FUNDS REQUESTED
CALENDARED*	6	4	$15,231,858
DRAFT PROPOSALS RECEIVED	8	8	$19,777,229
TOTAL	**14**	**12**	**$35,009,087**

AVERAGE TIME FROM FINAL to COMMISSION CALENDAR
50 days†



* **October:** Alameda (3), San Francisco (1)
November: City of Berkeley (1)
January: Calaveras (1)
† This excludes four (4) plans involving existing project extensions and Tech Suite additions

Previous FY Trends:



Number of Counties that have presented an INN Plan to the Commission since 2013 ǂ	
54	**92%**

	FY 14/15	FY 15/16	FY 16/17	FY 17/18	FY 18/19 (to date)
APPROVED INN Funds:	$127,742,348	$46,920,919	$66,625,827	$143,871,714	$106,853,989
APPROVED Ext. Funds:	$1,111,054	$5,587,378	$2,008,608	$5,172,606	$3,131,120
Plans Received:	N/A	N/A	33	34	24
Plans APPROVED:	26	17	30 (91%)	31 (91%)	24 (100%)
Participating Counties:	16	15	18 (31%)	19 (32%)	18 (31%)
Participating Counties APPROVED:	N/A	N/A	17 (94%)	16 (84%)	18 (100%)

ǂ Number of counties that have NOT presented an INN Plan to the Commission since 2013: 5 (8%)

STATUS	COUNTY	PLAN NAME	FUNDING AMOUNT REQUESTED	PROJECT DURATION	DRAFT PROPOSAL SUBMITTED TO OAC	FINAL PLAN SUBMITTED TO OAC	COMMISSION MEETING
CALENDARED	Alameda	Community Assessment and Transport Team (CATT)	$9,878,082.00	5 Years	3/22/2018	8/6/2018	OCTOBER
CALENDARED	Alameda	Transitional Age Youth Emotional Emancipation Circles	$501,808.00	2 Years 6 Months	3/22/2018	8/6/2018	OCTOBER
CALENDARED	Alameda	Introducing Neuroplasticity to Mental Health Services for Children	$2,054,534.00	4 Years	4/18/2018	8/6/2018	OCTOBER
CALENDARED	San Francisco	Wellness in the Streets-WITS	$1,750,000.00	5 Years	5/17/2018	9/14/2018	OCTOBER
CALENDARED	City of Berkeley	Trauma-Informed Care for Educators	$336,825.00	3 Years	6/29/2018	9/4/2018	NOVEMBER
CALENDARED	Calaveras	Enhancing the Journey to Wellness Peer Specialist Program	$710,609.00	5 Years	6/6/2018	9/17/2018	JANUARY

CALENDARED: County has met all the minimum regulatory requirements for Innovation - Section 3580.010, and three (3) local approval

STATUS	COUNTY	PLAN NAME	FUNDING AMOUNT REQUESTED	PROJECT DURATION	DRAFT PROPOSAL SUBMITTED TO OAC	FINAL PLAN SUBMITTED TO OAC	COMMISSION MEETING
DRAFT	San Diego	Statewide Early Psychosis Learning Health Care Network	PENDING		9/10/2018		
DRAFT	Solano	Statewide Early Psychosis Learning Health Care Network	PENDING		9/10/2018		
DRAFT	Los Angeles	Statewide Early Psychosis Learning Health Care Network	PENDING		9/10/2018		
DRAFT	Orange	Statewide Early Psychosis Learning Health Care Network	PENDING		9/10/2018		
DRAFT	San Benito	Behavioral Health-Diversion and Re-Entry Court	$2,264,566	5 Years	8/28/2018		

STATUS	COUNTY	PLAN NAME	FUNDING AMOUNT REQUESTED	PROJECT DURATION	DRAFT PROPOSAL SUBMITTED TO OAC	FINAL PLAN SUBMITTED TO OAC	COMMISSION MEETING
DRAFT	Colusa	Social Determinants of Rural Mental Health Project	$403,419	3 Years	8/30/2018		
DRAFT	San Bernardino	Innovative Remote Onsite Assistance Delivery-InnROADS	$17,024,309.00	5 Years	9/12/2018		
DRAFT	Mono	Eastern Sierra Learning Collaborative: A County Driven Regional Partnership	$84,935		10/1/2018		

DRAFT: A County plan submitted to the OAC that contains some of the regulatory requirements, including but not limited to a full budget

Mental Health Services
Oversight & Accountability Commission

COMMISSION MEETING PRESENTATION GUIDELINES

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. **PowerPoint Presentation**
    a. Recommend bulleted slides to allow County to discuss and highlight project and dialogue
    b. 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?

3. **County Brief (optional)**
    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

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 Innovation Team upon Commission calendaring for the following items: Presenter Names, Biographies, County Brief, and PowerPoint presentation.

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Calendar of Commission Meeting Draft Agenda Items

Proposed 10/12/18

All agenda items and meeting locations are subject to change

November 14-15 (2-day meeting): Riverside, Mission Inn

November 14th:

- **Statewide Early Psychosis Learning Health Care Network Collaborative**
  The Commission will hear a presentation on the Early Psychosis Collaborative: San Diego, Solano, Los Angeles, and Orange County
- **Innovation Project: City of Berkeley (Extension)**
- Trauma Informed Care Training
- **Programs, Providers, and Services Tool**
  The Commission will receive a progress report and demonstration of the Programs, Providers, and Services Transparency Tool.
- **Use of County Innovation Funds**
  The Commission staff will provide an overview of county uses of Innovation funds outside of Innovation approval.
- **Draft Innovation Incubator Business Plan**
  The Commission will hear an update on the draft Innovation Incubator Plan
- **Fellowship Advisory Committee Appointments**
  Appointments to the Fellowship Advisory Committee will be announced
- **Legislative Priorities**
  The Commission will consider legislative priorities for the 2019 legislative session

November 15th:

- **Strategic Planning Session**
  The Commission will continue the facilitated strategic planning discussion about the role of the Commission, and the goals and objectives of the Strategic Plan which will be developed through the strategic planning process led by Susan Brutschy, President of Applied Survey Research.

December: No Meeting

January 24: Sacramento, MHSOAC

- **Innovation Project: Calaveras County**
  1. Enhancing the Journey to Wellness Peer specialist Program
- **Triage Program Update**
  The commission will hear an update on the status of the Triage grants and will receive information about how Triage counties adjusted to the reduction of funding.
- **Overview of Governor's Budget**
  The Department of Finance will provide an overview of the Governor's proposed budget for fiscal year 2019-20 and its impact on the community mental health system.
- **Immigrant/Refugee RFP Outline**
  The Commission will consider approval of an outline for an Immigrant and Refugee RFP.
- **Legislative Priorities**
  The Commission will consider legislative priorities for the 2019 legislative session.

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Calendar of Commission Meeting Draft Agenda Items

February 28: Sacramento, MHSOAC

- **Presentation of Stakeholder State of the Community reports**
  The Commission will hear a presentation by each of the seven contracted stakeholders on their State of the Community reports; a required contract deliverable outlining the work done on behalf of the specific populations.
- **Innovation Projects**
  The Commission will consider approval of county Innovation plans.
- **Legislative Priorities**
  The Commission will consider legislative priorities for the 2019 legislative session.

March 28: Location TBD

- **Innovation Projects**
  The Commission will consider approval of county Innovation plans.
- **Schools and Mental Health Final Report**
  The Commission will consider adopting the Schools and Mental Health final report.
- **Legislative Priorities**
  The Commission will consider legislative priorities for the 2019 legislative session.

April 25: Location TBD

- **Awarding of the Immigrant/Refugee Stakeholder contract**
  The Commission will consider awarding a stakeholder contract in the amount of $2,010,000 to the highest scoring applicant for the Immigrant and Refugee Stakeholder contract.

Agenda Item 6, Enclosure 6: DHCS Status Chart of County RERs Received
October 25, 2018 Commission Meeting

Attached below is a Status Report from the Departent of Health Care Services regarding County MHSA Annual Revenue and Expenditure Reports received and processed by Department staff, dated October 25, 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

DHCS MHSA Annual Revenue and Expenditure Status Update

	FY 12-13		FY 13-14		FY 14-15		FY 15-16		FY 16-17		
County	Electronic Copy Submission Date	Final Review Completion Date	Electronic Copy Submission Date	Final Review Completion Date	Electronic Copy Submission Date	Final Review Completion Date	Electronic Copy Submission Date	Final Review Completion Date	Electronic Copy Submission Date	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	7/23/2018		7/23/2018
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	7/20/2018
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	7/6/2018		7/9/2018
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	7/25/2018	7/26/2018	7/25/2018	7/26/2018	9/12/2018	9/12/2018	
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	7/23/2018
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	7/2/2018	7/20/2018
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	7/26/2018
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	10/4/2018	10/4/2018	10/4/2018		10/4/2018
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	7/20/2018	7/25/2018	8/13/2018		8/13/2018
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	9/25/2018		9/27/2018
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	7/19/2018	7/20/2018	8/15/2018		8/16/2018
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	7/23/2018
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	7/27/2018		
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	7/13/2018		7/23/2018
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	8/15/2018	8/17/2018	8/15/2018	8/17/2018	8/15/2018	8/17/2018	8/15/2018	5/1/2018	8/17/2018
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	7/25/2018		7/26/2018
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	59	59	59	59	59	58		56

Current Through: 10/04/2018

State of California
Mental Health Services Oversight and Accountability Commission
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2018 Legislative Report to the Commission
October 1, 2018

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. 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: 9/30/18 Vetoed by the Governor

Governor's Message: To the Members of the California State Senate: I am returning Senate Bill 1019 without my signature. This bill would require the Mental Health Services Oversight and Accountability Commission to allocate at least half of its triage grant funds to local and mental health partnerships. The bill as written would limit the Commission's authority to exercise its judgment in the distribution of these grants. I believe the better practice would be to leave this matter to the Commission. Sincerely, Edmund G. Brown Jr.

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: 9/11/18 Signed by the Governor. Chaptered by Secretary of State. Chapter 354, Statutes of 2018.

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SUPPORTED LEGISLATION

Senate Bill 192 (Beall) – Support in concept.

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 for a Local Mental Health Services Fund shall not exceed 33% of the average Community Services and Support revenue received, in the preceding 5 years. The bill would require the county to reassess the maximum amount of the prudent reserve every 5 years and to certify the reassessment as part of its 3-year program and expenditure plan required by the MHSA.

Status/Location: 9/10/18 Signed by the Governor. Chaptered by Secretary of State. Chapter 328, Statutes of 2018.

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: 9/30/18 Signed by the Governor and not yet Chaptered.

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: 9/14/18 Signed by the Governor. Chaptered by Secretary of State. Chapter 403, Statutes of 2018.

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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: 9/30/18 Vetoed by the Governor.

Governor's Message: To the Members of the California State Senate: I am retuning Senate Bill 906 without my signature. This bill requires the Department of Health Care Services to establish a certificate program for peer support specialists in Medi-Cal. Currently, peer support specialists are used as providers in Medi-Cal without a state certificate. This bill imposes a costly new program which will permit some of these individuals to continue providing services but shut others out. I urge the stakeholders and the department to improve upon the existing framework while allowing all peer support specialists to continue to work. Sincerely, Edmund G. Brown Jr.

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 specified 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: 9/27/18 Signed by the Governor. Chaptered by Secretary of State. Chapter 843, Statutes of 2018.

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: 7/18/18 Signed by the Governor. Chaptered by Secretary of State - Chapter 128, Statutes of 2018.

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LEGISLATION UNDER REVIEW

Senate Bill 1101 (Pan)

Title: Mental health.

Summary: Would require the commission, on or before January 1, 2020, to establish statewide objectives for the prevention, early intervention, and treatment of mental illness, the promotion of mental health and well-being, and innovation as a strategy for transformational change, and metrics by which progress toward each of those objectives may be measured.

Status/Location: 8/31/18 Failed Deadline pursuant to Rule 61(b)(18).

Assembly Bill 1215 (Weber)

Title: Mental Health Services Act: innovative programs: research

Summary: Would, if research is chosen for an innovative project, require a county mental health program to consider, but not require, to implement, research of the brain.

Status/Location: 8/28/18 Signed by the Governor. Chaptered by Secretary of State - Chapter 227, Statutes of 2018.

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: 5/25/18 Failed Deadline pursuant to Rule 61(b)(8).

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: 8/31/18 Failed Deadline pursuant to Rule 61(b)(18).

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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 include any appropriation or transfer to the No Place Like Home Fund from the General Fund or other funds as moneys required to be paid into the No Place Like Home Fund. The bill would specify that the service contracts between the authority and the department may be single-year or multiyear contracts and provide for payments to the department from amounts on deposit in the Supportive Housing Program Subaccount.

Status/Location: 8/31/18 Failed Deadline pursuant to Rule 61(b)(18).