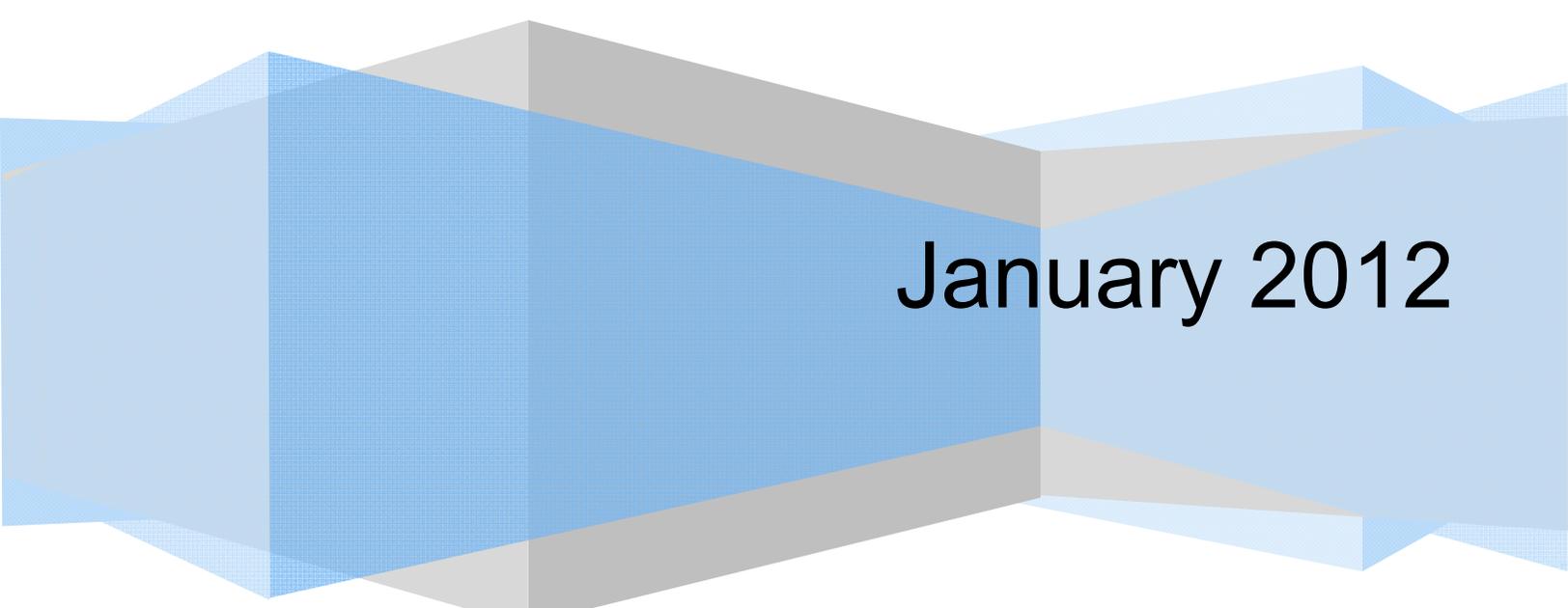




Mental Health Services Act Innovative Programs

Initial Trends

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Statute and Regulations

Operational Definition: Innovation Programs

Welfare and Institutions Code (WIC), section 5830, provides for the use of Mental Health Services Act (MHSA) funds for Innovative Programs (Innovations or INN). The MHSA does not define “Innovative Programs.” The Department of Mental Health’s (DMH) *Innovation Guidelines*, consistent with the Mental Health Services Oversight and Accountability Commission’s (MHSOAC) Innovation Resource Paper (Appendix 1), provides the following definition:

“INN projects¹ are novel, creative and/or ingenious mental health practices/ approaches that contribute to learning and that are developed within communities through a process that is inclusive and representative, especially of unserved, underserved, and inappropriately served individuals....An Innovation project is defined, for purposes of these guidelines, as one that contributes to learning rather than a primary focus on providing a service. By providing the opportunity to ‘try out’ new approaches that can inform current and future [mental health] practices/ approaches in communities, an Innovation contributes to learning in one or more of the following three ways:

- Introduces new mental health practices/approaches including prevention and early intervention that have never been done before, or
- Makes a change to an existing mental health practice/approach, including adaptation for a new setting or community, or
- Introduces a new application to the mental health system of a promising community-driven practice/approach or a practice/approach that has been successful in non-mental health contexts or settings.

To clarify, a practice/approach that has been successful in one community mental health setting cannot be funded as an INN project in a different community even if the practice/approach is new to that community, unless it is changed in a way that contributes to the learning process. Merely addressing an unmet need is not sufficient to receive funding under this component. By their very nature, not all INN projects will be successful.”

Innovation projects are similar to pilot or demonstration projects and are subject to county-defined time limitations within which to assess and evaluate their efficacy. Through this approach, the MHSA’s Innovation component provides California the opportunity to develop and test new, unproven mental health models with the potential to become tomorrow’s best practices.

¹ While the Department of Mental Health *Innovation Guidelines* refers to Innovation (INN) Projects, this *Trends Report* refers to Innovation Programs or Innovations, consistent with the terminology in the MHSA.

Scope of Innovation Programs

Consistent with the MHSOAC policy guidance for the Innovation component, *Innovation Guidelines* allow counties the broadest possible scope to pilot new and adapted mental health approaches:

“INN projects may address issues faced by children, transition-age youth, adults, older adults, families (self-defined), neighborhoods, tribal and other communities, counties, multiple counties, or regions. The project may initiate, support and expand collaboration and linkages, especially connections between systems, organizations and other practitioners not traditionally defined as a part of mental health care. The project may influence individuals across all life stages and all age groups, including multigenerational practices/approaches.... As long as the INN project contributes to learning and maintains alignment with the MHSA General Standards set forth in CCR, Title 9, section 3320, it may affect virtually any aspect of mental health practices or assessment of a new application of a promising approach to solving persistent, seemingly intractable mental health challenges” (*Innovation Guidelines*). Examples cited in the *Guidelines* of possible arenas for innovation include administrative/governance/organizational practices, processes or procedures; advocacy; education and training for service providers; outreach; community development and capacity building; planning; policy; system development; public education; and research.

MHSOAC Responsibilities for Innovation Programs

The MHSA, as originally adopted by California voters, stated, “County mental health programs shall receive funds for their Innovation programs upon approval by the Mental Health Services Oversight and Accountability Commission.” In March 2011 the MHSA was amended by Assembly Bill 100, Chapter 5 of Statutes of 2011 (AB 100) to state, “It is the intent of the Legislature to streamline the approval processes of the State Department of Mental Health and the Mental Health Services Oversight and Accountability Commission of programs developed pursuant to Sections 5891 and 5892.... In eliminating state approval of county mental health programs, the Legislature expects the state, in consultation with the Mental Health Services Oversight and Accountability Commission, to establish a more effective means of ensuring that county performance complies with the Mental Health Services Act.”

As a result of these changes, the MHSOAC ended its review and approval of counties’ proposed Innovation programs and expenditures. The MHSOAC retains responsibility to “issue guidelines for expenditures pursuant to Part 3.2 (commencing with Section 5830), for innovative programs...no later than 180 days before the fiscal year for which the funds will apply.”

Trends in California’s First Innovative Work Plans

Before the adoption of AB 100, the MHSOAC approved over \$158 million in funding for 86 Innovative Programs based on work plans developed by 32 counties. The average time from the county’s submission of the work plan to MHSOAC approval was 29 business days.

The MHSOAC’s *Innovation Trends Report* reports results of analysis of work plan descriptions of all 86 Innovation pilot programs. The report is based only on counties’

stated intentions for their Innovative Programs, not whether or how these programs have been implemented. All references to Innovation programs refer to programs as described in counties' work plans.

Innovative System Change During a Fiscal Crisis

The Innovation component requires a change in focus: from service delivery utilizing proven effective practices to piloting unproven practices to address community priorities for which existing practices are either non-existent or not applicable. Many counties and their community stakeholders experienced this shift as extremely challenging – exacerbated by simultaneous widespread and significant cutbacks from all sources of mental health funding. Especially when service needs are so urgent and core programs are being eliminated or reduced, the mandate to develop and test new or adapted approaches to intractable mental health issues can feel like an unaffordable luxury and unwelcome burden.

Despite this inherent difficulty, many counties and stakeholders embraced the challenge of Innovation as particularly relevant in a time of funding and service upheaval. The Placer County's *Innovative Community Collaboration Grants Program* illustrates this approach.

The issue facing most counties in California is the unpredictability of funding for core mental health services. The current model of funding programs and then cutting them when money runs out is inefficient and ineffective. Based on this unstable funding model, Placer recognizes it will not be able to consistently serve everyone with the current service delivery model. There simply are not enough on-going resources to serve everyone's needs. Another issue is that traditional agency-based services are not meeting the needs of everyone. Many are seeking supports for mental health issues in non-traditional, community-based settings....The aim of the [Innovation] grants program is to test a community collaboration model in the mental health service sector that puts resources into the community to support natural networks which, as the recovery model states, is key to long-term wellness. The change we expect to see is a model of providing mental health support through community that is sustainable and durable throughout the erratic budget conditions and is less stigmatizing and more accessible. (Placer County *Innovation Work Plan*)

Stanislaus County's *Evolving a Community-Owned Behavioral Health System of Supports and Services* also focused on transforming its Behavioral Health and Recovery Services system to a stronger and expanded partnership with its community.

This dilemma of rapidly declining revenues, steadily increasing costs, and rapidly increasing need is made worse by the expectations created by the passage of the Mental Health Services Act. With the passage of Proposition 63 in 2004, many people expected a dramatic expansion of services for people suffering from mental health issues or co-occurring mental health and substance use disorders, and now struggle to understand why clinics have been closed and other services reduced or eliminated.

We describe this dilemma as adaptive because we believe we cannot resolve these challenges and improve behavioral health outcomes through traditional strategies for managing budget shortfalls.

Acknowledging the reality of this dilemma, and working to understand the growing scope of unmet need, have led Behavioral Health and Recovery Services (BHRS) leaders to the conclusion that BHRS can never serve all people who struggle with mental health and substance abuse issues in Stanislaus County. The gap is too large, even when limited only to people who struggle with serious and persistent mental illness and severe addictions. This was true before the most recent budget contractions; it is simply more true now.

The reality of this yawning gap of unmet need has led us to a second conclusion: that BHRS leaders and staff are not, and cannot be, solely responsible for the behavioral health and emotional well-being of all county residents, and that the Department's budget is not the only resource available for this purpose. The BHRS budget is one part of an array of resources—including private sector resources, non-profit and community resources, volunteer resources and others—that county residents allocate to support their behavioral and emotional well-being.

While BHRS leaders and staff, by ourselves, cannot meet the behavioral health needs of all Stanislaus County residents, we believe BHRS can be a catalyst for creating better alignment and more effective leveraging of the array of resources present in the County. To play such a role, however, will require BHRS leaders to improve our capacity to collaborate with other county agencies, non-profit and community-based organizations, and community leaders, one of the primary purposes for this Innovation. (Stanislaus County, *Innovation Work Plan*)

These counties, and many others throughout California, are using the opportunity of MHSA Innovation not only to pilot new programs but also to test ways to redesign their approach to behavioral service delivery to one that they believe will be more sustainable and stable and will enhance recovery, wellness, and resilience through community partnerships.

Definition of Innovation: New, Adapted, or Adopted

Most counties are testing adapted Innovations: making a change to an existing established mental health practice. Counties’ planned evaluations of these “adapted” Innovations focus on the element of the practice that is changed.

Definition	Percent
Introduces new mental health practices/approaches including prevention and early intervention that have never been done before	18%
Makes a change to an existing mental health practice/approach, including adaptation for a new setting or community	58%
Introduces a new application to the mental health system of a promising community-driven practice/approach or a practice approach that has been successful in non-mental health contexts or settings	24%

Examples of “non-mental health contexts of settings” for “adopted” Innovations include diverse communities, Native American tribes, health, social services, philanthropy, business, justice, social media, and education.

Primary Purpose

The MHSA identifies the following purpose for Innovative Programs:

- Increase access to underserved groups
- Improve the quality of services, including better outcomes
- Promote interagency collaboration.
- Increase access to services.

From a service delivery perspective, most counties’ selected Innovations, if successful and implemented long-term, can be expected to address all four MHSA primary purposes. MHSOAC staff encouraged counties to identify the primary purpose most associated with the expected learning from their Innovation: the element that was new or changed compared to existing mental health practice. From this perspective, counties’ first Innovative Programs addressed the following primary purposes:

Primary Purpose	Percent
Increase access to services	9%
Increase access to services for underserved populations	27%
Improve the quality and outcome of services	48%
Promote interagency collaboration	16%

Counties did not use consistent criteria to differentiate between “increase access to services” and “increase access to services for underserved populations,” since the MHSA provides no specific definition for “underserved populations.” A number of Innovations intend to increase access for individuals with/at risk of serious mental illness who are isolated by a range of circumstances: culture and language, age, geographic

isolation, experience (for example, veteran status, homelessness, poverty, and trauma), sexual preference/gender, and physical disability. Many of the target populations fit into more than one of these categories. It is most accurate to conclude that improving access to some county-defined underserved population was the primary purpose for 36% of these Innovation programs and a significant focus of approximately 2/3 of Innovation programs.

Counties that focused primarily on Innovative approaches to collaboration frequently expanded beyond the MHSA focus on promoting “interagency collaboration” as one of the four purposes for Innovation. Instead, counties tended to emphasize collaboration with the broader community, including clients and families and community organizations and service providers.

Continuum of Mental Health Interventions

Counties are piloting Innovations at all stages of mental health support and intervention, from prevention through post-crisis. In addition to piloting direct service approaches along this continuum, many counties are using the opportunity of Innovation to address other challenges in their mental/behavioral health systems.

Mental Health Intervention	Percent ²
Prevention	23%
Early Intervention	37%
Treatment	55%
Crisis Response	32%
Other (system change, funding, evaluation, planning, collaboration, infrastructure, mental health work force education and training, etc.)	45%

Most counties included individuals with serious mental illness as a significant focus of their Innovation programs. The rest address a broader range of prevention and early intervention, evaluation, collaboration, and funding approaches.

Mental Health Challenge	Percent ³
Serious mental illness	70%

The following are a few examples of Innovative Programs that intended to serve individuals with serious mental illness.

² Categories are not mutually exclusive.

³ Percentage is based on the 76 Innovation Programs that included services to individuals.

Tuolumne County will explore whether community collaboration will result in more support for a recovery-at-home approach to treating people with serious mental illness. *Building a Life at Home* is an innovative collaboration between Tuolumne County's Behavioral Health Department, consumers and families, Spanish-speaking and Native American residents, Child Welfare, Adult Protective Services, law enforcement, and other diverse stakeholders who all play a part in the decision to conserve severely mentally ill residents in long-term residential and out-of-county facilities, which occurs more frequently in the county than statewide. A community Task Force will oversee the development, implementation, and assessment of a best practice case management model that emphasizes peer recovery and resiliency for mentally ill consumers. The project seeks to learn whether this active community engagement will shift culture, attitudes, and beliefs from the view that institutionalization of severely mentally ill individuals is best for consumers and safest for the community to a new perspective that consumers can live at home independently and safely and contribute to the community, with availability of effective recovery, wellness, and resilience services.

San Francisco County's *Supported Employment and Cognitive Training (SECT) Project* is an effort to improve mental health and cognitive outcomes and increase employment for consumers who are seriously mentally ill with co-occurring substance abuse and who have a history of homelessness and involvement in the criminal justice system. This Innovative Program will combine two interventions: Supported Employment and a newly developed, computerized Cognitive Training program that aims to improve clients' thinking, memory, and problem-solving skills. The county will test whether the interventions combined will be more effective than when administered separately, and also will test their effectiveness in "real life" field conditions.

Santa Clara County's *Mental Health Law Enforcement Post-Crisis Intervention* features teams comprised of a family/peer advocate and a mental health clinician who will meet with individuals and/or families who have experienced a mental health crisis that resulted in a law enforcement response. Although they will serve all ethnicities, team members will be recruited and selected to meet the linguistic and cultural needs of Vietnamese and Hispanic clients. Within 24 hours of the law enforcement response, team members will initiate contact to listen, support, and help link the client and any interested family members to culturally responsive services, based on their individual needs and preferences.

The following are examples of county programs that address various phases of mental/behavioral health intervention.

Prevention

An important focus of the MHSA is to “prevent mental illnesses from becoming severe and disabling.” Almost a quarter of surveyed counties included a focus on prevention in their Innovative Programs.

Placer County’s *Innovative Community Collaboration Grants Program* uses the leverage of a grants program to build community capacity, sustain prevention and promotion efforts of natural networks, and keep people out of more intensive mental health treatment. The program focuses on developing sustaining partnerships with small community agencies outside of the framework of traditionally funded agencies, particularly community groups that serve Latinos, Native Americans, older adults, and transition-age youth. The goal is “a more consistent and prevention-based approach for consumers and could have a very positive impact for hundreds, if not thousands, of people in Placer County.” (Placer County *Innovation Work Plan*)

Early Intervention

According to the MHSA, “Early diagnosis and adequate treatment provided in an integrated service system is very effective; and by preventing disability, it also saves money.” The MHSA calls for “outreach to families, employers, primary care health care providers, and others to recognize the early signs of potentially severe and disabling mental illnesses.” Through their Innovative Programs, a number of counties are piloting new ways to reach people with mental illness and provide appropriate interventions as early as possible.

Santa Clara County’s *Early Childhood Universal Screening Project* will place computer kiosks with developmental screening tools in pediatric clinics. The Innovation will pilot a new Spanish audio component of the *Ages and Stages Questionnaire-III* to increase independent use by monolingual Spanish families. If successful, this Innovation will provide a new culturally appropriate application of pediatric mental health screening, parent engagement, and referral that efficiently links parents and pediatricians to mental health services.

Treatment

The Innovation component provides counties the opportunity to develop and test new treatment models, especially for diverse communities for whom established best practices are not always applicable.

San Luis Obispo County will test a unique model of *Multi-Modal Attachment Focused Play Therapy* to address behavioral issues in children age 0-6 diagnosed with attachment problems. The innovative dimensions of this pilot include expanding parent choice and involvement, combining and linking three evidence-based practices, and providing treatment in the homes of isolated families.

San Bernardino County's *Coalition against Sexual Exploitation* will develop a comprehensive and collaborative model of treatment that facilitates a safe haven and clinical rehabilitation for exploited children who are drawn into prostitution. In addition to clinical interventions that build on best practices for treating trauma, the new model will address planning, outreach, education, and outcome measures.

Crisis Response

A significant number of counties are using Innovation funds to design and test new ways to respond to mental health crises, especially using approaches designed and delivered by peers. For some counties, the focus on alternative crisis response is part of a larger effort to transform the behavioral health system to a greater and more systemic focus on recovery with an increased reliance on services provided by consumers and family members.

Marin County combined its Innovation funds with MHSA PEI and Capital Facilities and Technology funds to create *Client Choice and Hospital Prevention Program*. "Marin County strongly believes that consumer choice and empowerment are fundamental underpinnings of wellness and recovery. We believe that if we can learn to become a hospital prevention organization, we will have higher quality services resulting in an increase in positive, healthy, and recovery-focused outcomes. In order to continue to transform Marin's mental health system towards one that values recovery and client choice over institutional and involuntary treatment, Marin's proposed Client Choice and Hospital Prevention Program project has been designed to create a recovery-oriented, community-based response to psychiatric crises... while supporting clients, families and communities to increase resiliency. Additionally, it will promote a reorientation of perception of how the mental health system and community can best respond to and help prevent psychiatric crises....our proposed project will combine three effective strategies—consumer-developed crisis plans, community-based crisis services, and integrated peer/professional staffing—in a unique way and will seek to embed the concept of operating as a hospital prevention organization as a core system value." (Marin County, *Innovation Work Plan*)

Kern County's *Freise HOPE (Helping Others through Peer Empowerment) House* is a consumer/peer-managed, short-term, recovery-oriented, 24-hour crisis residential program that will provide crisis beds in a "step-down" progression from inpatient hospitalization. "Peer Specialist"—staff who have experienced mental health and/or substance use challenges and have received treatment for those issues—will provide most services. The county also expects that this approach will expand recovery in their system of care, eliminate the often-negative stigma and differentiation between peer and professional staff, and improve mental health outcomes for clients.

Mental Health Services Infrastructure

As described, *Innovation Guidelines* provide counties great flexibility to identify local mental health service challenges for which available solutions are non-existent or not applicable and test new potential solutions. The following are some examples of counties' Innovations in areas other than direct service delivery:

Monterey County's *Mental Health Evaluation Model, Outcome Data, and Reporting Plan* intends to create "a 'culture of evaluation' – an institutional commitment to learning from evaluation – that will help build...capacity to provide appropriate services through self-examination, data quality, analytic expertise, consumer input, and collaborative partnerships....The Innovation will model a comprehensive data extraction, analysis, interpretation, and utilization-based evaluation reporting framework (Monterey County, *Innovation Work Plan*).

Santa Clara County's *Interactive Video Simulator Training Project* is a collaborative effort involving consumers, families, ethnic community members, NAMI, the San Jose Police Department, the Santa Clara County Sheriffs Department and the Santa Clara County Mental Health Department. Consumers and family members, especially from ethnic communities, will design and create the first mental health training delivery system for law enforcement field officers that uses Interactive Video Simulator Training (IVST) technology to address simulated scenarios of mental health-related crises involving people from diverse cultural backgrounds. The video scenario will adjust based on the officer's decisions and actions. The technology will give law enforcement personnel opportunities to practice skills to recognize diverse people with mental illness who are in crisis, analyze and make good decisions in "real time," de-escalate crisis situations, increase referrals, and improve outcomes in culturally diverse environments.

Sonoma County is testing *Reducing Disparities Community Fund Initiative*, a community-driven grant-funding model, as a way to increase access to underserved groups living with or at risk for serious mental illness. The Innovation intends to build on Sonoma County communities' commitment to transforming the mental health system that has manifested through previous MHSAs efforts. The grants program will allow community members to make decisions on how public funds are distributed, as well as encourage them to design and test outreach, engagement, and service projects that address barriers to service access by underserved groups, particularly communities of color. Alameda, Placer, and San Francisco counties are also piloting community grants programs, with slightly different areas of emphasis.

Demographics

Innovation Guidelines also provide complete flexibility to counties regarding who is the focus of Innovations, including individuals and families across the lifespan. Counties, not surprisingly, developed and tested Innovative Programs for a broad diversity of people.

Age Group	Percent ⁴
Children	34%
Transition-Age Youth	83%
Adults	72%
Older Adults	61%

The following are examples of Innovative Programs that focus on particular age groups.

Children

Orange County's Consumer Early *Childhood Mental Health* features consumers and family members who, under the supervision of licensed professionals, will provide brief behavioral intervention services to families of young children experiencing behavioral problems. The target population is children and families from underserved groups, including both ethnic and linguistic minorities. Consumers and family member providers will be chosen from those same underserved groups. The Innovation will measure clients' satisfaction with services and mental health outcomes, and will compare results of services provided by consumers and family members to similar services offered by professionals.

⁴ Percentage is based on the 76 Innovation Programs that included services to individuals. Categories are not mutually exclusive.

Transition-Age Youth (TAY)

San Francisco County's Innovation plan included a number of programs for TAY.

Adapt the WRAP intends to use youth culture (e.g., rap, spoken word, multi-media) to educate TAY about self-management tools to manage their mental illness and promote recovery and wellness. The Innovation will assess whether this approach, already documented as effective with adults, will help TAY self-manage their mental illness and make more effective use of community resources.

Mindfulness-based Interventions for Youth and their Providers tests whether adaptations of mindfulness-based interventions will promote recovery in youth who have experienced trauma, especially violence.

Youth-led Evaluation of Behavioral Assessment Tools provides the opportunity for TAY who reflect the diversity of San Francisco's youth population to assess the user-friendliness and recovery focus of assessment instruments.

Humboldt County's *Adaptation to Peer Transition Age Youth (TAY) Support* will create a peer-based approach to improving mental health outcomes for older TAY with severe mental illness, especially those who have experienced foster care. The Innovation will pair each client with a Peer Support Specialist who will provide a broad range of services and supports. A unique aspect of Humboldt County's Innovation is that the Peer Support Specialists will be active participants in a range of County Department of Health and Human Services youth-focused and youth-driven initiatives, and will be active participants in program development and treatment planning, in addition to providing direct services.

Adults

Mono County's *Peapod Innovation Program* is an effort to increase the effectiveness of support groups in English and Spanish for diverse new parents countywide, including Native American and indigenous county residents. The Innovation will pilot various strategies to see which are most effective for fostering early recognition of emergent post-partum and other mental disorders, providing a forum to discuss mental health issues, promoting mental health, and encouraging utilization of any needed mental health treatment.

Older Adults

San Luis Obispo County's *Older Adult Family Facilitation* is an effort to create positive solutions that enhance choice, safety, comfort, support, and well being for older adults with mental illness. The program combines elements from Child Welfare Services' Family Group Decision Making (FGDM) and Elder Mediation, with emphasis on creating meaningful connections to a broad range of community resources and supports. The program intends to fill service gaps between existing Full Service Partnerships and Prevention/Early Intervention services.

Race and Ethnicity

While all MHSOAC-approved county Innovation plans met MHSA standard for cultural competency, some focused specifically on new/adapted approaches for serving un/underserved (including inappropriately served) populations.

Race/Ethnicity	Percent ⁵
African Americans	11%
Asian/Pacific Islanders	21%
Latinos	37%
Native Americans	16%

The following are example Innovations that are assessing new approaches to meet the mental health needs of diverse populations.

⁵ Percentage is based on the 76 Innovation Programs that included services to individuals. Categories are not mutually exclusive.

Monterey County's *Alternative Healing and Promotores de Salud* significantly expands the focus of a promotores program to include the needs of individuals with serious mental illness, and their families. "The Mental Health Services Act offers the opportunity to transform service delivery especially when reaching out to unserved and underserved populations. While 85% of Monterey County's Medi-Cal population is Latino, only 45% of individuals who participate in Monterey County's Mental Health Plan are Latino. The idea behind this innovative project is to seek an alternative method of service delivery across the continuum of care. By using a community health-based model, culturally relevant education, outreach and engagement methods will be made available for preventive and early intervention services while more intensive services will be made available to individuals requiring higher levels of treatment. Options for alternative treatment methods such as the use of holistic medicines—a practice that is commonly accepted in many Latino cultures and traditions—will be integrated into the array of service options" (Monterey County, *Innovation Work Plan*).

The program will develop a curriculum and training program to educate both promotores and clinical staff regarding symptoms of and responses to emotional and mental distress specifically for the Latino community.

Butte County's *A Community-based Treatment for Historical Trauma to Help Hmong Elders* will create a supportive community for Hmong older adult trauma survivors by adapting an evidence-based Western trauma recovery model combined with Hmong spiritual practices. These services will be provided by Hmong clinicians and Hmong Wellness staff members, including counselors, peer partners, and healers. Most services will be provided in Hmong community settings. The program will offer outreach including accompanied transportation to services. A key focus is to break down barriers of culture, language and stigma, as well as the fear of reaching out for services that many trauma survivors experience.

Orange County's *Project Life Coach* will combine counseling and support to strengthen families struggling with mental illness and unemployment. The purpose is to improve individual and family mental health and functioning and promote employment of underserved monolingual or Limited English Proficiency Latino, Iranian and Asian Pacific Islanders with mental illness. Project Life Coach will collaborate with a network of community-based social service providers long-established as gatekeepers in Orange County's Latino, Korean, Vietnamese, and Farsi-speaking communities and also with local ethnic businesses and leaders within each community. The county expects that this program will increase collaboration across ethnic communities, providing opportunities to share insights and strategies.

Other Groups

Some counties are testing Innovations for particular populations, including LGBTQ individuals, veterans, and individuals with physical disabilities.

Group/Issue	Percent ⁶
LGTBQ	13%
Physical disabilities	5%
Veterans	8%

The following are some examples.

LGBTQ youth are at higher risk than their heterosexual peers for a number of mental health and related problems, including anxiety, depression, alcohol and drug abuse, dropping out of high school, HIV infection, and suicide⁷. Orange County's *OK to Be Me* will use a promotores model in which TAY and adult peer employees will provide culturally competent outreach, education, and linkages to mental health and co-occurring disorder services, both by phone and in person. Peers will provide home visits to LGBTQ individuals at high risk for suicide, depression, and risky and self-destructive behaviors. The peer employees will also work with family members, and will endeavor to inspire hope and expectation for wellness, recovery and resiliency among their clients.

⁶ Percentage is based on the 76 Innovation Programs that included services to individuals.

⁷ Trauma among lesbian, gay, bisexual, transgender, or questioning youth. (2006). *Culture and Trauma Brief*, 1(1), The National Child Traumatic Stress Network. Available at http://www.nctsn.org/nctsn_assets/pdfs/culture_and_trauma_brief_LGBTQ_youth.pdf.

People who are deaf and who have a serious mental illness or emotional disturbance face very significant barriers to receiving mental health treatment and other services. Policy and services need to take into account deaf culture⁸. Orange County's *Training to Meet the Mental Health Needs of the Deaf Community* will use an existing accredited Mental Health Worker Certificate training program to train individuals from the Deaf community with mental illness using ASL as the primary language. Graduates of the program will be qualified for employment within the public mental health system as mental health workers or peer mentors. The program will also encourage them to continue their education to gain an AA degree, and then work toward a bachelor's or graduate degree in the mental health field. An ultimate goal of this Innovative Program is to increase the number of people from the Deaf and Hard of Hearing communities who are licensed mental health professionals.

Orange County's *Vet Connect* will create a centralized place for veterans with post-traumatic stress disorder, traumatic brain injury, and severe depression, including those dually diagnosed with substance abuse disorders and their families to access treatment and supportive services, including shelter, food, and employment. The program will offer "warm linkages" for veterans who are too fragile to navigate the VA system. Services will be provided in an atmosphere that intends to decrease stigma and reinforce positive interactions. Most services will be provided by employed veteran peer mentors who are in recovery with mental health conditions. The program will also create a network of providers and volunteers trained on military culture and resources.

Focus Areas of Innovation

The chart below illustrates significant areas in which new mental health approaches are being developed, piloted, and evaluated by counties' Innovation programs.

Area of Focus	Percent
Expanded service design and delivery by persons with mental illness and their family members (peer services)	64%
Combating or preventing stigma and discrimination	49%
Comprehensive and integrated approaches for individuals with co-occurring mental health, substance-use, and/or physical health issues	42%
Community-based prevention, early intervention, and treatment models	40%

⁸ Critchfield, AB. (2002). Cultural diversity series: Meeting the mental health needs of persons who are deaf. National Technical Assistance Center for State Mental Health Planning. Available at http://www.nasmhpd.org/general_files/publications/ntac_pubs/reports/Deaf.pdf.

Area of Focus	Percent
by and for diverse populations	
Community Collaboration	37%
Treating mental health impact of trauma	28%
Mental health workforce	24%
Wellness, holistic approaches	24%
Addressing mental health consequences of homelessness	21%
Addressing mental health needs of individuals at risk of or involved in criminal justice system	20%

Please refer to Appendix 2 for a complete list of Innovative Programs approved by the MHSOAC listed by area of focus.

The following are examples of counties' planned Innovative Programs in prevalent focus areas.

Peer Service Design and Delivery

Counties' use of the MHSA's Innovation component has significantly expanded the scope of peer involvement in design, delivery, and evaluation of their behavioral health services. For more than two-thirds of counties, expanded roles for peers are a major area of focus for their Innovations. A number of these programs are highlighting expanded roles for peers in responding to behavioral health crises.

Through its *Recovery Learning Center*, Riverside County is using Innovation funds to increase the roles and responsibilities of mental health clients and family members in the design and delivery of recovery-focused mental health services. The Innovation models a multi-cultural and multi-language peer-led recovery center in rural and urban clinic sites as an alternative level of care within the existing Mental Health delivery system. Services delivered by peer staff at all levels are central to treatment rather than auxiliary. The model features *Wellness Recovery Action Plans* and other wellness tools as key components of recovery, as well as ancillary services, including medication management, provided by a psychiatrist and nurse who have lived experience of serious mental illness.

“As Riverside County continues to learn from recovery transformation, our stakeholders have provided feedback on the successes and challenges of recovery’s practical application into our service delivery. Though we have made notable changes, our stakeholders have stated that they want to see our service delivery become even more consumer-driven and our service outcomes to be more directly related to consumer-led interventions....The intent of the MHSA and recovery practice is to create a new service delivery model, one that is “consumer-driven”, not just consumer-enhanced. Peer run centers

typically function only for support and offer socialization, vocational, and consumer education. In order to address our stakeholders' desire to have a more consumer-driven, mental health delivery system, we wondered if developing mental health services that were envisioned, developed, and led by peer practitioners would best meet this concern." (*Riverside County, Innovation Work Plan*)

Los Angeles County's *Integrated Peer-Run Model* tests two models of peer-run services that expand the roles of peer staff, including administration and supervision by peers, with a focus on peers from diverse communities. Peer-Run Integrated Services (PRISM) is a client-driven, holistic alternative to formal public mental health services that allows uninsured peers to secure needed physical health, mental health, and substance abuse options designed to support and encourage people to take responsibility for their own recovery. PRISM utilizes a "whatever it takes" philosophy in a context of personal choice. Alternative Peer-Run Crisis Houses are client-driven, holistic alternatives to hospitalization, designed to provide a warm, safe, welcoming environment for uninsured people in psychiatric distress who are not a danger to others. Two houses will be located in separate service areas; one will be dedicated to peer support to people in crisis who are being released from jail.

San Diego County's *Peer and Family Engagement Project* and Madera County's *New Model for Access into Services* test new roles for mental health consumers, including transition-age youth, and family members in hospital emergency rooms to respond to psychiatric emergencies. Team members will also be available to provide support after discharge and will welcome clients and families to the outpatient mental health system.

Trinity County embraced the opportunity presented by the Innovation component to advance its progress toward a recovery-based mental health system through its *Respite Support Project*.

"Because Trinity County is a rural frontier county resources and services are often limited, and consumers have been restricted in their choices of where they can receive mental health interventions. Currently, Trinity County has two options when providing an intervention for a consumer; outpatient services or hospitalization. In effect, because of fiscal constraints Trinity County Behavioral Health Services will be relying on the strengths of consumers and family members to partner with the mental health system to fill an important

service need. This project would not only fill in the substantial gap between the two but will give the County the invaluable opportunity to learn if utilizing the strengths of consumers and family members and integrating all of the MHSA components will improve services and outcomes for consumers... This proposed strategy will move Trinity County more assertively in the direction of Recovery Model practice.” (Trinity County, *Innovation Work Plan*)

Combating Stigma and Discrimination Related to Mental Illness

While many county Innovations address stigma and discrimination related to mental illness indirectly by devising non-stigmatizing strategies and points of access, several focus more directly on addressing this critical issue.

Contra Costa County’s *Social Supports for Lesbian, Gay, Bi-sexual, Transgender, Queer, Questioning, Inter-sex, Two-Spirit Youth (LGBTQQI2-S)* addresses LGBTQQI2-S youth’s frequent experience of stigma and stress related to their communities’ and families’ negative reaction to their sexual orientation and/or gender identity. Prejudice and negative treatment can directly contribute to a higher prevalence of mental disorders in LGBTQQI2-S individuals, compared to heterosexuals, including suicide, affective disorders, and alcohol and substance abuse disorders.⁹ Contra Costa’s Innovation is an effort to improve mental health outcomes of LGBTQQI2-S by increasing family, community, and school support, directly combating stigma and discrimination.

San Luis Obispo’s *Atascadero Student Wellness Career Project*, a peer-counseling model with a public health emphasis, includes a youth-directed stigma reduction campaign. The Innovation is a response to input from TAY community planning participants:

“As youth we have identified depression and mental health as a major issue in our community and school. Self injury, suicidal thoughts, sadness, hopelessness, despair, vulnerability, thinking you’re alone, the inability to function. These are the feelings that our students, our family members, and our friends are having. Who are we supposed to tell if our friend is depressed? Where can we go? How do we reach out to them? Unfortunately students in our community feel they can’t talk about their feelings, or ask for somebody to help. Depression and mental health can be treated and helped, however only 20% of depressed teens ever receive help. We need a safe environment, where professionals and teens partner to serve a population of people, specifically high school age youth, who will not ask their parents or teachers for help, or who may not understand their feelings” (San Luis Obispo, *Innovation Work Plan*).

⁹ Meyer, IH, (2003). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: Conceptual issues and research evidence, *Psychological Bulletin* 129(5), 674-697.

Integrated Models for Co-Occurring Disorders

A significant focus of a number of Innovations is integrated service delivery for people with mental illness, physical illness, and/or substance-use disorders. Many counties choosing this priority are responding to federal healthcare reform as well as to research documenting that people with serious mental illness who receive services from a public mental health system die, on average, at least 25 years earlier than the general populations, generally from various chronic physical illnesses.¹⁰ MHSOAC-approved Innovations go beyond established effective practices for integrated service delivery. Many feature expanded roles for peers. Others explore new ways of integrating physical health services into behavioral health settings.

Orange County's *Integrated Community Services* will test a model of integrated physical and mental health services at both behavioral health and physical health sites for individuals with mental and physical health diagnoses and, often, with co-occurring alcohol/substance abuse problems. Services at primary medical care community clinics will include mental health care provided by consumer paraprofessionals supervised by licensed clinicians and also psychiatric consultation to primary care providers. At behavioral healthcare sites, consumer Medical Care Coordinators, supervised by registered nurses, will monitor the physical health and healthcare of behavioral health clients. Physicians from community clinics will also provide direct medical care in the behavioral health setting. The evaluation of this Innovative Program will include a comparison of the two approaches.

¹⁰ Parks J, et al. (2006). Morbidity and mortality in people with serious mental illness. 13th in a Series of Technical Reports, National Association of State Mental Health Program Directors. Available at http://www.dsamh.utah.gov/docs/mortality-morbidity_nasmhpd.pdf.

The Modoc County's *Taking Integration Personally* will promote interagency collaboration through implementation and evaluation of integrated treatment for consumers with co-occurring mental health and substance use disorders and/or serious medical conditions. A principal County goal is an innovative approach to collaboration that works in a small, rural county with a culture of independence. The initial focus of the Innovation is integrating "mental health, alcohol and other drug services, and public health, with strong linkages to primary care, social services, collaborative treatment courts, and other partners. The Project will include integration of assessment tools and processes, as well as fully integrated team treatment provision, with a unique treatment team for each consumer client depending upon the assessed needs. In a frontier, rural setting where each partner, including mental health, is small and challenged, the *Taking Integration Personally Project* affords the opportunity to improve collaborative processes, improve system integration, and, ultimately, improve the health outcomes of individuals and the entire community" (Modoc County, *Innovation Work Plan*).

Santa Cruz County's *Work First for Individuals with Co-Occurring Disorders* responds to input from consumers that one cannot be mentally healthy without meaningful daily activity and that work can be foundational to recovery. This Innovation intends to address the needs of the approximately 75% of the county's "Full Service Partnership for Transition-Age Youth" participants who have a co-occurring disorder. Santa Cruz County estimates that 90% of these youth are not receiving targeted substance abuse services both because of a lack of available co-occurring diagnosis services and many participants' unwillingness to participate in "traditional" substance-use or mental health treatment. The program also addresses the concern that many individuals with co-occurring disorders identified in jail and inpatient psychiatric hospitals are released without appropriate follow-up care because they are not known to the mental health system or because their co-occurring disorder is not identified. Program goals are to improve mental health outcomes, reduce recidivism, increase employment, and increase community integration. In addition to supports to engage in employment, the model also features holistic health support and 50% peer staffing.

Community-Based Models by and for Diverse Populations

Recent national policy reports have documented disparities in access to, quality of, and outcomes of behavioral health services for diverse racial and ethnic populations, and have called for a national approach to reducing these disparities. Research is beginning to document the efficacy of community intervention approaches as a major paradigm to

reduce these disparities and promote public health, including behavioral health.¹¹ A number of California counties are contributing to this effort, using their Innovation funds to test new community-defined and community-led approaches to culturally appropriate mental health service delivery.

Los Angeles County's *Community-Designed Integrated Service Management Model* seeks to bridge the divide between ethnic communities and the mental health system by supporting communities to direct how mental health, physical health, and substance abuse services are integrated into ethnic communities' trusted and established institutions. The Innovation will create distinct models of care defined by each of five communities: African immigrant/African American, American Indian, Asian/Pacific Islander, Eastern European/Middle Eastern, and Latino. The approach is expected to promote collaboration and partnerships between formal and non-traditional service providers, community-based organizations, and peers to integrate physical health, mental health, substance abuse, and other needed care to support the recovery of consumers with mental health issues.

Merced County's *Strengthening Families Project* will develop and test a new way to address the attachment needs of children in underserved, unincorporated areas of the county. Priority populations are Latino families, children in stressed families, at-risk and trauma-exposed youth, and all ethnicities within specific underserved communities, many of whom live in poverty. Experts and community members collaboratively will develop a culturally competent training curriculum and model to teach diverse parents and caregivers about attachment and developmental milestones. Family members and community leaders will act as "developmental partners" to support parents and other caregivers and children/youth during developmental milestones and life transitions, with a focus on enhancing secure attachment and intervening early in the event of developmental problems. They will also encourage stressed parents and caregivers to strengthen their networks of emotionally supportive friends, family, and neighbors to make it easier to care for their children and themselves. The Innovation will assess both individual mental health and community outcomes.

¹¹ Wells K, et al. (2004). Bridging community intervention and mental health services research. *American Journal of Psychiatry*, 161, 955-963.

Orange County's *Focused Crisis Management and Community Outreach* will adapt the NAMI model of family support and empowerment by and for ethnic and cultural groups within communities. The goal is to help families of a loved one with mental illness to learn, as soon as possible, about available services and resources. Consumer and family member paraprofessional employees from the relevant communities will provide short-term case management, facilitate family communication, and share knowledge and resources to assist all family members, offering services in Orange County threshold languages (Spanish, Vietnamese and Farsi) and also in Arabic, Korean, and American Sign Language. The Innovation will include satellite offices co-located within ethnic-specific NAMI-affiliated agencies. A licensed clinician will provide supervision and back up.

Community Collaboration

Many counties are using the opportunity of Innovation to transform their mental health service delivery through collaboration: with individuals at risk of or experiencing serious mental illness and their families, members and leaders of diverse communities, volunteers, first responders, faith communities, and service providers within and outside mental health systems. These Innovative collaborations significantly expand the MHSA focus on “interagency collaboration” to true community collaboration.

Amador County's *Community-Driven Delivery of Self-Management Practices* tests how an organized network of volunteer wellness trainers, engaged consumers, and family members using tested self-management techniques, backed by coordination and support from the county's behavioral healthcare department, can combine to create a robust system of community-driven mental health services. The county believes that the model, which is an adaptation of established community health worker programs, will empower consumers and family members and expand access to services across the county's broad rural geography.

Santa Clara County's *Transitional Mental Health Services to Newly Released County Inmates Project* is an effort to increase access to services and improve outcomes for newly released county inmates with mental health needs through an innovative collaboration between the County Mental Health Department, faith communities, and other service providers. County data estimate that at least 80% of released inmates have a substance-related issue and 64% have a recent untreated mental health problem. The Innovation will offer training on mental health interventions, support coordination among diverse faith communities, increase organizational capacity and infrastructure, and work to remove systemic barriers to effective services and supports. All services will be available without regard to a participant's belief, adherence, or participation in any faith.

Trauma

Trauma is a significant risk factor for many mental illnesses¹² and members of racial-ethnic minorities are at greater risk for post-traumatic stress disorder.¹³ Several county Innovations are developing new approaches to trauma-informed treatment.

San Bernardino County's *Community Resilience Model (CRM)* will adapt an existing Trauma Resiliency Model (TRM) for use by diverse ethnicities, communities, and un/underserved populations to address personal and community traumatic events. The County expects the model to be implemented by non-clinicians, paraprofessionals, and multi-cultural groups, emphasizing the participation of native cultural brokers who can effectively serve as credible and accepted "first responders." The CRM will include links to integrated treatment for individuals with co-occurring mental health and substance-use disorders. Besides the expected benefits to individuals suffering from the consequences of trauma, the county hopes that the *Community Resiliency Model* will strengthen the Department of Behavioral Health's linkages and collaboration with the county's diverse cultures and communities including the LGBTQ community and veterans and their families.

¹² Grubaugh, AL, et al. (2011). Trauma exposure and posttraumatic stress disorder in adults with severe mental illness: A critical review. *Clinical Psychology Review*, 31(6), 883-899.

¹³ Pieterse, AL, et al. (2011). Perceived racism and mental health among black American adults: A meta-analytic review. *Journal of Counseling Psychology*. See also, Gaillot, SJ, (2010). Disparities in trauma and mental health service use. RAND Corporation. Available at http://www.rand.org/content/dam/rand/pubs/rgs_dissertations/2010/RAND_RGSD272.pdf.

San Diego County's *Positive Parenting for Men in Recovery* tests an integrated approach that incorporates parenting skills, mental health wellness, substance abuse education, and violence/trauma prevention for 300 fathers who are in Alcohol and Other Drug treatment. This program will enhance parenting and coping skills for these fathers and address negative consequences that arise from trauma, mental illness, substance abuse, and violence in order to produce better outcomes for fathers and their children.

Mental Health Workforce

According to the MHSOAC policy paper on mental health workforce education, “The major changes needed in California’s mental health services and systems—changes made possible by the Mental Health Services Act (MHSA)—cannot come about without equally major changes in the mental health workforce.... Change will require training and support for existing workers, infusion of new workers, effective leadership, new ideas, greater resources and a transformed and expanded educational and training capacity¹⁴.” Almost a quarter of county Innovative Programs included a focus on education and training of the behavioral health work force, including the following examples.

The purpose of San Francisco's *Peer Education/Advocacy on Self Help Movement (PeerEd) Project* is to increase the quality of services by improving educational training for professionals. The *PeerEd Project* will develop a recovery-based curriculum for peer-led classroom instruction for postsecondary students and faculty in five certificate and/or degree programs in behavioral health, medicine, or social work. The Innovation will also provide peer-led consultation and support for faculty, campus counseling offices, dorm advisors, and other support personnel to ensure that universities and other training programs are best equipped to promote recovery, wellness, and resilience.

¹⁴ Feldman S and Lee D. (2007). Mental Health Oversight and Accountability Commission position paper training and education. Available at http://www.mhsoac.ca.gov/docs/ImplementationUpdates/TrainingEducationRolesPriorities_07Mar7Final.pdf.

Through its *System Empowerment for Consumers, Families, and Providers*, San Luis Obispo County plans to design and test an approach to mutual learning and enhanced collaboration among consumers, family members, and mental health providers. Key elements include a trust-building gathering followed by mutual development of a core training program and curriculum for participants (consumers, family members, providers) within the public mental health system. The county also expects the Innovation to initiate policies that enhance education of mental health providers and improve communication.

Orange County's *Education, Training, and Research Institute* is an effort to create a new kind of partnership between the Behavioral Health Department and an independently funded Institute in order to leverage non-MHSA funds to support education and training activities and also to sustain successful Innovative Programs. The Innovation will explore whether this approach is a viable method to secure additional funding to develop and sustain workforce education, training and research projects that fall within MHSA guidelines but cannot be fully funded with MHSA dollars.

Wellness, Holistic Approaches

A focus on wellness and health for people with and at risk of mental illness is a key priority for the Substance Abuse and Mental Health Services Administration (SAMHSA) and many mental health advocates. SAMHSA's wellness vision is for a "future in which people with mental and substance use disorders pursue optimal health, happiness, recovery, and a full and satisfying life in the community via access to a range of effective services, supports, and resources."¹⁵ Of course, communities and cultures differ in their definitions of and approach to health and wellness. A number of county Innovative Programs are devising new mental health service delivery models that focus on increasing wellness and resilience using holistic approaches.

San Diego County's *Wellness and Self-Regulation for Children and Youth* will create an integrated therapeutic experience for children and TAY with serious emotional disturbance who live in a residential treatment center or participate in day treatment. The approach combines several non-pharmacological interventions to restructure the "therapeutic day" and teach children and youth multiple ways to re-regulate their arousal level to elevate mood, physical health, and social interaction. Family involvement is a key program element. The program's goals are to improve participants' mental health and levels of functioning.

¹⁵ (2011). About SAMHSA's wellness efforts: Why wellness matters. SAMHSA. Available at <http://www.promoteacceptance.samhsa.gov/10by10/default.aspx>.

San Luis Obispo County is piloting *Wellness Arts 101*, a for-credit community college course in expressive art primarily for students who have been engaged in or referred for mental health services. The Innovation was developed by and for college students with a mental illness. The course, to be offered in partnership with Cuesta College, combines academics with opportunities to develop social and life skills and coping mechanisms while participating in a therapeutic activity in an environment free from stigma. TAY stakeholders described their difficulties on college campuses including depression and anxiety caused or exacerbated by academic and social pressures, resulting in such negative consequences as substance abuse, crime, truancy, and dropping out of school. Evaluation of the program will measure both mental health and academic outcomes.

Homelessness

According to a SAMHSA study, 20-25% of individuals who are homeless in the United States have a severe mental illness, compared to 6% of Americans overall¹⁶. A number of counties (21%) are testing new approaches to address the needs of individuals who are homeless and mentally ill. California voters in counties with high rates of homeless were instrumental to the approval of Proposition 63 in 2004.¹⁷

In Butte County, fragmentation and lack of coordination of services creates stress for people who are homeless and mentally ill as well as for the service system, especially for first responder services. The county's *Homeless Shelter Collaboration* will test whether successful outcomes for people experiencing homelessness and mental illness can be achieved with integrated on-site service delivery and follow-up offered through a collaboration of the county's Public Health, Behavioral Health, and Social Services Departments. A multi-disciplinary support team will bring coordinated behavioral health, medical, and financial services to shelters. The county will assess whether the approach engages consumers in recovery and wellness plans, increases their length of stay at the shelter to allow time for services to be effective, increases seamless access to services, helps individuals reach their goals, improves their functioning, and reduces future first responder involvement.

¹⁶ (2009), Mental illness and homelessness, National Coalition for the Homeless. Available at http://www.nationalhomeless.org/factsheets/Mental_Illness.html.

¹⁷ Scheffler R and Adams N. (2005). Millionaires and mental health: Proposition 63 in California. *Health Affairs*, 10, 212-224.

Los Angeles County's *Integrated Mobile Health Team Model* will deploy a mobile, enhanced, integrated and multi-disciplinary team to serve individuals with a diagnosis of mental illness and their families who are homeless or have recently moved into permanent supportive housing. The same team will support individuals and families after they move into permanent supportive housing. Borrowing concepts successfully used in Section 8 project-based rental subsidies, the County plans to use project-based service vouchers to create a market that engages affordable housing developers and service agencies into a collaborative effort to increase the availability of permanent supportive housing. The *Integrated Mobile Health Team Model* is an effort to change existing fragmented approaches by unifying currently separate funding streams, charts, care plans, and lines of supervision.

Santa Barbara County's *Benefit Acquisition for High-Risk Indigent Individuals* will adapt benefits counseling programs currently practiced in health and social service systems, including the well evaluated SAMHSA-funded SSI/SSDI Outreach, Access and Recovery (SOAR) model¹⁸, to improve outcomes for individuals with severe and persistent mental illness who are homeless. Specialized benefits acquisition teams will provide integrated, recovery-oriented services and supports, including psychiatric treatment, case management, support groups, and medication management, in addition to helping people acquire benefits. The program will be evaluated by a team of diverse stakeholders, including consumers, family members, and representatives of ethnic communities.

Santa Clara County's *Peer-Run Transition-Age Youth (TAY) Innovation Project* will develop leadership by TAY in the design and delivery of services in a voluntary 24-hour care setting for TAY who are homeless, in crisis, and experiencing or at risk of experiencing mental health problems. TAY staff members will conduct outreach and make significant program decisions, serving as the primary service providers. The program also intends to address issues of stigma that can interfere with TAY who are homeless and experiencing a mental health crisis from seeking services. "Successful outcomes from the project would support broader inclusion of TAY views and perspectives in future programming and policy-related decision-making" (Santa Clara County, *Innovation Work Plan*). Monterey County's *Transition Age Youth Housing Project* takes a similar approach.

¹⁸ SSI/SSDI Outreach, Access and Recovery for people who are homeless. SAMHSA. Available at <http://prainc.com/soar/>.

Justice System Response and Involvement

A number of California communities have experienced tragic results of police responses to an individual experiencing a mental health crisis. While many counties have adopted evidence-based practices to improve the response to such crises—such as crisis response teams and training for law enforcement—some counties are using Innovation funds to test enhancements to existing approaches. Many of these Innovations expand roles for mental health consumers and their family members.

During a traumatic 12 months (2007-2008), four Sonoma County residents in severe mental distress were shot and killed by members of three law enforcement agencies (*Press Democrat*, March 22, 2008). Sonoma County law enforcement personnel have also been injured when responding to crisis calls. In part in response to such tragedies, Sonoma County's *Interdisciplinary Mobile Intervention Team* intends to increase the quality of services to people experiencing a behavioral health crisis by integrating consumers and their family members as core members of an interdisciplinary mobile crisis response team, in addition to licensed clinicians and alcohol/drug services counselors. The inclusion of clients and family members in response teams goes beyond existing CIT models, which the county has already adopted. Sonoma County plans to measure client-level, organization-level, and system-level outcomes of this Innovation.

Current models of mental health services to Juvenile Sex Offenders are stand-alone. Monterey County's *Juvenile Sex Offender Response Team (JSORT)* is an effort to design and test a comprehensive, county-wide approach in which all responding agencies work collaboratively and seamlessly toward a "best practice" response to juvenile sex offenders as early as possible in their offending cycle. The collaborative will identify or develop the most effective mental health interventions for juveniles and their families from first response through mental health treatment and after-care. This Innovation is expected to maintain juveniles in their home communities while they receive mental health services whenever safety allows, rather than placing them away from families and community support.

Support to Counties: Training and Technical Assistance

In order to fulfill the potential of the Innovation component, counties, including program participants and other community stakeholders, must have the capacity to implement their Innovations, evaluate both their outcomes and the relevant program elements and activities that most contributed to outcomes, make course adjustments based on what they learn, and communicate the results within the county and throughout the state. The goal is the adoption and dissemination of successful Innovations.

MHSOAC TA for Innovation Work Plan Development

The MHSOAC provided technical assistance to 38 counties to support the development of their Innovation work plans and to an additional seven counties to help with the revisions of their Innovation work plans.

MHSOAC developed several tools to assist counties in working with their communities to plan, prioritize, and write their Innovation work plans.

Innovation Decision Path

MHSOAC staff developed a tool to help counties and community planning participants focus on key decisions to consider in deciding Innovation priorities. The tool was designed to help with the shift to a “model development” approach.

Issue for County	Barrier	Essential Purpose for Innovation (MHSA)	County’s Learning/ Change Goal	Innovative Mental Health Practice/ Approach to Test
What significant, local challenge (consistent with the one or more of the four MHSA purposes) does the county want to address by piloting and evaluating a new/changed mental health approach?	What (besides funding) has prevented the county from meeting this challenge? Why are existing (in the field of mental health) approaches lacking, insufficient, or inappropriate?	Which of the four MHSA Innovation purposes for Innovation is the primary area of intended change and learning?	What will the county and the field of mental health learn by piloting this new or changed practice? How will they measure this learning?	What specific new, adapted, or adopted mental health practice or approach does the county want to try out as its vehicle for learning? If the Innovation is successful, what practice will the county continue (without Innovation funding)? How is the practice consistent with applicable MHSA General Standards?

Other Innovation Training Tools

MHSOAC also developed a *Top Ten List* (Appendix 3) and *Innovation Jeopardy* (Appendix 4) to help counties, including their community stakeholders, address Innovation’s focus on developing and testing new mental health models. The *MHSOAC Decision Path* and *Top Ten List* were translated into Spanish.

Counties also developed many teaching tools for community stakeholders to support planning and decision-making for the Innovation component.

Support to California Institute for Mental Health

The MHSOAC provided support to the California Institute for Mental Health (CiMH) in its development and implementation of training and technical assistance for counties’ Innovation efforts, including three topic-based learning groups, an Innovation Clearinghouse (<http://www.mhsainn.org/>), and an interactive e-learning curriculum on

evaluation for Innovation (<http://www.mhsainn.org/measuring/>) that helps counties identify effective program elements that should be replicated and disseminated.

MHSOAC also convened bi-weekly meetings with CiMH staff to support their provision of technical assistance to counties on the development of Innovation work plans and to ensure consistent guidance that would support efficient plan approval and quality Innovative Programs.

Additional Support for Counties and Communities

Currently, counties are receiving minimal post-implementation support for Innovation. Additional assistance could be available for implementation; local evaluation; and county adoption and dissemination of successful Innovations.

It has been suggested that “Fiscal strategies, including those championed by the OAC, should create incentives for the use of evidence-based practices, including those developed through the Innovation component. Thus fiscal incentives should create demand for innovation, and the evaluation of those innovations, and thereby contribute to the inventory of evidence-based approaches.”¹⁹

Innovation Trends Post-AB 100

Assembly Bill 100 was enacted in March 2011.²⁰ Since its passage, counties do not submit plans to any statewide entity and there is no statewide review or approval of plans or funds. The State Controller distributes Local Mental Health Service Funds directly to counties for all MHSA components, including Innovation. Local County Mental Health Boards continue to review and make recommendations regarding proposed programs and expenditures after a required 30-day public review and public hearing.²¹

As a result of the AB-100 changes, there is no notification to any statewide entity when a county approves a new Innovation work plan and the plan descriptions are not posted in any centralized location, making it difficult to get a comprehensive view of Innovation plans approved locally.²²

The MHSA authorizes the MHSOAC to “obtain data and information from the State Department of Mental Health, or other state or local entities that receive Mental Health Services Act funds, for the commission to utilize in its oversight, review, and evaluation capacity regarding projects and programs supported with Mental Health Services Act funds.” (Part 3.7, Welfare and Institutions Code, Section 5845(d)(6)) The Commission intends to determine an appropriate method to track and ensure accountability for MHSA programs in a post-AB 100 environment.

¹⁹ Ewing T. (2010). Developing an evaluation strategy for the Innovation program. California Research Bureau (unpublished).

²⁰ Chapter 5 Statutes 2011.

²¹ Welfare & Institutions Code Section 5848.

²² MHSOAC staff identified 48 Innovation plans from 22 counties approved locally between March and November 2011. A total of 47 counties with approved work plans for 134 Innovation programs were identified as of December 1, 2011; this number includes seven counties that had Innovation plans approved both before and after the passage of AB 100.

Evaluation of Innovative Programs

Evaluation is at the core of MHSA Innovation, since all programs are pilots to be tested. Statewide evaluation can assess the impact of the Innovation component overall, including the success of Innovation pilots and the extent to which successful Innovations are implemented by counties as ongoing practices and replicated by other counties and beyond. Toby Ewing, PhD, formerly Director of the California Research Bureau wrote a paper making recommendations regarding evaluation of the Innovation component in which he suggested that statewide evaluation of the Innovation component should include 1) specific Innovations at the project level, 2) links between innovations, evaluation, and use of evidence-based practices at the community level, and 3) extent to which the Innovation Program leads to informed state-level decisions.²³

To date there has been no statewide evaluation of the Innovation component and no assessment of the progress of local county evaluations of their Innovative Programs.

Recommendations

The following are recommendations regarding critical next steps to ensure the optimal positive impact of the MHSA Innovation component.

1. Prioritize and ensure adequate support for counties to pilot and evaluate their Innovation programs, communicate results, and implement and disseminate successful Innovations
2. Prioritize and implement statewide evaluation of the Innovation component and use results to improve quality of component as well as improved mental health service delivery
3. Create central clearinghouse for all new Innovation program work plans (descriptions of planned Innovations) approved locally
4. Consider clarifying language in the MHSA regarding one of the purposes of Innovative Programs: to promote interagency and community collaboration.

²³ Ewing T. (2010). Developing an evaluation strategy for the Innovation program. California Research Bureau (unpublished).

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