



State of California

**MENTAL HEALTH SERVICES
OVERSIGHT AND ACCOUNTABILITY COMMISSION**

Minutes of Teleconference
March 27, 2014

MHSOAC
1325 J Street, Suite 1700
Sacramento, California 95814

866-817-6550; Code 3190377

Members Participating

Richard Van Horn, Chair
David Pating, M.D., Vice Chair
Khatera Aslami-Tamplen
John Boyd, Psy.D.
Sheriff Bill Brown
John Buck
Victor Carrion, M.D. (Teleconference)
David Gordon
Larry Poaster, Ph.D. (Teleconference)
Tina Wooton (Teleconference)

Staff Present

Andrea Jackson, Executive Director
Kevin Hoffman, Deputy Executive Director
Filomena Yeroshek, Chief Counsel
Deborah Lee, Ph.D., Consulting Psychologist
Jose Oseguera, Committee Operations Chief
Norma Pate, Administrative Chief
Kristal Carter, Staff Services Analyst

Members Absent

Assemblymember Bonnie Lowenthal
Senator Lou Correa
Paul Keith, M.D.
LeeAnne Mallel
Christopher Miller-Cole, Psy.D.
Ralph Nelson, Jr., M.D.

1. CALL TO ORDER AND ROLL CALL FOR TELECONFERENCE MEETING

Chairman Richard Van Horn called the teleconference meeting of the Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission) to order at 8:36 a.m. and welcomed everyone. Administrative Chief, Norma Pate, called the roll and announced a quorum was not yet present. A quorum was achieved after Commissioners Boyd and Buck arrived.

**2. APPROVE THE JANUARY 23, 2014, MHSOAC MEETING MINUTES (ACTION)
JANUARY 23, 2014, MHSOAC MEETING MINUTES AND MOTIONS SUMMARY
MARCH 2014 MHSOAC EVALUATION DELIVERABLES DASHBOARD**

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

The MHSOAC approves the January 23, 2014, MHSOAC Meeting Minutes as presented.

- Roll call was taken and the motion was passed unanimously.

3. APPROVE IMPERIAL COUNTY INNOVATION PLAN (ACTION)

Jose Oseguera, Chief of Plan Review and Committee Operations, stated Imperial County is requesting \$1,498,366 for a three-year Innovation (INN) program, titled “MHSA First Steps to Success” (FSS), to assess whether a collaborative relationship between Behavioral Health Services, education, and parents will increase access to services for kindergarten and first grade students who are at-risk of serious mental illness. FSS consists of a universal screening, school intervention, and training and support. Ongoing evaluation and annual reviews of the collaborative process will be conducted to identify areas of improvement and sustainability.

Commissioner Questions and Discussion:

Chair Van Horn asked if the various school districts in the county are supportive of the universal screening.

Leticia Plancarte-Garcia, the Deputy Director of Children Services of the Imperial County Behavioral Health Services (ICBHS), stated school districts have been involved in the planning process, participate in regular meetings, and are supportive of implementing the program.

Commissioner Carrion thanked the ICBHS for considering ways to increase integration between education and mental health.

Vice Chair Pating asked if there is overlap with First 5, if the ICBHS is talking with Superintendent Torlakson’s office about the pilots they are hoping to roll out, and if screening is temperament-based or more sophisticated mental health screenings.

Ms. Plancarte-Garcia stated the INN plan focuses on developing collaborative relationships and is different because part of the staff will be mental health staff that will be integrated in the school setting. The schools provide a classroom for mental health staff to provide daily group and individual services. Ms. Plancarte-Garcia stated the ICBHS is not looking at Superintendent Torlakson’s pilots. School and behavioral health personnel will receive training on how to access and evaluate. The universal screening includes behavioral observations and completion of specific tools by both the education staff and the parents to identify children who are most at-risk.

Commissioner Boyd asked how many screening programs targeted for this group are in the state, and what the ICBHS benchmarked against within the state or the rest of the country as it relates to diversity variables for screening protocols and instruments chosen.

Ms. Plancarte-Garcia stated the ICBHS looked at programs that would be successful, based on their data and outcomes related to the population of Imperial County. The ICBHS consultant recommended programs that would integrate with education. The FSS is an evidence-based model that has been implemented in schools. The ICBHS focused on how to collaborate with schools, develop, sustain, and maintain the collaborative relationship, and to identify and establish a relationship with younger at-risk populations.

MHSOAC Consulting Psychologist Dr. Deborah Lee stated the FSS is an evidence-based practice, with the innovation of utilizing this evidence-based practice to build a long-standing collaboration to bring an ongoing presence of mental health to schools with very young children.

Commissioner Boyd asked if the ICBHS has a network with other like programs.

Maria Wyatt, the Behavioral Health Manager of Children Services of the ICBHS, stated Imperial County has collaboratives with elementary and high school children, but there is a misconception

that kindergarten and first grade is too young for mental health issues; the ICBHS is not called in until there is a crisis.

Commissioner Boyd encouraged the ICBHS to reach out to like programs, because sharing with people that are trying to do the same thing is especially powerful and important.

Ms. Wyatt agreed and stated the ICBHS plans to reach out into the community once the program is approved.

Commissioner Carrion asked how the county will determine if the way these relationships are built is successful, and, if not, how the approach could be changed to make it more effective.

Ms. Plancarte-Garcia stated this will be part of the evaluation done by the contractor.

Commissioner Aslami-Tamplen asked what tool will be used to evaluate stigma.

Ms. Plancarte-Garcia stated it will be developed as the consultant does the evaluation.

Action: Commissioner Buck made a motion, seconded by Commissioner Boyd, that:

The MHSOAC approves Imperial County's Innovation Program, titled "MHSA First Steps to Success."

- Roll call was taken and the motion was passed unanimously.

4. APPROVE SAN BERNARDINO COUNTY INN PLAN (ACTION)

Jose Oseguera, Chief of Plan Review and Committee Operations, stated San Bernardino is requesting \$6,666,923 for a four-year INN program, titled "Recovery Based Engagement Support Teams" (RBEST), to examine the viability of providing outreach and engagement services to community members who are chronically mentally ill, unserved, or inappropriately served to increase their participation in treatment. RBEST consists of field-based services in outreach, engagement, case management, family education, support, and therapy for adult clients who suffer from untreated mental illness to reduce the use of crisis services and hospitalizations and increase access to services and coping strategies for families.

Commissioner Questions and Discussion:

Commissioner Aslami-Tamplen asked for clarification on the target population.

Sarah Eberhardt-Rios, the Deputy Director of the San Bernardino Department of Behavioral Health (SBDBH), stated RBEST targets individuals who are untreated, those who have not yet engaged in services but are still considered to be chronically and persistently mentally ill, or those who are engaged in emergency services but have not engaged in outpatient or case management services and have been accessing care that has not addressed their needs.

Commissioner Buck stated California has ignored the growing problem within the mental health system of people who were unengaged or unengageable for far too long. He asked if the SBDBH will include incarceration and jail time pre-post as an outcome.

Ms. Eberhardt-Rios answered in the affirmative, and stated the SBDBH will also measure the emergency services systems, working on the 9-1-1 level.

Commissioner Buck asked about the plans for engaging the unengageable.

Paula Rutten, the Program Manager of Hospital Services of the SBDBH, stated RBEST teaches that traditional engagement techniques do not always work, and will evaluate whether it is a relationship rather than a clinician directive that will eliminate obstacles. The teams will include peer and family advocates, as well as a psychiatrist and clinicians, who will go into the community to make

relationships and evaluate clients. She stated it will take months of contact to establish the trust it will take for clients to allow someone to help them overcome their obstacles.

Ms. Rutten stated the SBDBH will help to strategize the best approach to define the population that does not utilize traditional systems. The four teams will create a profile from every geographical area served and will be connected to a major clinic.

Dr. Lee stated another dimension to the evaluation is to evaluate both in a traditional outcomes-based approach, and in an innovative, client-directed approach.

Commissioner Aslami-Tamplen asked about the recovery training for the team.

Ms. Rutten stated the training will be similar to Dr. Xavier Amador's LEAP Institute perspective of the importance of strong relationships in treating illness.

Commissioner Aslami-Tamplen stated there are also other recovery-based trainings that are evidence-based practices and promote recovery and support, such as the Wellness Recovery Action Planning trainings.

Ms. Rutten stated the first six months of the program will explore trainings, set up tools, and set up the teams.

Commissioner Boyd asked how many individuals RBEST will reach during the innovation period.

Ms. Eberhardt-Rios answered that RBEST will reach three hundred individuals per year.

Public Comment:

Jim Gilmer, of the California MHSA Multi-Cultural Coalition (CMMC), the Racial and Ethnic Mental Health Disparities Coalition (REMHDCO), and the African American Strategic Plan Workgroup, stated he did not note a relationship-building process with community-defined stakeholders in the project. Also, he stated the need for the field-based teams to build relationships with the faith community, spirituality, and nontraditional strategies and methods to assist people in recovery twenty-four/seven.

Mr. Gilmer stated he would like to see the project answer why men and women of color do not participate in evidence-based practices while incarcerated, and why they are underrepresented in these programs but overrepresented in prison.

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

The MHSOAC approves San Bernardino County's INN Program, titled "Recovery Based Engagement Support Teams."

- Motion carried, 9-0

5. ADJOURN TELECONFERENCE MEETING

Chair Van Horn adjourned the teleconference meeting.



State of California

**MENTAL HEALTH SERVICES
OVERSIGHT AND ACCOUNTABILITY COMMISSION**

Minutes of Meeting
March 27, 2014

MHSOAC
1325 J Street, Suite 1700
Sacramento, California 95814

866-817-6550; Code 3190377

Members Participating

Richard Van Horn, Chair
David Pating, M.D., Vice Chair
Khatera Aslami-Tamplen
John Boyd, Psy.D.
Sheriff Bill Brown
John Buck
David Gordon

Staff Present

Andrea Jackson, Executive Director
Kevin Hoffman, Deputy Executive Director
Filomena Yeroshek, Chief Counsel
Deborah Lee, Ph.D., Consulting Psychologist
Jose Oseguera, Committee Operations Chief
Norma Pate, Administrative Chief
Kristal Carter, Staff Services Analyst

Members Absent

Assemblymember Bonnie Lowenthal
Victor Carrion, M.D.
Senator Lou Correa
Paul Keith, M.D.
LeeAnne Mallel
Christopher Miller-Cole, Psy.D.
Ralph Nelson, Jr., M.D.
Larry Poaster, Ph.D.
Tina Wooton

1. CALL TO ORDER AND ROLL CALL FOR IN-PERSON MEETING

Chair Van Horn opened the in-person meeting of the MHSOAC. Administrative Chief Pate called the roll and announced a quorum was achieved.

2. PRESENTATION: BAGLEY-KEENE ACT AND COMMISSION PROCEDURES

Chief Counsel Filomena Yeroshek explained the public policy and duties behind the Bagley-Keene Open Meeting Act: to give adequate notice of meetings, to conduct meetings in an open session, and to provide an opportunity for public comment. Ms. Yeroshek went through the different elements of the Bagley-Keene Open Meeting Act including notice requirements for different types of meetings;

prohibition of serial communication, and requirements for public comment. She asked Commissioners to email or call her with any questions.

3. ROUND TABLE DISCUSSION: BREAKING THE FAIL FIRST CYCLE - PRIMARY GRADES KINDERGARTEN THROUGH THIRD

Presenters:

Dave Gordon, MHSOAC Commissioner

Dr. Victor Carrion, MHSOAC Commissioner

Subject Matter Experts:

Rusty Selix, Executive Director, Mental Health Association of California

Ken Berrick, President/CEO, Seneca Family of Agencies

Chair Van Horn stated this is the first of two panels on student mental health. The next Commission meeting will have a presentation on the later age group.

Commissioner Gordon stated the only preventive program in the early nineties in the area of mental health was the grant-funded Primary Intervention Program, which enabled early identification and clinical intervention in grades K through 3. The program was effective, but operated only in a limited number of school districts.

In the mid to late nineties, a program called Neverstreaming was piloted to identify and correct early reading deficiencies at the earliest possible point. Neverstreaming hypothesized that reading deficiencies left unaddressed would result in a child falling so far behind that they would finally qualify for special education services, and thus directed intensive reading improvement interventions that precluded the need for special education for these students. The success of this approach, in part, led to a modification of the state special education funding formula to fund districts and Special Education Local Plan Areas (SELPA's), which operate special education at a state average of ten percent, rather than continuing to incentivize the fail-first model.

A variant on Neverstreaming, Response to Intervention (RTI), was shortly thereafter placed in federal law and is now a requirement. It behooves this Commission to seek ways to pilot and then implement effective interventions. There is a greater understanding of and tools to identify the early signs of mental health issues in young children. Teacher trainings and behavioral interventions are more effective, and mental health is now a funded medical service, which can support clinical treatment based on diagnoses where needed.

Commissioner Carrion explained how children experience threats and how threats affect how they perform emotionally and academically. The areas of the brain that are impacted by stress are the same areas that are used for managing emotion and learning. The accumulation of stressors is called the allostatic load. Today's presentation will address how to protect children and help them build coping mechanisms so that they can manage stressors in a way that does not impact their function.

A stressor, such as child maltreatment, causes hyper-arousability that makes whatever they are genetically vulnerable to develop more quickly. In a threshold model, a child may need to go through several stressors to pass that threshold to develop what make them vulnerable. Individuals that do not get close to the threshold are called resilient. Right now, two groups of children are being confused: children that are truly resilient and children that are getting closer and closer to that threshold.

The younger children are, the more vulnerable they are. Results from trauma and stress depend on the age of the child. There is a development reaction. Since 1980, Post-Traumatic Stress Disorder (PTSD) developed because of the experience of combat veterans and the symptoms they were experiencing. Very young children that experience trauma develop similar symptoms to the ones that adults develop after combat, but the way they are expressed is different. Children do have

an adaptive mechanism, but they can become fixed and maladapted, dissociate when they see a trigger, and miss a lot of what is happening in the classroom.

Trauma also robs children of play and the way that children communicate and develop social and motor skills. When trauma and stress occur, there is such a need to process the event that play becomes a means to express that trauma. Cognitive distortions can also become fixed and remain there until adulthood. They can become intrusive and interfere with social and academic function.

As children get older, symptoms manifest differently with attention and concentration problems. Without good assessments or histories of what stressors the children are experiencing, there can be misdiagnoses. Many children get misdiagnosed with Attention Deficit Hyperactivity Disorder (ADHD), which leads to wrong treatments and exacerbated symptoms.

Night time seems to be a particularly vulnerable time for children when they experience stress and trauma. Research shows that the hormone that helps process traumatic experiences, cortisol, remains high at nighttime in children that have post-traumatic symptoms. What these high levels of cortisol do to young, developing brains requires further research.

The hippocampus is the area of the brain that processes memory. The prefrontal cortex is for organization and attention. Cortisol goes to these areas of the brain and affects the function and development of this region. The amygdala is the center of emotional processing. Children that have post-traumatic symptoms activate the amygdala significantly more than children with no traumatic symptoms. Children who are experiencing interpersonal violence become very good at scanning the environment, which is good for safety, but not good for learning.

Commissioner Carrion stated the need for methods, programs, approaches, and innovative plans to teach cognitive flexibility, so children know when it is appropriate to perform hyper-vigilant scans and when, in safe environments, the amygdala can calm down.

The hippocampus, cortex, and amygdala are part of the limbic system, which is very vulnerable to the effect of stress and the environment. However, psychosocial interventions or therapies that can undo or improve these conditions include Head Start, Trauma-Focused CBT, Parent-Child Interactive Therapy, Cue-Centered Treatment, and other school-based interventions. Commissioner Carrion stated the need for programs that take advantage of the fact that the brain responds to the environment by altering that environment. There also is a need for group therapies, such as the Cognitive Behavioral Intervention for Trauma in Schools from University of California, Los Angeles (UCLA), with cognitive tools in a classroom setting, wellness programs like mindfulness and yoga, and integrated centers where pediatricians work with mental health professionals in a trauma-informed system.

An eight-minute video of a school intervention in a PBS Newshour report titled “Low-Income Students Combat Stress with Mindfulness” was presented.

One way of conceptualizing stressors is through Adverse Childhood Experiences (ACEs). Stanford reviewed more than seven hundred children’s charts from the Bayview Hunters Point neighborhood of San Francisco and found that twelve percent of them had already accumulated, in allostatic load, four or more ACEs. The average age in this study was seven years old.

The Stanford study found there was a link to physical illness in that these children had double the risk of obesity, which puts them at-risk for disorders like high blood pressure and diabetes. Mental health is transmitted to all aspects of health. The Stanford study also found that there were thirty-six times more learning and behavior problems in this group. Ninety-seven percent of children that had less than one ACE had no learning or behavioral problems. There is a clear need for universal screening of stressors in urban centers serving youth.

The University of California, San Diego Chadwick Trauma-Informed Systems Project defined a trauma-informed system as a system in which all parties involved recognize and respond to the varying impact of traumatic stress on children, caregivers, families, and those who have contact

within the system. Programs and organizations within the system infuse knowledge, awareness, and skills into their organizational cultures, policies, and practices. They act in collaboration, using the best available science, to facilitate and support resiliency and recovery.

Commissioner Carrion stated the belief that trauma-informed systems can also be mental health-informed systems, and encouraged the Commission to discuss this. He thanked the donors who have done this work, including the National Institute of Mental Health (NIMH). He directed Commissioners to the Chadwick Trauma-Informed System Project at U.C.S.D., the National Child Traumatic Stress Network at U.C.L.A., the Early Life Stress Program at Stanford, and the Zero to Three and Zero to Six Collaborative Networks as resources about child learning and stressors.

Rusty Selix

Rusty Selix, the Executive Director of the Mental Health Association of California, stated his role in this presentation is to set the context. Executive Director Andrea Jackson was working with then-Assemblyman Darrell Steinberg, and Commissioner Buck was the president of the California Council of Community Mental Health Agencies in the fall of 2002, when that board voted to spend \$75,000 to determine whether it was feasible to do an initiative that became Proposition 63 (Act). Chair Van Horn was part of the first focus groups that were begun, where the words “mental health” were put on a flipchart and people were asked what came to mind. In every focus group the answer was the same - the public thinks of street people when they hear “mental health.” When probed deeper, the groups asked why people have to become homeless, have to fail, before they get help for their mental health problems.

That is where the concept of prevention and early intervention (PEI) was born. The reality is that California has a fail-first system. Those who were involved in the campaign made a goal to move from fail-first to help-first, from waiting for people to hit rock-bottom before they could get help to helping at the earliest signs of potential need. That is what this round table discussion is about today.

There are three unbelievable game changers in PEI that are more important than all of the other things combined. The first was known when the Act was written - the early psychosis programs and catching schizophrenia early. Catching the most devastating mental illness early would allow people to live normal lives. The second was learned about five years ago - that everyone could and should be screened in primary care for mental health and linked directly to services that start immediately. This integration concept grew out of finding that the physical health problems of unattended mental illness affects the whole health care system.

When the Act was written, schools had a fail-first system. Children received help only after they fell at least two years behind normal school productivity and qualified for a special education program at the average age of eleven, although mothers knew something was wrong when their children were three years old, and teachers knew who was going to fail.

The next part of the presentation concerns two programs from opposite ends of the state. One is in an urban setting led by a community mental health agency, and the other is in a more rural setting led by a SELPA. Both have the key element of being contract providers under Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Medi-Cal services to county mental health, and the programs represent a partnership between school districts and county mental health.

Both of these programs demonstrate that providing comprehensive services starting at the earliest ages pays for itself in nonpublic school placements in special education, which represents over half of all special education spending and is the highest cost.

The challenge is how to make these exceptional programs the rule rather than the exception. Mr. Selix encouraged the MHSOAC, the State Department of Education, the Department of Health Care Services, the Legislature, and other state bodies to make this happen. He also stated that county mental health, school districts and SELPAs, statewide organizations such as CalMHSA, the California Mental Health Directors Association (CMHDA), the associations of school boards, and

school administrators need to be involved to make these programs happen. He encouraged Commissioners to do everything they can over the next several months to make what Ken Berrick will present become the norm statewide.

Chair Van Horn stated a program called Healthy Start was beginning to identify children earlier through small parent-run collaboratives in clusters of schools and the engagement of volunteers from various child-serving agencies in that territory. He suggested the Commission research what happened to Healthy Start. He asked Commissioners to consider what the Commission's role will be in pushing this ahead.

Ken Berrick

Ken Berrick, the President and CEO of Seneca Family of Agencies, stated Seneca Family of Agencies began as a residential and day treatment program for the one-half of one percent of most troubled children in the system, and found out very quickly that intervening at that late stage makes it difficult for children to trust or form attachments. Seneca moved into intensive treatment foster care, helped pioneer wraparound in California with partner organizations, and moved into school-based intervention and prevention, where work was being done, but lacking effectiveness and success. Seneca began to ask why all the work did not achieve the outcomes and impacts anticipated, and why principals and educators were skeptical about mental health intervention.

Seneca started developing collaborations around these intervention systems and found that there is a cyclical relationship between trauma, learning disabilities, and mental health. Mr. Berrick gave the example of a teacher passing out an assignment with a promise of free time when completed, and the last child left who was unable to complete the assignment. He stated there are two things that happen in this frustrating circumstance if it happens over and over again: children will either internalize and give up the minute the paper lands on the desk or they will externalize and find a way out of that circumstance.

Learning problems and attention problems are common. He asked at what point there should be an intervention, how to intervene, and what resources to use. If viewed as a learning problem, a learning intervention is used, except that the typical Individualized Education Program (IEP) process can only begin when children are identified as being so far behind that they need a special education intervention. He asked Commissioners to consider where the student is not just educationally but emotionally at that point. Screenings are important because teachers can tell by second grade with remarkable predictability when a child needs help.

Affluent parents have the ability to find a tutor so the child never gets to the place where they give up, but what happens when the family is not as affluent? Mr. Berrick indicated a much broader population than Dr. Carrion discussed, where there was trauma as another overlay. Even without trauma as an overlay, those academic struggles lead to frustration, frustration-tolerance issues, depression, and internalization.

Additionally, teachers are pressured to bring those students along, because special education cannot be assessed at this stage. Teachers are told to devise a system to serve those children. Mr. Berrick gave the example of a second grade class of twenty-two to thirty children operating from nonreader to reading at a fourth-grade level, and asked how to create a system that supports all students and breaks this cycle.

Mr. Berrick stated the approach that he is presenting began with a single student. He got a call from a charter school referring a child to a nonpublic school day treatment program, a segregated site for children that have serious emotional problems and learning issues, but, since the child did not need to be in a segregated-site session, Seneca created a program for that child.

That led to a discussion about developing a program that fully integrated mental health, special education, school climate, and school culture in a tiered approach to integrate at the earliest

opportunity point when a child's learning disability, emotional problem, or traumatic history presented itself.

The problem with multi-tiered systems is that they are typically implemented by someone from the administration telling the principal and teachers to put in a multi-tiered system, form committees, perform learning disability interventions in small groups or individually, and be responsible for implementing the school climate, school culture, and curriculum such as RTI, Positive Behavioral Intervention and Supports (PBIS), Tribes, and Caring Communities. The problem is the principal and teachers already work long hours and the top five students take between thirty and forty percent of their teacher's time. Yet, they will try to implement these systems on their own, but there are no resources to do them so they get frustrated and angry because they are unable to accomplish these good programs.

Schools conclude that multi-tiered systems do not work. They are right. They do not work when they are under-resourced or unresourced. The solution is to create a collaborative resource allocation method that secures the needed type and intensity of service quickly, which is the traditional RTI model. But, in the current structure, this kind of intervention system will never be funded because fully sixty percent of resources in special education and mental health go to the top five to fifteen percent of students, because those interventions are applied so late in a child's progression that the intensity of service that is necessary to mitigate these children's conditions is incredible, and they require a tremendous investment. Late intervention is also not as effective.

Desert Mountain SELPA and the Seneca model are similar. They fully integrate mental health, special education, regular education, tiered intervention systems, and school climate and school culture. School climate/school culture active intervention systems are one of the most basic and effective mental health and educational intervention systems. Many schools have a framework of values, such as treating everyone with respect, but there is a misconception that that framework is the school climate/school culture curriculum.

A school climate/school culture curriculum is a full implementation of something like PBIS in an attachment-based system, where every person in the school is trained and understands and implements a consistent set of interventions and values. It creates a positive school atmosphere and a standard for deeper interventions around positive interventions, positive reinforcement, and attachment, which is an environment in which all other interventions become more effective.

When school climate/school culture is implemented, there is a tiered intervention system with a series of whole-school interventions, including academic and social/emotional, a series of more individualized group-focused interventions that are also less costly, and some high-end intensive interventions. The key is that those interventions and resources, instead of being focused in a special education department that is outside the school, are reallocated and brought into the school.

Mr. Berrick stated he uses different terms when speaking with mental health and education colleagues. For example, he speaks of "school climate," not "stigma reduction" with education colleagues. He does not speak of "violence prevention" with mental health colleagues; he speaks of "healthy integrations of mental health in order to help people." In a comprehensive school climate/school culture curriculum, all of these ways of thinking are integrated. While achieving these shared goals on a broad community level is an enormous endeavor, within schools it is a limited and achievable task with potential for profound impacts on lifelong learning, wellbeing, and achievement.

Commissioner Questions and Discussion:

Chair Van Horn asked Commissioners to consider what the Commission's role might be in a mental health/education collaborative future. The mental health world has managed replication and is trying to push toward more fully integrating the tiers. Full Service Partnerships (FSPs) could be broader than they are currently defined in regulation. He asked what FSPs would look like in the education world if the early interventions presented here were done, and what potential responsibilities the Commission has to move this forward.

Vice Chair Pating stated, for prevention, there is early psychosis intervention, screening in primary care, and early and comprehensive childhood interventions. He asked if the Commission is happy with these three core interventions, and how can it be proven that these three are the three that everyone needs to do; if Deborah Lee has inventoried what the Commission has done in terms of these three areas for intervention; how to move this along other than MHSOAC evaluations; and what the costs are for a wraparound program.

Mr. Selix stated this is not MHSA-funded, but that does not mean the Commission should not evaluate it. The role of the Commission is broader than evaluating how MHSA dollars are spent. This program should pay for itself. Counties and school districts need to partner, and school administrators, rather than avoiding identifying children with mental health problems because they think that will drive up special education costs, need to understand that it costs less to implement a proactive strategy.

Mr. Selix agreed with the three core interventions that should be implemented on a broader scale than they are now. Early psychosis and screening in primary care with linkages to services are on track; it is just a matter of determining the best practices, and evaluation is the obvious next step. Early and comprehensive childhood interventions have the farthest to go. The learning curve and the hill to climb are larger, yet the opportunities are also much larger.

Vice Chair Pating asked if something was missed that did not allow this to happen under the MHSA.

Mr. Berrick stated something was missed. There was excitement about PEI in the children's community, but there was so much suppressed need in the adult community, and EPSDT was seen as a solution in the children's community. Very little MHSA funds were deployed into school-based programs because there was so much suppressed need in the community. The problem with that is that the amount of investment for large returns on the MHSA side is very small. There is an enormous return on investment in school climate/school culture and screenings. The biggest problem is, it is hard to believe, because there is typically a start-up investment for the first two years and more like three years before any returns are realized in highly impacted schools. But, after that, it is a self-perpetuating system, because the reinvestment pool on the special education side exists.

Commissioner Brown stated the problem is there are different disciplines having different priorities and different silos within the county, all doing great and separate work but without an integrated approach. He suggested that the Legislature require some kind of amalgamation for funding streams to be provided so the silos could begin to work collaboratively towards this.

Commissioner Boyd suggested making counties aware this program exists and inviting them to bring forward an innovation grant request. He asked what direction the Commission should be going with PEI, if it has missed the mark, and if it could benefit from a shift in focus.

Mr. Selix stated training and technical assistance is in the Commission's scope of authority, and part of promoting this as an innovation project and as a strategy for PEI is bringing the schools to the table and providing training and education for them. PEI needs to be implemented in systems outside the mental health system, because PEI is too late once someone is in the mental health system. The problem is that the MHSA PEI dollars belong to the mental health system. Early psychosis is on the mark because it has been a core-type activity from the outset and is being expanded.

It was known from the outset that schools were a key place and the best place to help students early, but it had never been done before. Allowing for experimentation, the first round showed good results. Mr. Selix gave the example that the number of Latinos served has almost doubled, and the PEI program is a large contributor to that change. He stated the need for the second and third rounds of funding to be focused on what worked the best. The key to this program is it pays for itself after the initial investment.

PEI has only missed the mark because no one knew where that mark was. Now, school funding must be concentrated on that comprehensive program, because the more services provided and the more comprehensive it is, the more cost-effective it becomes. What sounds like it costs more turns out to actually cost less.

Chair Van Horn asked what stance the Commission should take to encourage this, as there will soon be a second round of innovation proposals.

Commissioner Carrion suggested rewording the presentation toward education. As the Commission develops systems of support that are mental health-focused, they also have to be educational-focused in order for the districts to implement them and still fulfill their goals.

Chair Van Horn stated he and Commissioner Gordon can meet with Tom Torlakson to discuss whether the Commission should move more toward education. Also, the Commission has a staff person at the Department of Education, Monica Nepomuceno, and her task center could be moved this direction.

Mr. Berrick agreed with Commissioner Carrion, as this is effectively an education initiative that has integrated mental health. Superintendents are disappointed with the outcomes of the investment in special education dollars. This is an opportunity to make special education dollars produce outcomes that change the nature of what is going on in schools.

Commissioner Buck stated the need for statistics to back up the claims. He asked how long Mr. Berrick's program has been running. A good researcher could show some trend numbers that indicate that this is at least a promising practice that school districts will want to replicate.

Mr. Berrick stated it has been three years since implementing the first full-service partnership, and is three-quarters of the way through developing the model. He stated there are already good outcomes, but the next year or two will bring in an improved return on investment.

Chair Van Horn asked Jennifer Whitney to get two or three media placements for the Commission that would begin to move this out into the community.

Commissioner Gordon suggested creating a work group as a vehicle to give voice and visibility to this idea, possibly augmented by members of the education system. A point both Mr. Selix and Mr. Berrick made is that this effort needs to be led by education with great participation from mental health. He suggested prompting action by demonstrating that mental health and education can effectively collaborate by holding meetings around the state, through grants, incentivizing, and evaluating.

Commissioner Carrion stated, although PEI and CSS are considered separate silos, they are essentially the same individuals in a different time. Targeting individuals when they are very young is the only way to keep them from being the CSS of the future.

Mr. Selix stated there was an early school-based mental health initiative that had incredible cost-effectiveness data; yet, despite all the data, not very many schools continued the program after the three-year grant ran out. What is being proposed today provides cost savings that are much more tangible to the schools, are more comprehensive, and do more for them.

Chair Van Horn thanked the panel for an incredibly enlightening presentation and discussion, and he stated he looked forward to the next focus, in two months, on how to deal with older elementary, middle, and high school students. It is perhaps a little beyond the most conservative view of what the Commission's role is, but it is certainly within the broad scope that Mr. Selix and Executive Director Jackson thought of as they were crafting this twelve years go.

4. GENERAL PUBLIC COMMENT

Mr. Gilmer stated Commissioner Carrion's presentation hit some major points for communities of color; but, having had experience working in gang-infested communities, it misses some of the

points of real expansion and partnership. He suggested the involvement of faith-based organizations so children have a safe place. Having respite centers in neighborhood congregations can also add to this dimension. He also suggested having cultural representation while crafting the assessment questions and in this broad initiative to ensure they are culturally appropriate.

Commissioner Boyd commended Mr. Gilmer for his mentoring work, and agreed that community-based and faith-based organizations are an essential part of the fabric of any neighborhood. He stated the need for community-based and faith-based organizations to work harder at being inclusive, so that children, adolescents, and lesbian, gay, bisexual, and transgender individuals that need that same level of support can find a home in those faith-based, community-based organizations.

Reina Florez stated she stumbled upon this meeting. Until today, she did not know the Commission existed, and she has been to the attorney general, the lieutenant governor, the governor, the behavior board, the physicians' board, the Sacramento city mayor, and the board of supervisors. She is grateful to have found the Commission. She agreed with Vice Chair Pating about marketing and getting the word out about the Commission. She encouraged Commissioners to reach out to the judicial system. She stated she believes she would be an asset and would like the opportunity to speak with someone on the Commission.

Raja Mitry, of REMHDCO and CMMC, stated his concern that, although he knows the Commission widely distributed availability of the Client Stakeholder Project survey and the U.C. Davis Reducing Disparities Draft Report for public comment, there were lost opportunities for stakeholder involvement in these important evaluation projects because his county was without an MHSA coordinator for six months. Were it not for his involvement with MHSOAC Committees, he would not have heard about either one of these projects locally. He commended those counties that make efforts to reach stakeholders and provide opportunity for their voices to be heard at the local level.

His county has a new MHSA coordinator and he does not anticipate that the missed opportunities will happen again, but he wanted to make the Commission aware of what can happen at the local level where stakeholders, especially from underrepresented, underserved communities, are sometimes deprived of the opportunity to speak. All stakeholders must have their input honored. Vigilance at the local level is required at all times to assure timely dissemination of important taxpayer-funded projects to community stakeholders.

Emma Oshagan, Ph.D., of CMMC and the Armenian Program Development at Pacific Clinics, stated the presentation was enlightening. She agreed with the importance of addressing mental health problems early. She stated culture makes a difference and interferes with whatever intervention is implemented, and it helps to understand the culture being worked with. CMMC has a project learning about the needs of different ethnic communities in mental health, along with the California Reducing Disparities Project (CRDP). She suggested the Commission have a round table discussion where CMMC and the CRDP can share their findings about the different ethnic communities. This discussion will help with the initiative to reach children in schools.

Steve Leoni, a consumer and advocate, informed the Commission that the building security may be a problem in this meeting location. A couple of weeks ago, he phoned ahead to drop off some material to staff. He arrived carrying a clear plastic bag with about two inches of papers in it. The guard insisted on rifling through his papers. He stated, when he offered to help the guard, he was ordered to stand back and the guard put on a defensive posture. A staff member entering the building vouched for him, but the guard would only let the staff member he phoned escort him up.

Mr. Leoni spoke to staff about his reception and they assured him that the Commission will go through protocols. He asked that the guards be trained. He stated his concern for the constituency this Commission is mandated to listen to. The reception he received by the guard at the door is a barrier to meeting attendance. He recommended a presentation given to the Planning Council in

San Diego by Alliant University on trauma-informed care, and asked the Commission to speak with Jane Adcock about the presentation.

Executive Director Jackson added that the ATF and many federal agencies are housed in the building. Staff is working with them to help them understand the Commission and who the Commission serves. She stated, as it is a federal building, the guards will always have guns, but staff will educate them. It will be an easier process, but may take a little time.

Chair Van Horn stated this is a federal building and this is the first public meeting in this building. He thanked Mr. Leoni for making the Commission aware of the issue.

Rhena Keyes stated she is a health educator with a son who has been diagnosed with Pervasive Developmental Disorder Not Otherwise Specified (PDD-NOS), and bipolar disorder. She agreed the program could work, but emphasized the need to be sensitive to the needs of people of color. When her son began to complain that his IEP team mistreated him, she met with the team and they told her students from her school district and students who live in low-income developments did not succeed. They also gave her misinformation about available tests for her son. She moved him to a small school environment where he did succeed. This proves the initiative can work.

5. PRESENTATION: SAN FRANCISCO COUNTY TRIAGE GRANT PLAN OVERVIEW (NO ACTION)

San Francisco County was one of the counties that the Commission awarded a Triage Grant. San Francisco County presented an overview of the grant proposal.

Ken Epstein, Ph.D. LCSW, the Director of the San Francisco Children, Youth, and Families System of Care, Community Behavioral Health Services, stated San Francisco County (SFC) has many crisis services, but no connection between the crisis services and the prevention of crisis and/or ongoing services.

The Services of San Francisco

SFC has a twenty-bed psych emergency service for adults, a fourteen-bed urgent care for adults, a twenty-four-hour suicide hotline prevention, a mobile crisis team for adults, and a mobile crisis team for children.

The Gaps in Services

1. There is no child- and family-centered place for children and youth to be assessed in San Francisco. They are typically assessed in emergency rooms or in an adult psych emergency service. Also, SFC has only one psychiatric hospital in San Francisco for adolescents and it is often filled, so children are taken by ambulance to a non-family-friendly, distant hospital.
2. While child crisis and adult crisis go out to determine eligibility to psychiatric hospitalization, SFC does not have the capacity to provide a longer, more intensive, more engaging intervention and does not have teams that could stay with the family.
3. SFC does not have phone triage outside of a twenty-four-hour suicide hotline.

The Triage Grant Proposals

1. SFC proposed to develop two crisis triage teams that would focus on communities in San Francisco where children, youth, and families experience daily exposure to complex and historical trauma.

The first crisis triage team will be reflective of the community, come from the community, and be multifaceted, including clinicians, community workers, a peer, a family member and/or someone with lived experience, and a youth peer on each team that would be able to work with the network that is been affected by the tragedy or trauma that is being experienced.

The second crisis triage team will respond to the general San Francisco community. They will respond directly to schools, afterschool programs, or other facilities.

Both teams will be available twenty-four/seven, and they will not stay just until the engagement, but they will do a brief intervention over a couple of weeks or months. The intervention will be family-centered and focused on helping the family and youth either move into longer-term services or engage further in treatment.

2. SFC proposed to develop a twenty-three-hour hospital diversion stabilization program for youth. One of SFC's providers is converting a cottage on the campus so children will have a family-friendly place that is in the city that they can be transported to, and they will be assessed appropriately for services. This setting will provide flexibility in treatment and length of stay up to twenty-three hours.

3. SFC proposed to develop a twenty-four/seven warmline that will be staffed by both peers and clinical staff, to be able to talk for any length of time about pre-suicidal issues, so that SFC can prevent the escalation of further crisis. The warmline will have a diverse staff, including triage managers, triage specialists, crisis triage counselors, nurses, and youth and adult peers, with a total staff of sixty-two.

These three services are family-centered and are focused on the child in the context of their family, their community, and their culture. When trauma happens, it does not only impact one person. It also impacts the family and the community. The child or youth that is experiencing the problem sometimes is experiencing many symptoms. They can be served more effectively in more child- and family-friendly settings.

The Outcomes

Over four years, SFC expects to serve over 23,000 individuals, reduce hospitalizations and emergency room use, reduce the youth in the adult psych emergency service, increase coordination and communication between crisis services, improve triage, follow-up, and long-term care, and provide better service to the children, families, and adults in San Francisco.

Commissioner Questions and Discussion:

Commissioner Boyd asked how a two-bed stabilization unit was determined.

Dr. Epstein stated it is what SFC could afford to staff. SFC already has one bed that it has been using for the last three years. SFC is expanding that by two beds.

Commissioner Boyd stated the ratio is one manager for every nine staff, and asked if crisis triage managers are going to be working managers.

Dr. Epstein stated there are different ratios for each program. There is a high manager-to-staff ratio for the warmline, where the manager works on the warmline and also oversees it. The twenty-three-hour triage is more intense and has a lower manager-to-staff ratio. The lowest ratio is in the triage teams that are in the community.

Vice Chair Pating asked how the program will be part of a continuum.

Dr. Epstein stated the Children Protection Center that is located in the basement of the general hospital, which is not a family- or child-friendly place, will move to the twenty-three-hour crisis service facility. Children that end up in the Child Protection Center because of crisis often also have psychiatric and behavioral crises. The foster care system funds some centralization of assessment and care, and will contribute to the triage center.

Dr. Epstein stated SFC does have a wide system, but it is often fragmented so it is not used most effectively. Instead of making quick and often reactive decisions to just find an open spot, by having this kind of centrality, SFC can be more thoughtful in assessments and placements about the best location to engage them that is most culturally reflective of their needs.

6. PRESENTATION: YOLO COUNTY TRIAGE GRANT PLAN OVERVIEW (NO ACTION)

Presenters:

Mark Bryan, Assistant Director, Yolo County Health Services

Karen Larsen, Yolo County Mental Health Director and AOD Administrator

Roberta Chambers, Psy.D., Senior Associate, Resource Development Associates

Yolo County was one of the counties that the Commission awarded a Triage Grant. Yolo County presented an overview of the grant proposal.

Dr. Chambers stated Yolo County is a mix of activity from agriculture, academia, and industrial employment, and has three very different population centers: U.C. Davis, Woodland, the county seat, and West Sacramento, which is predominantly rural.

Yolo County used the stakeholder process from the MHTA three-year plan development to inform the program design. Also, law enforcement and probation participated in the community program planning process, as there is a strong collaboration between law enforcement and the Yolo County Alcohol, Drug, and Mental Health Services Department.

The Needs Assessment Findings

There are few options to deal with psychiatric crises, which results in over-utilization of jails, hospitals, and emergency rooms.

There are no mobile services, which results in over-utilization of law enforcement.

There are no alternatives to hospitalization after hours, which results in over-utilization of hospitals and emergency rooms.

There are few opportunities for meaningful employment for people with lived experience.

The diversity and size of Yolo County makes accessing services challenging.

The Plan

To expand the number of mental health personnel available

To ensure that crisis services are available throughout the community

To ensure that there is a cost-effective recovery focus throughout the services

To ensure everyone is enrolled in care post-crisis to keep from cycling back into crisis

To build people with lived experience into the program design

The Design

Yolo County designed four mobile crisis teams made up of a clinician and a peer counselor: one for each of the three population centers, and one available in the western rural part of the county. The crisis clinician is co-located at each of the law enforcement agencies so they can immediately go out with law enforcement on crisis calls. The peer counselor will follow up the next business day to provide interim support, safety and potential self-care planning, and enrollment in ongoing care.

Yolo County studied the crisis call data from the law enforcement agencies and identified a period of forty hours with the highest volume of crisis calls. The clinician will work with law enforcement five days a week from three-thirty until midnight, and will be on-call when the mobile crisis is unavailable. The peer counselors will be available when the mobile crisis is open, since part of their job is to link people with ongoing care.

The target population is any Yolo County resident who comes in contact with law enforcement during a psychiatric crisis. Based on the data, Yolo County anticipates 2,250 individuals per year, although some of those may be repeats.

Yolo County is committed to developing fast-track appointments, so the crisis clinician will have access to the patient's scheduling and can schedule an appointment for that person before they leave. If they are not able to come up with a safety plan and stay where they are, the clinician will

have direct access to the hospital and the crisis residential. The peer counselor will provide short-term case management and connect them to recovery supports to continue the self-care planning process.

The Unique Program Elements

Mobile access to Avatar, the electronic health record, so that the crisis clinicians can schedule appointments in place and do real-time charting and documentation.

Weekly meetings, alternating between all-staff group supervision, and clinical staff and peer counseling staff meeting separately for their own case conferences.

The Logic Model

Decreased utilization of emergency rooms, hospitals, and jails following crisis events

Decreased per-person cost as a result of increased utilization outpatient services and alternatives to high-cost emergency services

Reduction in the repetitive use of emergency rooms, hospitals, and jails

Increased use of alternatives to hospitalizations

Increased participation in regular ongoing service

Improved collaboration across the systems

Commissioner Questions and Discussion:

Chair Van Horn asked if Yolo County has a history on the number of duplicated calls, and why the mobile crisis team does not work on Thursday.

Mr. Bryan stated the crisis response data comes directly from law enforcement and did not identify individual clients. With the mobile crises teams in the field, Yolo County will be able to track that and report back on the repeat numbers. The data from law enforcement showed that Thursdays and Sundays had much fewer crisis calls.

Commissioner Boyd asked if they included the data from suicide prevention and if that data matched the data of law enforcement. He recommended CommuniCare as another possible partner in this work.

Mr. Bryan stated suicide prevention was part of the stakeholder process, but Yolo County did not pull their crisis line data. There are links with them and Yolo County helps fund their suicide prevention line.

Commissioner Gordon asked if the calls are evenly spaced across the population centers.

Mr. Bryan stated the highest volume of calls is from Woodland and West Sacramento, then Winters and Esparto in the rural corridor.

Commissioner Boyd suggested measuring the length of stay in the emergency department for individuals that were provided crisis support yet still went into the emergency department. He stated the patient should stabilize more quickly to reduce the length of stay in the emergency department if Yolo County is providing effective stabilization resources at the front end of the encounter.

Chair Van Horn encouraged Yolo County to sit down with Commissioner Buck, one of the principle providers of Yolo County, and Dave Palan and Rusty Selix, who are developing an outcome structure for Avatar, to ensure that the needed outcomes tell the story of what is happening in the transformation of mental health services in California as Avatar is developed and refined.

Mr. Bryan stated his appreciation for any assistance they could give.

Commissioner Brown asked what the clinician does when they are not on a crisis call.

Mr. Bryan stated it has yet to be determined, but will be different jurisdiction to jurisdiction.

Commissioner Brown asked if law enforcement writes the 5150s, and if it will continue with this program.

Mr. Bryan stated law enforcement currently initiates a 5150 in the field, and then transports the person to the ER, where the ER staff take over. The goal is that the crisis clinician will write the 5150s, which will result in higher-quality holds, as they will be based upon clinical expertise and will benefit hospitals in knowing exactly what is happening in the field.

Commissioner Brown asked if someone will be on-call after hours or if it will revert to the existing system.

Mr. Bryan stated the community-based crisis response team and the contractor that handles afterhours calls will be on call.

Public Comment:

Nicki King, from the Yolo County Local Mental Health Board in Yolo County and part of the CRDP, stated her excitement for the program that is both mobile and for crisis outside of normal working hours.

Mr. Gilmer asked for clarification relative to the distribution of racial, ethnic, and cultural target populations in the last two presentations. He stated he appreciated including peers as community workers, as they have excellent street knowledge and can be important in a crisis team. He stated his hope that peer workers will also work after hours when most crises occur.

7. PRESENTATION: SACRAMENTO COUNTY RESPITE CARE SERVICES UNDER MENTAL HEALTH SERVICES ACT (NO ACTION)

Presenters:

Ebony Chambers, Co-Chair, Respite Partnership Collaborative

Myel Jenkins, Program Officer, Sierra Health Foundation: Center for Health Program Management

Jane Ann LeBlanc, MHSA Program Manager, Sacramento County Department of Health and Human Services

Ms. Chambers stated the Community Innovation Work Group met in 2010 to address mental health needs in the community and the need for alternatives to hospitalizations and emergency rooms for psychiatric crises, and the twenty-two-member Respite Partnership Collaborative (RPC) was formed.

The Components

A public and private partnership between Sierra Health Foundation and the Department of Behavioral Health Services

A community-driven approach including a diverse group of stakeholders

A continuum of respite services to address mental health crisis

The Definition of Respite

To serve individuals at-risk of or in the midst of a psychiatric crisis

To serve as an alternative to emergency departments and psychiatric hospitalizations

To be a short-term, limited break in a safe environment that provided time to stabilize.

The Innovation

Ms. LeBlanc stated, while addressing crisis and implementing respite services is important, respite services are not an innovative approach. The innovation comes through testing a new approach to delivering respite services through the public/private partnership as well as the RPC in the community-driven process.

Grant awards for respite services of \$5 million are being distributed in three funding rounds through 2015. The RPC has released funding in rounds one and two with seven respite services, ranging

from planned to crisis respite. The RPC is working with Sacramento County and the Center for Health Program Management, as the administrative entity, to elevate mental health respite as a critical component in the continuum of care.

The Community Engagement Model

Community stakeholders are actively engaged in the decision-making on project components. They defined respite for the purpose of this project, and they determine the funding mechanism for the respite services, the criteria used, and the programs awarded. RPC members, especially those with lived experience, feel valued and strongly support the work of the collaborative.

The Plan

To promote a framework and a definition of mental health respite as an alternative to emergency department visits and psychiatric hospitalizations

To value respite services as an important component within the continuum of behavioral health services

To test the effectiveness of this new approach that brings together the public/private partnership and the community collaborative to fund and implement these new mental health respite services.

She noted Sacramento County did not have mental health respite services before this project was implemented.

The Model

The RPC is developing a model, where they collaborate with partners to determine what the services should be and who should be funded and review the evaluation data to improve the effectiveness of the approach and the service delivery for the respite services. The evaluation looks at the approach and what is being tested, the effect, and the impact of services on those who receive mental health respite through the project. This connects the RPC to the larger policy opportunities that exist at the local, regional, and state level.

The Implementation

Ms. Jenkins stated one of the strategies of implementation was establishing a continuum of respite services in Sacramento County by releasing grant awards to seven community-based organizations. The seven organizations use different respite services to provide respite to five populations identified by the Community Innovation Work Group during the community planning process of the innovation plan.

The five populations are children with complex mental health needs in crisis, specialized cultural or ethnic populations, adults/older adults in crisis who have dependent children, adults/older adults in crisis, and teens/transition-age youth in crisis. Turning Point Community Programs and Transitional Living Community Support provide respite services twenty-four/seven.

The Community Impact

In the first round of funding, Capital Adoptive Families Alliance, United Lu-Mien Community, Turning Point, and Del Oro provided services to five hundred unduplicated clients in the first six months in 2013.

The Structure

The core of the RPC project is the partnership between Sacramento County Division of Behavioral Health Services, Sierra Health Foundation: Center for Health Program Management, and the RPC. Four subcommittees, grantees, and public agencies make recommendations to the RPC.

The Learning Innovation Component

Mental health respite is valuable, should be built into a continuum of services, and should influence policy.

A continuum of respite services with multiple approaches to mental health respite produces new approaches of service implementation.

A community-driven collaborative provides the opportunity to share community engagement information.

The Challenges

One-time innovation funding

Shaping public perception of mental health respite

Bridging cultural definitions of respite

The Policy Opportunities

Sacramento County acknowledges there are already policy initiatives and projects in place that are aligned with the RPC's direction that can be bridged to, such as: regionally, Communities Creating Solutions, Building Capacity in Communities of Color, and the Sacramento County MHSA - Mental Illness: It is Not Always What you Think; and statewide, Mental Health Parity in Medi-Cal Expansion, Investment in Mental Health Wellness Act of 2013, and the MHSA and California Mental Health Services Authority Statewide Anti-Stigma Campaign.

Commissioner Questions and Discussion:

Vice Chair Pating asked if there are other large collaboratives in the state, and if Sacramento County looked at public and private partnerships as sources of sustainable funding.

Ms. Leblanc stated it has not, specifically around respite services. Sacramento County looked closely at Sierra Health Foundation, which has links to other philanthropic organizations, and continues to look for other opportunities for mental health respite to become part of a larger continuum of crisis services in Sacramento.

Vice Chair Pating encouraged Sacramento County to look for ways to make respite a billable service; it would be valuable and add to sustainability. He asked Commissioner Buck what he has found.

Commissioner Buck thanked Sacramento County for selecting his agency in the first round to provide residential respite services. He stated his organization learned that, since the money did not come through Sacramento County but through the RPC, offsite treatment services are excluded from being able to bill for Medi-Cal services. It is MHSA dollars, but the RPC is the administrator of the contractor.

Commissioner Aslami-Tamplen asked who the community stakeholders are and how many peers are involved in staffing and in supporting this effort in the seven contracts that have been awarded.

Ms. Chambers stated there are a large number of consumers, peers, and family members who are also reaching out to cultural communities to be represented and be a part of the RPC.

Ms. Jenkins added that the seven funded respite services each have a different approach. Turning Point is a home that provides respite up to five days. TLCS is a crisis respite center that provides respite for up to twenty-three hours. The on-site Children's Receiving Home provides respite for teens and transition-age youth. The on-site Saint John's Shelter Program for Women and Children provides respite for up to fourteen days. Capital Adoptive Families Alliance and United Lu-Mien Community provide respite off-site.

Vice Chair Pating stated Sacramento has had one of the higher hospitalization rates per capita in the state. The Yolo County program and the Sacramento respite programs starting up in this scenario is heartwarming, because it is MHSA dollars in action serving real needs and meeting real problems.

8. PRESENTATION: CALIFORNIA MILITARY DEPARTMENT USE OF MENTAL HEALTH SERVICE ACT FUNDS (NO ACTION)

Presenters:

Lieutenant Colonel Susan Pangelinan, California National Guard Behavioral Health Agency Coordinator

Captain Dustin Harris, California National Guard Behavioral Health Operations Officer

The National Guard Behavioral Health Office (BHO) is funded by MHSAs administrative funds, and provides education, outreach, support, and referral more than clinical treatment.

Captain Harris manages the seven MHSAs-funded field providers, who are licensed clinical social workers, assigned to regional areas of California to provide twenty-four/seven coverage and response capability for behavioral health concerns for the sixteen to twenty thousand National Guardsmen and their families. The regional areas are separated by the density of Guardsmen in a particular region of California. For example, there is one behavioral health officer assigned to the Los Angeles Area, one who is assigned to the area below Los Angeles to the Mexico border, and one who is assigned from above San Francisco to the Oregon border.

Lieutenant Colonel Pangelinan gave the analogy that the services the BHO provides are similar to that of an EMT. They go to the crisis and stabilize, then ensure the soldier follows through with case management that is part of the California National Guard structure, who continues follow-up with the soldier until the situation is resolved or in stable treatment. The BHO responds to the soldier concern.

Executive Director Jackson asked for clarification on “a soldier concern,” and how the BHO is notified.

Lieutenant Colonel Pangelinan stated “a soldier concern” is a soldier who may be in distress. All crises, known as a Serious Incident Report, are funneled through the Joint Operations Center. Any soldier, airman, or family member who has an issue or concern or is in distress can contact the Operations Center and Captain Harris’s providers will respond twenty-four/seven to provide support, referrals, and resources.

The seven providers visit the armories within their assigned region, veteran’s services organizations, and private and public behavioral health treatment areas, and they participate in community collaboratives to learn about that region and become better informed of available resources for referral. They participate in milestone events to be available to provide support, resources, clinical prevention, and education. They receive calls from commanders, supervisors, and peers who are concerned about a soldier that they notice is having an issue. They also conduct awareness campaigns and partner with the Chaplain Corps for the spiritual connection.

The 2013 expansion brought a profound change in the numbers of individuals and follow-ups that Captain Harris and his seven junior providers serviced. In 2013, Captain Harris’s team saw 7,475 soldiers in the behavioral health department, and 969 of them required a referral, not just resource materials.

Lieutenant Colonel Pangelinan stated her excitement about the direction of the outreach, that BHO can reach more soldiers, and that they can now go out in front of the problem.

Commissioner Questions and Discussion:

Executive Director Jackson asked how many counties they are in, and how many licensed clinical social workers are on the team.

Lieutenant Colonel Pangelinan stated they are in all fifty-eight counties, and there are six licensed clinical social workers throughout the seven regions.

Commissioner Boyd commended BHO for having a statewide presence, and with only seven providers. He asked how they manage access to treatment issues and how they track it.

Lieutenant Colonel Pangelinan stated that Guardsmen only have military health care benefits when they are drilling, which is maybe two days per month.

Captain Harris stated it is not a resource problem in the military, but a linkage problem. He stated doing more outreach and researching the area to find the available resources and linkages is important, because the resources are out there for troops. It is linking them to those resources that can be the difficult part.

Chair Van Horn asked for clarification on the augmentation authorized by the Legislature out of MHSA administrative funds.

Lieutenant Colonel Pangelinan stated it went from \$561,000 to \$1.5 million, so they were able go from three funded people to seven.

Chair Van Horn stated there have been many issues with the military receiving service, particularly the National Guard, who were deployed and came home to no services.

Lieutenant Colonel Pangelinan agreed and stated it takes one to three years for a problem to emerge. That first year, there tends not to be an issue. Guardsmen are no longer eligible for federal support after the six months upon return. If an issue comes up a year or two later, the soldier does not tend to link it to their combat service. Because Captain Harris's team is reaching out and intervening, there will not be as many soldiers in emergency rooms and sheriff's departments. They can stay ahead of the crisis, and the counties will save money.

Lieutenant Colonel Pangelinan stated prevention is important. The National Guard has had a number of suicides every year for the past seven years. Each of those numbers is a person, and a family and community are impacted. She stated she and Captain Harris are profoundly grateful to get this kind of support from the state of California to help get services to soldiers and airmen in the National Guard.

9. COMMISSIONER COMMENTS

Chair Van Horn stated there will be a forum discussion on older children and adolescents in May. He asked staff to prepare potential next steps for the Commission in relation to young children and mental health, and guidance on the actions to encourage more innovation grants that begin to look at early childhood mental health.

The Commission receives questions and comments about things the Commission has no control over or no relationship to but are of interest to stakeholders. He encouraged Commissioners to consider the issues that are raised which may not be under the Commission's purview as California moves into health reform.

The Commission looked at transformation in terms of the children's system this morning. Chair Van Horn stated the Commission also needs to look at transformation in terms of the adult system. This morning was about tiers of service; the more started at the lowest tier, the less to do in the upper tiers. Rusty Selix made a promise about ten years ago that, within a generation, instead of eighty percent of the money being spent on high-end services, eighty percent of the money would be spent on PEI, because the need for high-end services would have been solved as PEI is increased. That promise may lie just a generation ahead, but the Commission needs to begin looking at FSPs, which has been one of the discussions in the CMHDA in terms of looking at what defines full service.

Full service can be a variety of things, because there are many people who no longer need a FSP. They have recovered to a level where the service demands are much lower, but the much lower service demands are still for them full service. The Commission needs to look toward the redefinition of full service. The CMHDA has provided a four-level version of this, the first level being peer delivered services up to the most intensive, with Level 5 being hospitalization.

The additional people qualifying for the expanded Medi-Cal in California will dramatically impact how to look at lower-level services, because most of those people will need something different from the old FSP. Counties are interpreting this very differently, but there needs to be a standard that operates across the state.

Commissioner Buck stated his concern about the accountable care organizations that approach behavioral health organizations asking for agreements, only asking because they are required to have agreements, and then offering low rates of reimbursement. Commissioner Buck stated he has engaged in no contracts. The accountable care organizations also expect him to hire staff and wait because they do not know the number of referrals to expect. He stated his worry that there will be such barriers to behavioral health created that people will not avail themselves of it. The longer they go untreated, the more difficult it is to get control.

Chair Van Horn agreed that this is a real problem and one the Commission must look at, because the demand is going to change radically.

10. GENERAL PUBLIC COMMENT

Patricia Baxted, of the Wellness and Recovery Center - North, hoped to see an investment in consumers' hopes and dreams via a collaborative effort of increased volunteerism channeled through the Wellness and Recovery Centers in Sacramento County, such as a volunteer center within the Wellness Centers for both the north and the south under the already-successful and cost-effective consumer self-help model. Having its staff solely to coordinate volunteer activities and provide related coaching and volunteer readiness support could model to consumers that achieving one's hopes and dreams through meaningful activity is possible when working synergistically and innovatively together.

Ms. Baxted stated the need for appropriate designated processes and staff in place to help draw out members' skill, talents, and meaningful engagement abilities. By putting these assets to work, members can continue to make meaningful contributions.

Commissioner Buck stated he admires the Wellness and Recovery Centers and Meghan Stanton, the CEO. He suggested Ms. Baxted go through the local MHSA funding process, as they are now establishing committees.

Chair Van Horn added that another contact would be the Project Return Peer Support Network in Los Angeles, which has a budget of about \$2.5 million dollars a year.

Laurel Benhamida, Ph.D., of REMHDCO, the Reducing Mental Health Disparities Coalition Steering Committee, and the Vice President of the Muslim American Society - Social Services Foundation, stated requiring respondents of RFPs to focus on groups that experience disparities in life expectancy, mental health, and wellness because of the environment of society is better than performing evaluations afterwards. These communities have been waiting a long time for services. She gave two examples in which the interaction of mental health and the criminal justice system have resulted in a short life expectancy. She gave two other examples where new trauma and fear was caused on the behalf of individuals who would like to walk in public spaces.

Stacie Hiramoto, Director of REMHDCO, stated she was lucky enough to be with Commissioner Buck and others in the original presentation that the military gave and was impressed with what the National Guard is accomplishing. They comfortably answered her questions on cultural competence. She stated she was unsure from the other presentations how they are addressing reducing disparities, or who they are serving. She requested that the Commission ask their presenters to address how they are reducing disparities, some demographics about the area they serve, who they serve, and how they served underserved communities. She suggested providing the presenters with a form of things to remember.

Mr. Gilmer stated Dr. Benhamida's testimony brought tears to his eyes because of the racial profiling and other things that happen in everyday life with her population. He stated he sometimes feels he

comes before the Commission saying the same things over and over again. He stated the need to work closer together and be represented around the table. He has asked the Commission to bring CMMC and REMHDCO in on the front end, because these issues are very deep. He stated the military presentation was outstanding and recommended a racial and ethnic program called Vet to Vet, a peer-based model, who will accept anyone with prior military experience. He urged the Commission to use their policy and legislative strength to support the veterans in the community and the National Guard.

Helena Liber, of the Client Stakeholder Project and the Pool of Consumer Champions, asked if the Sacramento County program employed peer workers in those programs. She asked for more information on the Yolo County respite programs.

Commissioner Buck offered to send her information on each of the programs.

Ms. Liber stated she was glad to have the military program, but questioned the use of MHSA funds.

Chair Van Horn stated the extra money that was given to the military department was directed by the Legislature, responding to specific needs in the National Guard, as the National Guard does not qualify for VA benefits. The funds came out of administrative funds, which do not go to the counties for direct services.

Sally Zinman, the Program Director of the Client Stakeholder Project and the California Association of Mental Health Peer-Run Organizations (CAMPHRO), clarified on behalf of all the consumer-run programs in the state that Meghan Stanton is the executive director, and is an officer in CAMPHRO.

11. ADJOURN IN-PERSON MEETING

There being no further business, the meeting was adjourned at 4:10 p.m.