ALAMEDA COUNTY
HEALTH CARE SERVICES
AGENCY
COLLEEN CHAWLA, Director

AGENDA _____ July 24, 2018

ADMINISTRATION & INDIGENT HEALTH
1000 San Leandro Boulevard, Suite 300
San Leandro, CA 94577
TEL: (510) 618-3452
FAX: (510) 351-1367

July 6, 2018

The Honorable Board of Supervisors
Administration Building
1221 Oak Street
Oakland, CA 94612

Dear Board Members:

SUBJECT: ADOPT THE ALAMEDA COUNTY BEHAVIORAL HEALTH CARE SERVICES MENTAL HEALTH SERVICES ACT AB 114 PLAN FOR FISCAL YEARS 2017-18 THROUGH 2019-20 AND THE MENTAL HEALTH SERVICES ACT INNOVATION PLAN FOR FISCAL YEARS 2018-19 THROUGH 2022-23

RECOMMENDATIONS

A. Adopt the Mental Health Services Act AB 114 Plan for Fiscal Years 2017-18 through 2019-20;

B. Adopt the Mental Health Services Act Innovation Plan for Fiscal Years 2018-19 through 2022-23; and

C. Authorize the Alameda County Mental Health Director and the Auditor Controller to certify the AB 114 plan and the Innovation plan in accordance with Welfare & Institutions Code Section 5847.

SUMMARY

Board adoption of the Mental Health Services Act (MHSA) AB 114 Plan and Innovation Plan is necessary in order for Alameda County Behavioral Health Care Services (BHCS) to submit the Plan to the Mental Health Services Oversight & Accountability Commission (MHSOAC) within 30 days after the Board of Supervisors' adoption. Your recommendation and approval of both Plans will allow for fiscal appropriation and spending through Fiscal Year 2019-2020 for the AB 114 funds and Fiscal Year 2022-23 for the MHSA Innovation funds. Non approval of these Plans will significantly increase the risk for reversion of these funds to the California Department of Health Care Services. Both Plans must be certified by the designated Mental Health Director and the Auditor-Controller of Alameda County, to meet specified MHSA requirements in accordance with Welfare & Institutions Code Section 5847, attesting that:

- Alameda County has complied with any fiscal accountability requirements as directed by the Department of Health Care Services (DHCS);
- All expenditures are consistent with the MHSA requirements; and
- County mental health department prepared and circulated a draft AB 114 Plan and a draft Innovation Plan for review and comment for at least 30 days to representatives of stakeholder interests or interested parties.

Both the AB 114 Plan for Fiscal Years 2017-18 through 2019-20 and the Innovation Plan for Fiscal Years 2018-19 through 2022-23 meet those requirements. The AB 114 Plan provides an overview of MHSA funds that were deemed reverted

and reallocated to the county of origin, per Assembly Bill 114, and how those funds will be spent. The Innovation Plan provides a programmatic and fiscal overview of four new Innovation (INN) projects that will be implemented if approved by the MHSOAC. The Innovation Plan is tied to the AB 114 Plan in that the Innovation funds that are listed in the AB 114 Plan will be used to fund the first two years of the four new Innovation projects.

DISCUSSION

AB 1467-Omnibus Health Trailer Bill for Fiscal Year 2012-13, chaptered into law on June 27, 2012, implemented changes to the MHSA law. AB 1467 requires each county mental health program to prepare and submit an Innovation Plan that is adopted by the Board of Supervisors and then submitted to the MHSOAC for final approval before project implementation can begin.

AB 114- Committee on Budget, Public health Trailer Bill for Fiscal Year 2017-18, chaptered into law on July 10, 2017, amended specific Welfare and Institutions Code (WIC) Sections related to the reversion of MHSA funds.

AB 114 implemented provisions concerning funds subject to reversion as of July 1, 2017. Funds subject to reversion as of July 1, 2017, were deemed to have been reverted and reallocated to the county of origin for the purposes for which they were originally allocated (WIC Section 5892.1 (a)). Funds that could be subject to reversion as of July 1, 2017, were distributed to counties from Fiscal Year (FY) 2005-06 through FY 2014-15. By July 1, 2018, the California Department of Health Care Services (DHCS) is required to prepare a report to the Legislature identifying the amounts of funds subject to reversion by county. Prior to releasing the report, DHCS is required to provide each county with the amount DHCS determined is subject to reversion and a process for counties to appeal that determination (WIC Section 5892.1 (b)). Additionally, by July 1, 2018, counties are required to have a plan to spend those funds by July 1, 2020 (WIC Section 5892.1 (c)). Pursuant to WIC Section 5892.1 (e), DHCS has provided counties with Information Notice 17-059 to implement these requirements.

Information Notice 17-059 requires that each county must develop a plan to spend its reallocated funds and post it to the county's website for a 30 day public comment period. Each county's Board of Supervisors (BOS) must adopt a final plan within 90 days of the county posting the plan to the county's website. Each county must submit its final plan to DHCS and the MHSOAC within 30 days of adoption by the county's BOS.

On April 13, 2018, BHCS posted both the AB 114 Plan and the Innovation Plan on its web site for 30 days for public comments. The Mental Health Board hosted a public hearing on May 14, 2018, at which time BHCS addressed public questions and concerns. BHCS presented both the AB 114 Plan and the Innovation Plan to the Alameda County Board of Supervisors Health Committee at its public meeting on June 25, 2018, and the Health Committee recommended that both the AB 114 and Innovation Plan go to the full Board for adoption.

The AB 114 Plan documents how reverted funds will be spent in the areas of Workforce Education and Training, Innovation and Capital Facilities and Technology. Updates to the spending of these funds will be described in the MHSA FY 2018-19 Plan Update.

The Innovation Plan documents the development of four new Innovation projects that BHCS hopes to implement once approved by the MHSOAC. A summary of each of the four new projects is listed below:

INN Project 1: Community Assessment & Transport Team (CATT)

The CATT project will promote interagency collaboration among core Alameda County Health Care Services Agency programs - Behavioral Health Care Services, Emergency Medical Services, and Alameda Care Connect (Whole Person Care) – as well as other partners – 911 dispatch, the County Sherriff's Office, city police departments, city health and human services, and other relevant service - to develop a highly responsive and efficient mobile psychiatric crisis response system.

This collaboration will develop, implement, support and evaluate changes to the crisis system in order to achieve the desired outcomes. Two core changes that will be implemented are:

1) A mobile crisis team comprised of a behavioral health provider and an Emergency Medical Technician (EMT) in a non-emergency vehicle. This staffing model enables assessment and transport for a broad range of dispositions (PES, CSU, sobering center, emergency departments, etc.)
2) Technical support that provides the greatest capacity for the team. This includes:
    - ReddiNet: A web-based emergency communications system. Alameda has been using it since 2008 to track hourly bed availability for emergency departments and during multi-casualty incidents. The collaboration will work with ReddiNet to expand the system to include beds, appointments and slots in crisis stabilization units, crisis residential sites, sobering/detox centers, and other behavioral health services, as well as alerting providers when the psychiatric emergency services is on diversion.
    - Video translation services: A program to provide a translator on screen.
    - Shared client records: In 2019, BHCS clinicians will have access to Community Health Records through Alameda's Care Connect (Whole Person Care), including physical and mental health history and information about providers engaged with client, as well as allowing them to add the current episode to the shared records.

INN Project 2: Cannabis Policy and Education for Young Adults

The purpose of this project is to reduce the risks and harms associated with cannabis access and use for young adults (21-24 years old) experiencing serious mental illness. This project will build on existing public health and harm reduction approaches that are not specific to mental health clients and do not fully leverage the role that the cannabis industry can play. This project provides an opportunity to test new approaches, in a changing landscape, before adopting them as ongoing practices. BHCS proposes to accomplish this through collaboration:

Policy Committee including behavioral health, physical health, law enforcement, schools, the cannabis industry, and others. This committee will focus on determining effective practices and policies among these institutions given the complex legal status of cannabis. Actions may include getting a full understanding of the legal considerations; developing guidelines for educating individual with serious mental illness about cannabis usage; developing education and guidelines for the cannabis industry, such as a component for a "Responsible Vendor" training that addresses mental health issues and considerations.

Consumer and Family Committee including family members, consumers, and behavioral health providers. This committee will focus on developing an educational campaign informed by both consumers and the Policy Committee. Strategies to be considered may include peer education and technology-based education. In addition, mental health providers' knowledge and skills will be increased through consultation with experts, trainings, toolkits, etc.

INN Project 3: Emotional Emancipation Circles for Young Adults

BHCS worked with African American young adults to pilot Emotional Emancipation Circles (EEC) to address the needs they identified. EECs are a community-defined practice developed by the Community Healing Network (CHN) and Association of Black Psychologists (ABPsi). The participants felt the EECs were valuable but needed to be tailored to better engage young adults. This project will:

- Work with young adult EEC facilitators to conduct outreach, tailor them to young adult needs, and provide 6 EEC series,
- Conduct evaluations of each series to contribute to tailoring of the model.

The learnings from this project will help counties address common challenges regarding serving the African American young adults by providing data on whether EECs improve mental health and functioning and by providing a version of EECs that is well-adapted for young adults. The learnings will be shared with behavioral health divisions throughout the state, as well as through the CHN and ABPsi networks.

INN Project 4: Introducing Neuroplasticity to Mental Health Services for Children

This Innovation project aims to provide neurodevelopmental interventions for youth experiencing moderate and serious mental health issues in an accessible manner. Trained HANDLE® (Holistic Approach to Neuro-Development and Learning Efficiency) instructors provide training for clinical and non-clinical providers in unique assessment procedures and specific interventions. In addition, this project would evaluate the impact on mental health symptoms. This project proposes to:

- Train school and BHCS staff in the HANDLE model,
- Have school staff refer students (K-5) exhibiting emotional/behavioral symptoms,
- Conduct eligibility screening, gain parent permission,
- Assess students, including a neurodevelopment assessment, in order to develop an intervention plan and
- Provide 4-6 months of services each day in school by trained HANDLE practitioners.

Integrating neurodevelopmental assessments and interventions into mental health services is a significant change to existing practice that may lead to improved outcomes for youth experiencing a wide variety of mental health issues. Alameda County aims to learn: *Can neurodevelopmental interventions provided in a non-clinical setting for youth with emotional and behavioral disorders reduce their symptoms and improve their functioning?*

FINANCING

The adoption of the plans will have no impact on net County cost.

Very truly yours,

Colleen Chawla, Director
Health Care Services Agency

CC:TH:dh

Attachments:
Mental Health Services Act (MHSA) Three-Year Program and Expenditure Plan, with Certificate
MHSA Innovation Plan, with Certificate

MENTAL HEALTH SERVICES ACT

ALAMEDA COUNTY

FY 2018 - 2020

AB 114 REVERSION PLAN

Public Comment Period:

April 13, 2018-May 13, 2018

Introduction and Overview

On December 28, 2017 Alameda County Behavioral Health Care Services (BHCS) received Information Notice (IN) 17-059 from the California Department of Health Care Services (DHCS) Mental Health & Substance Use Disorders Services (MHSUDS). The purpose of Information Notice 17-059 was to inform counties of the following:

• The process the Department of Health Care Services (DHCS) will use to determine the amount of unspent Mental Health Services Act (MHSA) funds subject to reversion as of July 1, 2017;

• The appeal process available to a county regarding that determination; and

• The requirement that by July 1, 2018, each county must prepare and publicly post a plan for MHSA funding subject to reversion from Fiscal Years 2005-06 through 2014-15.

Background and Local Impact for IN 17-059

Assembly Bill (AB) 114 (Chapter 38, Statutes of 2017) became effective July 10, 2017. The bill amended certain Welfare and Institutions Code (WIC) Sections related to the reversion of MHSA funds. AB 114 implemented provisions concerning funds subject to reversion as of July 1, 2017. Funds subject to reversion as of July 1, 2017, were deemed to have been reverted and reallocated to the county of origin for the purposes for which they were originally allocated (WIC Section 5892.1 (a)). Funds that could be subject to reversion as of July 1, 2017, were distributed to counties from Fiscal Year (FY) 2005-06 through FY 2014-15.

Spending Plan for Funding subject to AB 114

Pursuant to AB 114 (Chapter 38, Statues of 2017) and the Department of Health Care Services Information Notice 17-059, each County must prepare and publically post a plan for MHSA funding subject to reversion from Fiscal Years 2005-06 through 2014-15.

As of April 5, 2018 Alameda County, in conjunction with the California Department of Health Care Services, has identified the following funds that were subject to reversion as of July 1, 2017.

Component	Fund Amounts	From Fiscal Year
Workforce Development and Training (WET)	1,571,685	FY 06/07
Innovation (INN)	5,013,354	FY 08/09 FY 09/10 FY 10/11
Capital Facilities and Technology (CFTN)	7,530,171	FY 07/08

It should be noted that no Community Services and Supports (CSS) or Prevention Early Intervention (PEI) funds are included in this calculation or at risk for reversion.

The following is a plan to spend the deemed reverted funds by June 30, 2020.

Workforce Education and Training (WET)

The reverted funds under Workforce Education and Training will be applied to FY 17/18 as listed in Alameda's MHSA FY 18-20 Three Year Plan which can be found at www.ACMHSA.org under Documents/MHSA Plans.

Funding specifics include:

1. Workforce Staffing Support: $490,240

Program Description: Provides infrastructure to manage the development, implementation and evaluation of all Workforce Education and Training (WET) programs and initiatives. Spearheads partnerships with community-based organizations, peer-run agencies, educational institutions and local, regional and state agencies.

2. Consumer & Family Training, Education and Employment: $480,929

Program Description: Offers an integrated, coordinated approach to consumer and family member employment and supports consumer and family employees at all stages of the employment process, from recruitment to retention. The goal is to develop and retain authentic consumer and family member voices in leadership roles as we develop new wellness, recovery and resiliency practices across the system.

3. Training Institute: $135,844

Program Description: Provides a coordinated, consistent approach to training and staff development. Develops, researches and provides a broad array of training related to mental health practice; wellness, recovery and resiliency; peer employment and supports and management development.

4. Internship Program: $1,000

Program Description: Coordinates academic internship programs across the ACBHCS workforce. Meets with educational institutions to publicize internship opportunities and provides training to interns.

5. Educational Pathways: $99,172

Program Description: Develops a mental health career pipeline strategy in community colleges, which serve as an academic entry point for consumers, family members, ethnically and culturally diverse students, and individuals interested in human services education, and can lead to employment in the ACBHCS workforce.

6. Financial Incentives Program: $364,500

Program Description: Offer financial incentives as workforce recruitment and retention strategies, and to increase workforce diversity. Financial Incentives are offered to individuals employed in ACBHCS and to graduate interns placed in ACBHCS and contracted community-based organizations, and who are linguistically and or culturally able to serve the underserved and unserved populations of the County.

Innovation

Innovative Programs are intended to provide mental health systems with an opportunity to learn from innovative approaches. Innovation Programs are not designed to support existing or ongoing programs or services, but rather to provide the mental health system with innovative demonstration projects that will support system change in order to increase access to services and improve client/ consumer outcomes.

Alameda County has developed four new Innovation projects based on community input received during its recent Community Planning Process (CPP) which is documented in Alameda's MHSA FY 18-20 Three Year Plan at www.ACMHSA.org under Documents/MHSA Plans. Summary details on the CPP are listed below.

Alameda's CPP for the MHSA FY 18-19 Three Year Plan was conducted from June – October 2017. During that process BHCS staff provided updates and information on current MHSA programs and community members provided input on mental health needs and services, including new Innovation ideas, activities and programming. There were three modes for providing input:

- Five large community forums (one in each Supervisorial District);
- Eighteen community focus groups: Chinese speaking family members, African American family members, providers for refugees, providers for LGBTQ community, transitional age youth (2 focus groups), Afghan immigrants, older adults, API and refugee providers and advocates, providers for individuals with developmental disabilities and mental illness, and the Pool of Consumer Champions (Alameda County's mental health consumer leadership group), and
- Community Input Surveys in all threshold languages: submitted by 550 unique individuals. Respondents were very diverse in age, race, and ethnicity. Survey respondents included: mental health consumers (25%), family members (17%), community members (15%), education (2%), community mental health (14%), homeless/housing services (6%), county behavioral health (1%), faith-based (2%), community substance use services (1%), hospital/healthcare (4%), law enforcement (1%), NAMI (1%), veteran/veteran services (1%), other community services (5%), other/decline to state (9%).

The proposed Innovation programs have been vetted by BHCS and are based on the recent CPP process where the following themes emerged as areas for Alameda to provide increased attention and innovation:

- Community Violence and Trauma;
- The need for increased and alternative Crisis Services;
- Substance Use among the SMI and SED population, and
- Underserved communtities.

Below is a summary of the four new Innovation projects as well as the final 18-month grant round from Alameda's approved Innovative Grant Program that will focus on increasing engagement in mental health services for the API and Refugee communities.

Information on this final grant round is also listed in Alameda's MHSA FY 18-20 Three Year Plan at www.ACMHSA.org under Documents/MHSA Plans. Please see the new Alameda County INN Plan FY 2019-2023 at http://www.acbhcs.org/mhsa-doc-center/ or at www.ACMHSA.org for details on the four new Innovation projects. A summary of the four new Innovation projects is listed below.

Summary of New Innovation Projects

1. Community Assessment and Transport team (CATT) : $9,878,082 over five years (FY 18/19-22/23)

Many counties and cities struggle with developing a crisis response system that is efficient and effective – getting clients to the right services at the right time, without unnecessary use of first responder and client time, and in a respectful and non-stigmatizing manner. In Alameda, there have been a variety of efforts made to improve crisis response. But the impact has been limited – Alameda has the highest rate of 5150 holds in California, people who do not qualify for 5150 holds are not successfully linked to planned services and continue to over-use emergency services, and first responders spend many hours addressing behavioral health related 911 calls that would be better served in a different manner.

Alameda County proposes to test two primary strategies to improve the crisis response system:

- A collaboration among core Alameda County Health Care Services Agency programs - *Behavioral Health Care Services, Emergency Medical Services, and Alameda Care Connect (Whole Person Care)* – as well as other partners – *911 dispatch, the County Sheriff's Office, city police departments, city health and human services, and other relevant services* - to ensure the crisis response system is more agile and flexible.

- Combining a unique crisis transport staffing model with current technology supports to enable them to connect clients to a wider array of services in the moment.

This project is beyond adding a discrete service to a challenged system, it is a *test of concept for how to improve the system* through a collaborative approach and change in staffing models paired with technological support. If successful, it will contribute to increased efficiency for the emergency system, more appropriate services for the client, and a model that other counties can adopt or adapt to significantly improve their crisis response system.

Funds from FY 08/09, FY 09/10 and part of FY 10/11 will be applied to the first two fiscal years of operation through June 30, 2020.

2. Cannabis Policy and Education for Young Adults: budget $1,484,375 3years 3 months (FY 18/19- FY 21/22)

Legalization of cannabis and resulting increased access may lead to increased use and increased negative consequences among mental health consumers. The purpose of this project is to reduce the risks and harms associated with cannabis access and use for young adults (21-24 years old) experiencing serious mental illness.

The results of this process are expected to lead to:

- A model for working with the cannabis industry to develop and implement effective practices to support the health of mental health consumers
- A well informed and collaborative education/harm reduction campaign/learning tools/approaches regarding cannabis and young adult consumers given the current legal environment

Funds from FY 10/11 will be applied to the first two fiscal years of operation through June 30, 2020.

3. **Transitional Age Youth Emotional Emancipation Circles: $501,808 over 2.5 years (FY 18/19-FY 20/21)**

Emotional Emancipation Circles℠ (EEC) are support groups designed for African American people to "work together to overcome, heal from, and overturn the lies of White superiority and Black inferiority." This Innovation project will:

- Tailor the EEC model to specifically target the needs of African American young adults, while ensuring fidelity to the model, and

- Evaluate mental health and functional outcomes: The current EEC evaluation process focuses on participant satisfaction. By expanding the scope of the evaluation we can determine if young adults felt engaged and if it resulted in positive mental health and functional outcomes.

Funds from FY 10/11 will be applied to the first two fiscal years of operation through June 30, 2020.

4. **Introducing Neuroplasticity to Mental Health Services for Children: $2,054,534 over 4 years (FY18/19- 21/22)**

Many children with emotional and behavioral disorders have underlying neurodevelopmental differences that exacerbate the emotional and behavioral disorders. Finding a way to provide neurodevelopmental interventions, in addition to mental health interventions, should lead to better mental health and functional outcomes.

This Innovation proposal integrates a neurodevelopmental approach into mental health services to achieve better outcomes. Holistic Approach to Neuro-Development and Learning Efficiency (HANDLE®) is a practice based on brain research on neuroplasticity and the effect of stress responses on learning, mood and behavior. It includes an initial assessment to determine inefficiencies in the communication between the body and the brain leading to functional difficulties. Based on that assessment a treatment plan is developed that specifies interventions to address the neurodevelopmental weaknesses. HANDLE does not teach coping mechanisms, it improves brain function, which ultimately reduces or eliminates the underlying neurodevelopmental problems contributing to emotional and behavioral symptoms.

Funds from FY 10/11 will be applied to the first two fiscal years of operation through June 30, 2020.

Round Five Innovation Grant Project: $2,000,000 over two years (FY 18/19-19/20)

Program Name: (INN 5B) Improving Mental Health Services Utilization for Asian/Pacific Islanders (API) and Refugees

Program Description: The API population in Alameda County remains persistently underserved or mostly unserved. Specifically, API Medi-Cal beneficiaries and API with a Serious Mental Illness and/or Serious Emotional Disturbance continue to have the lowest rate of seeking mental health help and substance use disorder treatment. ACBHCS seeks to improve this situation and to help produce a strategic plan to move forward in serving and working with the API community.

Also please note Alameda will be working on additional Innovation projects and will utilize any remaining reverted INN funds on new Innovation projects approved by the MHSOAC as funds are available.

Capital Facilities and Technology

The reverted funds under Capital Facilities and Technology will be applied to FY 17/18-FY 19/20 as listed in Alameda's MHSA FY 18-20 Three Year Plan. Funding specifics include:

Capital Facilities Projects FY 17/18

Project Name: South County Homeless Project (SCHP), also known as the A Street Shelter: $690,913

Project Description: The South County Homeless Project (SCHP) emergency shelter provides 24 shelter beds for men and women with serious mental illness currently experiencing homelessness. The shelter operates out of a county-owned property located at 259 A Street in Hayward and has not received any significant maintenance or upgrade work since it was first used for this purpose in 1989.

At the request of BHCS with BHCS financing, the Alameda County General Services Agency (GSA) completed an assessment of the property and identified key areas in need of repairs including the Heating, Ventilation, and Air Conditioning (HVAC) systems, electrical, plumbing, fire safety and prevention systems, and other areas identified in their report. The proposed repairs can be completed within a 30-45 day period provided that the site can be entirely vacated for this time period.

Project Name: Villa Fairmont Renovation: $754,000

Project Description: This is a county-owned property on the Villa Fairmont campus at 15200 Foothill Blvd. in San Leandro. This building is utilized by the company Telecare, which operates a 97-bed licensed Mental Health Rehabilitation Center. It serves adults with a history of severe mental illness and repeated hospitalizations. The flooring within the Villa Fairmont building is in need of renovation as they have not received maintenance and repairs in many years.

Technology Projects FY 17/18

Program Name: MHSA Technology Project: $4,716,622

Program Description: Purchase, installation and maintenance of a new Behavioral Health Management Information System, to include: billing, managed care, e-prescribing functions, data interoperability and functions as needed to support clinical and fiscal operations of BHCS. Additional expenditures for the necessary support staff during the implementation process, and other projects that provide access to consumers and family members to their personal health information and other wellness and recovery supports. In addition, BHCS developed and has implemented Yellowfin (a BHCS dashboard of utilization data) to facilitate client data collection and outcome evaluation. The following is a detailed list of all activities under this project.

Technology Projects FY 17/18

Behavioral Health Management Systems	$1,056,897
Web-Based Dashboard	$97,000
Technical Assistance	$225,000
Electronic File Storage and Document Imaging	$42,256
Clinician's Gateway Interface	$424,340
County Equipment and Software Update	$1,300,000
CFTN Administration	$126,216

Technology Projects FY 18/19

Program Name: MHSA Technology Project: $3,085,180

Behavioral Health Management Systems	2,988,180
Web-Based Dashboard	97,000

Public Comment:

This Plan was posted for a 30-day public review and comment period from 4/13-5/13. A public hearing was held on May 14, 2018 at 2pm, 1100 San Leandro Blvd. San Leandro. No comments were recevied on this Plan during the 30 day public review and comment period.

REFRENCES

1. Welfare & Institutions Code 5829.1 -6(h)(1).
2. Department of Health Care Services Information Notice.: 17-059

All information in this Plan are true and correct.

James Wagner, LMFT/LPCC

Deputy Director of Alameda County Behavioral Health Care Services

4/13/18

WELLNESS • RECOVERY • RESILIENCE

MENTAL HEALTH SERVICES ACT

ALAMEDA COUNTY

FY 2019 - 2023 INNOVATION PLAN

Public Comment Period: April 13, 2018-May 13, 2018

Alameda County MHSA FY 19-23 Innovation Plan

Table of Contents

Executive Summary

In 2017 Alameda County Behavioral Health Care Services (BHCS) engaged in a Community Planning Process (CPP) to develop its Mental Health Services Act (MHSA) Three Year Program and Expenditure Plan for FY 2018-2020. During that process BHCS staff provided updates and information on current MHSA programs and community members provided input on mental health needs and services, including new Innovation ideas, activities and programming. The community was able to provide input in three ways: 1) verbal input at one of the five large community forums, 2) verbal input at one of the 18 smaller focus groups and/or 3) written input through the Community Input Survey which was translated into Mandarin, Cantonese, Spanish, Farsi, Vietnamese and Korean. Additionally, the members of the Pool of Consumer Champions (Alameda County's mental health consumer group) outreached to and engaged with community members, including individuals who were homeless, to provide input through the MHSA surveys.

From the CPP, BHCS was able to: identify current gaps and needs; increase our understanding of the community's view of underserved groups; and learn about potential areas of innovation. Based on all of the CPP data the BHCS Systems of Care identified possible Innovation projects that have been vetted by MHSA staff based on whether they addressed the community priorities as well as other external factors such as rates of crisis, substance use trends, etc. The four Innovation projects listed in this Plan cover the areas of:

- The need for increased and alternative Crisis Services;
- Substance Use among the SMI and SED,
- Underserved populations, and
- Community Violence and Trauma.

In the area of crisis, the community was very vocal about wanting alternative crisis services developed that assisted people in crisis who met, as well as did not meet, the mental health criteria for a 5150 hold. Community Survey data through the CPP also show that "Persons experiencing a mental health crisis" were identified as the second-most underserved population (54%). Due to the significant need expressed at the community input meetings and the external data on mental health crisis and 5150 rates in Alameda County, BHCS has developed a five year Innovation project to implement a *test of concept for how to improve the crisis system* through a collaborative approach and change in staffing models paired with technological support and transportation. This project is called: Innovation Project 1: Community Assessment and Transport Team (CATT).

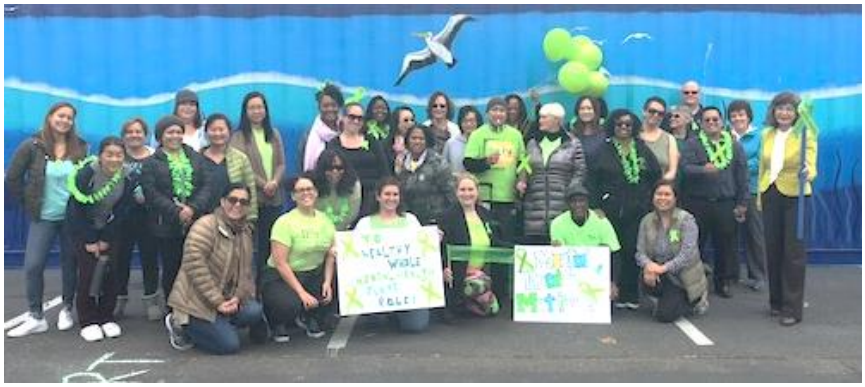
In the area of substance use, during the recent CPP, parents and consumers expressed significant concern about the impact of cannabis use on individuals experiencing mental illness. They expressed the need for new approaches to substance use, concerns about poly-pharmacy, and specific concerns about increased access to cannabis. The Community Survey data show that substance use/abuse was the third top concern identified for Youth/Transitional Age Youth

during the CPP. Moreover, Alameda County's TAY triage project funded by SB82 kept daily records on TAY clients experiencing mental health crises. They estimate approximately 70% of youth had used cannabis within 24 hours before the onset of the crisis. For these reasons BHCS developed Innovation Project 2: Cannabis Policy and Education for Young Adults.

In the area of underserved populations the Community Survey data from Alameda's CPP for the MHSA Three Year Plan show that 44% of respondents identified both young adults and the African American community as underserved. The data also highlights a significant interest in developing more peer-run program models under Innovation. Data from the BHCS Transition Age Youth (TAY) System has also identified five key factors to better support TAY including the factor of developing supports that allow them to feel valued and connected to an inclusive community as a pathway to achieving independence and self-sufficiency. Additional data from the California Reducing Disparities Project (CRDP) emphasizes the need for community-defined practices in order to be responsive to underserved communities. Given all of this information Alameda developed a third innovation project called: Innovation Project 3: Emotional Emancipation Circles for Young Adults.

In the area of community violence and trauma the Community Survey data show that 71% of respondents identified violence and trauma as a priority issue for youth. Additionally, the survey data show that the community has requested that Innovation try to find additional ways to address behavioral and emotional issues – whether related to trauma or not – *in schools.* Currently, BHCS funds access and linkage programs at the school district level to implement Coordination of Services Teams (COST). These COST Teams are not assessing for neurodevelopmental weaknesses or strategies for strengthening neural pathways. However, many students have experienced different levels of community violence and trauma, which can lead to neurodevelopmental issues. Alameda's current level of MHSA funded PEI services is missing this critical piece around neurodevelopmental issues and recovery from them. So as a result of this information Alameda has developed a children's focused innovation program targeting the areas of trauma and resiliency/recovery. The project is called: Innovation Project 4: Introducing Neuroplasticity to Mental Health Services for Children.

For details on Alameda's CPP and MHSA FY 18-20 Three Year Plan please go to www.ACMHSA.org under Documents/MHSA Plans



Project Summary

County:	**Alameda County**
Date submitted:	4/13/2018
Project Title:	**Community Assessment and Transport Team (CATT)**
Total amount requested:	$9,878,082
Duration of project:	5 years

General Requirement	Makes a change to an existing practice in the field of mental health, including but not limited to, application to a different population
Primary Purpose	Promotes interagency and community collaboration related to Mental Health Services or supports or outcomes

Problem

Many counties and cities struggle with developing a crisis response system that is efficient and effective – getting clients to the right services at the right time, without unnecessary use of first responder and client time, and in a respectful and non-stigmatizing manner. In Alameda, there have been a various efforts made to improve crisis response, but the impact has been limited:

- Alameda has the highest rate of 5150 holds in California;
- Of those on a 5150 hold transferred to the psychiatric emergency services unit (PES), 75-78% did not meet medical necessity criteria for inpatient acute psychiatric services;
- People who do not qualify for 5150 holds are not linked to planned services and continue to over-use emergency services;
- First responders spend many hours addressing behavioral health related 911 calls that would be better served in a different manner;
- While Alameda's practice of having ambulances transport individuals on a 5150 hold has many benefits, it is an expensive approach to transport; diverts resources from life threatening emergencies; and leads to clients, law enforcement, and other responders experiencing lengthy wait times for ambulances.

There are many agencies that play a role in crisis response. This project hypothesizes that in order to effectively change the Alameda County crisis response system from one with the highest rates of 5150 holds to a model of efficient and effective response, a collaborative effort to support creative solutions is required. (Winters, S. Inter-professional collaboration in mental health crisis response systems: a scoping review. *Perspectives in Rehabilitation.* Jan 14, 2015).

Project

Alameda County proposes to test two primary strategies to improve the crisis response system:

1) A collaboration among core Alameda County Health Care Services Agency programs - *Behavioral Health Care Services, Emergency Medical Services, and Alameda Care Connect (Whole Person Care)* – as well as other partners – *911 dispatch, the County Sheriff's Office,*

city police departments, city health and human services, and other relevant services - to ensure the crisis response system is effective and efficient. For example:

- Participating partners will provide the staff time, training, and support to ensure that in-the-moment client services are responsive, such as keeping records up to date so the mobile crisis teams have current information about the client and available services.
- Conduct ongoing Continuous Quality Improvement process to ensure that system improvements are made in a timely manner, resulting in better outcomes, such as understanding why clients in crisis continue to be routed to services they do not meet eligibility criteria for and developing systemic solutions to get them routed correctly.

2) Combining a unique crisis transport staffing model with current technology supports to enable them to connect clients to a wider array of services in the moment.
   a. A mental health provider and an Emergency Medical Technician in a van to provide mental and physical assessment and transport to a wide range of services.
   b. Technological support, such as ReddiNet to provide current availability of beds and Community Health Records to provide up-to-date information about the client's physical and mental health history. This assists with connecting a client to the most appropriate service in the moment, especially if they are not on a 5150 hold.

This project proposes to make the collaborative process the focus of the project and evaluation, recognizing that this is essential to making the level of systems change that is needed. This will allow Alameda to put the necessary time and resources behind working together to design the system improvements, monitoring the results, and making timely course corrections.

Evaluation (See Logic Model for more details)

Alameda County has two primary learning goals:

1. Determine if and how collaboration among agencies responding to mental health crises can contribute to developing an effective and efficient crisis response system.
   - Actions taken to improve the crisis response system, and the results
   - Collaborative members perception of the effectiveness of the collaboration
2. Determine if and how the changes in the crisis response system result in community and county priorities: better client services and more efficiency in the system.
   - Number of clients served
   - Number of clients not on 5150 hold that are transported to services

This project is beyond adding a discrete service to a challenged system, it is a *test of concept for how to improve the system* through a focused collaborative approach and innovative change in staffing model paired with technological support. If successful, it will contribute to increased efficiency for the emergency system, more appropriate services for the client, and a model that other counties can adopt or adapt to significantly improve their crisis response system.

Budget

Salaries *$7,435,761*	BH Clinicians Emergency Medical Technicians Clinical Supervisor Program Specialist to coordinate the program
Operating *$403,875*	Data plan for tablets, mobile phones, fuel, vehicle maintenance
Non-Recurring *$0*	Vehicles, radios, vehicle modifications, Tablets, phones, laptops, software Staff training
Consultants *$750,000*	Peer/family stipends to assist with data gathering and analyzing data Evaluator
Indirect *$1,288,446*	15% for BHCS to administer project

Other funding: Measure A, a local funding source, and MediCal billing will cover additional costs.

Community Assessment and Transport Team (CATT) **Logic Model**

Situation: Alameda has the highest rate of 5150 holds in California; people who do not qualify for 5150 holds are not successfully linked to planned services and continue to over-use emergency services; and first responders spend many hours addressing behavioral health related 911 calls that would be better served in a different manner.

Inputs	Outputs		Outcomes -- Impact		
	Activities	*Participation*	*Short*	*Medium*	*Long*
Collaboration (INN) Personnel Time: - Program Specialist - Clinical Supervisor - Behavioral health clinician/EMT teams (INN) Technology: shared records, ReddiNet (INN) Modified vans, technology hardware Training Evaluator with Peer/Family	Monthly meetings Mental & physical assessments, de-escalation, pre-transport services (10,794) Transport clients to range of services (5,594 – 5150 holds) (2,600 – non-5150) Training in CATT approach and technology Eval: CQI, process, numbers served, outcome, client satisfaction	BHCS, EMS, Whole Person Care, 911 dispatch, law enforcement, others CATT (BH clinician and EMT) (with law enforcement) CATT (BH clinician and EMT) (with receiving entities) CATT staff, collaborative partner staff Evaluator, Peer/Family, Collaborative partners	Collaborative partners design and implement policies and practices that improve crisis response (protocols, up to date records, ReddiNet expanded, etc.) Collaborative quickly identifies and addresses areas for improvement Clients served by CATT are connected to wide range of services at time of need (5150 and non-5150)	Clients transported to most appropriate service (5150, non 5150) due to: - up to date client and service availability records - expanded assessment and pre-transport services Clients engage in planned services (900) Clients satisfied with services, including perceptions of stigma (60%)	CATT service is more efficient than other options (25%) Reduction in 5150 transports to ED for medical clearance (25%) Reduction in 5150s (30% of those served by CATT) Reduce time spent on psychiatric crises: - Law enforcement (30%) - Ambulances (50%)

Assumptions
BH clinician and EMT team, supported by technology, will increase transport to most appropriate and non-emergency services. Transport at time of need to non-emergency services will increase engagement in planned services. Engagement in planned services will reduce use of emergency services.

External Factors
- Level of law enforcement partnering with CATT regarding assessments and transport.

INNOVATIVE PROJECT PLAN DESCRIPTION

County: Alameda Date Submitted 4.13.18
Project Name: Community Assessment and Transport Team (CATT)

I. Project Overview

1) Primary Problem

In the United States between 2009 and 2014 the number of police encounters with individuals experiencing a mental health crisis increased 43-50%. In Alameda County, the primary means of addressing these encounters is for law enforcement officers to place the individual on a California Welfare and Institutions Code Section 5150 hold – a 72 hour involuntary hold for psychiatric evaluation. The California Department of Health Care Services (DHCS) report on involuntary detentions for FY2015-16 shows Alameda County with the highest rates of 5150 detentions at 75.3/10,000 for children and 195.7/10,000 for adults. **Of those on a 5150 hold transferred to the psychiatric emergency services unit (PES), 75-78% did not meet medical necessity criteria for inpatient acute psychiatric services.**

In Alameda, individuals on 5150 holds are generally transported by ambulance, rather than police vehicles, to reduce stigma, trauma and possible negative outcomes due to law enforcement involvement. In 2016, this resulted in 13,143 individuals on psychiatric holds being transported by ambulance. This represents 11% of all ambulance transports. **This is a very expensive approach to transport; diverts resources from life threatening emergencies; and leads to clients, law enforcement, and other responders experiencing lengthy wait times for ambulances.**

Those placed on a 5150 hold experience one of two options:

- In 2016, 56% were determined to require a medical clearance and therefore were transported to a medical emergency department (ED) before going to Psychiatric Emergency Services (PES). The wait times between a 5150 hold and formal mental health evaluation can be 12 hours or more.
- In 2016, 44% did not need a medical clearance and therefore were transported directly to the PES unit. The wait times from 5150 hold to a formal mental health evaluation can be two or more hours.

Common issues that result in unnecessary 5150 holds and/or long waits include:

- Law enforcement has limited options for responding to psychiatric crises;
- 5150 holds can only be discontinued by psychiatrists in designated facilities;
- Psychiatric crisis situations are usually not medical emergencies, and therefore are not prioritized by the ambulance transport system;

- Paramedics' scope of practice, as set by the state, only allow them to transport behavioral health clients to an Emergency Department (ED) or Psychiatric Emergency Service (PES) in Alameda;
- Wait times at EDs and PES are often long, and
- The number of agencies involved in responding to one client often leads to lack of coordination of care, and therefore unnecessary or inappropriate care.

Another limitation of the current system is that **individuals in a psychiatric crisis who are not eligible for 5150 holds receive essentially no services.** If a law enforcement officer has the capacity, they may provide information about resources, but the individual is left in place with no effective linkage to needed services. Unfortunately most counties are familiar with the cycle that leads to over-utilization of emergency services: **When an individual interfaces with an emergency service, they often do not get successfully connected to the appropriate planned services, resulting in repeated use of crisis services.**

There are many agencies that play a role in crisis response. In addition, a number of efforts have been made to improve the system, without achieving the level of success desired. This project hypothesizes that in order to effectively change the Alameda County crisis response system from one with the highest rates of 5150 holds to a model of efficient and effective response, a collaborative effort to support creative solutions is required.

a) Describe what led to the development and prioritization of the idea for your INN project

Alameda County stakeholders have consistently raised concerns about the high rate of inappropriate 5150 holds, the lengthy process for transport and engaging in resulting services, and the difficulty of getting clients to services if they are not assessed to qualify for a psychiatric hold. In the planning process for the most recent MHSA Three Year Program and Expenditure Plan "Persons experiencing mental health crises" were identified as the second most "underserved population" (www.ACMHSA.org under Documents/MHSA Plans). The first most underserved population identified was those experiencing homelessness, many of whom will benefit from this project.

In Alameda, the cities with the most 5150 transports are shown here:

5150 Hold Transports by Emergency Medical Services in 2017*

	Emergency Dept.	Psychiatric Facility	Total
Oakland	2762	2537	5299
Hayward	754	588	1342
San Leandro	660	546	1206

**Berkeley is not included in this list, as it has a separate MHSA funding allocation.*

Increases in homelessness, marginally-housed individuals, and the opioid epidemic have put a tremendous strain on law enforcement, Emergency Medical Services (EMS), emergency

departments, and psychiatric crisis services. **Various agencies have made efforts to improve the situation without achieving the level of success desired. This is clearly a "persistent, seemingly intractable mental health challenge" in Alameda that other counties also struggle with. At this point, Alameda County Emergency Medical Services, Behavioral Health Care Services, and others are actively coming to the table to address this.** In addition, Alameda County was awarded Whole Person Care funding for four years. The Whole Person Care effort provides a supportive context for this Innovation plan, but does not itself include a crisis services component.

2) What Has Been Done Elsewhere To Address Your Primary Problem?

Alameda County proposes to transform itself from the county with the highest 5150 rate, to one with a model psychiatric crisis response system that gets clients to the *right place at the right time.* In order to do this, a significant collaboration among various agencies will be required to design, support and effectively implement multiple strategies. A key strategy is combining a behavioral health provider and Emergency Medical Technician (EMT) with up-to-date technology and information in a non-emergency vehicle to provide mobile crisis assessment and transport. **Alameda has not been able to identify another program that uses this collaborative approach, staffing model, and technological access to increase the efficiency and effectiveness of their crisis response system.**

BHCS conducted internet and literature research into transport for persons experiencing a psychiatric crisis that included identifying existing models throughout the United States, understanding federal funding sources, and understanding local legal code (Appendix A: MET Recommendations). Based on that research, the development of a crisis response team that includes a behavioral health provider and an EMT was recommended for a number of reasons. EMTs have fewer restrictions than paramedics on where they can transport clients. A team of an EMT and a behavioral health clinician can assess a client's mental and physical health, transport in a non-emergency vehicle, and conduct procedures such as a TB screening – resulting in more potential dispositions for the client in a more timely manner than most team staffing models. Potential transport destinations go beyond an emergency department or psychiatric facility to include crisis residential, sobering centers, and other non-emergency behavioral health services.

An internet search on related literature provided support for the need for collaboration to support change in mental health crisis response systems, but indicated a lack of conceptual clarity, lack of client perspectives, and need for further research (Winters, S. Inter-professional collaboration in mental health crisis response systems: a scoping review. *Perspectives in Rehabilitation.* Jan 14, 2015).

In addition, BHCS research and county-to-county networking identified projects that provided insight into staffing and transport models. There have been a number of projects implemented

addressing mobile crisis response, especially with SB82 funds. A few most relevant to Alameda's proposed model:

- San Diego crisis teams include a paramedic and behavioral health staff. Including an EMT on the team instead of a paramedic, as Alameda proposes, increases the disposition options the team has to address a client's need. San Diego's pilot project was specific to clients on 5150 holds, while Alameda's proposed project will include assessing and transporting clients *not* on holds.
- San Mateo developed a program to train paramedics in assessing patients in mental health crisis and placing 5150 holds. A single paramedic responds in an unmarked car with a barrier that can transport the patient to their PES or a local Emergency Department. The single paramedic can contact the psychiatrist at PES when consultation is needed. This program has resulted in fewer patients being placed on a 5150 hold, but they report the impact is limited due to the staffing model, as many situations call for more specialized mental health expertise.
- San Mateo also has a Crisis Collaboration that convenes quarterly. This collaboration includes BHRS supervisors, law enforcement, fire, EMS, hospitals, PES, Kaiser, community partners and others. Much of the focus is on educating providers about available services and when to refer to those services. Alameda proposes a more targeted collaborative that addresses systems improvement.

Alameda County has implemented a number of efforts to improve the crisis system of care:

- BHCS, EMS, and Care Connect all participate in the Alameda County Multi-Disciplinary Forensic Team (MDFT), a voluntary coalition of law enforcement, BHCS, and allied providers. The MDFT functions similarly to San Mateo's Crisis Collaboration, sharing resources and determining appropriate referrals for individuals in the justice system who have mental health, substance use or developmental disabilities.

- Crisis Response Program (CRP): In 1988, the CRP began providing short-term case management for adults with serious mental health diagnoses to reduce unnecessary hospitalizations – generally accessed through walk-in and appointments. In addition, teams of two (2) mental health clinicians provide mobile crisis response (not transport) in Oakland Monday-Friday from 10:00 am to 8:00 pm.

- Transition Age Youth Triage (SB82): The Hope Intervention Program (HIP) provides crisis prevention services to TAY (16-24). HIP aims to reduce use of crisis services by addressing services gaps, including mobile outreach (not transport), developing individualized crisis support plans, targeted intensive case management and linkage.

- Mobile Evaluation Teams: Beginning in 2014, behavioral health providers have been teamed with police officers in Oakland to reduce unnecessary 5150 holds by having the behavioral health provider conduct the assessments. While it has had some impact on 5150's, it does not address transport. This INN project develops crisis teams that can transport individuals to a range of services, whether or not they are on a 5150 hold, increasing the likelihood

individuals will get connected to needed services, and reducing the likelihood they will over-utilize emergency services.

- SB82 Proposal: BHCS was recently partially funded for a proposal to the Investment in Mental Health Wellness Act Round 2 Triage program. That proposal funds a few discrete services to fill gaps in the crisis continuum, including expanding the existing Mobile Crisis Team, a Post Crisis Follow-up Team, Education and Consultation Hotline, and Transition Age Youth (TAY) Multi-Disciplinary Team (MDT) for TAY in Santa Rita jail. None of these services provide transport.

This Innovation proposal does not just provide a discrete service, it is a test of concept to improve crisis response through a collaborative approach and change in staffing models paired with technological support and transport. Before adopting this staffing model across the system, this INN project will allow for testing whether it improves the transport system, and how it does this. INN will also support the testing of a robust collaboration to ensure effective changes are implemented, since the model requires active involvement in systems improvement from multiple agencies.

3) The Proposed Project

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

Given that Alameda has the highest rates of 5150 holds, has implemented strategies to address this with limited results, and has some uncommon crisis system features– a PES not attached to an ED and a reliance on ambulance transports – it seems necessary to **develop an interagency collaboration to design, implement and support a crisis response system that reduces the rate of involuntary detentions and increases the efficiency and effectiveness of linking clients to needed services. This system would include an innovative combination of staffing, technology, and collaboration to maximize the options available to the mobile crisis response team when assessing and transporting clients to needed services.**

The CATT project will promote interagency collaboration among core Alameda County Health Care Services Agency programs - *Behavioral Health Care Services, Emergency Medical Services, and Alameda Care Connect (Whole Person Care)* – as well as other partners – *911 dispatch, the County Sherriff's Office, city police departments, city health and human services, and other relevant service* - to develop a highly responsive and efficient mobile psychiatric crisis response system. A Senior Program Specialist will coordinate the collaboration to meet regularly throughout the project to design system changes; clarify each partner's role in implementation; ensure training, staffing and policies support the determined changes; ensure course corrections are made in a timely manner; and oversee program evaluation.

Examples of issues the collaboration will address:

- Criteria for determining the most appropriate service to transport a client to

- Understanding why clients in crisis do not meet criteria to receive certain services, such as PES, and developing systemic solutions to routing clients appropriately
- Ensuring client records and service availability is up to date and accessible to CATT

This collaboration will develop, implement, support and evaluate changes to the crisis system in order to achieve the desired outcomes. Two core changes that will be implemented are:

1) A mobile crisis team comprised of a behavioral health provider and an Emergency Medical Technician (EMT) in a non-emergency vehicle. This staffing model enables assessment and transport for a broad range of dispositions (PES, CSU, sobering center, emergency departments, etc.). The staffing model, as well as the collaboration, will contribute to the team successfully accessing all available dispositions. The staffing model will provide the professional capacity to assess and refer to the dispositions. EMTs are able to transport to a wider range of destinations than paramedics, while also being able to conduct medical assessments and initiate medical requirements, such as TB screening, to assist with transition into services. Mental health clinicians can conduct assessments to determine the most appropriate behavioral health service. An unmarked non-emergency vehicle reduces stigma and increases possible transport destinations ambulances cannot transport to. The collaboration will help ensure the disposition sites efficiently and successfully receive the clients.

2) Technical support that provides the greatest capacity for the team. This includes:
    - ReddiNet: A web-based emergency communications system. Alameda has been using it since 2008 to track hourly bed availability for emergency departments and during multi-casualty incidents. The collaboration will work with ReddiNet to expand the system to include beds, appointments and slots in crisis stabilization units, crisis residential sites, sobering/detox centers, and other behavioral health services, as well as alerting providers when the psychiatric emergency services is on diversion. In addition it sends alerts to all EDs, ambulances, transport teams, and other pertinent agencies if Alameda's regionally dedicated PES or other behavioral health facilities are close to full. ReddiNet has been implemented in a number of counties in California, although likely they do not all use the bed capacity feature. Alameda BHRS aims to achieve full utilization of the bed capacity feature through this project's collaboration by ensuring all relevant partners participate and keep it up-to-date.
    - Video translation services: A program to provide a translator on screen.
    - Shared client records: In 2019, BHCS clinicians will have access to Community Health Records through Alameda's Care Connect (Whole Person Care), including physical and mental health history and information about providers engaged with client, as well as allowing them to add the current episode to the shared records. The EMT can maintain clinical records in the existing electronic patient record that is used by 911 ambulance system. The collaboration will be essential to ensuring these records are updated, useful and accessible.

The project would provide services from 7:00 am until midnight, seven days per week – as those are the times when the large majority of 5150s are placed in Alameda County. Teams of one behavioral health clinician and one EMT will be deployed in unmarked vehicles fitted with appropriate technological capacities and safety features. Safety features include special seating for clients, a barrier between the driver and back passenger seats, customized locks and windows, locking storage cabinets, and other modifications similar to the inside of a police vehicle. The services would be dispatched by the 911 system for behavioral health related calls. A police officer would arrive first to assess safety.

- By developing a strong relationship between the police department and BHCS, law enforcement can make it a practice to wait on making a determination regarding a 5150 hold until the crisis team arrives. This should reduce unnecessary 5150 holds.
- If a hold is appropriate the CATT can transport the client to PES or to an ED for medical clearance prior to PES. The EMT physical assessment will reduce the number of clients on a 5150 hold needing to be taken to the ED for medical clearance. This can be achieved in two ways: 1) the EMT can clear people who are not required to be taken to the ED based on protocol, but might have been taken to the ED as a precaution, and 2) Adjusting current protocols regarding who must be take to the ED. For example, the current requirement that all clients over the age of 60 must be taken to the ED could be amended for those served by CATT. This should reduce the time law enforcement and ambulance staff, as well as ED staff, spends on behavioral health calls.
- The CATT can also assess, refer and transport individuals *not on a hold* to programs such as a sobering center, crisis residential, crisis stabilization unit, or peer respite. The EMT can complete an initial medical evaluation required before transport to the ED, PES or Sobering Center, as well as completing checklists that will streamline intake for programs such as crisis residential. Use of ReddiNet will help ensure there are services available before a client is transported. This should increase the ability to efficiently link clients not on a 5150 hold to services. Over time this should lead to an increase in use of planned services and reduction in use of emergency services. (ReddiNet will be expanded to include beds, appointments and slots available at crisis stabilization units, crisis residential sites, sobering/detox centers, and other behavioral health services, as well as when PES or emergency department go on diversion. In case services are at capacity, PES will always accept clients from the field.)
- Use of BHCS electronic records, as well as Community Health Records, will increase accuracy of assessments and continuity of care.

Initially CATT will deploy two vehicles to serve two communities in Alameda County. San Leandro is the city with the fourth highest number of 5150 holds in Alameda County (1,206) (Appendix B: EMS 5150 Transports by City). It does not have an alternative crisis response, just police and EMS. San Leandro has committed to participation (letter of support pending). Hayward is the city with the second highest number of 5150 holds in Alameda County (1,342). It also does not have an alternative crisis response in place. Hayward has committed to participation (letter of support pending).

Piloting this project in these two communities will allow for testing out systems and ensuring they are functioning well before expanding to a more complicated environment. After 18 months, the project will expand to Oakland (letter of support pending). Oakland is the city with by far the highest number of 5150 holds (5,299). It has Mobile Evaluation Teams and a Crisis Response Program, neither of which provide transport. In order to see if the CATT project can have a significant effect on the overall crisis response system, it is essential to test it in Oakland. Two vehicles will be deployed in Oakland.

b) *Identify which of the three approaches specified in CCR, Title 9, Sect. 3910(a) the project will implement*

This proposal makes a change to an existing practice in the field of mental health. While there have been a variety of approaches to improving crisis transport systems, Alameda has not been able to identify another program that uses this collaborative approach, staffing model, and technological access to increase the efficiency, accuracy and number of disposition options.

c) *Briefly explain how you have determined that your selected approach is appropriate*

Alameda's experience with SB82 and other system change efforts underscores the need for an active collaboration to ensure that barriers that are encountered can be addressed in a timely manner in order to realize the potential of the efforts. Crisis response models in other regions have provided insight into the potential of alternative staffing models for mobile crisis teams. The recent progress in electronic capabilities provides additional opportunities.

4) Innovative Component

a) *If you are adapting an existing mental health model or approach, describe how your approach adds to or modifies specific aspects of that existing approach and why you believe these to be important aspects to examine.*

The MHSOAC's "Triage Grant Information Gathering Brief – June 29, 2017" pointed out central challenges experienced within the Triage programs under SB82 – implementation delays, developing and maintaining successful collaborations, and effective evaluation of the programs. This has influenced the Triage grants to increase the use of collaboration to achieve the primary goals of SB82. Literature reviews support the need for interagency collaboration to improve crisis systems, and find that such efforts have been limited. **This project proposes to make the collaborative process the focus of the project and evaluation, recognizing that this is essential to making the level of systems change that is needed in Alameda County. This will allow Alameda to put the necessary time and resources behind working together to design the system improvements, as well as monitor them and make timely course corrections to ensure effectiveness**.

The collaboration will:

- Design the system changes

- Ensure that the staffing, training and policies are in place for effective implementation of innovative changes, including the EMT/behavioral health clinician crisis team, the use of ReddiNet and other shared records that all agencies must keep up to date, and the transport of clients to non-emergency services that will receive the clients efficiently
- Conduct continuous quality improvement to ensure timely course corrections
- Document and evaluate the process to assist with replication

In addition, the central strategies to be implemented are informed by, but go beyond, previous efforts of Alameda and other counties. **This project tests the provision of crisis assessment and transport for clients (whether they are on a 5150 hold or not) by a team that includes a behavioral health provider and an EMT in a non-emergency vehicle with technology supports that provide information about bed availability and client history.** This team maximizes the number of disposition options available and enables more efficient transfer of clients into services. Transitioning clients from one program to another is frequently the cause of delays, lack of follow-through, and loss of care continuity. Ideally this project will reduce 5150s both by providing thorough assessments on the scene and by connecting clients to planned services, reducing use of emergency services in the future.

5) Learning Goals / Project Aims

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

Alameda County has two primary learning goals:

1. Determine if and how collaboration among agencies responding to mental health crises can contribute to developing an effective and efficient crisis response system.
    - This learning goal focuses on whether the actions of the collaboration result in:
        - An effective system: One that gets clients to the services that they need at the right time. Such as reducing unnecessary 5150 holds and getting clients not on a hold to a service, increasing their engagement with planned services.
        - An efficient system: One that reduces the time spent by clients waiting to be transitioned to a service and reduces the time law enforcement/ambulances spend on psychiatric crises.
    - The central hypothesis is that intensive collaboration is required to make significant improvements to crisis response systems. This project will evaluate the role that collaboration plays in making improvements in a timely manner.

2. Determine if and how the changes in the crisis response system result in community and county priorities: better client services and more efficiency in the system.
    - This project will evaluate whether combining a unique staffing model in a non-emergency vehicle with technology supports to provide crisis assessment and transport leads to improved outcomes, including:

- Better client services: Client are better served by a crisis response system if it results in them being connected to the services they need without stigma.
- Efficiency: Reduce the time clients wait to be connected to services and the time law enforcement/ambulances spend on psychiatric crisis response.

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

1. Determine if and how collaboration among agencies responding to mental health crises can contribute to developing an effective and efficient crisis response system.
    - Developing a collaboration to design, implement and support changes to the crisis response system is a key element of this Innovation plan. Based on past experience, the findings of SB82 Triage efforts to date, and existing literature, collaboration seems to be a necessary but not fully implemented element. This project will test this hypothesis, as well as inform sustainability and replication.

2. Determine if and how the changes in the crisis response system result in community and county priorities: better client services and more efficiency in the system.
    - The key change proposed is implementing a new crisis assessment and transport staffing model with appropriate technological support, resulting in the most disposition options for the client. This project will test if this new approach leads to success and how.

6) Evaluation or Learning Plan

1. Determine if and how collaboration among agencies responding to mental health crises can contribute to developing an effective and efficient crisis response system.

Data to collect	Data collection method
Who participates in the collaborative • Are the necessary partners participating Collaborative meetings and other activities • Is the collaborative meeting regularly	○ The Program Specialist will collect via membership rosters, sign-in sheets, meeting agendas, etc.
Continuous quality improvement efforts: • What issues are brought to the collaboration • How they are resolved • How quickly they are resolved • What the result is	○ The Program Specialist will collect via meeting minutes. ○ The evaluators will collect via observation and annual focus groups or key informant interviews with collaborative members.
Collaborative members actions • Are they taking actions to support:	○ The evaluators will collect via annual surveys and focus groups or key

shared client records; a system for tracking available service slots; timely access to crisis services; etc.	informant interviews with collaborative members.
Collaborative members perception of the effectiveness of the collaboration, including what contributed to or impeded success	○ The evaluators will collect via annual surveys and focus groups or key informant interviews with collaborative members.

2. Determine if and how the changes in the crisis response system result in community and county priorities: better client services and more efficiency in the system.

Short-Term Outcomes

Data to collect	Data collection method
Number of clients served by CATT *Estimated: 10,794*	○ Electronic health records, including number assessed and number transported *Estimate: See Numbers Served section*
Number of clients not on 5150 hold transported to services *Estimated: 2,600*	○ Electronic health records show number of transports including 5150 status and final disposition of client *Estimate: This includes individuals that would not have been put on 5150 hold before CATT, as well as those diverted from 5150 by CATT. Assumes 50% of non-5150 clients consent to transport.*
Number of transported clients not on 5150 hold who engage in services *Estimated: 900*	○ Electronic health records show what services clients engaged in. Analyze level of engagement in planned mental health, substance use, or other relevant services before CATT transport to after CATT transport. Look at records 3 months after CATT transport.
Client satisfaction, including perceptions of stigma *60% of clients will report satisfaction*	○ Post crisis survey call by peer provider

Long-Term Outcomes

Linking non-5150 clients to appropriate services should result in lowered use of crisis services. In addition, CATT response should result in less involvement from law enforcement and ambulances in psychiatric crisis. The evaluators will look at impacts on the crisis system that are related to CATT implementation. Some examples:

Data to collect	Data collection method
Efficiency of CATT	○ EMS measures ambulance response time to every request

response compared to other responses *CATT will take 25% less time to complete service than current system*	via 911 system, as well as time of transport to receiving destination and vehicle/crew time at receiving destination. This data will also be recorded for CATT. Data for EMS vs CATT will be compared, either by looking at matched cases or at comparable pools of cases.
Percent change in numbers of 5150 transports to ED for medical clearance *25% reduction*	○ EMS tracks number of 5150 transports by city broken down by ED and PES destinations. This data can be compared for each city with CATT services for the few years before CATT to data after CATT implemented.
Number of 5150 holds avoided *30% reduction among those served by CATT*	Data collection options: ○ Compare trends in 5150 hold rates by city before and after implementation. Compare changes between participating and non-participating Alameda County cities to increase the ability to show the impact of this program, versus other factors. ○ Compare trends in rates of clients brought to PES on a 5150 hold who meet medical necessity criteria for acute psychiatric services in Alameda before and after implementation. ○ Compare CATT client frequency of 5150 before and after CATT service ○ Perception of CATT responders as to portion of clients that might have been put on 5150 hold but were not due to CATT involvement
Change in time spent by law enforcement and ambulance services on psychiatric emergencies *30% reduction for law enforcement* *50% reduction for ambulance*	Evaluators will analyze change in time in cities with CATT services. Methods may include: ○ Analyze pre-CATT records to estimate likely change in time spent ○ Compare pre-CATT records to post-CATT records, taking into consideration other factors that affect # of calls and time spent

Data collection, evaluation and reporting for this project will be in alignment with the current Innovation Regulations. This includes collecting indicated demographic data, tracking changes made to the project in the course of implementation, and providing annual and final reports covering all required elements.

Evaluation of this project will be contracted out. The evaluators will assist in finalizing the evaluation plan, developing the appropriate tools, gathering and analyzing the data, and vetting the evaluation plan and tools with appropriate stakeholders. They will document factors that might affect the outcomes and will attempt to increase the validity of the results.

7) Contracting

The implementation of this project will be lead by BHCS staff. Some of the staffing will be provided by EMS.

II. Additional Information for Regulatory Requirements

1) Certifications

2) Community Program Planning

The community planning process for the MHSA Three Year Plan was conducted from June – October 2017. During that process ACBHCS staff provided updates and information on current MHSA programs and community members provided input on mental health needs and services. There were three modes for providing input:

- Five large community forums (one in each Supervisorial District);
- Eighteen focus groups were conducted throughout Alameda County: Chinese speaking family members, African American family members, providers for refugees, providers for LGBTQ community, transitional age youth (2), Afghan immigrants, older adults, API and refugee providers and advocates, providers for individuals with developmental disabilities and mental illness, and Pool of Consumer Champions (BHCS's mental health consumer group);
- Community Input Surveys in all threshold languages: submitted by 550 unique individuals. Respondents were very diverse in age, race, and ethnicity. Fifty percent of respondents were from Oakland, while they make up only 30% of Alameda's population. Survey respondents included: Mental health consumers (25%), family members (17%), community members (15%), education agency (2%), community mental health providers (14%), homeless/housing services (6%), county Behavioral Health staff (1%), faith-based organization (2%), substance abuse services provider (<1%), hospital/provider care (4%), law enforcement (1%), NAMI (1%), Veteran/Veteran services (1%), other community (Non-MH) service provider (5%), other/decline to state (9%).

Details of the process are provided in the MHSA Three Year Plan (www.ACMHSA.org under Documents/MHSA Plans).

The BHCS Systems of Care and BHCS Housing Department were asked to submit proposals that addressed the needs identified in the community planning process. The proposed projects were vetted by MHSA staff based on whether they addressed community priorities, as well as other factors. For example, "Persons experiencing a mental health crisis" were identified as the second-most underserved population (54%). The first most underserved population identified was those experiencing homelessness, many of whom will benefit from this project.

This proposal was posted for 30-day public comment (April 13-May 13, 2018) and a public hearing was held on May 14, 2018. Substantive comments and responses are included here.

Comment: There is a definite need for improved crisis response systems for the consumers in Alameda County. Adding a mental health specialist as well as a transport team appears to be a promising idea. This will likely improve the onsite assessment process to determine the priority need for the individual at that point in time. Of all the proposals, it is great to see the one has plans to expand into Oakland, as Oakland is one of the most high need areas.

However, this proposal does not address the lack of resources available in the community for many of our consumers. As the housing market continues to rise, the number of vacancies in crisis residential homes, shelters, detox centers, etc. continue to decrease due to increased demand and longer lengths of stay because of limited long term housing options. While it is great that the consumer's needs will be better assessed in the crisis; systemic change may be limited by lack of placements for these individuals, thereby continuing to overflow the ED services.

Additionally, with the significant growing older adult population in Alameda County, there is not enough attention being paid to older adult needs. Will the transport vehicles be ADA accessible for individuals utilizing assistive devices and/or who have a physical limitation? Will the medical clearance still be required for any individual over the age of 60? Or will this transport team be able to provide that clearance? This medical clearance requirement often significantly delays older adults from getting the services they actually need when they need them.

In line with the Whole Person Care initiative, there is a need for increased medical and nursing services available in the community and in the homes for consumers. There are many situations in which a crisis appears psychiatric but may in fact be due to or combined with an underlying medical cause; however, the individual does not have enough supports available to assist them in maintaining their health in the community to prevent these crises. To streamline crisis services and over use of ED services, Alameda County needs a plan to address the individuals experiencing grave disability and need for increased medical care. It would be interesting to know how the new CATT team will be addressing individuals with these sorts of crises, because as it stands right now, these individuals will likely continue using the emergency services (one example being due to CCL licensing requirements prohibiting non-ambulatory individuals).

Response: Behavioral Health Care Services (BHCS) is aware of the shortage of resources for our client population and is working on this through other avenues and funding streams, i.e. a new crisis residential and crisis stabilization program is currently being built, a new crisis residential for TAY is also currently being built and almost completed, additional crisis services are in the planning phase, Full Service Partnership slots will be expanded as of July 1st as well as Substance Use Disorder (SUD) services. The CATT proposal is truly a test of concept to see if this model will be able to get people to the right resource to help stabilize them, reduce future crisis episodes and increase quality of life for Alameda County residents.

In response to the transport vehicles and ADA compliance: Vehicles will be easily accessible but not ADA compliant. If a client needs accommodation beyond what the vehicle affords, an

ambulance will provide the transport. If this project moves beyond a pilot, BHCS would consider adding some ADA type vehicles based on need identified during the pilot.

In response to the medical clearance question: The Alameda County Emergency Medical Services (EMS) Department is evaluating changing some physical health parameters, While they currently do not intend to change the requirement that individuals over 60 years old receive medical clearance in general, they may pilot a change to this requirement for those served by CATT. The head of EMS will have to make that determination as that is not within BHCS purview.

Comment by Family Member: I am concerned that this program may be intended to reduce 5150's and hospitalizations at places like John George. This is NOT NECESSARILY a measure of success. We need more beds at John George, etc., and longer stays- a few days or weeks for people who need them to stabilized and benefit!

Response: Thank you for your comment. While we expect a reduction of inappropriate 5150s, this project would not reduce appropriate 5150s or hospitalizations. This program is testing a concept to see if through this new model of collaboration, transportation, different staffing pattern and technology, BHCS can get clients to the services they are eligible for in the most efficient way. Once the project is approved an evaluation team will be brought on to work with multiple stakeholder groups including (but not limited to) the program staff, the MHSA Stakeholder Committee, family members and consumers to refine the outcome measures.

3) Primary Purpose

Promote interagency collaboration related to mental health services, supports, or outcomes.

4) MHSA Innovative Project Category

Makes a change to an existing mental health practice that has not yet been demonstrated to be effective, including, but not limited to, adaptation for a new setting, population or community.

5) Population

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

This project serves people experiencing a behavioral health crisis in the community that results in a 911 response, but that does not require emergency medical services. Numbers to be served are based on the current rates of 5150 holds during the hours of operation. Approximately 70%

of 5150s are placed from 7:00 am to midnight. Numbers served include most of those currently put on 5150 holds between 7:00 am to midnight, as well as other psychiatric crises not resulting in 5150 holds.

Numbers Served

Start Date	Community Served	5150 /year	CATT Svc/day	Year 1	Year 2	Year 3	Year 4	Year 5	TOTAL
Oct 2018	San Leandro	1,200	~2	495	660	660	660	660	3,135
Oct 2018	Hayward	1,300	~2	513	684	684	684	684	3,249
Feb 2020	Oakland	5,300	~5	0	0	760	1,825	1,825	4,410
TOTAL		7,800	~9	1,008	1,344	2,104	3,169	3,169	10,794

b) Describe the population to be served

This table shows the demographics of the communities to be served.

	San Leandro	Hayward	Oakland
Total Population	90,465	144,186	412,040
Race/Ethnicity *			
Asian/Pacific Islander	32%	25%	17%
Black/African American	14%	12%	28%
Latino	40%	41%	25%
White	29%	34%	26%
American Indian	3%	1%	1%
Other/Unknown	8%	2%	3%

Adds up to more than 100% as some people may be more than one race/ethnicity

c) Does the project plan to serve a focal population, e.g., providing specialized services for a target group, or having eligibility criteria that must be met? If so, please explain.

This project serves people experiencing a behavioral health crisis in the community that results in a 911 response. Eligibility includes:

- Services are required in a location and during a time CATT is in service
- The situation must be assessed as safe by a law enforcement officer
- The individual cannot be in need of emergency medical services

BHCS and EMS will develop specific eligibility criteria in the initial phase of this project.

6) MHSA General Standards

a) Community Collaboration: The focus of this project is collaboration among BHCS, EMS, law enforcement, community providers and others. The roll-out of this project will also be presented to local consumer and family groups to provide information and get feedback. Alameda's Whole Person Care project, Care Connect, conducts consumer convenings to ensure community input. Updates on this project will be presented regularly at the convenings to solicit input on implementation and evaluation.
b) Cultural Competency: Program staff will receive cultural competency training. Efforts will be made to hire staff who reflect the diversity of the communities they will serve. Updates on this project will be presented regularly to BHCS' Cultural Competency Advisory Board to solicit input on implementation and evaluation.
c) Client-Driven: As described under Community Collaboration, ongoing input will be solicited from groups that include consumers. In addition, clients and family members will participate in development, implementation and analysis of the project evaluation.
d) Family-Driven: Care Connect records include crisis plans developed by consumers. These plans, and other means, will be used to repatriate clients with their support network as quickly as possible. At times families will participate in the "client satisfaction" phone surveys conducted, providing feedback about the services.
e) Wellness, Recovery, and Resilience-Focused: This program aims to reduce involuntary holds and increase access to services that support recovery.
f) Integrated Service Experience for Clients and Families: The goal of the collaborative is to integrate services toward efficiency and appropriate services. For example, sharing of records among agencies responding to crises, and particularly with the crisis teams, will lead to better coordination of care.

7) Continuity of Care for Individuals with Serious Mental Illness

Individuals with serious mental illness will be served by this project. Given that the services are crisis response services, if elements of this project do not continue, it will not disrupt continuity of care. Ideally, any changes that have been made and found to be successful will be sustained in one of three ways:

- The changes may be integrated into ongoing operations and will not require ongoing funding. This may include changes in policies and procedures, upkeep of shared data systems, collaborative relationships, etc.
- The changes may be sustained through non-MHSA funds. For example, once the billing for services has been established successfully the staffing model may be funded through reimbursements. Other costs may be covered by increased efficiencies.
- If other aspects of the project, such as the formal collaboration, need to be continued, BHCS will consider supporting these costs as described in question 9.

8) INN Project Evaluation Cultural Competence and Meaningful Stakeholder Involvement.

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

The evaluation plan will be presented to BHCS' Cultural Competency Advisory Board (CCAB), the MHSA Stakeholder Committee and the Whole Person Care consumer convenings for feedback on the methods and outcomes. In addition, there will be regular presentations to the CCAB, MHSA Stakeholder Committee and consumer convenings as the evaluation is implemented in order to get ongoing feedback on issues that arise. Client/family satisfaction questions will be reviewed by members of the target groups prior to implementation and conducted in the appropriate language.

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

The collaboration participants will be actively involved in project implementation, including working with the evaluator to develop evaluations plans, tools, and data analysis. In addition, clients and family members will be paid to assist with planning and implementing the clients' satisfaction component, as well as data analysis. The CCAB, MHSA Stakeholder Committee and consumer convenings will contribute to evaluation planning, implementation, and analysis.

9) Deciding Whether and How to Continue the Project Without INN Funds

BHCS will support the continuation of this project or components of this project based on a number of internal and external factors and processes including: 1) the evaluation results from the project, 2) support and buy-in from the Adult & Older Adult System of Care 3) Continued buy-in from law enforcement 4) recommendations from the MHSA Stakeholder Committee & the CCAB, and 5) available funding. This project will be able to generate revenue through Medi-cal billing, which will help offset the overall costs and thus increase the probability of being sustained if there are positive results from the factors listed above. MHSA Community Services and Supports will be considered for costs not covered by Medi-Cal or other sources.

10) Communication and Dissemination Plan

a) How do you plan to disseminate information to stakeholders

The CATT collaborative will be responsible for disseminating results to their agencies, other stakeholders, and other counties. Updates on the project will be provided to stakeholders on an ongoing basis via email and presentations at existing meetings. The final evaluation report for this project will be shared widely by posting it on the BHCS website and announcing via email to stakeholders, including to mental health directors, Alameda County Mental Health Board, MHSA coordinators, and EMS agencies throughout the state. In addition presentation will be made to the MHSA Stakeholder Group, the Cultural Competency Advisory Board (CCAB), the

Whole Person Care consumer convenings, other consumer groups, NAMI, the Board of Supervisors, and other appropriate entities.

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

The CATT collaborative members will be responsible for sharing the results with their agencies, providing presentations to the organizations listed above, and forwarding email announcements to their stakeholders. The Program Specialist will be responsible for website postings and email announcements.

c) *KEYWORDS for search:*

Collaborative crisis response system; Mobile mental health crisis response; Multidisciplinary psychiatric crisis transport

11) Timeline

a) *Specify the total timeframe (duration) of the INN Project:* **5 Years**
b) *Specify the expected start date and end date of your INN Project:*

Start Date: October 2018 End Date: September 2023

c) *Include a timeline that specifies key activities and milestones*

Prior to implementation of the Innovation project, some aspects of the project will be underway due to Measure A funding (see budget narrative). This will include:

- MOUs in place with initial two participating communities
- Hiring of staff and contractors funded under Measure A
- CATT vehicles purchased and modified to CATT specifications
- Work with 911 dispatch to create system to dispatch CATT

Month	Milestone
Oct-Dec 2018	Assign Program Specialist from BHCS staff Begin monthly collaborative meetings Identify evaluator through competitive process Hire additional staff Staff training Begin program in two communities (San Leandro, Hayward)
Jan-Mar 2019	Develop evaluation plan Develop Continuous Quality Improvement (CQI) process Community Health Record access in all vehicles
Apr-Jun 2019	Begin implementation of evaluation plan
Jul-Sep 2019	Evaluation of program implementation to date
Oct-Dec 2019	Implement changes to project based on evaluation findings

	Staff hired for Oakland teams
Jan-Mar 2020	Staff training for Oakland teams Begin program in Oakland
Apr-Jun 2020	Begin evaluation of Oakland program
Jul-Sep 2020	Evaluation of program implementation to date
Oct-Dec 2020	Implement changes to project based on evaluation findings
Jan-Mar 2021	Begin sustainability evaluation and planning
Apr-Jun 2021	Continue CQI
Jul-Sep 2021	Evaluation of program implementation to date
Oct-Dec 2021	Implement changes to project based on evaluation findings
Jan-Mar 2022	Continue CQI
Apr-Jun 2022	Continue CQI
Jul-Sep 2022	Evaluation of program implementation to date
Oct-Dec 2022	Implement changes to project based on evaluation findings
Jan-Mar 2023	Continue CQI
Apr-Jun 2023	Preliminary data shared with stakeholders for input on data analysis Initial evaluation report shared with stakeholder to discuss sustainability
Jul-Sep 2023	Project completion Evaluation report completed, disseminated and presented Sustainability planning completed

This timeline allows for implementing the collaboration and new crisis response strategies in two communities to ensure the processes are running smoothly before implementing in Oakland, a much larger and more complex environment. Annual evaluation, Continuous Quality Improvement, and ongoing sharing of updates will ensure that evaluation and stakeholder input is supported. Time is allocated near the end of the project to allow for stakeholder input in data analysis and decisions about sustaining the project, as well as dissemination of final results.

12) INN Project Budget and Source of Expenditures

This INN Plan will use FY 08/09, FY 09/10 and part of FY 10/11 funds that were deemed reverted back to the county of origin under **AB 114.**

Alameda County has been awarded **SB82 funds** to initiate and expand a number of crisis response efforts to reduce crises and assist law enforcement with psychiatric crises. These projects are being implemented, but they do not address crisis transport and only support the level of collaboration needed to implement the discrete services in the SB82 projects.

This INN Plan is being implemented in partnership with Alameda County Emergency Medical Services (EMS). EMS has already secured **Measure A funds** through a competitive process to support the start-up of this project. Measure A was approved by voters in 2004 to support an

array of services for low-income residents of Alameda County. Leveraging Measure A and Innovation funds sets the groundwork for a robust collaboration.

Project Budget by Year - Narrative

Salaries

FY18-19: 9 months (Oct-Jun):

7.2 FTE BH Clinicians at $60 per hour = $777,600

7.2 FTE EMTs at $34.25 = $461,635

This staffing level allows for two mobile teams from 7:00 am until midnight, seven days per week.

1 FTE Clinical Supervisor at $150,000 annual wages and benefits = $112,500

1 Program Specialist at $135,000 annual wages and benefits = $101,250

Staff partly funded by Measure A. Total INN funds = $820,047

FY19-20: Jan-Jun 2020 the staff increases to a total of 14.4 FTE BH Clinicians and 14.4 FTE EMTs for Oakland teams = $692,453. This staffing level allows for four mobile teams from 7:00 am until midnight, seven days per week.

Staff partly funded by Measure A. Total INN funds = $1,775,301

FY20-21: Staff stays at same level. *No Measure A funds. MediCal billing factored in.*

Total INN funds = $1,613,471

FY21-22: Staff stays at same level. *No Measure A funds. MediCal billing factored in.*

Total INN funds = $1,613,471

FY22-23: Staff stays at same level. *No Measure A funds. MediCal billing factored in.*

Total INN funds = $1,613,471

FY23-24: 3 months (Jul-Sep): No additional costs incurred for final report dissemination and sustainability planning

Total INN Funds = $7,435,761

Operating Costs

Data plan for tablets, mobile phone plans, fuel, and vehicle maintenance. *Measure A will cover these costs in FY18-19.* Total INN funds = $403,875

Non-Recurring Costs

Vehicles, radios, vehicle modifications, Tablets, phones, laptops, software, staff training. *Measure A will cover these costs.* Total INN funds = $0

Consultant Costs/Contractors

Evaluation consultant costs at roughly 5% of project cost ($125,000) with the exception of Yr 4 which will be higher ($200,000) to allow for deeper evaluation and sustainability planning as we near end of project.

Peer/Family stipends to assist with gathering and analyzing data and outcomes:
$20/session x 500 sessions = $10,000 year

Total INN funds = $750,000

Indirect

15% for county administration of the project. Applies to Personnel, Operating and Contract expenditures to provide Human Resources, Accounting, Budgeting, Information Technology, Business Services Office, and Legal management of staff and contract positions; rent, utilities, insurance; and other expenses necessary to administer the project.

Total INN funds = $1,288,446

Expend by Fund Source - Narrative

Administration

- 68% of Program Specialist time will be spent on program development and implementation = $416,822
- Indirect expenses (see above) = $1,288,446

Total INN funds = $1,705,268

Evaluation

- 32% of the Program Specialist time will be spent on evaluation design and implementation = $200,213
- Evaluator (contracted) = $700,000
- Peer/Family stipends to conduct client satisfaction surveys, assist with evaluation planning and data analysis = $50,000

Total INN funds = $950,213

Non-MHSA Funding

- FFP: Once billing systems are developed, MediCal will reimburse for some services
- Other Funding: Measure A (described above)

B. New Innovative Project Budget By FISCAL YEAR (FY)*							
EXPENDITURES							
PERSONNEL COSTs (salaries, wages, benefits)		**FY 18-19 9 months**	**FY 19-20**	**FY 20-21**	**FY 21-22**	**FY 22-23**	**Total**
1	Salaries	**$820,047**	**$1,775,301**	**$1,613,471**	**$1,613,471**	**$1,613,471**	**$7,435,761**
2	Direct Costs						**$0**
3	Indirect Costs	**$ 123,007**	**$ 266,295**	**$ 242,021**	**$ 242,021**	**$ 242,021**	**$ 1,115,365**
4	Total Personnel Costs	**$ 943,054**	**$ 2,041,596**	**$ 1,855,492**	**$ 1,855,492**	**$ 1,855,492**	**$ 8,551,126**
OPERATING COSTs		**FY 18-19**	**FY 19-20**	**FY 20-21**	**FY 21-22**	**FY 22-23**	**Total**
5	Direct Costs	**$ -**	**$ 80,775**	**$ 107,700**	**$ 107,700**	**$ 107,700**	**$ 403,875**
6	Indirect Costs	**$ -**	**$ 12,116**	**$ 16,155**	**$ 16,155**	**$ 16,155**	**$ 60,581**
7	Total Operating Costs	**$ -**	**$ 92,891**	**$ 123,855**	**$ 123,855**	**$ 123,855**	**$ 464,456**
NON RECURRING COSTS (equipment, technology)		**FY 18-19 9 months**	**FY 19-20**	**FY 20-21**	**FY 21-22**	**FY 22-23**	**Total**
8	**Vehicles and Equipment**	**$0**					**$0**
9	**Training**	**$0**					**$0**
10	Total Non-recurring costs	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
CONSULTANT COSTS/CONTRACTS (clinical, training, facilitator, evaluation)		**FY 18-19 9 months**	**FY 19-20**	**FY 20-21**	**FY 21-22**	**FY 22-23**	**Total**
11	Direct Costs	**$135,000**	**$135,000**	**$135,000**	**$210,000**	**$135,000**	**$750,000**
12	Indirect Costs	**$20,250**	**$20,250**	**$20,250**	**$31,500**	**$20,250**	**$112,500**
13	Total Consultant Costs	**$155,250**	**$155,250**	**$155,250**	**$241,500**	**$155,250**	**$862,500**
OTHER EXPENDITURES (please explain in budget narrative)		**FY 18-19 9 months**	**FY 19-20**	**FY 20-21**	**FY 21-22**	**FY 22-23**	**Total**
14							**$0**
15							**$0**
16	Total Other expenditures	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
BUDGET TOTALS							
Personnel (line 1)		**$820,047**	**$1,775,301**	**$1,613,471**	**$1,613,471**	**$1,613,471**	**$7,435,761**
Direct Costs (add lines 2, 5 and 11 from above)		**$135,000**	**$215,775**	**$242,700**	**$317,700**	**$242,700**	**$1,153,875**
Indirect Costs (add lines 3, 6 and 12 from above)		**$143,257**	**$298,661**	**$278,426**	**$289,676**	**$278,426**	**$1,288,446**
Non-recurring costs (line 10)		**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Other Expenditures (line 16)		**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
TOTAL INNOVATION BUDGET		**$1,098,304**	**$2,289,737**	**$2,134,597**	**$2,220,847**	**$2,134,597**	**$9,878,082**

C. *Expenditures By Funding Source and FISCAL YEAR (FY)*							
Administration:							
A.	**Estimated total mental health expenditures for ADMINISTRATION for the entire duration of this INN Project by FY & the following funding sources:**	**FY 18-19 9 months**	**FY 19-20**	**FY 20-21**	**FY 21-22**	**FY 22-23**	**Total**
1	Innovative MHSA Funds	$ 209,079	$ 386,411	$ 366,176	$ 377,426	$ 366,176	$ 1,705,268
2	Federal Financial Participation						
3	1991 Realignment						$ -
4	Behavioral Health Subaccount						$ -
5	Other funding*						
6	**Total Proposed Administration**	**$ 209,079**	**$ 386,411**	**$ 366,176**	**$ 377,426**	**$ 366,176**	**$ 1,705,268**
Evaluation:							
B.	**Estimated total mental health expenditures for EVALUATION for the entire duration of this INN Project by FY & the following funding sources:**	**FY 18-19 9 months**	**FY 19-20**	**FY 20-21**	**FY 21-22**	**FY 22-23**	**Total**
1	Innovative MHSA Funds	$ 146,213	$ 182,250	$ 182,250	**$ 257,250**	$ 182,250	$ 950,213
2	Federal Financial Participation						$ -
3	1991 Realignment						$ -
4	Behavioral Health Subaccount						$ -
5	Other funding*						$ -
6	**Total Proposed Evaluation**	**$ 146,213**	**$ 182,250**	**$ 182,250**	**$ 257,250**	**$ 182,250**	**$ 950,213**
TOTAL:							
C.	**Estimated TOTAL mental health expenditures (this sum to total funding requested) for the entire duration of this INN Project by FY & the following funding sources:**	**FY 18-19 9 months**	**FY 19-20**	**FY 20-21**	**FY 21-22**	**FY 22-23**	**Total**
1	Innovative MHSA Funds	$ 1,098,304	$ 2,289,737	$ 2,134,597	$ 2,220,847	$ 2,134,597	$ 9,878,082
2	Federal Financial Participation			$ 1,150,000	$ 1,150,000	$ 1,150,000	$ 3,450,000
3	1991 Realignment						$ -
4	Behavioral Health Subaccount						$ -
5	Other funding* (Measure A)	$ 920,293	$ 564,557				$ 1,484,850
6	**Total Proposed Expenditures**	**$ 2,018,597**	**$ 2,854,294**	**$ 3,284,597**	**$ 3,370,847**	**$ 3,284,597**	**$ 14,812,932**

*If "Other funding" is included, please explain.

Measure A are local funds already secured by Alameda County Emergency Medical Services for this project. See Budget Narrative.

APPENDIX A.

MEMORANDUM

To: Kate Jones

From: Mary Skinner

Re: MET Transport Challenges and Recommendations

A. Transportation Challenges for MET

The challenge of providing relief to MET members waiting for transport for persons having a mental crisis revolves around the use of an ambulance. Ambulances may take some time to arrive because medical emergencies take priority. Not only is the person having the mental crisis waiting in the back of a police vehicle, the on scene officers are spending considerable time waiting. These wait times heightens stress and create stigma to an already difficult situation for those involved.
Three facets of California's current EMS statutes and regulations impede the development and implementation of most EMS/paramedicine programs:

1. The requirement that callers to 911 must be taken to an acute care hospital having a basic or comprehensive ED (Health & Safety Code Division 2.5, section 1797.52).

2. The locations where paramedics can practice — i.e., at the scene of a medical emergency, during transport to an acute care hospital with a basic or comprehensive emergency department, during inter- facility transfer, while in the ED of an acute care hospital until responsibility is assumed by hospital staff, or while working in a small and rural hospital pursuant to sections 1797.52, 1797.195, and 1797.218 (California Code of Regulations [CCR], title 22, section 100145, and Health & Safety Code 2.5, section 1797).

3. The specification of the paramedic scope of practice. Specific procedures and medications approved for use are contained in regulation (CCR, title 22, section 100145 and Health & Safety Code 2.5, section 1797).

Paramedics have a larger scope of practice that is designed to assist with significant medical and trauma related conditions that are rarely needed by patients with an acute mental health crisis.

Despite a more limited scope of practice, EMT's don't have the same restrictions and can transport patients to a variety of institutions (Emergency departments, PES, sobering centers, unlocked CIU's, residential crisis beds, clinics)

There are many cities and counties that have same or similar programs as Alameda County's MET. However, the most glaring difference is that they do not require an ambulance for transportation, nor do they have regulations precluding use of a paramedic for transportation to a facility that is not an "acute care hospital". Unless there is a medical need, individuals are transported directly by the law enforcement officers who are members of the mobile crisis program, or by the clinician/peer team member.

Cities/counties commonly use unmarked vehicles or what one referred to as the "therapeutic transport team". (All transports required referrals to the receiving facility.)
This doesn't discount there are city and counties struggling with the obligation of transporting psychiatric patients in ambulances. Their struggle is the same as Alameda County. The ambulance takes time away from answering medical emergencies, and the ambulance creates a stigma for the person in crisis. Allina Health, which owns Abbott Northwestern and 11 other hospitals statewide in Minnesota, now keeps an unmarked Ford Escape among its fleet of ambulances at its emergency medical base in Mounds View, a city considered part of Twin Cities Metropolitan Area.

The state of Minnesota has been struggling with the same issues of transporting persons having a mental health crisis. There, the issue surrounding wait time is transport may take hours not only because of responding to medical emergencies, but because facility locations can be miles away. Some as far as a three hour drive. Minnesota Legislature created a special class of non-emergency transports under state law. Advocacy groups are trying to include non-emergency transport as a reimbursable expense under Medical Assistance, Minnesota's version of Medicaid because many of these transports go unpaid.

There are other cities/counties/states that use non-emergency vehicles. Atlanta is one such city. Their vehicles are vans with a partition so patients are separated from the driver. The most unique is the state of Tennessee. Under TN state law, a sheriff or third party designated by the sheriff may make the transport for an involuntary admission. Though this doesn't sound unique, the waiting time is: by law, the receiving facility is notified and given an estimated time of arrival; if the sheriff or agent arrives within the stated time frame, the sheriff or agent waits no longer than 1 hour and 45 minutes for evaluation; if they do not arrive in the stated time, then they must stay at the facility for the duration. This law does not apply to counties with more than 600,000 people.
Here, they only have to deliver the person to the facility. No waiting involved.

B. EMT inclusion/replacement within MET

Although there are no mobile crisis team models which is EMT and clinician based responding on scene, Charleston, South Carolina (area covered encompasses two counties: Charleston and Dorchester) is rolling out a program which will be EMS and telehealth based. The model is basically an EMT using a video type service (much akin to Skype, Facetime, etc.) that is HIPPA compliant to consult with the clinician on duty while the EMT is on scene. The EMT will then be able to transport, if necessary, the person to a facility or other services that may be required. Charleston-Dorchester's model is interesting not only because of its EMT usage, but the coverage area, approximately 545,000 people, is spread out across two counties (approximately 1,937 square miles). They also have the majority of mental health crisis contacts in one area, North Charleston, just as Oakland encompasses the majority of Alameda County's contacts. Charleston-Dorchester's roll out begins the week of March 27th. The Director of Special Operations, Melissa Camp, has agreed to share information regarding "lessons learned" as the pilot program progresses. A close second model is in the state of North Carolina. NC's model is called Community Paramedicine Behavioral Health Crisis Response which began in 2013. In response to overwhelmed EDs and rules that EMS agencies would not be able to bill unless the patient went to the ED, the state decided more effective strategies were needed. Regional mental health authorities and communities provided developed advanced training for EMS departments and their paramedics. The EMS personnel now obtain specialized training for treating mental illness and substance use to assist in diverting individuals in mental health crisis from hospital EDs to other facilities. EMS staff consult with a doctor before bypassing ED. WakeBrook Crisis Center in Raleigh (Wake County) redirected 250 patients away from the ED saving 3,400 ED bed hours. Wake EMS was on track to redirect more than 320 patients in 2013.1

In CA, Stanislaus County is doing a pilot program modeled on North Carolina. The program focuses on Medi-Cal and uninsured patients though it includes insured and Medicare patients. Stanislaus obtained an approval from OSHPD (Office of Statewide Health Planning and Development) because CA law prohibits EMS from transporting patients to alternate facilities and places limitations on an EMS' scope of practice. Here, the community paramedic is called per request of the ambulance EMS, or police. If patient requires transport, an ambulance is used. The evaluation report for first-year results is due in 2017. (See Attachment A for One Page Notes)

C. Recommendations to EMT Preclusions

In order for EMS personnel to be used to improve transportation challenges and EMS assisting MET, an amendment to Health
& Safety Code Division 2.5 and California Code of Regulations, Title 22, Division 9: Prehospital Emergency Medical Services (See Attachment B for codes) would need to be amended. One of the hopeful outcomes from the Stanislaus County pilot program is a change in legislation.

Alameda County could apply to OSHPD under a Health Workforce Pilot Projects (HWPP) Program. This is the program Stanislaus County obtained approval for their pilot program. The programs allows organizations to test, demonstrate, and evaluate new or expanded roles for healthcare professionals or new healthcare delivery alternatives before changes in licensing laws are made by the legislature. However, the review process could take up to or more than six months and there is no guarantee for approval.

Another possibility is instead of an EMT, using a nurse practitioner in the same role. There are no statutes or regulations that limit the scope of practice on nurses as specifically as the EMT regulations do. Although an NP has extended training and medical knowledge over an EMT, an EMT's skill set for direct community interaction, especially exposure to persons with mental health crisis, may be greater. (Note: NPs are merely being suggested because they were used in a successful San Francisco program begun in 2004 and ended in 2009 due to lack of funds. See Attachment C)

D. Optional Recommendation: Psychiatric Advance Directives (PAD)

The National Alliance on Mental Illness' position is that "PADs should be considered as a way to empower consumers to take a more active role in their treatment, and as a way to avoid conflicts over treatment and medication issues." Proponents suggest that PADs:

- promote autonomy
- foster communication between patients and treatment providers
- increase compliance with medication
- reduce involuntary treatment and judicial involvement.2

PADs improve psychiatric and recovery-oriented outcomes by empowering consumers with serious mental illness to take an active role in their own care.3 In the spirit of increasing satisfaction with clients, an Advance Directive can be a measure of empowerment to clients because they are involved in their treatment choices when it is found they are incapable of making healthcare decision. Psychiatric patients having a joint crisis or advanced directive plan compared to a group of psychiatric patients without a plan showed a reduction in compulsory admissions and treatment, 13% and 27% respectively.4 A similar study with patients who developed advanced directives without assistance from the outpatient health team were compared to patients without a PAD.5 No difference was found in the number of psychiatric hospital admissions. These two studies suggests a positive impact of a joint advanced directive plan developed by the patient and his or her outpatient treatment team on hospital admission outcomes.

The CalMHSA article "*Recovery Focused Hospital Diversion and Aftercare…*" states Marin County has a crisis residential program which includes assistance for people to develop crisis plans. In Marin County, a person with lived experience in the mental health system facilitates the development of Advance Directives as a component of this program.6 However, at the time of this writing, I have been unable to confirm they use PADs and if they do, what is their protocol. Otherwise, there are no other cities who have incorporated PADs into their follow ups.

Although no cities/counties use PADs in follow ups, there are a few states that use a state registry that file PADs either with the Secretary of State or with the state's division of mental health (New Jersey has such a registry). Registry access is generally given only to the directive holder, then persons the holder has given permission to access the registry. However, two states, New Jersey and Washington, have their registry accessible to both health and mental health providers.

California has a registry for advance directives. It does not accept PADs. Accordingly, the directive holder should keep a copy; an additional copy sized for a wallet; copy to their PAD agent; and mental health facilities and programs they may access. It is also suggested to give a copy to a trusted friend or family member.

How effective PADs would be for marginalized community members is unknown. However, the studies show promise in their usage, and discussion of availability may bring empowerment to a disenfranchized population.

1 http://www.northcarolinahealthnews.org/2013/11/08/mental-health-crisis-initiative-announced/

2 National Alliance on Mental Illness. Psychiatric advance directives. http://www.nami.org/Template.cfm?Section=Issue_Spotlights&Template=/Tagg....

3 Swanson JW, Tepper M, Backlar P et al. Psychiatric advance directives: an alternative to coercive treatment? Psychiatry 2000; 63:160-72.

4 Henderson C, Flood C, Leese M, Thornicroft G, Sutherby K, Szmukler G. Effect of joint crisis plans on use of compulsory treatment in psychiatry: single blind randomized controlled trail. BMJ. 2004; 329:136–138.

5 Papageorgiou A, King M, Janmohamed A, Davidson O, Dawson J. Advance directives for patients compulsorily admitted to hospital with serious mental illness. Brit J Psychiatry. 2002; 181:513–519. 6 CalMHSA, Recovery Focused Hospital Diversion and Aftercare – Transformation in Services Will Equal Transformation in Lives, June 2015, Pub #CM62.01; 34.

ATTACHMENT A
(This is an excerpted page from the Overview)


Illustration by Ruben DeLuna

In response to a 911 call, community paramedics transport patients with behavioral health needs, but no emergent medical needs, to a mental health crisis center instead of to an emergency department (ED).

Results (as of September 30, 2016)

- 98% of patients were evaluated at the behavioral health crisis center without the long delay of a preliminary ED visit.
- Less than 3% of patients required subsequent transfer to the ED, and there were no adverse outcomes. After refining the field medical evaluation protocols, the rate of transfer to an ED fell to zero.
- The project yielded savings for payers, primarily Medi-Cal, because screening behavioral health patients in the field for medical needs and transporting them directly to the mental health crisis center obviated the need for an ED visit with subsequent transfer from an ED to a behavioral health facility.
- For uninsured patients, the amount of uncompensated care provided by ambulance providers and hospitals also decreased.

How It Works

Many California EDs are overcrowded. Some of the patients served in an ED could be treated safely and effectively in other settings, including some who arrive via ambulance.

Behavioral health patients are often transported to an ED for medical clearance or when there is no capacity to evaluate them at a crisis center. These patients can spend hours in an ED waiting for medical clearance, and in some cases they can spend days in the ED waiting for a bed at an inpatient behavioral health center, without getting definitive behavioral health care during their ED stay.

In Stanislaus County, community paramedics are dispatched in response to 911 calls that a dispatcher determines to be a behavioral health emergency or when another paramedic or a law enforcement officer identifies a patient with behavioral health needs. Community paramedics are also dispatched to the mental health crisis center to assess patients who arrive on their own and who need to be medically cleared before being admitted to the county's inpatient psychiatric facility. The community paramedics provide these services as needed in addition to responding to traditional 911 calls.

Once on scene, a community paramedic assesses the patient for medical needs or intoxication due to alcohol or drug consumption. If the patient has no emergent medical needs, is not intoxicated, and is not violent, the community paramedic contacts the mental health crisis center to determine bed availability at the county inpatient psychiatric facility. Upon a patient's arrival, mental health professionals on the crisis center staff evaluate the patient to determine the most appropriate level of care for their condition. Eligibility is limited to nonelderly adults who are uninsured or enrolled in Medi-Cal because the county inpatient psychiatric facility does not accept patients with other health insurance.

Partners

LOCAL EMS AGENCY	LEAD AGENCY	HEALTH CARE SYSTEM PARTNER	EMS PROVIDER PARTNER	LOCATION
Stanislaus County	Mountain Valley EMS	Stanislaus County Behavioral Health and Recovery Services	AMR Stanislaus County	Stanislaus County

ATTACHMENT B

California Health and Safety Code Division 2.5

§1797.52. (Advanced Life Support) "Advanced life support" means special services designed to provide definitive prehospital emergency medical care, including, but not limited to, cardiopulmonary resuscitation, cardiac monitoring, cardiac defibrillation, advanced airway management, intravenous therapy, administration of specified drugs and other medicinal preparations, and other specified techniques and procedures administered by authorized personnel under the direct supervision of a base hospital as part of a local EMS system at the scene of an emergency, during transport to an acute care hospital, during interfacility transfer, and while in the emergency department of an acute care hospital until responsibility is assumed by the emergency or other medical staff of that hospital. (*Amended by Stats. 1984, Ch. 1391, Sec. 4.*)

California Code of Regulations Title 22

§100145. Scope of Practice of Paramedic.

(a)) A paramedic may perform any activity identified in the scope of practice of an EMT-I in chapter 2 of this division, or any activity identified in the scope of practice of an EMT-II in chapter 3 of this division.

(b)) A paramedic shall be affiliated with an approved paramedic service provider in order to perform the scope of practice specified in this Chapter.

(c)) A paramedic student or a licensed paramedic, as part of an organized EMS system, while caring for patients in a hospital as part of his/her training or continuing education under the direct supervision of a physician, registered nurse, or physician assistant, or while at the scene of a medical emergency or during transport, or during interfacility transfer, or while working in a small and rural hospital pursuant to section of the Health and Safety Code, may perform the following procedures or administer the following medications when such are approved by the medical director of the local EMS agency and are included in the written policies and procedures of the local EMS agency.

(1) Basic Scope of Practice:

(A)) Perform defibrillation and synchronized cardioversion.
(B)) Visualize the airway by use of the laryngoscope and remove foreign body(-ies) with forceps.
(C)) Perform pulmonary ventilation by use of lower airway multi-lumen adjuncts, the esophageal airway, and adult oral endotracheal intubation.
(D)) Institute intravenous (IV) catheters, saline locks, needles, or other cannulae (IV lines), in peripheral veins and monitor and administer medications through pre-existing vascular access.
(E)) Administer intravenous glucose solutions or isotonic balanced salt solutions, including Ringer's lactate solution.
(F)) Obtain venous blood samples.
(G)) Use glucose measuring device.

(H)) Perform Valsalva maneuver.
(I)) Perform needle cricothyroidotomy.
(J)) Perform needle thoracostomy.
(K)) Monitor thoracostomy tubes.
(L)) Monitor and adjust IV solutions containing potassium, equal to or less than 20 mEq/L.
(M)) Administer approved medications by the following routes: intravenous, intramuscular, subcutaneous, inhalation, transcutaneous, rectal, sublingual, endotracheal, oral or topical.
(N)) Administer, using prepackaged products when available, the following medications:

1. 25% and 50% dextrose;
2. activated charcoal;
3. adenosine;
4. aerosolized or nebulized beta-2 specific bronchodilators;
5. aspirin;
6. atropine sulfate;
7. bretylium tosylate;
8. calcium chloride;
9. diazepam;
10. diphenhydramine hydrochloride;
11. dopamine hydrochloride;
12. epinephrine;
13. furosemide;
14. glucagon;
15. midazolam;
16. lidocaine hydrochloride;
17. morphine sulfate;
18. naloxone hydrochloride;
19. nitroglycerine preparations, except intravenous, unless permitted under (c)(2)(A) of this section;
20. sodium bicarbonate; and
21. syrup of ipecac.

(2) Local Optional Scope of Practice:

(A)) Perform or monitor other procedure(s) or administer any other medication(s) determined to be appropriate for paramedic use, in the professional judgement of the medical director of the local EMS agency, that have been approved by the Director of the Emergency Medical Services Services Authority when the paramedic has been trained and tested to demonstrate competence in performing the additional procedures and administering the additional medications.

(B)) The medical director of the local EMS agency shall submit Form #EMSA-0391 dated 1/94 to, and obtain approval from, the Director of the EMS Authority in accordance with section

ATTACHMENT C

Case Study 1

San Francisco Program to Address the Needs of Chronic Inebriates

San Francisco developed a program to appropriately address the needs of chronic inebriates — The San Francisco Fire Department (SFFD) Homeless Outreach & Medical Emergency (HOME) Team. The program was developed in response to a small number of individuals who were chronic inebriates that frequently called 911, had extensive ED use, and incurred high uncompensated health care costs.

The San Francisco HOME Team was designed to connect at-risk individuals with a system of care to better serve their needs and to stop the unproductive cycle of ambulance transports and hospital stays. Analysis by the HOME Team found that heavy EMS system users are typically 40- to 60-year-old homeless male chronic inebriates who have comorbid mental illness and medical conditions, and high mortality rates. Prior to this program, San Francisco General Hospital estimated a total of $12.9 million in annual uncompensated charges associated with 225 frequent users.

The HOME Team program started in October 2004 under the SFFD EMS through a joint effort of SFFD, San Francisco Department of Public Health, and San Francisco Human Services Agency. The team was led by one paramedic captain and included intensive case managers or outreach workers as well as nurse practitioners. Typical response involved outreach to find all frequent users, connect them to community- based care (typically, substance abuse treatment and medical detoxification), and advocate for long term care when necessary. The program was able to develop a web of resources and partners including case workers, mental health professionals, primary care providers, housing resources, substance abuse treatment programs, and law enforcement. These partners came together to create and evaluate systems of care for the frequent users. This clinical planning brought forth new long term care placement options for dual diagnosis patients with both mental health and substance abuse conditions, including locked programs and boarding programs with care management. Over an 18-month period, there were reductions in ambulance activity for high users and a decrease in ED diversion rates at local hospitals. The HOME Team was funded by the San Francisco Department of Public Health at approximately $150,000 annually; however, funding was rescinded due to the department having other budget priorities, and the program has been on hiatus since June 2009.

(Source: *The San Francisco Fire Department HOME Team: An Urban Community Paramedic Pilot Project,* presentation by Captain Niels Tangherlini, June 27, 2012. [Cited from *Community Paramedicine: A Promising Model for Integrating Emergency and Primary Care*, Kizer, K. W.; Shore, K.; Moulin, A.; July 2013.])

APPENDIX B.

Alameda County EMS 5150 Transports 2017						
	Emergency Department Destination		Psychiatric Facility Destination		Grand Total	
Response City	Distinct count of Arrived at Hospital	% of Total Distinct count of Arrived at Hospital along Table (Down)	Distinct count of Arrived at Hospital	% of Total Distinct count of Arrived at Hospital along Table (Down)	Distinct count of Arrived at Hospital	% of Total Distinct count of Arrived at Hospital along Table (Down)
Oakland	2,762	37.0%	2,537	47.8%	5,299	41.5%
Hayward	754	10.1%	588	11.1%	1,342	10.5%
Berkeley	764	10.2%	535	10.1%	1,299	10.2%
San Leandro	660	8.8%	546	10.3%	1,206	9.4%
Fremont	709	9.5%	166	3.1%	875	6.9%
Alameda	217	2.9%	232	4.4%	449	3.5%
Livermore	307	4.1%	115	2.2%	422	3.3%
Pleasanton	236	3.2%	102	1.9%	338	2.6%
Castro Valley	204	2.7%	127	2.4%	331	2.6%
Union City	210	2.8%	84	1.6%	294	2.3%
Emeryville	151	2.0%	86	1.6%	237	1.9%
Dublin	164	2.2%	65	1.2%	229	1.8%
Newark	169	2.3%	38	0.7%	207	1.6%
San Lorenzo	99	1.3%	63	1.2%	162	1.3%
Albany	51	0.7%	24	0.5%	75	0.6%
Piedmont	18	0.2%	3	0.1%	21	0.2%
Sunol	7	0.1%	1	0.0%	8	0.1%
Total	**7,482**	**100.0%**	**5,312**	**100.0%**	**12,794**	**100.0%**

ALAMEDA COUNTY
Behavioral Health Care Services

ALCOHOL, DRUG & MENTAL HEALTH SERVICES
CAROL F. BURTON, MSW, INTERIM DIRECTOR

Alexander Jackson, LCSW
Transition Age Youth Division Director
Child and Young Adult System of Care
2000 Embarcadero Cove, Suite 400
Oakland, California 94606
Office: (510) 567-8123
Fax: (510) 567-8130
E-Mail: alexander.jackson@acgov.org

May 21, 2018

To: Mental Health Services Oversight and Accountability Commission

This letter is sent on behalf of Alameda County Behavioral Health Care Services (BHCS) Transition Age Youth (TAY) Division in support of the Community Assessment and Transport Team (CATT) project. TAY experiencing mental health issues are at risk for mental health crises. We know that many times a young person experiencing early signs of psychosis come into contact with crisis services, but are not successfully engaged in planned services. We are working to better address this, and believe that the CATT project will be a great contribution. We fully support taking a collaborative approach to systems improvement. Often systems improvement is slow, but the approach proposed in this project offers the opportunity to learn how to do it more quickly.

In addition, the CATT service model is one that is more likely to help TAY get the services they need. Families report many difficulties when they call 911 regarding their child. Having a team arrive in an unmarked car that can take the time to work with the youth and the family to de-escalate the situation, as well as do a thorough assessment, will lead to much more successful outcomes, as well a better experience for the client and family. Most importantly the team will be able to take the client to the services they need, whether or not they are appropriate for a 5150 hold. This will greatly increase the likelihood they get connected to services effectively.

The BHCS TAY Division will gladly participate in these collaborative efforts. We expect that what is learned through this project will improve crisis and planned services for our young clients.

Sincerely,

Alexander Jackson, LCSW
TAY Division Director
Behavioral Health Care Services

Candy DeWitt
Voices of Mothers and Others
1028 Buena Vista Ave.
Alameda, CA 94501

May 24, 2018

To: Mental Health Services Oversight and Accountability Commission

Re: Community Assessment and Transport Team model

I am the parent of a beautiful son who through no fault of his own became ill with the terrible illness of schizophrenia at the young age of 18. Sadly because of our inability to get sustained care in our current mental health system our family story ended in a great tragedy. Our son now sits at Napa State Hospital after being found Not Guilty By Reason of Insanity. The personal loss we have all suffered is unimaginable and the financial cost to our system is enormous.

At the time our son became ill I knew very little about serious mental illness and even less about our health care system. I soon learned very quickly about both. Our family repeatedly experienced a lack of coordination among crisis services during psychiatric emergencies that directly impacted the outcome of care for our son. This is not uncommon among the family-experience. I strongly believe the Community Assessment and Transport Team model that is being considered is critically important because agencies who are able to work together to develop a seamless process for individuals will help to ensure that people in mental health crisis get the services they deserve.

Having a team arrive in the course of a psychiatric emergency to assess and transport persons to the appropriate service in an unmarked vehicle would be also be a great improvement over the current procedure of police involvement. Police are often not trained on how to respond to persons who may be experiencing delusions, paranoia or hallucinations and for this reason situations can escalate and sometimes end up in heartbreak. In addition, calling the police for help for your loved one when in mental health crisis creates distrust and often harms the family relationship a bond that is vital to the care and support needed of loved ones for years to come if not the rest of their lives.

There are many changes we need to make in our system before we stop the revolving door of our hospitals and jails for our most severely mentally ill and so they instead get the help they so desperately need. However the opportunity to try this new approach of a Community Assessment and Transport Team is one solution that is certain to make a difference for individuals and their families.

Please support this proposal.

VTY

Candy DeWitt

Voices of mothers and others

voicesofmothersandothers@gmail.com 510.527.8770 510.523.3239

Voices of mothers and others

May 17, 2018

To: Mental Health Services Oversight and Accountability Commission

Fourteen years ago my son was in the early stages of his illness and refusing to meet with doctors. When he experienced his first psychotic break and began engaging in behaviors that put him at risk, his doctor recommended we call for a 5150. Unfamiliar at the time with this process, I thought a mental health professional would come to our house to meet with him. Instead, police showed up, handcuffed my son, and took him away in an ambulance. I will forever remember the disbelief in my son's eyes as he was escorted away; we have never recovered the trust that was lost that day and on so many others when we have felt we had no other recourse than to make that call for an intervention. Unfortunately, these desperate calls rarely result in sustained care that would justify the trauma that they cause. There has historically been little coordination between the varying levels of the system, and thus there is little continuity of care. Police who bring patients to Psychiatric Emergency Rooms often find that the individuals are back on the streets before their shifts are even over. Or a patient may be held for crisis stabilization services for days or weeks and then put back on the street with a prescription and a BART pass and without being connected to follow-up outpatient services.

Emergency Room services are the most expensive services available, and they should be reserved for those for whom they are truly needed. For others, a referral to a less restrictive placement may be more appropriate and would be less traumatic. It would also lessen the burden on Acute Inpatient facilities so they can hold individuals needing longer term inpatient care until sub-acute beds become available for them.

I feel strongly that the Community Assessment and Transport Team model can help various agencies work together to develop a more seamless process for individuals to get to the service that they need. Having a team arrive in the course of a psychiatric emergency that can assess and transport to the most appropriate service, in an unmarked van, is a better alternative than the current one which relies so heavily on police responders and the criminal justice system. The challenges with the crisis response system have been going on for a long time and new approaches are long overdue. As part of a larger re-alignment within the Behavioral Health System, it could help to end the revolving door of 5150s and arrests that does so little to alleviate the suffering of those with serious and untreated mental illness. But to be truly effective, this new program must be accompanied by other changes to the system such as increasing the number of inpatient beds to meet the demand of our demographic size, and the improvement of these facilities and the services they offer so that they provide more therapeutic settings for those who use them, enabling them to return rehabilitated to their families and communities.

Thank you for considering this proposal.

Sincerely,

Patricia Fontana-Narell

Voices of Mothers co-founder
prfontana@comcast.net

voicesofmothersandothers@gmail.com 510.527.8770 510.523.3239

Mental Health Services Oversight and Accountability Commission

Community Assessment and Transport Team (CATT) Proposal

Alameda County Emergency Medical Services (ALCO EMS) is an integral partner with Behavioral Health Care Services (BHCS) and Paramedics Plus in developing the Community Assessment and Transport Team proposal. Alameda County chose to conduct 5150 transports via ambulances to reduce the stigma and risks associated with law enforcement transport. That was a significant improvement to the crisis system, but has resulted in many hours of EMS services engaged in psychiatric crisis response.

We expect the CATT model to improve the crisis system in a number of ways. A key aspect will be the focused collaboration among agencies involved in the system to work together to identify problems and test out solutions rapidly. Most of the time individual agencies work in silos, or when collaboration happens it happens much more slowly that necessary.

The CATT project pairs Paramedics Plus Emergency Medical Technicians (EMTs) with mental health providers to conduct assessments and transport. EMTs can conduct the necessary assessments to triage clients, as well as being able to transport clients to a wider variety of services than paramedics are legally able to. Adding technology like ReddiNet and shared client records will allow us to test out the full potential capacity of CATT to get clients to the most appropriate service quickly and efficiently.

We are excited to be a part of this program and are working closely with ALCO EMS to deliver an excellent service model.

Sincerely,

Rob Lawrence

Rob Lawrence
Chief Operating Officer
Paramedics Plus

City of San Leandro
Civic Center, 835 E. 14th Street
San Leandro, California 94577
www.sanleandro.org

June 18, 2018

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

Dear Commissioners:

It is with great enthusiasm that the City of San Leandro supports Alameda County's application for MHSA funding for the Community Assessment and Transport Team (CATT).

The City of San Leandro experiences the third highest 5150 emergency transport and repeat hold in Alameda County. Currently, our police department is the only personnel that may 5150 individuals in San Leandro. The City is committed to the health and human services needs of our community. In fact, 99 percent of our police force and 100 percent of the dispatch staff has completed the Crisis Intervention Training (CIT). Although the police are a very important part of the emergency system, they should respond to crises as deemed necessary. A potential mental health crisis without public safety concerns should be addressed by mental health professionals.

Additionally, the City of San Leandro commissioned a human services gap analysis and found 5150/mental health crises is one of the priority issues to be addressed by the City and County partners. Recently the City was awarded the California League of Cities/Helen Putnam Award for Innovation and Economic Development as a result of the close collaboration between the police and human services department and several community-based organizations to address homelessness. We are well-positioned to move forward with the County to implement the CATT.

The CATT team allows for a more appropriate emergency response for individuals to receive mental health services and enter into a system of care. Further, it will allow for the team to provide ongoing linkages for services. This is especially significant for those persons that are in a psychiatric crisis and not eligible for a 5150 hold. We would be eager to partner and leverage the findings from this project to other parts of the mental health system.

We very much look forward to your consideration and approval of MHSA funds for the CATT.

Sincerely,

Jeff Tudor, Chief
Police Department

Jeanette Dong, Director
Recreation and Human Services Department

Hospital Council
of Northern & Central California
Excellence Through Leadership & Collaboration

June 20, 2018

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

Dear Members of the Commission:

On behalf of the Hospital Council of Northern and Central California and our hospital members in Alameda County, I am writing in support of the Alameda County Behavioral Health Care Services' application to fund the Community Assessment and Transport Team (CATT) project.

Currently, hospital emergency departments are experiencing high volumes, including a significant increase in the number of patients experiencing a mental health crisis. Taking care of these patients is complicated, time-consuming, and often requires a level of clinical expertise that many hospital emergency departments do not have readily available.

With the requested funding, Alameda County will be able to significantly improve its crisis services by having a professional team respond to an individual in the course of a psychiatric emergency, assess the individual, and transport them to the most appropriate service – potentially avoiding the need for an unnecessary emergency room visit.

The CATT project is an important and innovative step forward toward ensuring that individuals needing psychiatric services get the right care at the right time and place. We strongly support this project, which will greatly benefit our patients and the communities we serve as hospitals.

If you have any questions regarding this letter of support, then please do not hesitate to contact me at 925-746-1550 or rrozen@hospitalcouncil.org.

Sincerely,

Rebecca Rozen

Rebecca Rozen
Regional Vice President

Project Summary

County: **Alameda County**
Date submitted: 4/13/2018
Project Title: **Cannabis Policy and Education for Young Adults**
Total amount requested: $1,380,875
Duration of project: 3 years 3 months

General Requirement	Applies a promising community driven practice or approach that has been successful in a non-mental health context or setting to the mental health system
Primary Purpose	Promotes interagency and community collaboration related to Mental Health Services or supports or outcomes

Problem

The Adult Use of Marijuana Act (AUMA) legalizes "recreational" use and cultivation of cannabis for those 21 years of age and older in California. While the issues associated with cannabis use are not new, they have been changing due to easier access and increased potency. In addition, the process of legalization brings attention to the benign and beneficial aspects of cannabis, while minimizing the potential harms, which can produce an inaccurate public perception. One of the challenges in addressing cannabis policy and education is its complex legal status, which impacts policy, practice, and funding considerations.

California's legalization of recreational cannabis puts mental health clients at particular risk for negative consequences. While there is still much debate about the relationship between cannabis use and serious mental illness, National Institute on Drug Abuse (NIDA) has reviewed the literature and concludes there are correlations emerging in the research, including increased risk of psychosis and worsening outcomes for individuals with schizophrenia. Moreover, there are concerns about poly-pharmacy specific to mental health medications; challenges for physicians in determining the appropriate medications and dosages to prescribe; and reduced adherence to treatment protocols, including medications and behavioral interventions.

Alameda County's transition age youth triage project funded by SB82 estimated approximately 70% of youth had used cannabis within 24 hours before the onset of a crisis.

Project

The purpose of this project is to reduce the risks and harms associated with cannabis access and use for young adults (21-24 years old) experiencing serious mental illness. This project will build on existing public health and harm reduction approaches that are not specific to mental health clients and do not fully leverage the role that the cannabis industry can play. This project provides an opportunity to test new approaches, in a changing landscape, before adopting them as ongoing practices. We propose to accomplish this through collaboration:

Policy Committee including behavioral health, physical health, law enforcement, schools, the cannabis industry, and others. This committee will focus on determining effective practices and policies among these institutions given the complex legal status of cannabis. Actions may include getting a full understanding of the legal considerations; developing guidelines for educating individual with serious mental illness about cannabis usage; developing education and guidelines for the cannabis industry, such as a component for a "Responsible Vendor" training that addresses mental health issues and considerations.

Consumer and Family Committee including family members, consumers, and behavioral health providers. This committee will focus on developing an educational campaign informed by both consumers and the Policy Committee. Strategies to be considered may include peer education and technology-based education. In addition, mental health providers' knowledge and skills will be increased through consultation with experts, trainings, toolkits, etc.

Evaluation (See Logic Model for more details)

Alameda County aims to learn: Can a collaboration that includes the cannabis industry, consumers, and other key stakeholders result in practices that reduce potential harm to young adult (21-24) mental health consumers in regards to cannabis usage?

1. Determine how to develop a successful collaboration that includes the cannabis industry.
    - What policies and practices are implemented by collaborative partners?
    - How were the cannabis industries attitudes and practices affected?
2. Determine if and how a collaboration results in effective practices for reducing potential harm for young adult consumers in regards to cannabis usage.
    - Changes in provider knowledge and practices
    - Changes in client knowledge, attitudes and behaviors regarding cannabis usage
    - Changes in negative consequences associated with cannabis usage

This project may create a model for reducing potential harm associates with cannabis use among individuals with serious mental illness. The results will be shared with mental health and substance use divisions throughout California, and with many others.

Budget

Salaries *$292,500*	BHCS Program Coordinator (0.5 FTE)
Operating *$215,000*	Stipends for peers/family to participate and provide peer education Education materials including technology
Non-Recurring *$90,000*	Educational technology development
Consultants *$615,000*	Content experts, materials development, training, technology maintenance Evaluator
Indirect *$168,375*	15% for BHCS to administer project

Cannabis Policy and Education for Young Adults **Logic Model**

Situation: Adult Use of Marijuana Act (AUMA) legalizes "recreational" use and cultivation of cannabis for those 21 years of age and older in California under state law. When similar legislation was enacted in Colorado, rates of cannabis use among 18-24 years olds increased from 21% (2006) to 31% (2014). While individuals experiencing serious mental illness face unique risks related to cannabis use, no harm reduction programs specifically address them.

Inputs	**Outputs**		**Outcomes -- Impact**		
	Activities	*Participation*	*Short*	*Medium*	*Long*
Incentives for participation (food, stipends for clients/family members) Personnel Time - Program Coordinator - Peer educators - BHCS providers Topical Expertise: legal, curriculum, content, training, technology, etc. Outreach and education materials Evaluator	<u>Policy:</u> Collaboration by Policy Committee: research legal/social/ health, develop/ implement policy guidelines, etc. <u>Client Education:</u> Consumer/Family Committee: survey target population, develop education campaign Implement education campaign (i.e. peer education, technological strategies) <u>Provider Education:</u> Train providers in practices and educational campaign developed	Behavioral health, physical health, law enforcement, schools, the cannabis industry, others Family members, consumers, behavioral health providers Providers, Peer educators, Collaborative partners BHCS clients (ages 21-24) Providers, Trainers (30 trained)	<u>Policy:</u> Collaborative partners implement policies informed by cannabis legal status & health research (i.e. Responsible Vendor Training, messaging that recognizes cannabis not benign) <u>Client Education:</u> Young adult (ages 21-24) BHCS clients receive cannabis education provided by this project (836) <u>Provider Education:</u> Providers increase knowledge and skills (80%) and implement practices (70%)	Changes in cannabis industry and others knowledge, attitudes, practices Changes in client knowledge, attitudes, and behaviors regarding cannabis use - 50% avoid/reduce purchase - 50% avoid/reduce use - 70% increase knowledge	Cannabis industry and others contribute to protecting the health of young adults with mental illness *(not within the scope of this project evaluation)* Changes in negative consequences associated with cannabis use (statistically significant changes in indicators such as crisis incidents, hospitalizations, CANS, completion of treatment goals)

Assumptions

Cannabis use presents unique risks for individuals experiencing serious mental illness that may include poly-pharmacy, adherence to treatment, addiction and worse mental health outcomes. All stakeholders – from the cannabis industry to mental health clients – are important collaborative partners in developing effective health protecting policies and education campaigns.

External Factors

- The extent to which collaborative partners will participate in the development and implementation of health protecting policies.

INNOVATIVE PROJECT PLAN DESCRIPTION

County: Alameda Date Submitted 4.13.18
Project Name: Cannabis Policy and Education for Young Adults

I. Project Overview

1) Primary Problem

California's legalization of recreational cannabis puts older Transitional Age Youth mental health clients at particular risk for negative consequences.

The Adult Use of Marijuana Act (AUMA) legalizes "recreational" use and cultivation of cannabis for those 21 years of age and older in California under state law. Commercial sale, cultivation, and production of cannabis are allowed only by licensed providers. Trends in Colorado since similar legislation was enacted there in 2012 included:

- Rates of cannabis use among 18-24 years olds increased from 21% (2006) to 31% (2014)
- Cannabis-related calls to poison control centers increase from 44 (2006) to 227 (2015)
- Cannabis-related arrests decreased by 46% between 2012 and 2014.

While the reduction in legal system involvement due to legalization can be beneficial, the increased access to cannabis may have other negative effects on mental health consumers. The National Institute on Drug Abuse (NIDA) has reviewed the literature and determined that consequences of cannabis use include:

- anxiety and paranoia (present during intoxication);
- impaired learning and coordination and sleep problems (lasts longer that intoxication, but may not be permanent);
- increased risk for substance use disorders (Timberlake DS. *Susbst Use Misuse.* 2009.), learning and memory impairments, and loss of IQ when there has been heavy use during adolescence

drugabuse.gov/publications/cannabis/there-link-between-cannabis-use-psychiatric-disorders

While there is still much debate about the relationship between cannabis use and serious mental illness, NIDA concludes these correlations are emerging in the research:

- People with a genetic variation who used cannabis daily had seven times more likelihood of developing psychosis than those who used it infrequently or not at all (DiForti et al. *Biol Psychiatry*. 2012.)
- Adults with a genetic variation have a higher risk of psychosis if they used cannabis in adolescence (Caspi et al. *Biol Psychiatry*. 2005.)

- Cannabis worsens the course of illness in individuals who have schizophrenia (Foti et al. Am J Psychiatry. 2010.)
- Cannabis, especially at high dosage, can produce an acute psychotic reaction in individuals without schizophrenia (Morgan CJA. *Br J Psychiatry J Ment Sci.* 2013.)

Moreover, there are concerns about the interaction between cannabis and other pharmaceutical medications that might put mental health consumers at risk. While more research needs to be conducted, the medical field is reporting that cannabis use should be avoided when using benzodiazepines, selective serotonin reuptake inhibitors (SSRIs), serotonin and norepinephrine reuptake inhibitors (SNRIs), and anti-psychotics. While these medications have different interactions with cannabis, general side effects include sleepiness, dizziness, over sedation, and potential serotonin fluctuations. In addition to side effects, it can be very challenging for physicians to prescribe the most appropriate antidepressant or similar drug at the right dose to patients who also use cannabis, and co-occurring cannabis use can impede their ability to accurately assess efficacy of prescribed drugs. As a final note, physicians anecdotally report that some patients who use cannabis, alcohol, or other drugs during treatment — particularly those with severe depression or bipolar disorder — are less likely to adhere to their treatment protocols, including prescription drugs and behavioral interventions (e.g., cognitive behavioral therapy, psychotherapy, etc.).

Alameda County's transition age youth triage project funded by SB82 kept daily records on TAY clients experiencing mental health crises. They estimate approximately 70% of youth had used cannabis within 24 hours before the onset of the crisis. In the recent community planning process for Alameda County's MHSA Three Year Plan, parents and consumers expressed significant concern about the impact of cannabis use on individuals experiencing mental illness.

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

While the issues associated with cannabis use are not new, they have been changing due to easier access and increased potency. In addition, the process of legalization brings attention to the benign and beneficial aspects of cannabis, while minimizing the potential harms, which can produce an inaccurate public perception. One of the challenges in addressing cannabis policy and education is its complex legal status. While it has been legalized at the state level, it remains illegal at the federal level, impacting policy, practice, and funding considerations. Given that the new laws regarding cannabis in California just took effect on January 1, 2018, there is a surge of interest in the issue and a change in the environment that provides a unique opportunity to develop a positive and proactive collaboration with the cannabis industry, consumers, families, providers and others to support the health of consumers. For example, one of Alameda's Supervisors has been convening meetings regarding cannabis, including working with dispensaries on licensing requirements. **There is a need to determine effective policy and practices for service providers and the cannabis industry, as well as education**

strategies, to protect mental health consumers proactively within the complex legal environment that exists.

2) What Has Been Done Elsewhere To Address Your Primary Problem?

Alameda County Behavioral Health Care Services (BHCS) staff has been researching the intersection of cannabis use and mental illness, prevention and harm reduction education efforts, and models in other states. Some of this research has been done online, but given that legalization is a more recent trend, attendance at conferences has been a successful approach to get up-to-date information. Most recently, BHCS staff attended California Institute for Behavioral Health Solutions' Adolescent Early Intervention and Substance Use Disorder Treatment Summit. While it focused on substance use treatment, it provided an opportunity to learn about current research and practices, as well as make connections with experts in cannabis and youth. It *did not* address cannabis use and youth with mental illness, but it did provide information about the changing cannabis landscape and substance use prevention that is helpful in shaping this proposal.

SAMHSA has education and treatment materials for youth. Colorado has an extensive public health effort. Colorado also has developed a "responsible vendors" training and certification that engages the cannabis industry. In California, there are discussions about cannabis prevention given the change in legal status, but they are focused on regulating the industry and public health campaigns. The California Department of Public Health (cdph.ca.gov) "Let's Talk Cannabis" campaign also targets the general public. What we have not been able to find is an effort that focuses on mental health clients. There are a variety of differences between developing a harm reduction campaign for the general population versus mental health clients. For example, BHCS and other providers have in depth relationships with their clients that can provide information and support far beyond brochures, short trainings, and public messaging. In addition, clients have specific predispositions and poly-pharmacy issues that need to be addressed on an individual level.

This project aims to build on existing public health and harm reduction approaches in order to mitigate harm to mental health clients. The existing approaches are not specific to mental health clients and do not fully leverage the role that the cannabis industry can play. This INN project provides an opportunity to test new approaches, in a changing landscape, before adopting them as ongoing practices.

3) The Proposed Project

Legalization and resulting increased access to cannabis may lead to increased use and increased negative consequences among mental health consumers. **The purpose of this project is to reduce the risks and harms associated with cannabis access and use for young adults (21-24 years old) experiencing serious mental illness.**

We propose to accomplish this by developing a collaborative approach among key stakeholders, including consumers, families, and the cannabis industry. Developing a positive and proactive collaboration with the cannabis industry is a unique approach to support the health of consumers. This collaboration will enable us to:

- Understand the impact of state legalization of cannabis on mental health consumer's perceptions of and level of use.
- Improve the cannabis industry's understanding of mental illness and the effect of cannabis use on mental health consumers.
- Influence cannabis industry marketing and sales efforts to reduce risk and promote safety for mental health consumers.
- Tailor individual, group, and community harm reduction and psycho-education interventions to incorporate consumer and family perspectives.

Two advisory committees will be formed:

1) **Policy Committee:** A collaborative task force including behavioral health, physical health, law enforcement, schools, the cannabis industry, and others. The focus of this collaboration will be to share expertise, conduct research, and develop practice guidelines for participating sectors, educational efforts, relevant policies, and other areas. Including the cannabis industry provides an opportunity to incorporate their knowledge and get them on board with protecting the health of consumers. **This committee will focus on determining effective practices and policies among these institutions given the complex legal status of cannabis.** Actions may include:

    - Consulting with State and federal agencies, such as California Department of Health Care Services (DHCS), regarding legal and funding issues affecting potential service and education policies.
    - Working with the Alameda County Counsel to survey legislative landscape.
    - Developing policies and guidelines for educating consumers about cannabis usage and serving consumers who use cannabis.
    - Developing education and guidelines for the cannabis industry, such as a component for a “Responsible Vendor” training that addresses mental health issues and considerations.

2) **Consumer and Family Committee**: Develop a collaborative task force including family members, consumers, and behavioral health providers. **This committee will focus on better understanding cannabis usage from the consumers’ perspective**, as well as providing input on the work of the Policy Committee. Actions may include:

    - Developing and implementing a study of cannabis use by BHCS young adult (21-24) clients. This will help determine baseline data, as well as inform the development of policies and practices.

    - Developing an educational campaign informed by both consumers and the Policy Committee. Strategies to be considered may include:

- Peer education: We expect that TAY clients will participate in implementing the educational campaign as peer educators. Their exact role will depend on the education strategies chosen.
- Technology-based education: Given that technology is an effective way to reach the target age group, we expect that an educational App will likely be developed. The scope of such an App would have to be informed by legal counsel.
- Guidelines or toolkits for providers: This would include information and materials providers can use to implement the education campaign with their clients. There may also be version for family members.
- Other ideas may be generated through the collaborative process.

- Developing expertise among BHCS providers in cannabis use and mental health by working with expert consultants. Experts can provide trainings, manuals, and individual consultation for mental health and non-mental health providers serving young adult consumers.

The results of this process are expected to lead to:

1) **A model for working with the cannabis industry to develop and implement effective practices to support the health of mental health consumers**
2) **A well informed and collaborative education/harm reduction approach regarding cannabis and young adult mental health consumers given the current legal environment**

a) *Identify which of the three approaches specified in CCR, Title 9, Sect. 3910(a) the project will implement*

This project adapts existing public health and harm reduction practices from non-mental health settings to target young adult mental health clients.

b) *Briefly explain how you have determined that your selected approach is appropriate.*

There are existing public health and harm reduction campaigns regarding cannabis, as well as other legal and illegal substances, that have a lot to contribute to this project. There is research on the effects of these substances, effective messaging, etc. Some states have successfully engaged the cannabis industry to receive training in being responsible vendors. This provides a model that this project can build on. But this project proposes to adapt these models, through a collaborative process, to provide a deeper and tailored approach specifically for mental health consumers.

4) Innovative Component

One aspect of this project that is innovative is proactively working with the cannabis industry to protect the health of mental health consumers. While there are efforts to train dispensaries to be responsible vendors in terms of age limits and quantities, this project aims to engage industry representatives in an active role to protect the health of mental health clients. Historically, industries such as tobacco, alcohol, and firearms have only engaged in consumer protection after legal intervention. We have an opportunity to proactively engage the cannabis industry to assist in developing and enacting practices to protect health and empower consumers. Such practices may include providing educational materials resulting from this project, adding education about mental health related issues to vendor trainings, or other strategies developed through this project.

The central innovation is that we are adapting models for the general public to focus on the health of mental health consumers. There are substance use prevention programs, cannabis public health campaigns, and other models that can be borrowed from, but none of them focus on mental health consumers. To address mental health consumers, scope and strategies will need to be tested and *tailored* for the mental health consumer population. For example, policies, practices and strategies will:

- Focus on deeper work with clients, rather than general education campaigns.
- Focus on the risks and behaviors of mental health clients.

This is imperative because the success of any informational materials, campaigns and/or tool kits will depend on clear and targeted messaging; this is something that will be tested as BHCS adapts existing models from the general public.

California finds itself in a new legal environment regarding cannabis. Our goal would be to develop effective practices that other county mental health systems can adapt for their clients. **We hope that by being proactive we can influence the effects on young adult mental health consumers right from the start.**

5) Learning Goals / Project Aims

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

Alameda County aims to learn:

Can a collaboration that includes the cannabis industry, consumers, and other key stakeholders result in practices that reduce potential harm to young adult mental health consumers in regards to cannabis usage?

Learning Goals

1. Determine how to develop a successful collaboration that includes the cannabis industry.
    - This project hypothesizes that working collaboratively with the cannabis industry to protect the health of mental health clients is an essential, but untested, strategy.
    - A successful collaboration will: engage the key stakeholders – including the cannabis industry; result in implementation of suggested actions by collaborative partners; and result in partners reporting that the collaboration is successful.

2. Determine if and how a collaboration results in effective practices for reducing potential harm for young adult consumers in regards to cannabis usage.
    - The central reason for this project is to protect the health of mental health consumers given the current cannabis environment. This project seeks to understand the legal environment that impacts this goal and the needs of the consumers to inform effective practices.
    - While there are debates about the potential harm of cannabis use to mental health consumers, overall there is reason to believe that reduced use of cannabis, and informed/responsible use, can lead to better outcomes: lower rates of addiction, less chance of poly-pharmacy problems, better adherence to medication regimens and less risk of crisis incidents.

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

Learning Goals

1. Determine how to develop a successful collaboration that includes the cannabis industry.
    - The cannabis industry has been engaged as partners to enforce regulations, such as age and quantity limits. We believe they can be engaged to help develop and implement practices to protect the health of our clients. This project will test this hypothesis, as well as inform sustainability and replication.

2. Determine if and how a collaboration results in effective practices for reducing potential harm for young adult consumers in regards to cannabis usage.
    - Given the unique status of cannabis in California, developing policies and education will require learning from similar projects, but also understanding and applying current legal parameters. In addition, understanding the needs and perspectives of young adult mental health clients and others is key to developing effective practices.

6) *Evaluation or Learning Plan*

Learning Goals

1. Determine how to develop a successful collaboration that includes the cannabis industry.

Data to collect	Data collection method
○ Engagement efforts conducted with the cannabis industry ○ The response of the cannabis industry	○ The project coordinator will track activities and results
○ Who participates in the collaborative ○ Collaborative meetings and other activities ○ Collaborative discussions, decisions, and actions intended to protect the health of consumers	○ The project coordinator will collect via membership rosters, sign-in sheets, meeting minutes, etc.
○ Actions taken by collaborative members, such as implementing practices determined by the project ○ Collaborative members perception of the effectiveness of the collaboration, including what contributed to or impeded success	○ Surveys and focus groups with collaborative members. These would take place each year at regularly scheduled collaborative meetings.

2. Determine if and how a collaboration results in effective practices for reducing potential harm for young adult consumers in regards to cannabis usage.

Data to collect	Data collection method
○ What policies, practices, or campaigns resulted from the collaborative effort	○ The project coordinator will track products of the collaborative work.
○ How were the policies, practices, or campaigns implemented (by whom, for whom, in what context, etc.),	○ Surveys and focus groups with staff of organizations participating in implementation. Conduct at the conclusion of the project.
○ What were the strengths/weaknesses of the policies, practices, or campaigns in practice	○ Surveys and focus groups with staff noted above. Surveys and focus groups with consumers and family members receiving services informed by this project. Conduct at the conclusion of the project.
○ How were the cannabis industry's attitudes and practices affected	○ Surveys and focus groups with cannabis industry representatives. Conduct at the conclusion of the project. Cannabis industry collaborative members will help recruit participants.

○ Changes in provider knowledge and practices - 30 trained - 80% of providers trained show increased knowledge - 70% of providers trained implement practices developed by this project	○ Pre/post surveys of participating providers regarding knowledge about cannabis and mental health ○ Focus groups at end of project with participating providers about the effect on their practices
○ Changes in client knowledge, attitudes and behaviors regarding cannabis use. Goal for clients receiving a minimum number of services developed by this project: - 50% avoid/reduce purchase - 50% avoid/reduce use - 70% increase knowledge	○ The evaluator will develop a brief questionnaire (3-5 questions) that BHCS providers will ask clients (ages 21-24) and record answers in the EHR at regular intervals. It will be designed to provide data on: # of youth avoiding or reducing cannabis purchase # of youth avoiding or reducing cannabis use # of youth with increased understanding of the risks of cannabis use on their overall health and recovery
○ Changes in negative consequences associated with cannabis use. Goal for clients receiving a minimum number of services developed by this project: - Statistically significant difference in these indicators compared to those not receiving the services	Possible indicators for clients receiving a minimum number of services developed by this project: ○ Compare number of crisis incidents, hospitalizations and/or incarcerations in year before intervention and year after ○ Compare changes in Child and Adolescent Needs and Strengths (CANS) before and after intervention ○ Percent who complete their BHCS treatment goals

Data collection, evaluation and reporting for this project will be in alignment with the current Innovation Regulations. This includes collecting indicated demographic data, tracking changes made to the project in the course of implementation, and providing annual and final reports covering all required elements.

Evaluation of this project will be contracted out. The evaluators will assist in developing appropriate tools, finalizing the evaluation plan, gathering and analyzing the data. They will document factors that might affect the outcomes, such as the increased access to cannabis. While those factors cannot be controlled for, the evaluation design will attempt to increase the validity of the results.

7) Contracting

The implementation of this project will be lead by BHCS staff with assistance from several consultants. BHCS will provide a .5 FTE program coordinator to lead the project, which will include, but not be limited to: working with county counsel and the Department of Health Care Services to stay abreast of the legal landscape regarding cannabis, creating outreach strategies, facilitating the workgroups, engaging various stakeholder groups (consumers and family members, the cannabis business community, other public departments, etc.) and overseeing the work of the contracted evaluators and consultants.

II. Additional Information for Regulatory Requirements

1) Certifications

2) Community Program Planning

The community planning process for the MHSA Three Year Plan was conducted from June – October 2017. During that process BHCS staff provided updates and information on current MHSA programs and community members provided input on mental health needs and services. There were three modes for providing input:

- Five large community forums (one in each counry supervisorial district);

- Eighteen focus groups were conducted throughout Alameda County: Chinese speaking family members, African American family members, providers for refugees, providers for LGBTQ community, transitional age youth (2), Afghan immigrants, older adults, API and refugee providers and advocates, providers for individuals with developmental disabilities and mental illness, and Pool of Consumer Champions;

- Community Input Surveys in all threshold languages: submitted by 550 unique individuals. Respondents were very diverse in age, race, and ethnicity. Fifty percent of respondents were from Oakland, while they make up only 30% of Alameda's population. Survey respondents included: Mental health consumers (25%), family members (17%), community members (15%), education agency (2%), community mental health providers (14%), homeless/housing services (6%), county Behavioral Health staff (1%), faith-based organization (2%), substance abuse services provider (<1%), hospital/provider care (4%), law enforcement (1%), NAMI (1%), Veteran/Veteran services (1%), other community (Non-MH) service provider (5%), other/decline to state (9%).

Details of the process are provided in the MHSA Three Year Plan www.ACMHSA.org (click on Documents/MHSA Plans).

The BHCS Systems of Care and BHCS Housing Department were asked to submit proposals that addressed the needs identified in the community planning process. The proposed projects were vetted by MHSA staff based on whether they addressed community priorities, as well as other factors. For example, substance use/abuse was identified as the top concern for Youth/ Transitional Age Youth by 63% of participants during the planning process. In addition, specific comments were made about the need for new approaches to substance use, concerns about poly-pharmacy, and concerns about increased access to cannabis. Community concern about the potential impact of cannabis legalization has resulted in responses from the Board of Supervisors including a cannabis workgroup focusing primarily on regulation. The significant level of attention to this issue provides both an incentive and an opportunity for this work.

This proposal was posted for public comment from April 13-May 13, 2018 and a public hearing with help on May 14, 2018. Substantive comments and responses are included here.

Comment: MHSA Stakeholder Committee Member: *It is important that Alameda County address the legalization of marijuana and what impact this potentially has for individuals experiencing serious mental illness, in particular, the TAY group which may be the most vulnerable. Harm reduction and educational models appear to be a good start to address those who may not be ready to make more substantial change. Including consumers and families in the task force development group is necessary, as their opinion will be important.*

The main concern on how to make this project successful is how best to engage this population. Points of entry would seem to be the cannabis industry itself (the dispensaries, delivery services, etc.), the acute/emergency/crisis facilities (once the individual has detoxed/stabilized) and those individuals already engaging with mental health service providers. The proposal is somewhat unclear as to what type of materials or interventions will be developed, and will need to address how to engage individuals in a pre-contemplative stage of change. It would appear that multiple materials and strategies would be needed, depending on point of access with the consumer. There was suggestion of creating a smartphone app, however, it is likely that this would not be used by consumers who are not yet motivated for change.

The idea overall is a good one, especially with potential on how to expand across other counties in the state, but is hard to conceptualize at this phase when it is more philosophical and abstract.

Response: Behavioral Health Care Services appreciates the feedback and will be working during this Innovation project timeline to move from abstract thinking to implementing practical policies/procedures, toolkits, targeted messaging etc. and we hope, and very much welcome, engagement from our MHSA Stakeholder Committee in this process.

3) Primary Purpose

Promote interagency collaboration related to mental health services, supports, or outcomes

4) MHSA Innovative Project Category

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

5) Population (if applicable)

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

This project is intended to inform services provided for mental health consumers ages 21-24. In FY2016-17, BHCS served 1,673 young adults (21 to 24), which would represent the maximum number of possible consumers to be reached by this project. This project aims to reach about 50% (836) during the life of the Innovation project by the developed educational campaign, such as toolkits, brochures, trained providers, peer education, or other targeted strategies.

b) Describe the population to be served, including relevant demographic information

This project is intended to inform services provided for mental health consumers ages 21-24. Those consumers reflect the diversity of Alameda County and therefore any materials produced would be translated into all threshold languages.

Demographics of BHCS clients ages 21-24 FY 2016-17

	Males N=999	**Females N=674**
Race/Ethnicity		
Asian/Pacific Islander	8%	6%
Black/African American	34%	34%
Latino	17%	19%
White	17%	15%
Other/Unknown	24%	26%

Primary Language		
English	87%	87%
Spanish	9%	9%
Other/Unknown	4%	4%

c) *Does the project plan to serve a focal population, e.g., providing specialized services for a target group, or having eligibility criteria that must be met? If so, please explain.*

Eligibility: BHCS clients ages 21-24.

6) MHSA General Standards

a) Community Collaboration: The focus of this project is community collaboration, including having consumers, family members, and community organizations as key participants in determining effective practices.
b) Cultural Competency: Collaboration members will represent the diversity of the Alameda County population. The policies, practices and campaigns proposed by the collaboration will also be reviewed by the BHCS Cultural Competency Advisory Board before final approval. In addition, the project will incorporate perspectives from consumers, families, and community members in regards to current and traditional use of cannabis in order to develop effective harm reduction strategies for working with clients.
c) Client-Driven: Consumers will be active participants of the collaboration that develops effective practices and educational campaigns, as well as oversees the evaluation of this INN project. The Alameda County MHSA Stakeholder Committee will also be involved in monitoring the progress of this project through bi-annual updates and presentations from the program coordinator.
d) Family-Driven: Family members will be active participants of the collaboration that develops effective practices and educational campaigns, as well as oversees the evaluation of this INN project.
e) Wellness, Recovery, and Resilience-Focused: This project embraces the importance of recovery, empowerment, self-responsibility and self-determination and therefore seeks to develop effective practices based on what consumers determine they need to achieve these goals. The harm reduction framework works with clients where they are and engages them in self-determination in their recovery process.
f) Integrated Service Experience for Clients and Families: This project integrates cannabis harm reduction approaches into regular mental health services for BHCS clients.

7) Continuity of Care for Individuals with Serious Mental Illness

Young adults (21-24) with serious mental illness will receive services informed by the research, guidance, and practices developed by this project.

- Any changes to policies and practices that have been made and found to be successful will be integrated into ongoing operations and will not require ongoing funding.
- The expertise developed by BHCS staff will remain with them, but time to keep up-to-date and provide training and consultation for others will require funding.
- Depending on what educational strategies are developed, they may require ongoing funding, such as upkeep of technology based strategies or peer services.

8) INN Project Evaluation Cultural Competence and Meaningful Stakeholder Involvement.

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

The Cultural Competency Advisory Board (CCAB) and the Consumer and Family Committee of this project, made up of diverse consumers, family members and providers, will vet the evaluation framework, methods and tools. In addition, the Consumer and Family Committee will review initial evaluation findings to assist with interpretation of results and identifying additional questions for analysis.

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

In addition to the involvement of the CCAB and the Consumer and Family Committee described above, the Policy Committee of this project, made up of providers, cannabis industry, and other stakeholders, will vet the evaluation framework, methods and tools. In addition, it will review initial evaluation findings to assist with interpretation of results and identifying additional questions for analysis.

9) Deciding Whether and How to Continue the Project Without INN Funds

The evaluation of this project will be essential for determining whether the process and the product are successful. This will inform decisions about whether to terminate or continue components, as well as whether to expand or replicate components.

BHCS will support the continuation of this project or components of this project based on a number of internal and external factors and processes, including: 1) the evaluation results from the project, 2) support and buy-in from the Children and Youth System of Care and 3) recommendations from the MHSA Stakeholder Committee and the CCAB, and 4) available funding. MHSA Community Services and Supports funds will be considered for continuing the

program since it focuses on services for clients experiencing serious mental illness. BHCS would also consider if aspects of the program are applicable to PEI efforts.

10) Communication and Dissemination Plan

a) *How do you plan to disseminate information to stakeholders within your county and (if applicable) to other counties?*

The committee members will be responsible for disseminating results to their agencies or organizations, other stakeholders, and other counties. Updates on the project will be provided to stakeholders on an ongoing basis via email and presentations at existing meetings. The final evaluation report for this project will be shared widely by posting it on the BHCS website and announcing via email to stakeholders, including to mental health directors, substance use directors, and MHSA coordinators throughout California. In addition, presentations will be made to the MHSA Stakeholder Group, the Cultural Competency Advisory Board, consumer groups, NAMI, the Board of Supervisors, and a special community forum.

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

The committee members will be responsible for sharing the results with their agencies, providing presentations to the organizations listed above, and forwarding email announcements to their stakeholders. The project coordinator will be responsible for website postings and email announcements.

c) *KEYWORDS for search:*

Cannabis education for mental health clients; Cannabis industry mental health prevention

11) Timeline

a) *Specify the total timeframe (duration) of the INN Project:* **3 Years 3 Months**

b) *Specify the expected start date and end date of your INN Project:*
Start: October 2018 End: December 2021

c) *Include a timeline that specifies key activities and milestones*

Timeline	Activities/Milestones	Responsible
Oct -Dec 2018	Project Coordinator start	BHCS staff
	Begin collecting evaluation data about the process	Project Coord
	Begin formal outreach to develop project committees	Project Coord

	Begin research on legal aspects of client education regarding cannabis.	Project Coord
Jan-Mar 2019	First meeting of the project committees: Clarify goals, roles and processes Begin developing evaluation plan Develop an understanding of the key issues regarding cannabis and mental health clients, legal issues, relevant models, etc. Develop an understanding of the key issues regarding cannabis and mental health clients, legal issues, relevant models. Develop survey for BHCS clients.	All Evaluator Policy Com Consumer/ Family Com
Apr-Jun 2019	Determine priority areas for policy and effective practices. Develop model policies and practices. Vet as appropriate. Implement client survey. Develop educational strategies. Vet as appropriate. Evaluation Plan: Vetted by project committees and CCAB Determine consultant roles and release RFPs	Policy Com Consumer/ Family Com Evaluator Proj Coord
Jul-Dec 2019	Identify role of peer educators and hire peers Contract with consultants (such as training, material development) Evaluation Tools: Vetted by project committees and CCAB	Committees Proj Coord Evaluator
Jan-Jun 2020	Gather and review initial feedback on committee effectiveness, policies, practices, educational strategies. Make adjustments Begin providing training and consultation to providers Implement initial model policies, practices, educational strategies.	Evaluator Consultant(s) Collaborative partners
Jul 2020-Jun 2021	Continue development and implementation of policies, practices, and educational strategies	Collaborative partners
July–Sep 2021	Complete collection of evaluation data Analyze evaluation data, with input from Committees	Evaluator
Oct-Dec 2021	Disseminate results Determine whether/how to continue project	Committees, Project Coord BHCS, Stakeholders

This timeline includes evaluation throughout the project, beginning with vetting and finalizing and evaluation plan with the project committees and the CCAB; developing the evaluation tools with similar input; gathering preliminary data to make course corrections; gathering final data; and analyzing the data with the project committees. The last six months of the timeline allows time for data collection, analysis, dissemination, and the process to determine whether and

how to continue the project. This work is feasible in this timeline because there will be efforts throughout the project to keep stakeholders informed and to consider sustainability plans.

12) INN Project Budget and Source of Expenditures

This INN Plan will use FY 10/11 funds, which will cover years 1 (FY 18/19) and 2 (19/20) of this project. These funds were deemed reverted back to the county of origin under **AB 114**.

Budget Narrative – Project Budget by Year

Salaries:

FY18-19 9 months (Oct-Jun) Program Coordinator (0.5 FTE) = $67,500 annual wages/benefits
FY19-20 Program Coordinator (0.5 FTE) = $90,000 annual wages/benefits
FY20-21 Program Coordinator (0.5 FTE) = $90,000 annual wages/benefits
FY21-22 9 months (Oct-Jun) Program Coordinator (0.5 FTE) = $45,000 annual wages/benefits

Total: $292,500

Operating:

FY18-19 (9 mos) Food and stipends for client/family participation in committee = $10,000

FY19-20 Food and stipends for client/family participation in committee = $10,000
Education: Materials, printing, updating technology education tool = $30,000
Stipends: $20/hour x 2000 hours (4 peers at 10 hrs/week) for providing peer education, planning, and evaluation services = $40,000

FY20-21 Food and stipends for client/family participation in committee = $10,000
Education: Materials, printing, updating technology education tool = $30,000
Stipends: $20/hour x 2000 hours (4 peers at 10 hrs/week) for providing peer education, planning, and evaluation services = $40,000

FY21-22 (6 mos) Food and stipends for client/family participation in committee = $5,000
Education: Materials, printing, updating technology education tool = $20,000
Stipends: $20/hour x 1000 hours (4 peers at 10 hrs/week) for providing peer education, planning, and evaluation services = $20,000

Total = $215,000

Non-Recurring:
Due to targeting 21-24 year olds, the education campaign will likely include technology-based strategies. Costs are for development of the technology based strategy Total = $90,000

Consultants/Contracts:
Evaluation consultant: $60,000/year x 3.25 years = $195,000
Other consultants will be hired on the basis of need and expertise, such as content experts, materials development, training, and technology maintenance.

Total = $615,000

Indirect

15% for county administration of the project. Applies to Personnel, Operating and Contract expenditures to provide Human Resources, Accounting, Budgeting, Information Technology, Business Services Office, and Legal management of staff and contract positions; rent, utilities, insurance; and other expenses necessary to administer the project.

Total = $168,375

Budget Narrative – Expend by Fund Source

Administration:

50% of Program Coordinators time would be administration = $146,250
Indirect costs are administration = $168,375

Total: $328,125

Evaluation:

50% of Program Coordinators time would be administration = $146,250
Evaluation consultant: $60,000/year x 3.25 years = $195,000
Consumer/family stipends to participate in evaluation = $5,000

Total: $346,250

B. New Innovative Project Budget By FISCAL YEAR (FY)*						
EXPENDITURES						
	PERSONNEL COSTs (salaries, wages, benefits)	**FY18-19 9 months**	**FY19-20**	**FY20-21**	**FY21-22 6 months**	**Total**
1	Salaries	$ 67,500	$ 90,000	$ 90,000	$ 45,000	**$ 292,500**
2	Direct Costs	$ -				**$ -**
3	Indirect Costs	$ 10,125	$ 13,500	$ 13,500	$ 6,750	**$ 43,875**
4	Total Personnel Costs	**$ 77,625**	**$ 103,500**	**$ 103,500**	**$ 51,750**	**$ 336,375**
	OPERATING COSTs	**FY18-19 9 months**	**FY19-20**	**FY20-21**	**FY21-22 6 months**	**Total**
5	Direct Costs	$ 10,000	$ 80,000	$ 80,000	$ 45,000	**$ 215,000**
6	Indirect Costs	$ 1,500	$ 12,000	$ 12,000	$ 6,750	**$ 32,250**
7	Total Operating Costs	**$ 11,500**	**$ 92,000**	**$ 92,000**	**$ 51,750**	**$ 247,250**
	NON RECURRING COSTS (equipment, technology)	**FY18-19 9 months**	**FY19-20**	**FY20-21**	**FY21-22 6 months**	**Total**
8	**Technology**		$ 40,000	$ 40,000	$ 10,000	**$ 90,000**
9						**$ -**
10	Total Non-recurring costs	**$ -**	**$ 40,000**	**$ 40,000**	**$ 10,000**	**$ 90,000**
	CONSULTANT COSTS/CONTRACTS (clinical, training, facilitator, evaluation)	**FY18-19 9 months**	**FY19-20**	**FY20-21**	**FY21-22 6 months**	**Total**
11	Direct Costs	$ 55,000	$ 280,000	$ 180,000	$ 100,000	**$ 615,000**
12	Indirect Costs	$ 8,250	$ 42,000	$ 27,000	$ 15,000	**$ 92,250**
13	Total Consultant Costs	**$ 63,250**	**$ 322,000**	**$ 207,000**	**$ 115,000**	**$ 707,250**
	OTHER EXPENDITURES (please explain in budget narrative)	**FY18-19 9 months**	**FY19-20**	**FY20-21**	**FY21-22 6 months**	**Total**
14						**0**
15						**0**
16	Total Other expenditures	**0**	**0**	**0**	**0**	**0**
BUDGET TOTALS						
Personnel (line 1)		$ 67,500	$ 90,000	$ 90,000	$ 45,000	**$ 292,500**
Direct Costs (add lines 2, 5 and 11 from above)		$ 65,000	$ 360,000	$ 260,000	$ 145,000	**$ 830,000**
Indirect Costs (add lines 3, 6 and 12 from above)		$ 19,875	$ 67,500	$ 52,500	$ 28,500	**$ 168,375**
Non-recurring costs (line 10)		$ -	$ 40,000	$ 40,000	$ 10,000	**$ 90,000**
Other Expenditures (line 16)		$ -	$ -	$ -	$ -	**$ -**
TOTAL INNOVATION BUDGET		**$ 152,375**	**$ 557,500**	**$ 442,500**	**$ 228,500**	**$ 1,380,875**

C. *Expenditures By Funding Source and FISCAL YEAR (FY)*						
Administration:						
A.	**Estimated total mental health expenditures <u>for ADMINISTRATION</u> for the entire duration of this INN Project by FY & the following funding sources:**	**FY18-19 9 months**	**FY19-20**	**FY20-21**	**FY21-22 6 months**	**Total**
1	Innovative MHSA Funds	$ 53,625	$ 118,500	$ 103,500	$ 52,500	**$ 328,125**
2	Federal Financial Participation					$ -
3	1991 Realignment					$ -
4	Behavioral Health Subaccount					$ -
5	Other funding*					$ -
6	**Total Proposed Administration**	**$ 53,625**	**$ 118,500**	**$ 103,500**	**$ 52,500**	**$ 328,125**
Evaluation:						
B.	**Estimated total mental health expenditures <u>for EVALUATION</u> for the entire duration of this INN Project by FY & the following funding sources:**	**FY18-19 9 months**	**FY19-20**	**FY20-21**	**FY21-22 6 months**	**Total**
1	Innovative MHSA Funds	**$ 68,750**	**$ 110,000**	**$ 110,000**	**$ 57,500**	**$ 346,250**
2	Federal Financial Participation					$ -
3	1991 Realignment					$ -
4	Behavioral Health Subaccount					$ -
5	Other funding*					$ -
6	**Total Proposed Evaluation**	**$ 68,750**	**$ 110,000**	**$ 110,000**	**$ 57,500**	**$ 346,250**
TOTAL:						
C.	**Estimated TOTAL mental health expenditures (this sum to total funding requested) for the entire duration of this INN Project by FY & the following funding sources:**	**FY18-19 9 months**	**FY19-20**	**FY20-21**	**FY21-22 6 months**	**Total**
1	Innovative MHSA Funds	$ 152,375	$ 557,500	$ 442,500	$ 228,500	**$ 1,380,875**
2	Federal Financial Participation					**$ -**
3	1991 Realignment					**$ -**
4	Behavioral Health Subaccount					**$ -**
5	Other funding*					**$ -**
6	**Total Proposed Expenditures**	**$ 152,375**	**$ 557,500**	**$ 442,500**	**$ 228,500**	**$ 1,380,875**
*If "Other funding" is included, please explain.						

May 1, 2018

To: Mental Health Services Oversight and Accountability Commission

Bay Area Community Services (BACS) is excited to support Alameda County Behavioral Health Care Services' "Cannabis Policy and Education for Young Adults" innovation project. We regularly see young adults struggling with substance use and mental health issues who are going to be impacted by the change in laws regarding cannabis. They need relevant information and support to make good choices around cannabis use – especially given the changes in access and attitudes. We also believe that having young adults and the cannabis industry participate in developing the policies and education strategies will help ensure they are effective.

BACS' provides a variety of mental health and substance use services. Our youth services have provided substance use and chemical dependency treatment to more than 7,000 adolescents and their families since 1987 at one of the only youth substance use residential treatment facilities in the Bay Area. Every year, we also provide compassionate and strengths-based behavioral health services to more than 2,000 people and operate the County's Transition Age Youth (TAY) Triage Program, assessing and linking youth to much needed services so they avoid a life of chronic mental health issues. Our programs help change the narrative for those struggling with substance use and mental health issues. Mental health and substance use issues can trap young people in the criminal justice system, without giving them a chance to succeed. All of our services prioritize wellness and recovery, using a harm-reduction and person-centered philosophy to guide our services, and are steeped in cultural responsiveness and fluidity of service.

We are prepared to participate in this effort and learn from BHCS' experience. We are hoping that this project provides practices and strategies that will benefit our clients in these changing times. Alameda County Behavioral Health Care Services is a strong partner and funder to BACS and supports all of the high quality services we deliver for youth in the community; we fully support this proposal.

Sincerely,

Jamie Almanza, MBA
Executive Director
Bay Area Community Services

ALAMEDA COUNTY
HEALTH CARE SERVICES
AGENCY
COLLEEN CHAWLA, Director

OFFICE OF THE AGENCY DIRECTOR
1000 San Leandro Boulevard, Suite 300
San Leandro, CA 94577
TEL (510) 618-3452
FAX (510) 351-1367

May 1, 2018

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

Dear Mental Health Services Oversight and Accountability Commissioners,

This letter is sent on behalf of the Alameda County Health Care Services Agency (HCSA) in support of the **Cannabis Policy and Education for Young Adults Project** proposed by the Alameda County Behavioral Health Care Services.

The passage of Proposition 215 in 1996 legalized medical cannabis in California, while Proposition 64 in 2016 legalized cannabis possession and use for those 21 years of age and older in California. There are concerns about the interaction between cannabis and other pharmaceutical medications that might put mental health consumers at-risk. Alameda County's transition age youth (TAY) triage project, funded by SB 82, kept daily records of TAY clients experiencing mental health crises. They estimated that approximately 70% of youth had used cannabis within 24 hours before the onset of the crisis.

Applying public health models to cannabis harm reduction for mental health clients is relevant and essential. Having worked in HIV prevention for many years, I recognize the importance of harm reduction messaging that is tailored for the intended population. The cannabis industry plays an active role in the marketing and messaging of cannabis products. An innovative component of the Cannabis Policy and Education for Young Adults Project is the collaboration with the cannabis industry to develop and implement effective practices to support and protect the health of our mental health consumers.

HCSA will support the implementation of this program, including providing expertise and experience in harm reduction, public health messaging, and other areas. We believe the insights learned through this project will contribute to improving our policy and education efforts beyond the specific scope of the proposal.

Thank you for considering the Cannabis Policy and Education for Young Adults Project for the Mental Health Services Act Innovations Grant funding. Feel free to contact me if you have questions.

Sincerely,

Colleen Chawla, Director
Alameda County Health Care Services Agency

THE OFFICE OF FAMILY EMPOWERMENT
ALAMEDA COUNTY BEHAVIORAL HEALTH CARE SERVICES

May 7, 2018

To: Mental Health Services Oversight and Accountability Commission

On behalf of the Alameda County Office of Family Empowerment (OFE) I am writing to express our support for the Cannabis Policy and Education project proposed by Behavioral Health Care Services. OFE works extensively with family members to ensure their perspectives are part of the development of programs and policies. We are aware of a high level of concern among families about the impact increased access to cannabis may have on their loved ones. Concerns include issues with cannabis use affecting their efforts towards recovery and interacting with other medications. Mainly, they worry that their loved ones will not have the information they need to make good decisions.

The Cannabis Education project will bring family perspectives into policy and program development. It will also bring the cannabis industry into the process, so they can understand and act upon the experience of individuals with mental health issues and their families. We appreciate this innovative approach and will support the project by assisting with family member participation.

Sincerely,

Tanya R. McCullom
Program Specialist

PEERS
333 Hegenberger Road, Suite 250, Oakland, CA 94621
Phone: 510-832-7337 Fax: 510-452-1645

April 26, 2018

To: Mental Health Services Oversight and Accountability Commission

Peers Envisioning and Engaging in Recovery Services (PEERS) strongly supports Alameda County Behavioral Health Care Services' "Cannabis Policy and Education for Young Adults" innovation project.

Our youth are clamoring for more information on this topic. However, as a peer based organization we recognize the importance of including the young adults in developing an education campaign. Including a technology-based component to that campaign is essential for reaching the younger population. PEERS has developed video and social media approaches to reaching people and would be happy to share our expertise.

PEERS is a diverse community of people with mental health experiences. Our mission is to promote innovative peer-based wellness strategies. We create culturally-rich, community-based mental health programs that honor diverse experiences and eliminate stigma and discrimination. We provide Wellness Recovery Action Plan (WRAP) workshops, as well as young adult specific programs.

We believe this project will result in practices that PEERS can integrate into our services to better support young adults with mental health challenges achieve the highest possible state of wellness.

Sincerely,

Lynn May Rivas
Associate Director
Peers Envisioning and Engaging in Recovery Services (PEERS)

Project Summary

County: **Alameda County**
Date submitted: 4/13/2018
Project Title: **Emotional Emancipation Circles for Young Adults**
Total amount requested: $501,808
Duration of project: 2 years 6 months

General Requirement	Makes a change to an existing practice in the field of mental health, including but not limited to, application to a different population
Primary Purpose	Increases the quality of mental health services, including measured outcomes

Problem

African Americans are a historically inappropriately served population. The Mental Health Services Act (MHSA) California Reducing Disparities (CRDP) report on African Americans found that many of the key issues revolve around racism, stigma, marginalization, and isolation – in society and within mental health services. Fundamentally, African Americans feel that their experiences and perspectives are not heard, respected or acted upon by the mental health system.

In Alameda County, after receiving on average more hours of mental health outpatient services, African American young adults (18-30) showed significantly less improvement than White young adults. Focusing time, energy and funding on developing new services that respond to the needs African Americans have identified and take into account the complexity of their experience – poverty, trauma, racism, etc. – is essential to reduce disparities.

Local African American young adults have identified the need to address isolation and to value one another, culturally and ethnically, despite the negative images communicated by the media or community. Alameda County Behavioral Health Care Services (BHCS) aims to address this need as a pathway to fostering independence and self-sufficiency.

Project

BHCS worked with African American young adults to pilot Emotional Emancipation Circles (EEC) to address the needs they identified. EECs are a community-defined practice developed by the Community Healing Network (CHN) and Association of Black Psychologists (ABPsi). The participants felt the EECs were valuable but needed to be tailored to better engage young adults. This project will:

- Work with young adult EEC facilitators to conduct outreach, tailor them to young adult needs, and provide 6 EEC series
- Conduct evaluations of each series to contribute to tailoring of the model

Evaluation

This Innovation Project aims to tailor the EEC model, a community-defined practice within the mental health field, to answer:

Can Emotional Emancipation Circles that are tailored for young adults result in participants feeling valued and connected to an inclusive community, contributing to independence and self-sufficiency?

1. How can EECs be tailored to effectively engage young adults?
    - In what way were EECs tailored? (program records)
    - Did young adults engage with and complete the series? (participation records)
    - Were young adults satisfied with their experience? (surveys, focus groups)
2. Will participants in young adult EECs experience improved mental health and functional outcomes, specifically independence and self-sufficiency?
    - Do they experience changes in well-being, connectedness and self-worth?
    - Do they experience changes in education and/or employment activities?
    - Do they experience changes in their use of planned services? (surveys, focus groups)
    - Do BHCS clients who participate have better outcomes than non-participants? (compare BHCS client records)

The learnings from this project will help counties address common challenges regarding serving the African American young adults by providing data on whether EECs improve mental health and functioning and by providing a version of EECs that is well-adapted for young adults. The learnings will be shared with behavioral health divisions throughout the state, as well as through the CHN and ABPsi networks. Alameda County will use the learnings to determine what aspects to continue under MHSA PEI or CSS funding.

Budget

Salaries *$102,374*	Project Administrator: BHCS staff to oversee implementation (0.3 FTE)
Operating *$55,080*	Materials, transportation, accessible meeting spaces, incentives Young Adult Facilitator stipends
Non-Recurring *$5,000*	Culturally-based displays to establish desired tone in the room
Consultants *$274,553*	Lead Trainers from ABPsi Peer Project Coordinator (37 hours/week) Evaluator
Indirect *$64,801*	15% for BHCS to administer project

Emotional Emancipation Circles for Young Adults **Logic Model**

Situation: In Alameda County, after receiving on average more hours of mental health outpatient services, African American young adults (18-30) showed significantly less improvement than White young adults. Focusing time, energy and funding on developing new services that respond to the needs African Americans have identified and take into account the complexity of their experience – poverty, trauma, racism, etc. – is essential to reduce disparities. Local African American young adults have identified the need to address isolation and to feel valued ethnically and culturally.

Inputs	Outputs		Outcomes -- Impact		
	Activities	*Participation*	*Short*	*Medium*	*Long*
Personnel Time: - Project Administrator - Lead Trainers - Peer Project Coordinator - Peer Facilitators (6-8) EEC curriculum, materials EEC access (accessible location, food, transport) Young adult participants (age 18-30) Evaluator	Outreach to potential participants Peer Facilitators conduct 6 EEC series Young adults participate in EECs (20 x 6 series = 120) Tailor EEC model for young adults, including conducting various formats and multiple series, incorporating participant feedback in tailoring process Ongoing evaluation and tailoring	Peer Project Coordinator, Peer Facilitators African Americans ages 18-30 experiencing or at risk for serious mental illness or emotional disturbance Project Administrator, Lead Trainers, Peer Project Coordinator, Peer Facilitators, Participants Project Administrator, Lead Trainers, Peer Project Coordinator, Peer Facilitators, Participants, Evaluator	EECs reach full registration (20 per series) Participants complete the series (75% complete 75% of series) Participants satisfied with EEC experience during the series (65-80%)	Participants report improved mental health (well-being, connectedness, self-worth) upon conclusion of participation (65%) Average participant satisfaction with EEC experience increases between first (65%) and last series (80%)	3 months after conclusion of participation: Participants report improved functional outcomes (employment and education activities) (50%) Appropriate use of planned services increases for participants (35%) BHCS clients that participate show better outcomes than non-participating clients (30%)

Assumptions
EECs, a community defined practice developed for and by African Americans, can be adapted for AA young adults to address "isolation and feeling valued ethnically and culturally." Addressing these issues will lead to increased sense of connectedness and self-worth, which in turn will improve mental health and functional outcomes.

External Factors
- Life circumstances of young adult participants that interferes with completion of the program or affects the desired outcomes

INNOVATIVE PROJECT PLAN DESCRIPTION

County: Alameda Date Submitted 4.13.18
Project Name: Emotional Emancipation Circles for Young Adults

I. Project Overview

1) Primary Problem

a) What primary problem or challenge are you trying to address?

African Americans are a historically inappropriately served population. The California Reducing Disparities project report on African Americans highlights the need to integrate their experiences and perspectives into the development and provision of services. Within Alameda County, African American young adults have identified the need to address isolation and to feel valued ethnically and culturally. From their input, Alameda County Behavioral Health Care Services has developed five aims, including providing supports that allow young adults to feel valued and connected to an inclusive community as a pathway to achieving independence and self-sufficiency. This Innovation project provides a model for this.

In FY2016-17, 6,188 young adults aged 18-30 received specialty mental health services from Alameda County Behavioral Health Care Services. Of these, 2,010 (32%) are African-American. African Americans often do not receive culturally responsive services. On a statewide level, the California Reducing Disparities Project report, *"We Ain't Crazy! Just Coping With a Crazy System" – Pathways into the Black Population for Eliminating Mental Health Disparities*, documents the many challenges African Americans experience in receiving appropriate services. Many of the key issues revolve around racism, stigma, marginalization, and isolation – in society and within mental health services. **Fundamentally, African Americans feel that their experiences and perspectives are not heard, respected or acted upon by the mental health system.**

Alameda County statistics reveal a similar pattern as statewide statistics:

- African American young adults (18-30) have an increased penetration rate:
  7.13% for African American young adults versus 4.73% for White (FY16-17)
- The impact of the services is less for African American young adults (18-30):
  After receiving on average more hours of outpatient services in 2016 (489 hours per African American client vs 383 hours for White clients), the African American clients showed less improvement from 2015 to 2017:
  - The number of African American young adults using crisis services reduced 17%, while there was a 37% reduction for White young adults, and
  - The number of African American young adults hospitalized reduced 12%, while there was a 37% reduction for White young adults.

These statistics speak to the lack of appropriateness of the services for the needs of the African American young adults. **Focusing time, energy and funding on developing new services that respond to the needs African Americans have identified and take into account the complexity of their experience – poverty, trauma, racism, etc. – is essential to reduce disparities.**

In Alameda County, an African American Utilization study was produced in 2011. This report defined young adults as ages 16-29 *due to patterns of delayed access to treatment for African Americans*. It identified the top two priorities for young adults as:

- **Decrease social isolation and marginalizing of African American young adults at risk for serious mental health issues due to social determinants.**
- **Provide culturally responsive treatment and services for those already being served in the young adult system of care.**

Young adults have identified discrimination, not feeling that the services are safe, lack of systems support, and lack of cultural diversity among service providers as reasons why they do not prioritize mental health services in their journey of staying well. **They express the need to value one another, culturally and ethnically, despite the negative images communicated by the media or community.**

BHCS conducted a Results Based Accountability (RBA) process with young adult providers. Based on the input they heard from young adults, the process determined five key factors to better support them. **One of those factors is developing supports that allow them to feel valued and connected to an inclusive community as a pathway to achieving independence and self-sufficiency.** Community integration is considered a corner-stone of wellness and recovery. In addition, social connectedness and ethnic identity among racial minorities are also understood to impact mental health outcomes and functional outcomes for adolescents (Lamblin et al, 2017) (Phinney & Kohatsu, 1997). These influences contributed to the development of BHCS's key support factor.

b) Describe what led to the development and prioritization of the idea for your INN project

The data noted above speaks to the need to increase the availability of services that respond to the expressed needs of African American young adults. The California Reducing Disparities Project (CRDP) emphasizes the need for community-defined practices in order to be responsive to underserved communities. In addition, in Alameda's recent Community Planning Process for the MHSA Three Year Plan, there was significant interest in developing more peer-run program models under Innovation. The issue of "Social Isolation/Feeling Alone" among young adults was also identified as a problem by 60% of respondents. Additionally, young adults and the African American community were both identified by 44% of respondents as underserved populations. (www.ACMHSA.org under Documents/MHSA Plans)

Alameda County, along with many other counties, is challenged to appropriately serve African American clients, as well as effectively engage young adults. Alameda BHCS' core strategy is to act upon their input by providing supports that allow them to feel valued and connected to an

inclusive community as a pathway to independence and self-sufficiency. Given Alameda County's experience with piloting a community-defined practice designed for the African American community, Emotional Emancipation Circles, it feels essential to continue developing this practice to respond to the expressed needs of African American young adults.

2) What Has Been Done Elsewhere To Address Your Primary Problem?

The primary challenge is to better serve African American young adults by respecting and acting upon their perspectives and expressed needs. Alameda BHCS has already identified a strategy based on their input: developing supports that allow young adults to feel valued and connected to an inclusive community as a pathway to achieving independence and self-sufficiency.

In considering potential services, programs included in the Substance Abuse and Mental Health Services Association database, the CRDP Black Population report, and other young adult focused services have been reviewed.

- The programs in SAMHSA generally focus on addressing a mental health or substance use problem, rather than the process of connection to community as a strategy that addresses a number of challenges.

- A popular approach to engaging young adults from underserved communities is to use arts, music and social media for them to express themselves. Some examples include San Diego's Urban Beats and Richmond's RYSE Center. While they do seem to be effective with engaging young adults and improving outcomes, this program is looking to specifically address the need expressed by African American young adults to value one another, culturally and ethnically, despite the negative images communicated by the media or community.

- The CRDP report includes a few programs that specifically address community connection, such as Emotional Emancipation Circles (EECs), named Community Healing Circles at that time. Alameda has previously piloted EECs and received very positive feedback from young adults.

The Association of Black Psychologists (ABPsi) has identified a lack of practices that are responsive to the needs of African Americans. They have worked in collaboration with the Community Healing Network (CHN) to develop Emotional Emancipation Circles (EECs), a community defined practice. EECs are self-help support groups to address the impact of historical forces and ongoing racism, learn emotional wellness skills, heal through the valuing of the African American experience, and build a supportive community. There is a developed curriculum and training for EEC facilitators. Evaluation to date has mostly focused on participant satisfaction, although the Community Healing Network is working with the California Institute of Behavioral Health Solutions (CIBHS) to include an outcome evaluation.

In 2016, ABPsi and Alameda County BHCS ran a pilot program in which twenty (20) African American young adults became certified EEC facilitators. Four (4) of the trained young adults helped to run one EEC series (8 workshops). The facilitators and participants completed surveys and participated in a focused discussion about the experience. They indicated that they benefited from the experience and that it should continue. They also indicated that some of the format and approaches were not engaging for them as young adults. The areas they most felt needed to be added were:

- Age appropriate activities and mediums for addressing the Seven Keys curriculum
- Removing participation barriers (transport, schedule, etc.)
- Aligning housing, employment, education, wellness and community supports

This previous pilot effort also only evaluated satisfaction, not outcomes. In addition, further EECs were not conducted due to lack of allocated funds. Conducting EECs as an Innovation project will enable BHCS to include many more participants, **tailor the model for African American young adults' needs and interests** and **conduct an outcome evaluation as a test of concept to lay the groundwork for the expansion of this model.**

3) The Proposed Project

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

BHCS will tailor the EEC model to specifically target the needs of African American young adults, while ensuring fidelity to the model. Two EEC trainers who are ABPsi members will provide technical support for this. The implementation steps include:

1. Work with existing young adult EEC facilitators trained during the pilot project to host six (6) EEC information sessions to recruit young adults to participate in an EEC session;
2. Update the certification of 6-8 existing young adult EEC facilitators that commit to facilitating EECs. They will be provided stipends and other types of support to enable participation;
3. Work with the ABPsi members and the certified young adult trainers to *tailor* the curriculum to better serve the target population. Tailoring will include:
    - Having young adults co-facilitate the EECs;
    - Incorporating modes relevant to young adults, such as young adult independence development models, music and media, and a framing of the topics and activities to speak to their experiences and interests;
    - Incorporating components that address housing, education, employment and other needs, such as sharing of information and providing linkages;
    - Developing marketing to appeal to young adults;
    - Offering the sessions at times and places that fit their schedules, providing food and transportation assistance, and

- Developing appropriate evaluation tools.

4. Conducting six (6) EEC series for twenty (20) participants per series. A series is eight (8) 90-minute workshops or two (2) extended workshops covering the Seven Keys outlined in the EEC curriculum. Between each series adjustments will be made based on participant and facilitator feedback. Most likely there will be one female only, one male only, and four mixed gender series. Four (4) of the sessions will be offered once a week on a weekday and two (2) will be offered as two extended workshops on Saturdays. In addition, there are evaluation and graduation sessions.

Emotional Emancipation Circles℠ (EEC) are support groups designed by and for African American people to "work together to overcome, heal from, and overturn the lies of White superiority and Black inferiority." In the workshop series participants share their stories and feelings, learn about historical forces that have shaped their experiences, develop a healing and validating relationship with each other, learn wellness skills for living in a racist society, and learn to value themselves as African American individuals and as a people. The participants and facilitators can influence how the Seven Keys are covered as long as the essential curriculum is adhered to.

b) Identify which of the three approaches specified in CCR, Title 9, Sect. 3910(a) the project will implement

This proposal makes a change to an existing practice in the field of mental health.

c) Briefly explain how you have determined that your selected approach is appropriate

EECs are a community-defined practice developed to address the lack of African American focused mental health service models. The first circle was conducted in 2007 in Connecticut by the Community Healing Network (CHN). By 2012, CHN and ABPsi had developed the EEC curriculum. At this point about 500 trainers have been certified in the United States, United Kingdom, Africa and elsewhere. EECs are a unique tool for supporting the development of racial and ethnic identity for African Americans as valued members of a community. While there is limited data on the impact of them, this project aims to evaluate the mental health impact for young adults.

4) Innovative Component

Tailoring EECs for young adults may expand the use of a community-defined practice within the mental health field. Innovation provides an opportunity to test the concept in two ways:

1) Tailor EECs to better engage and serve young adults: The current EEC format is more appropriate for older participants. By working with young adults to implement changes,

while remaining true to the model, we can find best practices for appealing to and supporting young adults.

2) Evaluate mental health and functional outcomes: The current EEC evaluation process focuses on participant satisfaction. By expanding the scope of the evaluation we can determine if young adults felt engaged and if it resulted in mental health and functional outcomes.

5) Learning Goals / Project Aims

African Americans have been identified as an underserved/inappropriately served population by Mental Health Services Act. Many counties struggle with improving engagement of and services for African Americans. In addition, engaging young adults in services is a widespread challenge. A fundamental concern identified in the CRDP African American population report is that African American's do not feel that their experience and perspective is integrated into service development or provision. Based on African American young adult input, Alameda would like to test:

Can Emotional Emancipation Circles that are tailored for young adults result in participants feeling valued and connected to an inclusive community, contributing to independence and self-sufficiency?

Learning Goals

1. How can EECs be tailored to effectively engage young adults?
    - Tailoring EECs for young adults is one of the two changes being made in this project. It is essential to evaluate which strategies were effective in order to contribute to successful expansion or replication of this model.

2. Will participants in young adult EECs experience improved mental health and functional outcomes, specifically independence and self-sufficiency?
    - Mental health measurements will include emotional wellbeing, sense of self-worth and connectedness. Functional outcomes, such as independence and self-sufficiency, will include progress in education, employment, ability to access resources when needed, etc.
    - Expanding the evaluation of EECs to capture outcomes is one of the two changes being made in this project. This is a core learning goal in order to test if EECs contribute to key outcomes for young adults, specifically independence and self-sufficiency.

6) Evaluation or Learning Plan

Learning Goals

1. How can EECs be tailored to effectively engage young adults?

Data to collect	Data collection method
In what way were EECs tailored	Project Coordinator will track all ways the EECs were tailored for young adults
How many young adults participated and for how much of the series *120 participants* *75% complete 75% of series*	Sign in sheets will provide data on how many participants attended each workshop within a series
Satisfaction with the services *65% of participants in first series will report satisfaction with services* *80% will report satisfaction in last series*	Feedback will be gathered from facilitators and participants in survey and focus group format at the conclusion of each workshop and each series to determine effective/ineffective elements
Family Perspective	Family/caregivers will be given a survey at the graduation event regarding their observations about their family members' participation, such as what the participant shared about their experience and any changes noticed

2. Will participants in young adult EECs experience improved mental health and functional outcomes, specifically independence and self-sufficiency?

Data to collect	Data collection method
Changes in mental health *65% of participants report improvement*	Conduct a survey and focus group at the end of each series with the participants to determine self-reported changes in mental health status, including the effects of the EEC on their sense of well-being, connectedness and self-worth. Participants will be asked to what extent and how the EECs contributed to changes in mental health. The evaluator will help identify, and adapt as needed, existing tools for measuring well-being, self-worth and connectedness.
Changes in functioning 50% of participants report improvement	Conduct a survey and focus group at end of each series and 3 months later with the participants to determine changes in functioning towards independence and self-sufficiency, including progress in pursuing education, employment, and other positive outcomes. Participants will be asked to what extent and how the EECs contributed to changes in functioning. Correlate changes in

	connectedness and self-worth with progress towards independence.
Changes in service engagement 35% of participants report accessing appropriate services	Conduct a survey and focus group at the end of each series and 3 months later with the participants to determine changes in service use patterns, such as accessing appropriate planned services.
Improved quality of care Participants show 30% better outcomes than non-participants	For those participants who are also BHCS clients, compare changes in their routine assessments and outcomes (3 months after completing the EEC) to comparable BHCS clients who did not participate in an EEC.

Data collection, evaluation and reporting for this project will be in alignment with the current Innovation Regulations. This includes collecting indicated demographic data, tracking changes made to the project in the course of implementation, and providing annual and final reports covering all required elements.

BHCS will engage a contractor to conduct the evaluation. This will include:

- Developing a final evaluation plan that will be effective with young adults and their attendance patterns
- Determining survey and focus group tools
- Conducting the focus groups at the final workshop of each series
- Analyzing the survey and focus group data

The evaluators will work closely with the young adults, staff, and trainers implementing this project to develop the plan, tools and analysis. They will document factors that might affect the outcomes and attempt to increase the validity of the results.

7) Contracting

The implementation of this project will be led by BHCS staff.

II. Additional Information for Regulatory Requirements

1) Certifications

2) Community Program Planning

The community planning process for the MHSA Three Year Plan was conducted from June – October 2017. During that process Alameda County BHCS staff provided updates and

information on current MHSA programs and community members provided input on mental health needs and services. There were three modes for providing input:

- Five large community forums (one in each Supervisorial District);
- Eighteen focus groups were conducted throughout Alameda County: Chinese speaking family members; African American family members; providers for refugees; providers for LGBTQ community; transitional age youth; Afghan immigrants; older adults; API; refugee providers and advocates; providers for individuals with developmental disabilities and mental illness; and Pool of Consumer Champions (Alameda County's local consumer leadership group); and
- Community Input Surveys in all threshold languages: submitted by 550 unique individuals. Respondents were very diverse in age, race, and ethnicity. Fifty percent of respondents were from Oakland, while they make up only 30% of Alameda's population. Survey respondents included: Mental health consumers (25%); family members (17%); community members (15%); education agency (2%); community mental health providers (14%); homeless/housing services (6%); county Behavioral Health staff (1%); faith-based organization (2%); substance abuse services provider (<1%); hospital/provider care (4%); law enforcement (1%); NAMI (1%); Veteran/Veteran services (1%); other community (Non-MH) service provider (5%); and other/decline to state (9%).

Details of the process are provided in the MHSA Three Year Plan www.ACMHSA.org (click on Documents/MHSA Plans).

The BHCS systems of care and BHCS Housing Department were asked to submit proposals that addressed the needs identified in the community planning process. The proposed projects were vetted by MHSA staff based on whether they addressed community priorities, as well as other factors. In 2011, the Alameda County African American Utilization study identified the top need for African American young adults as "Address social isolation and marginalization of young adults at risk for serious mental health issues due to social determinants." In addition, in Alameda's recent Community Planning Process for the MHSA Three Year Plan, there was significant interest in developing more peer-run program models under Innovation. The issue of "Social Isolation/Feeling Alone" among young adults was also identified as a problem by 60% of respondents. And, young adults and the African American community were both identified by 44% of respondents as underserved populations.

This proposal was posted for public comment from April 13-May 13, 2018 and on May 14, 2018 a public hearing was held. Substantive comments and responses are included here.

Comment: Providing more culturally appropriate and impactful services to engage this population is critical. The concept behind the Emancipation circles appears to appropriately address the needs for this group to start to heal and recover. It is the hope that Alameda County continues to value this sort of support system, aside from what is typically considered "success"

or "utility" of an intervention measured only by traditional outcome measures.

Peer support has often been shown to be effective in engaging consumers who might not otherwise see a professional, due to concerns about stigma, ability to relate to their experiences, etc. While the peer run component is likely one of the most impactful aspects, the question arises about what happens when there is a larger mental health crisis or need for more services aside from the support circle. Are facilitators trained in how best to connect group participants to resources in the community? Are they trained to assess and appropriately manage a crisis, in addition to their own potential triggers or reactions to participant responses to group material? In working with trauma, especially with own lived experience, this kind of work can be very activating, thereby necessitating that there is sufficient support for the facilitators.

Additionally, given the intensity of topics and experiences in the room, what is done about attrition from the circles? Is there an outreach component should an individual stop attending for a period of time?

It would be interesting to know more about the outcome measures, it would seem one of the main points of these circles are to improve connection to community/each other, which may be hard to measure. This increased connection would likely influence mental health wellbeing and healing from trauma, but may be hard to objectively assess.

Response: In response to the question regarding facilitation training: The facilitators will be trained in the EEC model as well as informed about available community resources through Behavioral Health Care staff.

In response to the measurement question: each project will have an evaluator that will work with multiple stakeholder groups (the EEC project staff and TAY, BHCS staff and the MHSA stakeholder committee staff) to fully develop the outcome measures around "increased connection."

In response to the question around crisis management: Yes, management of crises and their own potential triggers are supported with frequent observation of the space and the discussions, often leading to pauses in the session to re-group and address the triggers. We strongly communicate to participants in each session to take breaks and remove his/herself for self-care. Self-care may include taking moments to lead the group in deep breathing exercises, allowing folks to vent emotions via a writing activity, or supporting a participant in taking a short walk to re-center his/herself. As facilitators we do not take on the role as clinician's or mental health counselors. The sessions are not therapy, but community inclusive groups to support one another in healing from trauma and learning from each other's experiences.

In response to the question regarding attrition: While the EEC sessions typically run 6-8 weeks, participants sometime part from the groups, but ongoing outreach such as information emails and unending invites to circles and planning/debrief groups are executed. The beauty of working with the TAY population is their need for change and transition. The EEC's support the needs of this population by embracing variation and respecting life change in an effort to address trauma. No one is ever excluded from ongoing participation in the circles.

Comment: The B.I.Z. Stoop Founder/CEO, I am in great support of the TAY Emotional Emancipation Circles Proposal. I've been an observer and facilitator and agree, there is need to get a youth perspective on the module - to strengthen its long lasting impact.

Response: Thank you for your comment and interest in the project.

3) Primary Purpose

Increase the quality of mental health services, including measurable outcomes

4) MHSA Innovative Project Category

Makes a change to an existing mental health practice that has not yet been demonstrated to be effective, including, but not limited to, adaptation for a new setting, population or community.

5) Population

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

It is expected that one hundred and twenty (120) African American young adults experiencing or at risk for serious mental illness or emotional disturbance will be served by this project. There will be six (6) series with twenty (20) participants per series.

b) *Describe the population to be served, including relevant demographic information*

Participants will include young adults (18-30) in Alameda County who identify as African American/African Descent who experience or are at risk for mental illness. They will have a history of accessing mental health treatment services, mental health wellness services, or other relevant services, such as youth development centers, juvenile justice, and employment support.

c) *Does the project plan to serve a focal population or eligibility criteria*

Participants will include young adults (18-30) in Alameda County who identify as African American/African Descent who experience or are at risk for mental illness. They will have a history of accessing mental health treatment services, mental health wellness services, or other relevant services, such as youth development centers, juvenile justice, and employment support. More specific eligibility criteria will be established if needed.

6) MHSA General Standards

a) Community Collaboration: This project works closely with African American young adults to adapt and implement a service.
b) Cultural Competency: The model this project is based on was developed by and for African Americans. The implementation of it will be done by African American providers in collaboration with African American young adults. In addition, the project, evaluation plan, and results will be presented to the Cultural Competency Advisory Board (CCAB), MHSA Stakeholder Committee and Alameda County African American Health and Wellness Steering Committee for their input.
c) Client-Driven: African American BHCS clients will be involved in the development, implementation, and evaluation of this project. It is a peer-centered model that engages young adults as facilitators and interactive group participants.
d) Family-Driven: At the graduation event for each series, parents/family will be asked to provide feedback on what they saw in terms of the participants' experience and changes. This feedback will be considered in developing the next series.
e) Wellness, Recovery, and Resilience-Focused: This project aims to increase the independence and self-sufficiency of young adults experiencing or at risk for serious mental illness or emotional disturbance.
f) Integrated Service Experience for Clients and Families: This project does not specifically address integration of services.

7) Continuity of Care for Individuals with Serious Mental Illness

Participation in an EEC series is in addition to ongoing services provided for young adults with serious mental illness. Participants generally attend just one series, and therefore this program does not affect continuity of care.

8) INN Project Evaluation Cultural Competence and Meaningful Stakeholder Involvement.

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

This project is focused on providing culturally competent services for African American young adults. The model is developed by and for African Americans. The African American young adult facilitators will participate in tailoring the model, implementing the program, ongoing quality improvement, and final evaluation of the project. In addition, the project, evaluation plan, and results will be presented to the Cultural Competency Advisory Board (CCAB), MHSA Stakeholder Committee and Alameda County African American Health and Wellness Steering Committee for their input.

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

The African American young adult facilitators will participate in providing ongoing feedback about the program, developing the evaluation, and analyzing the resulting data. In addition, the project, evaluation plan, and results will be presented to the Cultural Competency Advisory Board (CCAB), MHSA Stakeholder Committee and Alameda County African American Health and Wellness Steering Committee for their input.

9) Deciding Whether and How to Continue the Project Without INN Funds

BHCS will support the continuation of this project or components of this project based on a number of internal and external factors and processes including: 1) the evaluation results from the project, 2) support and buy-in from the Children/Youth/TAY and Adult Systems of Care and 3) recommendations from the MHSA Stakeholder Committee & the CCAB, and 4) available funding. MHSA Prevention and Early Intervention (PEI) and Community Services and Supports (CSS) funds will be considered for supporting these services.

10) Communication and Dissemination Plan

a) *How do you plan to disseminate information to stakeholders within your county and (if applicable) to other counties?*

Updates on the project will be provided to stakeholders on an ongoing basis via email and presentations at existing meetings. The final evaluation report for this project will be shared widely by posting it on the BHCS website and announcing via email to stakeholders, including to mental health directors, MHSA coordinators, and Ethnic Services Managers throughout California. In addition, presentations will be made to the MHSA Stakeholder Group, the Cultural Competency Advisory Board, consumer groups, NAMI, the Board of Supervisors, and the Alameda County African American Health and Wellness Steering Committee.

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

The young adult facilitators will assist with sharing information about the program and outcomes, including outreaching to potential participants, developing social media posts, and participating in providing presentations to stakeholder meetings. The project coordinator will be responsible for website postings and email announcements. The Association of Black Psychologists and the Community Healing Network (CHN) will also disseminate information about the project to their members and stakeholders.

c) *KEYWORDS for search*

African American young adult healing; healing racial trauma; community connection for African American young adults; young adult Emotional Emancipation Circles

11) Timeline

a) *Specify the total timeframe (duration) of the INN Project:* **2 Years 6 Months**
b) *Specify the expected start date and end date of your INN Project:*
Start: October 2018 End: March 2021
c) *Include a timeline that specifies key activities and milestones*

Timeline	Activities/Milestones	Responsible
Oct-Nov 2018	Recruit existing young adult facilitators to participate Recruit PEER Project Coordinator Determine evaluator through RFP process	Project Administrator
Dec 2018	Peer Project Coordinator hired Outreach Plan developed Determine schedule/locations of all EECs Young adult facilitators certification updated	Project Administrator Project Coordinator Project Coordinator Lead Trainers
Jan 2019	Evaluation Plan developed and vetted Outreach for participants begins Begin tailoring of EECs for young adults	Evaluator Project Coord/Facilitators Project Admin/Coord/ Facilitators/Lead Trainers
Feb 2019	Continue tailoring of EECs for young adults	Project Admin/Coord
Mar 2019	Start EEC Series #1	Project Admin/Coord/ Facilitators/Lead Trainers
Apr-May 2019	Complete EEC Series #1 Graduation Celebration for EEC Series #1 Evaluation and debriefing of EEC Series #1	Project Admin/Coord/ Facilitators/Lead Trainers Evaluators
Jun 2019	Determine adjustments to activities and materials Prepare for EEC Series #2 Continue outreach	Project Admin/Coord/ Facilitators/Lead Trainers
Jul 2019	Start EEC Series #2	Project Admin/Coord/ Facilitators/Lead Trainers
Aug-Sep 2019	Complete EEC Series #2 Graduation Celebration for EEC Series #2 Evaluation and debriefing of EEC Series #2 Three month follow-up for Series #1	Project Admin/Coord/ Facilitators/Lead Trainers Evaluators Evaluators
Oct 2019	Determine adjustments to activities and materials Prepare for EEC Series #3 Continue outreach	Project Admin/Coord/ Facilitators/Lead Trainers
Nov-Dec 2019	Conduct EEC Series #3 (Saturdays) Graduation Celebration for EEC Series #3 Evaluation and debriefing of EEC Series #3	Project Admin/Coord/ Facilitators/Lead Trainers Evaluators

	Three month follow-up for Series #2	Evaluators
Jan 2020	Determine adjustments to activities and materials Prepare for EEC Series #4 Continue outreach	Project Admin/Coord/ Facilitators/Lead Trainers
Feb 2020	Start EEC Series #4	Project Admin/Coord/ Facilitators/Lead Trainers
Mar-Apr 2020	Complete EEC Series #4 Graduation Celebration for EEC Series #4 Evaluation and debriefing of EEC Series #4 Three month follow-up for Series #3	Project Admin/Coord/ Facilitators/Lead Trainers Evaluators Evaluators
May 2020	Determine adjustments to activities and materials Prepare for EEC Series #5	Project Admin/Coord/ Facilitators/Lead Trainers
Jun-Jul 2020	Conduct EEC Series #5 (Saturdays) Graduation Celebration for EEC Series #5 Evaluation and debriefing of EEC Series #5 Three month follow-up for Series #4	Project Admin/Coord/ Facilitators/Lead Trainers Evaluators Evaluators
Aug 2020	Determine adjustments to activities and materials Prepare for EEC Series #6 Continue outreach	Project Admin/Coord/ Facilitators/Lead Trainers
Sep 2020	Start EEC Series #6	Project Admin/Coord/ Facilitators/Lead Trainers
Oct-Nov 2020	Three month follow-up for Series #5 Complete EEC Series #6 Graduation Celebration for EEC Series #6 Evaluation and debriefing of EEC Series #6	Evaluators Project Admin/Coord/ Facilitators/Lead Trainers Evaluators
Dec 2020	Complete collection of evaluation data	Evaluator
Jan-Feb 2021	Analyze evaluation data with input from young adults and various committees Preliminary data shared with stakeholders to discuss continuing project Three month follow-up for Series #6	Evaluator Project Admin/Coord/ Facilitators/Lead Trainers Stakeholders Evaluator
Mar 2021	Evaluation report completed Disseminate Results Determine whether/how to continue project	Evaluator Project Administrator BHCS, stakeholders

This timeline includes evaluation throughout the project, beginning with vetting and finalizing and evaluation plan with the project committees and the CCAB; developing the evaluation tools with similar input; gathering preliminary data to make course corrections; gathering final data; and analyzing the data with the project committees. The last six months of the timeline allows time for data collection, analysis, dissemination, and the process to determine whether and how to continue the project. This work is feasible in this timeline because there will be efforts throughout the project to keep stakeholders informed and to consider sustainability plans.

12) INN Project Budget and Source of Expenditures

This INN Plan will use FY 10/11 funds that were deemed reverted back to the county of origin under **AB 114** to cover FY18-19 and FY19-20 expenses.

The funding for this project is for two purposes:

- To put a high level of focus on listening to and responding to the needs of African American young adults to tailor EECs as a potentially effective service. To date the African American community receives proportionally more BHCS services while experiencing lower outcomes. It will require additional investment to find solutions to these disparities.
- To evaluate whether and how EECs can be an effective service for African American young adults. This project runs six (6) cycles of EECs to allow for evaluation and quality improvement between each cycle.

A. Project Budget by Year - Narrative

Salaries

FY18-19 9 months (Oct-Jun) Project Administrator: 0.3 FTE wages and benefits = $30,712

FY19-20 Project Administrator: 0.3 FTE wages and benefits = $40,950

FY20-21 9 months (Jul-Mar) Project Administrator: 0.3 FTE wages and benefits = $30,712

Total = $102,374

Operating Costs

EECs are 8 short workshops or 2 extended workshops, 2 evaluation meetings, 1 graduation

There are 20 participants and 2 young adult facilitators at each workshop/meeting

Facilitator Stipends: $20/hour x 2 facilitators x 60 hours x 6 EECs = $14,400

Accessible meeting room for EECs: average $180/meeting x 60 meetings - $10,800

Food at EEC meetings: 22 people per meeting x $9.30/person x 58 meals = $11,880

Graduation: $500 incidentals x 6 EECs = $3,000

Training Materials (handouts, booklets, etc.): $1500 x 6 EECs = $9,000

Participant/Facilitator Transport: $1000 x 6 EECs = $6000

Total = $55,080

Non-Recurring Costs

Culturally-based displays and artifacts to establish the desired tone in the room that are re-used at each EEC.

Total = $5,000

Consultant Costs/Contractors

Lead Trainers (ABPsi): $200/hour x 2 lead trainers x 30 hours per year X 3 FY = $36,000

Peer Project Coordinator: Contract with a young adult employer for 37 hours/week

FY18-19 less than 8 months = $39,773

FY19-20 12 months = $62,160

FY20-21 9 months = $46,620

Evaluator: $30,000 per year = $90,000 Total = $274,553

Indirect

15% for county administration of the project. Applies to Personnel, Operating and Contract expenditures to provide Human Resources, Accounting, Budgeting, Information Technology, Business Services Office, and Legal management of staff and contract positions; rent, utilities, insurance; and other expenses necessary to administer the project.

Total = $64,801

Expend by Fund Source – Narrative

Administration

50% of Project Administrator time = $51,187

50% of Peer Project Coordinator time = $74,276

Indirect expenses = $64,801 Total = $190,264

Evaluation

50% of Project Administrator time = $51,187

50% of Peer Project Coordinator time= $74,276

50% of Lead Trainers time = $18,000

Evaluator = $90,000 Total = $233,463

B. New Innovative Project Budget By FISCAL YEAR (FY)*					
EXPENDITURES					
PERSONNEL COSTs (salaries, wages, benefits)		**FY2018-19 9 months**	**FY2019-20 12 months**	**FY2020-21 9 months**	**Total**
1	Salaries	$ 30,712	$ 40,950	$ 30,712	**$ 102,374**
2	Direct Costs				**$ -**
3	Indirect Costs	$ 4,607	$ 6,143	$ 4,607	**$ 15,357**
4	Total Personnel Costs	**$ 35,319**	**$ 47,093**	**$ 35,319**	**$ 117,731**
OPERATING COSTs		**FY2018-19 9 months**	**FY2019-20 12 months**	**FY2020-21 9 months**	**Total**
5	Direct Costs	$ 9,180	$ 32,130	$ 13,770	**$ 55,080**
6	Indirect Costs	$ 1,377	$ 4,820	$ 2,066	**$ 8,262**
7	Total Operating Costs	**$ 10,557**	**$ 36,950**	**$ 15,836**	**$ 63,342**
NON RECURRING COSTS (equipment, technology)		**FY2018-19 9 months**	**FY2019-20 12 months**	**FY2020-21 9 months**	**Total**
8	Workshop materials	$ 5,000			**$ 5,000**
9					**$ -**
10	Total Non-recurring costs	**$ 5,000**	**$ -**	**$ -**	**$ 5,000**
CONSULTANT COSTS/CONTRACTS (clinical, training, facilitator, evaluation)		**FY2018-19 9 months**	**FY2019-20 12 months**	**FY2020-21 9 months**	**Total**
11	Direct Costs	$ 82,773	$ 103,160	$ 88,620	**$ 274,553**
12	Indirect Costs	$ 12,416	$ 15,474	$ 13,293	**$ 41,183**
13	Total Consultant Costs	**$ 95,189**	**$ 118,634**	**$ 101,913**	**$ 315,736**
OTHER EXPENDITURES (please explain in budget narrative)		**FY2018-19 9 months**	**FY2019-20 12 months**	**FY2020-21 9 months**	**Total**
14					**$ -**
15					**$ -**
16	Total Other expenditures	**$ -**	**$ -**	**$ -**	**$ -**
BUDGET TOTALS					
Personnel (line 1)		**$ 30,712**	**$ 40,950**	**$ 30,712**	**$ 102,374**
Direct Costs (add lines 2, 5 and 11 from above)		**$ 91,953**	**$ 135,290**	**$ 102,390**	**$ 329,633**
Indirect Costs (add lines 3, 6 and 12 from above)		**$ 18,400**	**$ 26,436**	**$ 19,965**	**$ 64,801**
Non-recurring costs (line 10)		**$ 5,000**	**$ -**	**$ -**	**$ 5,000**
Other Expenditures (line 16)		**$ -**	**$ -**	**$ -**	**$ -**
TOTAL INNOVATION BUDGET		**$ 146,065**	**$ 202,676**	**$ 153,067**	**$ 501,808**

C. *Expenditures By Funding Source and FISCAL YEAR (FY)*					
Administration:					
A.	**Estimated total mental health expenditures <u>for ADMINISTRATION</u> for the entire duration of this INN Project by FY & the following funding sources:**	**FY2018-19 9 months**	**FY2019-20 12 months**	**FY2020-21 9 months**	**Total**
1	Innovative MHSA Funds	$ 54,142	$ 77,491	$ 58,631	**$ 190,264**
2	Federal Financial Participation				**$ -**
3	1991 Realignment				**$ -**
4	Behavioral Health Subaccount				**$ -**
5	Other funding*				**$ -**
6	**Total Proposed Administration**	**$ 54,142**	**$ 77,491**	**$ 58,631**	**$ 190,264**
Evaluation:					
B.	**Estimated total mental health expenditures <u>for EVALUATION</u> for the entire duration of this INN Project by FY & the following funding sources:**	**FY2018-19 9 months**	**FY2019-20 12 months**	**FY2020-21 9 months**	**Total**
1	Innovative MHSA Funds	$ 71,742	$ 87,055	$ 74,666	**$ 233,463**
2	Federal Financial Participation				**$ -**
3	1991 Realignment				**$ -**
4	Behavioral Health Subaccount				**$ -**
5	Other funding*				**$ -**
6	**Total Proposed Evaluation**	**$ 71,742**	**$ 87,055**	**$ 74,666**	**$ 233,463**
TOTAL:					
C.	**Estimated TOTAL mental health expenditures (this sum to total funding requested) for the entire duration of this INN Project by FY & the following funding sources:**	**FY2018-19 9 months**	**FY2019-20 12 months**	**FY2020-21 9 months**	**Total**
1	Innovative MHSA Funds	$ 146,065	$ 202,676	$ 153,067	**$ 501,808**
2	Federal Financial Participation				**$ -**
3	1991 Realignment				**$ -**
4	Behavioral Health Subaccount				**$ -**
5	Other funding*				**$ -**
6	**Total Proposed Expenditures**	**$ 146,065**	**$ 202,676**	**$ 153,067**	**$ 501,808**

*If "Other funding" is included, please explain.

May 31, 2018

To: Mental Health Services Oversight and Accountability Commission

The Community Healing Network (CHN) and the Association of Black Psychologists (ABPsi) look forward to working with Alameda County BHCS to implement Emotional Emancipation Circles (EECs) for young adults.

Given the majority of EEC participants are over 30 years old, this project is a great opportunity to widen the appeal of the circles for younger participants, providing an opportunity to change the course of people's lives earlier. This project will significantly add to the evaluation data on EECs by focusing on mental health and functional outcomes for participants. Doing so will allow the relevance of the EEC model to be better documented. Overall this project can lead to a wider use of the EECs among populations of African ancestry that could benefit from a community-defined evidence practice approach.

CHN and ABPsi have worked together to develop the curriculum and training for facilitators for EECs for over 10 years. The EECs have grown out of a need identified in the African American community for an ethnically focused practice that addresses their cultural experiences. EECs have been developed by and for African Americans to strengthen their racial and ethnic identity by connecting with other people of African ancestry and together transforming negative associations to positive associations. The circles provide tools and culturally relevant experiences to help heal negative self concepts, confront negative cultural messages, and contribute to the well-being of the African American community.

As an EEC Trainer, I am committed to supporting the implementation of the BHCS project by providing consultation, training and support as needed. We expect the learning from this project to contribute to increased use of EECs within mental health contexts. As the Coordinator of Safe Black Space Community Healing Circle and leader of efforts in Sacramento to get over 30 EEC facilitators trained in May 2018, I am interested in cross learning and support. Facilitators in Sacramento will implement EECs over the next six-twelve months to support the local community in response to racial trauma experienced as a result of the killing of Stephon Clark by the Sacramento Police.

Now more than ever, given the current racial climate in which we live, efforts such as these are necessary. Alameda County BHCS will play a significant role in positively impacting the lives of young Black youth with this project.

Sincerely,

Kristee L. Haggins, Ph.D.

Kristee L. Haggins, Ph.D.
EEC Trainer
Safe Black Space Coordinator

THE ASSOCIATION OF BLACK PSYCHOLOGISTS, INC.
7119 ALLENTOWN ROAD, SUITE 203
FT. WASHINGTON, MD 20744
TEL: (301) 449-3082 FAX: (301) 449-3084

May 31, 2018

To: Mental Health Services Oversight and Accountability Commission

Attention: Ms. Kristen Gardner
kgardner@alum.mit.edu

Dear Ms. Gardner,

It is with extreme pleasure and excitement that I submit this letter of support. The Community Healing Network (CHN; http://www.communityhealingnet.org/) and Association of Black Psychologists, Inc. (ABPsi; www.abpsi.org) are looking forward to working with Alameda County BHCS to implement Emotional Emancipation Circles℠ (EEC℠) for young adults. A large majority of participants are over 30 years old. This project is a great opportunity to widen the appeal of EECs℠ for young adult participants of African ancestry, providing an opportunity to change the course of people's lives earlier. Also, this project will significantly add to the evaluation data of EECs℠. Though the EECs℠ are not designed to provide mental health services, it can be postulated that participants do experience increased coping skills in relation to psychological stressor. More specifically, participants may be better consumers of mental health services where warranted. By focusing on mental health and functional outcomes for participants, the relevance of the EEC℠ model will be better documented. Overall, this project can lead to a wider use of the EEC℠ model among populations that could benefit from this culturally-centered community-defined approach.

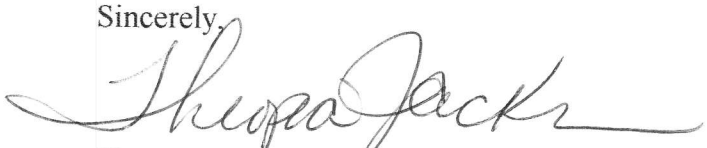
The CHN and ABPsi have worked together to develop the curriculum and training for facilitators for EECs for over 10 years. The EEC model has grown out of a need identified in African American communities worldwide for an ethnically focused practice that addresses their experiences centered on culturally-affirming healing processes. It has been developed by and for persons of African ancestry to strengthen ethnic identity formation, which has been shown to be essential for optimal development/wellness, as well as a protective factor in the face of complex trauma and racial stress.

In closing, on behalf of CHN and ABPsi, I applaud the leadership of Alameda County BHCS in embracing this innovative community

defined practice. It sets the stage for other counties to follow. Know that my colleagues and I are committed to implementing the BHCS project by providing consultation, training, and support as needed. We expect the learning from this project to contribute to the increased use of EECs within holistic mental health and wellness contexts.

Please do not hesitate to contact me if any questions or additional information warranted.

Sincerely,



Theopia Jackson, PhD
2017-2019 President Elect
The Association of Black Psychologists, Inc.
t.jackson@abpsi.org
(925) 786 – 6815

BAY AREA CHAPTER OF THE ASSOCIATION OF BLACK PSYCHOLOGISTS

P.O. Box 29665
Oakland, CA 94604

To: Mental Health Services Oversight and Accountability Commission

The Cultural Healing Network (CHN) and Association of Black Psychologists (ABPsi) are looking forward to working with Alameda County BHCS to implement Emotional Emancipation Circles (EEC) for young adults. A large majority of participants in the training are over the age of 30 years. This project is a great opportunity to widen the appeal of EECs for younger participants, providing an opportunity to change the course of people's lives earlier. Also, this project will significantly add to the evaluation data on this community-defined approach. By focusing on mental health and functional outcomes for young participants, the relevance of the EEC model will be better documented. Overall this project can lead to a wider use of the EEC model among populations that could benefit from it.

CHN and ABPsi have worked together to develop the EEC curriculum and training for facilitators for over 10 years. The EEC model has grown out of a need identified in the African American community for an ethnically focused practice that addresses their experience in this culture. It has been developed by and for African Americans to strengthen their racial and ethnic identity by connecting meaningfully with other African Americans and together challenging and transforming the historically negative associations to positive associations. This experience provides tools and experiences to heal emotional trauma connected to negative self-concepts, to confront negative cultural messages, and contribute to the well-being of communities of African ancestry.

We are committed to implementing the BHCS project by providing consultation, training and support as needed. We expect the learning from this project to contribute to increased use of EECs within mental health contexts.

Sincerely,

Tony Jackson

Dr. Tony Jackson (Heru)
President, Bay Area Chapter of the Association of Black Psychologists

Project Summary

County: **Alameda County**
Date submitted: 4/13/2018
Project Title: **Introducing Neuroplasticity to Mental Health Services for Children**
Total amount requested: $2,054,534
Duration of project: 4 years

General Requirement	Applies a promising community driven practice or approach that has been successful in a non-mental health context or setting to the mental health system
Primary Purpose	Increases the quality of mental health services, including measured outcomes

Problem

Many children with emotional and behavioral disorders have underlying neurodevelopmental differences that exacerbate the emotional and behavioral disorders. For example, childhood trauma and related stress may result in a delay in organized neurodevelopment due to prioritizing safety (fight/fright/freeze). This frequently results in functional issues such as hypersensitivity to touch, an inability to know where one is in space or a need to move constantly, as well as other behaviors that result in discipline, interrupted learning, and mental health services. Unfortunately, mental health practitioners are not trained to identify, nor treat, the neurodevelopmental disorders that may be contributing to the emotional and behavioral symptoms.

Data is not available to estimate the number of youth with emotional/behavioral issues who also have neurodevelopmental issues, but based on rates of emotional/behavioral symptoms and trauma among children, we can estimate that 67-90% (19,939 to 26,784) of students aged 5-12 in Alameda schools who exhibit emotional/behavioral symptoms have experienced trauma, a leading cause of neurodevelopmental issues.

In Alameda's recent Community Planning Process (CPP) for the MHSA Three Year Plan, 71% of respondents identified violence and trauma as a priority issue for youth. While MHSA Prevention, Education, and Innovation (PEI) provides some trauma related training and services in schools, the community requested that Innovation try to find additional ways to address behavioral and emotional issues – whether related to trauma or not – in schools.

Project

Brain research has helped us to understand the link between neurodevelopment and mental health. This has led to inter-disciplinary efforts and well developed assessments, but limited specific interventions. Most of these efforts are only available to clients in specialty centers and clinical settings. In addition, while the existing research supports the effectiveness of these efforts in regards to mental health outcomes, the research focusing on mental health is limited.

This Innovation project aims to provide neurodevelopmental interventions for youth experiencing moderate and serious mental health issues in an accessible manner. Trained HANDLE® (Holistic Approach to Neuro-Development and Learning Efficiency) instructors provide training for clinical and non-clinical providers in unique assessment procedures and specific interventions.In addition, this project would evaluate the impact on mental health symptoms. This project proposes to:

- Train school and BHCS staff in the HANDLE model
- Have school staff refer students (K-5) exhibiting emotional/behavioral symptoms
- Conduct eligibility screening, gain parent permission
- Assess students, including a neurodevelopment assessment, in order to develop an intervention plan
- Provide 4-6 months of services each day in school by trained HANDLE practitioners

Evaluation

Integrating neurodevelopmental assessments and interventions into mental health services is a significant change to existing practice that may lead to improved outcomes for youth experiencing a wide variety of mental health issues. Alameda County aims to learn:

Can neurodevelopmental interventions provided in a non-clinical setting for youth with emotional and behavioral disorders reduce their symptoms and improve their functioning?

Learning Goals *(see Logic Model for more detail)*

1. Determine if implementing a neurodevelopmental approach to mental health changes the way educators and mental health providers understand children with emotional and behavioral disorders.
2. Determine if neurodevelopmental interventions, using the HANDLE model, with youth with emotional and behavioral disorders reduces their emotional and behavioral symptoms and academic outcomes.

The project could provide a model for improving underlying neurodevelopmental issues that lead to emotional and behavioral symptoms for a wide range of youth. The results will be shared statewide with mental health divisions, as well as regionally with schools, and further.

Budget

Salaries *$943,631*	BH Clinical Supervisor (1.0 FTE) coordinate the program oversee Clinician II Clinician II (0.6-0.75 FTE) oversee HANDLE trained practitioners *Clinicians (0.2 FTE x 6 staff) attend training, conduct assessments (BHCS in-kind)*
Operating *$80,200*	Substitute teacher time for teachers to attend training Materials, snacks, incentives
Consultants *$762,720*	Parent Aids: parents or others who become trained HANDLE practitioners (2.0 FT) HANDLE Trainers; Evaluator
Indirect *$267,983*	15% for BHCS to administer project

Introducing Neuroplasticity to Mental Health Services for Children **Logic Model**

Situation:
- Alameda County Stakeholders requested Innovative approaches to addressing mental health issues in schools
- Over 19% of Alameda County students (K-8) have been identified as having behavioral/emotional symptoms
- 55-90% of these students have experienced trauma, a leading cause of neurodevelopmental issues
- Mental health providers are not trained to identify or address neurodevelopmental issues

Inputs	**Outputs**		**Outcomes -- Impact**		
	Activities	*Participation*	*Short*	*Medium*	*Long*
Training in HANDLE ® Personnel Time - BHCS program manager - BHCS clinicians - School staff - Student Aides (parents and others who are stipended) Substitutes to cover school staff as needed Materials Evaluator	Training - Concept, basic interventions - Screener training - Advanced training Students with emotional or behavioral problems and neuro-developmental weaknesses receive neuro-developmental interventions every school day for 4 mos (6 mos advanced) (200 students) Pre/post evaluations	- All participating staff, other school staff, parents, etc. (150) - Clinicians, school staff (12) - Clinicians, school staff (6) Trained Practitioners assess students referred by school Student Aides provide interventions for students Parents/students, providers, school staff	Increase in knowledge and skills regarding neurodevelopment framework, assessment and interventions (75%) Students receiving interventions experience improved neuro-development (35%/50% advanced), emotional or behavioral symptoms (50%), and school performance (25%)	Increase neurodevelopment-informed response to students (50%) Students continue to show improvement (review of IEPs one year after intervention)	Increase understanding of student behavior (70%) Students experience long-term improved mental health and functional outcomes *(not within scope of program evaluation)*

Assumptions
Neurodevelopmental issues can cause/exacerbate behavioral/emotional symptoms. Strengthening neurodevelopment can reduce emotional/ behavioral symptoms. HANDLE provides effective assessment and interventions that clinical and non-clinical people can be trained to conduct.

External Factors
- The number of schools that participate and level of follow-through. (So far 2 schools have committed to participation and training time).
- Parents approval of students' participation in services
- Participants exposure to further trauma

INNOVATIVE PROJECT PLAN DESCRIPTION

County: Alameda Date Submitted 4.13.18
Project Name: Introducing Neuroplasticity to Mental Health Services for Children

I. Project Overview

1) Primary Problem

a) What primary problem or challenge are you trying to address?

Many children with emotional and behavioral disorders have underlying neurodevelopmental differences that exacerbate the emotional and behavioral disorders. Finding a way to provide neurodevelopmental interventions, in addition to mental health interventions, should lead to better mental health and functional outcomes.

The causes of emotional disturbance, neurodevelopmental disorders, and other challenges among youth are complex and interactive – a mix of genetic, experiential and physical environment factors. Trauma is one of the more studied causes of neurodevelopmental disorders. Adverse childhood experiences (ACEs) can cause significant neurodevelopmental and brain dysfunction, which can result in physical, cognitive, emotional and behavioral issues (Perry et al, 1995; Felitti et al, 1998). A study of over 17,000 adults revealed a strong positive relationship between ACEs and the increased likelihood of behavioral health issues, suggesting disordered brain functioning in response to child trauma (Anda et al, 2006).

A common example is a child that develops a nervous system which functions in a high state of sympathetic response due to experiencing trauma. This state of flight/fight/freeze affects their emotions, behaviors, and ability to learn. Such a child is then diagnosed and treated based on their set of symptoms. If they are diagnosed with primarily a learning disorder, then they get one course of services. If they are diagnosed with primarily a mental health disorder they will be served within the mental health system. Unfortunately, **mental health practitioners are not trained to identify, nor treat, the neurodevelopmental disorders that may be contributing to the emotional and behavioral symptoms.** Mental health approaches focus on thoughts, emotions and behaviors to lower stress, and address symptoms of a child's diagnosis. It may help the child to manage the symptoms, but does not necessarily improve the underlying neurodevelopmental issues.

Due to lack of attention to the overlap of emotional or behavioral symptoms and neurodevelopmental weaknesses in children, it is hard to know how many children are experiencing this. But we have a few points of data that help us to estimate:

- In 2016, 4.2% (6,510) of Alameda County students ages 5-12 received special education services for emotional disturbance according to Lucile Packard's Foundation for Children's Health.

- In addition, approximately 15% (23,250) of general education students in Alameda County are referred to Mental Health Services Act (MHSA) Prevention and Early Intervention (PEI) funded services by school staff due to exhibiting behavioral/emotional issues.

While there is no way to know how many of these students have neurodevelopmental weaknesses, we do know:

- More than 2/3 of children report at least one traumatic event by age 16 (SAMHSA)
- Due to the link between trauma and mental health issues, 90% percent of clients in public behavioral health care setting have experienced trauma (integration.samhsa.gov/clinical-practice/trauma).

So we can estimate that 67-90% of children with behavioral health issues have experienced trauma. **This means between 19,939 and 26,784 students ages 5-12 in Alameda schools exhibit emotional/behavioral symptoms and have experienced trauma, a leading cause of neurodevelopmental issues.**

b) Describe what led to the development of the idea for your INN project

In Alameda's recent Community Planning Process (CPP) for the MHSA Three Year Plan, 71% of respondents identified violence and trauma as a priority issue for youth. MHSA Prevention and Early Intervention (PEI) programs currently provide some training to school staff to be better equipped to receive youth experiencing trauma. The Transition Age Youth (TAY) Full Service Partnership (FSP) also aims to provide trauma informed care. **In the CPP the community requested that Innovation try to find additional ways to address behavioral and emotional issues – whether related to trauma or not – in schools.** Currently, BHCS funds access and linkage programs at the school district level to implement Coordination of Services Teams (COST). These COST Teams are not assessing for neurodevelopmental weaknesses or strategies for strengthening neural pathways. However, many students have experienced different levels of community violence and trauma, which can lead to neurodevelopmental issues. Our current level of MHSA funded PEI services is missing this critical piece around neurodevelopmental issues and recovery from them.

Innovation offers a way to test an intervention before determining whether to formally integrate it into ongoing BHCS programs and practices. **This INN project tests whether addressing underlying neurodevelopmental weaknesses can reduce mental health symptoms. If successful it could be widely integrated into existing school-based services.**

2) What Has Been Done Elsewhere To Address Your Primary Problem?

BHCS staff has conducted research on the scientific framework of this project, as well as potential models through inter-net research and informational interviews. This research has focused on understanding the link between neurodevelopment and mental health for children, as well as models for addressing it.

- Christopher Gillberg, MD/PhD and professors of child and adolescent psychiatry, has developed the neurodevelopmental comorbidity framework for multi-disciplinary assessment and intervention.
- The MIND Institute in Davis focuses on non-mental health diagnoses and, like Gillberg, incorporates a multi-disciplinary approach to assessment and intervention.
- Bruce Perry, MD/PhD and expert in childhood trauma, has looked at the relationship between trauma and neurodevelopmental changes.
- Rick Gaskill, PhD/LCP and expert in childhood trauma, collaborates with Bruce Perry to educate about the neurodevelopmental impact of trauma, assessment protocols, and potential interventions.
- San Mateo Behavioral Health and Recovery Services began using the Neurosequential Model of Therapeutics (NMT) in their youth services in 2012. While there is limited evaluation data on the effect on emotional/behavioral outcomes, their experience supports its benefit. In 2016, San Mateo implemented an Innovation project to adapt these services for adults.

While the above work and Alameda's proposed project are based on the same brain research and intervention frameworks, the interventions are different. Gillberg and MIND's interdisciplinary approach requires a level of staffing not feasible in most settings. It is mainly used in specialty centers. NMT certification focuses on an approach, not specific interventions, and is open only to clinical providers. None of the models have substantial data showing the impact of the services on mental health outcomes for children.

This Innovation project aims to provide neurodevelopmental interventions for youth experiencing moderate and serious mental health issues in an accessible manner. Unlike the models above, Holistic Approach to Neuro-Development and Learning Efficiency (HANDLE®) provides training for clinical and non-clinical providers in assessment and specific interventions. In addition, this project would evaluate the impact on mental health symptoms.

3) The Proposed Project

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

This Innovation proposal integrates a neurodevelopmental approach into mental health services to achieve better outcomes. Holistic Approach to Neuro-Development and Learning Efficiency (HANDLE®) is a practice based on brain research on neuroplasticity and the effect of stress responses on learning, mood and behavior. It includes an initial assessment to determine inefficiencies in the communication between the body and the brain leading to functional difficulties. Based on that assessment a treatment plan is developed that specifies HANDLE interventions to address the neurodevelopmental weaknesses. HANDLE does not teach coping

mechanisms, it improves brain function, which ultimately reduces or eliminates the underlying neurodevelopmental problems contributing to emotional and behavioral symptoms.

Examples of interventions include:

- A child that skips the crawling stage of development may exhibit higher levels of clumsiness, an inability to focus, anxiety, frustration and ultimately hopelessness due to underdevelopment of the interconnections between the left and right hemispheres of the brain and interconnected neurodevelopmental systems. Activities, such as one that combines bouncing a ball in an intentionally rhythmic and repetitive manner, will recreate the neural connections that originally would have been developed during the child's crawling stage.

- A child diagnosed with PTSD due to physical abuse may be over- or under-sensitive to touch. This trauma expresses itself in learning difficulties and problematic behavior driven by the system's overreaction to physical contact. The child's brain has formed neural connections that interpret tactile sensation as a threat. A HANDLE treatment plan may include rolling a softball-sized ball along the child's arms in an organized rhythm to allow him to efficiently integrate sensory information from the tactile stimulation. By intentionally and repetitively creating appropriate stimuli in a safe environment, neural connections are formed, and the tactile sensation is reinterpreted by the brain as non-threatening. The trained adults around him (parents, teachers) will interpret his behavior and respond to it more appropriately. Rather than a punitive or 'fix him' approach, they will find ways to create an environment that is safe internally and externally in which he can heal, connect, develop positive self-esteem, and diminish symptomatic behavior.

The program will include the following steps:

1) Identify participating schools sites and staff to receive HANDLE training. (Initial engagement and commitments have already been developed.)

2) Provide an overview training about HANDLE to approximately 150 BHCS youth services staff, staff from participating schools, and parents of BHCS clients or students at the participating schools. School staff may include teachers, teacher's aides, behavioral specialist, psychologists, physical therapists, occupational therapists, and others. This training will be provided at the beginning of the project, and then periodically throughout the project as additional schools or personnel need training.

3) Provide training and certification for implementation partners:
    a. Parent Aides (2.0 FTE, up to 6 part-time positions): Aides will include parents of BHCS clients and students at participating schools, among others. Aides will be screened appropriately and paid to provide the interventions for participating students. They will learn basic interventions during the overview training. Staff receiving HANDLE Practitioner training will teach them additional interventions as needed.

b. Practitioners: Approximately 6 school staff and 6 BHCS staff will attend a 14-day training in conducting assessments and more specific interventions that takes place over two months. One school district has offered two schools sites and committed to the training requirements for participating staff (see letter of support). Six of the HANDLE Practitioners will later attend a 25-day training in more advanced assessments and interventions. This takes place over several months.

4) Implement assessment and intervention services.
    a. Identification: Students exhibiting emotional and behavioral problems will be identified by the school personnel. The parent(s) and teacher will be asked to complete a brief questionnaire and mark a checklist of concerns provided by HANDLE. Parent permission will be required to continue.
    b. Assessment: Based on the results of the initial surveys, the children who meet criteria will be assessed by a trained HANDLE Practitioner.
    c. Intervention: The HANDLE Practitioner will develop an intervention plan based on the neurological weaknesses identified. The Practitioner will meet with the student's caregiver and assigned Parent Aide to review the intervention plan. The Parent Aide will provide the intervention every school day for 4 months. In year 2 and 3 of the project, students who are assessed with more significant needs can be provided a more intensive 6-month intervention. For continuity of care for BHCS clients receiving these services, they will be screened by BHCS staff or the Practitioners will collaborate with BHCS staff.

    As with other services provided through school settings, parent permission is required. With HANDLE, parent involvement is also welcome. Every effort will be made to present these services in a non-stigmatizing and sensitive way, especially given the potential involvement of parental abuse or neglect. HANDLE is an inherently nonjudgmental approach concerned with how to support the student's ability to navigate his/her inner and outer worlds efficiently. This is communicated to parents in writing and in informational meetings. Parental communication and a nonjudgmental approach is a significant part of the training process for HANDLE Practitioners.

5) Evaluate the effectiveness of the HANDLE interventions regarding emotional, behavioral and academic outcomes.

b) Identify which of the three approaches specified in CCR, Title 9, Sect. 3910(a) the project will implement.

This proposal applies a promising practice that has been successful in non-mental health contexts. HANDLE's neurodevelopmental interventions, and neurodevelopmental approaches in general, are applied more often to cases of autism, learning disabilities, developmental delays, brain injury, and other situations not identified as primarily a mental health issue. They

have also been applied in cases where emotional/behavioral/mental health issues are present, but evaluation for mental health outcomes is extremely limited.

c) Briefly explain how you have determined that your selected approach is appropriate.

Neurosequential Model of Therapeutics (NMT) is based on the same brain research and frameworks as HANDLE. Some studies have found evidence of increased social-emotional development and improvements in problematic behavior in children receiving NMT (Barfield, Gaskill, Dobson, & Perry, 2012). In addition, San Mateo BHRS reports that among a sample of 10 youth receiving NMT assessments and NMT informed interventions, all showed improved self-regulation, and two-thirds showed improvements in sensory integration, relational, and cognitive domain measures. **This provides reason to believe that HANDLE, which is based on the same framework, would produce positive emotional and behavioral outcomes.**

HANDLE is a promising practice in childhood neurodevelopment with limited implementation and evaluation. HANDLE practitioners are scattered across several continents, with twelve certified Practitioners residing in California. While these HANDLE Practitioners' experience is that this approach significantly assists individuals experiencing a variety of developmental, behavioral and emotional issues, the evaluation of the practice is limited and not mental health specific. Studies to date suggest functional improvements in individuals who experienced traumatic brain injury and increased behavioral/emotional stability in children with ADHD diagnosis and those in out of home placement with childhood trauma.

HANDLE offers a feasible way to provide neurodevelopmental services for children experiencing emotional and behavioral issues, without requiring clinical level services.

4) Innovative Component

Neurodevelopmental research is still an emerging area. The research findings, but not the interventions, have recently become common curricula at university training programs for Masters in Social Work or Marriage and Family Therapy. Therapists currently working in the field are unlikely to have received any formal training in their master's degree programs in identifying and treating underlying neurodevelopmental issues that may be contributing to emotional and behavioral symptoms. While some mental health providers may have sought out training in this area, it is not a widely recognized approach. **Integrating neurodevelopmental assessments and interventions into mental health services is a significant change to existing practice that may lead to improved outcomes for youth experiencing a wide variety of mental health issues.**

5) Learning Goals / Project Aims

Alameda County aims to learn:

Can neurodevelopmental interventions provided in a non-clinical setting for youth with emotional and behavioral disorders reduce their symptoms and improve their functioning?

Learning Goals

1. Determine if implementing a neurodevelopmental approach to mental health changes the way educators and mental health providers understand children with emotional and behavioral disorders.
2. Determine if neurodevelopmental interventions, using the HANDLE model, with youth with emotional and behavioral disorders reduces their emotional and behavioral symptoms and academic outcomes.

Given that this project is implementing a model that has already been developed and implemented in non-mental health contexts, the core question is whether it improves mental health outcomes. In addition, a neurodevelopmental paradigm changes the understanding of emotional and behavioral challenges. This can affect many aspects of how the children are treated, such as whether or not they are referred for the services, how schools handle discipline, etc.

6) *Evaluation or Learning Plan*

Learning Goals

1. Determine if implementing a neurodevelopmental approach to mental health changes the way educators and mental health providers understand children with emotional and behavioral disorders.

Data to collect	Data collection method
Who participates *4 schools*	Project coordinator will track which schools participate
Who receives neurodevelopmental training *150 providers, school staff, parents* *12 clinicians, school staff* *6 clinicians, school staff (advanced)*	Project coordinator will track the number of people trained in each level of training, including their name and role (i.e., teacher, mental health provider, parent aide, etc.)
Attitudes, knowledge, skills, action regarding neurodevelopment framework, assessment, interventions *75% trained will show basic knowledge/skills* *50% trained refer students to HANDLE or implement practices* *70% trained express understanding of student behavior*	A survey will be conducted with participants at the end of each training. Referral patterns and implementation of practices will be tracked. Focus groups will be conducted at the conclusion of the project with participants.

2. Determine if neurodevelopmental interventions, using the HANDLE model, with youth with emotional and behavioral disorders reduces their emotional and behavioral symptoms and academic outcomes.

Data to collect	Data collection method
Who receives the services *200 receive intervention*	Project coordinator will keep records of students: - Referred for HANDLE assessment - Completing HANDLE assessment - Provided a HANDLE treatment plan - Provided HANDLE interventions, number/type of interventions In addition, if a youth referred for assessment did not receive services, the reason why will be recorded (i.e.; assessed as not appropriate for services, family declined service, etc.)
Improvement in areas student was weak in at time of assessment *35% of those receiving 4 month intervention* *50% of those receiving 6 month intervention*	Participating students receive an initial assessment to determine eligibility and interventions. A post-test at the conclusion of services will be used to determine changes in neurodevelopment.
Improvement in emotional or behavioral symptoms *50% of those receiving intervention*	Parent, school staff, teacher, and/or MH provider complete a measurement tool at the time of the assessment and at the conclusion of the services. A standardized, validated tool will be determined in consultation with the evaluators and include changes in mental health symptoms and emotional regulation. Examples: level of defiance, isolation, aggressiveness, fear/worry, flexibility, etc.
Improvement in school performance *25% of those receiving intervention*	Teachers will complete a tool at the time student is referred for assessment and again at completion of services regarding attendance, reading and math levels, discipline frequency, and other key indicators.

Data collection, evaluation and reporting for this project will be in alignment with the current Innovation Regulations. This includes collecting indicated demographic data, tracking changes made to the project in the course of implementation, and providing annual and final reports covering all required elements.

Longitudinal: Evaluators will review Individual Education Plans (IEP) for HANDLE participants that have an IEP. They will compare IEPs prior to services with those one year after the services to see if there are trends that can be discerned. These might include rate of growth in learning, presence of behavioral intervention plans, and other indicators.

Evaluation of this project will be contracted out. The evaluators will assist in developing appropriate tools, finalizing the evaluation plan, gathering and analyzing the data. They will provide a data entry method and review data on a regular basis to ensure appropriate quantity and quality, and provide technical assistance as needed. They will document factors that might affect the outcomes, such as normal developmental changes and changes in the home. While those factors cannot be controlled for, the evaluation design will attempt to increase the validity of the results.

7) Contracting

The implementation of this project will be led by BHCS staff.

- MOUs will be developed between BHCS and participating schools before school staff participate in certification process to clarify certification, implementation, and data collection expectations. These MOUs will be monitored on an ongoing basis by BHCS project lead to ensure compliance or need for amending the agreement.
- Written agreements will be developed with BHCS staff prior to certification process regarding certification, implementation and data collection. These expectations will be part of their BHCS position on monitored by their supervisor and the project lead
- Written agreements will be developed with Parent Aides prior to being hired regarding their scope of work. The project lead will meet regularly with Parent Aides to provide supervision.

II. Additional Information for Regulatory Requirements

1) Certifications

2) Community Program Planning

The community planning process for the MHSA Three Year Plan was conducted from June – October 2017. During that process Alameda County BHCS staff provided updates and information on current MHSA programs and community members provided input on mental health needs and services. There were three modes for providing input:

- Five large community forums (one in each Supervisorial District)
- Eighteen focus groups were conducted throughout Alameda County: Chinese speaking family members, African American family members, providers for refugees, providers for LGBTQ community, transitional age youth (2), Afghan immigrants, older adults, API and refugee providers and advocates, providers for individuals with developmental disabilities and mental illness, and Pool of Consumer Champions
- Community Input Surveys in all threshold languages: submitted by 550 unique individuals. Respondents were very diverse in age, race, and ethnicity. Fifty percent of respondents were from Oakland, while they make up only 30% of Alameda's population.

Survey respondents included: Mental health consumers (25%), family members (17%), community members (15%), education agency (2%), community mental health providers (14%), homeless/housing services (6%), county Behavioral Health staff (1%), faith-based organization (2%), substance abuse services provider (<1%), hospital/provider care (4%), law enforcement (1%), NAMI (1%), Veteran/Veteran services (1%), other community (Non-MH) service provider (5%), other/decline to state (9%).

Details of the process are provided in the MHSA Three Year Plan www.ACMHSA.org (click on Documents/MHSA Plans).

The BHCS systems of care and BHCS Housing Department were asked to submit proposals that addressed the needs identified in the community planning process. The proposed projects were vetted by MHSA staff based on whether they addressed community priorities, as well as other factors. For example, "Community Violence and Trauma" was identified as the second top priority for youth. (The first priority for youth was suicide prevention, which is being addressed by other BHCS projects.) For Innovation, there were multiple suggestions to address behavioral issues and trauma related issues in school settings.

This proposal was posted for public comment from April 13-May 13, 2018 and on May 14, 2018 a public hearing was held. Substantive comments received are included here.

MHSA Stakeholder Committee member: Collaborative services addressing the whole person has been a trend in the healthcare world, the theory behind which would ensure providers are adequately trained to see the whole picture. Therefore the idea of addressing neuroplasticity for children is an interesting one. Rebuilding brain connections to improve function would presumably be useful for all children who live in communities impacted by trauma and violence. In review of the proposal, it appears the population is defined as children experiencing behavioral and emotional issues but who do not have a learning disability or developmental or intellectual disability. Controlling for this is likely challenging, as assessing diagnostic criteria specifically enough to effectively rule out other overlapping conditions may be hard.

It is unclear how casual relationships will be determined between intervention and outcome given the children may be receiving mental health services in addition to the HANDLE services at the same time. The measures span a broad range of outcomes (emotional, behavioral, academics, etc.) The project has potential to focus very specifically, or address a wide range of things. E.g. either train specific providers to work with a specific identified population or train all individuals involved (parents, teachers, etc.) on the basics to provide service to all children in high need areas.

Response: Where the commenter wrote "it appears the population is defined as children experiencing behavioral and emotional issues but who do not have a learning disability or developmental or intellectual disability...." this is incorrect. The language in the proposal states students exhibiting emotional and behavioral problems **not explained by** intellectual or development disability will be identified by the school personnel. The reason for this is those

with a primary diagnosis of intellectual/developmental disability are eligible for more appropriate services through the Regional Center. We have amended the language in the proposal to clarify that.

This is a mental health grant thus the criteria for participation is based on mental health criteria. Although learning disabilities alone are not a criteria to qualify for the program, we expect children participating in the program may also have learning disabilities.

We agree with the comment that this type of intervention can help many people with trauma and we did need to focus criteria to evaluate the effectiveness of the interventions. This collaborative grant trains school personnel, enabling them to provide services in the future for students not served within this project.

While this project will not study the impact of HANDLE in isolation from other services, the project will have a professional evaluator to design methods to help determine the impact as best as possible. The evaluator will also work with multiple stakeholder groups (the HANDLE project staff, BHCS staff, families and the MHSA stakeholder committee staff) to fully develop the outcome measures, tools, and processes.

Family member of a client with serious mental illness: Is it clear that the Neuroplasticity Innovation Project under INN proposals in not expected to treat or reduce the incidence of schizophrenia, schizo-affective disorder, or bipolar disorder?

Response: Yes. This project offers a feasible way to provide neurodevelopmental services for children experiencing emotional and behavioral issues, without requiring clinical level services. This is a practice that's not directed at specific diagnoses. It addresses the neurodevelopment of each individual to increase his/her ability to process emotions, behaviors, symptoms and internal world more efficiently so that each can negotiate one's external world more effectively.

3) Primary Purpose

Increase the quality of mental health services, including measurable outcomes

4) MHSA Innovative Project Category

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

5) Population (if applicable)

a) *If your project includes direct services to mental health consumers, family members, or individuals at risk of serious mental illness/serious emotional disturbance, please*

estimate number of individuals expected to be served annually. How are you estimating this number?

This project expects to serve 70 students each year, leading to approximately 200 students receiving intervention services over three years. This is based on the rates of behavioral health issues among students and the likely participating schools. San Leandro Unified has committed to having one elementary school participate and potentiallyadding another if successful. Hayward Unified and Castro Valley Unified are also interested in participating. Assuming 4 schools participate with a total population of 2,000 students (5-12 years old), approximately 19% (380) have behavioral/emotional issues including those in Special Ed due to emotional disturbance and those referred to PEI services. Of those 380 students, at least 55% (209) have experienced trauma, a leading cause of neurodevelopmental issues. So, we expect that at least 200 students at participating schools would be eligible for services in any given year. Due to program capacity, a portion of those children would be identified each year.

b) *Describe the population to be served, including relevant demographic information.*

This project is intended to serve students from 5-12 years old. Those youth and families reflect the diversity of Alameda County and therefore any client materials produced would be translated into all threshold languages.

c) *Does the project plan to serve a focal population, e.g., providing specialized services for a target group, or having eligibility criteria that must be met? If so, please explain.*

Students exhibiting emotional and behavioral problems not explained by intellectual or development disability will be identified by the school personnel. Students with a primary diagnosis of intellectual or developmental disability are eligible for other services more appropriate for their needs. The parent(s) and teacher will be asked to complete a brief questionnaire and mark a checklist of concerns provided by HANDLE. Parent(s) would also complete a consent for participation. Based on the results of the initial surveys, the children who meet criteria will be assessed by a trained HANDLE Practitioner to determine eligibility.

6) MHSA General Standards

a) Community Collaboration: This project relies on schools and parents to participate in developing, implementing and evaluating this project. The project coordinator will work closely with the schools and Parent Aides to ensure that they are kept informed about program development and that their input guides the implementation.
b) Cultural Competency: The implementation plan will be presented to the BHCS Cultural Competency Advisory Board for input. The partner schools will be selected in part based on the student population in terms of race, ethnicity, and free and reduced lunch statistics to ensure underserved populations have access to these services. In addition, ensuring

culturally and linguistically appropriate services will be a factor in selecting those to be trained in HANDLE.

c) Client-Driven: This project is focused on youth ages 5-12, so there will be limited client input into the project development.
d) Family-Driven: Family members will be among those recruited and paid to be trained in HANDLE and provide intervention services, as well as provide input on implementation and evaluation.
e) Wellness, Recovery, and Resilience-Focused: This project aims to help clients re-wire neural pathways to reverse underlying neurodevelopmental problems leading to emotional and behavioral symptoms – contributing to recovery.
f) Integrated Service Experience for Clients and Families: This project integrates traditional mental health services with a neurodevelopmental approach – which usually is only available to families that are in a position to seek out and pay for such services themselves. In addition, it provides the services within school settings, reducing the barriers to accessing the services.

7) Continuity of Care for Individuals with Serious Mental Illness

This project will serve some youth experiencing serious emotional disturbance. If for some reason the project is not sustained, trained BHCS providers can still provide assessments and train caregivers to provide the interventions, but there would not be Parent Aides to provide the services.

8) INN Project Evaluation Cultural Competence and Meaningful Stakeholder Involvement.

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

This project would aim to be culturally competent by:

- Selecting culturally and linguistically diverse providers, parents, and school staff to provide services as well as provide input on the program implementation and evaluation
- Presenting the implementation plan and evaluation plan and tools to the BHCS Cultural Competency Advisory Board for input

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

The schools and providers will be engaged throughout the process to provide input on the evaluation plan and tools. They will also participate in selecting Parent Aides and be part of an ongoing committee to support integration of the program in a school setting.

9) Deciding Whether and How to Continue the Project Without INN Funds

BHCS will support the continuation of this project or components of this project based on a number of internal and external factors and processes including: 1) the evaluation results from the project, 2) support and buy-in from the Children's System of Care and 3) recommendations from the MHSA Stakeholder Committee & the CCAB, and 4) available funding. MHSA Prevention and Early Intervention (PEI) and Community Services and Supports (CSS) funds will be considered for ongoing funding of this project.

10) Communication and Dissemination Plan

a) *How do you plan to disseminate information to stakeholders within your county and (if applicable) to other counties?*

The participating schools will be responsible for disseminating results within their schools and to other schools. The project coordinator will be responsible for reaching other stakeholders and counties. Updates on the project will be provided to stakeholders on an ongoing basis via email and presentations at existing meetings. The final evaluation report for this project will be shared widely by posting it on the BHCS website and announcing via email to stakeholders, including to mental health directors, and MHSA coordinators throughout California. In addition, presentations will be made to the MHSA Stakeholder Group, the Cultural Competency Advisory Board, consumer groups, NAMI, the Board of Supervisors, and school communities.

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

The participating schools will be responsible for sharing the results within their schools and with other schools, providing presentations to the organizations listed above, and forwarding email announcements to their stakeholders. The project coordinator will be responsible for website postings and email announcements.

c) *KEYWORDS for search: Please list up to 5 keywords or phrases for this project that someone interested in your project might use to find it in a search.*

Mental health and neurodevelopmental disorders; Neurodevelopmental interventions for mental health disorders; HANDLE

11) Timeline

a) *Specify the total timeframe (duration) of the INN Project:* **4 Years**
b) *Specify the expected start date and end date of your INN Project:*

Start: October 2018 End: September 2022

c) Include a timeline that specifies key activities and milestones

Timeline	Activities/Milestones
Oct-Dec 2018	Engage potential participating schools Develop training timeline Hire evaluator
Jan-Mar 2019	Introductory training for schools, BHCS staff, parents, potential Parent Aides Recruit potential Parent Aides
Apr-Jun 2019	Confirm participating schools Develop MOUs with schools
Jul-Aug 2019	On-board Parent Aides Finalize evaluation plan in collaboration with project staff and partners
Sept-Oct 2019	HANDLE Practitioner training conducted
Nov 2019	Begin process of referring students for assessments for Year 1 Begin screening students for Year 1
Dec 2019	Begin intervention services for students by Parent Aides for Year 1 Identify implementation issues with schools and make necessary changes
Jan-Mar 2020	Referral and screening concludes Intervention services continue
Apr 2020	Intervention services conclude
May 2020	Gather post tests for Year 1
Jun-Aug 2020	Identify implementation issues with schools and make necessary changes for Year 2 Determine additional trainings needs for school, Parent Aides, etc. Confirm Parent Aides for Year 2 Data analysis conducted by evaluators
Sept 2020	Implement additional trainings as needed Begin process of referring students for assessments for Year 2 Begin screening students Begin intervention services
Oct-Dec 2020	Continue screenings Continue intervention services Advanced training for 6 HANDLE Practitioners conducted
Jan 2021	Conclude screenings Continue intervention services Advanced training for HANDLE Practitioners concludes Identify children appropriate for advanced level of services
Feb-May 2021	Intervention services continue through April Begin advanced service assessments and services Gather post tests
Jun-Aug	Identify implementation issues with schools and make necessary changes for Year 3

2021	Confirm Parent Aides for Year 3 Data analysis conducted by evaluators
Sept 2021	Begin process of referring students for assessments for Year 3 Begin screening students Begin intervention services, including advanced services
Oct-Dec 2021	Continue screenings Continue intervention services
Jan 2022	Conclude screenings Continue intervention services
Feb-Apr 2022	Intervention services continue through April Gather posttests, including for advanced services
May-Jun 2022	Preliminary report on outcomes Share and discuss preliminary outcome report with stakeholders Determine whether or not to continue the program and funding
Jul-Sept 2022	Final INN program report Disseminate final report Finalize funding and plans to continue implementation if required

Interventions are provided every school day for 4 months (or 6 months for advanced interventions), therefore intake into services concludes 4 (or 6) months before the end of each school year.

This timeline includes evaluation throughout the project, including finalizing the evaluation plan and tools with input from project staff and partners; gathering data throughout the project; and analyzing the data with the project staff and partners. The last five months of the timeline allows time for data collection, analysis, dissemination, and the process to determine whether and how to continue the project. This work is feasible in this timeline because there will be efforts throughout the project to keep stakeholders informed and to consider sustainability plans.

12) INN Project Budget and Source of Expenditures

This INN Plan will use FY2010-11 funds that were deemed reverted back to the county of origin under **AB 114** to cover FY18-19 and FY19-20 expenses.

Participating schools will be contributing in-kind staff time and resources to this project. At this time that contribution is not calculated in the budget.

Project Budget by Year - Narrative

Salaries

FY18-19: 9 months (Oct. – June) Behavioral Health Clinical Supervisor at $172,657 annual salary and benefits = **$129,493**

FY19-20: Behavioral Health Clinical Supervisor (1 FTE) at $172,657 FT annual salary & benefits = **$172,657**

Clinician II (0.6 FTE) at $141,032 FT annual salary & benefits = **$84,619**

FY20-21: Behavioral Health Clinical Supervisor (1 FTE) at $172,657 FT annual salary & benefits = **$172,657**

Clinician II (0.75 FTE) at $141,032 FT annual salary & benefits = **$105,774**

FY21-22: Behavioral Health Clinical Supervisor (1 FTE) at $172,657 FT annual salary & benefits = **$172,657**

Clinician II (0.75 FTE) at $141,032 FT annual salary & benefits = **$105,774**

FY22-23: 3 months (Jul-Sep) incurs no additional costs for disseminating report and finalizing continuation of the project as appropriate

Total = $943,631

Operating Costs

FY18-19 – FY21-22: Materials: Office supplies, HANDLE manuals, intervention tools (balls, etc). $8000 total

Snacks and incentives: A safe environment is required for providing interventions, therefore food and other comforting items will be provided to participating students. $5000 total

Mileage: BHCS staff travel to schools. $6000 total

FY19-20 and FY20-21: Substitute teacher time to cover for teacher's attending training. $170/day x 10 days x 6 teachers x 3 school districts x 2 yrs = $61,200 total

Total = $80,200

Consultant Costs/Contractors

FY18-19 - FY21-22 Evaluator: $30,000 per year x 4 years = $120,000 total

FY19-20 - FY21-22 Parent Aides: Mental Health Specialist II (2 FTE) at $84,620 wages & benefits. The 2 FTE will be filled by up to 6 part time aides to ensure adequate staffing at times that students are available for services. 3 years = $507,720

FY19-20 HANDLE Trainer: Introductory and HANDLE Practitioner trainings. $45,000

FY20-21 HANDLE Trainer: Introductory and Advanced trainings. $90,000

Total = $762,720

Indirect

15% for county administration of the project. Applies to Personnel, Operating and Contract expenditures to provide Human Resources, Accounting, Budgeting, Information Technology, Business Services Office, and Legal management of staff and contract positions; rent, utilities, insurance; and other expenses necessary to administer the project.

Total = $267,983

Expend by Fund Source – Narrative

Administration

- 50% of BH Clinical Supervisor time for program development & implementation = $323,732
- Indirect expenses (as stated above) = $267,983

Total = $591,715

Evaluation

- 50% of BH Clinical Supervisor time for program development & implementation = $323,732
- Evaluator: $30,000 per year x 4 years = $120,000

Total = $443,732

BHCS In-Kind Funding

Behavioral Health Clinician II (0.2FTE x 6 positions) at $134,316 FT = $161,179/yr x 3 yrs
These clinicians will participate in trainings, assessments, and intervention plans

Total = $483,537

B. New Innovative Project Budget By FISCAL YEAR (FY)*						
EXPENDITURES						
PERSONNEL COSTs (salaries, wages, benefits)		**FY2018-19 9 months**	**FY2019-20**	**FY2020-21**	**FY2021-22**	**Total**
1	Salaries	$ 129,493	$ 257,276	$ 278,431	$ 278,431	**$ 943,631**
2	Direct Costs					**$ -**
3	Indirect Costs	$ 19,424	$ 38,591	$ 41,765	$ 41,765	**$ 141,545**
4	Total Personnel Costs	**$ 148,917**	**$ 295,867**	**$ 320,196**	**$ 320,196**	**$ 1,085,176**
OPERATING COSTs		**FY2018-19 9 months**	**FY2019-20**	**FY2020-21**	**FY2021-22**	**Total**
5	Direct Costs		$ 38,350	$ 36,850	$ 5,000	**$ 80,200**
6	Indirect Costs	$ -	$ 5,753	$ 5,528	$ 750	**$ 12,030**
7	Total Operating Costs	**$ -**	**$ 44,103**	**$ 42,378**	**$ 5,750**	**$ 92,230**
NON RECURRING COSTS (equipment, technology)		**FY2018-19 9 months**	**FY2019-20**	**FY2020-21**	**FY2021-22**	**Total**
8						**$ -**
9						**$ -**
10	Total Non-recurring costs	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
CONSULTANT COSTS/CONTRACTS (clinical, training, facilitator, evaluation)		**FY2018-19 9 months**	**FY2019-20**	**FY2020-21**	**FY2021-22**	**Total**
11	Direct Costs	$ 30,000	$ 244,240	$ 289,240	$ 199,240	**$ 762,720**
12	Indirect Costs	$ 4,500	$ 36,636	$ 43,386	$ 29,886	**$ 114,408**
13	Total Consultant Costs	**$ 34,500**	**$ 280,876**	**$ 332,626**	**$ 229,126**	**$ 877,128**
OTHER EXPENDITURES (please explain in budget narrative)		**FY2018-19 9 months**	**FY2019-20**	**FY2020-21**	**FY2021-22**	**Total**
14						**$ -**
15						**$ -**
16	Total Other expenditures	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
BUDGET TOTALS						
Personnel (line 1)		**$ 129,493**	**$ 257,276**	**$ 278,431**	**$ 278,431**	**$ 943,631**
Direct Costs (add lines 2, 5 and 11 from above)		**$ 30,000**	**$ 282,590**	**$ 326,090**	**$ 204,240**	**$ 842,920**
Indirect Costs (add lines 3, 6 and 12 from above)		**$ 23,924**	**$ 80,980**	**$ 90,678**	**$ 72,401**	**$ 267,983**
Non-recurring costs (line 10)		**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
Other Expenditures (line 16)		**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
TOTAL INNOVATION BUDGET		**$ 183,417**	**$ 620,846**	**$ 695,199**	**$ 555,072**	**$ 2,054,534**

	C. *Expenditures By Funding Source and FISCAL YEAR (FY)*					
Administration:						
A.	**Estimated total mental health expenditures for ADMINISTRATION for the entire duration of this INN Project by FY & the following funding sources:**	**FY2018-19 9 months**	**FY2019-20**	**FY2020-21**	**FY2021-22**	**Total**
1	Innovative MHSA Funds	$ 88,671	$ 167,309	$ 177,007	$ 158,730	**$ 591,717**
2	Federal Financial Participation					**$ -**
3	1991 Realignment					**$ -**
4	Behavioral Health Subaccount					**$ -**
5	Other funding*					**$ -**
6	**Total Proposed Administration**	**$ 88,671**	**$ 167,309**	**$ 177,007**	**$ 158,730**	**$ 591,717**
Evaluation:						
B.	**Estimated total mental health expenditures for EVALUATION for the entire duration of this INN Project by FY & the following funding sources:**	**FY2018-19 9 months**	**FY2019-20**	**FY2020-21**	**FY2021-22**	**Total**
1	Innovative MHSA Funds	$ 94,747	$ 116,329	$ 116,329	$ 116,329	**$ 443,734**
2	Federal Financial Participation					**$ -**
3	1991 Realignment					**$ -**
4	Behavioral Health Subaccount					**$ -**
5	Other funding*					**$ -**
6	**Total Proposed Evaluation**	**$ 94,747**	**$ 116,329**	**$ 116,329**	**$ 116,329**	**$ 443,734**
TOTAL:						
C.	**Estimated TOTAL mental health expenditures (this sum to total funding requested) for the entire duration of this INN Project by FY & the following funding sources:**	**FY2018-19 9 months**	**FY2019-20**	**FY2020-21**	**FY2021-22**	**Total**
1	Innovative MHSA Funds	$ 183,417	$ 620,846	$ 695,199	$ 555,072	**$ 2,054,534**
2	Federal Financial Participation					**$ -**
3	1991 Realignment					**$ -**
4	Behavioral Health Subaccount					**$ -**
5	Other funding*		$ 161,179	$ 161,179	$ 161,179	**$ 483,537**
6	**Total Proposed Expenditures**	**$ 183,417**	**$ 782,025**	**$ 856,378**	**$ 716,251**	**$ 2,538,071**

*If "Other funding" is included, please explain. BHCS in-kind for clinician time to attend training, conduct assessments, etc.

Example of a parent information sheet about HANDLE used by a practitioner

HANDLE

Often when a person experiences difficulties in behavior and functioning it is actually because they are doing the best they can within themselves to process the information they get through their senses from the world. When, for whatever reasons – no blame necessary – the information or the ability to process it is disorganized or irregular, the body/brain comes up with 'workarounds' that can look dysfunctional and can seem purposeful. When we are in high stress responses – whether these are motivated by internal or external stimuli, it is harder to connect, learn, and think clearly. We all protect ourselves in unconscious ways and when our bodies/brains do not communicate well together, we can often experience heightened sensitivity/reactiveness to others, anxiety, depression, difficulties in bowel/bladder control, relationship difficulties, speech and learning difficulties, etc. Calming strategies are temporary when the culprit for the stress is disorganized neurodevelopmental functioning. Interventions –social, emotional, and academic – are more effective when based on efficiently working foundational neurodevelopmental systems.

HANDLE is an acronym for Holistic Approach to NeuroDevelopment and Learning Efficiency. It is a paradigm that recognizes the body's wisdom in communicating where inefficiencies in the body-brain connection reside. Once we recognize those inefficiencies, HANDLE provides a unique approach, through a home based movement based activity program {15 min a day usually} that helps to calm, organize and support the body/brain so behavior and functioning can improve. When people can do better, they generally do!

HANDLE activities are simple and individualized to the needs of each client. They are doable and many families find the time spent together doing them improves their relationships. They provide functional and developmental organization from the inside out, while reducing the stress response. The only requirements are a willingness to do the activities consistently, a willingness for things to be different, and a willingness to go slowly and gently so when the body/nervous system is stressed, activities are stopped. How to do all of this is taught and the willingness must be there.

May 10, 2018

To whom it may concern:

I very much support the incorporation of HANDLE into the school system. Before becoming a HANDLE Practitioner and Instructor, I got involved with this modality as a HANDLE Mom. My son was fourteen and "highly functioning on the autism spectrum" when we took on an individualized program for him. He was struggling with learning and attention; he was very uncoordinated; he was isolated socially and angry about it. His self-esteem was very low, as he believed that all his failures had to do with stupidity. Had you asked me at the time if I could imagine him taking college classes, driving, managing his social activities, dating, holding a job, traveling independently – I would have said no. Not maybe.

And yet he's done all of these. A young adult now, he is completing an AA degree this month and is three classes away from completing a second one. He was a juror on one occasion and worked on a farm overseas for several months, living with roommates. He made it to Ethiopia and back in one piece and made a few good decisions when facing bullies and others who tried to take advantage of him. He shops for himself and cooks for himself and balances his check book and manages his social life and work schedule. He drives. He is optimistic. This would not have happened without the gentle, respectful, effective support that he got from his HANDLE program and his HANDLE provider, Sindy Wilkinson.

I have since become a provider of HANDLE services, so I have seen many who benefited from this modality, including, but not limited to, people on the autism spectrum or those suffering from anxiety, depression and bipolar disorder.

I would love to see this support available to all the students who need it, and I welcome your questions.

Thank you for your consideration,

Dror Schneider
3254 Magowan Drive
Santa Rosa, CA 95405

May 9, 2018

I am happy to see that there is a possibility to offer HANDLE training to the teachers of young children in your schools

I am 76 years old and was fortunate to receive a HANDLE program from a friend 16 years ago. Although I was reasonably successful, I had struggled for most of my life with difficulties that I blamed on emotional or psychological issues. The things I learned about myself through this program convinced me that my nervous system had not fully developed when I was a child and that this was the cause of many of my difficulties. The HANDLE process taught me some simple movements and activities to educate the parts of my brain that had missed development all those years ago. It worked. Even today, with the challenges of an aging brain, I can manage better than when I was younger.

I do sometimes wonder how different my life might have been if I had been "HANDLED" when I was a child. I hope that you will give that opportunity to some of the children in your schools. It will help them to be calm and to learn and that will change the course of their lives.

Than you for receiving my opinions and experiences.

Marie McGarrity
m.mcgarrity@comcast.net

I lived in Alameda County for more than the 12 years my children were in public school; I'm aware of the range of student capabilities and issues. As a retired HANDLE Practitioner, I'm also aware of how HANDLE contributes to all learning, not limited to students with named "problems" that authoritative testing names as a "special" need. Additionally, my daughter has been an elementary school teacher for more than 20 years. Her experiences bolster my conviction that if teachers everywhere had HANDLE training to apply in their classrooms, and someone monitored performance change, district administrators would applaud themselves for having brought this approach into their schools.

When you validate that hypersensitivities, and distress over unusual behaviors, and a need to move, and distractibility... etc... impede use of what's taught, you will welcome HANDLE as a means to calm all such interference. I urge you to validate all that. Instead of thinking of single-child needs, acknowledge the reality that all of us can make our lives easier. The classroom setting would uniquely benefit because as teachers apply HANDLE principles and practices, the impact isn't perceived as "therapy" but as a kind of infrastructure for making best use of a curriculum.

Absent neurophysiological and emotional readiness, learning can be seriously blocked. HANDLE programs create that readiness. Please help your teachers help your students to do their best.

Marlene Bluestone Suliteanu
For information about the Holistic Approach to NeuroDevelopment and Learning Efficiency check out www.handle.org

From: Mike Wilson [mailto:wilson.mtw17@gmail.com]
Sent: Wednesday, May 02, 2018 8:56 PM
To: Mental Health Services Act <MHSA@acgov.org>
Subject: HANDLE evaluation

Hello,

It has come to my attention that Alameda County is evaluating HANDLE and I wanted to share a few things with you.

HANDLE treatment changed my family's future. It saved my son's life and opened up a world we never imagined.

Some would say that my son was on the spectrum and while it would be very easy to assume that he was on the very low side of the spectrum, it is true that he had many difficulties as a young boy. Through very careful attention from our HANDLE practitioner and diligent follow through by my wife and I, we were able to help our son become a different person.

Here is an essay he wrote describing his experience before and after HANDLE. I truly hope you will find a way to allow this process to be a part of your system.

Sincerely,

Mike Wilson

My Story... by Alex Wilson

If you asked me to think back to my earliest memories and describe myself I would have to say that I always felt that something was a little off. I never felt connected to the larger group of kids around me. I was alone and I couldn't figure out why. It's impossible in our culture to be different and left alone at the same time. The attention you get when you're different will eventually break you down.

School was torture. I wonder how I learned anything because I was so miserable. Every day I would come home, head to my room and cry. I was miserable. Never a day went by that I didn't spend time crying and feeling utterly hopeless.

Concentrating in class was nearly impossible. I was constantly in trouble with the teacher because I just couldn't pay attention no matter how simple the concepts were. Distractions came easy but it wasn't because I didn't care. I could read and retain information easily enough on my own, but in a larger learning environment there were just too many things going on in the classroom.

My son has been doing HANDLE therapy for almost a year now and I have seen the improvement in both school and home. I was able to learn more about how his body works in one HANDLE assessment than I have in all his psychological assessments combined. He likes doing the activities and he has seen the change in himself. He had gone into his appointment very hyper and unfocused. He couldn't sit still. As soon as we did the HANDLE activities he instantly had a calm body and mind. He was able to focus for 30 minutes. It was like seeing a completely different child. It happened like that at another appointment too. He came in really upset and agitated and instantly calmed and was happy after doing the activities. I am usually the skeptical parent but I truly believe in HANDLE Therapy. I have seen a drastic change within minutes of doing the activities. I don't know any other therapy that can do that. In addition, his teachers have said that he has more focus and has been able to remember more. He used to also have his aide write almost all his assignments. He is now writing everything himself. I am so glad he is doing HANDLE Therapy and I am so thankful for his therapist, Sindy. My son has been known to not connect with his therapist but he has with her. She is really great with him. I think that is really important.

Nicolette
Mom to 12 year old with Bipolar, ADHD, Anxiety, Auditory Processing Disorder, Speech and Language Disorder

Hello -

I am writing to urge support for the Alameda County Behavioral Health Care Services 2019-2023 Innovation Plan, specifically for program number four, Introducing Neuroplasticity to Mental Health Services for Children.

As a parent of a child with neurodevelopmental issues that manifested as severe behavioral problems in elementary school, it is clear that schools are not equipped to understand or address the growing number of children who face the academic and social challenges caused by underdeveloped neural pathways. HANDLE, the intervention being proposed, has succeeded where every other approach could not, and over the course of a year helped my son to overcome the excruciating discomfort that had caused him to act out in destructive ways and to alleviate the massive shame that accompanied his behavior for years.

Our HANDLE practitioner, Sindy Wilkinson, is part of the BHCS team who would bring the approach to Alameda County schools. With her help, my husband and I have learned to do a HANDLE program with our son and the results have not only been personally astonishing but have greatly impacted his academic outcomes: able to manage his emotions and better navigate his physical surroundings, my son has gone from multiple incidents that caused him to miss several hours of classroom instruction to none. At the end of fifth grade, he completed roughly 50 percent of his work, and as he ends his sixth-grade year, that is now 100 percent. His early school years would have been so much easier not only for him but for his teachers, the school staff and administration and his classmates, if the underlying neurodevelopmental causes of his behavior and the fairly simple exercises to support his development were more widely known and understood.

Not every case of emotional disturbance or disruptive behavior may be due to neurodevelopmental issues, but children acting out in ways that are disrupting their school and home environments would be better served by considering this cause along with the more mainstream diagnoses whose treatment is harder to access and may only treat symptoms for a limited time. Imagine if this intervention could be applied to just a fraction of the children who currently qualify for special education and other health services - the long-term effects would change the trajectory of their academic and social success and reduce the need for ongoing services, lightening the burden on these already-limited resources.

I cannot urge support of this innovation plan strongly enough and hope to see HANDLE in many schools someday.

Thank you,

Sybil Wartenberg
Lafayette, CA

San Leandro Unified School District

May 23, 2018

To: Mental Health Services Oversight and Accountability Commission

San Leandro Unified School District (District) is excited to implement Alameda County Behavioral Health Care Services' "Introducing Neuroplasticity to Mental Health Services for Children" project. The District serves a socio-economically and ethnically diverse population of approximately 9000 students. The impact of trauma, behavioral, and emotional issues is a daily challenge for our students, families and staff. This project is an innovative approach to addressing the students' needs in an affordable and convenient way. Most often neuro-developmental interventions can only be accessed through out-of-pocket specialty programs, which many of our families cannot access.

The District has committed to implementing this program in one elementary school to begin with, including ensuring school staff participates in the necessary training and activities. The District believes this investment will result in better outcomes for students and more effective use of staff time. Once the project is up and running and the impact of the program is reviewed, we are interested in expanding the model to other schools in the district.

We are committed to this program's success, including reaching out to other school districts and helping to spread the word about our experience and learning.

Sincerely,

Dr. Michael McLaughlin
Superintendent
San Leandro Unified School District

MHSA COUNTY FISCAL ACCOUNTABILITY CERTIFICATION[1]

County/City: ALAMEDA

☐ Five-Year Program and Expenditure Plan
☐ Annual Update
☐ Annual Revenue and Expenditure Report

Local Mental Health Director	County Auditor-Controller / City Financial Officer
Name: JAMES WAGNER, DEPUTY DIRECTOR	Name: STEVE MANNING
Telephone Number: (510) 567-8100	Telephone Number: (510) 272-6565
E-mail: James.wagner@acgov.org	E-mail: Steve.Manning@acgov.org
Local Mental Health Mailing Address: 2000 EMBARCADERO COVE, SUITE 400 OAKLAND, CA 94606	

I hereby certify that the Five-Year Program and Expenditure Plan, Annual Update or Annual Revenue and Expenditure Report is true and correct and that the County has complied with all fiscal accountability requirements as required by law or as directed by the State Department of Health Care Services and the Mental Health Services Oversight and Accountability Commission, and that all expenditures are consistent with the requirements of the Mental Health Services Act (MHSA), including Welfare and Institutions Code (WIC) sections 5813.5, 5830, 5840, 5847, 5891, and 5892; and Title 9 of the California Code of Regulations sections 3400 and 3410. I further certify that all expenditures are consistent with an approved plan or update and that MHSA funds will only be used for programs specified in the Mental Health Services Act. Other than funds placed in a reserve in accordance with an approved plan, any funds allocated to a county which are not spent for their authorized purpose within the time period specified in WIC section 5892(h), shall revert to the state to be deposited into the fund and available for counties in future years.

I declare under penalty of perjury under the laws of this state that the foregoing and the attached update/revenue and expenditure report is true and correct to the best of my knowledge.

JAMES WAGNER, DEPUTY DIRECTOR _____ _____
Local Mental Health Director (PRINT) Signature Date

I hereby certify that for the fiscal year ended June 30, 2017, the County/City has maintained an interest-bearing local Mental Health Services (MHS) Fund (WIC 5892(f)); and that the County's/City's financial statements are audited annually by an independent auditor and the most recent audit report is dated 12/18/17 for the fiscal year ended June 30, 2017. I further certify that for the fiscal year ended June 30, 2017, the State MHSA distributions were recorded as revenues in the local MHS Fund; that County/City MHSA expenditures and transfers out were appropriated by the Board of Supervisors and recorded in compliance with such appropriations; and that the County/City has complied with WIC section 5891(a), in that local MHS funds may not be loaned to a county general fund or any other county fund.

I declare under penalty of perjury under the laws of this state that the foregoing, and if there is a revenue and expenditure report attached, is true and correct to the best of my knowledge.

STEVE MANNING, AUDITOR-CONTROLLER _____ _____
County Auditor Controller / City Financial Officer (PRINT) Signature Date

[1] Welfare and Institutions Code Sections 5847(b)(9) and 5899(a)

Enclosure 4

MHSA COUNTY REVERSION CERTIFICATION

County/City: ALAMEDA FY: 2018 - 2020

Local Mental Health Director	**County Auditor-Controller / City Financial Officer**
Name: JAMES WAGNER, DEPUTY DIRECTOR	Name: STEVE MANNING
Telephone Number: (510) 567-8100	Telephone Number: (510) 272-6565
E-mail: James.wagner@acgov.org	E-mail: Steve.Manning@acgov.org
Local Mental Health Mailing Address: 2000 EMBARCADERO COVE, SUITE 400 OAKLAND, CA 94606	

I hereby certify that the Adjustments Worksheet is true and correct and that the County has complied with all fiscal accountability requirements as required by law or as directed by the State Department of Health Care Services and the Mental Health Services Oversight and Accountability Commission, and that all expenditures are consistent with the requirements of the Mental Health Services Act (MHSA), including Welfare and Institutions Code (WIC) sections 5813.5, 5830, 5840, 5847, 5891, and 5892; and Title 9 of the California Code of Regulations sections 3400 and 3410. I further certify that all expenditures are consistent with an approved plan or update and that MHSA funds will only be used for programs specified in the Mental Health Services Act.

I declare under penalty of perjury under the laws of this state that the foregoing and the attached Appeal Worksheets are true and correct to the best of my knowledge.

JAMES WAGNER, DEPUTY DIRECTOR _____

Local Mental Health Director (PRINT) Signature Date

I hereby certify that for the fiscal year ended June 30, **2017**, the County/City has maintained an interest-bearing local Mental Health Services (MHS) Fund (WIC 5892(f)); and that the County's/City's financial statements are audited annually by an independent auditor and the most recent audit report is dated **12/18/17** for the fiscal year ended June 30, **2017**. I further certify that for the fiscal year ended June 30, **2017**, the State MHSA distributions were recorded as revenues in the local MHS Fund; that County/City MHSA expenditures and transfers out were appropriated by the Board of Supervisors and recorded in compliance with such appropriations; and that the County/City has complied with WIC section 5891(a), in that local MHS funds may not be loaned to a county general fund or any other county fund.

I declare under penalty of perjury under the laws of this state that the foregoing, and if there is a revenue and expenditure report attached, is true and correct to the best of my knowledge.

STEVE MANNING, AUDITOR-CONTROLLER _____

County Auditor Controller / City Financial Officer (PRINT) Signature Date