Psychiatric Advance Directives

MULTI-COUNTY COLLABORATIVE

Mental Health Services Act Innovations Project

CONCEPTSFORWARD

CONSULTING

Innovations Work Plan

Participating counties: Fresno[1], Mariposa, Monterey, Orange, and Shasta

Project Title: Multi-County Psychiatric Advance Directives (PADs) Innovations Project

Duration of Project: July 1, 2021- June 30, 2025

[1] Fresno County has already submitted an Innovations Project plan to the MHSOAC detailing its plan to participate in this project; this plan was approved by Delegated Authority June 2019.

Section 1: Innovations Regulations Requirement Categories

General Requirement:
"*Introduces a new practice or approach to the overall mental health system, including, but not limited to, prevention and early intervention.*"

Innovations Incubator background and previous Psychiatric Advance Directives (PADs) approval:

A key element of the Mental Health Services Oversight and Accountability Commissions (MHSOAC), Strategic Plan 2020-2023 is the development and implementation of a collection of collaborative projects. These projects are to advance the Mental Health Services Act (MHSA) priorities and illuminate how MHSA Innovations funds can transform service and lives.

With support from the Governor and Legislature, MHSAOC had launched several multi-county collaboratives, including the Innovations Incubator. One of the topics explored in the Innovation Incubator is that of Psychiatric Advanced Directives (PADs). In 2019, three counties explored options to deploy PADs to improve the response to individuals in crisis from law enforcement (LE) and physical and behavioral health workers. At that time, only Fresno County was able to obtain approval for the project. Almost concurrently the COVID-19 Pandemic hit, and all efforts came to a standstill.

In January 2021, the MHSOAC determined counties needed additional technical assistance and project management support to move the project forward. Since that date, four additional counties have joined Fresno to move the PADs Innovation project forward throughout California.

Primary Purpose:
"Increases the quality of mental health services, including measured outcomes."

Using PADs, current clients and non-engaged consumers will gain autonomy in decision-making toward their mental health care supports and services. This county-wide project will provide the groundwork for community collaboration, creating PADs Teams, a standardized PADs county "tool-kit," and evaluate the process and success in engaging clients and non-engaged consumers.

PADs are a form of Supportive Decision-Making (SDM), a decision-making methodology where people work with friends, family members, and professionals who help them understand the situations and choices they face so they may make their own informed decisions and direct their lives. The process of developing a PAD, with support from, among others, county mental health professionals, can help people clarify their preferences for treatment so that they will receive appropriate support and care, especially during mental health crises. When handled skillfully, a PAD is a powerful tool to increase a person's quality of care within the mental health and justice-involved settings.

This proposed project will meet several unmet needs across the state:

1. Provide standardized training to increase understanding of the existence and benefits of PADs by communities and stakeholders.
2. Develop and implement a standardized PAD template, ensuring that individuals have autonomy and are the leading "voice" in their care, especially during a mental health crisis.
3. Utilize peers to facilitate creation of PADs so that shared lived experience and understanding will lead to more open dialogue, trust, and improved outcomes.
4. Develop and implement a standardized training "tool-kit" to enable PAD education, policy, and practice fidelity from county to county.

5. Align mental health PADs with medical Advance Directives, with a focus on treating the "whole person" throughout the life course.
6. Utilize a technology platform for easy access to training, materials, creation, storage, and review of PADs.
7. Create a fully functioning cloud-based PADs Technology Platform, for ease of use by consumers, LE, or hospitals for in-the-moment use.
8. Use legislative and policy advocacy, with consumer voices in the lead, to create a legal structure to recognize and enforce PADs, so that consumer choice and self-determination are recognized and respected throughout California.
9. Evaluate (a) the effectiveness of this project; (b) the ease of use and recognition of PADs,; (c) the impact of PADs on the quality of mental health supports and services; and (d) most importantly, the impact of PADs on the quality of life of consumers.

Section 2: Project Overview

Primary Problem:

In 2006, the Center for Medicare and Medicaid Services (CMS) made it clear that PADs should be a part of psychiatric care. Approximately 27 states have enacted laws and policies recognizing PADs since the 1990s. However, PADs are often written with a focus on physical health, with little to no room for psychiatric health, plans, arrangements, or instructions to assist in the event of a mental health crisis. Also, the length and number of different PADs templates make it confusing for the individual filling out the PAD and the health care and LE charged to comply with them. With such confusion, how can LE or hospitals know whether a PAD is valid or not?

As stated on the website of the National Resource Center on Psychiatric Advanced Directives (NRC), "Psychiatric advance directives are relatively new legal instruments that may be used to document a competent person's specific instructions or preferences regarding future mental health treatment. Psychiatric advance directives are used to plan for the possibility that someone may lose the capacity to give or withhold informed consent to treatment during acute episodes of psychiatric illness." (National Resouce Center on Psychiatric Advance Directives, n.d.), The website further explains that California does not currently have a specific legal statute encouraging or recognizing PADs, thus leading to the underutilization of PADs in the state

Californians with mental illness continue to face high rates of recidivism, inpatient non-voluntary hospitalization, homelessness, and incarceration. These problems persist despite the state's efforts to avoid or reduce 5150 involuntary hospitalizations and incarceration. For example, California has deployed teams to conduct outreach to homeless individuals to engage them in services. Unfortunately, these and other efforts have not led to meaningful reductions in hospitalization and incarceration, or improved treatment outcomes.

On February 6, 2020, *Capital Weekly* wrote an article documenting the increased rates of mental illness in California jails, stating, "the Board of State and Community Corrections discovered a 42 % increase in mental health cases reported and an 80 % increase in inmate medication prescriptions over the last ten years." (Hice, 2020) The article further found that one in four inmates meets the threshold for "serious psychological distress." Further research documented that, in 2018, there were 127,709 people incarcerated in California state-level facilities, with over one-quarter (36,963) receiving at least minimal mental health care.

There is a great deal of information on the Cal Matters website describing California's incarcerated mentally ill. As of January 2020, of 72,000 inmates, 22,000 have open mental health cases.

Of those, 6,280 men and 173 women are so ill they require enhanced mental health care. The average cost to house a seriously mentally ill person in our state jails is $31,000 annually; that is a cost of $200,043,000 annually for the 6453 seriously mentally ill individuals in our state jails. Could PADs potentially reduce recidivism and decrease the population of people with mental illness in our jail system by helping consumers obtain individualized services focused on their desired physical and mental health care outcomes?

In a psychiatric emergency, when consumers are delusional or psychotic, it may be impossible to engage in even the most basic conversations about patient care, symptoms, diagnosis, and treatment preferences. A PAD would help prevent the "guesswork" of the treating physician by providing a "blueprint" to the patient's exact needs, medication support, and even the ability to contact their chosen advocate.

Proposed Project:

The proposed Innovations Project seeks to:

1. Engage the community, consumers, peers, families, consumer advocacy groups, LE, and the judicial system.
    a. Provide training and ongoing informational webinars and/or in-person discussions on:
        i. What is a PAD?
        ii. Why are PADs essential for consumer choice, self-determination, physical and mental health, and improved treatment outcomes?
    b. Enable consumer participation through workgroups, focus groups, and surveys.
    c. Ensure that consumers are the leading voice in creating the standardized PADs template in California.
    d. Lead discussions on access and consent to treatment through PADs.
    e. Engage consumers in discussion on legislation, policy, and advocacy on PADs.
    f. Work with people from diverse ethnic and cultural backgrounds to ensure cultural competency.
2. Develop Community-wide standardized training for understanding, accessing, recognizing, and implementing PADs within the Mental Health Plan, crisis centers, hospitals, LE, homeless services, and transitional-aged youth (TAY) services.
    a. Create a library or “tool-kit” of resources.
    b. Create standardized videos and training material.
3. Create a standardized PAD template.
    a. Submit to the NRC for inclusion in the California section of the website.
    b. Create a step-by-step training guide/video for development and implementation of PADs.
4. Training of Trainers
    a. Identify Peer trainers
    b. Identify PAD Teams
    c. Train PADs Teams
    d. Train community providers
    e. Train clinicians
    f. Create a standard video module to be added to the technology platform for future use by additional counties.
5. Draft and advocate for legislation enabling PAD use, accessibility, adherence, and sustainability.

6. Create a statewide PADs Technology Platform.
    a. Ensure medical and mental health parity.
    b. Identify access points for LE, hospitals, and crisis teams.
    c. Utilize consumers and consumer advocacy groups for PADs facilitation, access, and consent discussion.
    d. House training videos and templates for ease of statewide use and accessibility.
    e. Ensure Platform ease of use during a crisis encounter by LE, hospitals, and crisis response teams.
7. Evaluate the impact of PADs with process and impact data and outcomes.
    a. Hold focus groups.
        i. Was training effective?
        ii. Understanding PADs
        iii. Consumer use of PADs
    b. Surveys
    c. Evaluate county-specific priority pilot populations.
    d. Evaluate impact on access to and quality of mental health services and supports
    e. Evaluate impact on consumer quality of life.

Five counties (Fresno, Mariposa, Monterey, Orange, and Shasta), in collaboration with Concepts Forward Consulting, seek approval from the MHSOAC to use Innovation Funds to develop the infrastructure for sustainable PADs usage in the state of California. This project, led by the five counties and in partnership with Concepts Forward Consulting will seek to partner with stakeholders, advocacy groups, consumers, and peers with lived experience. Together, they will develop a standardized PAD template, training resources and a "toolkit" (all in multiple languages), PADs accessibility platform, and recommendations for statewide PAD legislation, policy, and procedures.

Counties will work with their stakeholders to identify priority populations to utilize PADs. These groups could range in number and may address an array of diverse county populations such as TAY, older adults, recently incarcerated, homeless, or hospitalized individuals.

The project's evaluation will focus on a review of the processes used to develop and implement PADs, to involve and engage consumers and stakeholders, and to ensure accessibility of PADs. The evaluator(s) will collect consumer-level data, as well as data on targeted outcomes for country priority populations. Lessons learned from the evaluation will lead to more robust and effective community conversations, training, and PADs roll-out and ensure quality and fidelity. Orange County will evaluate the process, usability, and accessibility of the PADs technology platform. Ultimately a PADs "tool-kit" will be created for standardization and ease of use throughout the state of California.

Continued Development of County collaboration:

This project is being designed for additional California counties to join at any time. Each county will provide an appendix to this project explicitly related to their county needs and priority populations. Concepts Forward Consulting will work with all interested counties to ensure a successful Innovation submittal.

Research on INN Component:

What is a PAD? A Psychiatric Advance Directive is a direct link to and tool to effectuate SDM. A PAD does not mandate ongoing clinical treatment. It is not a document to allow for or require ongoing

medication management or involuntary inpatient care. A PAD allows a person in a mental health crisis to retain their decision-making capacity by choosing supporters to help advocate for their choices. This supporter is a known and trusted individual to the person creating their PAD. The supporter agrees to uphold the decisions and directions to the best of their ability, and within the law's confines, in the event the individual is in crisis. PADs are a legal document; in California, they require two witness signatures, like a will or medical advanced planning document, allowing the person with mental illness to identify their preferences for treatment in advance of a crisis. PADs serve to protect a person's autonomy and ability to self-direct care.

PADs have been shown to improve outcomes, improve treatment satisfaction and even reduce recidivism in jail or hospitalization. PADs offer greater self-determination, less victimization, and more community integration. It is thought that just completing a PAD can increase trust with and within mental health care services. PADs ideally embody a recovery-oriented model by encouraging consumers to predetermine their treatments for times of future mental health crisis. Research has shown that consumers who have executed PADs express and endorse feelings of self-determination, autonomy, and empowerment and have less negative coercive treatment experiences. This is particularly important because a person's fear of coercive treatment interventions, such as hospitalization, reduces their willingness to interact with the mental health system and engage in treatment.

> “In 2006, the Center for Medicare and Medicaid Services made it clear that PADs should be part of psychiatric care in their publication of final rules on seclusion and restraint. From the Federal Register: "(1) The patient has the right to participate in the development and implementation of his or her plan of care. (2) The patient or his or her representative (as allowed under State law) has the right to make informed decisions regarding their care. The patient's rights include being included in care planning and treatment and requesting or refusing treatment. This right must not be construed as a mechanism to demand the provision of treatment or services deemed medically unnecessary or inappropriate. (3) The patient has the right to formulate advance directives and to have hospital staff and practitioners who provide care in the hospital comply with these directives. (4) The patient has the right to have a family member or a representative of his or her choice and his or her physician notified promptly of his or her admission to the hospital." CMS also issued inpatient psychiatric facility quality reporting measures which included that the standard of care for the transition of a patient out of the hospital should include an advanced care plan. Hospitals, health facilities, and managed care organizations must provide information about PADs to patients and inquire if the person has a PAD. Though hospitals may note whether the person has an advance directive in their discharge plan, they have yet to reach the standard that CMS will require. They are not yet part of routine care, and there has not been much technical assistance to promote their use.” (SAMHSA, n.d.)

In California, "Psychiatric advance directives are relatively new legal instruments that may be used to document a competent person's specific instructions or preferences regarding future mental health treatment. Psychiatric advance directives can be used to plan for the possibility that someone may lose the capacity to give or withhold informed consent to treatment during acute episodes of psychiatric illness." California does not currently have a statute explicitly requiring LE, hospitals, or others to honor a person’s PAD. NRC houses PADs information nationwide. The California section on the website has a template addressing “Advance Directives” with little room to include information on psychiatric needs and SDM directions.

Since the 1990s, 27 states have enacted instructional PAD statutes, allowing specific legal mechanisms to declare in advance specific treatment preferences and instructions for future psychiatric interventions or hospitalizations. "Patient Self Determination Act of 1990 established patients' ability to develop advance directives for their treatment at the end of life. The law also applies more broadly to psychiatric types of treatment." (Congress.Gov, 2019). However, the expected widespread use of PADs never came to fruition. Substance Abuse and Mental Health Services Administration (SAMHSA), sites barriers such as functional impairment of the individual, social isolation, and difficulty engaging persons with mental illness while in crisis. Other barriers may be lack of awareness or understanding of the PADs instrument or "tool," focus on physical health verse whole-person health, skepticism that the PADs will not be honored in the time of a crisis, perception that PADs are cumbersome and time-consuming, and legal constraints that may or may not be realistic.

The Joint Commission reported low utilization of PADs might cause operational barriers such as lack of access to the document, lack of training, and insufficient clinician education about legal implications of PADs. A major hindrance is the lack of a single portal for the storage, access to, and retrieval of a PAD. Once a person fills out a PAD, it is their legal document. However, if a person is within the revolving door of incarceration, psychiatric hospitalization, or homelessness, how would a person keep a sizeable legal document safe yet accessible? Research indicates that organizations such as LE, hospitals, and other health care professionals often cannot access PADs during a mental health crisis. Improved use of and access to PADs could enhance communication between consumers and LE, hospitals, crisis teams, and others and help de-escalate crises, leading to improved treatment outcomes. For example, PADs saying that it is best to speak to the person in a low voice, use or do not use a particular medication, or call a specific support person, would be invaluable if accessible when needed. Unfortunately, there are no effective technological means to ensure PAD accessibility. While SAMSHA has developed an app allowing a person to create and store a PAD on their smartphone, only the user of the smartphone (who knows the password to it) may access the PAD. In a crisis situation, people may not wish to surrender their phone or may not remember their password. In addition, many people, particularly those who are homeless, do not have access to smartphones or have older generation phones that do not have the capacity to store and access PADs.

There are also barriers to completing a PAD. Some advocates say the document's length could hinder a person from completing a PAD. Consumer or clinical misunderstanding as to the value and use of PADs also may be a disincentive to completing a PAD, as can a consumer’s fear of the unknown or mistrust of authority. Some may argue that only a peer, a person with lived experience, could genuinely help a person complete a PAD. Finally, some professionals resist PADs because they feel that consumers will seek to alter their previous treatment preferences during a crisis.

On the contrary, though thought to be in the perceived role of power, clinicians can also effectively facilitate PAD development. "The peer's role emphasizing empowerment and recovery may be a natural fit with PADs facilitation because peers may be particularly able to help consumers achieve recovery outcomes, serve as role models in recovery, and foster a person-centered process in successful PAD completion. On the other hand, clinicians' training may make it easier to formulate treatment preferences into clinically feasible and effective PADs." (Easter MM, 2017). SAMHSA also suggests "the mental health and emergency response workforce may benefit from training on the utility and practical application of PADs, along with the principles of shared decision-making, supported decision-making and decision support aids. (Improving care with psychiatric advance directives, 2020)

Either way, training is the key. Whether a peer, clinician, legal aide, veteran, or other supporter, whoever assists in creating PADs, must have standardized training in doing so. Often people may be

hesitant to revisit a past mental health crisis even to address how they wish a future crisis to be handled. They may not understand SDM and how to choose supporters. However, conversations handled skillfully will assist in empowering a person and support their path to recovery and appropriate treatment.

This project is designed to learn from the success and challenges other counties, states, and even countries have encountered as they have tried to implement PADs. Many countries have a varying degree of SDM and PADs interventions. These include: France (seven hospitals in three French cities, Lyon, Marseille, and Paris), India (Indian Mental Healthcare Act), England (Mental Health Act), Canada (Patient Self-Determination Act) and Taiwan (Patient Self-Determination Act). Each of these countries faces the challenges of facilitating PADs, engaging persons with mental illness in creating and implementing PADs and ensuring accessibility of the PADs when needed.

Within the United States, Texas, Georgia, West Virginia, Washington, New York, Virginia, and most recently, Colorado have entered the arena of PADs. Virginia appears to be the first state to commit to statewide implementation of PADs, beginning in 2007 and revised in 2009-2010. "After the revisions, the Commission recognized that despite the natural fit between psychiatric advance directives and Virginia's shift toward recovery-oriented services, implementation would require additional work. Although many stakeholders view PADs as promising tools for responding to crises, it is generally recognized that their promise has not yet been fully realized because of low rates of execution and variable rates of access and use by clinicians. With this in mind, the Commission convened the stakeholder leadership to translate these important legal innovations into service innovations by embedding the execution of psychiatric advance directives into routine mental health care." (Heather Zelle, 2015)

Colorado most recently enacted a law pertaining to behavioral health-related advance directives. Colorado House Bill 19-1044 created a new "behavioral health order form" so that an adult may communicate his or her behavioral health history, decisions, and preferences (also referred to as a psychiatric advance directive) in the event he or she lacks the decisional capacity to provide consent to, withdrawal from, or refusal of his or her behavioral health treatment or medication in the future." (Colorado's New Psychiatric Advance Directive process goes into effect August 2, 2019, 2019)

Texas, led by attorney Laurie Hallmark of the Texas Rio Grande Legal Aid, which serves sixty-eight counties from Austin to El Paso and the entire border region, has been implementing PADs successfully with legal aid staff and law students. Texas's challenges are implementing PADs in a statewide effort and ensuring access to the PAD during immediate crisis by LE, hospitals, and crisis teams. PADs documents are giving to the consumer and their assigned support persons. Texas law states signatures can be witnessed or acknowledged by a notary, and digital or electronic signatures are allowed when specific requirements are met.

The potential of PADs is clear, yet they remain underutilized with little movement worldwide towards technology use and training of consumers and other stakeholders to fully implement and recognize PADs. This multi-county PADs Innovation Project will learn from other counties, states, and countries as we move into proper integration with medical health to whole-person health within California, PADs are a vital part of this transition; they are the tool for ideal communication between an individual and their treatment provider. California stands to be the first state to have a standardized template, training "tool-kit," and a PADs technology platform for consumer-identified access in the event of a mental health crisis. In California and beyond, PADs offer full autonomy of physical and mental health, where decisions will be honored, represented, and accessible.

Evaluation and Learning Plan:

RAND Corporation, a chosen contractor identified two primary aims: 1) to successfully implement PADs in participating counties, and 2) PADs to positively affect consumer outcomes. Below, we describe how we will evaluate whether these aims were met. Note that certain specific details of the evaluation are subject to change, depending on precisely how the PADs program is implemented (e.g., we refer to "Peers" below, but it is possible that other kinds of staff may be involved in PADs).

Aim 1: Successfully implement PADs in participating counties. Design a PADs template, adopt it in participating counties, and train Peers and other staff in working with consumers to complete PADs. To assess this Aim, the evaluation will examine the PADs Innovation Project's implementation, with attention to Peers' training and delivery experiences and county-level execution of the project. Specifically, the evaluation will:

1.1. Evaluate Peers' training-related outcomes. Using a survey for Peers in each county, we will assess Peers' knowledge, attitudes, and perceptions regarding PADs and training satisfaction and acceptability. The findings from our quantitative data analysis can inform future adaptations of the training as well as potential continuing education opportunities.

1.2. Assess gaps and areas for improvement in Peers' training and delivery of the PADs program. We will elucidate Peers' experiences supporting consumers and surrogates throughout the PADs implementation process through focus group discussions with Peers from each county. Qualitative analysis of these data will identify potential gaps and successes regarding the training curriculum's relevance to Peers' "real-world" experiences with delivering the PADs program with consumers.

1.3. Document the process of the PADs program implementation within and across counties. Using focus group discussions with county implementors, we will assess PAD program implementation, barriers, and facilitators, stakeholder engagement, and lessons learned. We will collect data at earlier and later stages of PADs implementation. Qualitative analysis of focus group data will allow us to understand counties' experiences with PADs implementation and ways they have adapted PADs programs to their respective priority populations and specific county context.

1.4. Quantify PADs completion across counties. We will track PADs completion using data reported by each county at regular intervals. We will standardize the reporting structure and metrics to track (e.g., PADs completed, PADs option refused, number of participating sites, key demographics) across counties to support data reporting. Quantitative data analyses will enable us to examine PADs completion rates among target populations in each county.

Aim 2: Positively affect consumer outcomes using PADs. We aim for the PADs project to increase consumer satisfaction, autonomy, and engagement in treatment. Ultimately, we strive for PADs to increase the frequency with which consumers' treatment preferences are considered.

The evaluation will identify and measure consumer-level and county-level outcomes of the PADs innovation project to assess this aim. Specifically, the evaluation will:

2.1. Assess consumers' experiences with PADs. Through focus group discussions with consumers from each county, we will solicit qualitative information on consumers' experiences with PADs completion, whether and how PADs affect client satisfaction, empowerment, autonomy, engagement in treatment, and concordance between documented preferences and treatment received. If feasible, we will also conduct focus groups with consumers who refused PAD participation to understand the motivations for their refusal, their experiences with the PAD opportunity, and their perceptions of PADs. Qualitative data analysis will be used to identify key themes.

2.2. Assess and quantify consumers' experiences with PADs. Informed by findings from 2.1 and the broader innovation project's goals, we will utilize a survey to assess consumers' experiences with PADs and PADs-associated impacts on patient-centeredness and treatment. We anticipate that prior evaluation activities will inform the design of this survey (e.g., implementation focus groups; consumer focus groups). Quantitative data analyses will allow us to understand a wide range of consumer experiences with PADs in a more systematic manner that complements the in-depth qualitative analyses in 2.1.

Contracting:

All contractors will work in unison for the overall benefit of participating counties, with the goal of statewide systemic change. If at any time a contractor fails to complete their duties or are unable to fulfill their four-year contract, the contractor may be replaced with notification to the MHSOAC. There must be a two-thirds or majority vote of the participating counties to request the removal of a contractor. Any significant change to the scope of work, contractors, or budget must be approved by the MHSOAC.

This project will utilize the following contractors (Appendix A)

Kiran Sahota, MA, President, Concepts Forward Consulting. Concepts Forward Consulting will be the assigned Lead Project Manager. Ms. Sahota brings over 25 years of experience within the behavioral health field; working with youth, families, TAY, older adults, law enforcement, and in the foster care setting. She most recently worked for six years as the MHSA Senior Behavioral Health Manager within a California county Mental Health Plan. Her work over the years with the MHSOAC Innovations Subcommittee and the more recent multi-county Full-Service Partnership, as county lead, position her as the ideal project manager for this robust endeavor. Ms. Sahota previously oversaw the County of Ventura law enforcement Crisis Intervention Team and will bring her expertise with CIT programs, training, and jail recidivism. As Lead Project Manager Ms. Sahota will be responsible for actions including, but not limited to, the following:

- Leading county and contractor activities through the Innovations PADs project from start to completion.
- Working closely with the MHSOAC staff, to ensure all requirements are met.
- Oversight of all project deals, requesting county input as needed.
- Overseeing financial oversight of sub-contractors.
- Approving all invoices and scope of work materials.
- Managing county relationships and expectations of contractors.
- Coordinating with all contractors to ensure proper flow of project and inclusion of all counties and stakeholders.

- Identifying achievable goals.
- Providing and managing project timeline with flexibility as allowed.
- Coordinating with counties on financial matters, contractors, and data oversight to ensure funding is spent following Innovation guidelines.
- Ensuring all deadlines are met.
- Assisting in the coordination of all statewide and county-specific stakeholder meetings.
- Creating required written reports for both the MHSOAC and country-specific needs.
- Working with stakeholders and outside agencies to draft and advocate for the passage of legislation to empower creation, implementation, recognition, and sustainability of PADs statewide.

Additional contractors

Laurie Hallmark, Attorney and Special Project Director, with Texas Rio Grande Legal Aid. Ms. Hallmark is the resident expert on PADs in Texas and PADs advisor to the MHSOAC and Fresno County. Ms. Hallmark will bring her expertise to work with consumers, stakeholders, and counties to create a statewide PADs initiative. Ms. Hallmark will provide information on PADs for peers, consumers, and various country-specific priority populations. She will provide technical assistance for individual counties in their efforts and expertise to the multi-county project as a whole. Ms. Hallmark will bring her experience in consumer advocacy to work with peers and consumers in formulating a standardized training and PADs template to be used throughout California. Also, Ms. Hallmark will bring her legal expertise when speaking to stakeholder groups such as families, judicial, and law enforcement when providing coordination across the system of care. Ms. Hallmark will enlist a group of trainers to provide the Train the Trainer model of PADs creation, allowing counties to become training experts who may then, in turn, train other counties or interested consumer organizations. PADs offer many challenges that Ms. Hallmark has encountered in the State of Texas; her expertise in problem-solving these challenges will assist California in preventing or moving seamlessly through some of the same challenges.

Idea Engineering (IE) is a full-service marketing agency specializing in communications that create community. They have worked with several county mental health systems as well as multiple MHSA funded campaigns. Idea Engineering's work is seen in suicide prevention efforts, Prevention and Early intervention projects, and drug and alcohol prevention marketing videos and print campaigns. IE will provide expert consultation with stakeholders and integrate consumers' input to create a user-friendly PADs form template, informational videos in nine languages, and print material in seven languages (two languages do not have a written language). IE will create a standardized training video and PADs "tool-kit" for any county or county contracted provider to use in the future. The "tool-kit" will be housed in the technology platform. IE will create a video documentary that will demonstrate the project's progress, illustrate lessons learned, and create a statewide platform to educate stakeholders about PADs.

The RAND Corporation is a nonprofit institution that helps improve policy and decision-making through research and analysis. For seven decades, The RAND Corporation has used rigorous, fact-based research and analysis to help individuals, families, and communities throughout the world be safer and more secure, healthier, and more prosperous. Their research spans the most critical issues, such as energy, education, health care, justice, the environment, international affairs, and national security. As a

nonpartisan organization, The RAND Corporation a widely respected for operating independently of political and commercial pressures. Quality and objectivity are two of their core values. The RAND Corporation will bring their highly respected expertise with data outcomes and evaluations. They will provide this analysis by first holding several focus groups, targeted consumer and stakeholder conversations, and survey questionnaires. With the assistance of The RAND Corporation outcomes and evaluation, PADs will be able to pivot and change as needed to become standard practice in California.

Peer organization (to be determined). As peer involvement and voice is a key factor for success of PADs in California, a peer organization will be identified by participating counties and contracted for input in all stakeholder meetings, creation of the PADs technology platform, trainings, and the PADs template. Mariposa County will be funding this portion of the statewide effort to benefit the multi-county collaborative.

Professional advisement (to be determined). The project will engage an organization that is expert in the field of evaluation, disability rights, technology, and legislative efforts to assist in the development and implementation of this project. It is anticipated that the Burton Blatt Institute at Syracuse University, led by Professor Peter Blanck, PhD., J.D. will lead this effort.

Technology Platform Company (to be determined), "in the moment" access to PADs is a primary desired outcome of this project. As previously stated in the research, the most significant barrier to PADs success is the lack of a technological platform to ensure accessibility of PADs when needed most. It is unrealistic to ask an individual to pull out their PADs paper or open an app on their smartphone in the moment of crisis. Ultimately a PADs Platform will give LE, hospitals, and crisis response services in the moment access to the person's PAD. The Platform will be built with consumer voice and direction. In other words, each step of the way – from concept to design to content to means of access and implementation of the PADs - will be primarily envisioned and directed by peers and consumer stakeholders.

The PADs technology platform will be secure, private, and completely voluntary. With consent of the consumer, the PAD form can be downloaded to a hospital or crisis team or given to a support person. Through our community engagement process, we will identify access points where it will be critical for LE and hospitals to have access to and comply with PADs. Levels of consent and removal of consent will also be determined during the community engagement process.

As the state moves towards interoperability or the sharing of information between medical and mental health, individuals may opt to have their PADs given to whomever they choose. Stored in a cloud-based HIPAA compliant system, PADs will be able to travel with individuals as they move about their lives. Picture a time when, with advanced technology, LE dispatchers can search for a PAD and use it to inform an officer about an individual's immediate mental health needs and requests, aiding in de-escalation and avoiding involuntary hospitalization and incarceration. <u>The individual's own voice will be the key tool to de-escalate a crisis.</u>

Orange County, who is working on a Health Navigation Platform, identified Chorus Innovations to support the PADs platform build. Their sole source justification is in the Orange County Appendix of this project write-up. Chorus's work can be seen in the current State of California funded https://www.calhope.org/ a COVID-19 web-based resource page. Since Orange County is further along in the desire for technology, they have opted to generously fund the staffing costs for Chorus Innovations, or another Platform if agreed upon, to build a statewide PADs technology Platform. All

PADs project participating counties would have the ability to use their technology stakeholder funding to engage in this Platform's development.

Orange County recently made a side-by-side comparison of PAD's technology and currently available local resource technology. As noted, only SAMHSA has a smartphone or web-based application for PADs, yet they are not accessible “in-the-moment” by anyone but the individual, and they are only accessed via the application. Orange County’s funding will create a custom PADs Platform for the State of California, with sharing capabilities nationwide.

Understanding and implementing technology can be challenging to comprehend and slow to adopt. Before COVID-19, there were counties that did not utilize Telepsychiatry or saw it as "less than treatment;" however those same counties now embrace Telepsychiatry as truly transformational for mental health access within their counties. The same holds true for the PADs Technology Platform. Over the first six months of the project, all counties will be included in conversations with Chorus innovations and other technology experts, and encouraged to seek out their own information on technology. Technology, in this setting, requires more than just local access. It must include statewide access and interoperability with partnering Platforms such as LE CLETS, Cerner, EPIC, and behavioral health EHR’s, as well as being a standalone resource for PADs information, training videos, PADs template, housing of the actual completed PAD form and instant accessibility.

PADs Vision, Goals & Resources

Features & Functionality	oscER (NAMI San Diego; mobile app)	Mental Health Crisis Plan (SAMHSA; mobile app)	PADs Portal (*proposed mobile app*)
Ability to create, update and store an individualized PAD		✓	✓
Ability to upload existing PAD		✓	✓
Ability for person to share PAD with providers (e.g., PDF, QR code)	✓	✓	✓
Direct access to call crisis resources within the app	✓	✓	✓
Direct access to call a broad range of behavioral health and community support services	✓	✓	✓
Access to in-app training and educational information			✓
Interoperability for exchange of health information allowing providers to directly access PADs (i.e., hospitals, CLETS)			✓
Direct access to online or digital support systems (i.e., CalHope, OC Navigator)			✓
Interactive platform, using Artificial Intelligence			✓
Ability to create an enhanced personal profile for multi-purpose use (i.e., OC Navigator)			✓
Community involvement in development (i.e., design, user interface, features and functionality)		**$14.2M; 5yrs**	**$8M; 4yrs**

Community Program Planning Process (CPPP) and Stakeholder involvement:

Community and stakeholder involvement is of the utmost importance to the success of the PADs project. It is well known that the lack of ongoing success of PADs nationwide is the lack of understanding, lack of community and consumer "buy-in," and lack of a standardized process. Before the Innovations Project's start date of July 1, 2021, there will be a series of MHSA Community Program Planning Process stakeholder meetings (Appendix B). Due to the restriction of COVID, these meetings will take place on Zoom. The sessions will be held in English with Spanish interpretation. The idea is to introduce PADs to the public and MHSA county stakeholders. The target groups will be law

enforcement, Behavioral Health Advisory Boards and Commissions, Board of Supervisors, local NAMI chapters, MHSA stakeholders, CAMHPRA, CAMHPRO, REMCO, CPEHN, Disability Rights, and local consumer advocacy groups, consumers, and peers. Additional sessions to address the needs of each county will be scheduled as needed.

Upon the start of the project, the first year is built for ongoing workgroups and community involvement. The creation of the video training, training the Peers to implement PADs, training on PADs teams, legislation advocacy, and creating the PADs template. Each step of the project will not take place without participation from consumers and peers. In addition, we aim to include nine threshold languages across the four participating counties. It is imperative to have the voice of ethnic and culturally diverse communities every step of this project. We will reach out to engage diverse communities during the proposed project to ensure representation in our workgroups, including underserved minorities in terms of race, ethnicity, sex, gender identity, sexual orientation, disability status, and immigration/documentation status. The diverse communities will offer the best solutions to reach their communities as we focus on learning about PADs outreach. Doing so will lay the foundation for a standardized tool kit fundamental in moving PADs forward in California.

An ongoing workgroup will also be established for the technology platform build. It will be essential to have legal counsel, consumers, hospital Emergency Department, Disability Rights, consumer groups, supporters, and counties discuss the PADs platform and accessibility needs. How access will be achieved, how and what data can be aggregated, what information is relevant to which agency, and how the consumer will opt-in or out—all with the CMS-ONC interoperability mandate in mind.

Each step of the project will include a "check-in" with our workgroups, focus groups, and stakeholder participants. For PADs to have a successful roll-out, the ability to change or pivot based on feedback will be necessary. These steps of community collaboration, cultural competency, client and family-driven, supported decision-making, wellness, and recovery, and whole-person health integration directly speak to all of the MHSA general standards. Organizations are welcome to offer letters of support for the PADs project. (Appendix C)

Sustainability and continuity of care:

A substantial strength of the PADs project is its built-in sustainability and ease of replicability by additional counties. By the completion of the project, the PADs Platform will house a library of standardized videos and print material templates in multiple languages, the state-approved PADs template, a training video for PAD teams, and the train the trainer protocol for interviewing persons with mental illness in completing PADs. As counties successfully work with priority populations and community stakeholders, the ability to move to different populations and community groups such as veterans, AB-12 non-minor dependent foster youth, older adults, homeless, and the recently incarcerated will flow effortlessly.

PADs, in their true nature, assist those persons with mental illness that may not typically seek mental health help. Thus, they strengthen the continuity of care for these individuals by building trust in services or service providers, providing supportive housing, and bridging the relationship with hospitals and LE. As a result, PADs give consumers autonomy and the self-assurance of knowing their mental health directive will be followed.

A second Innovation Project would ideally commence after year four of this project. At that time, all counties involved (and perhaps the entire state mental health system) may continue to test PADs in the virtual arena and the PADs Platform will be able to accept PADs from around the state. The second project will evaluate the way LE, hospitals, and other community organizations provide training

on, access, and comply with PADs. in other words, the current project will empower people to create and implement PADs, the second will evaluate how LE and other stakeholder respond to PADs.

The last key component of substantiality is that of legislation. This Innovation Project intends to partner with influential individuals and organizations including statewide NAMI, consumer, peer, and Disability Rights advocacy groups to bring forth a funded, enforceable PADs statute in the State of California. Further, this project will include a standardized PADs template, similar to the template attached, yet created with the voice and leadership of consumers, peers and stakeholders (Appendix D), a standard training "tool kit," a cloud-based PADs Platform with revokable consumer consent, and digital witnessing. Through this legislation and its inevitable influence, California's mental health consumer rights, autonomy, and recovery will be at the forefront of PADs Innovation anywhere in the world.

Communication and dissemination plan

The counties and contractors will communicate the results of this project in a variety of ways:

1. Results of the RAND evaluation will be communicated with stakeholders and counties via presentations at the California Behavioral Health Directors Association MHSA Committee meeting, annually or more frequently as requested. The results will also be made available to the MHSOAC for website publication or annual updates to the MHSOAC Commission upon request.
2. Each county will report to its stakeholder groups and Behavioral Health Advisory Board/Commission annually or more frequently as requested. The topics of the report-out will be based on the findings and evaluations for county-specific populations.
3. Results of the evaluation will also be published in peer-reviewed academic journals or presented at conferences to share our findings with the larger community.
4. Annual reports will be shared with the MHSOAC and other county or state groups.
5. Products from this project (e.g., webinars, written products, presentations) will be available within the PADs technology platform.

Keywords for Search: Psychiatric Advance Directives, PADs, Supportive Decision-Making, self-determination, autonomy.

Timeline

A complete implementation timeline of the different contracted aspects for this Innovation Project is located
in Table 1. It is estimated this project will start promptly July 1, 2021 and conclude on June 30, 2025 (a four-year project). Implementation activities over the five years will include, but are not limited to:

Year 1: Finalizing all contractor and county contracts. All contractors will participate in monthly statewide coordinating meetings. These meetings will utilize consumer's voice, consumer advocacy groups and MHSA stakeholder groups to identify PADs template priority questions and finalize a standardized PADs template; initiate consumer and MHSA stakeholder groups to assist in the creation of standardized informational videos, to include nine languages some of which will have voice-overs as they do not have a written language (Arabic, English, Farsi, Hmong, Korean, Mandarin, Mixteco, Spanish and Vietnamese) and create the statewide PADs project identity and guideline. PADs expert trainer Laurie Hallmark will provide ongoing community engagement and outreach to offer a fundamental understanding of PADs and SDM. This expert trainer will assist the county level with outreach to identify priority pilot populations, identify PADs teams, and one-on-one county support with LE, legal aid, public

defender's office, judges, and family/consumer groups. The start of conversations with Chorus, technology experts or county self-investigation of PADs technology platforms. Begin stakeholder engagement for the desired PADs platform outcome, look, operability, backend, interface, and front-end build. Through participation in stakeholder meetings from the beginning, the RAND Corporation project evaluator will begin to identify focus groups and survey questions and work with individual counties' needs to evaluate chosen priority populations. Legislation conversations will start with consumer advocacy groups, CBHDA, and all potential groups interested in moving PADs as SDM statute forward in the state of California.

Year 2: All contractors and counties will continue to participate in statewide monthly to quarterly meetings, as necessary. Pads trainer Laurie Hallmark will work with a team identified by her to provide a Train the Trainer model to create PADs, train PADs Teams, and work in a micro-county setting with all identified priority pilot groups requested by counties. PADs template integration into the cloud-based Platform. Creation of document flow and document housing will be decided with consumer input as an interim to the future cloud-base upload. Finalizing legislation language to pass a bill requiring PADs to be fully integrated into whole-person health, honoring a person with mental illnesses desire for self-determination, and require law enforcement and hospitals to identify if an individual has a PAD and to utilize digital signatures as a legal acknowledgment of PADs. The PADs "tool-kit" includes standardized training material, informational videos, the statewide PADs template, and social media webpage information to be created for upload to the PADs technology platform. A statewide evaluation of the PADs process will begin to occur with stakeholder, consumer, peer, and trainer focus groups and survey questions. Additional counties are welcome to join the Multi-county Innovations PADs Project at any time throughout the year. All project update reports and presentations will be supplied throughout year two.

Year 3: All contractors and counties will continue to participate in statewide monthly to quarterly meetings, as necessary—full implementation of PADs with priority pilot groups. Counties may opt to pivot or expand roll-out as necessary within their counties and with stakeholder input. PADs technology beta testing to begin. Engage consumers and consumer advocacy groups and law enforcement, crisis teams, and hospitals to discuss PADs information, consumer consent, and access. PADs expert and trainer Laurie Hallmark will continue to provide micro assistance to counties for the continued smooth transition of PADs implementation to priority pilot populations. Integrate the PADs template as the official State of California PADs template to be added to the NRC·PADs website. Create QR Code and webpage portal. Technical assistance for counties that opt to utilize social media marketing of PADs within their county. Data Evaluation through The RAND Corporation to begin quantitative analysis. Additional counties welcome to join the Multi-county Innovations PADs Project at any time throughout the year.

Year 4: Full implementation of PADs with priority pilot groups will continue. Counties may opt to pivot or expand roll-out as necessary within their counties and with stakeholder input. PADs forms are self-sustaining at this juncture; counties can continue to grow population outreach and community-based organization roll-out—final data analysis report and Innovation report to be completed. Additional counties welcome to join phase two the Multi-county Innovations PADs Project. The PADs technology platform is fully operational and ready for full state access.

Phase Two Innovations PADs Data Interoperability and Integration. If counties so desire, the entire data upload and housing of documents can begin in California, making it the only state in the nation to have a fully integrated and accessible PAD. This expanded project will enlist LE, hospital, primary care, and crisis teams to access PADs, QR Code, and web portal and encourage the completion of PADs for use to de-escalate a crisis situation or to identify the person with mental illness' self-determined legal requests during a crisis. This project would seek to integrate PADs fully into the State of California mental and physical health systems.

Table 1

Year One	Year Two
Concepts Forward Consulting	**Concepts Forward Consulting**
Organize all counties efforts	Organize all counties efforts
Identify Scope of Work tasks for all contractors to complete within year one.	Identify Scope of Work tasks for all contractors to complete within year two.
Interface with counties and contractors	Interface with counties and contractors
Conduct and participate in all Stakeholder meetings	Conduct and participate in all Stakeholder meetings
Mitigate challenges	Mitigate challenges
Create Scope of Work, Performance Agreements and financial oversight as needed	Enforce all scope of work and performance agreements.
Assist counties with decision making	Assist counties with decision making
Report out to counties, state, and stakeholders as needed	Report out to counties, state, and stakeholders as needed
Laurie Hallmark	**Laurie Hallmark**
Lead the discussion to create a PADs template	Lead Teams in the training of PAD Teams
Participate in discussion for "Informational Training Videos."	Lead Train the Trainer for Peers/PADs implementation
Assist in identifying PADs Teams	Continue county-specific informational sessions
Present Statewide informational sessions	Micro train county-specific providers to provide PADs (Peers, clinicians, contractors)
Present county-specific informational sessions	Participate in statewide meetings
Assist in legislation advocacy	Assist in legislation advocacy
Training on how to obtain PADs clients	Technical Support 1:1 with counties
Participate in training material creation (Train the Trainer)	Assist with Data integration discussion
Participate in statewide meetings	**Idea Engineering**
Assist with standardized training material	Finalize Communications Package
Participate in Data integration discussion	Create PADs Identification Materials for Consumers
Idea Engineering	Provide County specific Technical Support
PADs Identity & Guidelines	Participate in statewide meetings
Create Introductory Videos	**RAND**

Create Training Videos	Focus groups county implementors
Create Form Design	Focus groups train the trainer/Peers
Participate in statewide meetings	Participate in stakeholder meetings
RAND	Participate in statewide meetings
Participate in stakeholder meetings	interim report
Participate in statewide meetings	TA Technical Support
TA with counties 1:1 for evaluation priorities	**Technology Platform**
Technology Platform	Begin to build the Platform
Engage in technology conversations and planning	Identify PADs template and video upload needs
Lead robust Stakeholder meetings	
Identify interoperability, access needs.	
Identify what the backend, front end, and user interface will be.	
All counties can seek additional Platform information.	

Year Three	Year Four
Concepts Forward Consulting	**Concepts Forward Consulting**
Organize all counties efforts	Organize all counties efforts
Identify Scope of Work tasks for all contractors to complete within year three.	Identify Scope of Work tasks for all contractors to complete within year four.
Interface with counties and contractors	Interface with counties and contractors
Conduct and participate in all Stakeholder meetings	Conduct and participate in all Stakeholder meetings
Mitigate challenges	Mitigate challenges
Assist counties with decision making	Assist counties with decision making
Report out to counties, state, and stakeholders as needed	Report out to counties, state, and stakeholders as needed
Lead legislative efforts, working with interested agencies and community groups	Follow legislative efforts
Laurie Hallmark	Write Phase Two Innovations PADs Statewide Cloud-based Data project.
Technical Support 1:1 with counties	**Laurie Hallmark**
Assist in legislation advocacy	Technical Support 1:1 with counties
Participate in statewide meetings	Participate in statewide meetings
Idea Engineering	Participate in the final report and statewide presentations
Provide County specific Technical Support	**Idea Engineering**
RAND	Provide County specific Technical Support
Focus group consumers	Create Project Documentary Video
Survey to assess consumer experience	Participate in the final report and statewide presentations
Aggregate data	**RAND**
Conduct analysis	Aggregate Final data
TA Technical Support	Conduct Final analysis
Participate in statewide meetings	Provide Final evaluation report
Technology Platform	Participate in the final report and statewide presentations

Upload all templates and videos	**Technology Platform**
Meet with consumer groups to discuss access and consent need and parameters	Continue to upload PADs on a Pilot basis.
Test Beta platform examples	Identify ongoing needs to complete statewide access.
Quarter 4 upload PADs on a pilot basis	Pilot QR Code and webpage portal
	Licensing fees, funding for sustainability

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Appendix

A. Budget
    a. Total Project Budget
    b. Contractors
    c. Counties
        i. Fresno
        ii. Mariposa
        iii. Monterey
        iv. Orange
        v. Shasta
B. Letters of Support
C. Presentation Flyers
D. Psychiatric Advance Directive sample template

Appendix A: Budgets and Contractors

Total Budget: Multi-county PADs Innovations Project*

BUDGET BY FISCAL YEAR AND SPECIFIC BUDGET CATEGORY*							
EXPENDITURES							
	PERSONNEL COSTS (salaries, wages, benefits)	**FY 21/22**	**FY 22/23**	**FY 23/24**	**FY 24/25**		**TOTAL**
1.	Salaries	$388,809.00	$395,044.00	$401,521.00	$408,251.00		$1,593,626.00
2.	Direct Costs	$81,553.00	$83,389.50	$85,287.00	$87,247.00		$337,475.00
3.	Indirect Costs	$95,546.00	$96,595.00	$97,688.00	$98,827.00		$388,656.00
4.	**Total Personnel Costs**	$565,908.00	$575,028.00	$584,496.00	$594,325.00		$2,379,758.00
	OPERATING COSTS*						
5.	Direct Costs	$65,266.00	$65,266.00	$65,266.00	$65,266.00		$261,063.00
6.	Indirect Costs	$3,000.00	$3,000.00	$3,000.00	$3,000.00		$12,000.00
7.	**Total Operating Costs**	$68,266.00	$68,266.00	$68,266.00	$68,266.00		$273,064.00
	NON-RECURRING COSTS (equipment, technology)						
8.		$20,000.00					$20,000.00
9.							
10.	**Total non-recurring costs**	$20,000.00					$20,000.00
	CONSULTANT COSTS / CONTRACTS (clinical, training, facilitator, evaluation)						
11.	Direct Costs	$3,562,396.00	$3,509,325.00	$3,444,741.00	$3,228,166.00		$13,744,629.00
12.	Indirect Costs	$11,517.00	$38,574.00	$28,885.00	$28,083.00		$107,059.00
13.	**Total Consultant Costs**	$3,474,401.00	$3,551,960.00	$3,514,348.00	$3,310,980.00		$13,851,689.00
	OTHER EXPENDITURES (please explain in budget narrative)						
14.		$7,660.00	$7,660.00	$7,660.00	$7,660.00		$30,640.00

15.							
16.	**Total Other Expenditures**	$7,660.00	$7,660.00	$7,660.00	$7,660.00		$30,640.00
	BUDGET TOTALS						
	Personnel (total of line 1)	$388,809.00	$395,044.00	$401,521.00	$408,251.00		$1,593,626.00
	Direct Costs (add lines 2, 5, and 11 from above)	$3,709,215.00	$3,657,980.50	$3,595,294.00	$3,380,679.00		$14,343,167.00
	Indirect Costs (add lines 3, 6, and 12 from above)	$110,063.00	$138,169.00	$129,573.00	$129,910.00		$507,715.00
	Non-recurring costs (total of line 10)	$20,000.00					$20,000.00
	Other Expenditures (total of line 16)	$7,660.00	$7,660.00	$7,660.00	$7,660.00		$30,640.00
	TOTAL INNOVATION BUDGET	$4,235,747.00	$4,198,853.50	$4,134,048.00	$3,926,500.00		$16,495,148.00
BUDGET CONTEXT – 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:**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**FY 24/25**		**TOTAL**
1.	Innovative MHSA Funds	$3,268,017.00	$3,248,555.00	$3,247,241.00	$3,251,906.00		$13,015,717.00
2.	Federal Financial Participation						
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other funding						
6.	**Total Proposed Administration**	$3,268,017.00	$3,248,555.00	$3,247,241.00	$3,251,906.00		$13,015,717.00
EVALUATION:							
B.	**Estimated total mental health expenditures <u>for EVALUATION</u> for the entire duration of this INN**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**FY 24/25**		**TOTAL**

	Project by FY & the following funding sources:						
1.	Innovative MHSA Funds	$593,058.98	$597,914.16	$599,498.95	$598,319.62		$2,388,791.71
2.	Federal Financial Participation						
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other funding						
6.	**Total Proposed Evaluation**	$593,058.98	$597,914.16	$599,498.95	$598,319.62		$2,388,791.71
TOTALS:							
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 21/22**	**FY 22/23**	**FY 23/24**	**FY 24/25**		**TOTAL**
1.	Innovative MHSA Funds*	$4,131,506.00	$4,195,074.00	$4,192,914.00	$3,995,698.00		$16,515,190.00
2.	Federal Financial Participation						**$**
3.	1991 Realignment						**$**
4.	Behavioral Health Subaccount						**$**
5.	Other funding**						**$**
6.	**Total Proposed Expenditures**	$4,131,506.00	$4,195,074.00	$4,192,914.00	$3,995,698.00		$16,515,190.00

*** INN MHSA funds reflected in total of line C1 should equal the INN amount County is requesting.**

**** If "other funding" is included, please explain within budget narrative.**

*discrepancy is due to rounding differences per county.

Contractor Budgets:

Concepts Forward Consulting Budget Narrative

Personnel

The total personnel cost for the multi-county shared portion for case management and full project oversight is $711,406 over the four fiscal years. This includes all direct services and a three percent annual salary cost-of-living increase.

Year 1: 1248 hours annually, Year 2 and 3: 1040 hours annually, Year 4: 936 annually.

Supplies

The total cost for supplies will be $16,000. To include but not limited to project supplies, one handheld tablet device, computer supplies, printing, software, mobile hotspot subscription, web subscriptions and miscellaneous office supplies.

Travel

Travel costs will total $8,000 for the four-year project. Travel to resume in year 2.

Subcontracts

If Concept Forward Consulting is utilized as financial oversight, a payroll company, business attorney and accountant will be subcontracted. Payment will come out of the 9% allocated Administration fees.

Indirect Costs

If Concepts Forward Consulting is utilized as financial oversight a 9% Administration fee will be charged in the amount of $283,638 for the four years of the project.

Total Cost

$735,406 (non-financial oversight)

$1,019,044 (9% with fiscal administration)

Concepts Forward Consulting BUDGET BY FISCAL YEAR AND SPECIFIC BUDGET CATEGORY*							
EXPENDITURES							
	PERSONNEL COSTS (salaries, wages, benefits)	**FY 21/22**	**FY 22/23**	**FY 23/24**	**FY 24/25**		**TOTAL**
1.	Salaries						
2.	Direct Costs						
3.	Indirect Costs						
4.	**Total Personnel Costs**						**$**
	OPERATING COSTS*						
5.	Direct Costs	**$199,680**	**$171,392**	**$176,534**	**$163,800**		**$711,406**
6.	Indirect Costs- travel, office supplies	**$3,000**	**$6,000**	**$6,000**	**$6,000**		**$21,000**
7.	**Total Operating Costs**						**$ 732,406**
	NON-RECURRING COSTS (equipment, technology)						
8.	**One-hand held tablet**	**$3,000**					
9.							
10.	**Total non-recurring costs**						**$ 3,000**
	CONSULTANT COSTS / CONTRACTS (clinical, training, facilitator, evaluation)						
11.	Direct Costs						
12.	Indirect Costs						
13.	**Total Consultant Costs**						**$**
	OTHER EXPENDITURES (please explain in budget narrative)						
14.							
15.							
16.	**Total Other Expenditures**						**$**
	BUDGET TOTALS						
	Personnel (total of line 1)						**$**
	Direct Costs (add lines 2, 5, and 11 from above)						**$711,406**
	Indirect Costs (add lines 3, 6, and 12 from above)						**$21,000**
	Non-recurring costs (total of line 10)						**$ 3,000**
	Other Expenditures (total of line 16)						**$**
	TOTAL INNOVATION BUDGET						**$735,406**

Idea Engineering Budget and Narrative
OPERATING COSTS
Direct Costs
Professional services to develop core deliverables include:
Strategic consultation and creative direction
Video direction and production
Graphic design, copywriting and editing, Spanish translation, art production, production coordination
Year 1 – FY 21/22
Strategic consultation and creative direction
180 hours x $165/hr = $29,700

Video direction and production
1,240 hours x $165/hr = $204,600

Graphic design, copywriting and editing, Spanish translation, art production, production coordination
370 hours x $110/hr = $40,700
Year 2 – FY 22/23
Strategic consultation and creative direction
210 hours x $165/hr = $34,650

Video direction and production
30 hours x $165/hr = $4,950

Graphic design, copywriting and editing, Spanish translation, art production, production coordination
420 hours x $110/hr = $46,200
Year 3 – FY 23/24
Strategic consultation and creative direction
120 hours x $165/hr = $19,800

Video direction and production
N/A

Graphic design, copywriting and editing, Spanish translation, art production, production coordination
260 hours x $110/hr = $28,600

Year 4 – FY 24/25
Strategic consultation and creative direction
140 hours x $165/hr = $23,100

Video direction and production
220 hours x $165/hr = $36,300

Graphic design, copywriting and editing, Spanish translation, art production, production coordination
135 hours x $110/hr = $14,850

NON-RECURRING COSTS

Printing and production of PADs communications materials such as consumer identity cards, lanyards, wristbands or key tags.

Year 2 – FY 22/23

142 units x $100/unit = $14,200

Year 3 – FY 23/24

16 units x $100/unit = $1,600

Year 4 – FY 24/25

7.5 units x $100/unit = $750

Idea Engineering BUDGET BY FISCAL YEAR AND SPECIFIC BUDGET CATEGORY*							
EXPENDITURES							
	PERSONNEL COSTS (salaries, wages, benefits)	**FY 21/22**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY xx/xx**	**TOTAL**
1.	Salaries						
2.	Direct Costs						
3.	Indirect Costs						
4.	**Total Personnel Costs**						**$**
	OPERATING COSTS*						
5.	Direct Costs	$275,000	$85,800	$48,400	$74,250		$483,450
6.	Indirect Costs						
7.	**Total Operating Costs**						**$483,450**
	NON-RECURRING COSTS (equipment, technology)						
8.	Printing and production of PADs communications materials		$14,200	$1,600	$750		$16,550
9.							
10.	**Total non-recurring costs**						**$ 16,550**
	CONSULTANT COSTS / CONTRACTS (clinical, training, facilitator, evaluation)						
11.	Direct Costs						
12.	Indirect Costs						
13.	**Total Consultant Costs**						**$**
	OTHER EXPENDITURES (please explain in budget narrative)						
14.							
15.							
16.	**Total Other Expenditures**						**$**

	BUDGET TOTALS						
	Personnel (total of line 1)						**$**
	Direct Costs (add lines 2, 5, and 11 from above)	$275,000	$85,800	$48,400	$74,250		**$483,450**
	Indirect Costs (add lines 3, 6, and 12 from above)						**$**
	Non-recurring costs (total of line 10)		$14,200	$1,600	$750		**$ 16,550**
	Other Expenditures (total of line 16)						**$**
	TOTAL INNOVATION BUDGET	**$275,000**	**$100,000**	**$50,000**	**$75,000**		**$500,000**

RAND Corporation Budget and Narrative

Contractor Contact and Specific Dates

Primary Contractor Contact

Technical: Nicole Eberhart, eberhart@rand.org, 310-393-0411 x6083

Contractual: Emily Palumbo, epalumbo@rand.org, 412-683-2300 x4127

Budget Narrative for County Specific Needs:

Personnel (narrative)

For the evaluation component, RAND staff are described below. Total personnel is budgeted at $526,561.

Salaries. (Year 1 $12,605, Year 2 $67,725, Year 3 $48,317, Year 4 $31,148, Total $159,795)

Nicole Eberhart, Co-Principal Investigator (Co-PI). Dr. Eberhart is a Senior Behavioral Scientist at RAND and a licensed clinical psychologist. Eberhart will provide senior oversight of the evaluation. Eberhart is budgeted for 388 hours of effort over the 4 year project period (48.5 days).

Daniel Siconolfi, Co-Principal Investigator (Co-PI). Dr. Siconolfi is a Behavioral Scientist at RAND. Siconolfi will oversee and direct implementation of all evaluation tasks. Siconolfi is budgeted for 616 hours over the 4 year project period (80 days).

Ryan McBain, Co-Investigator. Dr. McBain is a Policy Researcher at RAND. McBain will provide content expertise and consulting over the course of the evaluation. McBain is budgeted for 408 hours over the 4 year project period (51 days).

Julia Bandini, Task Lead. Dr. Bandini is an Associate Behavioral Scientist at RAND. Bandini will implement the qualitative data collection and analysis for those tasks (focus groups with Peers; focus groups with county implementors; focus groups with consumers). Bandini is budgeted for 376 hours over the 4 year project period (47 days).

Research Assistant (to be named). We will identify an appropriate RAND Research Assistant at the time of evaluation funding. The research assistant will support the implementation of the consumer survey (e.g., management of enrollment, follow-up, and incentive distribution. The RA is budgeted for 216 hours over the 4 year project period (27 days).

Research Programmer and Analyst (to be named). We will identify an appropriate RAND programmer/analyst at the time of evaluation funding. The programmer will conduct quantitative analysis of a survey of consumers and administrative data on PAD completion. The Programmer is budgeted for 280 hours over the 4 year project period (35 days).

Olatunda Martin, Administrative Assistant. Martin will support the general scheduling and administrative needs of the project, and will also support the scheduling of participants for the various data collection activities (e.g., focus groups). Martin is budgeted for 64 hours over the 4 year project period (8 days).

RAND Internal Quality Assurance Reviewer. A senior-level reviewer with relevant content and methodological expertise will provide peer review of the study memos and reports, per RAND's Quality Assurance requirements. The internal reviewer is budgeted for 24 hours over the project period (3 days).

Direct Costs. (Year 1 $25,159, Year 2 $135,923, Year 3 $94,637, Year 4 $61,911, Total $317,630)

RAND's direct costs to personnel include fringe benefits, research management costs, and research and analysis fee. These cost estimates are based on an analysis of the work to be undertaken and the cost experience of similar RAND projects. Actual costs will be accumulated in accordance with RAND's

audited accounting procedures. For financial reporting purposes, personnel costs will be reported by aggregate.
Indirect Costs. (Year 1 $3,771, Year 2 $18,066, Year 3 $17,776, Year 4 $9,523, Total $49,136) Other Indirect Costs (at 15% of direct costs) consisting of corporate, unit, and facilities capital cost of money.

Other Costs
Technology Service Allocation. (Year 1 $1,476, Year 2 $8,256, Year 3 $6,665, Year 4 $3,492, Total $19,889) RAND's Technology Services Allocation is calculated at a flat rate of $7.88 per hour of staff time. The budget reflects an inflation adjustment for costs in future budget periods. These costs include the following:

- Technology services, consisting of computers per staff member; exchange services (voicemail, email, calendaring) and associated file storage; access to collaborative information resources, software provided on network servers; remote access to RAND through encrypted tunneling and Web-based AnywhereCo,636nnect; printing, copying, faxing, and scanning on "public" (network) machines, including troubleshooting and supplies; and SharePoint Web-based sites for team collaboration.
- Telecommunications, consisting of videoconference facility use and maintenance; telephones and related moves, repairs, maintenance, administration; local, long-distance, international calling, 800 numbers for voice access by RAND travelers; RAND phone directory, database updates, and maintenance; RAND switchboard support; and three-party conference calling.
- System Support Services, including but not limited to consulting and troubleshooting; troubleshooting to ensure that a computer is up and running or to assist with Microsoft Word, PowerPoint, or Excel; consultation on hardware and software for RAND work; assistance with printing, operating system, file sharing, email and communication software (including for remote access), Web browser, and calendaring software; RAND-specific documentation, product testing and evaluation.

Survey Vendor. (Year 1 $5,000, Year 2 $5,000, Year 3 $5,000, Year 4 $5,000, Total $20,000) To collect quantitative data (e.g., Peer training evaluation, PAD consumer experience survey), we will use a survey platform that provides adequate data collection, storage, and protection capabilities. An appropriate vendor will be confirmed during implementation. We budgeted costs assuming 4 years of access to the Qualtrics XM platform.
Publications. (Year 2 $4,002, Year 3 $4781, Year 4 $8,147, Total $16,930) RAND publication costs for the interim memos, interim evaluation report, and final report.
External Quality Assurance Reviewer. (Year 2 $750, Year 3 $750, Year 4 $750, Total $2,250) An external researcher with relevant content and methodological expertise will provide peer review of the study memos and reports, per RAND's Quality Assurance requirements. External reviewers are paid via Letter of Agreement.
Transcription. (Year 2 $2,200, Year 3 $2,200, Total $4,400) Professional transcription of focus groups with Peers and focus groups with PADS consumers.
Study Incentives. (Year 3 $27,600, Total $27,600) Incentives for consumers participating in focus groups and in a quantitative survey.

Total Estimated Budget
The RAND Corporations total estimated 4-year budget is $617,630. A detailed breakdown of the budget by fiscal year is provided in the grid below. Budget sheets taken from Innovations Template.

RAND BUDGET BY FISCAL YEAR AND SPECIFIC BUDGET CATEGORY*							
EXPENDITURES							
	PERSONNEL COSTS (salaries, wages, benefits)	**FY 21/22**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**TOTAL**
1.	Salaries	**12,605**	**67,725**	**48,317**	**31,148**		**159,795**
2.	Direct Costs	**25,159**	**135,923**	**94,637**	**61,911**		**317,630**
3.	Indirect Costs	**3,771**	**18,066**	**17,776**	**9,523**		**49,136**
4.	**Total Personnel Costs**	**41,535**	**221,715**	**160,730**	**102,582**		**$ 526,561**
	OPERATING COSTS*						
5.	Direct Costs						
6.	Indirect Costs						
7.	**Total Operating Costs**						**$**
	NON-RECURRING COSTS (equipment, technology)						
8.							
9.							
10.	**Total non-recurring costs**						**$**
	CONSULTANT COSTS / CONTRACTS (clinical, training, facilitator, evaluation)						
11.	Direct Costs						
12.	Indirect Costs						
13.	**Total Consultant Costs**						**$**
	OTHER EXPENDITURES (please explain in budget narrative)						
14.	**Technology Services Allocation**	**1,476**	**8,256**	**6,665**	**3,492**		**19,889**
15.	**Survey Vendor - Qualtrics**	**5,000**	**5,000**	**5,000**	**5,000**		**20,000**
16.	**Publications**		**4,002**	**4,781**	**8,147**		**16,930**
17.	**External Peer Reviewer**		**750**	**750**	**750**		**2,250**
18.	**Transcription**		**2,200**	**2,200**			**4,400**
19.	**Survey Incentives**			**27,600**			**27,600**
20.	**Total Other Expenditures**	**6,476**	**20,208**	**46,996**	**17,389**		**$ 91,069**
	BUDGET TOTALS						
	Personnel (total of line 1)	**12,605**	**67,725**	**48,317**	**31,148**		**$159,795**
	Direct Costs (add lines 2, 5, and 11 from above)	**25,159**	**135,923**	**94,637**	**61,911**		**$317,630**
	Indirect Costs (add lines 3, 6, and 12 from above)	**3,771**	**18,066**	**17,776**	**9,523**		**$49,136**
	Non-recurring costs (total of line 10)						**$**

	Other Expenditures (total of line 20)	**6,476**	**20,208**	**46,996**	**17,389**		**$91,069**
	TOTAL INNOVATION BUDGET	**48,011**	**241,922**	**207,726**	**119,971**		**$617,630**

Budget Narrative PADs expert trainer, Laurie Hallmark:

Personnel

The total personnel cost for the multi-county shared portion for county training in PADs, participation in stakeholder discussion, county technical assistance, legislation expertise, personnel stipends and PADs presentations is $289,000 over the four fiscal years.
Year 1: 720 hours annual, Year 2: 240 hours annual, plus 5 x $5000 for training stipends, Year 3 and Year 4: 180 hours each annual for technical assistance.

Supplies

The total cost for supplies will be $3,500, miscellaneous office supplies.

Travel

Travel costs will total $6000 to commence in year two.

Laurie Hallmark BUDGET BY FISCAL YEAR AND SPECIFIC BUDGET CATEGORY*							
EXPENDITURES							
	PERSONNEL COSTS (salaries, wages, benefits)	**FY 21/22**	**FY 22/23**	**FY 23/24**	**FY 24/25**		**TOTAL**
1.	Salaries						
2.	Direct Costs						
3.	Indirect Costs						
4.	**Total Personnel Costs**						**$**
	OPERATING COSTS*						
5.	Direct Costs	**$144,000**	**$48,000**	**$36,000**	**$36,000**		**$264,000**
6.	Indirect Costs- stipends		**$25,000**				**$25,000**
7.	**Total Operating Costs**						**$ 289,000**
	NON-RECURRING COSTS (equipment, technology)						
8.							
9.							
10.	**Total non-recurring costs**	**$2,500**	**$5,000**	**$1,000**	**$1,000**		**$**
	CONSULTANT COSTS / CONTRACTS (clinical, training, facilitator, evaluation)						
11.	Direct Costs						
12.	Indirect Costs						
13.	**Total Consultant Costs**						**$**
	OTHER EXPENDITURES (please explain in budget narrative)						
14.	**Miscellaneous office supplies, travel**						**$9,500**

15.							
16.	**Total Other Expenditures**						**$ 9,500**
	BUDGET TOTALS						
	Personnel (total of line 1)						**$**
	Direct Costs (add lines 2, 5, and 11 from above)						**$264,000**
	Indirect Costs (add lines 3, 6, and 12 from above)						**$25,000**
	Non-recurring costs (total of line 10)						
	Other Expenditures (total of line 16)						**$9,500**
	TOTAL INNOVATION BUDGET						**$298,500**

County Budgets

Appendix: Fresno County

Summary

Fresno County was approved for the Psychiatric Advance Directive (PAD) Using Supportive Decision-Making Statewide Innovation Program in June 2019. It began work on the Innovation Project later in 2019. Fresno County has worked continuously to study specific local PADs efforts, as detailed in its Annual Update, and is now working with the other participating counties in defining and implementing a statewide project. Until recently, the overall statewide project did not have other formal participants, and thus actual costs for such a program were unknown. As a statewide project is now defined and costs for statewide efforts have been more thoroughly explored, Fresno County is seeking to increase the project budget in order to ensure success of the statewide project and to be able to provide its share of costs. Thus, Fresno County is seeking to increase the project total for its five-year plan.

History

Fiscal Year 2021-2022 will mark Fresno County's third year of participation in this statewide INN project. In the first year of the project Fresno was the sole participating county. The County began planning and identifying learning outcomes and goals, but this work was derailed by the COVID 19 pandemic. At the end of the first year, Fresno sought an extension from the Mental Health Services Oversight and Accountability Commission (MHSOAC) to extend its plan from a three-year plan to a five-year plan, due to the delays caused by COVID 19.

In the second year, Fresno progressed slowly in order to ensure its work would not "out-run" the overall statewide project and much of its costs. Careful consideration was given to ensure the project implementation would factor in statewide learning, goals, and program costs. In the past year Fresno County has worked with the MHSOAC, contractors, and other counties in the efforts to implement the PADs Innovation Program.

Update

The purpose of this brief is to describe the increase of funding to the Fresno Innovation Plan for statewide Psychiatric Advance Directive (PAD) with Supportive Decision-Making project by $500,000. Fresno County has initiated the community planning process needed to approve an amendment to the plan to increase the total funding and seek formal approval from the Mental Health Services and Oversight and Accountability Commission (MHSOAC). This process will be completed by the time this item is heard on the MHSOAC agenda.

Proposed Changes to Existing Plan

In June 2019, Fresno County became the first county to have an Innovation Plan approved for participation in the statewide Psychiatric Advance Directive (PAD) with Supportive Decision-Making project. The plan was approved for $950,000 over three years. The COVID-19 pandemic resulted in delays to other counties coming on-board the statewide project to help identify statewide learning and goals, and derailed much of the work during the first year of the project. In August of 2020, Fresno County sought and obtained approval from MHSOAC to change the program from a three-year to a five-year project in order to extend the time available to implement the project.

As the statewide PADs project moves forward with additional counties (Orange, Shasta, Monterey and Mariposa), clearer statewide goals and learning have emerged. There is now an actual statewide PADs plan; before this collaborative effort, Fresno was the only county signed on to the statewide effort. That additional input and design for the statewide effort has finally allowed the participating counties to determine an overall project cost. Fresno will focus on PADs development, implementation, and understanding of specific populations which can inform the statewide effort. Fresno County is committed to exploring a variety of options for data management systems, in order to help identify the system that best fits the future needs of project. Fresno County's approved project budget of $950,000 is short of what would be needed for both the statewide effort and the local application and implementation of PADs. To effectively participate and complete the statewide project, Fresno County projects the actual cost to be closer $1,450,000. This will increase the overall plan by $500,000. The increase will allow for Fresno County to contribute to the cost of statewide administrative fees and statewide coordination, PADs training, local partnerships for implementation, logistics, and the statewide evaluation.

$1,206,124.00 of the total budget will be allocated toward the statewide efforts, which include the evaluation, training, and statewide coordination and a logistic support assessment. Approximately $243,867 will be used specifically for Fresno County activities, including project management/administration and implementation, stipends for peers/trainers, any additional training, and local partner organization supports.

The additional $500,000 of requested funds are Innovation dollars that will be subject to reversion in FY 2021-2022. Allocating these funds to an existing MHSOAC-approved project will both ensure the project is effective in exploration of PADs and assist Fresno County in encumbering Innovation funds at risk of reversion.

Community Planning Process

Fresno County initiated its stakeholder planning process by presenting these proposed changes to its Behavioral Health Board on 04/21/21. The proposed changes were also posted on the Department's website and social media for 30 days, from 4/26/21 through 5/25/21. A summary of any comments provided will be available on 5/26/21. The Department hosted several virtual forums for public input to complete its stakeholder requirement. Should the Department receive MHSOAC approval to increase the project budget by $500,000, these changes will be documented in the both the Innovation Annual Update and the MHSA Annual Update for 2021.

FRESNO BUDGET BY FISCAL YEAR AND SPECIFIC BUDGET CATEGORY*							
EXPENDITURES							
	PERSONNEL COSTS (salaries, wages, benefits)	**FY 21/22**	**FY 22/23**	**FY 23/24**	**FY 24/25**		**TOTAL**
1.	Salaries						
2.	Direct Costs						
3.	Indirect Costs						
4.	**Total Personnel Costs**						**$**
	OPERATING COSTS*						
5.	Direct Costs						
6.	Indirect Costs						
7.	**Total Operating Costs**						**$**
	NON-RECURRING COSTS (equipment, technology)						
8.							
9.							
10.	**Total non-recurring costs**						**$**
	CONSULTANT COSTS / CONTRACTS (clinical, training, facilitator, evaluation)						
11.	Direct Costs	**$100,000**	**$200,000**	**$200,000**			**$500,000**
12.	Indirect Costs						
13.	**Total Consultant Costs**						**$500,000**
	OTHER EXPENDITURES (please explain in budget narrative)						
14.							
15.							
16.	**Total Other Expenditures**						**$**
	BUDGET TOTALS						
	Personnel (total of line 1)						**$**
	Direct Costs (add lines 2, 5, and 11 from above)						**$500,000**
	Indirect Costs (add lines 3, 6, and 12 from above)						**$**
	Non-recurring costs (total of line 10)						**$**
	Other Expenditures (total of line 16)						**$**
	TOTAL INNOVATION BUDGET						**$500,000**

Appendix: Mariposa County

Primary County Contact: *Laura Glenn Lglenn@mariposacounty.org 209-742-0823*
Date Proposal posted for 30-day Public Review: *Tentative Date of May 13th*
Date of Local MH Board hearing: *Tentative Date of Monday June 14th.*
Date of BOS approval or calendared date to appear before BOS: *Tentative Date of Tuesday June 15th*

Description of the Local Need

Mariposa County is a small, rural county nestled in the Sierra Nevada foothills and is home to approximately 17,700 residents. As in other rural counties, Mariposa is characterized by the sparse number of individuals under the age of 18, a characteristic which is maintained and propelled by the lack of job opportunities which pushes young families out of the county in search of gainful employment. The county spans approximately 1,450 square miles and residences tend to be spread out. All services are provided in the unincorporated township of Mariposa, with some agencies, including Health and Human Services, providing limited services to those communities that are geographically removed from the town of Mariposa. The sparse population of the County in relation to its geographic size, couple with the lack of public transportation infrastructure, results in considerable social isolation.

Coupled with the lack of opportunity, the isolation of the County's residents created an environment ripe for depression, anxiety, and other mental and behavioral health disorders; this also provides and environment conducive for illegal activities and substance abuse. Additionally, many of those in need of services, face multiple barriers accessing them.

While Mariposa County hasn't seen a dramatic increase in hospitalization over the last couple of years, there has been a significant increase in the recidivism rate. High utilizers of our local hospital and crisis response are the individuals that are repeatedly being hospitalized.

Description of the Response to the Local Need

Implementing the use of psychiatric Advance Directives (PAD's) in our community will hopefully maximize decision-making and allow the clients an opportunity to express their choice through a collaborative discussion regarding their mental health treatment, before a crisis occurs. This really gives the individual the time and space to identify what helps, and what makes things worse if a crisis were to occur; potentially leading to an increase in the quality of mental services, including measurable goals.

One other important aspect of the PAD's project, is that it will enable the County to promote interagency and community collaboration related to mental health treatment and crisis with law enforcement, our jail, the hospital, and even our homeless shelter. Effective collaboration between agencies is vital to improving the quality of services. This also allows a more effective use of and leveraging resources.

Mariposa County has found many successes in the use of multi-disciplinary teams (MDT's) directly in mental health treatment. The principle that team decision making as a group can be more effective by integrating a variety of perspectives by those who are dedicated to meeting client goals. The PAD's project will allow the County to maximize this approach by encouraging and supporting individuals to engage in treatment and to address issues specific to mental health care and treatment and to identify

what works, what doesn't work, and even select a psychiatrist, facility or medication before the need occurs.

Implementing PAD's will also provide the individual to receive the care they actually want potentially improving the individuals care during a crisis and subsequently reducing the recidivism rate.

Description of the Local Community Planning Process

Mariposa County Behavioral Health Board Members were asked to join the psychiatric advance directive informal presentation held by USC's Saks Institute in collaboration with Kiran Sahota of Concepts Forward Consulting. Additionally an informative PowerPoint on Psychiatric Advance Directives will be presented to the Behavioral Health Board on May 5th 2021 to garner input and feedback.

Flyers for upcoming supported decision-making, and psychiatric advance directive webinars will be posted to our Facebook page, and sent directly to our Behavioral Health Board Members.

Mariposa County will be holding a separate stakeholder meeting on May 12th 2021, to invite all community partners, clients, family members, and organizations to provide their feedback and ideas around innovation. Flyers will be posted to our Facebook page and our County website. Additionally, the plan will be posted on the County website, our Facebook page, and several physical locations throughout the county beginning on May 13th 2021 for the 30 day public review period. At the end of the 30 days, in collaboration with the Behavioral Health Board, a public hearing will be scheduled for Monday June 14th. Stakeholders will be informed of the public hearing via our Facebook page, the local newspaper and the County website. All information and feedback from the public review period and hearing will be incorporated.

Budget Narrative for County Specific Needs:

Staff Analyst – MHSA Coordinator 0.15 FTE $13,178.38

Admin Anlayst 0.08 FTE $8,753.57

Peer Support Specialist 0.20 FTE $26,613.24

Operating Costs

The total estimated indirect cost for this 4-year project is: $ 58,143.59 (see table below)

Other Costs

Travel: $0.0 or $5,000 (this is up to the program team, and whether any physical travel will be done)

Contractor: $79,660, of this amount, $60,332 will be used to identify a peer organization to participate in statewide stakeholder meetings and trainings, this will be to the benefit of the multi-county participants.

Total Estimated Budget

County's total estimated 4-year budget is $517,231.28. A detailed breakdown of the budget by fiscal year is provided in the grid below. Budget sheets taken from Innovations Template.

Mariposa BUDGET BY FISCAL YEAR AND SPECIFIC BUDGET CATEGORY*							
EXPENDITURES							
	PERSONNEL COSTS (salaries, wages, benefits)	FY 21/22	FY 22/23	FY 23/24	FY 24/25		TOTAL
1.	Salaries	$55,198.49	$57,958.42	$60,856.34	$63,899.16		$237,912.41
2.	Direct Costs	$5,510.00	$5,785.50	$6,074.78	$6,378.51		$23,748.79
3.	Indirect Costs	$13,490.00	$14,164.50	14,872.73	15,616.36		$58,143.59
4.	**Total Personnel Costs**	$74,198.49	$77,908.42	$81,803.85	$85,894.03		$319,804.79
	OPERATING COSTS*						
5.	Direct Costs	$29,441.63	29,441.63	$29,441.63	29,441.63		117,766.52
6.	Indirect Costs						0
7.	**Total Operating Costs**						$ 117,766.52
	NON-RECURRING COSTS (equipment, technology)						
8.							
9.							
10.	**Total non-recurring costs**						$
	CONSULTANT COSTS / CONTRACTS (clinical, training, facilitator, evaluation)						
11.	Direct Costs	$35,408	$34,809	$4,928	$4,515		$79,660.00
12.	Indirect Costs						
13.	**Total Consultant Costs**						$79,660.00
	OTHER EXPENDITURES (please explain in budget narrative)						
14.							
15.							
16.	**Total Other Expenditures**						**$**
	BUDGET TOTALS						
	Personnel (total of line 1)	$55,198.49	$57,958.42	$60,856.34	$63,899.16		$237,912.41
	Direct Costs (add lines 2, 5, and 11 from above)	$70,359.63	$70.036.13	$40,444.41	$40,335.14		$221,175.31
	Indirect Costs (add lines 3, 6, and 12 from above)	$13,490.00	$14,164.50	$14,872.73	$15,616.36		$58,143.59
	Non-recurring costs (total of line 10)						**$**
	Other Expenditures (total of line 16)						**$**
	TOTAL INNOVATION BUDGET	**$123,555.12**	**$113,114.71**	**$131,160.47**	**$135,250.66**		**$517,274.13**

Budget by Fiscal Year and Specific Budget Category for County Specific Needs

Total Budget Context – 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:**	FY 21/22	FY 22/23	FY 23/24	FY 24/25		**TOTAL**
1.	Innovative MHSA Funds						
2.	Federal Financial Participation						
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other funding						
6.	**Total Proposed Administration**						**$515,112.42**
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:**	FY 21/22	FY 22/23	FY 23/24	FY 24/25		**TOTAL**
1.	Innovative MHSA Funds	**$215.98**	**$617.16**	**$722.95**	**$605.62**		**$2,161.71**
2.	Federal Financial Participation						
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other funding						
6.	**Total Proposed Evaluation**						**$2,161.71**
TOTALS:							
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 21/22	FY 22/23	FY 23/24	FY 24/25		**TOTAL**
1.	Innovative MHSA Funds*						**$517,274.13**
2.	Federal Financial Participation						**$**
3.	1991 Realignment						**$**
4.	Behavioral Health Subaccount						**$**
5.	Other funding**						**$**
6.	**Total Proposed Expenditures**						**$517,274.13**

*** INN MHSA funds reflected in total of line C1 should equal the INN amount County is requesting.**
**** If "other funding" is included, please explain within budget narrative.**

Appendix: Monterey County

County Contact and Specific Dates

Primary County Contact (Name, Email, Phone):
Wesley Schweikhard, schweikhardw@co.monterey.ca.us, (831) 755-4856

Date Proposal posted for 30-day Public Review:
April 23, 2020

Date of Local MH Board hearing:
May 28, 2020

Date of BOS approval or calendared date to appear before BOS:
June 30, 2020

Description of the Local Need

The need for participating in the Psychiatric Advance Directives (PAD's) Innovation Project was derived from Monterey County Behavioral Health (MCBH) having an organizational goal of delivering person-centered care, and local community input that advocated for enhanced crisis response, case management services, interagency collaboration, and policy change. The MCBH Adult System of Care (ASOC), which treats adults over the age of 18 in Monterey County with moderate to severe mental illness, delivers person-centered care by using the Reach Recovery Model of care when delivering services and managing client needs. This model supports the active participation of clients in determining their treatment plan and outcomes, and the intensity level of services delivered are tailored to a person's varying needs and goals. Throughout service delivery, it is expected that a person will move forward in recovery, learning skills to support their own mental wellness. Therefore, as a person progresses through treatment it is expected that their level of service intensity and supports from ASOC will decrease and change over time, as progression reflects the ability to of the individual to support oneself independently. If individuals need a higher level of support (due to new stressors, crisis, or other factors), they may need a higher level of service intensity to receive the supports needed at that time. To compliment this framework, MCBH began considering PAD's as an additional tool to equip an individual in their recovery process.

In October 2019, MCBH staff attended a webinar presented by the Saks Institute that covered the topic of PAD's and introduced the concept of a collaborative multi-county project to develop and implement PAD's in California. MCBH brought forward this idea of developing and implementing PAD's as a project funded under the Mental Health Services Act (MHSA) Innovation component during the MHSA FY2021 - 2023 Three-Year Program and Expenditure Plan community planning process. This community planning process involved 10 bi-lingual community workshops across the county and allowed the community members and MCBH stakeholders to evaluate and provide input on MHSA funded programming in Monterey County, including the PAD Innovation project. Participants in this community planning process, and subsequently the Monterey County Behavioral Health Commission and Board of Supervisors, all endorsed the PAD Innovation project as part of the MHSA FY2021-2023 Three-Year Program and Expenditure Plan. Please reference Monterey's MHSA FY2021 -2023 Three-Year Program and Expenditure Plan, previously submitted to the MHSOAC on July 23, 2020.

The MCBH stakeholder needs that were expressed during the community planning process, that were relevant to the PAD's, included a call for enhanced crisis response training, more consumer and family-driven case management services, and support for more interagency collaboration and policy change.

Crisis response and support services was frequently brought up during community workshops. As frequently noted during community planning processes in prior years, participants highlighted training and technical assistance are needed in Monterey County for practitioners, teachers, and community members that increase knowledge, understanding, and skills related to mental health. MCBH has responded to such feedback in the past, and as a result, implemented a robust Crisis Intervention Training (CIT) across the county. CIT efforts have been primarily focused on training first responders, and every law enforcement agency within Monterey County has participated, with several units such as Monterey City Police Department, having their entire unit trained. Nevertheless, at community workshops there is a persistent fear or distrust of law enforcement being expressed, with calls to "decriminalize" mental illness. As a result, the PAD's project offers an opportunity to expand on the successful CIT program and strong relationship between MCBH and local emergency responders, by introducing a new tool for collaboration, responding to individual's according to their unique needs, and providing additional transparency on how crisis response is managed.

As part of the community planning process, there was advocacy for more community, consumer, and family-driven decision making in policies, programs, and services. Participants identified the need for the community being served to be more actively involved in the design and implementation of services. The role of peers was central to this discussion, and there was strong support for increasing the peer workforce and incorporating the perspective of peers in policy and program decision-making. As peers are viewed as a critical element to developing and implementing PAD's, with peers having the anticipated role of informing the user experience of completing a PAD and assisting individuals completing a PAD, participants at community workshops valued the PAD Innovation project as an opportunity for offering additional peer supports.

Interagency collaboration and policy change were needs identified by consumers and service providers alike. This includes improving communication, coordination, and collaboration between MCBH and other county agencies, departments (for example, Adult Protective Services) and external entities (for example, primary care doctors, emergency rooms, community-based organizations, private providers, etc.). Participants of the community planning process also supported the PAD Innovation project as they believed it would address gaps in relationships or partnerships between community-based organizations, government departments and other organizations to lead to higher quality services and supports, and create a more cohesive, transparent system of care. Many participants expressed a need for supporting a stronger network of providers to enable more warm hand-offs, information, and referrals. These individuals expressed concern and noted challenges when trying to access services and navigate the system, often getting lost in the bureaucracy of how the county and local mental health services system functions, particularly in moments of crisis. There was strong sentiment that too much "red tape" exists when accessing emergency rooms and getting follow up care after a crisis. These participants felt the development of a PAD would be very beneficial in assisting consumers and their families to better understand local service options, as well as assist in their wellness and recovery action planning. Additionally, the justice system involved population, especially those recently released from jail, were highlighted to be a potential population of focus for the PAD's Innovation project in Monterey County, as this population is particularly disadvantaged when trying to access services. Local community service providers also identified the need to affect policy change and promote interagency collaboration. In the in one instance, a local mental health service provider noted they offer PAD's as part of the Wellness and Recovery Action Plan (WRAP) services they offer. However, currently, local

emergency rooms are not recognizing these PAD documents. Therefore, this PAD's Innovation project was supported as it may further legitimize the use of PAD's within and across local emergency services and other organizations.

Response to Local Need

In response to longstanding community-expressed needs surrounding crisis response, case coordination, interagency collaboration and policy change, MCBH adopted the idea of joining the collaborative multi-county PAD Innovation project. This course of action was also consistent with MCBH's continual efforts to further enhance the available person-centered care services made available within their ASOC, and create more supportive decision making opportunities for ASOC clients. The dialogue performed with community stakeholders during the MHSA FY2021-2021 Three-Year Program and Expenditure Plan community planning process further informed how the PAD project will respond the community needs more directly. The following goals to be achieved by the development and use of PAD's were established as a result of that process:

Increase in individual wellness scores

As a PAD provides a care management plan, particularly in moments of crisis, one perceived benefit would be increased comfort and confidence to clients and their families on the path towards recovery. Additionally, using a supportive decision-making approach in developing a PAD may improve the self-esteem and "buy-in" of participants, increase their understanding of their own recovery, and improve outcomes. This can be measured through various screening tools. In Monterey County, the Reaching Recovery suite of tools provides a rating of the Recovery Need Levels (RNL) of the individual person served as well as measurements of recovery throughout the duration if their participation in services.

Reduction in incarceration/criminal justice involvement as result of crisis

A vital impact of this program is to better equip first responders, and especially the Crisis Intervention Teams (CIT), to understand the care preferences of a person experiencing a psychiatric crisis and provide care according to their wishes. If this yields a reduction in arrests/incarceration, that will equate to less disruption of services for the individuals in care, less trauma to the individuals experiencing a psychiatric crisis, a reduction in the utilization of jails for individuals who may be in crisis and increases in opportunities for individuals to remain in their own community with their support systems after a crisis episode.

Reduction in long term hospitalization

Having a PAD may increase adherence to treatment by individuals and may also expedite their treatment which can return them to wellness sooner, and thus avoid long hospitalizations by applying treatment approaches which may be misaligned with the values, preferences, and strengths of the individual. A PAD may give crisis responders more options and guidance on how to best serve those individuals in order to assist them to return to wellness.

Reduce Recidivism

The existence of PAD may help prevent a client from "slipping through the cracks" or voluntarily leaving services in two ways. First, a PAD offers a strategic framework, offering a clear picture of resources for clients as they apply to a variety of circumstances, as well as promotes interagency communication.

These features may aid in minimizes gaps in care, where clients have previously become lost or disillusioned in the bureaucracy of navigating the mental and physical health care system. Second, a PAD identifies conditions of care for clients, particularly during moments of crisis where a client may not be able to advocate for themselves. This empowering feature may bolster confidence and levels of commitment by clients in continuing their path to treatment and recovery.

Reduce high utilization of services

The application of supportive decision-making and evaluation of resources involved in creating a PAD will aid clients in having a clear action plan for care during moments of crisis or uncertainty, and support first responders or other involved resource providers in facilitating the directives of the PAD. This informed approach to managing care may assist clients in avoiding the use of emergency rooms or initiating a path towards involvement with the criminal justice system.

Increased coordination of resources

The development of a local infrastructure to support PAD's will require resource agencies and emergency services to establish clear paths of communication for sharing client data and managing crisis response. These efforts will foster more warm hand-offs, as is desired by the local community. Additionally, the systemic and policy change that is created by this PAD Innovation project will resolve prior issues of emergency rooms or other involved parties not recognizing an existing client PAD.

Description of the Local Community Planning Process

This Innovation Plan was developed during the Community Program Planning Process for the MCBH MHSA FY 2021-23 Three-year Program and Expenditure Plan. MCBH engaged in a robust CPPP using multiple approaches to ensure that residents could provide input and feedback to guide the development of the MHSA FY21-23 Three-Year Program and Expenditure Plan. MCBH adopted two primary strategies which included in-person Community Engagement Sessions and a Needs Assessment conducted via surveys of providers and community members (Addendum C). All flyers, surveys and planning materials were made available in English and Spanish.

A team of stakeholders comprised of consumers, contractors, MCBH staff and representatives from the County Board of Supervisors was convened to guide the development of the CPPP. Stakeholders provided input related to outreach for the sessions, key community leaders to invite, locations for meetings and other logistical details that would enhance community participation. MCBH contracted with a local consultant who has expertise in community engagement and prior experience with similar community planning processes in Monterey County to facilitate the CPPP sessions and to produce a report of the information and recommendations collected from participants to inform the development of this MHSA FY21-23
Three-Year Program and Expenditure Plan.

Ten Community Engagement Sessions were held between October 2019 to December 2019. Locations for each session were selected to provide convenient, broad access throughout Monterey County, with special attention to ensuring at least one (1) opportunity was offered in North County, Salinas, South County, and the Monterey Peninsula. The sessions were advertised via mass email, County Board of Supervisors email lists, social media, at the Monterey County Free Libraries and on the Health Department webpage. These Community Engagement Sessions were comprised of five (5) Regional Forums – one held in each District of the County and five (5) Focus Groups specific to the following

State-identified Prevention and Early Intervention priority areas: Early Psychosis & Suicide Prevention; Mental Health Needs of Seniors; Childhood Trauma Prevention; Culturally Responsive Approaches; and Mental Health Needs of College Age Youth. Flyers for these events are included in Addendum D.

During the sessions, participants received an overview of the MHSA funding components and the CPPP requirements with an emphasis on how the current CPPP would be used to inform the development of Monterey County's MHSA FY21-23 3-Year Program and Expenditure Plan. Participants were also asked to complete a Community Member Survey to gather their specific insights as part of the Needs Assessment strategy, and a separate survey to provide feedback about their experience participating in the CPPP. Professional interpreters were engaged to provide Spanish and English translation and provided simultaneous translation in both languages at several of the sessions.

The Innovation Plan was included in the MHSA FY 2021-2023 Three-Year Program and Expenditure Plan and was made available for public review and comment for a 30-day period prior to approval by the Monterey Behavioral Health Commission and Monterey County Board of Supervisors. The 30-day public comment period was conducted from April 23, 2020 to May 22, 2020. Opportunities for additional public comment were available at subsequent hearings conducted by the Monterey Behavioral Health Commission on May 20, 2020 and Monterey County Board of Supervisors June 30, 2020.

Budget Narrative for County Specific Needs:
The proposed project is estimated to cost $ over the course of the four-year period. The average cost annually will be $and includes all service delivery, data evaluation and dissemination costs. The project will utilize Innovation funding for the duration of the project.

Personnel Costs: The total estimated cost of MCBH personnel costs is $754,412 with an average annual salary cost of $188,602, over the four-year term of this project. This sum accounts for a 3% annual increase over the course of the project to reflect cost of living and step raise increases and is inclusive of the direct and indirect costs associated with these positions. The personnel costs cover the positions identified in Table 1. This Innovation project requires a robust team at the local level to further engage in stakeholder planning during the development of the PAD products and framework, and ultimately conduct trainings and implementation activities to support the acceptance and use of PAD's, PAD products, and the coordination of personal health information and crisis response. Several leadership positions across Administrative, Clinical and Information Technology departments will be required to provide oversight of this process, while more extensive participation will occur among staff participating in project coordination and reporting activities, and the deployment of PAD Teams in the field.
Table 1. PAD Innovation Project Personnel

Position	**Responsibilities**	**FTE**	**Average Annual Rate**
Program Coordinator	Project coordination, PAD product development review, project evaluation and reporting	0.25	$47,034
Clinical Therapist	PAD Team implementation	0.25	$46,816

Administrative Management Intern	Administrative support, evaluation and reporting	0.5	$16,316
Behavioral Health Bureau Administrator	Implementation planning, vendor procurement, PAD project development review	0.05	$13,903
Behavioral Health Services Manager	Implementation planning, clinical staff oversight, PAD product development review	0.05	$13,513
Quality Improvement Services Manager	Implementation planning, technology integration coordination, evaluation	0.05	$11,470
IT Services Manager	Technology integration planning and oversight, PAD product development review	0.05	$11,397
Behavioral Health Unit Supervisor	Implementation planning, clinical staff coordination, PAD product development review	0.05	$10,165
Accountant	Fiscal accounting and reporting	0.05	$9,348
Epidemiologist	Project evaluation	0.05	$8,640

Non-Recurring Costs: A budget of $5,000 has been established for the purchase of tablet devices to support the utilization of this application in the field.
Consultant Costs / Contracts: This Innovation project will require several consultants, with contracts to be established both through the multi-county collaborative and at the local level in Monterey County. The multi-county collaborative will be partnering in the acquisition of contracts for a statewide project manager, PAD subject matter experts, marketing and technology development vendors, and an evaluation consultant. Further description of these consultant costs is provided in the Innovation project application. Regarding rate of contribution towards contracts facilitated through the multi-county collaborative, Monterey County is contributing an amount that is equitable to its population within the group of participating counties. At the time of this application, Monterey County comprises 9% of the total population of the participating counties and are estimated at a total of $498,826 for the four-year term.

MCBH will also require consultants to support this Innovation project at the local level. This includes a part-time community engagement and project planning consultant at a rate of $50,000 annually, to assist in extensive stakeholder engagement and inter-agency coordination efforts as the PAD products are developed and deployed. Additionally, to support the requirements of staffing PAD Teams, MCBH will contract with legal aid and peer support providers. The estimated rate for contracting with a part-time legal aid is $30,000 annually. The estimated rate for contracting with a part-time peer staff coordinator and two peer support personnel is $100,000 annually. The costs identified in the 'Consultant Costs / Contracts' section of Table 2 below is inclusive of consultant costs occurred through the multi-county collaborative and locally through MCBH.

Use of Reversion Funds: This Innovation project will first utilize any unexpended Innovation funds from prior years that may be subject to reversion.

Table 2. Budget by Fiscal Year and Specific Budget Category for County Specific Needs

Monterey County BUDGET BY FISCAL YEAR AND SPECIFIC BUDGET CATEGORY*						
EXPENDITURES						
	PERSONNEL COSTS (salaries, wages, benefits)	**FY 21/22**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**TOTAL**
1.	Salaries	$115,827	$119,302	$122,881	$126,568	$484,578
2.	Direct Costs	$52,043	$53,604	$55,212	$56,868	$217,726
3.	Indirect Costs	$12,455	$12,829	$13,214	$13,610	$52,107
4.	**Total Personnel Costs**	$180,325	$185,735	$191,307	$197,046	$754,412
	OPERATING COSTS*					
5.	Direct Costs					
6.	Indirect Costs					
7.	**Total Operating Costs**					
	NON-RECURRING COSTS (equipment, technology)					
8.	Equipment – Tablets	$5,000				$5,000
9.						
10.	**Total non-recurring costs**	$5,000				$5,000
	CONSULTANT COSTS / CONTRACTS (clinical, training, facilitator, evaluation)					
11.	Direct Costs	$319,520	$304,102	$298,645	$296,559	$1,218,826
12.	Indirect Costs					
13.	**Total Consultant Costs**	$319,520	$304,102	$298,645	$296,559	$1,218,826
	OTHER EXPENDITURES (please explain in budget narrative)					
14.						
15.						
16.	**Total Other Expenditures**					
	BUDGET TOTALS					
	Personnel (total of line 1)	$115,827	$119,302	$122,881	$126,568	$484,578
	Direct Costs (add lines 2, 5, and 11 from above)	$371,563	$357,706	$353,857	$353,427	$1,436,552
	Indirect Costs (add lines 3, 6, and 12 from above)	$12,455	$12,829	$13,214	$13,610	$52,107
	Non-recurring costs (total of line 10)	$5,000				$5,000
	Other Expenditures (total of line 16)					
	TOTAL INNOVATION BUDGET	**$504,845**	**$489,837**	**$489,952**	**$493,605**	**$1,978,237**

Table 3. Total Budget Context – Expenditures by Funding Source and Fiscal Year (FY):

BUDGET CONTEXT – 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:**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**TOTAL**
1.	Innovative MHSA Funds	$488,002	$468,540	$467,226	$471,891	$1,895,657
2.	Federal Financial Participation					
3.	1991 Realignment					
4.	Behavioral Health Subaccount					
5.	Other funding					
6.	**Total Proposed Administration**					
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:**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**TOTAL**
1.	Innovative MHSA Funds	$16,843	$21,297	$22,726	$21,714	$82,580
2.	Federal Financial Participation					
3.	1991 Realignment					
4.	Behavioral Health Subaccount					
5.	Other funding					
6.	**Total Proposed Evaluation**					
TOTALS:						
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 21/22**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**TOTAL**
1.	Innovative MHSA Funds*	$504,845	$489,837	$489,952	$493,605	$1,978,237
2.	Federal Financial Participation					
3.	1991 Realignment					
4.	Behavioral Health Subaccount					
5.	Other funding**					
6.	**Total Proposed Expenditures**	$504,845	$489,837	$489,952	$493,605	$1,978,237

*** INN MHSA funds reflected in total of line C1 should equal the INN amount County is requesting.**
**** If "other funding" is included, please explain within budget narrative.**

Appendix: (Orange County)

County Contact and Specific Dates

- Primary County Contact: Flor Yousefian Tehrani, fyousefiantehrani@ochca.com, (714) 834-3104
- Date Proposal posted for 30-day Public Review: April 23, 2021
- Date of Local MH Board hearing: May 26, 2021
- Date of BOS approval or calendared date to appear before BOS: June 22, 2021

This proposal is specific to Orange County's participation in the Psychiatric Advance Directives (PADs) multi-county Innovation Project. It does not include all elements of an Innovation proposal (i.e., primary purpose, innovative component, full list of project activities, timeline, etc.). A comprehensive description of this MHSA Innovation Project is available in the full project proposal prepared by the PADs multi-county project manager.

Description of the Local Need

Orange County has identified an increasing need for behavioral health support and crisis services within its criminal justice and behavioral health systems. According to the 2019 Integrated Services Report, Orange County's jails and juvenile detention facilities are now, by default, its largest mental health institutions. Between May 2018 and April 2019, an estimated 43,000 individuals were booked. Of those 43,000 individuals who self-reported or were diagnosed while in-custody, approximately 21% had a mental illness; 40% suffered from substance use disorder and 10% have a co-occurring disorder[1].

Within the Behavioral Health System, Orange County has experienced an increase in suicide rates in recent years. From 2015 to 2018, the County experienced a 27% increase in suicide deaths, with the highest rates among White, male and middle age to older adult populations[2]. Furthermore, in a recent survey of Orange County residents, the rate of serious psychological distress increased from 12% in 2018-19, to 28% at the end of 2020[3].

Description of the Response to the Local Need

In response to these needs, Orange County identified specific strategies within each of these systems through the Integrated Services 2025 Vision and the Fiscal Year (FY) 2020-23 MHSA Strategic Priorities:

Integrated Services 2025 Vision

The Integrated Services Strategy is a collaborative success strategy focused on implementing enhanced care coordination for the County's highest utilizers of the Community Corrections System. Through this strategy, the County plans to work with community partners to implement programs, services and solutions that are measurable and meaningful. Integrated Services is categorized into Five Pillars of Service that mirror the County's corrections system. Each Pillar is comprised of a series of Action Items necessary to achieve the County's Integrated Services 2025 Vision.

FY 2020-23 MHSA Strategic Priorities

The FY 2020-23 MHSA Strategic Priorities are based on results from the 2019 MHSA community program planning process. Input from stakeholders identified three areas of mental health-related needs, gaps and barriers, including mental health awareness and

[1] Integrated Services 2025 Vision
[2] Suicide Deaths in Orange County, California, 2014-2018
[3] Orange County COVID Stress Survey

stigma reduction, suicide prevention and access to behavioral health services. The MHSA Three-Year Program and Expenditure Plan emphasizes Orange County's plans to expand support to behavioral health consumers to ensure that crisis services and suicide prevention efforts are responsive to the needs of the different MHSA priority populations. Additional information about the 2019 MHSA community program planning process and strategic priorities is available in the MHSA Three Year Program and Expenditure Plan.

The PADs project aligns with the goals in the Integrated Services 2025 Vision and FY 2020-23 MHSA Strategic Priorities and blends seamlessly into the objectives and actionable goals identified within these current priorities. The process of developing a PAD can help people clarify their preferences for treatment and plan for a future mental health crisis, serving as a powerful tool to increase a person's quality of care within the mental health and justice-involved settings. Furthermore, the ability to access and share PADs across providers and systems will allow providers and first responders to provide personalized, responsive and coordinated care.

Target Population

The target population for this multi-county project includes individuals living with serious mental illness who are at risk of needing involuntary care, criminal justice involvement and involuntary hospitalization. Based on the identified target population, the County's needs within the criminal justice and behavioral health systems and their associated strategic priorities, Orange County is proposing to pilot the development and implementation of PADs within its Correctional Health Services and Behavioral Health Services programs. The pilot project will focus on Transitional Age Youth (TAY) ages 18-21, and adults, 18 and older, from the following programs:

***Program of Community Assertive Treatment (PACT)*:** The PACT program utilizes the evidence-based Assertive Community Treatment model to provide comprehensive, "whatever it takes", field-based outpatient services to youth, ages 14-21 or 18-25, who are living with serious emotional disturbance or serious mental illness. Individuals enrolled in PACT may also have a co-occurring substance use disorder, experience social, cultural and/or linguistic isolation, and have had difficulty engaging with more traditional outpatient mental health services.

The PACT program provides an individualized treatment approach, utilizing a strengths-based model to help participants customize their treatment plans. The program is staffed with a multidisciplinary team that includes Mental Health Specialists, Clinical Social Workers, Marriage and Family Therapists, Peer Specialists, Psychiatrists and Supervisors. Peer Specialists serve as positive models and provide valuable support and information both to the participants and the other team members.

Pilot Plan: Orange County PACT program staff, participants and their families will be invited to PADs informational sessions, as well as interactive, multi-county workgroups to provide feedback on the development of a standardized PADs template. Stakeholders from all participating counties in this project will also be invited to workgroups to discuss the development of a PADs platform. The future implementation of PADs will be integrated into PACT program daily operations as part of clinical, case management and peer specialist support services. Throughout the duration of this project, the PADs project Peers will provide training and support to PACT program staff and participants, as needed.

***Correctional Health Services*:** Adult Correctional Health Services (ACHS) provides medical, dental, nursing, infections control, health education and pharmaceutical services at a community standard of care to all adult inmates in the County's correctional facilities and contracts with hospitals for inpatient and specialty care. ACHS also provides mental health services including 24-hour emergency triage and crisis intervention, suicide prevention, treatment beds, individual and group therapy, and substance abuse counseling, medication assessment and discharge planning to all adult inmates in the County's five correctional facilities. Services also include collateral contacts with Sheriff's Department, criminal justice system, mental health professionals, families, and friends for the purpose of effective continuing care during incarceration. ACHS provides care coordination services for linkage, referral to community mental health services and discharge planning for post custody treatment service, as well as coordination with long term care for psychiatric hospitalization, as appropriate.

Pilot Plan: To facilitate a successful integration of PADs in ACHS, the process should begin in the community, with the development of PADs integrated into Orange County's Substance Use Disorder (SUD) clinics, Crisis Stabilization Units (CSUs), Psychiatric Emergency Response Team (PERT), and PACT program, where many inmates typically receive services prior to incarceration. The prior development of a PAD will allow the ACHS team access to valuable information about the individual during the initial assessment and mental health treatment. PADs would also be developed with individuals during their incarceration, as well as upon discharge, to help support their needs and reduce recidivism.

In the first year of the PADs project, program staff from ACHS, SUD clinics, CSUs and PERT will be invited to informational sessions to learn about the purpose, use and benefits of PADs. Staff, participants and support persons will also be invited to multi-county workgroups to provide feedback on the development of a PADs template and platform. Throughout the duration of this project, the PADs project Peers will be available to support ACHS and the various associated programs.

Orange County also recognizes the importance of supporting youth under age 18. Although this age group is not a target population for this project, Orange County plans to facilitate preliminary discussions to explore the feasibility of implementing PADs with youth, particularly discussions around legal, clinical and ethical implications. These learnings will be shared with the participating counties in this project to support any future work with the target population.

Learning Objectives

Orange County's evaluation and learning plan is consistent with the two primary aims identified in the multi-county collaborative proposal, which include 1) to successfully implement PADs in participating counties, and 2) for PADs to positively affect consumer outcomes.

Orange County also proposes to include an additional process evaluation of the PADs technology platform. The evaluation will examine responsiveness to community feedback during platform development, level of user satisfaction, and the intuitive nature of the platform (i.e., ease of use). The iterative cycle and feedback loop from community engagement meetings will be documented to illustrate the evolution of the PADs platform. This process evaluation will be shared with the

participating counties and ensure, to the extent possible, that the platform meets high user satisfaction and can help inform the likelihood of long-term adoption and use.

Description of the Local Community Planning Process
The PADs multi-county project opportunity was introduced at the April 20, 2020 MHSA Steering Committee meeting. At the subsequent meeting on May 27, 2020, subject matter experts from the USC Gould Saks Institute for Mental Health Law, Policy and Ethics provided specific information about the project description and proposed activities. However, during this time, Fresno County, the lead for this multi-county project, announced that all project planning activities were placed on hold due to the impact and response to the COVID-19 pandemic. In January 2021, a project manager was bought on board by the Mental Health Services Oversight and Accountability Commission (MHSOAC) to support the continuation of this multi-county effort. Orange County, along with the other interested counties, resumed planning discussions for the PADs Innovation project in February 2021. As part of the Community Program Planning Process, Orange County consumers, family members and providers were invited to a PADs informational session on April 1, 2021. The following week, on April 7, 2021, an informational session was held for Behavioral Health Boards, Supervisors and Commissions, as well as representatives from criminal justice. On April 15, 2021, Orange County MHSA staff hosted a community planning meeting to focus specifically on the County's proposed participation in this project. Orange County stakeholders will continue receiving invitations to various informational sessions throughout April and May.

The project was posted for 30-day public comment on April 23, 2021, and a public hearing will be held on May 26, 2021. Orange County plans to seek Board of Supervisor approval for this Innovation project on June 22, 2021.

Budget Narrative for County Specific Needs:
The total proposed budget for this four-year project is $12,888,948. This proposal will utilize and encumber funds from FY 2019-20, FY 2020-21 and future years, as well as any unspent funds from previously approved Innovation projects. Project expenditures are categorized into four main areas and described in detail below.

OC Personnel
A Full-Time Equivalent (FTE) position equals 40 hours per week. All FTE positions include benefits. Orange County's implementation of the PADs Innovation project will include the following proposed staffing:

- *Administrative Manager (0.05 FTE)* – This position is responsible for administrative oversight of the project such as monitoring project expenditures; attending collaborative meetings, as needed; and providing ongoing status updates to local stakeholders. The estimated budget for 0.05 FTE is $5,895 annually; $23,579 over four years.

- *PADs Project Manager (0.50 FTE)* – This position is responsible for direct project management. This includes attending project implementation meetings; coordinating and communicating with pilot programs; and supporting project peers. The estimated budget for 0.50 FTE is $45,739 annually; $182,956 over four years.

- *Peers (2.5 FTE)* – This position is responsible for supporting the implementation activities of the project. This includes providing community PAD trainings, as needed; attending PAD multi-county planning and implementation meetings; and supporting Orange County pilot programs

participating in the project. The estimated budget for 2.5 FTE is $146,150 annually; $584,602 over four years.

The implementation of PADs will also be supported through in-kind staffing from the Orange County pilot programs, as part of program service delivery. Indirect costs were also calculated at 18% of personnel costs to support Orange County Health Care Agency (HCA) Compliance, Information Technology, County Counsel and Contract departments providing local county consultation, as needed. Orange County's total estimated personnel cost is $933,542 over four years.

Operating Costs
Direct operating costs include:

- *Subscriptions, licenses:* Norton antivirus $100 annually for two laptops to be used by Peers; $400 over four years
- *Print/Materials* – $2,000 annually; $8,000 over four years
- *Translation* – $60,000 total for translation of program materials and related content into Orange County's threshold languages (i.e., Arabic, Farsi, Korean, Mandarin, Spanish and Vietnamese), as well as Khmer and Tagalog.
- *Smartphone service and data plan* – $2,724 annually for two smartphones to be used by Peers; $10,896 over four years

Orange County's total estimated direct operating cost is $79,296 over four years.

Consultants

- *Collaborative Consultants:* Orange County's contribution to this multi-county project is calculated at 65.9% of direct and indirect consultant costs. This percentage is based on Orange County's total population size among the five participating counties (i.e., Fresno, Mariposa, Monterey, Orange and Shasta). Costs include contracts with various consultants for project management, PAD trainings, project evaluation, and media and marketing. The budget also includes 9% administrative costs.

  The collaborative consultant costs include two areas that do not relate to Orange County and are not calculated as part of its collaborative contribution. These areas include consultants for stakeholder engagement in the development of a PADs technology platform and an associated 9% administrative fee. Orange County budgeted for a stakeholder process as part of the local technology consultant costs described below and because it is proposed as a local contract, an administrative fee is not necessary.

  Orange County's total estimated contribution to collaborative consultants is not to exceed $1,545,470 over four years. Collaborative costs may change in the event additional counties are approved by the MHSOAC to join this Innovation project.

- *Local Orange County Consultants*:

  Technology Consultants: Orange County is proposing to support the technology consultant staffing costs for the PADs platform through a direct contract with Chorus Innovations, Inc. Orange County is currently working with Chorus Innovations, Inc. for the development of a digital resource navigation tool, OC Navigator, as part of a separate MHSOAC-approved

Innovation project, (i.e., Behavioral Health System Transformation). The OC Navigator is being developed using the Chorus platform and is currently being piloted within the County's OC Links and mobile Crisis Assessment Team programs to support a single behavioral health access line for Orange County residents. Utilizing the Chorus platform for the development, storage and access of PADs would enable Orange County to leverage its existing efforts with the OC Navigator, expanding its capacity and creating a more comprehensive tool for Orange County residents.

The Chorus platform provides a base on which core functions can be built and allows for custom functionality, integration and capacity building. The development of a product built on this platform is driven by a participatory engagement process where community members provide input on design features. This allows the product that is being built to adapt to local needs and continuously improve based on community feedback.

The capabilities of the Chorus platform, including interoperability to exchange health information, access to other existing digital support systems and ability to create a user profile, result in an interactive platform. PADs would be housed in a centralized location, allowing providers who have permission to view the PAD to access it when an individual is in crisis. This allows a flow of information across multiple systems – connecting and coordinating in a way that does not currently exist in the access and sharing of PADs. At present, for a provider or first responder to access a PAD during crisis, an individual must actively access and share their PAD *in the moment* or have shared it with the provider or first responder *prior to* the crisis. This poses challenges and barriers for an individual in crisis. A platform that allows law enforcement, hospitals, correctional health facilities to access PADs will coordinate care and allow them to respond in a way that meets the needs of the individual.

With the development of the OC Navigator already in progress, Orange County would be able to coordinate care through a single system, creating efficiency through a streamlined system. Because this is a multi-county project, Orange County will extend the opportunity for other counties in this project to participate in the development of the PADs platform via Chorus if they so choose. For counties that choose to also utilize the Chorus platform, their stakeholders would be invited to actively participate in workgroups and provide input on the development of the PADs platform. In the event counties select different platform(s) for PADs, Orange County will explore the interoperability of the Chorus platform with the different platform(s) to maintain its coordinated system.

The total estimated cost for supporting technology consultant staff is $2,000,000 annually; $8,000,000 over four years.

Evaluation: Because PADs and the OC Navigator would be developed on the same Chorus platform, Orange County is proposing to also support the evaluation of the platform, allowing the participating counties to leverage the work and resources that are currently underway. The total estimated budget Orange County will add to the evaluation is $575,000 annually; $2,300,000 over four years.

Orange County's total estimated contribution to collaborative and local consultants is $11,845,470 over four years.

Other Costs

- *Travel*: travel costs include quarterly statewide meetings, as well as mileage expenses for local travel. The total estimated budget for travel is $7,660 annually; $30,640 over four years.

Orange County's total estimated other costs are $30,640 over four years.

Total Estimated Budget

Orange County's local project costs are $11,343,478 and its contribution to the collaborative is $1,545,470, over 4 years. The total estimated four-year budget for Orange County's participation in the multi-county PADs Innovation Project is not to exceed **$12,888,948**.

A detailed breakdown of the budget by fiscal year is provided in the grid below. Numbers in **orange** reflect Orange County's contribution in the PADs INN Project. These budget sheets were taken from Innovations Template.

Budget by Fiscal Year and Specific Budget Category for County Specific Needs

Orange BUDGET BY FISCAL YEAR AND SPECIFIC BUDGET CATEGORY						
EXPENDITURES						
	PERSONNEL COSTS (salaries, wages, benefits)	**FY 21/22**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**TOTAL**
1.	Salaries	$197,784	$197,784	$197,784	$197,784	$791,137
2.	Direct Costs					
3.	Indirect Costs	$35,601	$35,601	$35,601	$35,601	$142,405
4.	**Total Personnel Costs**	$233,385	$233,385	$233,385	$233,385	**$933,542**
	OPERATING COSTS					
5.	Direct Costs	$19,824	$19,824	$19,824	$19,824	$79,296
6.	Indirect Costs					
7.	**Total Operating Costs**	$19,824	$19,824	$19,824	$19,824	**$79,296**
	NON-RECURRING COSTS (equipment, technology)					
8.						
9.						
10.	**Total non-recurring costs**					**$0**
	CONSULTANT COSTS / CONTRACTS (clinical, training, facilitator, evaluation)					
11.	Direct Costs: Project Manager and County TA Lead OC costs @65.9%	$199,680 $131,589	$171,392 $112,947	$176,534 $116,336	$163,800 $107,944	$711,406 $468,817
12.	Indirect Costs: Travel, Office Misc., Technology OC costs @65.9%	$6,000 $3,954	$6,000 $3,954	$6,000 $3,954	$6,000 $3,954	$24,000 $15,816
11.	Direct Costs: PAD Trainer	$144,000	$73,000	$36,000	$36,000	$289,000

	OC costs @65.9%	$94,896	$48,107	$23,724	$23,724	$190,451
12.	Indirect Costs: Travel, Office Misc., Technology OC costs @65.9%	$2,500 $1,648	$5,000 $3,295	$1,000 $659	$1,000 $659	$9,500 $6,261
11.	Direct Costs: Evaluation OC costs @65.9%	$54,716 $36,058	$150,522 $99,194	$177,289 $116,833	$144,109 $94,968	$526,636 $347,053
12.	Indirect Costs: Travel, Office Misc., Technology OC costs @65.9%	$6,992 $4,608	$25,809 $17,008	$29,268 $19,288	$28,925 $19,062	$90,994 $59,965
11.	Direct Costs: Media/Print/Video production, Social Marketing OC costs @65.9%	$275,000 $181,225	$85,800 $56,542	$48,400 $31,896	$74,250 $48,931	$483,450 $318,594
12.	Indirect Costs: Travel, Office Misc., Technology OC costs @65.9%		$14,200 $9,358	$1,600 $1,054	$750 $494	$16,550 $10,906
11.	Direct Costs: Administration 9% OC costs @65.9%					$193,638 $127,607
11.	Direct Costs *(4 counties only)*: Platform Stakeholder Engagement OC costs	$250,000	$250,000	$250,000	$250,000	$1,000,000 N/A
11.	Direct Costs *(4 counties only)*: Platform Stakeholder Engagement Administration 9% OC costs	$22,500	$22,500	$22,500	$22,500	$90,000 N/A
11.	Direct Costs *(OC Only)*: Technology Consultants	$2,000,000	$2,000,000	$2,000,000	$2,000,000	$8,000,000
11.	Direct Costs *(OC Only)*: Evaluation	$575,000	$575,000	$575,000	$575,000	$2,300,000
13.	Total Consultant Costs (5 Counties) OC Collaborative Consultant Costs Local Consultant Costs **Total OC Consultant Costs**					$2,345,174 $1,545,470 $10,300,000 **$11,845,470**

	OTHER EXPENDITURES (please explain in budget narrative)					
14.	HCA Travel	$7,660	$7,660	$7,660	$7,660	$30,640
15.	**Total Other Expenditures**	$7,660	$7,660	$7,660	$7,660	**$30,640**
	BUDGET TOTALS					
	Personnel (total of line 1)	$197,784	$197,784	$197,784	$197,784	$791,137
	Direct Costs (add lines 2, 5, and 11 from above)	$2,957,954	$2,957,954	$2,957,954	$2,957,954	$11,831,818
	Indirect Costs (add lines 3, 6, and 12 from above)	$58,838	$58,838	$58,838	$58,838	$235,353
	Non-recurring costs (total of line 10)					$0
	Other Expenditures (total of line 16)	$7,660	$7,660	$7,660	$7,660	$30,640
	TOTAL INNOVATION BUDGET	$3,222,237	$3,222,237	$3,222,237	$3,222,237	**$12,888,948**

Total Budget Context – Expenditures by Funding Source and Fiscal Year (FY):

BUDGET CONTEXT – 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:**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**TOTAL**
1.	Innovative MHSA Funds	$2,647,237	$2,647,237	$2,647,237	$2,647,237	$10,588,948
2.	Federal Financial Participation					
3.	1991 Realignment					
4.	Behavioral Health Subaccount					
5.	Other funding					
6.	**Total Proposed Administration**	$2,647,237	$2,647,237	$2,647,237	$2,647,237	**$10,588,948**

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:**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**TOTAL**
1.	Innovative MHSA Funds	$575,000	$575,000	$575,000	$575,000	$2,300,000
2.	Federal Financial Participation					
3.	1991 Realignment					
4.	Behavioral Health Subaccount					
5.	Other funding					
6.	**Total Proposed Evaluation**	$575,000	$575,000	$575,000	$575,000	**$2,300,000**
TOTALS:						
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 21/22**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**TOTAL**
1.	Innovative MHSA Funds*	$3,222,237	$3,222,237	$3,222,237	$3,222,237	$12,888,948
2.	Federal Financial Participation					
3.	1991 Realignment					
4.	Behavioral Health Subaccount					
5.	Other funding**					
6.	**Total Proposed Expenditures**	$3,222,237	$3,222,237	$3,222,237	$3,222,237	**$12,888,948**

*** INN MHSA funds reflected in total of line C1 should equal the INN amount County is requesting**

**** If "other funding" is included, please explain within budget narrative.**

Appendix: Shasta County

County Contact and Specific Dates

- **Primary County Contact**: Kerri Schuette, kschuette@co.shasta.ca.us, (530) 209-6284
- **Date Proposal posted for 30-day Public Review**: May 24, 2021
- **Date of Local MH Board hearing**: June 23, 2021
- **Date of BOS approval or calendared date to appear before BOS**: June 29, 2021

Description of the Local Need

When a person is experiencing a mental health crisis, it can be difficult for that person to state their preferences for treatment. Without a Psychiatric Advance Directive, law enforcement, hospital staff, and other care providers can be operating blindly in terms of what types of medications work well for the patient, what other medical conditions exist, what may de-escalate the patient, what may trigger the patient, and other variables that are critical to safe, effective care. Shasta County patients and families have expressed that they often feel helpless when dealing with law enforcement and hospital staff because they feel they have no control over their own situation, and a Psychiatric Advance Directive would empower that person to use their voice, even when they are incapacitated.

Locally, the timing is very good to begin working on a PAD system, as law enforcement and peer support have been added to the mental health care system in several significant ways. Crisis Intervention Trainings have become more standardized in our local law enforcement agencies, and a mobile crisis team was launched earlier this year, in which law enforcement and clinicians go out on calls together and work as a team to assist people experiencing mental health crisis. Our peer support specialists have trained hundreds of people in WRAP techniques, and they believe a standardized system for creating and retrieving person-centered Psychiatric Advanced Directives would be a useful next step in helping patients access the services they need more effectively, so they can return to independence more quickly. Shasta County is also inspired by other jurisdictions' experiences in which creation of PADs has built trust with community members, prompting them to voluntarily seek more preventative levels of mental health care, and it is our strong desire to replicate that.

We anticipate focusing first on people experiencing homelessness, and will rely on stakeholders to advise on what populations would be a priority next as the program rolls out and we learn more about it.

Description of the Response to the Local Need

This project will help Shasta County:

- Build community capacity among law enforcement, peers, the court system, mental health care providers and others to ensure consumer choice and collaborative decision-making.
- Improve participant care in a crisis.
- Reduce recidivism.
- Engage participants in their treatment and recovery.

Description of the Local Community Planning Process

The PAD concept was described to stakeholders during a March 30, 2021, quarterly stakeholder meeting, and the concept was received favorably. Stakeholders were invited to the online

informational meeting on April 7, with information also posted on our website. Three Shasta County residents attended the April 7 meeting, including a Mental Health, Alcohol and Drug Advisory Board member. The Mental Health Services Act coordinator also described this project to the Mental Health, Alcohol and Drug Advisory Board on March 3, and board members supported the concept. This plan will be circulated for public comment starting May 24, 2021, and it will go to the Mental Health, Alcohol and Drug Advisory Board on June 23, 2021. It is scheduled to go before the Shasta County Board of Supervisors on June 29, 2021.

Budget Narrative for County Specific Needs:

In addition to the personnel costs detailed below, Shasta County's budget includes peer incentives or training, office materials, and technology needs, such as laptops for the three direct services staff. We do not anticipate other large expenses for this project at this time.

Personnel (narrative)

Shasta County will employ a Community Development Coordinator to serve as liaison between the PAD team, the Program Manager II (the Mental Health Services Act coordinator), and the consultant. The PAD team would include a peer support specialist who would conduct the interviews with clients, and a medical services clerk who would take notes during the interviews so the peer support specialist could fully engage with the client. The staff services analyst would be responsible for managing evaluation, and the accountant auditor is responsible for the budget.

Personnel will include:

Community Development Coordinator (.20 FTE)
Peer Support Specialist (.20 FTE)
Medical Services Clerk (.20 FTE)
Program Manager II (.10 FTE)
Staff Services Analyst (.20 FTE)
Accountant Auditor (.20 FTE)

Operating Costs

The total estimated indirect cost for this 4-year project is: $162,110.

Other Costs

N/A

Total Estimated Budget

Shasta County's total estimated 4-year budget is $630,731. A detailed breakdown of the budget by fiscal year is provided in the grid below. Budget sheets taken from Innovations Template.

Budget by Fiscal Year and Specific Budget Category for County Specific Needs

Shasta BUDGET BY FISCAL YEAR AND SPECIFIC BUDGET CATEGORY*							
EXPENDITURES							
	PERSONNEL COSTS (salaries, wages, benefits)	**FY 21/22**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY xx/xx**	**TOTAL**
1.	Salaries	**$20,000**	**$20,000**	**$20,000**	**$20,000**		**$80,000**
2.	Direct Costs	**$24,000**	**$24,000**	**$24,000**	**$24,000**		**$96,000**
3.	Indirect Costs	**$34,000**	**$34,000**	**$34,000**	**$34,000**		**$136,000**
4.	**Total Personnel Costs**	**$78,000**	**$78,000**	**$78,000**	**$78,000**		**$ 312,000**
	OPERATING COSTS*						
5.	Direct Costs	**$16,000**	**$16,000**	**$16,000**	**$16,000**		**$64,000**
6.	Indirect Costs	**$3,000**	**$3,000**	**$3,000**	**$3,000**		**$12,000**
7.	**Total Operating Costs**	**$19,000**	**$19,000**	**$19,000**	**$19,000**		**$76,000**
	NON-RECURRING COSTS (equipment, technology)						
8.	**Laptops, iPads, other equipment and technology**	**$15,000**					**$15,000**
9.							
10.	**Total non-recurring costs**	**$15,000**					**$15,000**
	CONSULTANT COSTS / CONTRACTS (clinical, training, facilitator, evaluation)						
11.	Direct Costs	**$56,798**	**$46,722**	**$45,477**	**$44,624**		**$193,621**
12.	Indirect Costs	**$1,307**	**$4,959**	**$3,930**	**$3,914**		**$14,110**
13.	**Total Consultant Costs**	**$58,105**	**$51,681**	**$49,407**	**$48,538**		**$207,731**
	OTHER EXPENDITURES (please explain in budget narrative)						

14.							
15.							
16.	**Total Other Expenditures**						**$**
	BUDGET TOTALS						
	Personnel (total of line 1)	**$20,000**	**$20,000**	**$20,000**	**$20,000**		**$80,000**
	Direct Costs (add lines 2, 5, and 11 from above)	**$96,798**	**$86,722**	**$85,477**	**$84,624**		**$353,621**
	Indirect Costs (add lines 3, 6, and 12 from above)	**$38,307**	**$41,959**	**$40,930**	**$40,914**		**$ 162,110**
	Non-recurring costs (total of line 10)	**$15,000**					**$15,000**
	Other Expenditures (total of line 16)						**$**
	TOTAL INNOVATION BUDGET	**$170,105**	**$148,681**	**$146,407**	**$145,538**		**$610,731**

Total Budget Context – Expenditures by Funding Source and Fiscal Year

BUDGET CONTEXT – 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:**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**TOTAL**
1.	Innovative MHSA Funds	**$4,000**	**$4,000**	**$4,000**	**$4,000**		**$16,000**
2.	Federal Financial Participation						
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other funding						
6.	**Total Proposed Administration**	**$4,000**	**$4,000**	**$4,000**	**$4,000**		**$16,000**
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:**	**FY 21/22**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**TOTAL**
1.	Innovative MHSA Funds	**$1,000**	**$1,000**	**$1,000**	**$1,000**		**$4,000**
2.	Federal Financial Participation						
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other funding						
6.	**Total Proposed Evaluation**	**$1,000**	**$1,000**	**$1,000**	**$1,000**		**$4,000**
TOTALS:							
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 21/22**	**FY 22/23**	**FY 23/24**	**FY 24/25**	**FY 25/26**	**TOTAL**
1.	Innovative MHSA Funds*	**$175,105**	**$153,681**	**$151,407**	**$150,538**		**$630,731**
2.	Federal Financial Participation						**$**

3.	1991 Realignment						**$**
4.	Behavioral Health Subaccount						**$**
5.	Other funding**						**$**
6.	**Total Proposed Expenditures**	**$175,105**	**$153,681**	**$151,407**	**$150,538**		**$630,731**

*** INN MHSA funds reflected in total of line C1 should equal the INN amount County is requesting**

**** If "other funding" is included, please explain within budget narrative.**

Appendix B- Letters of Support

California Association of Local Behavioral Health Boards and Commissions

April 20, 2021

Lynne Ashbeck, Chair
Mara Madrigal-Weiss, Vice Chair
Mental Health Services Oversight & Accountability Commission
& MHSOAC Commissioners
Via Email

Dear Chair Ashbeck, Vice Chair Madrigal-Weiss and Commissioners,

CALBHB/C's Governing Board is in strong support of the proposed multi-county collaborative **Psychiatric Advanced Directives (PADs) MHSA Innovation Project**.

PADs are an important tool to minimize mental health crisis and involuntary care. Drafted when a person is well enough to consider preferences for future mental health treatment, PADs allow:

- Individuals to document their preferences for mental health treatment.
- The appointment of a health proxy to interpret those preferences during a crisis.
- Use when a person becomes unable to make decisions during a mental health crisis.

This Innovation Project will help counties improve access to appropriate and effective care, while respecting a person's preferences. We are glad to see goals toward scaling the effective use of PADs throughout California, with efforts to standardize, integrate, communicate, train and provide ready access to PADs, while engaging the expertise of diverse ethnic, racial and cultural communities, "Peer Support Specialists", individuals with lived experience and their family members.

We encourage your support for the multi-county collaborative PADs MHSA Innovation Project.

Sincerely,

Harriette S. Stevens, Ed.D., President

Theresa Comstock, Executive Director

cc: Toby Ewing, Ph.D., Executive Director, MHSOAC

NAMI California
National Alliance on Mental Illness

Lynne Ashbeck, Chair
Mara Madrigal-Weiss, Vice Chair
Mental Health Services Oversight & Accountability Commission
& MHSOAC Commissioners

April 26, 2021

Dear Chair Ashbek, Vice Chair Madrigal-Weiss and Commissioners,

NAMI California is in strong support of the proposed multi-county collaborative **Psychiatric Advanced Directives (PADs) MHSA Innovation Project**. PADs are an important tool to minimize mental health crisis and involuntary care. Drafted when a person is well enough to consider preferences for future mental health treatment, PADs allow:

- Individuals to document their preferences for mental health treatment.
- The appointment of a health proxy to interpret those preferences during a crisis.
- Use when a person becomes unable to make decisions during a mental health crisis.

This Innovation Project will help counties improve access to appropriate and effective care, while respecting a person's preferences. We are glad to see goals toward scaling the effective use of PADs throughout California, with efforts to standardize, integrate, communicate, train and provide ready access to PADs, while engaging the expertise of diverse ethnic, racial and cultural communities, "Peer Support Specialists", individuals with lived experience and their family members.

We encourage your support for the multi-county collaborative PADs MHSA Innovation Project.

Sincerely,

Jessica Cruz, MPA/HS
CEO
NAMI California

NAMI California
425 University Ave., Suite 222
Sacramento, CA 95825
916-567-0163

Appendix C- CPPP Presentation Flyers

Psychiatric Advanced Directives Informational Presentation

March 18, 2021
10:00AM-11:30AM

Please join us for an informational session to learn about psychiatric advanced directives (PADs).

Mental Health Lawyer and Consumer Advocate **Laurie Hallmark** will discuss advocacy for people living with serious mental illness. Topics will include the use of PADs as a foundation for Supportive Decision Making and how PADs can assist in the reduction of recidivism within the cycle of incarceration, homelessness, and hospitalization. Ms. Hallmark is employed by the Texas Rio Grande Legal Aid, as a Special Projects Director for Mental Health Programs and is an advisor to the State of California MHSA multi-county Innovations PADs Project.

Who should attend:
Behavioral Health Advisory Boards and Commissions, Board of Supervisors, Law Enforcement, Public Guardians, County Mental Health Plans, local NAMI chapter and MHSA Stakeholders.

Zoom Information:

You are invited to a Zoom meeting.

When: Mar 18, 2021 10:00 AM Pacific Time (US and Canada)

Register in advance for this meeting:

https://zoom.us/meeting/register/tJcrcuCrrD4pG9DvPcRGG2uPXMDaDa8bfdJ2

After registering, you will receive a confirmation email containing information about joining the meeting.

For additional questions, please contact your county MHSA Coordinator or Kiran Sahota at ksahota@conceptsforward.com

Interested Counties:

DEPARTMENT of BEHAVIORAL HEALTH

This presentation is in accordance with the Mental Health Services Act, Community Program Planning Process; CCR, 9 CA ADC § 3200, 3200.060, 3200.270, 3200.90, 3300, 3315, 3320 & WIC 5848(a,b,f) & 5604.2(4).

Presentación informativa sobre las Declaraciones de Voluntad Psiquiátrica Anticipada

Marzo 18, 2021
10:00AM-11:30AM

Les invitamos a una sesión informativa para aprender sobre las Declaraciones de Voluntad Psiquiátrica Anticipada (PADs, por sus siglas en inglés).

Laurie Hallmark, licenciada en salud mental y defensora del consumidor, hablará sobre la defensa de personas que viven con enfermedades mentales graves. Los temas a tratar incluyen el uso de PADs como base para la toma de decisiones de apoyo, y cómo las PADs pueden ayudar a reducir la reincidencia en el ciclo de encarcelamientos. La Srta. Hallmark trabaja como Directora de Proyectos Especiales del Programa de Salud Mental en la Fundación de Asistencia Legal Texas Rio Grande, y además es asesora en el proyecto Innovations PADS que es parte de la Ley de Servicios de Salud Mental (MHSA) del estado de California y en el que participan varios condados.

Quién debe asistir: Comités y juntas asesoras de salud conductual, consejos de regidores, agencias de seguridad, defensores públicos, representantes de salud mental de los condados, delegaciones NAMI locales y grupos de interés en la ley MHSA.

Información de Zoom:

Está usted invitado a una reunión de Zoom:

Cuándo: 18 Marzo, 2021 10:00 AM hora Pacífico (EEUU y Canadá)

Inscríbase por adelantado para la reunión:

https://zoom.us/meeting/register/tJcrcuCrrD4pG9DvPcRGG2uPXMDaDa8bfdJ2

Tras inscribirse recibirá un correo electrónico de confirmación con la información sobre cómo asistir a la reunión. Si tiene más preguntas por favor póngase en contacto con el Coordinador MHSA de su condado o con Kiran Sahota ksahota@conceptsforward.com

Condados interesados:

DEPARTMENT of BEHAVIORAL HEALTH

Esta presentación se realiza de acuerdo con el Proceso de Planificación del Programa Comunitario de la Ley de Servicios de Salud Mental.CCR, 9 CA ADC § 3200, 3200.060, 3200.270, 3200.90, 3300, 3315, 3320 & WIC 5848(a,b,f) & 5604.2(4).

CONCEPTSFORWARD CONSULTING

MHSOAC Mental Health Services Oversight & Accountability Commission

CalMHSA

Psychiatric Advanced Directives Informational Presentation

April 1, 2021
10:00AM-11:30AM

Please join us for an informational session to learn about psychiatric advanced directives (PADs).

Mental Health Lawyer and Consumer Advocate **Laurie Hallmark** will discuss advocacy for people living with serious mental illness. Topics will include the use of PADs as a foundation for Supportive Decision Making and how PADs can assist in the reduction of recidivism within the cycle of incarceration, homelessness, and hospitalization. Ms. Hallmark is employed by the Texas Rio Grande Legal Aid, as a Special Projects Director for Mental Health Programs and is an advisor to the State of California MHSA multi-county Innovations PADs Project.

Who should attend:
Consumers and Consumer Advocacy Groups, Peers, Consumer service providers and MHSA Stakeholders.

Zoom Information:

You are invited to a Zoom meeting.

When: April 1, 2021 10:00 AM Pacific Time (US and Canada)

Register in advance for this meeting:

https://zoom.us/meeting/register/tJcsdemhrzosG90zrcNna9hh1M_-GwDyaNIt

After registering, you will receive a confirmation email containing information about joining the meeting.

For additional questions, please contact your county MHSA Coordinator or Kiran Sahota at ksahota@conceptsforward.com

Interested Counties:

The County of Fresno 1856 — Department of Behavioral Health

OC Health Care Agency

Monterey County Behavioral Health — Avanzando Juntos Forward Together

Shasta County Health & Human Services Agency

This presentation is in accordance with the Mental Health Services Act, Community Program Planning Process; CCR, 9 CA ADC § 3200, 3200.060, 3200.270, 3200.90, 3300, 3315, 3320 & WIC 5848(a,b,f) & 5604.2(4).

Presentación informativa sobre las Declaraciones de Voluntad Psiquiátrica Anticipada

Abril 1, 2021
10:00AM-11:30AM

Les invitamos a una sesión informativa para aprender sobre las Declaraciones de Voluntad Psiquiátrica Anticipada (PADs, por sus siglas en inglés).

Laurie Hallmark, licenciada en salud mental y defensora del consumidor, hablará sobre la defensa de personas que viven con enfermedades mentales graves. Los temas a tratar incluyen el uso de PADs como base para la toma de decisiones de apoyo, y cómo las PADs pueden ayudar a reducir la reincidencia en el ciclo de encarcelamientos. La Srta. Hallmark trabaja como Directora de Proyectos Especiales del Programa de Salud Mental en la Fundación de Asistencia Legal Texas Rio Grande, y además es asesora en el proyecto Innovations PADS que es parte de la Ley de Servicios de Salud Mental (MHSA) del estado de California y en el que participan varios condados.

Quién debe asistir: Consumidores y grupos de defensa del consumidor, personas interesadas, proveedores de servicios al consumidor y grupos de interés en la ley MHSA.

Información de Zoom:

Está usted invitado a una reunión de Zoom:

Cuándo: 18 Marzo, 2021 10:00 AM hora Pacífico (EEUU y Canadá)

Inscríbase por adelantado para la reunión:

https://zoom.us/meeting/register/tJcrcuCrrD4pG9DvPcRGG2uPXMDaDa8bfdJ2

Tras inscribirse recibirá un correo electrónico de confirmación con la información sobre cómo asistir a la reunión. Si tiene más preguntas por favor póngase en contacto con el Coordinador MHSA de su condado o con Kiran Sahota ksahota@conceptsforward.com

Condados interesados:

DEPARTMENT of BEHAVIORAL HEALTH

Monterey County Behavioral Health — Avanzando Juntos Forward Together

Shasta County Health & Human Services Agency

Esta presentación se realiza de acuerdo con el Proceso de Planificación del Programa Comunitario de la Ley de Servicios de Salud Mental.CCR, 9 CA ADC § 3200, 3200.060, 3200.270, 3200.90, 3300, 3315, 3320 & WIC 5848(a,b,f) & 5604.2(4).

Psychiatric Advance Directives Informational Presentation

April 7, 2021
10:00AM-11:30AM

Please join us for an informational session to learn about psychiatric advance directives (PADs).

Mental Health Lawyer and Consumer Advocate Laurie Hallmark will discuss advocacy for people living with serious mental illness. Topics will include the use of PADs as a foundation for Supportive Decision Making and how PADs can assist in the reduction of recidivism within the cycle of incarceration, homelessness, and hospitalization. Ms. Hallmark is employed by the Texas Rio Grande Legal Aid, as a Special Projects Director for Mental Health Programs and is an advisor to the State of California MHSA multi-county Innovations PADs Project.

Who should attend:
Behavioral Health Advisory Boards and Commissions, Board of Supervisors, Law Enforcement, Public Guardians, County Mental Health Plans, local NAMI

Zoom Information:

You are invited to a Zoom meeting.

When: April 8, 2021 10:00 AM Pacific Time (US and Canada)

Register in advance for this meeting:

https://usclaw.zoom.us/meeting/register/tJMqc-2trD8jE9GLcWC77DAfE6AkMBRfCZrX

After registering, you will receive a confirmation email containing information about joining the meeting.

For additional questions, please contact your county MHSA Coordinator Kiran Sahota at ksahota@conceptsforward.com or USC's Saks Institute Director Christopher Schnieders at cschnieders@law.usc.edu

Interested Counties:

DEPARTMENT of BEHAVIORAL HEALTH

MONTEREY COUNTY BEHAVIORAL HEALTH
Avanzando Juntos Forward Together

Shasta County Health & Human Services Agency

This presentation is in accordance with the Mental Health Services Act, Community Program Planning Process; CCR, 9 CA ADC § 3200, 3200.060, 3200.270, 3200.90, 3300, 3315, 3320 & WIC 5848(a,b,f) & 5604.2(4).

Presentación informativa sobre las Declaraciones de Voluntad Psiquiátrica Anticipada

Abril 7, 2021
10:00AM-11:30AM

Les invitamos a una sesión informativa para aprender sobre las declaraciones de voluntad psiquiátrica anticipada (PADs, por sus siglas en inglés).

Laurie Hallmark, licenciada en salud mental y defensora del consumidor, hablará sobre la defensa de personas que viven con enfermedades mentales graves. Los temas a tratar incluyen el uso de PADs como base para la toma de decisiones de apoyo, y cómo las PADs pueden ayudar a reducir la reincidencia en el ciclo de encarcelamientos. La Srta. Hallmark trabaja como Directora de Proyectos Especiales del Programa de Salud Mental en la Fundación de Asistencia Legal Texas Rio Grande, y además es asesora en el proyecto Innovations PADS que es parte de la Ley de Servicios de Salud Mental (MHSA) del estado de California y en el que participan varios condados.

Quién debe asistir: Comités y juntas asesoras de salud conductual, consejos de regidores, agencias de seguridad, defensores públicos, representantes de salud mental de los condados, delegaciones NAMI locales y grupos de interés en la ley MHSA.

Información de Zoom:

Está usted invitado a una reunión de Zoom:

Cuándo: 7 Abril, 2021 10:00 AM hora Pacífico (EEUU y Canadá)

Inscríbase por adelantado para la reunión:

https://usclaw.zoom.us/meeting/register/tJMqc-2trD8jE9GLcWC77DAfE6AkMBRfCZrX

Tras inscribirse recibirá un correo electrónico de confirmación con la información sobre cómo asistir a la reunión. Si tiene más preguntas por favor póngase en contacto con el Coordinador MHSA de su condado o con Kiran Sahota ksahota@conceptsforward.com o USC's Saks Institute Director Christopher Schnieders at cschnieders@law.usc.edu

Condados interesados:

Esta presentación se realiza de acuerdo con el Proceso de Planificación del Programa Comunitario de la Ley de Servicios de Salud Mental.CCR, 9 CA ADC § 3200, 3200.060, 3200.270, 3200.90, 3300, 3315, 3320 & WIC 5848(a,b,f) & 5604.2(4).

Supported Decision-Making Informational Presentation

April 20, 2021
10:00AM-11:30AM

Please join us for an informational session to learn about supported decision-making (SDM).

Mental Health Lawyers and Consumer Advocates will discuss autonomy and choice for people living with serious mental illness. The presentation will focus on understanding Supported Decision-Making (SDM). Speakers include: Elyn Saks (Saks Institute Founder); Jonathan Martinis and Peter Blanck (Burton Blatt Institute); Laurie Hallmark (Texas Rio Grande Legal Aid); and Rayshell Chambers and Tristan Scremin (Painted Brain) – contributors to State of California MHSA multi-county Innovations PADs Project.

Who should attend:
Behavioral Health Advisory Boards and Commissions, Board of Supervisors, Law Enforcement, Public Guardians, County Mental Health Plans, local NAMI chapter and MHSA Stakeholders.

Zoom Information:

You are invited to a Zoom meeting.

When: April 20, 2021 10:00 AM Pacific Time (US and Canada)

Register in advance for this meeting:

https://usclaw.zoom.us/meeting/register/tJwuce6rrDkrHdb1H3VDmXuEdM3i2RI-ls4Y

After registering, you will receive a confirmation email containing information about joining the meeting.

For additional questions, please contact your county MHSA Coordinator, USC's Saks Institute Director Christopher Schnieders at cschnieders@law.usc.edu or Kiran Sahota at ksahota@conceptsforward.com

Interested Counties:

DEPARTMENT of BEHAVIORAL HEALTH

This presentation is in accordance with the Mental Health Services Act, Community Program Planning Process; CCR, 9 CA ADC § 3200, 3200.060, 3200.270, 3200.90, 3300, 3315, 3320 & WIC 5848(a,b,f) & 5604.2(4).

Presentación informativa sobre la toma de decisiones con apoyo

20 DE ABRIL DE 2021
10:00AM-11:30AM

LES INVITAMOS A UNA SESIÓN INFORMATIVA PARA APRENDER SOBRE LA TOMA DE DECISIONES CON APOYO (TDA O SDM, POR SUS SIGLAS EN INGLÉS).

Abogados especializados en salud mental y defensores del consumidor nos hablarán sobre la autonomía y el derecho de tomar decisiones para las personas que viven con una enfermedad mental grave. La presentación se centrará en el conocimiento del proceso de la Toma de Decisiones con Apoyo. Los ponentes incluyen a Elyn Saks (Fundadora del Instituto Saks); Jonathan Martinis con Peter Blanck (Instituto Burton Blatt); Laurie Hallmark (Ayuda Legal de Texas, Río Grande) y Rayshell Chambers con Tristan Scremin (Painted Brain) – colaboradores del Proyecto de Innovaciones para las Declaraciones de Voluntad Psiquiátrica Anticipada (PAD) de acuerdo con la Ley de Servicios de Salud Mental (MHSA).

¿Quién debería asistir:
Consejos de Asesoría y Comisiones sobre la Salud Conductual, La Junta de Supervisores, Personal del Orden Público, Tutores Públicos, Personal de Planes sobre Salud Mental del Condado, el capítulo local de NAMI y los sectores interesados en asuntos relacionados con la ley MHSA.

Información sobre Zoom:

Está usted invitado a una reunión en Zoom:

Cuándo: 20 de abril de 2021 10:00 AM hora del Pacífico (Estados Unidos y Canadá)

Inscríbase con anticipación para la reunión:

https://usclaw.zoom.us/meeting/register/tJwuce6rrDkrHdb1H3VDmXuEdM3i2RI-ls4Y

Después de inscribirse recibirá un correo electrónico de confirmación con la información sobre cómo asistir a la reunión.

Si tiene preguntas adicionales favor de comunicarse con con el Director del Instituto Saks de la Universidad del Sur de California (USC) Christopher Schnieders en cschnieders@law.usc.edu o el Coordinador sobre la ley MHSA de su condado o con Kiran Sahota en ksahota@conceptsforward.com

Condados Interesados:

Esta presentación se realiza de acuerdo con el Proceso de Planificación del Programa Comunitario sobre la Ley de Servicios de Salud Mental; CCR 9 CA ADC § 3200, 3200.060, 3200.270, 3200.90, 3300, 3315, 3320 & WIC 5848(a,b,f) & 5604.2(4).

USC Gould School of Law
Saks Institute for Mental Health Law, Policy, and Ethics

Psychiatric Advance Directives and the Importance of Choice

Saks Institute for Mental Health Law, Policy, and Ethics supported by California's Mental Health Services Oversight & Accountability Commission

PRESENTS

SPRING SYMPOSIUM 2021

PSYCHIATRIC ADVANCE DIRECTIVES AND THE IMPORTANCE OF CHOICE

WEDNESDAY
MAY 5, 2021

10:00AM - 2:00PM

Join Peers, Consumer Advocates, Mental Health Lawyers and Professionals for a discussion about autonomy and choice for people living with serious mental illness.

This virtual symposium will focus on understanding Psychiatric Advance Directives as a form of Supported Decision-Making – and the State of California's MHSA multi-county Innovations PADs Project.

MHSOAC
Mental Health Services
Oversight & Accountability Commission

REGISTER ONLINE:
saks2021symposium.eventbrite.com

VIEW ONLINE SCHEDULE:
gould.usc.edu/faculty/centers/saks/events/symposium-2021/

FOR ADDITIONAL QUESTIONS, PLEASE CONTACT

CHRISTOPHER SCHNIEDERS
CSCHNIEDERS@LAW.USC.EDU

KIRAN SAHOTA
KSAHOTA@CONCEPTSFORWARD.COM

Appendix D- Sample PAD template

Advance Health Care Directive of _____

(Your name)

Instructions Included in My Directive

Put a check mark in the left-hand column for each section you have completed.

#	**PART I** **Appointment of an Agent for Healthcare**
1 ☐	Designation of Health Care Agent Designation of Alternate Health Care Agent
2 ☐	Authority Granted to My Agent
3 ☐	My choice as to a Court Appointed Conservator
#	**PART II(a)** **Statement of Individual Mental Health Care Instructions**
4 ☐	Who, In Addition to My Health Care Agent, Should Be Notified Immediately of My Admission To a Psychiatric Facility?
5 ☐	My Choice of Treatment Facility and Choices for Alternatives to Hospitalization If 24-Hour Care is Deemed Medically Necessary for My Safety and Well-being
6 ☐	My Primary Physician who is to Have Primary Responsibility for my Mental Health Care is:
7 ☐	My Choices about primary Physicians Who Will Treat Me if I Am Hospitalized and my Primary Physician is Unavailable
8 ☐	My Choices Regarding Methods for Avoiding Emergency Situations
9 ☐	My Choices Regarding Emergency Interventions
9(a) ☐	My Choices Regarding **Routine** Medications for Psychiatric Treatment
9(b) ☐	My Choices Regarding **Emergency** Psychiatric Medication
10 ☐	My Choices Regarding Electroconvulsive Therapy
11 ☐	The Following People Are to be Prohibited from Visiting Me
12 ☐	Other Instructions About Mental Health Care

#	**PART II(b)** **Individual Physical Health Care Instructions**
13 ☐	My Primary Physician who is to Have Primary Responsibility for my Physical Health Care is:
14 ☐	Statement of Desires, Special Provisions and Limitations
15 ☐	My Choices Regarding Experimental Studies and Drug Trials
16 ☐	My Instructions Regarding Life Sustaining Treatment
17 ☐	My Choices Regarding Contribution of Anatomical Gift
18 ☐	My Instructions Regarding Autopsy
19 ☐	Choices Regarding Disposition of My Remains

Advance Health Care Directive of _____

(Your name)

PART I
APPOINTMENT OF AN AGENT FOR HEALTH CARE

****MAKE SURE YOU GIVE YOUR AGENT**
A COPY OF ALL SECTIONS OF THIS DOCUMENT**

If no agent is designated under the Power of Attorney for Health Care section of this document, or if the agent cannot be located, health care providers must still follow any Individual Health Care Instructions contained in this document. Cal. Probate Code Sections 4670, 4671. An agent has priority over any other person in making health care decisions for the patients. Cal. Probate Code Section 4685.

STATEMENT OF INTENT TO APPOINT AN AGENT:

I, (*your name*) _____, being of sound mind, authorize a health care agent to make certain decisions of my behalf regarding my health treatment when I am incompetent to do so unless I mark this box ☐, in which case my agent's authority to make health care decisions for me takes effect immediately. I intend that those decisions should be made in accordance with my expressed wishes as set forth in this document. If I have not expressed a choice in this document, I authorize my agent to make the decision that my agent determines is the decision I would make if I were competent to do so.

1. Designation of Health Care Agent

A. I hereby designate and appoint the following person as my agent to make health care decisions for me as authorized in this document. This person is to be notified immediately of my admission to a psychiatric facility.

Name: _____

Address: _____

City, State, Zip Code: _____

Day Phone: _____ Evening Phone: _____

Pager: _____ Cell Phone: _____

Designation of Alternate Health Care Agent

If the person named above is unavailable, unable or unwilling to serve as my agent, I hereby appoint and desire immediate notification of my alternative agent as follows:

Name: _____

Address: _____

City, State, Zip Code: _____

Day Phone: _____ Evening Phone: _____

Pager: _____ Cell Phone: _____

2. Authority Granted to My Agent

If I become incapable of giving informed consent to health care treatment, or if I marked the box under "Statement of Intent to Appoint an Agent" causing my agent's authority to make decisions for me to immediately become effective, I hereby grant to my agent full power and authority to make health care decisions for me, including the right to consent, refuse consent, or withdraw consent to any health care, treatment, service or procedure, consistent with any instructions and/or limitations I have set forth in this advance directive EXCEPT as I state here. If I have not expressed a choice in this advance directive, I authorize my agent to make the decision that my agent determines is the decision I would make if I were competent to do so.

_____

_____

_____

_____

_____

_____

3. My Choice as to a Court-Appointed Conservator

In the event a court decides to appoint a conservator who will make decisions regarding my health treatment, I desire the following person to be appointed:

Name: _____ Relationship:_____

Address: _____

City, State, Zip Code: _____

Day Phone: _____ Evening Phone: _____

Pager: _____ Cell Phone: _____

The appointment of a conservator or other decision maker shall not give the conservator or decision maker the power to revoke, suspend, or terminate my individual health care instructions or the powers of my agent.

****MAKE SURE YOU GIVE YOUR AGENT AND ALTERNATE AGENT A COPY OF ALL SECTIONS OF THIS DOCUMENT****

Advance Health Care Directive of _____

(Your name)

PART II(a)
STATEMENT OF INDIVIDUAL
MENTAL HEALTH CARE INSTRUCTIONS

In this part, you state how you wish to be treated (such as which hospital you wish to be taken to, which medications you prefer) if you become incapacitated or unable to express your own wishes. If you want a paragraph to apply, put your initials before the paragraph letter. If you do not want the paragraph to apply to you, leave the line blank.

NO INDIVIDUAL MENTAL OR PHYSICAL HEALTH CARE INSTRUCTION CONTAINED IN THIS DOCUMENT MAY BE CARRIED OUT AGAINST MY WISHES.

4. Who, In Addition to My Health Care Agent, Should Be Notified Immediately of My Admission To a Psychiatric Facility? *Be sure to include the agent and any alternate agent you designate in your Durable Power of Attorney, if you have one.*

Name: _____

Address: _____

City, State, Zip Code: _____

Day Phone: _____ Evening Phone: _____

Pager: _____ Cell Phone: _____

Name: _____

Address: _____

City, State, Zip Code: _____

Day Phone: _____ Evening Phone: _____

Pager: _____ Cell Phone: _____

Name: _____

Address: _____

City, State, Zip Code: _____

Day Phone: _____ Evening Phone: _____

Pager: _____ Cell Phone: _____

Name: _____

Address: _____

City, State, Zip Code: _____

Day Phone: _____ Evening Phone: _____

Pager: _____ Cell Phone: _____

5. My Choice of Treatment Facility and Choices for Alternatives to Hospitalization If 24-Hour Care is Deemed Medically Necessary for My Safety and Well-being

☐ A. In the event my psychiatric condition is serious enough to require 24-hour care and I have no physical conditions that require immediate access to emergency medical care, I would prefer to receive this care at the following programs/facilities instead of psychiatric hospitalization.

Facility's Name: _____

Reason: _____

Facility's Name: _____

Reason: _____

Facility's Name: _____

Reason: _____

☐ B. In the event I am to be admitted to a hospital for 24-hour care, I would prefer to receive care at the following hospitals:

Facility's Name: _____

Reason: _____

Facility's Name: _____

Reason: _____

Facility's Name: _____

Reason: _____

☐ C. I do not wish to be admitted to the following hospitals or programs/facilities for psychiatric care for the reasons I have listed:

Facility's Name: _____

Reason: _____

Facility's Name: _____

Reason: _____

Facility's Name: _____

Reason: _____

6. My Primary Physician who is to Have Primary Responsibility for my Mental Health Care is:

Dr. _____ Phone _____

Address _____ Pager _____

City, State, Zip _____ _____

7. My Choices about the Physicians Who Will Treat Me if I Am Hospitalized and my Primary Physician is Unavailable

Put your initials before the letter and complete if you wish either or both paragraphs to apply.

____ A. My choice of treating physician if the above physician is unavailable is:

Dr._____ Phone _____

Address _____

OR if neither is available

Dr._____ Phone _____

OR if none of the above is available

Dr._____ Phone _____

____B. I do not wish to be treated by the following, for the reasons stated:

Dr._____ Reason:_____

OR _____

Dr._____ Reason:_____

OR _____

Dr._____ Reason:_____

_____

8. My Choices Regarding Methods for Avoiding Emergency Situations

If during my admission or commitment to a mental health treatment facility it is determined that I am engaging in behavior that **may** make emergency intervention necessary, I prefer the following choices to help me regain control:

Fill in numbers, giving 1 to your first choice, 2 to your second, and so on until each has a number. If your choice is not listed, write it in after "other" and give it a number as well.

- ❑ Provide a quiet private place
- ❑ Have a staff member of my choice talk with me one-on-one
- ❑ Allow me to engage in physical exercise
- ❑ Offer me recreational activities
- ❑ Assist me with telephoning a friend or family member
- ❑ Offer me the opportunity to take a warm bath
- ❑ Offer me medication
- ❑ Offer me a cigarette
- ❑ Allow me to go outside
- ❑ Provide me with materials to journal or do artwork
- ❑ Offer me assistance with breathing or calming exercises
- ❑ Provide me with a radio to listen to
- ❑ Other: _____

_____

_____

_____

9. My Choices Regarding Emergency Interventions

If, during an admission or commitment to a mental health treatment facility, it is determined that I am engaging in behavior that requires an emergency intervention (e.g., seclusion and/or physical restraint and/or medication), my wishes regarding which form of emergency interventions should be made as follows. I prefer these interventions in the following order:

Fill in numbers, giving 1 to your first choice, 2 to your second, and so on until each has a number. If an intervention you prefer is not listed, write it in after "other" and give it a number as well. If you do not want a listed intervention ever used, cross it out and explain why under "Reasons for my choices."

	Reasons for my choices
❑ Seclusion	_____
❑ Physical restraints	_____
❑ Seclusion and physical restraint (combined)	_____
❑ Medication by injection	_____
❑ Medication in pill form	_____
❑ Liquid medication	_____
❑ During seclusion and/or restraint, I prefer to be checked by **female** staff	_____
❑ During seclusion and/or restraint, I prefer to be checked by **male** staff	_____
❑ Other:_____	_____
_____	_____
See Section 9(b) for choices regarding emergency medication	_____

I expect the choice of medication in an emergency situation to reflect any choices I have expressed in this section and in Section 9(b). **The choices I express in this section and Section 9(b) regarding medication in emergency situations do not constitute consent to use of the medication for non-emergency treatment**.

9(a). My Choice Regarding *Routine* Medications for Psychiatric Treatment

In this section, you may choose any of the paragraphs A-G that you wish to apply. Be sure to initial those you choose.

If it is determined that I am not legally competent to consent to or to refuse medications relating to my mental health treatment, my wishes are as follows:

____ A. I consent to the medications agreed to by my agent, after consultation with my treating physician and any other individuals my agent may think appropriate, with the reservations, if any, described in (D) below.

____ B. I consent to and authorize my agent to consent to the administration of:

Medication Name or Medication Type	**Not to exceed the following dosage/day**	**OR**	**In such dosage(s) as determined by**
_____	_____		Dr. _____
_____	_____		
_____	_____		Or if unavailable, then by
_____	_____		
_____	_____		Dr. _____
_____	_____		
_____	_____		
_____	_____		

____ C. I consent to the medications deemed appropriate by Dr. _____ , whose address and phone number are: _____

_____

9(a) Continued

____D. I specifically do not consent and I do not authorize my agent to consent to the administration of the following medications or their respective brand name, trade name, or generic equivalents:

Name of Drug	**Reason for Refusal**
_____	_____
	_____
_____	_____
	_____
_____	_____
	_____
_____	_____
	_____

____ E. I am willing to take the medications excluded in (D) above if my only reason for excluding them is their side effects and the dosage can be adjusted to eliminate those side effects.

____ F. I am concerned about the side effects of medications and do ***not*** consent or authorize my agent to consent to any medication that has any of the side effects I have checked below at 1% or greater level of incidence (*check all that apply)*.

- ❑ Tardive dyskinesia
- ❑ Loss of Sensation
- ❑ Motor Restlessness
- ❑ Seizures
- ❑ Muscle/skeletal rigidity
- ❑ Tremors
- ❑ Nausea/vomiting
- ❑ Neuroleptic Malignant Syndrome
- ❑ Other _____
  _____
  _____

____ G. I have the following other choices about psychiatric medications:

_____

_____

9(b) My Choices Regarding *Emergency* Psychiatric Medication

If during my admission or commitment to a mental health facility, it is determined that I am engaging in behavior that requires emergency psychiatric medication, I prefer the following medication:

Medication Name or Medication Type	Not to exceed the following dosage/day	OR	In such dosage(s) as determined by
_____	_____		Dr. _____
_____	_____		
_____	_____		Or if unavailable, then by
_____	_____		
_____	_____		Dr. _____
_____	_____		
_____	_____		
_____	_____		

The choices expressed in this section regarding medication in emergency situations do not constitute consent to use of the medication for non-emergency treatment.

10. My Choices Regarding Electroconvulsive Therapy

☐ A. I **do not** consent to administration of electroconvulsive therapy.

B. Under California law, this Directive **cannot** be used to consent for electroconvulsive therapy. However, if I am administered electroconvulsive therapy, I have the following choices:

☐ I will be administered no more than the following number of treatments _____ .

☐ I will be administered the number of treatments deemed appropriate by Dr. _____, whose phone number and address is:

_____.

11. The Following People Are to be Prohibited from Visiting Me:

Name	Relationship
_____	_____
_____	_____
_____	_____
_____	_____

12. Other Instructions About Mental Health Care

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

(You may attach additional pages if you need more space to complete your statement. If you attach additional pages, you must sign and date EACH of the additional pages at the same time you sign and date this document.)

Advance Health Care Directive of _____

(Your name)

PART II(b)
INDIVIDUAL PHYSICAL HEALTH CARE INSTRUCTIONS

NO INDIVIDUAL MENTAL OR PHYSICAL HEALTH CARE INSTRUCTION CONTAINED IN THIS DOCUMENT MAY BE CARRIED OUT AGAINST MY WISHES

13. My Primary Physician who is to have primary responsibility for my physical health care is:

Dr._____ Phone _____

Address _____ Pager_____

City, State, Zip Code: _____

OR if the above physician is unavailable, then I request:

Dr._____ Phone _____

Address: _____

City, State, Zip Code: _____

OR if neither of the above is available, then I request:

Dr._____ Phone _____

Address: _____

City, State, Zip Code: _____

I specifically do not want to be treated by the following physicians:

Dr._____ Reason:_____

OR _____

Dr._____ Reason:_____

OR _____

Dr._____ Reason:_____

_____

14. Statement of Desires, Special Provisions and Limitations

☐ A. I specifically express the following desires concerning these health care decisions:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

☐ B. And I specifically limit this Advance Directive as follows:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

(You may attach additional pages if you need more space to complete your statement. If you attach additional pages, you must sign and date EACH of the additional pages at the same time you sign and date this document.)

15. My Choices Regarding Experimental Studies and Drug Trials

☐ I **will not** participate in experimental studies or drug trials.

Under recent changes to California law, a health care agent, if one has been appointed, a conservator, a family member, or domestic partner may consent to participation in a medical experiment on behalf of a person who is unable to consent under very specific circumstances. See Health and Safety Code, section 24178 for a list of these specific circumstances.

Complete this section **only** if you do not consent to participation in medical experiments under any circumstances.

16. My Instructions Regarding Life Sustaining Treatment

☐ A. I **do not** want my life to be prolonged and I **do not** want life-sustaining treatment to be provided or continued: (1) if I am in an irreversible coma or persistent vegetative state; or (2) if I am terminally ill and the application of life sustaining procedures would serve only to artificially delay the moment of my death; or (3) under any other circumstances where the burdens of treatment outweigh the expected benefits. I want the relief of suffering and the quality as well as the possible extension of my life considered in making decisions concerning life-sustaining treatment.

OR

☐ B. I want my life to be prolonged and I want life sustaining treatment to be provided **unless I am in a coma or vegetative state** which my doctor reasonably believes to be irreversible. Once my doctor has reasonably concluded that I will remain unconscious for the rest of my life, I **do not** want life-sustaining treatment to be provided or continued.

OR

☐ C. I want my life to be prolonged to the greatest extent possible without regard to my condition, the chances I have for recovery or the cost of procedures.

AND/OR

☐ D. I specifically express the following desires concerning life-sustaining treatment.

_____

_____

_____

_____

_____

17. My Choices Regarding Contribution of Anatomical Gift

If either statement reflects your desires, sign the line next to the statement. You do not have to sign either statement. If you do not wish to sign either statement, your agent (if you have one) and your family will have the authority to make a gift of all or part of your body under the Uniform Anatomical Gift Act.

☐ I **do** want to make a gift under the Uniform Anatomical Gift Act, effective upon my death, of:

☐ Any needed organs or parts; or

☐ The parts or organs listed:

_____

_____

_____

_____
(Signature)

☐ I **do not** want to make a gift under the Uniform Anatomical Gift Act, nor do I want my agent or family to do so.

_____
(Signature)

18. My Instructions Regarding Autopsy

If either statement reflects your desires, sign the line next to the statement. You **do not** *have to sign either statement. If you do not sign either statement, your agent (if you have one) and your family will be able to authorize an autopsy.*

☐ I **do** authorize an examination of my body after death to determine the cause of my death.

_____
(Signature)

☐ I **do not** authorize an examination of my body after death to determine the cause of my death.

_____
(Signature)

19. Choices Regarding Disposition of my Remains

If either statement reflects your desires, sign the line beneath the statement. You do not have to sign either statement. If you do not sign either statement, your agent (if you have one) and your family will be able to direct the disposition of your remains.

☐ I **do** authorize

_____ _____

(name) (phone)

_____

(address/city/state/zip)

to direct the disposition of my remains by the following method:

☐ Burial

☐ Cremation

_____

(signature)

OR

☐ I have described the way I want my remains disposed of in:

☐ A written contract for funeral services with:

_____

(name and phone of mortuary/cemetery)

_____

(address/city/state/zip)

☐ My will.

☐ Other:_____

_____

(signature)

By signing below, I am executing this advance directive for health care and, by so doing, am revoking any prior durable power of attorney for health care.

EFFECT OF COPY: A copy of this form has the same effect as the original.

SIGNATURE: Sign and date the form here in the presence of your witnesses/notary.

_____	_____
(date)	*(signature)*
_____	_____
(address)	*(print your name)*
_____	
(city) *(state)*	

STATEMENT OF WITNESSES: I declare under penalty of perjury under the laws of California (1) that the individual who signed or acknowledged this advance health care directive is personally known to me, or that the individual's identity was proven to me by convincing evidence, (2) that the individual signed or acknowledged this advance directive in my presence, (3) that the individual appears to be of sound mind and under no duress, fraud, or undue influence, (4) that I am not a person appointed as agent by this advance directive, and (5) that I am not the individual's health care provider, an employee of the individual's health care provider, the operator of a community care facility, an employee of an operator of a community care facility, the operator of a residential care facility for the elderly, nor an employee of an operator of a residential care facility for the elderly.

First Witness	Second Witness
_____	_____
(print name)	*(print name)*
_____	_____
(address)	*(address)*
_____	_____
(city) *(state)*	*(city)* *(state)*
_____	_____
(signature of witness)	*(signature of witness)*
_____	_____
(date)	*(date)*

ADDITIONAL STATEMENT OF WITNESSES: At least one of the above witnesses must also sign the following declaration:

I further declare under penalty of perjury under the laws of California, that I am not related to the individual executing this advance health care directive by blood, marriage, or adoption, and to the best of my knowledge, I am not entitled to any part of the individual's estate upon his or her death under a will now existing or by operation of law.

_____	_____
(signature of witness)	*(signature of witness)*

SPECIAL WITNESS REQUIREMENT: The following statement is required only if you are a patient in a skilled nursing facility – a health care facility that provides the following basic services: skilled nursing care and supportive care to patients whose primary need is for availability of skilled nursing care on an extended basis. The patient advocate or ombudsman must sign the following statement:

STATEMENT OF PATIENT ADVOCATE OR OMBUDSMAN

I declare under penalty of perjury under the laws of California that I am a patient advocate or ombudsman as designated by the State Department of Aging and that I am serving as a witness as required by Section 4675 of the Probate Code.

_____	_____
(date)	*(signature)*
_____	_____
(address)	*(print your name)*
_____	
(city) *(state)*	

ACKNOWLEDGEMENT OF NOTARY PUBLIC

State of California)

County of _____)

On _____, before me, _____(here insert name and title of the officer), personally appeared _____ personally known to me (or proved to me on the basis of satisfactory evidence) to be the person whose name is subscribed to the within instrument and acknowledged to me that he/she executed the same.

WITNESS my hand and official seal.

Signature: _____ (Seal)

This document is valid only if signed by two witnesses OR acknowledged before a notary public.