CHILDREN, YOUTH AND FAMILIES (CYF) BEHAVIORAL HEALTH SYSTEM OF CARE COUNCIL

MEETING AGENDA
May 10, 2021 – 9:00-10:30 A.M.

Zoom meeting link sent via Outlook meeting invitation

I. **Welcome** (Valerie Hebert) **5 minutes**

- May is Mental Health Month – Event Calendar can be accessed at: https://www.sandiegocounty.gov/content/sdc/hhsa/programs/bhs/mimhm_resources.html
  Please submit planned activities in celebration of May is Mental Health Month to: Nancy.Page@sdcounty.ca.gov for posting
  Enter events into meeting chat

II. **Approval of Meeting Summary** (Minola Clark Manson) **3 minutes**

- March 8, 2021 Meeting Summary-Handout-**Pages 4-7**
- Action Items from March 8, 2021-See meeting summary for completed action items-**Page 5**
- April 12, 2021 Combined Council Meeting Summary to be reviewed at next Combined Council Meeting

III. **Business Items** (Yael Koenig) **2 minutes**

Board Letters / Board Actions

- March 16, 2021-Item 02-Probation Department-Positive Youth Development Training and Professional Services Contract-Handout-**Pages 8-10**
- March 16, 2021-Item 03-Probation-Establishing the Youth Transition Campus-Handout-**Pages 11-12**
- March 16, 2021-Item 04-Probation-Request to Issue a Competitive Solicitation for Residential Treatment Program Services-Handout-**Pages 13-14**
- March 16, 2021-Item 12-Receive Update Regarding San Pasqual Academy and Authorize Request for Extension of Pilot Project-Handout-**Pages 15-17**
- March 16, 2021-Item 15-Literacy Campaign to Increase Access to Books in Low-Income Communities and Communities of Color and Boost Childhood Reading Comprehension and Writing-Handout-**Pages 18-19**
- March 16, 2021-Item 21-Amplifying Systems of Support for Youth Career Readiness and Employment-Handout-**Pages 20-21**
- April 6, 2021-Item 09-Strengthening Mobile Crisis Response Team Program: Additional Funding for Community Education Campaign, North Coastal Service Expansion, and Developing Data Sharing Agreements and Protocols with Law Enforcement and Other Entities, and Engaging Individuals with Lived Experience Through County Advisory Boards-Handout-**Pages 22-24**
- April 6, 2021-Item 10-Increasing Access and Enrollment in County Self-Sufficiency Programs to Serve Every Community Member in Need without Barriers to Entry-Handout-**Pages 25-27**
- April 6, 2021-Item 16-A Resolution Denouncing Xenophobia and Anti-Asian Racism Affirming San Diego County's Commitment to the Well-Being and Safety of Asian Pacific Islander Communities-Handout-**Pages 28-29**
- April 6, 2021-Item 17-Receive the Report Back on the Framework for Creating an Equitable County Government through the Lens of Equity, Racial Justice, and Belonging and Attachment A-Handout-**Pages 30-35**
- April 6, 2021-Item 25-Amending Legislative Program to Support Legislation Related to Background Checks on Firearm Purchases-Handout-**Pages 36-37**
- May 4, 2021-Item 05-Provide Legal Representation to Detained Immigrants Facing Removal Proceedings-Handout-**Pages 38-41**
- May 4, 2021-Item 11-Update on Advancing the Behavioral Health Continuum of Care and attachments-**Continued item from 04/06/2021 (11)** -Handouts-**Pages 42-78**
- May 4, 2021-Item 24-Supporting H.R. 1280, the George Floyd Justice in Policing Act-Handout-**Pages 79-80**

Link to Board of Supervisors Meeting Agendas: https://www.sandiegocounty.gov/cob/bosa/index.html

Information

- April 2021 BHS Director's Report to the Behavioral Health Advisory Board (BHAB)-Handout-**Pages 81-86**
- May 2021 BHS Director's Report to the BHAB-Handout-**Pages 87-89**
- Council Membership Rotation/CYF Council Private Sector Co-Chair Term ends June 30, 2021/Education Sector Co-Chair Term begins July 1, 2021
- Supplemental Security Income (SSI) for Children and Families-Handouts-**Pages 90-93**
- California Youth Empowerment Network (CAYEN)-Link: https://ca-yen.org/ (Bill Stewart)-Handout-**Page 94**

Follow-Up Items (see pages 95-112)

1. 'Beyond the ACE Score' Article introduced by Angela Rowe at the March 8, 2021 CYF Council meeting. Link: -Beyond the ACE score: Examining relationships between timing of developmental adversity, relational health and developmental outcomes in children - Archives of Psychiatric Nursing-Handout-**Pages 95-104**
2. ACEs crosswalk has been updated to include Positive Childhood Experiences (PCE) questions -Handout-**Pages 105-106**
3. Personal Commitment to Achieve Inclusion and Equity document from March 8, 2021 Council discussion facilitated by Rosa Ana Lozada-Handout-**Page 107**
4. Outreach and Engagement During the Pandemic Best Practices-Document created from the January 11, February 8, and March 8, 2021 CYF Council meetings discussion-Handout-Pages **108-112**

IV. **Mental Health Services Act (MHSA) Update** (Danyte Mockus-Valenzuela) **5 minutes**

V. **Hot Topic: Coffee with BHS Director** (Minola Clark Manson) **70 minutes**

Dr. Luke Bergmann's vision for serving children, youth, and families

- **Question 1** - What is your vision and plan for CYF SOC to take action to end disparities and racism?
- **Question 2** - Sometimes there is a delay in knowing the true impact of trauma on someone, especially a young child, since symptoms often present themselves months after the traumatic event and after a sense of safety has been established for that child. Knowing this, we anticipate seeing an even greater need for mental health services for young children and their caregivers as school returns to in-person in the fall. What steps and behavioral health resources will be put in place for the most vulnerable in our community, so the impact is not life long?
- **Question 3 -** How do you envision the CYF system working towards a population health orientation?
- Open Discussion

VI. **Announcements** (Valerie Hebert) **5 minutes**

- Input Session for BHS 5-Year Strategic Housing Plan is scheduled for May 14, 2021 from 1:00 to 2:30 P.M.-Handout-**Page 113**
- Mental Health for All-NAMI Walks-Your Way is scheduled for Saturday, May 22, 2021-**Flier-Page 114**
- 2021 CYF System of Care Training Academy Annual conference (virtual): Youth Substance Use: Risk, Resilience, Reconnection is scheduled for Thursday, May 27, 2021. Information and Registration at: https://youth-substance-use-risk-resilience-reconnection.eventbrite.com

Next Executive Committee Conference Call:
Date: May 27, 2021
Time: 11:30 A.M. to 12:00 P.M.

Next Council Meeting:
Date: Monday, June 14, 2021
Time: 9:00-10:30 A.M.

Sub-Committees/Sectors/Workgroups Meetings Information is located at the end of the meeting summary. For Council materials go to:
https://www.sandiegocounty.gov/content/sdc/hhsa/programs/bhs/mental_health_services_children/CYFBHSOCCouncil.html

County of San Diego
Children, Youth and Families Behavioral Health
System of Care Council
Vision, Mission, and Principles

Council Vision:
Wellness for children, youth and families throughout their lifespan.

Council Mission:
Advance systems and services to ensure that children and youth are healthy, safe, lawful, successful in school and in their transition to adulthood, while living in nurturing homes with families.

Council Principles:

1. **Collaboration of four sectors:** Coordination and shared responsibility between child/youth/family, public agencies, private organizations and education.

2. **Integrated:** Services and supports are coordinated, comprehensive, accessible, and efficient.

3. **Child, Youth, and Family Driven:** Child, youth, and family voice, choice, and lived experience are sought, valued and prioritized in service delivery, program design and policy development.

4. **Individualized:** Services and supports are customized to fit the unique strengths and needs of children, youth and families.

5. **Strength-based:** Services and supports identify and utilize knowledge, skills, and assets of children, youth, families and their community.

6. **Community-based:** Services are accessible to children, youth and families and strengthen their connections to natural supports and local resources.

7. **Outcome driven:** Outcomes are measured and evaluated to monitor progress and to improve services and satisfaction.

8. **Culturally Competent:** Services and supports respect diverse beliefs, identities, cultures, preference, and represent linguistic diversity of those served.

9. **Trauma Informed:** Services and supports recognize the impact of trauma and chronic stress, respond with compassion, and commit to the prevention of re-traumatization and the promotion of self-care, resiliency, and safety.

10. **Persistence:** Goals are achieved through action, coordination and perseverance regardless of challenges and barriers.

LIVE WELL SAN DIEGO

LIVEWELLSD.ORG

BEHAVIORAL HEALTH SERVICES

CHILDREN, YOUTH & FAMILIES FRAMEWORK

VISION

Children and youth are healthy, safe, lawful, successful in school and in their transition to adulthood, while living in nurturing homes with families.

PRINCIPLES

Collaborative, Integrated, Child, Youth & Family Driven, Individualized, Strength-based, Community-based, Outcome & Data Driven, Culturally Competent, Trauma Informed, Persistence

PRIORITIES

Ensure a full continuum of care through family-centered and youth-informed services that are compassionate and sensitive to the unique developmental needs of children and youth.

Strengthen partnerships with children/youth's circle of influence to create a supportive environment.

Provide services that empower children and youth to build a healthy sense of self and have confidence to make sound decisions so they thrive in an ever-changing world.

Live Well San Diego-Areas of Influence

HEALTH FACTORS

Standard of Living

- Economic & Nutrition Security
- Timely Access to Healthcare Inclusive of Behavioral Health Services
- Employment Readiness

Community

- Access to Parks, Playgrounds and Recreation Centers
- Usable Transportation
- Safe Neighborhoods & Schools
- Affordable Stable Housing
- Access to Extracurricular Activities

Health

- Daily Physical Activity
- Limited & Supervised Screen Time
- Affordable Healthy Food
- Zero Sugary Beverages, Drink More Water
- No Substance Use
- No Tobacco Use
- Up to Date Immunizations
- Connection to a Health Home

Social

- Supportive Families
- Nurturing Communities
- Connection to Natural Supports
- Positive Social Interactions

Knowledge

- Quality Education
- Quality Preschool For All
- Good School Attendance
- School Success
- No Suspensions or Expulsions
- Obtain a High School Diploma
- Access to Higher Education & Vocational Programs

Version 3/5/2021

CHILDREN, YOUTH AND FAMILIES (CYF)
BEHAVIORAL HEALTH SYSTEM OF CARE COUNCIL
MEETING SUMMARY

March 8, 2021 | 9:00-10:30 A.M.
Virtual Meeting

ITEM	SUMMARY AND ACTION ITEMS
I. Welcome/Introductions (Valerie Hebert)	
II. Approval of Minutes (Minola Clark Manson) • February 8, 2021 Meeting Summary-Handout-**Pages 4-7** • Action Items from February 8, 2021-See meeting summary for completed action items-**Page 5**	• Minutes approved through virtual platform process • Action items reviewed by Yael Koenig
III. Business Items (Yael Koenig) **Board Letters** • February 9, 2021-Item 03: Receive the First 5 San Diego 2020 Annual Report-Handout-**Pages 8-9** Link to the report: https://first5sandiego.org/about-us/reports/ • February 9, 2021-Item 04: Authorize Applications for and Acceptance of Funding For The Transitional Housing Program and Adopt a Resolution Authorizing Application and Acceptance Allocation Award Under the Transitional Housing Program-Handout-**Pages 10-13** • February 23, 2021-Item 01-Board Conference: Future of Probation-Handout-**Pages 14-16** • February 23, 2021-Future of Juvenile and Adult Probation Board Conference Agenda- Handout-**Pages 17-18** Link to the conference: https://www.youtube.com/watch?v=qtdwWwoKCtk • March 2, 2021-Item 12: A Sustainable Initiative to Uplift Boys and Men of Color-Handout-Pages **19-22** • March 3, 2021 (Land Use)-Item 11: Update: Measures to Provide Economic Access and Equity in the Cannabis Industry-Handout-**Pages 23-29** **Information** o March 2021 BHS Director's Report to the Behavioral Health Advisory Board (BHAB)-Handout-**Pages 30-39** o Family Urgent Response System (FURS) Live effective March 1, 2021-Fliers-Handouts-**Pages 40-41** o County of San Diego Emergency Rental Assistance Program (ERAP)-Applications opened March 2, 2021-Handout-**Pages 42-47** o California Conservation Corps (CCC)-Handouts-**Pages 48-56** o Services exclusive for San Diego Regional Center (SDRC) Clients ✓ Skills System Substance Use Disorders Program Brochure- Handout-**Pages 57-58** ✓ Skills System Brochure-**Pages 59-60** ✓ Rainbow Group Brochure-**Pages 61-62** o Public Health-Black Legacy Now https://blacklegacynowsd.com/	• Yael Koenig reviewed business items • Angela Rowe discussed article "Beyond the Ace Score" and the importance of supporting families • Black Legacy Now – Per Dr. Coleman for additional information please contact Josephine Young at Josephine.young@sdcounty.ca.gov with Public Health
IV. Mental Health Services Act (MHSA) Update (Dr. Danyte Mockus-Valenzuela)	• 2021 Prevention and Early Intervention Forum Series-Advancing Mental Health Prevention and Early Intervention Using Evaluation and Technical Support • MHSOAC PEI Forum 1 Zoom Link and Materials (March 17, 2021): https://mhsoac.ca.gov/news-events/events/prevention-and-early-intervention-forum-1-risk-protective-factors-role-strategic • PEI handout with infographic https://mhsoac.ca.gov/sites/default/files/PEI%20Fact%20Sheet.pdf

ITEM	SUMMARY AND ACTION ITEMS
V. Sub-Committees Updates (Yael Koenig) • Cultural Competence Resource Team (CCRT) – (Rosa Ana Lozada)-Handouts-**Pages 63-74**	• Rosa Ana Lozada reviewed the CCRT Mid-Year Sub-Committee Report • Rosa Ana Lozada provided interactive presentation on Personal Commitment to achieve inclusion and equity with intent to reach out and provide a summary document to the Council
Hot Topic: Live Well Schools (Deirdre Kleske and Emma Wan) • Tools for Schools-Handout-**Page 75** • Website https://www.livewellsd.org/toolsforschools/ • Video link: https://www.youtube.com/watch?v=l6CsJOgGwgo&t=6s	• Deirdre Kleske introduced Live Well Schools Tools for School • Emma Wan reviewed Tools for Schools Resources website • George Scolari recommended that the Healthy San Diego (HSD) Quick Guides be shared for consideration to upload to the Live Well Schools website
Hot Topic: Outreach and Engagement – Part III (Minola Clark Manson) • Finalize Summary of Recommendations Discussion (Amanda Lance-Sexton and Fran Cooper)-**Pages 76-82**	• Amanda Lance-Sexton and Fran Cooper shared CYF SOC Council summary recommendations and gathered input on finalizing document to be used as a resource
VI. Announcements • Critical Issues in Child and Adolescent Mental Health Conference-March 19, 2021: https://cicamh.com/ -Handout-**Pages 83-84** • 2021 California Mental Health Advocates for Children and Youth (CHMACY) Conference Scholarship Applications are open. Applications can be found at: https://forms.gle/9qhUKai7uYz6B7sE9 and must be submitted by March 26, 2021 (Rose Woods) • Save the Date: April 12, 2021-Combined Councils meeting- Please note time: 10:00 to 11:30 A.M.-Handout-**Page 85** • Save the Date: May 7, 2021: Youth Mental Health Well-Being, Virtual Gathering-Handout-**Pages 86-87** • 2021 CYF System of Care Training Academy Annual conference (virtual): Youth Substance Use: Risk, Resilience, Reconnection • is scheduled for May 27, 2021. Information and Registration at: https://youth-substance-use-risk-resilience-reconnection.eventbrite.com (Rose Woods)	• Valerie Hebert reviewed announcements
VII. Action Items	**Action Due/Status**
1. Provide update on the new date for Juvenile Health and Justice Symposium (original date was March 17, 2020)	• CYF Council will provide update when the information is available
2. Share 'Beyond the ACE Score' Article introduced by Angela Rowe ACEs crosswalk has been updated to includes that Positive Childhood Experiences (PCE)	• Provide at the May10, 2021 CYF Council meeting • Provide at the May 10, 2021 CYF Council meeting
3. Personal Commitment to Achieve Inclusion and Equity document created from the March 8, 2021 CYF Council discussion facilitated by Rosa Ana Lozada	• Provide at the May 10, 2021 CYF Council meeting
4. Provide the document created at the January 11, February 8, and March 8, 2021 CYF Council meetings discussion: Outreach and Engagement During the Pandemic- Best Practices	• Provide at the May 10, 2021 CYF Council meeting
5. Provide the Live Well Schools website organizer with the Healthy San Diego Quick Guides	Completed: Yael Koenig and George Scolari provided Deirdre Kleske the Healthy San Diego Quick Guides on March 8, 2021 • Drug Medi-Cal • Behavioral Health Medi-Cal • Medi-Cal Plan Contact Card

+=Member in Attendance O=Absent E=Excused

CONSTITUENCY		MEMBER	STATUS	ALTERNATE	STATUS
PUBLIC SECTOR					
1	Behavioral Health Advisory Board (BHAB)	Rebecca Hernandez	O	Bill Stewart	+
2	Behavioral Health Services (BHS)	Dr. Laura Vleugels	+	Dr. Charmi Patel	+
3	Public Safety Group/ Probation	Lisa Sawin	+	Chrystal Sweet	O
4	Child Welfare Services (CWS)	Steve Wells	+	Norma Rincon	O
5	HHSA Regions	VACANT		Jennifer Sovay	O
6	Public Health	Dr. Thomas R. Coleman	+	Adrienne Yancey	O
7	Juvenile Court	H. Ana Espana	+	Beth Brown	+
8	First 5 Commission	Alethea Arguilez	O	Dulce Aguilar-Cahue	O
EDUCATION SECTOR					
9	Special Education Local Plan Area (SELPA)	Cara Schukoske	O	Jamie Tate - Symons	O
10	Regular Education Pupil Personnel Services	Violeta Mora	+	Heather Nemour	O
11	School Board	Barbara Ryan	+	VACANT	
12	Special Education	Yuka Sakamoto	+	VACANT	
PRIVATE SECTOR					
13	San Diego Regional Center (SDRC) for Developmentally Disabled	Peggie Webb	O	Therese Davis	O
14	Alcohol and Drug Service Provider Association (ADSPA)	Angela Rowe	+	John Laidlaw	O
15	Alcohol and Drug Service Provider Association (ADSPA)	Marisa Varond	+	Claudette Allen Butler	+
16	Mental Health Contractors Association	Julie McPherson	+	Minola Clark Manson	+
17	Mental Health Contractors Association (MHCA)	Laura Beadles	+	Michelle Hogan	O
18	Fee- For-Service (FFS) Network	Dr. Sherry Casper	+	Marcelo A. Podesta	+
19	Managed Care Health Plan	George Scolari	+	Kathleen Lang	+
20	Healthcare/ Pediatrician	Dr. Pradeep Gidwani	+	VACANT	
FAMILY AND YOUTH SECTOR					
21	Family and Youth Liaison	Renee Cookson	O	Valerie Hebert	+
22	Caregiver of child/youth served by the Public Health System	Debbie Dennison	+	VACANT	
23	Youth served by the Public Health System (up to age 26)	Micaela Cunningham	+	VACANT	

24	Youth served by the public health system (up to age 26)	Christine Frey	+	Emma Eldredge	O
SUB-COMMITTEES (Non-voting members unless a member of the Council)					
-	Executive Sub-Committee	Valerie Hebert/ Minola Clark Manson	+/+		
-	Cultural Competence Resource Team (CCRT)	Rosa Ana Lozada	+		
-	CYF CADRE	Julie McPherson/ Marisa Varond	+/+		
-	Early Childhood Sub-Committee	Aisha Pope/Ginger Bial	+/+		
-	Education Sub-Committee	Heather Nemour/Violeta Mora	O/+		
-	Family and Youth as Partners Sub-Committee	Renee Cookson/ Valerie Hebert	O/+		
-	Outcomes Sub-Committee	Emily Trask/Eileen Quinn-O'Malley	O/+		
-	Training Sub-Committee	Rose Woods	+		

Sub-Committees/Sectors/Workgroups Meetings Information:

Due to COVID-19, most of the sub-committees' meetings are occurring virtually
Please reach out to the sector lead or Executive Subcommittee member to obtain location/link

Behavioral Health Advisory Board (BHAB) meeting: Meets the first Thursday of the month from 2:30 to 5:00 P.M.
Outcomes: Meets the first Tuesday of every other month from 11:30 A.M. to 12:30 P.M.
Early Childhood: Meets the second Monday of the month- from 11:00 A.M. to 12:00 P.M.
Education Advisory Ad Hoc: Meets as Needed, next meeting will be in September 2020.
TAY Council: Meets the fourth Wednesday of the month 3:00 to 4:30 P.M.
CYF CADRE: Meets quarterly on the second Thursday of the month from 1:30 to 3:00 P.M.
CYF System of Care Training Academy: Meets on the first Wednesday of the month from 9:00 to 10:00 A.M.
CCRT: Meets the first Friday of the month from 10:00 to 11:30 A.M.
Family and Youth as Partners: Meets every third Thursday of the month from 1:30 to 3:00 P.M.
Private Sector: Ad Hoc/Meets as needed.

COUNTY OF SAN DIEGO

AGENDA ITEM

DATE: **March 16, 2021** **02**

TO: Board of Supervisors

SUBJECT
PROBATION DEPARTMENT – POSITIVE YOUTH DEVELOPMENT TRAINING AND PROFESSIONAL SERVICES CONTRACT (DISTRICTS: ALL)

OVERVIEW
On February 23, 2021, the Board of Supervisors convened a Board conference to discuss the future of the Probation Department. Future national best practice trainings were identified as a critical gap in Probation's ongoing transformation. New trainings that align with recommendations from national experts at Georgetown University's Center for Juvenile Justice Reform and the Council of Juvenile Justice Administrators are key to supporting Probation's transition from a correctional and compliance-based model to a positive youth development philosophy.

San Diego State University Research Foundation's Academy for Professional Excellence (Academy) has provided relevant specialized training to the County of San Diego Health and Human Services Agency, Child Welfare Services staff over the last twenty-five years and to Probation staff over the last two Fiscal Years. The Academy's long-term relationship with the County of San Diego, current best practices trainings to Probation staff, and connections to San Diego State University's wealth of services and research makes them the premier training agency in Southern California and capable of delivering dynamic and national best practices training to Probation.

Today's request is for the Director, Department of Purchasing and Contracting, to enter into single source negotiations with San Diego State University Research Foundation's (SDSURF) Academy for Professional Excellence (Academy) to procure training services that will support the Probation Department's juvenile justice transformation.

RECOMMENDATION(S)
CHIEF ADMINISTRATIVE OFFICER
1. In accordance with Board Policy A-87, Competitive Procurement, approve and authorize the Director of the Department of Purchasing and Contracting to enter into negotiations with San Diego State University Research Foundation's (SDSURF) Academy for Professional Excellence (Academy) and subject to successful negotiations and a determination of a fair and reasonable price, award a contract for educational training

services for a term of three (3) years, with two (2) option years and up to an additional six (6) months if needed, subject to the availability of funds and a need for services, and to amend the contract as needed to reflect changes to services and funding that do not materially impact or alter the program, subject to the approval of the Chief Probation Officer.

FISCAL IMPACT
There is no direct fiscal impact associated with the requested action in the current fiscal year. Estimated contract costs will be included in the Fiscal Year 2021-23 CAO Recommended Operational Plan for the Probation Department. Once negotiations are complete and the final amount of the contract costs is known, staff will return to the board, as necessary, to request any additional appropriations for the first year of the contract. Funds for the remaining contract term will be budgeted in future years Operational Plans for the Probation Department. There will be no change in net General Fund cost and no additional staff years.

BUSINESS IMPACT STATEMENT
N/A

ADVISORY BOARD STATEMENT
N/A

BACKGROUND
San Diego County Probation Department Priorities
San Diego County's juvenile justice system is undergoing a historic transformation and implementing national best practices for supporting justice-involved youth and their families. On April 25, 2017 (4), the Board of Supervisors approved the Chief Probation Officer's request to apply for and accept the Georgetown University Center for Juvenile Justice Reform and Council for Juvenile Justice Administrators 18-month Youth in Custody Practice Model (YICPM) technical assistance program.

On April 9, 2019 (1), the Board directed the Chief Administrative Officer to conduct a Conditions of Confinement Study on San Diego's juvenile detention system. The study was led by the Council for Juvenile Justice Administrators (CJJA). On December 26, 2019, Probation shared the recommendations and assessment with the Board of Supervisors. Among the identified needs in the assessment, CJJA recommended that Probation separate youth and adult staff trainings. This would allow youth staff to receive focused and high-quality trainings on topics relevant to their field. In addition, CJJA recommended that Probation eliminate its common law enforcement "defensive tactics" training and transition to a national best practices conflict de-escalation curriculum. On June 11, 2020, Probation notified the Board of Supervisors that all juvenile detention staff would be trained in the Mandt System that is supported by CJJA. Mandt teaches staff that safety is found in relationships, communication, conflict de-escalation, and progressive responses to unsafe behavior while creating a supportive environment for youth and staff.

San Diego State University Research Foundation's Academy for Professional Excellence
Since 1996, the Academy has delivered a series of core, advanced, and specialized training courses to the County of San Diego (County) Health and Human Services Agency, Child Welfare Services

(CWS) for more than 25 years. The Academy is an agency committed to anti-racism and operating in a trauma-informed, therapeutic approach. Over the last 25 years, the Academy has delivered Social Worker Initial Training to nearly 1,100 newly hired and promoted CWS staff.

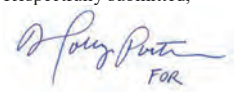
Through San Diego State University Research Foundation (SDSURF), the Academy is the sole contractor with the California Department of Social Services (CDSS) to provide the required Common Core training for new CWS social workers in Southern California. SDSURF's Academy currently provides workforce development to over 7,000 public child welfare staff throughout the southern California region.

On July 9, 2019 (13), the Board of Supervisors approved an amendment to County contract number 553340 to include Probation in trainings provided by the Academy. On September 29, 2020 (8), the Board approved an amendment to County contract number 553340 to include additional Academy trainings for Probation to ensure all juvenile Probation Officers are trained in adolescent brain development, trauma-informed care, implicit bias, and restorative practices. Historically, the Department has not standardized trainings for staff and allowed youth and adult staff to train together. Trainings through the Academy create consistency among youth serving agencies in the County as we support long-term success for the region's young people.

Today's action if approved, requests to enter into negotiations with the Academy for a contract to deliver youth development training and professional development services to Probation staff. This action supports the County's Live Well San Diego vision by furthering efforts to support a well-trained and prepared workforce that is culturally sensitive to the needs of the community to ensure youth and families are living healthy, safe and thriving.

LINKAGE TO THE COUNTY OF SAN DIEGO STRATEGIC PLAN
Today's proposed action supports the Operational Excellence and Living Safely Initiatives of the County of San Diego's 2021-2026 Strategic Plan by furthering efforts to support a well-trained and prepared workforce that is culturally sensitive to the needs of the community to ensure youth and families are building better health, living safely, and thriving.

Respectfully submitted,



HELEN N. ROBBINS-MEYER
Chief Administrative Officer

ATTACHMENT(S)
N/A

SUBJECT: PROBATION DEPARTMENT – POSITIVE YOUTH DEVELOPMENT TRAINING AND PROFESSIONAL SERVICES CONTRACT

AGENDA ITEM INFORMATION SHEET

REQUIRES FOUR VOTES: ☐ Yes ☒ No

WRITTEN DISCLOSURE PER COUNTY CHARTER SECTION 1000.1 REQUIRED
☐ Yes ☒ No

PREVIOUS RELEVANT BOARD ACTIONS:
July 9, 2019 (13), the Board approved amendment to contract 553340 to include additional trainings and increase in annual contract amount;
December 11, 2018 (12), the Board reviewed the Child Welfare Services Review Working Group report and recommendations;
May 14, 2002 (7), the Board approved a sole source contract with the San Diego State Research Foundation

BOARD POLICIES APPLICABLE:
A-87 Negotiated Procurement

BOARD POLICY STATEMENTS:
Pursuant to A-87, Procedure section 2.B. (categorical exemptions for educational services), this is a procurement for educational services with San Diego State Research Foundation's Academy for Professional Excellence (Academy), a not-for-profit organization.

Under Board Policy A-87 D, a single source may be used when "only one manufacturer, distributer, supplier or service provider can provide the required goods and/or services."
Section 6 applies, "The procurement is for goods and/or services where continuity of providers will provide efficiency or critical knowledge, and other providers of the goods and/or services cannot provide similar efficiencies or critical knowledge."

Item and Service and Term Period: Probation is requesting authority for Positive Youth Development Training and Professional Development Services by the Academy for a contract term effective July 1, 2021 through June 30, 2022 with 4 option years and an additional six months if needed.

Benefits to the County of San Diego: As the San Diego County Probation Department continues to implement a transformation model in juvenile detention facilities and field services around rehabilitative programming and behavioral health, specialized training services will empower Probation staff to continually adapt methods of providing supervision to youth and their families to decrease recidivism and increase success in the community. This robust programming focused on training and coaching staff, through the lens of holistic and restorative care, will also continue to create the best culture, atmosphere, and physical environment to enhance safety and treatment outcomes for youth and staff.

Justification: Established in 1943, San Diego State University Research Foundation (SDSURF) is a non-profit, auxiliary organization chartered to further the educational, research and community service objectives of San Diego State University. As a nonprofit corporation,

SUBJECT: PROBATION DEPARTMENT – POSITIVE YOUTH DEVELOPMENT TRAINING AND PROFESSIONAL SERVICES CONTRACT

SDSURF is governed by a Board of Directors that establishes policies and guides the corporation in achieving research and educational program objectives. Although the Academy is managed by SDSURF, it is a project of SDSU's School of Social Work, and the leadership team reports to the Schools' Director and the Dean of SDSU.

SDSURF is the only academic based research institution that has the capacity to deliver the specialized expertise and uniquely designed youth development trainings to Probation staff. For the past two Fiscal Years, the Academy has been delivering best practices trainings to probation staff. As Probation works very closely with other County departments to support youth on Probation, such as Child Welfare Services and Behavioral Health Services, the continuity of training from The Academy will support internal customer service and empower staff to improve collaboration across departments to increase youth's success. Service providers across County departments and in the community may receive conflicting trainings that prevent the juvenile justice system from moving in a singular direction. In addition to providing training for County staff, these same trainings will also be required of contracted providers, ensuring a strengthened continuum of care as youth receive services across county departments and in their community.

Fair and Reasonable Price: Probation has determined that the costs of these training services are fair and reasonable by comparing costs of comparable services to other County departments.

MANDATORY COMPLIANCE:
N/A

ORACLE AWARD NUMBER(S) AND CONTRACT AND/OR REQUISITION NUMBER(S):
Oracle Award 100425, *Pending*

ORIGINATING DEPARTMENT: Probation Department

OTHER CONCURRENCE(S): Department of Purchasing and Contracting

CONTACT PERSON(S):

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COUNTY OF SAN DIEGO

AGENDA ITEM

BOARD OF SUPERVISORS

NORA VARGAS
First District

JOEL ANDERSON
Second District

TERRA LAWSON-REMER
Third District

NATHAN FLETCHER
Fourth District

JIM DESMOND
Fifth District

DATE: **March 16, 2021** **XX**

TO: Board of Supervisors

SUBJECT
PROBATION – ESTABLISHING THE YOUTH TRANSITION CAMPUS (DISTRICT: 4)

OVERVIEW
On April 25, 2017 (4), the Board of Supervisors authorized the San Diego County Probation Department (Probation) to apply for the Youth in Custody Practice Model (YICPM) technical assistance program. The YICPM was co-created by Georgetown University's Center for Juvenile Justice Reform and the Council of Juvenile Justice Administrators to assist juvenile correctional agencies with implementing national best practices to support positive outcomes for youth and staff. National experts have played a critical role in helping Probation begin a shift from a correctional, compliance-based model of juvenile detention to a positive youth development approach.

On August 7, 2018 (7), the Board of Supervisors authorized the Departments of General Services and Purchasing and Contracting to advertise and award a contract for the Juvenile Justice Campus facility phased replacement project. This project is to establish a post-adjudication commitment facility for youth in extended custody and replace a portion of the 1952 Kearny Mesa Juvenile Detention Facility, located on the project site, with a trauma-informed, therapeutic facility to support youth.

In accordance with Board Policy F-46, Authority to Name County Buildings and Facilities, this is a request to adopt a resolution to establish the Youth Transition Campus. Creating the name of the new facility is a key part of Probation's philosophical shift to positive youth development. The new campus will fulfill the Department's goal to provide supportive and rehabilitative services to youth in custody and help foster their transition back to the community. The new name represents the Department's goal to provide supportive and rehabilitative services while youth stay in the Department's custody and support their transition back to the community.

RECOMMENDATION(S)
CHIEF ADMINISTRATIVE OFFICER
1. Adopt a resolution entitled: A RESOLUTION TO THE BOARD OF SUPERVISORS OF THE COUNTY OF SAN DIEGO NAMING THE YOUTH TRANSITION CAMPUS.

FISCAL IMPACT

There is no fiscal impact associated with this request.

BUSINESS IMPACT STATEMENT
N/A

ADVISORY BOARD STATEMENT
N/A

BACKGROUND
The San Diego County Probation Department (Probation) has been undergoing a significant transformation for the past five years. On April 25, 2017 (4), the Board of Supervisors authorized Probation to apply for and enter into a contract for technical assistance funding from Georgetown University's Center for Juvenile Justice Reform and the Council of Juvenile Justice Administrators. The Youth in Custody Practice Model (YICPM), assistance from national experts has helped Probation and juvenile justice partners to evaluate juvenile detention operations and align with national best practices. The YICPM has played a critical role in supporting Probation's transition from a correctional, compliance-based model of juvenile detention to a positive youth development philosophy.

On August 7, 2018 (7), the Board of Supervisors authorized the Departments of General Services and Purchasing and Contracting to advertise and award a contract for the Juvenile Justice Campus facility phased replacement project. This project was to establish a post-adjudication commitment facility for youth in extended custody and replace a portion of the 1952 Kearny Mesa Juvenile Detention Facility, located on the project site, with a trauma-informed, therapeutic approach to youth detention. When completed at the end of calendar year 2021, the first phase will include:

- 8, 12-bed residential housing units
- Standalone academic and vocational education services
- Indoor and outdoor recreation
- Family visitation
- Staff wellness spaces
- Indoor and outdoor dining for youth and staff

Establishing the Youth Transition Campus is a key component of Probation's ongoing philosophical transformation. When youth enter detention, national best practices recommend that the local agency immediately begin planning for reentry or transition back to their homes. Probation is committed to helping our region's justice-involved population be successful while in custody and after going home. In accordance with Board Policy F-46, Authority to Name County Buildings and Facilities, this is a request to adopt a resolution to establish the name Youth Transition Campus.

LINKAGE TO THE COUNTY OF SAN DIEGO STRATEGIC PLAN
Today's proposed action supports the Building Better Health Initiative of the County of San Diego's 2021-2026 Strategic Plan. The new facility name reflects a region that has fully optimized

its health and social service delivery system by establishing a trauma-informed, therapeutic approach to juvenile detention and supports youth needs when they enter custody.

Respectfully submitted,

HELEN N. ROBBINS-MEYER
Chief Administrative Officer

ATTACHMENT(S)
ATTACHMENT A - A RESOLUTION TO THE BOARD OF SUPERVISORS OF THE COUNTY OF SAN DIEGO NAMING THE YOUTH TRANSITION CAMPUS

COUNTY OF SAN DIEGO

AGENDA ITEM

DATE: **March 16, 2021** **04**

TO: Board of Supervisors

SUBJECT
PROBATION – REQUEST TO ISSUE A COMPETITIVE SOLICITATION FOR RESIDENTIAL TREATMENT PROGRAM SERVICES (DISTRICTS: ALL)

OVERVIEW

The San Diego County Probation Department (Probation) is committed to providing evidence-based services that help the justice-involved population successfully complete their terms of probation. On August 25, 2011 (2), the Board of Supervisors approved Probation's request to establish a Residential Treatment Program (RTP) to serve justice-involved adults with crucial substance use disorder treatment services to promote a community reentry from custody and to prevent additional incarceration. RTP contractors provide around-the-clock residential alcohol and other drug treatment, recovery, and ancillary services for approximately 200 adult clients annually who are under the supervision of Probation. Contractors provide critical therapy, relapse prevention, and self-care services for clients who would be at risk of incarceration if they were not in the program. RTPs fill a vital role in the public system of care by serving clients who would not otherwise be eligible to receive these services.

The current contracts are set to expire on December 31, 2021, and Probation has determined a multiple award Request for Proposals (RFP) as the most appropriate procurement method to continue these services for residential treatment program services. Today's request would authorize the Director, Department of Purchasing and Contracting, to issue a competitive solicitation for residential treatment program services and award contracts as needed for an initial term of six (6) months with four (4) one-year (1) option periods and up to an additional six (6) months if needed.

RECOMMENDATION(S)
CHIEF ADMINISTRATIVE OFFICER

1. In accordance with Section 401, Article XXIII of the County Administrative Code, authorize the Director, Department of Purchasing and Contracting, to issue a competitive solicitation for residential treatment program services for adult clients of Probation, and

upon successful negotiation and determination of fair and reasonable price, award a contract to multiple qualified providers countywide for an initial term of six (6) months with four (4) one-year (1) option periods and up to an additional six (6) months if needed, subject to the availability of funds and a need for the services, and to amend the contracts as needed to reflect changes to services and funding, subject to the approval of the Chief Probation Officer.

FISCAL IMPACT
If approved, this request will result in costs and revenue of approximately $1,100,000 in the Probation Department in Fiscal Year 2021-22 and $2,200,000 for each subsequent fiscal year. Funds for the initial six-month term will be included in the Fiscal Year 2021-22 CAO Recommended Operational Plan for the Probation Department. Funds for the remaining years will be budgeted in future years' Operational Plans for the Probation Department. The funding sources for the initial term and subsequent years are the State of California, Local Revenue Fund 2011, Community Corrections Subaccount; and the State Community Corrections Incentive Performance Fund (SB 678). There will be no net change in General Fund cost and no additional staff years.

BUSINESS IMPACT STATEMENT
N/A

ADVISORY BOARD STATEMENT
N/A

BACKGROUND
Residential Treatment Programs (RTPs) are an integral component of the County's system of care to address substance use disorder (SUD) and criminogenic needs to reduce recidivism for those under Probation supervision. Probation contracts with RTPs to immediately place clients who assess as high risk to recidivate, are in critical need of SUD residential treatment, and were ordered by court or referred by Probation to care. Approximately 60% of the assessed realigned and high-risk populations scored as having high need for SUD treatment. RTPs can be an alternative to jail; some court sentences allow people with substance use disorder to be released from jail to treatment, and when someone on community supervision violates probation terms because of addiction, a Probation Officer can connect the person to treatment instead of making an arrest. Most Probation clients who need SUD treatment receive care in the County's Drug Medi-Cal Organized Delivery system. The RTPs contracted by Probation serve clients not enrolled in Medi-Cal and not eligible for services in the Drug Medi-Cal Organized Delivery system.

RTPs help clients acquire interpersonal and life skills, access community support systems, and transition into more independent living. RTPs provide needs assessment, individual and group therapy sessions, relapse prevention and recovery services, discharge planning, aftercare, and drug testing through a trauma-informed approach. The individual's assigned Probation Officer and RTP staff incorporate Probation case plan goals into treatment services to encourage successful outcomes for the client.

The contract performance measures would focus on client success and contracted providers' success in engaging clients in treatment that reduces their risk factors for future criminal behavior. Performance measures may include clients remaining drug-free in the program and clients being successfully linked to the step-down services.

The current contracts expire December 31, 2021. If today's action is approved, Probation intends to continue providing these services through multiple new contracts countywide. A multiple award Request for Proposals (RFP) will allow the department to award a range of as-needed contracts, providing Probation Officers flexibility in accessing residential treatment services for clients. Continuing these services is an essential part of the Probation Department's evidence-based strategy of connecting the justice-involved population with residential treatment services for substance use disorders.

This request is to authorize the Director, Department of Purchasing and Contracting, to issue a competitive solicitation for residential treatment program services and award contracts as needed for an initial term of six (6) months (projected to begin January 1, 2022) with four (4) one-year (1) option periods and up to an additional six (6) months if needed.

LINKAGE TO THE COUNTY OF SAN DIEGO STRATEGIC PLAN
Today's proposed action supports the Living Safely Initiative of the County of San Diego's 2021-26 Strategic Plan by supporting efforts to reduce recidivism through rehabilitative services and increase public safety through client accountability.

Respectfully submitted,

HELEN N. ROBBINS-MEYER
Chief Administrative Officer

ATTACHMENT(S)
N/A

COUNTY OF SAN DIEGO

AGENDA ITEM

DATE: **March 16, 2021**

12

TO: Board of Supervisors

SUBJECT
RECEIVE UPDATE REGARDING SAN PASQUAL ACADEMY AND AUTHORIZE REQUEST FOR EXTENSION OF PILOT PROJECT (DISTRICTS: ALL)

OVERVIEW
San Pasqual Academy (SPA) opened in 2001 and is a first-in-the-nation residential education campus designed to meet the unique needs of adolescent youth from the foster care system and to prepare them for self-sufficiency upon exiting care. SPA is designed to be similar to a family home-based placement and serves as an alternative placement option for dependents of the Juvenile Court, 12-17 years old, and Non-Minor Dependents up to age 19 years old. Through a unique partnership of public and private agencies such as New Alternatives, Inc., San Diego County Office of Education, Access Inc. through the support of the San Diego Workforce Partnership, and the County of San Diego (County) Health and Human Services Agency, Child Welfare Services (CWS), youth are provided with a seamless delivery of residential, education, work readiness and child welfare case management services.

Over the last five years, federal and State legislation have shifted the statutory requirements for keeping children safely with families. On October 11, 2015, Assembly Bill 403, also known as the Continuum of Care Reform Act (CCR), was signed into law. CCR identifies home-based settings with resource families as the best placement option for youth and limits a youth's placement in congregate care settings. As a result of multiple discussions on how to preserve SPA's unique program as permitted through the parameters of CCR, an updated Program Statement for a three-year Pilot Project for the period of December 1, 2018 through December 31, 2021 was approved by the California Department of Social Services (CDSS) on August 17, 2018.

More recently, on February 9, 2018, the Family First Prevention Services Act (FFPSA) was signed into law as part of Public Law (P.L.) 115-123. FFPSA provides federal funding for prevention services and adds new requirements on reducing congregate care placements and increasing supports for children in foster care to live in kinship and community family settings.

On February 8, 2021, CWS was notified by CDSS that the SPA three-year Pilot Project would terminate effective October 1, 2021 rather than December 31, 2021 because SPA is not recognized as a family setting and does not meet the requirements to be a therapeutic placement setting outlined in federal requirements under FFPSA. Based on the positive outcomes demonstrated by

SUBJECT: RECEIVE UPDATE REGARDING SAN PASQUAL ACADEMY AND AUTHORIZE REQUEST FOR EXTENSION OF PILOT PROJECT (DISTRICTS: ALL)

youth placed at SPA and alumni, and the input received from stakeholders, today's action requests the Board provide authorization to request an extension from CDSS to continue operating SPA through June 30, 2022. If approved, this extension will provide CWS the opportunity to continue to engage youth and partners to explore other models that may extend the successful outcomes of SPA to a wider foster youth population. This action supports the County of San Diego's *Live Well San Diego* vision by providing a continuum of safe and thriving placement options and accelerated permanency to children and youth interacting with the child welfare and juvenile justice systems.

RECOMMENDATION(S)
CHIEF ADMINISTRATIVE OFFICER
1. Receive the update regarding the San Pasqual Academy.
2. Direct the Chief Administrative Officer to request an extension from the California Department of Social Services to operate San Pasqual Academy through June 30, 2022.

FISCAL IMPACT
Funds for San Pasqual Academy (SPA) are currently included in the Fiscal Year 2020-22 Operational Plan in the Health and Human Services Agency (HHSA). The funding sources include Title IV-E federal funding, federal Short-Doyle Medi-Cal funding, Realignment, and General Purpose Revenue. If approved by CDSS to continue operations at SPA, the County would need to invest approximately $1.4 million in additional one-time realignment funds to cover lost Title IV-E federal funding from October 1, 2021- June 30, 2022. There will be no change in net General Fund cost and no additional staff years.

BUSINESS IMPACT STATEMENT
N/A

ADVISORY BOARD STATEMENT
This item was presented to the Child and Family Strengthening Advisory Board as an informational item on March 12, 2021.

This item will be presented to the San Pasqual Academy (SPA) Advisory Board as an informational item on March 18, 2021.

BACKGROUND
San Pasqual Academy (SPA) opened in 2001 and is a first-in-the-nation residential education campus designed to meet the unique needs of adolescent youth in the foster care system and to prepare them for self-sufficiency upon exiting care. SPA is designed to be similar to a family home-based placement and serves as an alternative placement option for dependents of the Juvenile Court, 12-17 years old, and Non-Minor Dependents up to age 19 years old. Through a unique partnership of public and private agencies such as New Alternatives, Inc., San Diego

County Office of Education, Access Inc. through the support of the San Diego Workforce Partnership, and the County of San Diego (County) Health and Human Services Agency, Child Welfare Services (CWS), youth are provided with a seamless delivery of residential, education, work readiness and child welfare case management services.

Collaborative and comprehensive services and supports provided at SPA include:

- Individualized education on campus for grades nine through twelve;
- Independent living skills training;
- Health, wellness, and therapeutic services;
- Work readiness training, workshops, and internships;
- Extra-curricular and enrichment activities such as music lessons, intramural sports, and community services; and
- Family connections and permanent support systems.

Additionally, SPA provides youth with relational supports during their stay at SPA and post-graduation through the San Pasqual Academy Neighbors (SPAN) grandparents program and alumni services. The SPAN program consists of volunteers living on campus who develop natural relationships with the youth, offering mentoring and life skills opportunities. The alumni services offered by New Alternatives, Inc. allow alumni to return "home" from college during holidays and school breaks, as well as receive support during times of crisis.

Changes in Child Welfare System Landscape

SPA was designed to improve the outcomes of youth exiting foster care unprepared for independence, by providing a long-term placement in an independent living skills environment so youth could focus on completing their high school education. The youth originally identified and placed at the SPA were high school age youth, unlikely to return home, and in long-term foster care situations. Participating youth did not require the intensive treatment offered by other congregate care settings but were unable to be successfully placed in a foster home. Instead, the youth needed stability, structure, and support. Over the last ten years, in an effort to increase supports to youth in the child welfare and juvenile justice systems and continue the programming that SPA is designed for, SPA has accommodated the changing needs of the foster care population by considering the following types of youth for placement:

- In middle school to allow sibling groups to remain intact;
- In active family reunification cases;
- In dual status cases (youth interacting with both child welfare and juvenile justice systems);
- With low level offenses active to probation, and
- From neighboring counties.

The campus culture has shifted with more youth in active family reunification cases who are transitioning home or to relatives soon after placement, contributing to considerably shorter lengths of stay, which is a shift away from the SPA model. Additionally, the needs of youth referred and placed at SPA have also changed in the last five years. As CWS continues to deepen prevention and family strengthening efforts, fewer youth are entering into the child welfare and

SUBJECT: RECEIVE UPDATE REGARDING SAN PASQUAL ACADEMY AND AUTHORIZE REQUEST FOR EXTENSION OF PILOT PROJECT (DISTRICTS: ALL)

juvenile justice systems. The youth who cannot be safely maintained in their homes with their biological families and enter foster care have often been exposed to severe complex trauma and present with significant mental and behavioral health needs to include but not limited to, substance use history and behaviors consistent with the commercial sexual exploitation of children (CSEC). Youth presenting with these behaviors and intensive needs may require a higher level of care that is not in alignment with the SPA model.

Legislative Changes

Over the last five years, federal and State legislation have significantly shifted the statutory requirements for keeping children safely with families. On October 11, 2015, Assembly Bill 403, also known as the Continuum of Care Reform Act (CCR), was signed into law. CCR provides the policy and statutory framework to ensure that services and supports for children and youth and their families are tailored toward the ultimate goal of maintaining a stable family. Drawing upon a body of research that shows that youth who suffer from abuse and neglect do best when they can live in a supportive, home-based, family environment, CCR identifies home-based settings with resource families as the best placement option for youth. Additionally, CCR limits a youth's placement in congregate care settings to a new licensing category, Short-Term Residential Therapeutic Programs (STRTPs), with a duration of no longer than six months in order to receive intensive treatment to transition to a home-based setting. CCR eliminated the use of licensed group homes as a placement option for foster youth. Group homes were to convert to a STRTP or any other licensing category available to foster youth. While SPA is licensed by the California Community Care Licensing division as a group home, the distinctive services offered set the program apart from other licensed congregate care facilities.

CCR included language to help preserve SPA and recognizes that the program, though licensed as a group home, was built around a residential education environment that promotes independence and self-sufficiency while focusing on completing high school, preparing for the world of work, practicing independent living skills, and developing relational permanency. As a result of multiple discussions on how to preserve SPA's unique program as permitted through the parameters of CCR, an updated Program Statement for a three-year Pilot Project for the period of December 1, 2018 through December 31, 2021 was approved by California Department of Social Services (CDSS) on August 17, 2018. Subsequently, a Memorandum of Understanding (MOU #18-6017) between CDSS and the County outlined how SPA will promote the principles of CCR and solidified SPA's on-going operation.

More recently, on February 9, 2018, the federal Family First Prevention Services Act (FFPSA) was signed into law as part of Public Law (P.L.) 115-123. FFPSA paves the way for a family strengthening, prevention focused infrastructure intended to enhance supportive services for families to help keep children safely at home, reduce the reliance on and use of congregate care, and expand the capacity and use of kinship care and family-based settings to support children and families. In addition to funding for prevention services, FFPSA also places new requirements on reducing congregate care placements and increasing supports for children in foster care to live in kinship and community family settings. Child welfare systems must ensure alignment with the new FFPSA federal child welfare requirements prior to receiving federal prevention funding. California will fully implement FFPSA on October 1, 2021.

With multiple sweeping legislative changes and child welfare transformations to increase family strengthening and prevention efforts and improve permanency outcomes for youth in foster care, SPA continued to experience a shift in campus culture and be impacted by trends in the foster care population. Youth needs increased from multiple complex trauma experiences and required more intensive services, interventions, and stabilization prior to consideration for placement at SPA. SPA evolved in support of the changing child welfare landscape and bolstered collaborative efforts to increase SPA referrals to extend the unique services and supports offered and be in line with its licensing capacity for 184 youth, maintain programming operations, and sustain the viability of SPA as a placement option.

Operational Developments
In an effort to conform to State and federal laws, and align with national best practices and relevant research, CWS reduced the number of children in congregate settings (excluding San Pasqual Academy) by 69% over the past 10 years.

- As of January 1, 2021, CWS data reflects that only 216 of 2,238 children (ages 0-17) remain in congregate care settings.
    - 72 of which are at San Pasqual Academy;
    - 47 are at Polinsky Children's Center, a 10-day assessment center; and
    - 97 are in a STRTP.

- As of March 1, 2021, the current population of youth at SPA is 69.

Overall, CWS efforts continue to be on the right trajectory to align with the direction that child welfare is headed in nationally, and even with the changing landscape of child welfare, trends of youth in foster care, and legislation, SPA continues efforts to provide comprehensive services and prepare youth for self-sufficiency and maintain viability as an alternative placement option for adolescent youth interacting with the child welfare and juvenile justice systems. In consideration of the significant changes in State and federal policy on the use of congregate care settings, the significant decrease in the foster youth population overall, especially of those requiring long-term high level of care, and the impact on the ability to draw down federal funding based on new legislation, it was determined by CDSS that SPA is no longer a viable placement option for teens in foster care in San Diego County.

On February 8, 2021, CWS was notified by CDSS that the SPA three-year Pilot Project would terminate effective October 1, 2021 rather than December 31, 2021. CDSS informed the County that because SPA is not amending its operations and programming to convert to a STRTP or any other licensing category available to youth in foster care, its educationally based residential program is unsustainable for foster care under CCR. As of October 1, 2021, the beginning of the federal fiscal year, there will no longer be federal Title IV-E funding authority to operate SPA, because it is not recognized as a family setting nor does it meet the requirements to be a therapeutic placement setting outlined in federal requirements under FFPSA. Title IV-E federal funding covers approximately 14% of the SPA budget and the County would need to invest approximately $1.4 million in additional realignment funds to cover lost Title IV-E federal funding from October 1, 2021 - June 30, 2022.

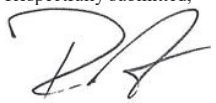
SUBJECT: RECEIVE UPDATE REGARDING SAN PASQUAL ACADEMY AND AUTHORIZE REQUEST FOR EXTENSION OF PILOT PROJECT (DISTRICTS: ALL)

Based on the positive outcomes demonstrated by youth placed at SPA and alumni, and the input received from stakeholders, today's actions request the San Diego County Board of Supervisors authorize the Chief Administrative Officer to request an extension from CDSS to allow SPA to continue operating through June 30, 2022. If approved, this extension will provide CWS the opportunity to continue to engage youth and partners to explore other models that may extend the successful outcomes of SPA to a wider foster youth population.

Next Steps - Community Engagement
Stakeholders, including current and former foster youth, have been vocal about the desire for the continuance of SPA to serve the unique needs of adolescent foster youth despite the implications of CCR and the FFPSA. In an effort to gather information and explore all feasible options best suited to meet the needs of adolescent foster youth, the County will utilize the Child and Family Strengthening Advisory Board (CFSAB) and its subcommittees as a forum for stakeholders and community members to provide input. Meetings and additional community forums are scheduled to engage and allow stakeholders, including current and former foster youth, to provide suggestions on feasible placement options, models, and next steps for SPA's program.

LINKAGE TO THE COUNTY OF SAN DIEGO STRATEGIC PLAN
This action supports the Building Better Health, Living Safely, and Thriving initiatives in the County of San Diego's 2021-2026 Strategic Plan, as well as the County of San Diego's *Live Well San Diego* vision by providing a continuum of safe and thriving placement options and accelerated permanency to children and youth interacting with child welfare and juvenile justice systems.

Respectfully submitted,



HELEN N. ROBBINS-MEYER
Chief Administrative Officer

ATTACHMENT(S)
N/A

NORA VARGAS
VICE-CHAIR
SUPERVISOR, FIRST DISTRICT
SAN DIEGO COUNTY BOARD OF SUPERVISORS

AGENDA ITEM

DATE: **March 16, 2021**

15

TO: Board of Supervisors

SUBJECT
LITERACY CAMPAIGN TO INCREASE ACCESS TO BOOKS IN LOW-INCOME COMMUNITIES AND COMMUNITIES OF COLOR AND BOOST CHILDHOOD READING COMPREHENSION AND WRITING (DISTRICTS: ALL)

OVERVIEW
Beyond the public health impacts of the Covid-19 pandemic, student learning and reading levels have been disproportionately impacting families with children, particularly for the early grade levels where reading fundamentals are the foundation. The pandemic poses even greater challenges for our English learner students. There are fewer resources for teachers and parents; more challenges for families to access technology; and the support at home to access the technology and language and reading programs face bigger challenges.

While studies show that enhancing a child's access to books at home has a significant impact on their long-term learning, many students in the San Diego County community do not have enough age-appropriate books in their home libraries, with parents on low-income households already struggling to make ends meet.

This Board Letter instructs the Chief Administrative Officer and San Diego County Libraries to create a Little Libraries initiative that will provide access to books from this neighbor-to-neighbor, community supported, and volunteer led book exchange and target implementation in communities of color. The intent of this initiative is to foster community and access to books and encourage at-home libraries and reading at home for students and their parents, and work with the appropriate stakeholders to reach communities of color and deploy the Little Libraries literacy campaign, and to provide support for augmenting literacy opportunities to further education and education success for advanced studies for continuing students.

I strongly urge your support for the recommendations in this letter. This is an opportunity for us to do more to promote literacy and to expand access to reading and learning opportunities for children, youth, and adults by increasing access to culturally appropriate library material and support services.

SUBJECT: LITERACY CAMPAIGN TO INCREASE ACCESS TO BOOKS IN LOW-INCOME COMMUNITIES AND COMMUNITIES OF COLOR AND BOOST CHILDHOOD READING COMPREHENSION AND WRITING (DISTRICTS: ALL)

RECOMMENDATION(S)
VICE-CHAIR NORA VARGAS
1. Direct the Chief Administrative Officer and San Diego County Libraries to create a Little Libraries initiative that will provide access to books for low-income communities & communities of color to help boost reading comprehension and writing skills
2. Direct the Chief Administrative Officer to work with stakeholders to develop a volunteer-led book exchange and focus implementation in low-income communities and communities of color and identify locations to install little libraries.

FISCAL IMPACT
Funds for this request are included in the Fiscal Year 2020-21 Operational Plan for the San Diego County Libraries. If approved, this request will result in costs of $20,000. The funding source is available prior year Library Fund fund balance. There will be no change in net General Fund cost and no additional staff years.

BUSINESS IMPACT STATEMENT
N/A

ADVISORY BOARD STATEMENT
N/A

BACKGROUND
As Read Across America launches it is important to highlight the extreme impact that the COVID-19 pandemic has had on all of our student learning. The challenges of doing more to support our children, teachers and educators have been present every day for our families since the start of online learning from home.

Beyond the public health impacts of the COVID-19 pandemic, student learning and reading levels have been disproportionately impacting families with children, particularly for the early grade levels where reading fundamentals are the foundation. The pandemic poses even greater challenges for our English learner students. There are fewer resources for teachers and parents; more challenges for families to access technology; and the support at home to access the technology and language and reading program are bigger challenges.

In 2020, the San Diego Council on Literacy found that approximately 560,000 local adults read at an elementary school level, or not at all. The Council on Literacy also points out that 60% of low-income students have no books at all at home. As families struggle through the pandemic, we must do all we can to help to our school children, to not lose more ground on their reading and language learning. School closures and virtual learning has exacerbated access and learning opportunities. On average, students could lose a staggering five to nine months of learning by the end of June 2021. Students of color could be six to 12 months behind.

SUBJECT: LITERACY CAMPAIGN TO INCREASE ACCESS TO BOOKS IN LOW-INCOME COMMUNITIES AND COMMUNITIES OF COLOR AND BOOST CHILDHOOD READING COMPREHENSION AND WRITING (DISTRICTS: ALL)

It currently takes 6 years for community college students in the San Diego region to transfer from colleges to universities due to additional requirements relating to language and literacy expectations. At the County, we have identified that one of our Live Well areas of influence is Knowledge with an Education indicator focused on high school graduation rates. While there has been progress made on graduation rates, advancement to further education still experiences challenges. As an example, data from the Council on Literacy points out that the percentage of students in District 1 that meet the language arts standards are the lowest in the region, which is between 35 and 40 percent. The same data indicates that students residing in Rancho Santa Fe are approximately at 90 percent. Furthermore, college graduation rates follow the same disparities with lower income communities of color in District 1, only achieving between 7.9 and 15 percent of college graduation, while students in Rancho Santa Fe are achieving a 65.8 percent college graduation rate.

While studies show that enhancing a child's access to books at home has a significant impact on their long-term learning, many students in the San Diego County community do not have enough age-appropriate books in their home libraries, with parents on low-income households already struggling to make ends meet. Researchers have identified that having as few as 20 books in the home (regardless of income level), has a positive impact on a child's level of education. Additionally, when parents and children read together it helps to increase vocabulary, raises self-esteem, and builds good communications skills.

In order to address the lack of access to books in the home, this initiative will connect our San Diego County Libraries with the national Little Free Library movement where their focus is to facilitate book exchanges. The Little Free Library is a non-profit whose mission is to expand book access. The Little Free Library facilitates a step-by-step establishment of little libraries in communities by: 1. Offering a community registry of little libraries that are identified on a Geographic Information System (GIS) map on their webpage and identifies locations in communities across the United States; and 2. The program offers pre-constructed little library structures for purchase and registry, thus facilitating deployment at several sites, as well as other resources for securing books. The intent of this initiative is to identify any existing little libraries in communities as well as identify areas of need and engage stakeholders and partners that will assist in establishing new locations and promoting local support for book exchanges in coordination with the San Diego County Libraries. An analysis of the Little Free Library GIS map presents that higher income communities in San Diego have good access to book exchanges using the Little Free Library, while only 4 sites in City of San Diego South Bay (San Ysidro, Otay); 1 site in Paradise Hills and no sites in National City or Imperial Beach. The San Diego County Library will also identify initial book offerings and working with stakeholders and partners identify opportunities to integrate books in other languages.

LINKAGE TO THE COUNTY OF SAN DIEGO STRATEGIC PLAN
Today's proposed actions support the Live Well San Diego Initiative in the County's Strategic Plan, and its vision for San Diego that is Building Better Health, Living Safely, Thriving, by supporting and empowering communities.

COUNTY OF SAN DIEGO

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CLERK OF THE BOARD OF SUPERVISORS

COUNTY OF SAN DIEGO

BOARD OF SUPERVISORS

1600 PACIFIC HIGHWAY, ROOM 335, SAN DIEGO, CALIFORNIA 92101-2470

AGENDA ITEM

DATE: **March 16, 2021**

21

TO: Board of Supervisors

SUBJECT

AMPLIFYING SYSTEMS OF SUPPORT FOR YOUTH CAREER READINESS AND EMPLOYMENT (DISTRICTS: ALL)

OVERVIEW

The impact of the COVID-19 pandemic has drastically impacted our lives. But the pandemic has a disproportionate impact on youth – especially those youth who have previously experienced limited economic opportunity. A report published by the San Diego Workforce Partnership estimated the youth population, those between the ages of 16 to 24 years of age, to number approximately 417,000 in the region. Within this group, 43,000 individuals are considered "opportunity youth" - individuals who are not in school and not working. The report notes the "missed social and economic opportunity in developing these individuals to become thriving members of society." We must not allow our youth to become so disconnected from society and must find ways to connect youth to employment opportunities through career readiness and workforce development.

In October 2020, the Board approved the development of the Live Well San Diego Youth sector which has the responsibility to hire youth ambassadors, provide training, lead townhalls, provide mentorship and engage youth in boards and commissions. To further amplify their voices and diversify to lived experiences of youth in the Youth Sector Program, I propose the formation of the Youth Environmental/Recreation Corp Program charged with addressing the economic needs of youth in our community.

Today, I am ask our County Board of Supervisors to establish the Youth Environment/Recreation Corp and provide $500,000 for Fiscal Year 2021-2022 and $500,000 Fiscal Year 2022-2023. The Youth Environment/Recreation Corp will amplify the work of the Live Well San Diego Youth Sector by providing career readiness, workforce development in collaboration with other county entities.

SUBJECT: **AMPLIFYING SYSTEMS OF SUPPORT FOR YOUTH CAREER READINESS AND EMPLOYMENT (DISTRICTS: ALL)**

RECOMMENDATION(S)

SUPERVISOR TERRA LAWSON-REMER AND SUPERVISOR NORA VARGAS

1. Direct the Chief Administrative Officer to return to the Board of Supervisors within 90 days with a proposal for development of the Youth Environment/Recreation Corp within the County to oversee, coordinate and implement the following:

    a. Funding of Community Organizations that support youth career readiness, workforce development, mentorship and access to green spaces. Grants and youth career readiness programs should focus outreach and participation on low-income youth.
    b. Department of Human Resources efforts to create County workforce, career development and employment training opportunities for youth.

2. Direct the Chief Administration Officer to refer to budget $500,000 for Fiscal Year 2021-2022 and $500,000 for Fiscal Year 2022-2023 for the Youth Environmental/Recreation Corp Program.

FISCAL IMPACT

There is no Fiscal Impact for Fiscal Year 2020-21 Operational Plan. Fiscal Impact of $500,000 in costs for Fiscal Years 2021-22 and 2022-23. There will be a net change to General Fund and additional staff years depending on the development of the program.

BUSINESS IMPACT STATEMENT

This action will support businesses in the community by providing funding to increase the number of youth internships and enhance environmental advancement in the County.

ADVISORY BOARD STATEMENT

N/A

BACKGROUND

The impact of the COVID-19 pandemic has drastically impacted our lives. But the pandemic has a disproportionately impact on the youth – especially those youth who have previously experience limited economic opportunity. A report published by the San Diego Workforce Partnership estimated the youth population, those between the ages of 16 to 24 years of age, at around 417,000 individuals in the region. Within this group, 43,000 individuals are considered "opportunity youth" - individuals who are not in school and not working. The report notes the "missed social and economic opportunity in developing these individuals to become thriving members of society." We must not allow our youth to become so disconnected from society and must find ways to connect youth to employment opportunities through career readiness and workforce development.

During March and April of last year, the COVID-19 pandemic caused the sharpest unemployment spike in modern history. While youth may have fewer health complications due to COVID-19,

they are greatly impacted by the downturn in employment and educational opportunities. Youth and those with less education are some of the hardest hit in our community by the current economic climate.

Youth are more likely to be employed in part-time and temporary positions and have fewer assets which increases their vulnerability during an economic downturn. According to a June 2020 Organization for Economic Co-operation and Development report, youth are especially concerned about, "the toll on mental health, employment, disposable income and education." A Center for Economic Policy Research report describes the dramatic impact of just one month of unemployment for 18-20 year-olds citing a 2% decrease in lifetime income.

The 2020 report published by the San Diego Workforce Partnership indicated:

- 417,000 youth ages 16-24 live in San Diego County with 38,000 who are not working.
- 2018 saw a slight increase of youth who are disconnected in our Region
- Opportunity Youth, defined as young people aged 16-24 who are neither working nor in school, are not just in one area of the county. Youth impacted are spread across the region with high pockets of Opportunity Youth in Fallbrook, Vista, Escondido, Lemon Grove, Chula Vista and National City.

The Department of Parks and Recreation (DPR) has offered after school and evening programs for many years at select DPR locations. In FY 2016-17, the Summer Night Lights program began operating at the Spring Valley Teen Center with a single pilot event for teens. The program grew to eight events in FY 2017-18. In FY 2018-19, DPR expanded the program to offer year-round activities and re-branded it as SD Nights (San Diego/Safe Destinations Nights). Part of the expanded program included the development of the Leadership Education and Development (LEAD) Squad, which provides employment opportunities for youth as young as 15 years old. For most of the participants, this is their first job. In the past two years the SD Nights program has hired 77 youth workers, to assist with planning and implementing over 200 events per year, keeping over 10,000 youth off the streets during critical hours. Although the COVID-19 pandemic has slowed down events and hiring, 10 of the SD Nights staff have been able to work in other parks, building their work experience and skill set, and 8 others have been accepted into collegiate level programs. DPR currently has over 80 employees in the opportunity youth age group serving as leaders in youth programs, performing administerial duties at recreation centers and the reservation desk and providing park maintenance and stewardship in parks. These positions are a path to full-time careers in DPR as Park Rangers, Park Maintenance Workers, Recreation Programmers, and Administrative Analysts.

The International Labor Organization estimates that efforts to move toward green economies will create 60 million new jobs worldwide by 2030. These jobs require relevant skills and training. The proposed Youth Environmental/Recreation Corp Program would provide skills and training opportunities to develop knowledge, practice skills, and gain work experience in this growing sector. Environmental issues are cross-sectional, impacting all sectors of our county. By investing in youth career readiness in these areas we can develop a future workforce of local stewards positioned for healing of community and environment.

SUBJECT: AMPLIFYING SYSTEMS OF SUPPORT FOR YOUTH CAREER READINESS AND EMPLOYMENT (DISTRICTS: ALL)

On June 2, 2020, the Board approved the Housing Our Youth Pilot Program in San Diego County aimed at supporting those youth experiencing homelessness. In addition, the board approved a pilot program of Fostering Academic Success in Education (FASE) aimed at providing wraparound supports for youth in the child welfare system through education partnerships. In October 2020, the Board approved the development of the *Live Well San Diego* Youth Sector which is tasked with leadership development, training, mentorship and youth participation on boards and commissions. The County is well positioned to amplify and support the needs of youth in our region.

San Diego County stands to benefit when our youth are connected to programs that support career readiness and workforce development. By investing in community organizations and programs that invest in our youth, we make an investment in the future of San Diego. I urge my colleagues to support these actions and invest in our youth.

LINKAGE TO THE COUNTY OF SAN DIEGO STRATEGIC PLAN
The requested action supports the *Live Well San Diego* Initiative in the County's 2020-2025 Strategic Plan, and its vision for a San Diego that is Building Better Health, Living Safely and Thriving, by supporting youth career readiness as we navigate the economic recovery of COVID-19.

Respectfully submitted,

NORA VARGAS
Supervisor, District 1

TERRA LAWSON-REMER
Supervisor, District 3

ATTACHMENT(S)
N/A

COUNTY OF SAN DIEGO

BOARD OF SUPERVISORS

1600 PACIFIC HIGHWAY, ROOM 335, SAN DIEGO, CALIFORNIA 92101-2470

AGENDA ITEM

DATE: **April 6, 2021**

09

TO: Board of Supervisors

SUBJECT

STRENGTHENING MOBILE CRISIS RESPONSE TEAM PROGRAM: ADDITIONAL FUNDING FOR COMMUNITY EDUCATION CAMPAIGN, NORTH COASTAL SERVICE EXPANSION, AND DEVELOPING DATA SHARING AGREEMENTS AND PROTOCOLS WITH LAW ENFORCEMENT AND OTHER ENTITIES, AND ENGAGING INDIVIDUALS WITH LIVED EXPERIENCE THROUGH COUNTY ADVISORY BOARDS (DISTRICTS: ALL)

OVERVIEW

People with untreated mental illness are 16 times more likely to be killed during a police encounter than other civilians approached or stopped by law enforcement.

A law enforcement response is not appropriate for someone experiencing a non-violent mental health or substance use crisis. Due to the very specific skills needed, trained clinical mental and behavioral health professionals are better suited than law enforcement to provide assistance in these crises.

In June 2019, the Board of Supervisors, created an initial framework to move towards Mobile Crisis Response Teams (MCRT) to dispatch trained teams comprised of mental health clinicians and peer support specialists, rather than law enforcement representatives, to respond to non-violent mental health crisis emergency calls. Teams are trained for crisis interventions. They arrive on site, assess a person's condition and spend time with the individual to calm them down, and figure out the best place to refer them to address their situation.

This initial board action authorized the Chief Administrative Officer (CAO) to accelerate operations of a pilot MCRT program in North Coastal, expand the service countywide in addition to implementing a community outreach campaign to educate the public.

Building on lessons learned from the pilot, in February 2021, the County released a Request For Proposal (RFP) to obtain a provider or providers to service five Health and Human Services Agency (HHSA) regions, as authorized by the June 20, 2020 Board Action. The five HHSA designated regions include North Inland, North Central, Central, South, and East and will operate

SUBJECT: STRENGTHENING MOBILE CRISIS RESPONSE TEAM PROGRAM: ADDITIONAL FUNDING FOR COMMUNITY EDUCATION CAMPAIGN, NORTH COASTAL SERVICE EXPANSION, AND DEVELOPING DATA SHARINGAGREEMENTS AND PROTOCOLS WITH LAW ENFORCEMENT AND OTHER ENTITIES, AND ENGAGING INDIVIDUALS WITH LIVED EXPERIENCE THROUGH COUNTY ADVISORY BOARDS (DISTRICTS: ALL)

24 hours/7 days a week response model, with a goal of integrating with 9-1-1 dispatch and is projected to come on-line late summer.

To help strengthen our local Mobile Crisis Response Teams (MCRT), we are proposing the following set of recommendations: expand MCRT operations designated in North Coastal Region to 24/7, allocate resources to ensure a robust community education campaign, create a process for community and individuals with lived experience to provide input into the new MCRT model, and build internal capacity within Behavioral Health Services to work with law enforcement to develop protocols for referrals and agreements for data sharing to improve client outcomes.

RECOMMENDATION(S)
CHAIR NATHAN FLETCHER AND SUPERVISOR TERRA LAWSON-REMER

1. Refer to budget the expansion of the North Coastal Mobile Crisis Response Team (MCRT) to provide twenty-four-hour and seven-days-per-week services.

2. Refer to budget up to $600,000 to cover cost of conducting a public awareness campaign educating the community about when and how to call the MCRT and the request to add 1.00 staff years to work with the public safety partners and lead efforts to coordinate points of access and create triage protocols countywide for San Diego County Crisis Line and 9-1-1 dispatch as well as develop roadmap for data sharing agreements between public safety and behavioral health services for mutual clients.

3. Direct the CAO to work with the chairs of the Behavioral Health Advisory Board and the Human Relations Commission to allow County staff to provide both entities with quarterly written updates about the MCRT services and to be present as requested at the meetings to answer questions and receive feedback.

4. Direct the CAO to report back to the Board within 90 days after the adoption of the Fiscal Year 2021-22 budget on the progress in implementing Recommendations 2 and 3 above, and to provide written quarterly reports.

FISCAL IMPACT

There is no fiscal impact to the FY 2020-21 CAO Operational Plan with today's recommendation. Costs associated with the recommendation in this board letter will be determined by the Chief Administrative Officer and referred to the budget.

BUSINESS IMPACT STATEMENT

N/A

SUBJECT: STRENGTHENING MOBILE CRISIS RESPONSE TEAM PROGRAM: ADDITIONAL FUNDING FOR COMMUNITY EDUCATION CAMPAIGN, NORTH COASTAL SERVICE EXPANSION, AND DEVELOPING DATA SHARINGAGREEMENTS AND PROTOCOLS WITH LAW ENFORCEMENT AND OTHER ENTITIES, AND ENGAGING INDIVIDUALS WITH LIVED EXPERIENCE THROUGH COUNTY ADVISORY BOARDS (DISTRICTS: ALL)

ADVISORY BOARD STATEMENT
N/A

BACKGROUND
People with untreated mental illness are 16 times more likely to be killed during a police encounter than other civilians approached or stopped by law enforcement.

A law enforcement response is not appropriate for someone experiencing a non-violent mental health or substance use crisis. Due to the very specific skills needed, trained clinical mental and behavioral health professionals are better suited than law enforcement to provide assistance in these crises.

To help strengthen our local Mobile Crisis Response Teams (MCRT), we are proposing the following set of recommendations: expand MCRT operations designated in North Coastal Region to 24/7, allocate resources to ensure a robust community education campaign, create a process for community and individuals with lived experience to provide input into the new MCRT model, and build internal capacity within Behavioral Health Services to work with law enforcement to develop protocols for referrals and agreements for data sharing to improve client outcomes.

As noted in *Crisis Now Transforming Services is Within Our Reach* published by the National Action Alliance for Suicide Prevention, "Mobile crisis interventions provide individuals with less restrictive care in a more comfortable environment that is likely to produce more effective results than hospitalization or Emergency Department utilization. When collaboration exists with hospitals, medical and behavioral health providers, law enforcement, and other social services, community-based mobile crisis is an effective and efficient way of resolving mental health crisis and preventing future crisis situations."

In June 2019, the Board of Supervisors, created an initial framework to move towards Mobile Crisis Response Teams (MCRT) to dispatch trained teams comprised of mental health clinicians and peer support specialists, rather than law enforcement representatives, to respond to non-violent mental health crisis emergency calls. Teams are trained for crisis interventions. They arrive on site, assess a person's condition and spend time with the individual to calm them down, and figure out the best place to refer them to address their needs. The initial MCRT June 2019 pilot program, called "The North Coastal Mobile Crisis Response Team" covers only the North Coastal region, and offers services from 8am to 6:30pm seven days a week but is not currently integrated with 9-1-1.

In June 2020, the Office of Chair Nathan Fletcher initiated a proposal seeking to accelerate and scale-up that initial pilot in North Coastal by expanding the service countywide and allocating $10 million to create regional coverage for Mobile Crisis Response Teams (MCRT). The proposal

SUBJECT: STRENGTHENING MOBILE CRISIS RESPONSE TEAM PROGRAM: ADDITIONAL FUNDING FOR COMMUNITY EDUCATION CAMPAIGN, NORTH COASTAL SERVICE EXPANSION, AND DEVELOPING DATA SHARINGAGREEMENTS AND PROTOCOLS WITH LAW ENFORCEMENT AND OTHER ENTITIES, AND ENGAGING INDIVIDUALS WITH LIVED EXPERIENCE THROUGH COUNTY ADVISORY BOARDS (DISTRICTS: ALL)

also instructed the CAO to work with law enforcement agencies to integrate the MCRT program with 9-1-1 dispatch and developing a community outreach campaign to educate the public.

Building on lessons learned from the pilot, in February 2021, the County released a Request For Proposal (RFP) to obtain a provider or providers to service five Health and Human Services Agency (HHSA) regions, as authorized by the June 20, 2020 Board Action. The five HHSA designated regions include North Inland, North Central, Central, South, and East and will operate a 24 hours/7 days a week response model, with a goal of integrating with 9-1-1 dispatch and is projected to come on-line late summer.

The above referenced MCRT RFP does not include the North Coastal pilot region, the service providers for this area was determined by a separate procurement. Today, we are requesting that this particular service area be expanded to 24 hours/7 days a week resulting in full day coverage across the entire county by next Fall when the current procurement is complete.

Community outreach, education, and public awareness are essential to increase access and use of this essential service. As the MCRT program transitions to a 24/7 model and is integrated with the 9-1-1 system, a multi-prong campaign is needed to increase the usage of a non-law enforcement response as appropriate situations arise anywhere in the County, no matter when they occur. As such, we are proposing to allocate dedicated resources for the development of a marketing campaign to ensure that the public knows when and how to request this service.

San Diego County has ten law enforcement agencies operating in our region that will need to be consulted in order to coordinate and arrive at agreed upon protocols to triage appropriate 9-1-1 dispatch calls that are non-violent to MCRT. Additionally, other points of access will need to be established with entities such as the San Diego County Crisis Line and the public. Although this is a best practice across the state and nation, it is new for San Diego stakeholders that are conditioned to calling 9-1-1 for help with responding to mental health crisis. It will take a concerted effort to change this norm.

As our county seeks to move away from a law enforcement response to a behavioral health crisis response, the integration of data from public safety, and health sectors will be essential to inform the program's development and track outcomes of clients. If the intervention is successful, we expect to see a reduction in hospitalizations and entry to jail for individuals that are touched by the MCRT. If we are able to create agreements in order to share data about common clients in real time we can better track and manage outcomes at the intersection of public safety and healthcare.

To enable the expeditious roll out of all aspects of MCRT and integration with law enforcement, we must have a dedicated staff person that can assist Behavioral Health Services to build partnerships with public safety, develop protocols with the ten law enforcement agencies and

other partners to coordinate dispatch of non-violent behavioral health related calls and develop agreements to share data across healthcare and public safety institutions. This position will be instrumental to help lead future strategies to divert individuals with untreated behavioral health disorders out of the justice system, and into proper care to improve outcomes, including Care Coordination and Jail Health reforms. We are proposing the creation of a position that can lead this work.

According to the Substance Abuse and Mental Health Service Administration (SAMHSA), a mobile crisis team care is one of three essential elements of a well-integrated crisis system of care. In its *National Guidelines for Behavioral Health Crisis Care*, SAMSHA notes that "To maximize effectiveness, the availability of mobile crisis services should match needs in the area/region they serve on a 24/7/365 basis and should be deployed and monitored by an air traffic control (ATC)-capable regional call center."

MCRT programs not only provide better outcomes but also reduces costs to healthcare and government. As published in the journal *Psychiatric Services* (2000), RL Scott notes the cost effectiveness of MCRT intervention, "The average cost per case was $1,520 for mobile crisis program services, which included $455 for program costs and $1,065 for psychiatric hospitalization. For regular police intervention, the average cost per case was $1,963, which consisted of $73 for police services and $1,890 for psychiatric hospitalization. In this study, mobile crisis services resulted in a 23 percent lower average cost per case."

In its 2009 report, SAMSHA notes the mental health crisis services "should afford opportunities for contact with others whose personal experiences with mental illness and past mental health crises allow them to convey a sense of hopefulness first-hand."

As such, we are recommending that the Behavioral Health Advisory Board and the Human Relations Commission, who advise our Board and made up of individuals with lived experience, receive regular updates on progress with the rollout as well as statistics on client outcomes and other performance measures to ensure community input and that the voice of individuals with lived experience help inform the program as it is initiated countywide and matures.

With the support of this Board fully investing in MCRT as an integral part of our continuum of behavioral health system, we will create a paradigm shift, providing those with immediate behavior health needs the opportunity to receive critically needed services as they cry out for help.

We urge your support for the recommendations in this proposal.

SUBJECT: STRENGTHENING MOBILE CRISIS RESPONSE TEAM PROGRAM: ADDITIONAL FUNDING FOR COMMUNITY EDUCATION CAMPAIGN, NORTH COASTAL SERVICE EXPANSION, AND DEVELOPING DATA SHARINGAGREEMENTS AND PROTOCOLS WITH LAW ENFORCEMENT AND OTHER ENTITIES, AND ENGAGING INDIVIDUALS WITH LIVED EXPERIENCE THROUGH COUNTY ADVISORY BOARDS (DISTRICTS: ALL)

LINKAGE TO THE COUNTY OF SAN DIEGO STRATEGIC PLAN
Today's proposed request supports the Live Well San Diego Initiative in the County's 2021-2026 Strategic Plan, and its vision for a San Diego that is Building Better Health, Living Safely and Thriving by creating a better service delivery system to serve individuals in behavioral health crisis.

Respectfully submitted,

NATHAN FLETCHER
Chair, Board of Supervisors
District 4

TERRA LAWSON-REMER
Supervisor, District 3

ATTACHMENT(S)
N/A

TERRA LAWSON-REMER
SUPERVISOR, THIRD DISTRICT
SAN DIEGO COUNTY BOARD OF SUPERVISORS

AGENDA ITEM

DATE: April 6, 2021

10

TO: Board of Supervisors

SUBJECT:
INCREASING ACCESS AND ENROLLMENT IN COUNTY SELF- SUFFICIENCY PROGRAMS TO SERVE EVERY COMMUNITY MEMBER IN NEED WITHOUT BARRIERS TO ENTRY (DISTRICT: 3)

OVERVIEW

The pandemic-induced recession pushed San Diegans to use their savings, rely on food banks, and seek economic support from our County's self-sufficiency programs. CalFresh, CalWORKs, Medi-Cal, Cash Assistance Program for Immigrants, and General Relief are five of San Diego County's self-sufficiency programs that support families during difficult economic times. While enrollment in these self-sufficiency programs is at an all-time high, barriers such as generational stigma, underfunded outreach efforts, racial biases, and misperceptions regarding guidance from the previous federal administration may limit optimal enrollment in these programs – especially at a time when families need this support the most.

There is a need to further understand the root causes of under-enrollment and develop a new strategy to target all eligible San Diego County residents given the impacts of the pandemic on the most vulnerable. It is concerning that so many individuals are not accessing the very programs designed to alleviate such problems given the sheer number of San Diego County residents who experience food insecurity, lack access to proper healthcare, and are underemployed or unemployed.

San Diego County is currently far behind in enrolling eligible individuals in its self-sufficiency programs. In 2010, the Rose Institute at Claremont McKenna College found that among the twelve largest counties in California, San Diego County was significantly behind in CalFresh, CalWORKs, and Medi-Cal enrollment. In 2013, San Diego County ranked 44th out of 58 California counties in CalFresh enrollment. In 2015, San Diego County only had a 50.9 percent CalFresh enrollment rate.

The County has an obligation to ensure that accessing CalFresh, CalWORKs, Medi-Cal, CAPI, and General Relief sufficiency programs is easy and consumer-friendly for every County resident

who is eligible. It has been more than a decade since the County thoroughly reviewed this issue. In 2010, the Board of Supervisors sent a memo to the Chief Administrative Officer requesting that the Social Services Advisory Board (SSAB) address the efficiency and effectiveness of the Supplemental Nutrition Assistance Program (SNAP), now known as CalFresh. The SSAB established a time-limited working group comprised of community-based organizations that had experience working with SNAP to provide recommendations for simplifying the eligibility process and removing perceived barriers that impede program participation.

11 years later, it is clear that the County must once again analyze, understand, recommend, and shift our program priorities to ensure every San Diegan in need obtains any benefits for which they may be eligible. The pandemic has highlighted how important it is that we make sure County benefits work for every San Diegan, regardless of their race, ethnicity, national origin, religion, gender identity, and/or sexual orientation.

I recommend that the Chief Administrative Officer convene a new stakeholder group under the SSAB that is dedicated to addressing the efficiency and effectiveness of the County's CalFresh, CalWORKs, Medi-Cal, CAPI, and General Relief enrollment programs.

RECOMMENDATION(S)
SUPERVISOR TERRA LAWSON-REMER

1. Request that the Chair of the Board of Supervisors send, on behalf of the Board, a letter requesting that the Social Services Advisory Board (SSAB) take the following actions:
   a. Establish a temporary ad hoc subcommittee called the 'Outreach, Accessibility, and Enrollment Task Force' (Task Force) comprised solely of less than a quorum of the SSAB's members.
   b. Request the Task Force to undertake a comprehensive review of enrollment barriers and plans to overcome these barriers for CalFresh, CalWORKs, Medi-Cal, Cash Assistance Program for Immigrants, and General Relief in an effort to increase outreach, accessibility, and enrollment for qualifying individuals in San Diego County.
   c. Request that the Task Force obtain the input of local experts and advocates with knowledge of health and human services in outreach, analyzing, and increasing enrollment in self-sufficiency programs in California.
   d. Request that the SSAB provide a monthly status report to the Board describing the Task Force's progress.
   e. Request that the SSAB report the Task Force's initial findings to the Board, along with any interim recommendations no later than October 4, 2021, and to provide a final report and recommendations no later than December 7, 2021.
2. Authorize the Director, Department of Purchasing and Contracting, to procure an agreement in accordance with Board Policy A-87, Competitive Procurement, and upon successful negotiations and a determination of a fair and reasonable price, enter into an agreement for a comprehensive assessment of the County's outreach, enrollment, and

accessibility for the CalFresh, CalWORKs, Medi-Cal, Cash Assistance Program for Immigrants, and General Relief programs, examining issues including, but not limited to, application requirements and processes, state and federal regulations, language barriers, technology barriers, customer-centered culture, case management, outreach strategies and tactics, community partner opportunities and staffing levels of eligibility workers, and to provide the Task Force support, as requested.

3. Direct the CAO to return to the Board with consultant-provided initial recommendations no later than October 4, 2021, and final recommendations no later than December 7, 2021.

FISCAL IMPACT
Funds for this request are included in the Fiscal Year 2020 – 2021 operational plan.

BUSINESS IMPACT STATEMENT
N/A

ADVISORY BOARD STATEMENT
N/A

BACKGROUND

Food insecurity and hunger have serious adverse effects on both children and adults. Hunger due to food insufficiency is associated decreased school readiness and success including lower grades, higher rates of absenteeism, repeating a grade, and an inability to focus in the classroom (Kleinman et al. 2002). Research has also shown that food hardship and hunger, even while controlling for other indicators of poverty, is also generally associated with behavioral problems in children. For adults, food insecurity is associated with an elevated risk of developing a myriad of health issues such as diabetes, high blood pressure, and other chronic illnesses (*Hunger in America,* 2014).

CalFresh provides financial assistance to those who need to purchase food, reducing food insecurity and hunger within our communities. Currently, 332,597 individuals are enrolled in the program. CalFresh recipients must be San Diego County residents, have a Social Security number, and have a total household gross monthly income that is less than or equal to 200 percent of the federal poverty level. Based on their income and household information, beneficiaries receive a monthly allotment in the form of an EBT card to cover basic food expenses.

CalWORKs is designed to help our community members transition from social welfare to attaining work opportunities by providing temporary cash assistance to eligible families with minor children. 37,458 individuals rely on CalWORKs. This program is integral to help families attain self-sufficiency, while still providing a social safety net. This program is income-sensitive as it factors other assistance such as unemployment.

SUBJECT: INCREASING ACCESS AND ENROLLMENT IN COUNTY SELF-SUFFICIENCY PROGRAMS TO SERVE EVERY COMMUNITY MEMBER IN NEED WITHOUT BARRIERS TO ENTRY

Medi-Cal is California's Medicaid health care program. Over 464,000 San Diegans rely on this program for a variety of medical services. Children and adults with limited income and resources rely upon this program for primary care, dental care and behavioral health services. This program is critical to increasing access to health care among our most vulnerable community members.

Cash Assistance Program for Immigrants (CAPI) is a state-funded cash aid program for certain immigrants who are not eligible for the federally funded Supplemental Security Income/State Supplementary Program (SSI/SSP). CAPI is an essential safety net program for immigrant community members who are not able to access many other welfare programs. To be eligible, applicants must be either aged 65 or older, blind, or disabled and not eligible for SSI/SSP solely due to their immigration status. Based on participants' immigration, marital, and disability status, CAPI provides a monthly payment to help cover living expenses.

General Relief provides temporary cash assistance for eligible county residents who have no other means of support. 2,347 individuals currently use this program. Applicants must be a San Diego County resident for at least 15 days, intend to remain in San Diego County, be a U.S. Citizens, or Legal Permanent Resident with income less than $449 (for a single person) or $614 (for a married couple).

San Diego County is currently far behind in enrolling eligible individuals in its self-sufficiency programs. In 2010, the Rose Institute at Claremont McKenna College found that among the twelve largest counties in California, San Diego County was significantly behind in CalFresh, CalWORKs, and Medi-Cal enrollment. In 2013, San Diego County ranked 44th out of 58 California counties in CalFresh enrollment. In 2015, San Diego County improved its rank by two places as it ranked 42nd out of the 58 counties with a 50.9 percent CalFresh enrollment rate.

Under-enrollment of immigrants in self-sufficiency programs may be due to fear of repercussions from proposed changes to the "Public Charge" rule. The change, which was in effect between 2019-2021, expanded the criteria through which immigrants may be denied U.S. admission/residency for having received public benefits or being deemed likely to receive public benefits in the future. A report by The Urban Institute found that 17.7 percent of adult immigrants in California avoided public benefits for fear of risking future green card status.

The San Diego Hunger Coalition estimates that as of November 2020, nearly 1 in 3 San Diegans (31 percent) are experiencing nutrition insecurity, up 25 percent from pre-pandemic levels. A nutrition insecure household struggles to provide enough healthy food for everyone under the roof, risking hunger and malnutrition. As of November, this nutrition insecurity extends to an estimated 603,882 adults (29 percent), 146,026 seniors (30 percent), and 284,459 children (40 percent). Not knowing where one's next meal will come from has several adverse effects on the physical, emotional, and educational wellbeing of children, according to many studies. The National Center for Chronic Disease Prevention and Health Promotion's Health and Academic Achievement report states that hunger due to insufficient food intake is associated with lower grades, higher rates of absenteeism, repeating a grade, and an inability to focus among students. Professor Kristen S. Slack (et al. 2005) found that food hardship and hunger, even while

controlling for other indicators of poverty, is also generally associated with behavioral problems in children.

The negative effects of hunger and food insecurity are not limited to children, but also extend to adults as well. Food insecure adults have an increased risk of developing diabetes, are associated with a variety of chronic illnesses, and may experience higher levels of aggression and anxiety. In addition, a 2014 report by Feeding America and Oxfam titled "From Paycheck to Pantry: Hunger in Working America" found that among the working-class households served by Feeding America, 28 percent reported having at least one member with diabetes and 50 percent having at least one member with high blood pressure. Both numbers are higher than the national percentages of people who suffer from such conditions, suggesting that working-class households have a higher incidence of these health problems. This relation between food insecurity and poor health is especially concerning given San Diego County's under-enrollment in both CalFresh and Medi-Cal.

Many families who are experiencing food insecurity also report having to make financial trade-offs, such as deciding whether to purchase food or pay for necessary health treatments. Over 69 percent of Feeding America working-class households reported choosing between paying for food and medicine or medical care in the past year. This could be alleviated if households had proper access to programs that provide financial assistance to cover both food and health expenses.

Health outcomes also have a unique relationship with employment and job retention. According to a 2018 Kaiser Family Foundation report, poor health was found to be associated with increased risk of job loss, while access to affordable health insurance has a positive effect on individuals' ability to obtain and maintain employment. Unemployment was also found to have a strong association with poor health outcomes. These findings indicate a principle that user-friendly access to healthcare is an integral part of maximizing self-sufficiency among San Diego County residents.

The SSAB established a time-limited working group in 2010 comprised of community-based organizations that had experience working with the Supplemental Nutrition Assistance Program (SNAP) to provide recommendations for simplifying the eligibility process and removing perceived barriers that impede program participation. The recommendations were compiled in a report titled "Recommendations for Improving the San Diego County Supplemental Nutrition Assistance Program" and was received by the Board of Supervisors in December 2010.

While the Board of Supervisors cited a 60 percent increase in SNAP participation due to some of the recommendations outlined by the working group, San Diego County still has some of the lowest enrollment rates among California counties. There is a need to further understand the root causes of our under enrollment and develop a new strategy to target all eligible San Diego County residents to be able to enroll and access CalFresh, CalWORKs, and Medi-Cal benefits.

LINKAGE TO THE COUNTY OF SAN DIEGO STRATEGIC PLAN

SUBJECT: INCREASING ACCESS AND ENROLLMENT IN COUNTY SELF-SUFFICIENCY PROGRAMS TO SERVE EVERY COMMUNITY MEMBER IN NEED WITHOUT BARRIERS TO ENTRY

Today's proposed request supports the Building Better Health Initiative of the County of San Diego's 2021-2026 Strategic Plan. Creating a stakeholder table to address the issues within our CalFresh, CalWORKs, and Medi-Cal enrollment program and increasing access to such programs achieves the 2021-2026 Strategic Plan's mission of promoting the implementation of a service delivery system that is sensitive to individuals' needs.

Respectfully submitted,

TERRA LAWSON-REMER
Supervisor, Third District

ATTACHMENT(S)
N/A

COUNTY OF SAN DIEGO

BOARD OF SUPERVISORS

1600 PACIFIC HIGHWAY, ROOM 335, SAN DIEGO, CALIFORNIA 92101-2470

AGENDA ITEM

DATE: **April 6, 2021** **16**

TO: Board of Supervisors

SUBJECT

A RESOLUTION DENOUNCING XENOPHOBIA AND ANTI-ASIAN RACISM AFFIRMING SAN DIEGO COUNTY'S COMMITMENT TO THE WELL-BEING AND SAFETY OF ASIAN PACIFIC ISLANDER COMMUNITIES (DISTRICTS: ALL)

OVERVIEW

Since the December 2019 outbreak of the novel coronavirus (COVID-19), Asian Pacific Islander (API) communities throughout the country have experienced a significant increase in acts of discrimination, racial profiling, microaggressions, violence, and hate crimes. While we know that racist incidents extend to other groups, the pandemic has exacerbated these actions against API and requires us to denounce it.

The California-based advocacy organization Stop AAPI Hate collected a reported 42 cases of racist incidents against Asian Americans and Pacific Islanders in San Diego County, mirroring a national trend of increased hate crimes. The organization's recorded over 2,800 firsthand accounts of anti-Asian hate from 47 states and the District of Columbia between the middle of March 2020 – when the pandemic hit – through the end of the year. According to their accounts, women were attacked 2 ½ times more than men.

Through this action the Board adopts a resolution to condemn anti-API hate and denounce xenophobia and anti-Asian racism.

RECOMMENDATION(S)
CHAIR NATHAN FLETCHER AND VICE CHAIR NORA VARGAS

1. Adopt the Resolution titled: A RESOLUTION DENOUNCING XENOPHOBIA AND ANTI-ASIAN RACISM AFFIRMING SAN DIEGO COUNTY'S COMMITMENT TO THE WELL-BEING AND SAFETY OF ASIAN PACIFIC ISLANDER COMMUNITIES

FISCAL IMPACT
N/A

BUSINESS IMPACT STATEMENT
N/A

ADVISORY BOARD STATEMENT
N/A

BACKGROUND

Since the December 2019 outbreak of the novel coronavirus (COVID-19), Asian Pacific Islander (API) communities throughout the country have experienced a significant increase in acts of discrimination, racial profiling, microaggressions, violence, and hate crimes. While we know that racist incidents extend to other groups, the pandemic has exacerbated hate crimes against API and requires us to denounce it.

In 2020, the San Diego County District Attorney's office filed charges in three cases of hate crimes against Asian Americans. Last May, the District Attorney's office setup a hotline for individuals to call or submit online reports of hate crimes and racist incidents. According to a KPBS news report from March 4, 2021, the hotline received 110 reports of racist incidents, 10 of which were specifically directed to people of Asian descent. We expect that these incidents are underreported due to fear of stereotypes or language barriers.

The California-based advocacy organization Stop AAPI Hate collected a reported 42 cases of racist incidents against Asian Americans and Pacific Islanders in San Diego County, mirroring a national trend of increased hate crimes. The organization's recorded over 2,800 firsthand accounts of anti-Asian hate from 47 states and the District of Columbia between the middle of March 2020 – when the pandemic hit – through the end of the year. According to their accounts, women were attacked 2 ½ times more than men.

A report from California State University, East Bay's Center for the Study of Hate and Extremism showed that anti-Asian hate crimes surged almost 150% last year. The report examined hate crimes in 16 of the largest cities in the United States, and found that the rise in anti-Asian hate crimes coincided with the rise in COVID-19 cases in March and April of 2020.

To begin to address these issues, San Diego County revived the Human Relations Commission on May 19, 2020 to focus on fostering a more inclusive and equitable San Diego. The Leon L. Williams San Diego County Human Relations Commission will look critically at government policies and practices to tackle racism issues, tackle difficult subjects, and increase cultural competency and empathy across society.

SUBJECT: A RESOLUTION DENOUNCING XENOPHOBIA AND ANTI-ASIAN RACISM AFFIRMING SAN DIEGO COUNTY'S COMMITMENT TO THE WELL-BEING OF ASIAN PACIFIC ISLANDER COMMUNITIES (DISTRICTS: ALL)

As currently formed, San Diego County's Human Relations Commission has 31 members with representatives from law enforcement, the District Attorney's Office, and from the Jewish, LGBTQIA, Asian-American Pacific Islander, African-American, and Native American communities. Representatives from other underrepresented groups will likely be included as well. Each supervisor appoints three representatives, including one young person each who is between the ages of 16 and 24.

Through this action, the Board adopts a resolution to condemn anti-API hate and denounce xenophobia and anti-Asian racism. Additionally, it activates the Leon L. Williams Human Relations Commission and Office of Equity and Racial Justice to work with community members to educate the public and actively work together with the API community in its efforts to denounce hate.

We urge your support.

LINKAGE TO THE COUNTY OF SAN DIEGO STRATEGIC PLAN
Today's proposed actions support a person's ability to live safely in San Diego County. Through this proposed action San Diego County reinforces its commitment to building a resilient community and making San Diego County the safest urban county in the nation.

Respectfully submitted,

NATHAN FLETCHER
Chair, Fourth District

NORA VARGAS
Vice-Chairwoman, First District

ATTACHMENT(S)
RESOLUTION DENOUNCING XENOPHOBIA AND ANTI-ASIAN RACISM AFFIRMING SAN DIEGO COUNTY'S COMMITMENT TO THE WELL-BEING AND SAFETY OF ASIAN PACIFIC ISLANDER COMMUNITIES.

COUNTY OF SAN DIEGO

AGENDA ITEM

DATE: **April 6, 2021** **17**

TO: Board of Supervisors

SUBJECT
RECEIVE THE REPORT BACK ON THE FRAMEWORK FOR CREATING AN EQUITABLE COUNTY GOVERNMENT THROUGH THE LENS OF EQUITY, RACIAL JUSTICE, AND BELONGING (DISTRICTS: ALL)

OVERVIEW
On January 12, 2021 (8) the Board of Supervisors passed a resolution declaring racism a public health crisis. Recognizing historic health, social, economic, and criminal justice disparities, the Board directed the Chief Administrative Officer to take bold actions that will begin to substantially transform our County values, policies, practices, and community engagement to be more inclusive, responsive, and anti-racist.

In declaring racism a public health crisis, the Board acknowledged that racism underpins health inequities throughout the region and has a substantial correlation to disproportionate impacts on the quality of life of county residents. As the public health agency for the region, the County has a responsibility to tackle this issue head-on to improve the overall health of our residents. The public health and racial inequity implications of County policies extend beyond decisions in County Public Health Services to all departments. The Board proposed measures to ensure that in making decisions, the County is promoting health equity, basing decisions on equity data, and engaging our communities in a participatory process.

In November of 2020, the County contracted with Urban Policy Development (UPD) Consulting and the Othering and Belonging Institute at UC Berkley to work with the San Diego County Leon Williams Human Relations Commission (HRC) to develop the Office of Equity and Racial Justice (OERJ) mission statement, roles, and responsibilities. Over the past few months, three community feedback meetings were held with over 200 participants. A survey was also sent to community stakeholders that garnered over 600 responses. An ad hoc committee of the HRC was formed to review the feedback from these community engagement activities and incorporate themes from the community into the mission statement.

Today's actions request the Board receive the report on the status of the recommendations, including the action plan for implementation and to receive the HRC adopted mission statement for the OERJ.

SUBJECT: RECEIVE THE REPORT BACK ON THE FRAMEWORK FOR CREATING AN EQUITABLE COUNTY GOVERNMENT THROUGH THE LENS OF EQUITY, RACIAL JUSTICE, AND BELONGING (DISTRICTS: ALL)

RECOMMENDATION(S)
CHIEF ADMINISTRATIVE OFFICER
1. Receive the status report on the creation and implementation of the framework for Creating an Equitable County Government.
2. Receive the Leon Williams Human Relations Commission adoption of the Office of Equity and Racial Justice Mission Statement.

FISCAL IMPACT
There is no fiscal impact associated with the Board's acceptance of the report; there is no change to net General Fund cost and no additional staff years. County staff will return to the Board at a later date, if necessary, for required approvals related to funding needed to implement actions resulting from these recommendations.

BUSINESS IMPACT STATEMENT
N/A

ADVISORY BOARD STATEMENT
N/A

BACKGROUND
As an enterprise, we seek to engage employees as well as our underserved communities in setting County department priorities. Following our Diversity and Inclusion (D&I) Strategic Plan on delivering four desired outcomes, which include: Exceptional service to our diverse customers; inclusion for all employees and customers; a motivated and engaged workforce; and, organizational effectiveness and innovation, the County has taken continuous action to address long-standing inequities to strengthen our region. This D&I Strategic Plan has strengthened our diversity and inclusion efforts throughout the County and provided the framework we follow to ensure our employees and customers can be authentic and feel respected. In 2020, the County's D&I Executive Council was expanded to include other County government disciplines, including law enforcement. The expanded D&I Executive Council began looking closely at the development of goals and actions needed to root out systemic and institutionalized racism. The D&I Executive Council then acted to incorporate these tenets across the enterprise, including embedding them into the County's broader Strategic Plan.

The Department of Human Resources further extended the diversity and inclusion strategy by creating the Equity, Diversity and Inclusion division. This division focuses on identifying a framework to assess policies, procedures, and practices in support of integrating equity and rooting out systemic racism; promoting equitable opportunities for career advancement and diverse leadership; and monitoring progress. In partnership with the D&I Executive Council, leadership and employee resources were created to enhance skills and knowledge to provide a culturally competent foundation for addressing and responding to bias.

The Department of Purchasing and Contracting (DPC) has also taken action to enhance diversity and inclusion in County procurement and contracting. The County of San Diego Business

Demographics Survey was implemented to inform and guide future supplier outreach strategy and ensure equitable access to County contracting opportunities. In partnership with the North San Diego Small Business Development Center (SBDC), DPC launched the County of San Diego Procurement Workshop Series. This series provides no cost education and resources to minority-owned and other disadvantaged businesses to better understand and assist in overcoming barriers in government contracting. Additionally, the County plans to establish a Community and Minority Business Contracting Group, co-chaired by the Directors of OERJ and DPC. This group will convene both community members, business associations and chamber of commerce organizations such as: the Strategic Alliance, Central San Diego Black Chamber of Commerce, San Diego County Hispanic Chamber of Commerce, Asian Business Alliance Association of San Diego, National Black Contractors Association, and other minority groups, to discuss and implement actions to enhance public contracting participation.

Recognizing racism underpins health inequities throughout the region and has a substantial correlation to poor outcomes in many facets of life, the Board of Supervisors declared racism a public health crisis on January 12, 2021 (8). Your Board directed staff to develop an action plan to address the Boards recommendations and return in 90 days to report progress. To accomplish the Board's directives, the Chief Administrative Officer directed the Assistant Chief Administrative Officer to work with the D&I Executive Council and the Director of the Office of Equity and Racial Justice (OERJ), to develop an action plan to implement the Board's direction.

The following outlines the plan to address each of the directives and provides an update on their implementation. A more detailed action plan can be found as Attachment A to this Board letter.

Recommendation – Policies and Practices:
Create a process to solicit community input to identify county policies and practices that lead to or perpetuate racial or ethnic disparity, with the goal of catalyzing change for just, safe, and healthier communities.

Action Plan:
Currently, there are some policies and procedures that have gone through or are currently in a review process to identify if they perpetuate racial or ethnic disparity. The County has not had a formal annual review process. The formal process to solicit community input to identify County policies and practices that lead to or perpetuate racial or ethnic disparity, will be a part of the annual strategic plan for the OERJ. Staff from the OERJ will request and facilitate a series of Leon Williams Human Relations Commission (HRC) subcommittee meetings annually to gather input on County policies and practices. These meetings will include the relevant County departments that oversee the policies and/or practices that are being discussed at the subcommittee meetings. An action plan will be developed to address these policies and practices that will include timeframes to provide updates to the HRC and Board of Supervisors as necessary. This process is anticipated to begin in the fall of 2021.

Recommendation – Values, Mission, and Vision:
Revise the statement of values, mission, vision, and strategic plan to represent equity and inclusion as a core principle of the County of San Diego and Board of Supervisors.

SUBJECT: RECEIVE THE REPORT BACK ON THE FRAMEWORK FOR CREATING AN EQUITABLE COUNTY GOVERNMENT THROUGH THE LENS OF EQUITY, RACIAL JUSTICE, AND BELONGING (DISTRICTS: ALL)

Action Plan:
Equity and belonging have been added to the County's values. Revisions to the County of San Diego's mission, vision and strategic plan will occur as follows:

- Mission & Vision – The D&I Executive Council has drafted a mission statement that includes the concepts of equity and belonging. Listening sessions will be held with County Diversity and Inclusion Champions and Employee Resource Groups to gain feedback on the draft mission and vision statements. Lastly, our revised mission statement will be presented to the HRC to obtain community feedback. It is anticipated that the new Mission and Vision will be adopted by July of this year.

- Strategic Plan – Updating the County's Strategic Plan will involve a process in which the County departments create Enterprise-Wide Goals that focus on the concepts of Belonging and Equity 2.0, also known as Targeted Universalism. Targeted Universalism is a framework developed by the Othering and Belonging Institute at UC Berkley, who is assisting the HRC and the County in developing the OERJ mission statement, roles, and responsibilities.

  Targeted Universalism means setting universal goals pursued by targeted processes to achieve those goals. Within a Targeted Universalism framework, universal goals are established for all groups concerned. Strategies are developed to achieve those goals by focusing on what is needed by the different groups situated within structures, culture, and across geographies, to obtain the universal goal. Targeted Universalism is goal oriented, and the processes are directed in service of the explicit, universal goal. Targeted Universalism will be the framework by which the Audacious Visions and Enterprise-Wide Goals in the County's Strategic Plan will be developed. The County's Operational Plan, also known as the Budget document, will contain the focused strategies needed to accomplish these goals.

  Staff from key departments will work through gaps and our community's needs based on the foundation provided by the OERJ mission statement work. This work will take place throughout the summer and fall with anticipated completion of strategic plan updates by November 2021. We anticipate fully incorporating these new strategies into the FY 2022/2024 Operational Plan cycle.

Recommendation – Equity Impact Statement:
Incorporate a section titled Equity Impact Statement in the Board Letter template for all county departments to identify and determine a systematic approach with standardized guidelines to express the equity impact of recommended actions.

Action Plan:
The OERJ has worked with Urban Policy Development Consulting (UPD) and the Othering and Belonging Institute to review best practices and create a tool, provide resources, and establish processes for reviewing Board letters to determine the equity

impact of our actions. A set of standardized guidelines and resources has been developed using the Government Alliance on Race and Equity's Racial Equity Toolkit.

The OERJ is currently working with Groups and departments to train staff on how to use the tools and resources. Departments will each form a core Justice, Equity, Diversity & Inclusion Team made up of a department head, assistant department head (or executive team appointee), diversity and inclusion lead, budget lead and data lead. Each core team will be trained to use the toolkit, and will be responsible for leading the development and review of the equity impact statement for their respective departments.

The Group Executive Office Diversity and Inclusion Lead will also be trained and responsible for review and approval of the impact statement. Lastly, the OERJ will be responsible for final review and sign-off of the equity impact statement in all Board letters. Initial trainings are scheduled to be completed by June 2021 with anticipated use of the equity impact tool by June 8, 2021.

Recommendation - Data:
Enhance data collection capabilities to identify racial disparities among programs and services that are meant to improve health, social, economic, educational, and criminal justice circumstances, and prioritize funding proportional to need when possible.

Action Plan:
The OERJ will work with the County's Data Governance Committee and the County's Data and Performance Analytics Unit to conduct an environmental scan to assess the current data and resources available, priorities, and needs. We anticipate this environmental scan being complete by June of this year.

We will also research best practices and determine resources needed to develop equity indicators. These indicators and the associated County data will be incorporated into an equity impact report to be presented to the Board of Supervisors annually. We anticipate the first equity impact report to be presented to your Board in the fall of 2022, in conjunction with the County's Annual Report.

Office of Equity and Racial Justice Mission Statement

In November of 2020, the County contracted with Urban Policy Development (UPD) Consulting and the Othering and Belonging Institute at UC Berkley to work with the HRC to develop the OERJ mission statement, roles, and responsibilities. Over the past few months, three community feedback meetings were held with over 200 participants. A survey was also sent to community stakeholders that garnered over 600 responses. An ad hoc committee of the HRC was formed to review the feedback from these community engagement activities and incorporate themes from the community into the mission statement. It was determined that there were three major criteria that the mission statement needed to meet:

- Champion change: the mission statement should include co-creating transformative & enduring change.
- Engage community: the mission statement should include co-creation with the community and have transparency for accountability.
- Advance/champion equity & justice: healing to alleviate harm of systemic racism, create belonging, and root out injustice.

The ad hoc committee met five times in-between community feedback sessions to review and refine the mission statement. The sixth and final ad hoc committee was held on March 22nd. During this meeting, the ad hoc committee came to a consensus on a mission statement that would be recommended to the full HRC for adoption. On March 23rd, the HRC met and adopted the ad hoc committee's recommended mission statement for the OERJ. The mission statement is as follows:

San Diego County's Office of Equity and Racial Justice partners with the community to co-create transformative, enduring, structural and systemic change in San Diego County government.

We bridge San Diego County departments and community voices to design bold policies and practices to advance equity.

We champion belonging for all and advocate for people suffering from structural and systemic racism and exclusion.

Today's recommendation asks that your Board receive the HRC adopted mission statement for the OERJ.

LINKAGE TO THE COUNTY OF SAN DIEGO STRATEGIC PLAN
Today's proposed actions support the County of San Diego's 2021-2026 Strategic Plan, of Building Better Health, Living Safely, Thriving, by supporting and empowering communities of color.

Respectfully submitted,

HELEN N. ROBBINS-MEYER
Chief Administrative Officer

ATTACHMENT(S)
A: Framework for creating an equitable county government through the lens of equity, racial justice, and belonging.

Recommendation A: Create a process to solicit community input to identify county policies and practices that lead to or perpetuate racial or ethnic disparity, with the goal of catalyzing change for just, safe, and healthier communities.		
EXPECTED OUTCOME	**PLAN**	**TIMEFRAME**
Policies and practices that are equitable and create a sense of belonging in County government.	Although there are some policies and procedures that have gone through or are currently in a review process to identify whether they perpetuate racial or ethnic disparity, the County has not had a formal annual review process. The formal process to solicit community input to identify County policies and practices that lead to or perpetuate racial or ethnic disparity will be a part of the annual strategic plan for the Office of Equity and Racial Justice (OERJ). OERJ will work with Groups & departments to develop an action plan to address policies and practices. The OERJ will provide resources to educate and train County department staff on structural and systemic racism to better equip staff to work with the OERJ to prioritize policies and procedures that require immediate review. The action plan will include timeframes to provide updates to the Leon Williams Human Relations Commission (HRC) as well as an anticipated deadline for completion. Staff from the OERJ will request and facilitate a series of HRC subcommittee meetings annually to gather input on County policies and practices. These meetings will include the relevant County departments that own the policies and/or practices that are being discussed at the subcommittee meetings. An action plan will be developed to address these policies and practices that will include timeframes to provide updates to the HRC and Board of Supervisors as necessary.	Ongoing/ Anticipated Rollout Fall 2021

FRAMEWORK FOR CREATING AN EQUITABLE COUNTY GOVERNMENT THROUGH TARGETED UNIVERSALISM PRINCIPLES AND BELONGING

ATTACHMENT A

Recommendation B: Revise the statement of values, mission, vision, and strategic plan to represent equity and inclusion as a core principle of the County of San Diego and Board of Supervisors.		
EXPECTED OUTCOME	**PLAN**	**TIMEFRAME**
Values that clearly articulate to the public our commitment to equity, racial justice and belonging.	Draft values completed. Listening sessions will be held in April with County Diversity and Inclusion Champions and Employee Resource Groups to gain feedback. Anticipate review by the HRC for public feedback at their May meeting.	May 2021
A lens of equity, racial justice and belonging for use by our County team that informs and influences all policies and operations.	Draft vision completed. Anticipate review by the HRC for public feedback at their May meeting.	May 2021
Create an equitable Mission Statement that clearly articulates to the public and our employees, a commitment to equity, racial justice and belonging.	Draft mission statement completed. Listening sessions will be held in April with County Diversity and Inclusion Champions and Employee Resource Groups to gain feedback. Anticipate review by the HRC for public feedback at their May meeting.	May 2021

A strategic plan that is guided by equity, belonging and racial justice that informs and helps align the County Operational Plan through the lens of equity, racial justice and belonging.	Updating the County's strategic plan will go through a process that allows the four business Groups to create Audacious Visions and Enterprise-Wide Goals that focus on the concepts of Belonging and Equity 2.0 also known as Targeted Universalism. Targeted Universalism is a framework developed by the Othering and Belonging Institute at UC Berkley, who is assisting the County with developing the Office of Equity and Racial Justice mission statement, roles, and responsibilities. Targeted Universalism means setting universal goals pursued by targeted processes to achieve those goals. Within a Targeted Universalism framework, universal goals are established for all groups. Strategies are developed to achieve those goals by focusing on what is needed for the different groups situated within structures, culture, and across geographies to obtain the universal goal. Targeted Universalism is goal oriented, and the processes are directed in service of the explicit, universal goal. The overarching goals (the universal goals) will be the Audacious Visions and Enterprise-Wide Goals in the County's Strategic Plan. The County's Operational Plan, also known as the Budget document, will contain the focused strategies needed to accomplish these goals. Staff will work with Groups, departments, and lead subject matter experts to create Audacious Visions and Enterprise-Wide Goals for each of the strategic initiatives. This work will take place throughout the summer. Review and approval by the General Managers, ACAO, and CAO will be completed by August of this year. Inclusion, update, and socialization of the strategic plan updates will occur October - December of this year. This will allow for the official update of the strategic plan for the 2022-24 Operational Plan development beginning in January 2022.	Dec 2021

FRAMEWORK FOR CREATING AN EQUITABLE COUNTY GOVERNMENT THROUGH TARGETED UNIVERSALISM PRINCIPLES AND BELONGING

ATTACHMENT A

Recommendation C: Incorporate a section titled Equity Impact Statement in the Board Letter template for all county departments to identify and determine a systematic approach with standardized guidelines to express the equity impact of recommended actions.

EXPECTED OUTCOME	PLAN	TIMEFRAME
A lens of equity, racial justice and belonging for our County team that informs and influences all policies, operations and programs brought to the Board via Board letter.	A set of standardized guidelines and a systematic approach has been developed using the Government Alliance on Racial Equity, Racial Equity Tool Kit. The OERJ is currently in the process of socializing and training staff on how to use the tools and resources. Initial trainings are scheduled to be completed by June 2021 with anticipated use of the equity impact tool by June 8, 2021. Each department will identify a core Justice, Equity, Diversity & Inclusion (JEDI) Team made up of the department head, assistant department head (or executive team appointee), D&I lead, administrative/budget lead and data lead. The JEDI teams will be trained to use the toolkit, apply it to Board letters, and in practice in all areas of their department operations. Each JEDI team will be responsible for leading the development and review of their departmental equity impact statement for Board letters. The Group executive office equity, diversity and inclusion lead will also be trained and responsible for review and approval of the impact statement. Lastly, the OERJ will be responsible for final approval of the equity impact statement in all Board letters.	Jun 2021

Recommendation D: Enhance data collection capabilities to identify racial disparities among programs and services that are meant to improve health, social, economic, educational, and criminal justice circumstances, and prioritize funding proportional to need when possible.		
EXPECTED OUTCOME	**PLAN**	**TIMEFRAME**
Clear use and coordination of data to drive outcomes through the lens of equity, racial justice and belonging.	The OERJ is working with the County's Data Governance Committee and the County's Data and Performance Analytics Unit, and they will be conducting an environmental scan to determine the current data and resources available, priorities, and needs. The environmental scan is anticipated to be completed by June of this year. The OERJ is also researching best practices to determine resources needed to develop, track, and monitor equity indicators. These indicators and the associated County data will be incorporated into an equity impact report to be presented to the Board of Supervisors annually. It is anticipated that the first equity impact report will be presented to the Board in the fall of 2022, in conjunction with the County's Annual Report.	Ongoing/Equity Impact Report – Fall 2022

TERRA LAWSON-REMER
SUPERVISOR, THIRD DISTRICT
SAN DIEGO COUNTY BOARD OF SUPERVISORS

AGENDA ITEM

DATE: **April 6, 2021**

25

TO: Board of Supervisors

SUBJECT
AMENDING LEGISLATIVE PROGRAM TO SUPPORT LEGISLATION RELATED TO BACKGROUND CHECKS ON FIREARM PURCHASES (DISTRICTS: ALL)

OVERVIEW
Even amid the COVID-19 pandemic, shootings and firearm-related incidents in the United States reached a 20-year-peak in 2020 according to data from the Gun Violence Archive. The County Board of Supervisors voted to adopt a new legislative platform on January 13, 2021, to actively engage on legislation at the state and federal levels that "protects the safety of those in our community." Given the ongoing crisis of mass shootings in America, we recommend that the Board direct the Chief Administrative Officer to update the County's Legislative Program to affirm the County's support for state and federal legislation that furthers gun reforms related to background checks for firearm purchases, budgetary commitments to invest in the communities most impacted by everyday gun violence, and/or new oversight and accountability measures for the gun industry. These are the priorities recently supported by a joint coalition of gun violence prevention organizations, including Brady United Against Gun Violence, the Coalition to Stop Gun Violence, Community Justice Action Fund, Giffords, March For Our Lives, Newtown Action Alliance, States United to Prevent Gun Violence, and Survivors Empowered.-

More than 41,500 people died by gun violence in the United States in 2020, marking the first time since at least 1981 the number has surpassed 40,000, according to the Centers for Disease Control and Prevention. This figure includes more than 23,000 individuals who died by suicide using a firearm.

Mass shootings, which are incidents where more than four people are injured or killed by a firearm, reached a five-year-peak last year, representing a nearly 50 percent increase compared to 2019 according to the Gun Violence Archive and the Britannia Group.

In keeping with this tragic trend, mass shootings have continued to roil the United States this year, prompting heightened calls for federal action to adopt common-sense gun regulations and greater awareness about the disproportionate impacts of firearm violence on communities of color. On March 16, 2021, a shooter killed eight people at three spa/massage parlor locations in the Atlanta,

Georgia area. Six of the victims were Asian women. While the shooter has not been charged with a hate crime at the time of this writing, Asian American and Pacific Islander groups across the nation saw the incident as watershed moment that underscored the potentially violent consequences of racism directed against Asians during the COVID-19 pandemic. The Georgia shooting highlighted the inequitable impact mass shootings have on minorities. For example, Black Americans represent nearly 70 percent of homicide victims in big cities, many of which involve firearms, according to non-profit firearm reform advocacy group Everytown for Gun Safety.

Following the Georgia mass shooting and another mass shooting in Boulder, Colorado on March 22, 2021, President Biden called for Congress to pass stronger background check laws.

The U.S. House of Representatives passed two bills on March 11, 2021, to address gun violence. H.R. 8 would close a loophole that allows private gun sales made by private unlicensed sellers, such as those online or at a gun show, to avoid background checks. H.R. 1446 would provide the FBI with more time to conduct background checks for gun sales, extending the period from three days to ten days.

Background checks are very popular according to polling. 92 percent of respondents in a 2018 Gallup poll supported universal background checks. A poll conducted by Everytown conducted after the 2020 election found 93 percent of Americans want universal background checks. 65 percent of Republicans and 67 percent of gun owners reported strong support in the poll.

Approval of this item would add this as a priority issue for the County's legislative platform, and authorize the County to support legislation, such as H.R. 8, H.R. 1446, or others, that support more robust gun background checks.

This action is consistent with the current County Legislative Program Priority Issues, as unanimously approved by the Board of Supervisors in January 2021, which states, "The County of San Diego will engage in legislation that protects the safety of those in our community" and "[i]t is vital not only that crime rates remain low, but that the community feels safe where they live, work, and play."

RECOMMENDATION(S)
SUPERVISOR TERRA LAWSON-REMER
Direct the Chief Administrative Officer to amend the Legislative Program Priority Issues and Guidelines to reflect the County's support for state and federal legislation that furthers gun reforms related to background checks for firearm purchases, budgetary commitments to invest in the communities most impacted by everyday gun violence, and/or new oversight and accountability measures for the gun industry.

FISCAL IMPACT
N/A

SUBJECT: PASTE SUBJECT HERE (NOT BOLD)

BUSINESS IMPACT STATEMENT
N/A

ADVISORY BOARD STATEMENT
N/A

BACKGROUND
An effective program of legislative representation includes proactively advocating the legislative policies of the Board of Supervisors to members, committees, and staff of the State Legislature and United States Congress, to the elected, appointed officials, and staff of State and federal agencies, boards, commissions and other entities, and to the office of the Governor and President.

Occasionally it may be necessary to direct legislative advocacy activities toward or with local or regional governmental bodies. These governmental bodies include, but are not limited to: city councils, local tribal nations, bi-national partners, San Diego Association of Governments (SANDAG), Metropolitan Transit System (MTS), North County Transit District (NCTD), the Regional Airport Authority, the Unified Port of San Diego, local school districts, and others.

The County's Legislative Policy establishes the parameters for the use of the annual Board adopted Legislative Program and provides direction to the Office of Strategy and Intergovernmental Affairs and the County's Sacramento and Washington, D.C. advocates. At times when advance notification and authorization of the Board is impracticable and where it is imperative that the County act quickly and proactively to ensure that the Board's established priorities are conveyed to the appropriate State and/or federal entities, this policy provides direction on how OSIA and outside advocates may advocate for the County's interests.

The current Legislative Program Priority Issues, as unanimously adopted by the Board on January 13, 2021, Item 14, states, "The County of San Diego will actively engage in legislation in the following areas at the state and federal level to ensure such legislation benefits County operations and the clients, customers, and constituents we serve.

Further, it states, "One of the most important roles of local government is ensuring the safety of the public. It is critical to keep all members of our community protected from crime and abuse. The aim of the County of San Diego is to advocate for policies that create a system that is equitable, fair, and just. It is vital not only that crime rates remain low, but that the community feels safe where they live, work, and play; and that includes fostering trust with members of the law enforcement community. Equally important is the County must have appropriate resources to respond to disasters and emergencies. The County of San Diego will engage in legislation that protects the safety of those in our community; provides necessary resources to our justice partners to provide training and rehabilitative programming; and provides services and supports to victims of crime, disasters, and emergencies."

SUBJECT: PASTE SUBJECT HERE (NOT BOLD)

LINKAGE TO THE COUNTY OF SAN DIEGO STRATEGIC PLAN
Today's proposed action to amend the Legislative Program Priority Issues and Guidelines related to gun reforms for background checks supports the Safe Communities Strategic Initiative for Excellence in the County's 2021=2026 Strategic Plan by ensuring the safety of families in our community.

Respectfully submitted,

TERRA LAWSON-REMER
Supervisor, Third District

ATTACHMENT(S)
N/A

TERRA LAWSON-REMER
SUPERVISOR, THIRD DISTRICT
SAN DIEGO COUNTY BOARD OF SUPERVISORS

DATE: **May 4th, 2021**

05

TO: Board of Supervisors

SUBJECT
PROVIDE LEGAL REPRESENTATION TO DETAINED IMMIGRANTS FACING REMOVAL PROCEEDINGS (DISTRICTS: ALL)

OVERVIEW
Deportation has immeasurable consequences for the person removed and the family and community that is left behind in the United States.

Immigrants' right to counsel in removal proceedings is a right that arises from multiple sources, including the Fifth Amendment to the U.S. Constitution, the Immigration and Nationality Act (INA), other federal statutes, and federal regulations[1]. The constitutional right to due process protects the fundamental rights of every "person" in this country. The Fifth Amendment guarantees that "[n]o person ... shall be deprived of life, liberty, or property" without due process of law. Immigrants in removal proceedings, i.e. those facing deportation and appearing before an immigration judge, have a right "of being represented … by counsel." I.N.A. § 240(b)(4)(A). While an immigrant's right to counsel of their own choice at their own expense in removal proceedings is protected by the Due Process Clause and INA, it is a right afforded to only the few that can pay the cost of such representation.

Many immigrants facing deportation or seeking asylum do not have access to legal representation. Legal fees can be extremely costly. Furthermore, immigration law is vast and complex, making it is very difficult to navigate without access to experts.

There is also strong evidence that when immigrants have access to counsel, the immigration courts run more efficiently. Immigration law is extremely complicated and changes frequently. Clients without a legal guide are lost. Represented clients are more likely to appear at their hearings and file fewer claims.[2]

[1] Kate M. Manuel, "Aliens' Right to Counsel in Removal Proceedings: In Brief", Congressional Research Service, 7-5700 www.crs.gov R43613 (March 17, 2016): 1-2.

[2] Ingrid Eagly and Steven Shafer, "A National Study of Access to Counsel in Immigration Court," University of Pennsylvania Law Review 164, no. 1 (December 2015): 1–91. https://scholarship.law.upenn.edu/cgi/viewcontent.cgi?article=9502&context=penn_law_review.

Exercising their constitutional right to being represented by an immigration attorney gives immigrants dignity, hope, and the ability to return to their affairs and continue contributing to their communities while their cases proceed through the courts. According to the American Immigration Council, immigrants in detention with legal representation who had a custody hearing were four times more likely to be released from detention, allowing them to return to their jobs, family and community while they awaited the results of their legal matter[3]. Legal representation has also been shown to help immigrants gain or maintain their legal work authorization, thus contributing to federal, state, and local tax revenue.

Communities experience a significant loss in economic activity and reduction of tax revenue when immigrants are detained -- revenue that often is collected through employers, mortgages, lease payments, businesses, education and other financial contributions. Furthermore, there are high costs of keeping individuals in immigration detention at the taxpayer's expense. For instance, in the FY 2016 federal budget, taxpayers spent $2 billion in detention of immigrants[4]. This amount would significantly decline as people access adequate representation and exit the detention system.

The lack of appointed counsel means that tens of thousands of people each year go unrepresented, including asylum seekers, longtime legal residents, immigrant parents or spouses of U.S. citizens, and even children. They are left to defend themselves in an adversarial setting and notoriously complex system against the United States government, which is always represented by counsel. According to the American Immigration Council, only 17 percent of detainees in San Diego have legal representation. Currently, San Diego County has many hard-working immigrant attorneys and organizations working to represent immigrants. [5]However, many of these organizations lack adequate resources to address the volume of cases.

The Supreme Court in *Gideon v. Wainwright*, 372 U.S. 335 (1963), held that "any person haled into court, who is too poor to hire a lawyer, cannot be assured a fair trial unless counsel is provided for [them]... in particular because "[g]overnments … quite properly spend vast sums of money to establish machinery to try defendants accused of crime". However this 6th amendment right to appointed counsel only applies to criminal proceedings, and immigration removal is a civil proceeding – so despite the fact that the consequences of deportation or the denial of asylum are often quite literally life and death, immigrants who are too poor to hire a lawyer are not

[3] Ingrid Eagly and Steven Shafer, "Access to Counsel in Immigration Court," American Immigration Council Special Report (September 2016): 1–28. www.americanimmigrationcouncil.org/research/access-counsel-immigration-court.
[4] Andrea Black and Joan Friedland, "Blazing a Trial, The Fight for Right to Counsel in Detention and Beyond", National Immigration Law Center, (March 2016): 8-9.
[5] Ingrid Eagly and Steven Shafer, "Access to Counsel in Immigration Court," American Immigration Council Special Report (September 2016): 1–28. www.americanimmigrationcouncil.org/research/access-counsel-immigration-court.

assured a fair trial and are denied due process.

The Vera Institute of Justice reports that two out of three people in the United States support government-funded representation for immigrants facing deportation, including 67 percent of likely voters.[6]

Los Angeles and Santa Clara County have successfully provided universal legal services to immigrants. Aware of the positive impact of informed legal defense, the County of Los Angeles, the City of Los Angeles, the Weingart Foundation, and the California Community Foundation responded to increased immigration enforcement practices by establishing the Los Angeles Justice Fund. This pilot grantmaking and capacity-building program was designed to strengthen the capacities of legal service providers to provide critical and timely legal representation for more immigrants in Los Angeles County who are detained by immigration officials or in removal proceedings. Santa Clara has a similar model where the County awards grants to immigration legal services who apply and are granted funds.

The San Diego Public Defender's Office currently provides criminal legal defense services to San Diego County. The Office of Assigned Counsel is expertly suited to manage an Immigrant Rights Legal Defense Program, by administering and overseeing contracts awarded by the Department of Purchasing and Contracting to various immigrant defense agencies and non-profits. The Office of Assigned Counsel already provides San Diego County with similar services when directly contracting criminal cases to criminal attorneys when multiple layers of conflict arise pursuant to the Penal Code. Their track record and ability to manage, budget, and assign multiple cases will advance the representation of detained immigrants more readily than any other agency.

With this action today, San Diego will join efforts to realize constitutional rights promised but left unfulfilled, and expand access to justice for our immigrant population. Today's request directs the Chief Administrative Officer to refer to budget $5 million for a one-year pilot Immigrant Rights Legal Defense Program, and work with the Director of the Office of Assigned Counsel to return to the Board within 90 days with a program plan for a permanent program to provide legal representation to detained immigrants facing removal proceedings in San Diego County.

[6] Karen Berberich and Nina Siulc, "Why Does Representation Matter? The Impact of Legal Representation in Immigration Court," Vera Institute of Justice (November 2018): 1–3. www.vera.org/downloads/publications/why-does-representation-matter.pdf.

SUBJECT: PROVIDE LEGAL REPRESENTATION TO DETAINED IMMIGRANTS FACING REMOVAL PROCEEDINGS

RECOMMENDATION(S)
SUPERVISOR TERRA LAWSON-REMER

1. Establish a permanent Immigrant Rights Legal Defense Program, to provide legal representation to detained immigrants facing removal proceedings in San Diego County.

    a. As a first step in establishing the permanent program, direct the Chief Administrative Officer to refer to budget $5 million for Fiscal Year 2021-2022 for a pilot Immigrant Rights Legal Defense Program.
        i. The program will be a one (1) year pilot with a FY 21-22 budget of $5 million. This shall include up to $500,000 for translation services.
        ii. The program shall be housed in the Office of Assigned Counsel of the Public Defender's Office.
        iii. The Department of Purchasing and Contracting will work with the Office of Assigned Counsel to manage the contracting of cases to various immigrant defense agencies and non-profits within the county.

2. Direct the CAO to work with the Director of the Office of Assigned Counsel of the Public Defender's Office and return to the Board of Supervisors within 90 days with a permanent program plan to provide legal representation for detained immigrants facing removal proceedings in San Diego county under a universal representation model.
    a) The program plan shall request a minimum yearly budget of $5 million, including up to $500,000 for translation services.
    b) The program shall provide detained immigrants facing deportation or removal proceedings in San Diego County access to legal representation at no cost to the individual facing deportation or removal proceedings.
    c) The program shall entail an annual report from the Public Defender's Office regarding:
        i. Number of immigrants represented
        ii. Number of days in custody before release, if released
        iii. Dollar amount of the bond if given bond
        iv. Substantive outcomes and substantive motions
        v. Status of pending cases:
            1. Returned to employment
            2. Returned to family
            3. Returned to community
            4. Remained in custody pending outcome
        vi. Number of interpreters needed to assist
        vii. Which language interpreters utilized
        viii. Relief from removal available and utilized

d) Require the Office of Assigned Counsel of the Public Defender's Office to use a case management system to capture other data that may be relevant or requested.
e) The program shall build on lessons learned from the initial pilot project, as well as best practices from other counties with similar programs.

FISCAL IMPACT
Funds for this request are not included in the County of San Diego's Fiscal Year 2020-2021 Operational Plan. Refer to budget for an additional $5 million to the FY 21-22 budget based on available prior year General Fund fund balance and anticipate a minimum of $5 million annually in subsequent fiscal years beginning in FY 2022-2023 based on available ongoing funding sources. The impact to net General Fund cost and staff will depend on the final program design.

BUSINESS IMPACT STATEMENT
N/A

ADVISORY BOARD STATEMENT
N/A

BACKGROUND
The promise that all people are created equal, that all people have a right to life, liberty, and the pursuit of happiness, as well as a right to due process, is what makes America unique in the world. This promise has always been aspirational. It has never been fully realized. The gap between the promise and the reality, and the long arc of work to close that gap, is the central thread of American history.

In order to close the gap between aspirations and reality, we must look closer at the inequities that exist in our legal system when immigrants facing removal proceedings are not afforded legal counsel. These immigrants include asylum-seekers; survivors of domestic violence, human trafficking, or torture; and lawful permanent residents and longtime community members with strong ties to the U.S.. Some may even be U.S. citizens who have wrongfully been detained. Although they might have different reasons why they ended in Immigration custody, one key issue they have in common, is that they all face deportation without an appointed immigration lawyer.

The Fifth Amendment of the Unites States Constitution guarantees that "[n]o person ... shall be deprived of life, liberty, or property" without due process of law. *Reno v. Flores*, 507 U.S. 292, 306 (1993) is the most recent case definitively clarifying that the Fifth Amendment entitles immigrants to due process of law in deportation proceedings. The Immigration and Nationality Act (INA) likewise establishes that immigrants in removal proceedings, i.e. those facing deportation and appearing before an immigration judge, have the right to be represented

by counsel[7]. Therefore an immigrant's right to counsel of their own choice at their own expense in removal proceedings is protected by both the Due Process Clause of the Constitution and by the INA statute, it is a right afforded to only the few that can pay the cost of such representation.

Legal fees can be extremely costly and often become burdensome on families. Furthermore, immigration law is vast and complex, making it is very difficult to navigate without access to experts. True due process of law and the right to a fair trial, fundamental principles in the American legal system, require that actual quality representation be made available *pro bono* to immigrants facing removal proceedings.

The Vera Institute published a first-hand account of the deportation legal process. Alicia Fullard, a supervisor and 20-year-employee at a nursing home, wrote, "I am an immigrant, and I am a citizen of the United States of America. But if it weren't for my immigration lawyer, I wouldn't be here today." She was born in Jamaica, and the United States has been her home for most of her life. She arrived in the United States 30 years ago with a Green Card. Ms. Fullard came to this country in search of opportunities that weren't available to her in her country of birth. She built the life she had hoped for by starting a career in elder care and raising a family. During all this time, she never had any trouble renewing her status as a lawful permanent resident.

Ms. Fullard returned to Jamaica in 2014 to visit relatives she hadn't seen in decades. On her way home to Albany, immigration officials stopped her at John F. Kennedy International Airport. She was stunned when officials informed her that her Green Card was being taken away, and she was being put in deportation proceedings. She discovered this was all happening because of an arrest from 16 years before, for which she had received three years of probation. No one had ever informed her that this conviction from 1998 could affect her immigration status. She had lived a quiet life ever since and had nothing else on her record.

She didn't know how to present her case in immigration court. Even though she had been steadily employed at a nursing home for 20 years, she didn't have the resources to pay for an immigration attorney. She was afraid she was going to be displaced to a country that, before her trip, she had not been to for almost 25 years. She was worried that she wouldn't get to see her nephew and her grandchildren grow up, that she would be torn away from her job and her community.

Through the New York Immigrant Family Unity Project, she met a *pro bono* immigration attorney. Her attorney connected her with a public defender who assisted her in getting the old conviction vacated—an option she didn't even know existed. With her record cleared, her immigration attorney successfully argued that there was no reason to deport her. To her great relief and her family's joy, the immigration judge terminated the removal case. Like many others out there, she had legal options and claims that she was not even aware of because she did not have a lawyer on her side.

[7] I.N.A. § 240(b)(4)(A).

An estimated 70 percent of people in detention are unrepresented and left to fend for themselves while facing government attorneys[8]. In 2018 it was reported that slightly more than half of all pending children's cases were unrepresented. [9]The New York Immigrant Family Unity Project, demonstrated a significant, causal effect of representation on case outcomes, independent of other factors: a 4 percent unrepresented success rate and a 48 percent represented success rate for detainees. Even if the attorney merely successfully argues for the immigrants' release from custody, release from detention allows people to return to their families, work in their communities while their case is pending, and prepare their affairs should the court ultimately order them to leave the country.

An Immigrant Rights Legal Defense Program in San Diego County would advance values of fairness and due process – principles that we hold deeply as Americans. In 2007-2012 only 17 percent of detainees in San Diego County had legal representation.[10] When detained immigrants lack access to counsel because of inability to pay, we cannot ensure our immigration system is upholding due process. "In order to have due process, you have to have representation of all of the parties before a judge," according to Immigration Judge Sarah Burr. "The fact is that the Constitution guarantees all people due process and equal protection."

Currently, San Diego County has many hard-working immigrant attorneys and organizations working to represent immigrants. However, many of these organizations are faced with difficult triage choices when determining which cases to take due to a lack of resources to meet the need. This leaves many immigrants without representation. This program would fill these gaps in legal representation.

Given the incredible danger in many places to which non-citizens are deported and the toll deportations take on communities and families, it is up to the County of San Diego to step up and provide support to many who have called San Diego home. No one should face the possibility of separation from their family just because they couldn't afford to hire an attorney. With today's action, San Diego will be joining efforts across the nation to provide pro bono attorneys and uphold the immigrant's rights of those facing removal proceedings.

[8] Transactional Records Access Clearinghouse (TRAC), "Details on Deportation Proceedings in Immigration Court," accessed January 13, 2020. https://trac.syr.edu/phptools/immigration/nta/.

[9] Karen Berberich and Nina Siulc, "Why Does Representation Matter? The Impact of Legal Representation in Immigration Court," Vera Institute of Justice (November 2018): 1–3. www.vera.org/downloads/publications/why-does-representation-matter.pdf.

SUBJECT: PROVIDE LEGAL REPRESENTATION TO DETAINED IMMIGRANTS FACING REMOVAL PROCEEDINGS

LINKAGE TO THE COUNTY OF SAN DIEGO STRATEGIC PLAN
Today's proposed request supports the Living Safely Initiative of the County of San Diego's 2021-2026 Strategic Plan. Offering legal representation to immigrants achieves the 2021-2026 Strategic Plan's mission of providing public services that build strong and Live Well San Diego sustainable communities. When immigrants feel supported and have the prospect of returning to their family and their community while awaiting their legal outcome, San Diego can ensure stronger communities. This also demonstrates integrity by putting forth character first and exhibiting the courage to do the right thing for the right reason.

Respectfully submitted,

TERRA LAWSON-REMER
Supervisor, Third District

ATTACHMENT(S)
N/A

COUNTY OF SAN DIEGO

AGENDA ITEM

DATE: **May 4, 2021** **11**

TO: Board of Supervisors

SUBJECT
UPDATE ON ADVANCING THE BEHAVIORAL HEALTH CONTINUUM OF CARE (DISTRICTS: ALL)

OVERVIEW
Under the leadership of the San Diego Board of Supervisors (Board), behavioral health care in San Diego County is in the midst of a profound transformation. The County of San Diego (County) is taking action and making strategic investments to move the local behavioral health care delivery system from a model of care driven by crises, to one centered on continuous, coordinated care and prevention. These efforts are guided by data; focused on equity; and designed to engender collaborative work across silos, within and outside of government.

Today's update to the Board includes a summary of the conceptual strategies underlying the County's behavioral health reform efforts, as well as a report on progress of the portfolio of projects that are bringing this transformation to life.

Additionally, today's action, if approved, would accept the updated Lanterman-Petris-Short (LPS) Designation Guidelines and Processes for Facilities within San Diego County to include all programs that meet State and local regulations, including community-based crisis stabilization units, a health care service that is crucial to driving toward a continuous care orientation.

These actions will advance the County's ongoing work across systems to support better care of individuals, better health for local populations, and more efficient health care resourcing. In doing so, today's item supports the County's *Live Well San Diego* vision for a region where all residents have the opportunity to build better health, live safely, and thrive.

RECOMMENDATION(S)
CHIEF ADMINISTRATIVE OFFICER
1. Receive an update on Advancing the Behavioral Health Continuum of Care.
2. Direct the Chief Administrative Officer to sunset time-certain reporting for the Behavioral Health Impact Fund and Laura's Law updates, and to shift reporting for the Behavioral Health Continuum of Care to coincide with significant developments.

3. Adopt the updated Lanterman-Petris-Short (LPS) Designation Guidelines and Processes for Facilities within San Diego County, revised to expand eligibility to all programs that meet applicable State and local requirements.

FISCAL IMPACT
There is no fiscal impact associated with this item. There will be no change in net General Fund costs and no additional staff years.

BUSINESS IMPACT STATEMENT
N/A

ADVISORY BOARD STATEMENT
Preliminary information regarding this item was presented at the Behavioral Health Advisory Board meeting on February 4, 2021, with new information shared at their meetings on March 4, 2021, and April 1, 2021.

BACKGROUND

Strategy Development: 2018-2019

Under the leadership of the San Diego County Board of Supervisors (Board), behavioral health care in San Diego County is in the midst of a transformation from a system disproportionately driven by crises, to one with an emphasis on prevention and continuous, coordinated care. There are three inter-related strategic pillars supporting this effort:

- The deeper integration of a ***population health*** approach into the behavioral health system – which emphasizes health outcomes and their distribution within a population, longitudinal patterns of health determinants, and the guiding policies and interventions that influence these factors.

- A renewed focus on defining ***key metrics*** across behavioral health programming to better measure program impacts, in alignment with nationally recognized best practices.

- Weaving nationally recognized strategies into the County of San Diego's (County) Behavioral Health Services (BHS) planning and operations. This includes the concept of the ***Triple Aim***, which is designed to 1) improve the health of populations, 2) enhance the experience and outcomes of individuals, and 3) reduce per capita costs of care. Examples of current work in alignment with the Triple Aim includes:

    - A new Population Health Unit was established within BHS, staffed by a team of epidemiologists. Additionally, BHS launched a data sciences initiative to enhance data governance and integrate data source systems, to better support measurement of program impact and promote equity in the delivery of services.

    - BHS is redesigning outpatient mental health program standards to ensure best individual patient outcomes, and is investing in an innovative care coordination

service that will enable individualized, data-driven care navigation and advocacy for people being discharged from inpatient care.

- Investments are being made now to avoid costs in future years through better care outcomes. This is exemplified by current work to expand the Augmented Services Program (Board and Care) capacity, which will reduce rehospitalization as well as performance-based incentives for contracted services that are designed to lead to better management of costs and support improved client outcomes including new payment models for crisis stabilization services and inpatient psychiatric care.

COVID-19 Strategic Pivot: 2020

The COVID-19 public health crisis and subsequent economic crisis were, and continue to be, accompanied by an epidemic in increased behavioral health need and have been the impetus for shifts in the modalities of behavioral health care in the region. Recent data have indicated alarming trends in psychological distress and key measures of population-level mental health compared to prior to the pandemic, with proportionately greater harm in areas more impacted by COVID-19. The pandemic has also been associated with a sustained increase in overdose deaths both locally and nationally, a trend which may be tied to disruptions in the illicit drug supply chain and typical use patterns as well as an increase in the prevalence of the super-potent synthetic opioid fentanyl. Concurrently, the pandemic dramatically changed patterns of behavioral health care utilization, with immediate reductions in specialty care utilization across the behavioral healthcare system and the most sustained reductions in substance use care.

The County responded with a multipronged approach. To address care access, the system of County-operated and contracted outpatient care pivoted to telephonic or tele-health services. To be responsive to pandemic-related pressures on mainstream health systems, several projects involving capital investment in hospital systems were delayed. Instead, focus shifted to high-impact, community-based programs and initiatives designed to divert individuals from more intensive levels of care and connect them to long-term housing and supports, and ongoing care coordination.

Focus on Value and Equity: 2020 and Moving Forward

In the past year there was a renewed attention to **racial justice**, with calls for the dismantling of structural racism and the promotion of equity within our government systems. In recognition of these calls for reform from the community and by the Board, BHS is taking tangible steps to lessen disparities and support equity within the behavioral health system, building on an existing foundation of equity-oriented activities, and in alignment with broader countywide racial justice efforts.

- The data sciences initiative noted above will enable the Population Health Unit to employ population health strategies to **identify health disparities across racial and ethnic groups**, as well as disparities across gender, sexual orientation, culture, language, and socioeconomic status. The Population Health Unit will work together with BHS leadership to engage in strategic planning and evaluation of programs to support proportional resource

allocation based on community need, and with design considerations led by the community's voice.

- BHS is working with the University of California, San Diego (UCSD) Health Services Research Center (HSRC) and Rady Children's Hospital Children and Adolescent Services Research Center (CASRC) toward the development of a "**Community Experience Project**" designed to establish a process for identifying and addressing unmet behavioral health needs, through the completion of four carefully developed areas of work:

  - Engagement with community members and key stakeholders in the identification, collection, analysis, and interpretation of data and in the development of plans for action.
  - Creation of a "Behavioral Equity Index" to highlight populations and neighborhoods at greatest risk for unmet behavioral health need.
  - Development of a "Community Experience Dashboard" to provide users with an interactive platform to investigate behavioral health experiences by subpopulation and subregional area using community data sources.
  - Development of action reports which will synthesize key findings and priorities for intervention.

BHS will work in concert with Public Health Services to ensure these efforts are integrated across healthcare and behavioral healthcare and are aligned with the actions set forward at the County level.

Continuing to Build a Regionally Distributed Continuum of Care

On February 18, 2021, Chair Fletcher's State of the County address affirmed that *we must build a network of comprehensive behavioral healthcare that delivers the right services, to the right person, at the right time* by:

- Expanding behavioral health hubs countywide,
- Ensuring discharged clients are paired with a care coordinator,
- Fully expanding innovative projects, such as the Mobile Crisis Response Team pilot,
- Implementing a series of actions to address the steep shortage of essential mental health workers,
- Offering more supportive housing paired with effective behavioral health treatment,
- Embracing harm reduction strategies, and
- Improving care to the justice-involved population.

Actions are underway, as directed by your Board and as shaped by community voices, that are building the necessary service capacity to achieve this vision. This includes:

- The advancement of the Central Region flagship behavioral health hub,
- New construction of a psychiatric health facility in Oceanside,

- The Mobile Crisis Response Team pilot program which became operational in March 2021, with plans to expedite countywide roll-out, and
- Increasing crisis stabilization services capacity through the expansion and addition of regional crisis stabilization units.

A complete description and update on all Continuum of Care projects can be found in Attachment A.

As noted above, **expansion of regional crisis stabilization services remains a priority**, with services provided in both hospital- and community-based settings. Hospital-based crisis stabilization units (CSUs) provide emergency psychiatric services adjacent to a hospital's emergency or urgent care unit, for individuals experiencing a psychiatric crisis to stabilize and connect them to ongoing services that meet their individual needs, while community-based CSUs provide emergency psychiatric services within a community-based setting. Services in CSUs include: law enforcement drop-offs, as a safe alternative to a jail or hospital; psychiatric services; medication; peer support; and transition planning, with stays of less than 24 hours, as per current California Code of Regulations.

Currently, hospital-based CSUs are designated Lanterman-Petris-Short (LPS) facilities which primarily allows for involuntary evaluation and treatment of individuals; however, community-based CSUs do not qualify under the current County LPS designation guidelines. If approved, today's action would change that by accepting the updated LPS Designation Guidelines and Processes for Facilities within San Diego County to include all programs that meet applicable State and local regulations. This would allow for the inclusion of community-based CSUs ensuring all crisis stabilization settings can operate consistently.

Additionally, efforts are underway to enhance collaborative work between HHSA and the San Diego County Sheriff's Department to support the expanded behavioral health care services in San Diego County's jails. This is in alignment with Chair Fletcher's State of the County priorities, as well as the Triple Aim approach to improve the health of populations, enhance the experience and outcomes of individuals, and ultimately reduce per capita costs of care.

Future Updates
Today's action also seeks approval to shift away from topic-specific reporting on a pre-set cadence – specifically, quarterly Continuum of Care, Laura's Law Assisted Outpatient Treatment services, and Behavioral Health Impact Fund reporting – to providing updates as key developments are identified. This will help ensure updates are provided to the Board in a timely and comprehensive manner.

LINKAGE TO THE COUNTY OF SAN DIEGO STRATEGIC PLAN
Today's action supports the County's 2021-2026 strategic initiative of Building Better Health by supporting the County of San Diego's goal of a fully optimized health and social service delivery system to make it an industry leader in efficiency, integration, and innovation. Additionally, today's item supports the Operational Excellence strategic initiative making health, safety, and thriving a focus of all policies and programs through internal and external collaboration.

SUBJECT: UPDATE ON ADVANCING THE BEHAVIORAL HEALTH CONTINUUM OF CARE (DISTRICTS: ALL)

Respectfully submitted,

HELEN N. ROBBINS-MEYER
Chief Administrative Officer

ATTACHMENT(S)
Attachment A – Behavioral Health Services Continuum of Care Key Updates
Attachment B – Lanterman-Petris-Short (LPS) Designation Guidelines and Processes for Facilities Within San Diego County (Clean Copy)
Attachment B-1 – Lanterman-Petris-Short (LPS) Designation Guidelines and Processes for Facilities Within San Diego County (Informational Copy)

BEHAVIORAL HEALTH SERVICES
CONTINUUM OF CARE KEY UPDATES

May 4, 2021

In 2018, the San Diego County Board of Supervisors (Board) initiated several actions to enhance, expand, and innovate behavioral health programs and services in the region. This body of work is broadly referred to as the Behavioral Health Continuum of Care (Continuum of Care). These actions have brought together diverse stakeholders, including justice partners, hospitals, community health centers and other community-based providers, to create system-wide changes and help ensure individuals can quickly access behavioral health services to meet their immediate needs, and support their long-term journey to recovery.

Prior to COVID-19, Continuum of Care updates were presented in the context of hubs and networks as follows:

- *Hubs*: Integrated care environments that are co-located and affiliated with a general acute care hospital, designed to accelerate transition from behavioral health crisis to sustainable, continuous care management through robust care coordination.
- *Networks*: A broad array of outpatient services and housing opportunities that help keep individuals stable and continuously connected to services.

However, the impact of COVID-19 has shifted the County's strategies in the following ways:

- Strategies are temporarily shifting away from large capital investments toward high impact services designed to support the influx of need due to elevated levels of mental distress.
- Leverage current federal and State regulatory changes that allow for flexibility and the rapid expansion of services, including telehealth and certification processes.
- Shift to community-based resources in order to relieve pressure upon the hospital system, which has been severely impacted during the pandemic.

These strategic shifts have also changed the way Continuum of Care updates are reported. Updates that were once reported in the categories of Hubs and Networks, are now reported within the categories of Diversionary Services, Investments to Support Continuous Care for Individuals with Behavioral Health Conditions, and Care Coordination Efforts. These new reporting categories are in alignment with strategic efforts to shift or delay large investments in capital infrastructure in hospital systems, and instead focus on programs and initiatives that yield high-impact result designed to *divert* individuals from high-acuity services and *connect* them to long-term housing and supports, and ongoing care coordination.

Diversionary Services

Regional Crisis Stabilization Units
On March 26, 2019 (02), the Board approved a recommendation to work collaboratively with the Sheriff's Department and District Attorney to establish regional mental health crisis stabilization units (CSUs) that provide 24/7 walk-in mental health and substance use disorder services for those in behavioral health crisis. Services in these CSUs include law enforcement drop-offs as a safe alternative to a jail or hospital, psychiatric services, medication, peer support, and transition planning, with stays of less than 24 hours.

- The North Coastal Community-Based CSU in Vista received approval for the conditional use permit application with construction expected to be completed in fall 2021. When operational, this facility will have 12 recliners available.
- The North Coastal Live Well Health Center Community-Based CSU in Oceanside continues to progress forward. The project is currently in the construction phase with anticipated completion occurring summer 2021 and services estimated to begin fall 2021. When operational, this facility will have 12 recliners available.
- The South Region Hospital-Based CSU located at Paradise Valley Hospital was approved by the Board on August 4, 2020 (05) and when operational, will have up to 12 recliners. All recliners are anticipated to be available by the end of Fiscal Year 2020-2021.
- The North Inland Hospital-Based CSU at the Palomar Hospital campus in Escondido was approved by the Board on May 19, 2020 (06) to expand from 8 to 16 recliners. All 16 recliners were available beginning January 2021.

Mobile Crisis Response Teams
On March 26, 2019 (02), the Board approved a recommendation to develop timely follow-up care to connect individuals to appropriate services after a mental health crisis involving law enforcement. To further explore reducing the extent of law enforcement involvement in serving behavioral health needs, on June 25, 2019 (01), the Board approved the establishment of a non-law enforcement Mobile Crisis Response Teams (MCRT) pilot program, in coordination with Behavioral Health Services (BHS), the Sheriff, and the San Diego County District Attorney, with initial efforts focused in the North Coastal Region. Subsequently, the Board approved a recommendation on June 23, 2020 (26), to fully fund an expedited rollout of MCRTs countywide.

As of March 2021, the North Coastal MCRT pilot program is operational and actively taking referrals. MCRTs are comprised of a trained clinician, case manager, and peer support specialist with teams currently deployed through the Access and Crisis Line, and plans are underway to evolve the service toward 9-1-1 dispatch.

Investments to Support Continuous Care for Individuals with Behavioral Health Conditions

Step-Down and Long-Term Care Investments
Increasing the availability of step-down and long-term care beds continues to be a vital need and priority. Since 2019, BHS has increased capacity by over 200 beds throughout the county, as reported in previous Continuum of Care updates, which provide transitional support for people experiencing an acute behavioral health need when they are discharged from an inpatient psychiatric hospital.

Augmented Services Programs (ASPs), provide enhanced services to individuals with serious mental illness who are receiving behavioral health services and are placed in licensed residential care facilities, also referred to as Board and Care facilities. The ASP program assists clients in maintaining and improving functioning in the community and to prevent or minimize institutionalization. These services are available at licensed Board and Care facilities, with the goal of stepping down to a lower level of care if clinically indicated. In support of this critical service, planning to enhance provider rates continues to ensure capacity can be maintained across ASP programs. BHS is working towards identifying prospective Board and Care providers with the goal of increasing ASP beds to serve the behavioral health system of care.

Inpatient Psychiatric Acute Care Rate Review Project
In a collaboration with providers, BHS is developing new, value-based reimbursement approaches for inpatient services. This includes the development of baseline per-diem rate(s) and working to establish additional incentive-based payment opportunities. BHS will work closely with the provider community to define performance measures and associated goals for these incentive payments. The chosen measures will support broader goals to improve behavioral health for San Diego and may include efforts to expand access, better coordinate care, and help people maintain recovery.

Tri-City Psychiatric Health Facility
In 2018, Tri-City Healthcare District (Tri-City), suspended its behavioral health unit (BHU), which provided adult inpatient psychiatric services, and its CSU, which provided adult crisis stabilization services. On June 25, 2019 (23), the Board directed the Chief Administrative Officer to negotiate an agreement with Tri-City, or related entity, to provide funding for construction of a psychiatric health facility (PHF) to meet the urgent and emergent behavioral health needs in North San Diego County. On January 14, 2020 (11), the Board approved final agreements between the County and Tri-City for the development and operation of a 16-bed PHF on vacant land located at the Tri-City Medical Center campus in Oceanside. Designs for the facility have been finalized and construction is currently slated to begin fall 2021 with services estimated to begin in late 2022.

Children's Behavioral Health Hub
On March 10, 2020 (04), the Board approved actions to begin the process of evaluating and potentially developing a behavioral health hub in North Central Region in partnership with Rady Children's Hospital (Rady) which would provide an array of services designed to meet the needs children and youth. Services for this hub include:

- Inpatient and acute care services
- Crisis stabilization services
- Partial hospitalization
- Care coordination services
- Medical and transitional care services for the County's Juvenile Hall

County staff continue to work with Rady on California Environmental Quality Act (CEQA) compliance; to design the program and clinical services; and outline the planning phases to build the new facility.

Care Coordination Efforts

Memorandum of Understanding with University of California, San Diego Health
On October 29, 2019 (31), the Board was informed that development of a vacant, County-owned parcel of land located on Third Avenue, San Diego, was feasible for a variety of mental health services. Subsequently, on January 28, 2020 (03), the Board directed staff to execute a memorandum of understanding between the County and the University of California, San Diego Health (UCSD), to operate and/or provide services at the Central Region Behavioral Health Hub and, as appropriate, provide interim services at San Diego County Psychiatric Hospital (SDCPH).

The County and UCSD continue to collaborate toward the establishment of longitudinal, data-supported care coordination for people with serious mental illness. This work is being supported through a recent community investment agreement of $1 million from Blue Shield Promise, and a soft launch is anticipated in the first half of Fiscal Year 2021-22.

Transitioning operations at the SDCPH to UCSD will require changes at Edgemoor Distinct Part Skilled Nursing Facility (Edgemoor) which is currently a distinct part and licensed under SDCPH. With planned changes in licensure at SDCPH there is an opportunity to reconfigure the relationship between SNF and adjacent services at Edgemoor. To optimize clinical coordination and best meet community need, an architect and the Department of General Services, with the guidance of OSHPD liaisons, are assisting with a review of options for augmenting services at Edgemoor.

Additional Updates in Support of Continuum of Care Efforts

Behavioral Health Impact Fund
On April 7, 2020 (03), the Board, in partnership with the City of San Diego (City), established a Behavioral Health Impact Fund (BHIF) with appropriations of $25 million for capital projects to support community-based behavioral health organizations in increasing their capacity to support long-term treatment. One-time funds for capital projects through a competitive procurement process will strengthen the regional Continuum of Care.

The BHIF request for proposal (RFP) was issued in May 2020, inviting offerors to submit proposals for capital funds to support the following critical service areas:

- Licensed adult residential facilities, also known as board and care facilities;
- Temporary and transitional housing and support for people with substance use disorders consistent with recovery residence settings;
- Residential mental health treatment services, including crisis residential programs for homeless populations and transition age youth;
- Residential substance use disorder treatment programs, inclusive of withdrawal management and detoxification services;
- Other temporary and transitional housing for homeless populations with behavioral health needs that may include a focus on youth who are victims of commercial sexual exploitation; and
- Information technology to support telehealth, data integration and innovation to optimize access and care for individuals with behavioral health care needs.

Behavioral Health Services (BHS) received proposals in June 2020 and began evaluations in July 2020. The evaluation process continues moving forward, with an anticipated staggered approach to award as evaluations are completed and recommendations for award are made. The source selection committee has completed the evaluation for multiple proposals and is finalizing recommendations, while multiple additional proposals continue to be evaluated. The anticipated timeline for making initial awards is spring 2021, with the potential for making additional awards in the following months.

Continuum of Care Projects on Hold

The Continuum of Care projects listed below began prior to the pandemic and are currently on hold due to the impacts of COVID-19 as noted in the opening narrative above:

- North Inland crisis residential services – On October 29, 2019 (05), the Board approved actions to competitively procure crisis residential services along the 78 corridor which, when operational, would have up to 16 beds.
- School-based crisis services – On March 26, 2019 (02), the Board approved a recommendation to work with school districts and the County Office of Education to develop enhanced school-based crisis response, including possible expansion of the existing PERT program for threats or crisis situations involving school youth.
- On October 29, 2019 (05), the Board approved actions to pursue development of a behavioral health hub in the North Inland Region in Escondido with services provided in partnership with Palomar Health. The feasibility of developing additional behavioral health hubs in other geographic areas of San Diego County, including South Region and East Region, were also being explored.

County of San Diego Health and Human Services Agency
Behavioral Health Services

LANTERMAN-PETRIS SHORT (LPS) DESIGNATION GUIDELINES AND PROCESSES FOR FACILITIES WITHIN SAN DIEGO COUNTY

LPS DESIGNATION GUIDELINES AND PROCESSES FOR FACILITIES WITHIN SAN DIEGO COUNTY

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County of San Diego Health and Human Services Agency
Behavioral Health Services (BHS)

LANTERMAN-PETRIS-SHORT (LPS) DESIGNATION GUIDELINES AND PROCESSES FOR FACILITIES WITHIN SAN DIEGO COUNTY

DECLARATION:

Facilities which meet the criteria and process requirements set forth in this document may be designated by the San Diego County Board of Supervisors to evaluate and treat persons involuntarily detained under the Lanterman-Petris-Short (LPS) Act, Welfare and Institutions Code Section 5000 (et seq.), and Title 9, Section 821.

OBJECTIVES:

The objectives of these LPS Designation Guidelines and Processes for Facilities within San Diego County are to:

1) Enhance the capability and overall quality of the mental health delivery system in San Diego County.
2) Ensure proper utilization of the designation authority by granting it to only those facilities which meet specified guidelines.
3) Establish the terms of and conditions pertaining to the delegation of authority by which individuals are taken into custody under the LPS Act.

I. LPS DESIGNATION GUIDELINES FOR FACILITIES

DELEGATION OF AUTHORITY TO INVOLUNTARILY DETAIN AND TREAT

A. The authority under the LPS Act for a facility to hold individuals and to involuntarily treat mental health patients is vested by state law by the San Diego County Board of Supervisors.

B. Involuntary detention under the LPS Act constitutes a significant deprivation of civil liberties that is supported under limited circumstances described in law and regulation.

C. Involuntary detention and treatment is deemed necessary when required to protect the safety of certain individuals and the community in circumstances permitted by law.

D. These guidelines describe the nature, extent, and processes by which authority for facilities to involuntarily detain and treat under the LPS Act is designated by the County of San Diego Board of Supervisors.

FACILITY OPERATIONS GUIDELINES

A. A designated facility (defined here as an entity that meets LPS State and local requirements) provides evaluation and treatment services for persons who, as a result of a mental disorder, are judged to be dangerous to self or others and/or gravely disabled. It adheres to those regulations and statutes relevant to the clinical, health, and safety needs of those persons.

1. The facility shall comply with applicable constitutional, statutory, regulatory, and decisional law, including but not limited to California Welfare and Institutions Code (WIC) Section 5000 et seq., the requirements set forth in California Code of Regulations (CCR) Title 9, Sections 663, 821-829 and 835-868, the requirements governing mental health facilities and/or treatment of Titles 22 and 24 of the CCR, the Civil Code, Health and Safety Code, and all applicable policies, procedures, or guidelines governing LPS designation established by the County of San Diego, Health and Human Services Agency Behavioral Health Services (BHS) department.
2. The facility shall maintain all applicable current licenses as appropriate for its type. No designated facility may show any gross violation of clinical practice and/or safety provisions relevant to the class of persons for whom the designation applies, although the violations may not be explicitly covered by licensing standards. Any such gross violations, as determined by the Director of BHS, can result in discontinuance of the facility designation.
3. All designated Skilled Nursing Facilities and Psychiatric Health Facilities shall comply with all provisions of Title 22 of the CCR and all laws, regulations, and standards of care as apply to them. The facility shall assume the full responsibility for assuring appropriate patient care and safety, and accepts all attendant legal obligations.
4. The facility shall have 24-hours-a-day, 7-days-a-week mental health admission, evaluation, referral, and treatment capabilities, and provide whatever mental health treatment and care involuntarily detained persons require for the full period they are held (WIC, Section 5152).
5. All areas of a general acute care hospital or acute psychiatric hospital may be designated, providing:
   a) The facility has one or more inpatient mental health units under the same licensure, patients with a mental health problem concurrently needing hospitalization in the medical floor or portion of the hospital will continue to receive mental health services in the physical health care portion, as would be appropriate for the patient's mental health status- such as a daily re-evaluation and/or psychiatric medication adjustment visit, client informing materials,

education for medical staff and capability for holding required hearings such as a private room.

b) To be LPS designated, an Emergency Department must be located in the same licensed facility as the LPS Inpatient Unit or under the same license as the LPS Inpatient Unit. However, Emergency Department physicians in non-LPS facilities who have successfully completed the BHS training and testing approved by the Director of BHS related to the WIC Sections 5150 and 5585.50 detention process can write 5150 holds[1].

c) An Urgent Care sharing a facility/building with an LPS Inpatient Unit may be designated as an LPS Urgent Care, as long as it has the documented capability to provide all required emergency care for LPS clients.

d) A community program may be designated as long as it meets all applicable LPS regulations as referenced within these guidelines.

e) Involuntarily detained patients shall be treated in areas other than the mental health unit only if their medical condition requires it.

f) Appropriate mental health staffing, assessments, programs and treatment shall be provided to all involuntarily detained patients regardless of their physical location within the facility.

g) Patients under the jurisdiction of the Department of Justice, Department of Corrections, or detained primarily pursuant to the jurisdiction of state or federal law enforcement shall be housed separately from the civilly detained or voluntary behavioral health patient population.

h) All rights guaranteed to mental health patients by statutes and regulations are observed for all individuals with specific exceptions (WIC Section 5326) for patients under the jurisdiction of the Department of Justice, Department of Corrections, or detained primarily pursuant to the jurisdiction of state or federal law enforcement. In order to ensure access to mental health services to patients under the jurisdiction of the Department of Justice, Department of Corrections, or detained primarily pursuant to the jurisdiction of state or federal law enforcement, the Director of BHS has adopted the following conditions under which certain rights may not be guaranteed:

- For patients from a Federal Detention facility under the jurisdiction of the Department of Justice, Department of Corrections, or imprisoned primarily pursuant to the jurisdiction of state or federal law, the Departments of Justice and Corrections or federal and state law enforcement shall have the authority to

[1] "5150" refers to provisions in California's *Welfare and Institutions Code* §5150 permitting qualified staff to detain and transport or cause the detention and transport of a person meeting certain criteria, for up to 72 hours, to an LPS-designated facility to determine whether further mental health evaluation and treatment is necessary.

determine if the right to make and receive phone calls, to receive visitors, to write or receive mail, or to access personal property may be allowed in the LPS facility. The grounds for such an abridgement of rights must be documented in the patient file given to the hospital and the removal of rights must be noted in the patient's hospital record.

- The rationale for denial of any rights, including those noted above that have been removed by the Department of Justice or the Department of Corrections, shall, in all cases, be entered into each patient's treatment record.

i) All rights to administrative and judicial review to which patients may be entitled, including but not limited to certification hearings, medication capacity hearings, and writs of habeas corpus, shall be properly initiated, implemented, and conducted.

j) Seclusion and restraints shall not be used to compensate for inadequate staffing, lack of program or building security. Use of seclusion and/or restraints shall comply with all Title 9, Title 22, Health and Safety Code, Centers for Medicare & Medicaid Services (CMS), and The Joint Commission (TJC) standards.

k) The involuntary treatment provisions of the LPS Act shall not be used to authorize or deliver medical treatment. Consent to medical treatment must be obtained as otherwise provided in law.

6. The facility ensures that, of the time patients spend in a non-designated medical facility emergency department to which they have come for medical treatment and wherein identified staff believe there is a need for 5150 evaluation, any detention time from the time that the person has been detained on the 5150 and is awaiting placement to a designated facility is deducted from the subsequent 72-hour detention period, pursuant to Health and Safety Code Section 1799.111.

7. Prior to admitting a person to a designated facility pursuant to WIC Section 5150, the professional person in charge of the facility or his or her designee shall assess the individual in person to determine the appropriateness of the involuntary detention, as per WIC Section 5151.

8. Once a facility accepts the patient for treatment, it shall assume the responsibility for seeing the case through to its appropriate disposition (i.e. the clinically indicated, available, and legally allowable treatment, referral or placement that best meets the patient's clinical needs and desires).

9. The facility shall ensure that information and services, rights, notifications, and advertisements are communicated in a language and modality accessible to the patient. The facility shall make arrangements for interpreters or for use of other mechanisms to ensure adequate communication

between patients and personnel, if any language or communication barriers exist between facility staff and patients.

10. The facility shall allow BHS to review the facility for initial designation and for site reviews which will occur every 3 years.
11. The facility shall allow the County of San Diego Patients' Rights Advocate access to all staff and patients at all times to conduct investigations to resolve specific complaints. Patients shall be allowed access to the Patients' Rights Advocate at any time.
12. The facility shall allow the Director of BHS or designee and the County of San Diego Patients' Rights Advocates access, upon request, to all treatment records, logs, policy and procedure manuals, contracts, credentials files and/or personnel records of staff empowered to initiate 72-hour holds, and other professional staff in order to conduct investigations and assess compliance with LPS and Patients' Rights statutes and regulations.
13. The facility shall abide by the procedures established by the Superior Court and BHS for all mental health-related court hearings that are facility-based (including but not limited to certification review [probable cause] hearings, medication capacity ["Riese"] hearings, inpatient admission of persons 14 – 17 year old [Roger S.] hearings and clinical reviews), and court-based hearings (including writs of habeas corpus, medication capacity appeals, and all conservatorship proceedings).
    a) The facility is responsible for transport and escort of patients to and from, and supervision at, all mental health-related court hearings.
    b) The facility provides adequate space and staff to ensure that all facility-based hearings are conducted without interruption and in an atmosphere that affords privacy and ensures confidentiality and safety.
14. The facility shall abide by all Patients' Rights Conditions of Participation as set forth by CMS in 42 CFR part 482 inclusive of seclusion and restraint requirements and ensures that a physician or qualified nursing staff perform face-to-face assessment of the patient within one hour of initiation of seclusion and/or restraint. The order of the treating physician details the date, time, and method of seclusion and/or restraint and the specific behavior supporting good cause for the intervention. The time limits of orders for restraint or seclusion are within CMS and TJC specifications. Staff shall continually assess, monitor, and evaluate patients in seclusion and/or restraints to ensure release at the earliest possible time. Facilities must abide by Title 22, Health and Safety Code (Div. 1.5 commencing with Section 1180-1180.6) requirements regarding seclusion and restraint. The facility's policies and procedures for using seclusion and/or restraints with mental health patients shall adhere to the following principles and practices.

    a) The use of seclusion and/or restraint is limited to those behavioral emergencies wherein a person's behavior presents an imminent danger of serious harm to self or others and property.
    b) Documentation supports staff awareness of patient's expressed preferences regarding de-escalation techniques and alternatives to seclusion and/or restraint, why patient preferences were not appropriate, and that seclusion and/or restraint was the least restrictive method available to prevent injury to patient or others.
    c) The original physician order for seclusion and restraint, if renewed for another period of time, does not exceed the time limits established in Title 22, Health and Safety Code (Div. 1.5 commencing with Section 1180-1180.6).
    d) There is documentation for each incident of use of seclusion and/or restraint of all rights denied.
    e) There is documentation, for each incident of use of seclusion and/or restraint, of all applicable rights having been restored after seclusion and/or restraint have ended.
15. The facility shall have a system and procedures in place to ensure the confidentiality, security, integrity, and accessibility of patient health information, inclusive of a contingency plan for the storage and protection of filed medical records against unauthorized intrusion and/or damage.
16. The facility shall submit required quarterly reports to the Director of BHS regarding involuntary detentions, patients' rights denials, and electroconvulsive treatment administered, as required by WIC 5326.1, 5326.15, and CCR, Title 9, Section 866, and Title 22. Critical incidents are reported to appropriate Licensing, State, and County agencies, as needed.
17. The facility shall notify BHS of any changes that may significantly affect the facility's conformance with the criteria for designation, including change of ownership, modification of physical structure, number of beds, demographic or diagnostic aspects of patient population, therapeutic services, or policies or procedures concerning staffing, program, or operations. Based on receipt and analysis of such information, the Director of BHS may require successful completion of a focused review as a condition of continued facility designation. The focused review will occur within 6 months of the change.
18. The facility shall indemnify, and hold harmless the County of San Diego BHS, County of San Diego Board of Supervisors, and the State Department of Health Care Services (DHCS), and their officers, agents and employees, from and against any and all claims, losses, liabilities, or damages arising out of, or resulting from the facility's or its designees' exercise of County-granted LPS authority to detain and treat patients on an involuntary basis.

STAFFING GUIDELINES

A. The facility shall have adequate 24-hour professional supervision to meet the clinical needs and ensure the safety of patients judged to be dangerous to themselves or others or gravely disabled.

B. Staff shall hold current and valid California professional licenses where required and, upon request, copies will be available onsite.

C. All staff involved in the evaluation and treatment of involuntary patients shall be fully conversant with the involuntary detention statutes (WIC, Section 5150 et seq.), with patients' rights statutes, (WIC, 5325 and 5325.1), and related regulations (CCR Section 860 et seq.), inclusive of residents, attending physicians and psychologists, allied health professionals, and clinical employees.

1. The facility shall make available for review required documentation of attendance of staff at in-service training concerning LPS and patients' rights statutes and regulations during orientation, at the time of hire, and at least annually thereafter.

POLICIES AND PROCEDURES

A. The facility shall have acceptable policies and procedures, plans, and contracts (without compensation or inducement for referring patients) which comport to WIC, CCR, and the California Business and Professions Code related to the legal, ethical, fiscally sound, and clinically appropriate psychiatric treatment of both voluntary and involuntary patients. These policies and procedures, plans, and contracts shall be made available for review and must include, but are not limited to, the following:

1. ADMISSIONS POLICIES AND PROCEDURES

a) To ensure that 5150 forms received by the facility contain documentation of a specific factual basis in support of each 5150

b) To ensure safe and orderly transfer of physical custody of the person from law enforcement

c) To ensure that a qualified professional conducts a face-to-face assessment of the person presented and makes the determination whether to admit pursuant to 5150, admit voluntarily, or refer for other services

d) For disposition of persons brought in by law enforcement or otherwise presented for evaluation and treatment who are not admitted, including those who decline alternative services

e) For establishing validity of conservatorship and obtaining approval for admission

f) To ensure that persons assessed and admitted, voluntarily or involuntarily, receive an evaluation as soon as possible after admission

g) To ensure that persons admitted receive whatever treatment and care his or her condition requires for the full period that he or she is hospitalized

h) Regarding release before the end of a 72-hour hold

i) To ensure documentation of patient's concerns, needs, limitations, and physical health needs (including assessment and documentation of pre-existing injuries), and determination of appropriate bed assignment (i.e. need for private room, proximity to nurse's station, factors affecting roommate selection, safety issues)

j) To ensure documentation of patient's needs and preferences regarding the use of seclusion/restraint, including triggers and/or precipitants to aggressive behavior, patient's preferred de-escalation techniques, pre-existing medical conditions, limitations, or disabilities that constitute risk factors and history of trauma, physical or sexual abuse

k) Regarding obtaining informed consent from the patient or conservator for psychotropic medication including explanation of type and dosage of medication, therapeutic effects, and potential side effects

l) Regarding emergency administration of medication

m) Regarding patient advisement of legal status

n) To ensure receipt of state mandated patients' rights handbook and other patients' rights notifications and advisements

o) Detailing methods for ensuring that treatment information and services, patient rights, due process (including procedures relating to rights, certification hearings, writs of habeas corpus, and medication capacity) notifications, advisements, are communicated in a language and modality accessible to the patient

p) Regarding Department of Justice firearms prohibition, notification, and filing of paperwork

q) Regarding patient consent for release of information, including circumstances requiring consent, information given to patient, documentation required, and method of ensuring patient receives copy of all signed consents

r) Regarding inventory and safeguarding of all patient property upon admission

s) Regarding filing of requests for Riese hearings

t) To ensure documentation of good cause for all incomplete advisements and procedures for ensuring that the required subsequent attempts to advise are made and documented

u) Regarding documentation of denials of patients' rights including documentation of good cause, appropriateness of denial as least restrictive, the time limit(s) of denial, and the end time of the denial period

v) Providing evidence that rights regarding receiving visitors, making and receiving phone calls, and sending and receiving mail and/or access to personal property are not to be earned by the patient or subject to limitation by parent, guardian, or conservator. For patients from a Federal Detention facility under the jurisdiction of the Department of Justice, Department of Corrections, or imprisoned primarily pursuant to the jurisdiction of

state or federal law, the Departments of Justice and Corrections or federal and state law enforcement shall have the authority to determine if those rights may be allowed in the LPS facility

w) Providing evidence that trained staff is available at all times to inform involuntary patients requesting release of right to file writ of habeas corpus, including providing and assisting with appropriate paperwork and ensuring timely filing

x) To ensure signed psychotropic medication consents are kept in the patient's chart

y) Detailing that, absent judicial determination of incompetence to consent, patients on 72-hour or 14-day holds or temporary conservatorship who refuse to give consent are medicated only in an emergency as defined in Section 853 of CCR

z) To ensure medications are not used in quantities that interfere with the patient's ability to routinely participate in the treatment program

aa) To ensure that, for any disclosure of records or information, the facility has appropriate documentation including: the date, circumstance under which disclosure was made, to whom disclosure was made and specific information disclosed

bb) Regarding separate consents to treatment including, but not limited to, psychiatric medications, voluntary treatment, voluntary ECTs, and medical treatment

cc) Regarding room searches and search of patients

2. FACILITY PRACTICES POLICIES AND PROCEDURES

a) Regarding facility code of ethics and conflict of interest; resolving patient complaints, grievance and appeal processes, and Advance Directives

b) Regarding criteria for identifying potential abuse, procedures for management of alleged physical and sexual abuse, mandated abuse reporting

c) Detailing program services and schedules and addressing staffing plans based on patient care

d) Regarding mobile assessment team including member names, professional licenses, proof of 5150 training, scope of authority, staffing schedules and procedures to ensure review of 5150s written by mobile assessment team

e) Regarding medication dispensing and control

f) Regarding internal monitoring, review and auditing of medical records on an ongoing basis

g) Regarding Utilization Review

h) Regarding identification, reporting and management of critical incidents

i) Detailing safety and disaster plans

j) Regarding 5150 training and list of designated staff

k) To ensure timely notification to court and to clients of hearings

l) Regarding elopement

m) Regarding safeguarding of patient belongings throughout hospitalization and during transfer and discharge

n) Regarding usage of the Tarasoff procedure

3. SECLUSION AND RESTRAINT POLICIES AND PROCEDURES

a) Reflecting that the use of seclusion and/or restraint is limited to those behavioral emergencies wherein a person's behavior presents an imminent danger of serious harm to self or others and property

b) Addressing practices staff must follow to obtain an order for the use of seclusion and/or restraint when the physician is not on site

c) To ensure documentation supports staff awareness of patient's expressed preferences regarding de-escalation techniques and alternatives to seclusion and/or restraint, the reasons why patient preferences were not appropriate in each instance, and that seclusion and/or restraint was least restrictive method available to prevent injury to patient or others

d) To ensure that a physician or qualified nursing staff performs a face-to-face assessment of the patient within one hour of initiation of seclusion and/or restraint

e) Describing necessary details to be included on the physician order for seclusion and/or restraint

f) To ensure that staff continually assess, monitor, and evaluate patients in seclusion and/or restraints to ensure release at the earliest possible time

g) Regarding debriefing following incidents of use of seclusion and/or restraint

4. AFTERCARE/DISCHARGE POLICIES AND PROCEDURES

a) To ensure that discharge planning begins upon a person's admission to the facility

b) Regarding an assessment of present level of functioning, including the person's capacity to self- provide food, clothing, and shelter

c) Regarding diagnosis, including treatment initiated, medications, and dosage schedules

d) Describing the specific programs and services required so the person can minimize future confinement and receive the treatment in the least restrictive setting

e) Regarding the identification of the mental health personnel responsible for the aftercare needs

f) To ensure referral and assistance in contacting providers of public social services, legal aid, educational, and vocational services

g) To ensure that if the patient is homeless, arrangements have been attempted for the voluntary placement of the person in a living environment suitable to his or her needs
h) To ensure the facility makes a copy of the written plan available to the patient
i) Describing discharges pursuant to court hearing or discharges Against Medical Advice (AMA)
j) Regarding routine discharge activities (i.e. return of property, transportation, follow-up care scheduling)

5. POLICIES AND PROCEDURES RELATED TO MINORS

a) Specification of educational or training needs, provided these needs are necessary for the minor's well-being
b) Facility obtains the necessary legal consents for admission, medication, medical treatment, etc., from the legally responsible adult
c) Facility adheres to and demonstrates a knowledge of administrative and legal procedures for admission of minors to acute care psychiatric hospital treatment
d) The facility makes every effort to notify the minor's parent or legal guardian as soon as possible after the minor is detained and to involve them in the clinical evaluation and treatment
e) When additional treatment is determined to be necessary, a written mental health treatment plan is completed which identifies the least restrictive placement alternative in which the minor can receive the necessary treatment
f) The facility consults with the minor's family, legal guardian, or caretaker to obtain further needed consents and consults regarding discharge planning and aftercare
g) Clinical evaluations include a psychosocial evaluation of the family and living environment
h) Notification of proper authorities and disposition of minor if the minor's parent, legal guardian or caretaker is unwilling or unable to accept physical custody of the minor upon release
i) Emancipated minors, married minors, and minors who are or have been in armed services are treated as adults
j) Responsible party may not limit the minor's exercise of rights including phone calls and visitors with noted exceptions for minors under the jurisdiction of the Department of Justice, Department of Corrections, or detained primarily pursuant to the jurisdiction of state or federal law enforcement

PHYSICAL ENVIRONMENT

A. All behavioral health units shall be maintained in a manner that ensures patient areas are safe, clean, and comfortable while meeting the clinical and physical needs of the patients.
B. The physical plant shall meet the structural standards provided in Title 24, as evidenced by the latest approval from State Licensing.
C. The facility shall provide a safe, accessible, and secure outdoor area for patient use.
D. Each behavioral health unit shall have at least one room specifically designated for the use of patient seclusion and/or restraints.
E. The facility's plant shall have a fire clearance (CMS 482.41).
F. The facility's physical plant shall allow for individual indoor storage space for each patient.
G. Telephones shall be available for patient use in locations and for periods of time that allow patient access and ensure confidential conversations.
H. The patient bathrooms shall ensure the maximum amount of patient privacy and dignity while ensuring patient safety.
I. The facility shall provide space for patients to receive visitors in an atmosphere that affords privacy but allows for patient safety.
J. A facility treating minor patients shall ensure they are housed in a separate unit away from the adult population (WIC, Section 5585.55 and 5751.7).
K. The facility shall provide adequate space and staff to ensure that all facility-based hearings can be conducted without interruption, in an atmosphere that affords privacy and ensures confidentiality and safety.
L. Patients' Rights posters shall be in visible and prominent places in the facility (WIC, Section 5325).

DOCUMENTATION AND TREATMENT GUIDELINES

The designated facility participates in quality improvement activities, including documentation, data collection, and quarterly reporting, using approved State-mandated forms, as specified by BHS.

A. Data Collection
    1. Monthly seclusions and restraints data for contracted LPS facilities is transmitted to BHS on a quarterly basis
    2. Denial of Rights/Seclusion and Restraint Monthly Report
        a) Number of patients denied each specified right or placed in seclusion or restraints, the number of days each type of right was denied or seclusion and/or restraint used
    3. Quarterly Report on Services Provided to Persons Detained in Jail Facilities
        a) Number of admissions to local inpatient services for evaluation and treatment
        b) Number of admissions to an LPS jail inpatient mental health program
        c) Count of persons receiving outpatient services provided within a jail facility
        d) Number of emergency screenings

4. Quarterly Report on Involuntary Detentions
    a) Admissions for 72-hour evaluation and treatment
    b) Certifications for 14-day treatment
    c) Additional 14-day intensive treatment for suicidal persons
    d) Certifications for 30-day intensive treatment
    e) Number of 180-day post-certification treatments
5. Electroconvulsive Therapy Treatments Administered – Quarterly Report
    a) Number of patients receiving
    b) Total treatments given
    c) Complications attributable to treatment
    d) Requests for, and Review Committee decision on, excessive treatment
6. Mental Health Rehabilitation Center (MHRC) license reports
    a) Denial of Rights—County Summary
    b) List of Facilities by type and bed capacity
    c) Number of patients denied rights and days each right denied
    d) Total number of patient days
    e) Percentage frequency of denial of rights

B. The facility shall ensure that initial assessments of referred patients are completed regardless of ability to pay.

C. Psychiatric assessments of voluntary and involuntary patients shall include documentation substantiating the need for current treatment and level of care and shall be completed within 24 hours by the attending practitioner.

D. Authorized members of the professional staff who initiate involuntary detentions shall participate in the care and treatment of the patients for whom they initiate 72-hour holds (inclusive of participation in treatment planning), pursuant to WIC, Section 5150 and CCR, Section 823.

E. The facility shall ensure that patients are appropriately involved in planning their care and treatment, as evidenced by documentation of patient participation in treatment planning.

F. The facility shall ensure that patients' medical problems are identified, addressed, and documented in treatment plans.

G. The facility shall meet BHS requirements for application and referral of clients to petition for establishment of LPS conservatorships.

H. The facility shall ensure that the attending practitioners are present and testify at all legal hearings for which their attendance is required by the Court (e.g., writs, LPS conservatorship hearings, and medication capacity hearings), and that treating physicians meet all expectations related to communication with, and testimony in, San Diego Superior Court.

I. The facility shall ensure that, upon discharge, patients receive appropriate referrals to community agencies and suitable placement, as evidenced by documentation in the Discharge and Aftercare Plans. Uninsured, non-Medi-Cal patients who need further psychiatric medication shall be discharged with prescriptions for psychiatric medications that are available through BHS uninsured formulary and consistent with the parameters for prescription of psychiatric medication.

J. The facility shall have a mechanism to review medical records on an ongoing basis for completeness and timeliness of information and shall take action to improve the quality and timeliness of documentation that impacts the care of voluntary and involuntary patients.

K. The facility shall establish and maintain a process for appropriately resolving complaints, grievances, and appeals.

L. The facility's professional staff shall establish and maintain a mechanism for proctoring and conducting an ongoing peer review of the knowledge base and competencies of designated professional staff members on involuntary detention procedures and 5150s. Criteria and outcomes of monitoring shall be made available for review by the Director of BHS upon request.

M. The facility notifies BHS of all serious incidents, including adverse drug reactions, suicide attempts and suicides, homicides, medication errors resulting in serious adverse outcomes, use of physical restraints, deaths, sexual assaults, and serious physical injuries involving psychiatric patients by appropriately transmitted documents within the timeframe set forth in the Inpatient Operations Handbook.

N. The facility shall establish and maintain a process for determining patient perception of the quality of the clinical treatment process and the satisfaction of individuals served. Data on patient perceptions and satisfaction shall be made available for review by the Director of BHS upon request.

II. DESIGNATION TO TAKE INDIVIDUALS INTO CUSTODY PURSUANT TO LPS ACT

GENERAL GUIDELINES RELATED TO DESIGNATED INPATIENT FACILITIES

A. Facility administration shall maintain a current roster and current credential files of professional staff members who have been privileged and authorized to initiate 72-hour detentions. The foregoing shall be made available on request to representatives of BHS.

B. Continuation of the designation status of the facility shall require that all professional staff of the facility comply with all applicable LPS requirements. These requirements include the limitation of involuntary detention to those individuals who meet LPS criteria and are taken into custody only by members of the professional staff with involuntary detention authority.

C. The facility shall ensure that all designees, whenever exercising or otherwise communicating either orally or in writing about their designation authority or related services, clearly identify their facility affiliation and wear the mandated identification badge in face-to-face interactions.

D. The facility shall ensure that the completed original 5150 detention form is present in the medical record of each involuntarily detained patient. A completed form shall contain, in legible fashion, the signatory's professional discipline, and the facility affiliation under whose authority the involuntary detention was initiated.

E. The facility shall ensure that the involuntary detention authority granted to a member of the professional staff of the designated facility is exercised at that facility only and is in relation to the professional staff member's responsibilities at that facility. In instances where an evaluation for possible involuntary detention is conducted off the facility premises, the authorized professional staff member with mobile response responsibilities shall:

1. Be an employee or a formal contractor of the designated facility (Exception: Designated Physicians).
2. Dress and travel in a manner that does not inappropriately attract attention to the individual being assessed.
3. Complete a face-to-face assessment of the client prior to initiating an involuntary detention for that client.
4. Conduct and document an assessment that considers the full range of available treatment modalities, sites, and providers, and results in the care that best meets the client's specific needs. Assessment of need is based upon condition, treatment needs, geography, and current fiscal and treatment relationships with providers. The care should be rendered without regard to profit or gain by the designee's parent facility.
5. Have available a comprehensive and current referral source list and be well versed in all relevant treatment resources in the client's area.
6. Honor the preference of the client and/or the parent of a minor, conservator, or legal guardian for the type and location of the desired treatment facility if administratively feasible and clinically appropriate.
7. Unless prohibited by specific circumstances, seek information from and involve the client's current providers of mental health care in order to support continuity of care.
8. Represent themselves to the public as affiliated with the facility from which they derive their designation authority.
9. Strongly consider the proximity of the designated facility to the patient's own community, family and support system. Alternatives to taking a patient to a more distant facility should be considered and documented on the off-site assessment form.

10. Ensure that proper interventions and/or treatment are provided to the client for whom they have initiated LPS evaluation until appropriate disposition is effected (e.g. one-to-one monitoring, removal of contraband.)
11. Give detainment advisements to each client in a language or modality that the client can understand, pursuant to WIC, Section 5157, inclusive of the name of the facility to which the client is being taken, and notification that the person is not under criminal arrest but is being taken for examination by mental health professionals.
12. Follow all statutory requirements regarding client confidentiality.
13. Maintain an accurate log of all requests for the facility staff's off-premises services. Such log shall be available for inspection by the Patients' Rights Office and/or other designees of the Director of BHS and shall include:
    a) Date and time of both request and response
    b) Referral source
    c) Name of client
    d) Time of intervention and departure
    e) Completion of a written assessment of client, including consideration of less-restrictive alternatives
    f) Services provided and/or referrals made
    g) Disposition of the client
    h) Name of staff involved
    i) A copy of the 72-hour hold if initiated
    j) Source of payment
14. Take reasonable precautions to preserve and safeguard the patient's property, pursuant to WIC, Sections 5156 and 5211.
15. Initiate 72-hour holds only within the boundaries of San Diego County, unless special written designation authority or an exception has been granted by the County Mental Health Directors involved allowing for cross-county designation privileges.
16. Initiate involuntary detentions only for persons who, based on the authorized staff member's professional assessment, are believed to be dangerous to self or others or gravely disabled because of a mental disorder.
17. Abide by all provisions in the WIC, Division 5, and accompanying regulations, and Mental Health Services policies regarding treatment, evaluations, patients' rights, and due process.
18. When the client does not meet criteria for involuntary detention, provide the client with information, referral to appropriate community services, and/or other intervention as appropriate to his/her circumstances.

19. Report conditions of abuse or neglect at residential facilities, such as suspected or possible unsafe and unsanitary living conditions, involving elder or dependent adults and children, to the appropriate agencies per WIC, Section 15630(a)-(h).

F. The facility shall have at least one privileged professional staff member, who can be a Qualified Medical Professional (QMP), with 5150 authority present within one hour for on-site assessment of individuals considered for involuntary detention and/or admission.

G. The facility shall have the ability to safely detain an individual pending 5150 assessment for up to one hour on-site pending the arrival of an authorized professional staff member.

III. INITIAL FACILITY DESIGNATION

PROCEDURES

A. The facility requesting designation notifies the Director of BHS who notifies his appointee, the LPS Designation Review Coordinator (LPS Coordinator) of BHS. The LPS Coordinator then sends an informational packet to the facility delineating the criteria and procedures for LPS designation, along with an application and agreement to be signed by the facility Director of BHS, which stipulates that the facility agrees to abide by all designation guidelines and criteria set forth by the County.

B. Once the facility Medical and/or Administrative Director receives the packet from BHS and believes that the facility meets the LPS designation guidelines, he or she submits the application and agreement to the LPS Coordinator and arranges for an on-site survey visit.

C. Representatives of County of San Diego BHS, including Patients' Rights Advocates and BHS Quality Management staff, shall conduct an on-site review of the facility (including the physical plant, staffing, policies and procedures, and credentials files) for compliance with the LPS designation guidelines and criteria. If the facility is already accepting patients, the assessment also includes an examination of treatment charts selected by the representatives and voluntary interviews with selected patients and staff. The representatives also review mental health facility licensing reports, patient complaint logs and the facility's denial of rights, seclusion and restraint, involuntary holds reports, and grievance logs on file with BHS . At the time of the visit (or prior to the visit, if so requested), the facility provides the survey team with a copy of their current operating license, staffing plans by discipline, patient-to-staff ratios, Fire Marshal clearance, governing body and medical staff bylaws, Performance Improvement and Utilization Review Plans, a verification of 24-hour admitting capacity, type of staff and management (directly operated or by contract), treatment schedules, and program descriptions. At the time of the visit, the facility also provides the survey team with access to appropriate meeting minutes, manuals (Administrative, Nursing, Program, Safety/Risk Management), in-service records, and contracts/agreements related to off-site mobile response individuals and/or teams.

D. If the facility's physical plant has not yet opened at the time of the on-site review, conditional LPS designation authority may still be granted based on physical plant, staffing, licensure, policies and procedures (inclusive of Bylaws, Manuals and Plans), and credentials evaluations. However, in this instance, reassessment shall be conducted three (3) months after commencement of the facility's operation and encompasses examination of treatment records, patient and staff interviews, in-service records, contracts with off-site mobile response individuals and/or teams, minutes, and logs and reports on file with the Patients' Rights Office.

E. If the facility is found to be in compliance with the LPS guidelines and criteria, the LPS Coordinator shall submit a written report to the Director of BHS with the recommendation that the facility be designated.

F. When the Director of BHS finds, based on all available information, that the facility meets all guidelines and criteria specified for LPS designation, the Director of BHS may, as delegate of the San Diego County Board of Supervisors, designate the facility for 5150 purposes. The Director of BHS shall relay this recommendation to DHCS.

G. The Director of BHS or designee notifies the Facility Director in writing of the designation decision.

H. If LPS Survey Team members find that a facility is not in compliance with LPS guidelines and criteria, they shall inform the facility and the Director of BHS and make specific recommendations for compliance. A return on-site visit is scheduled once the facility notifies the LPS Coordinator that the recommendations have been implemented.

I. If the LPS Survey Team determines that the facility is not in compliance with the LPS designation criteria and the facility disagrees, the facility may, if it chooses, present information and/or arguments directly to the Director of BHS.

J. Prior to the facility's exercising its designation authority, all individuals involved in the involuntary detention process shall have made application for approval to initiate involuntary evaluation and detention (5150). The application shall be accompanied by a signed attestation by the professional person clinically in charge of the facility that applicant has received San Diego County-approved training on LPS statutes and County policies and procedures concerning involuntary detention, as well as information on patients' rights and achieved a passing score on the written examination.

K. LPS facilities that change ownership shall be required to have a review within 6 months of change of ownership to ensure that designation will be continued. To facilitate transitions in ownership, the facility will retain a Conditional LPS status until the LPS review is completed.

L. LPS facilities which change location shall be required to have a review within 6 months of change of location to ensure that designation will be continued.

LENGTH OF DESIGNATION

A. Initial designation is provisional for six months but is revocable at any time should the facility fail to comply with the designation guidelines.

B. The facility is monitored by the contracted Inpatient Patient Advocacy Program during the six months provisional period. If found to be in compliance, the facility is designated from the time of the LPS review, unless such designation is subsequently suspended or withdrawn.

IV. FACILITY PERIODIC REVIEW

Each San Diego County LPS site will be routinely reviewed during a three year period to ensure that all LPS requirements continue to be met. County of San Diego Behavioral Health does not have a Redesignation Process per the December 6, 1994 (11), San Diego County Board of Supervisors resolution enabling each LPS facility to retain LPS designation baring exigent circumstances.

PROCEDURES

A. The LPS Coordinator sends an information packet to each facility being reviewed in a single Fiscal Year, delineating the criteria and procedures for LPS review and requesting an on-site visit.
B. The Facility Director and LPS Coordinator arrange for an on-site visit.
C. Under the auspices of the Director of BHS, the LPS Designation Review Committee conducts a review of each designated facility to assess compliance with LPS designation guidelines and criteria. Such review may encompass a tour of the patient units, survey of open and closed treatment charts selected by the reviewers, voluntary interviews with clients, review of facility vehicle for allowing clients to provide anonymous feedback, examination of policies, procedures, manuals, plans, minutes, and contracts, and discussion with facility staff. In preparation for the visit, the reviewers may examine: recommendations from the prior LPS designation survey(s); the facility's denial of rights, seclusion and restraint, 72-hour holds, minors' due process hearings, ECT administration (if any) monthly and quarterly data collection; TJC Accreditation Survey and Licensing reports; and any other relevant reports on file with the Patients' Rights Office regarding the facility.
D. The reviewers apprise facility staff of their findings orally at the conclusion of the visit and in writing within three months thereafter (via a preliminary draft and a final report), citing specific areas of compliance and noncompliance and making recommendations for remedial action where indicated. Reviewers may also ask for a specific plan of correction to address areas of noncompliance, to be submitted within 30 days of report receipt or as otherwise directed.
E. If the reviewers are unable to support continued designation, they may elect to conduct a repeat on-site visit upon their determination that sufficient time has elapsed for the facility to correct identified deficiencies. Gross violation(s) of clinical practice, patients' rights, and/or safety practices relevant to the class of persons for whom designation applies can result in temporary suspension and/or discontinuance of the designation.

F. If the facility fails to correct identified deficiencies, the Director of BHS takes appropriate remedial action up to and including termination of the facility's designation.
G. The facility is notified in writing of the above action. Temporary suspension of a designation or placement of the facility on conditional designation status is a departmental administrative action requiring no action by outside parties.

V. WITHDRAWAL OF DESIGNATION, CONDITIONAL DESIGNATION AND REINSTATEMENT OF DESIGNATION

CIRCUMSTANCES UNDER WHICH THE COUNTY OF SAN DIEGO, DIRECTOR OF BEHAVIORAL HEALTH SERVICES MAY WITHDRAW DESIGNATION OF A FACILITY

A. Gross violation and/or ongoing violations of clinical practice, patients' rights, quality of care, and/or safety precautions relevant to the class of persons to whom designation applies.
B. Failure to comply with the terms and ethical provisions of law and BHS policies regarding constitutional, statutory, regulatory and decisional law, including but not limited to WIC, Division 5; CCR, Titles 9 and 22; and the Business and Professions Code, Section 650, concerning compensation for referrals.
C. Repeated failure to verify and submit for authorization only fully qualified individuals; failure to assure that LPS designated staff are appropriately monitored and supervised; and/or that its representatives exercise the involuntary detention and treatment authority in accordance with established BHS guidelines and legal requirements.
D. Failure to allow the Director of BHS or designees to review the facility for designation or complaint resolution processes, including access to specified patients, staff, and records to establish compliance with San Diego County LPS guidelines and regulations.
E. Failure to correct circumstances within specified timelines that previously led to conditional designation.
F. Failure to truthfully disclose the material support provided to members of the authorized professional staff concerning off-site evaluation and detention activities or to ensure the support is in accordance with all applicable designation regulations.
G. Closure, loss of licensure, or loss of applicable facility accreditation.
H. Designation of the facility may be withdrawn/cease if the facility has not detained patients on an involuntary basis pursuant to the WIC Section 5150 and/or 5152 for a period of three years.
I. When, in the judgment of the Director of BHS, withdrawal of designation is required by community needs.

CIRCUMSTANCES UNDER WHICH THE COUNTY OF SAN DIEGO, DIRECTOR OF BEHAVIORAL HEALTH SERVICES MAY PLACE A DESIGNATED FACILITY ON CONDITIONAL DESIGNATION STATUS

A. Failure to submit a timely or acceptable corrective action plan as requested in writing for cited deficiencies.
B. Failure to ensure that all rights guaranteed to mental health patients by statutes and regulations are adhered to, including proper initiation and implementation of rights to administrative and judicial reviews, hearings, and writs.
C. Improper use of seclusion or restraint, including failure to routinely utilize preventive alternative interventions and/or to follow Title 22, or Health and Safety Code (Div. 1.5 commencing with Section 1180-1180.6) requirements for seclusion and restraint orders, use, and monitoring.
D. Occurrence of significant quality of care or safety issues or critical incidents requiring BHS investigation and prompt corrective action by the facility.
E. Failure to meet documentation and treatment guidelines by established deadlines.
F. Failure to notify BHS of an adverse event(s) or to submit reports as required by BHS within 30 days after end of reporting period.
G. Failure to provide whatever mental health treatment, care, and referrals involuntarily detained persons require for the full period that they are held.
H. Failure to notify BHS of any changes that may affect its conformance with the criteria for designation.

PROCEDURES FOLLOWING THE WITHDRAWAL OF THE LPS DESIGNATION OF A FACILITY

A. Except as described below in respect to emergencies, the Director of BHS shall notify the facility of his or her intention not less than 30 days in advance of taking the action. The notification will specify the reasons for which the action is being taken.
B. The facility may submit to the Director of BHS a written request for review within 14 days of receiving the notice of intention. In support of its written request, the facility may submit written documentation or other proof contradicting the specification made in the notice of intention. If the facility wishes to make an oral presentation or present witnesses to controvert the specifications in the notice of intention, its written request may also include a request for a meeting at which such oral presentation can be made.
C. If a request for a meeting or an oral presentation is made, the meeting shall be held not less than five or more than ten days from the date on which the facility requested the review. In no event shall the meeting take place more than 25 days after the notice of intent to withdraw the designation was received by the facility.
D. The meeting at which the facility makes its oral presentation shall be attended by the Director of BHS or designee and such other representatives as designated by the Director of BHS; the names of such

representatives will be given in writing to the facility administrator. The meeting may be attended by the facility administrator and Chief Medical Officer and such others as they designate in writing to the Director of BHS. The facility may make oral presentations that are pertinent to the specifications contained in the notice of intent. A reasonable period of time, as determined by the Director of BHS or designee, shall be permitted for the facility's oral presentation.
E. The Director of BHS shall consider all written, oral and other information submitted by the facility. The Director of BHS shall notify the facility in writing of his or her final decision not later than 29 days from the facility's receipt of the BHS notice of intention.

SUSPENSION OF A FACILITY'S LPS DESIGNATION

A. If, in the judgement of the Director of BHS, an emergency or threat of harm to consumers exists, the authority of the facility to involuntarily detain or treat under the LPS Act or the approval of a designated facility's designation of an individual may be suspended.
B. Such a suspension may be made while the notice of intention to apply for LPS designation is in process, as described above, or for such periods of time during which the Director of BHS judges the emergency or threat to exist.
C. The facility may request a review immediately or within 14 days of receiving the written notice of emergency suspension, such review to be held within three working days from the date on which the facility requested the review, unless another mutually agreeable time, not to exceed 14 days from the date on which the facility requested the review, is set.

PROCEDURES FOLLOWING AN LPS DESIGNATED FACILITY'S REQUEST TO OPT OUT VOLUNTARILY FROM LPS DESIGNATION

A. The LPS designated facility shall notify the Director of BHS of their intention not less than 60 days in advance of taking the action. The notification will specify the reasons for which the action is being taken.
B. The Director of BHS will review the request within 15 days and will notify the facility that he or she has received the request.
C. The Director of BHS shall consider all written, oral and other information submitted by the facility. The Director of BHS shall notify the facility in writing of his or her final decision not later than 29 days from the Director's receipt of the notice of intention.

County of San Diego Health and Human Services Agency
Behavioral Health Services

LANTERMAN-PETRIS SHORT (LPS) DESIGNATION GUIDELINES AND PROCESSES FOR FACILITIES WITHIN SAN DIEGO COUNTY

LPS DESIGNATION GUIDELINES AND PROCESSES FOR FACILITIES WITHIN SAN DIEGO COUNTY

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County of San Diego Health and Human Services Agency
Behavioral Health Services (BHS)

LANTERMAN-PETRIS-SHORT (LPS) DESIGNATION GUIDELINES AND PROCESSES FOR FACILITIES WITHIN SAN DIEGO COUNTY

DECLARATION:

Facilities which meet the criteria and process requirements set forth in this document may be designated by the San Diego County Board of Supervisors to evaluate and treat persons involuntarily detained under the Lanterman-Petris-Short (LPS) Act, Welfare and Institutions Code Section 5000 (et seq.), and Title 9, Section 821.

OBJECTIVES:

The objectives of these LPS Designation Guidelines and Processes for Facilities within San Diego County are to:

1) Enhance the capability and overall quality of the mental health delivery system in San Diego County.
2) Ensure proper utilization of the designation authority by granting it to only those facilities which meet specified guidelines.
3) Establish the terms of and conditions pertaining to the delegation of authority by which individuals are taken into custody under the LPS Act.

I. LPS DESIGNATION GUIDELINES FOR FACILITIES

DELEGATION OF AUTHORITY TO INVOLUNTARILY DETAIN AND TREAT

A. The authority under the LPS Act for a facility to hold individuals and to involuntarily treat mental health patients is vested by state law by the San Diego County Board of Supervisors.

B. Involuntary detention under the LPS Act constitutes a significant deprivation of civil liberties that is supported under limited circumstances described in law and regulation.

C. Involuntary detention and treatment is deemed necessary when required to protect the safety of certain individuals and the community in circumstances permitted by law.

D. These guidelines describe the nature, extent, and processes by which authority for facilities to involuntarily detain and treat under the LPS Act is designated by the County of San Diego Board of Supervisors.

FACILITY OPERATIONS GUIDELINES

A. A designated facility (defined here as an entity that ~~provides inpatient care under a single license although it may have multiple locations under the same license~~ meets LPS State and local requirements) provides evaluation and treatment services for persons who, as a result of a mental disorder, are judged to be dangerous to self or others and/or gravely disabled. It adheres to those regulations and statutes relevant to the clinical, health, and safety needs of those persons.

1. The facility shall comply with applicable constitutional, statutory, regulatory, and decisional law, including but not limited to California Welfare and Institutions Code (WIC) Section 5000 et seq., the requirements set forth in California Code of Regulations (CCR) Title 9, Sections 663, 821-829 and 835-868, the requirements governing mental health facilities and/or treatment of Titles 22 and 24 of the CCR, the Civil Code, Health and Safety Code, and all applicable policies, procedures, or guidelines governing LPS designation established by the County of San Diego, Health and Human Services Agency Behavioral Health Services (BHS) department.
2. The facility shall maintain all applicable current licenses as appropriate for its type. No designated facility may show any gross violation of clinical practice and/or safety provisions relevant to the class of persons for whom the designation applies, although the violations may not be explicitly covered by licensing standards. Any such gross violations, as determined by the Director of BHS, can result in discontinuance of the facility designation.
3. All designated Skilled Nursing Facilities and Psychiatric Health Facilities shall comply with all provisions of Title 22 of the CCR and all laws, regulations, and standards of care as apply to them. The facility shall assume the full responsibility for assuring appropriate patient care and safety, and accepts all attendant legal obligations.
4. The facility shall have 24-hours-a-day, 7-days-a-week mental health admission, evaluation, referral, and treatment capabilities, and provide whatever mental health treatment and care involuntarily detained persons require for the full period they are held (WIC, Section 5152).
5. All areas of a general acute care hospital or acute psychiatric hospital may be designated, providing:
   a) The facility has one or more inpatient mental health units under the same licensure, patients with a mental health problem concurrently needing hospitalization in the medical floor or portion of the hospital will continue to receive mental health services in the physical health care portion, as would be appropriate for the patient's mental health status- such as a daily

re-evaluation and/or psychiatric medication adjustment visit, client informing materials, education for medical staff and capability for holding required hearings such as a private room.

b) To be LPS designated, an Emergency Department must be located in the same licensed facility as the LPS Inpatient Unit or under the same license as the LPS Inpatient Unit. However, Emergency Department physicians in non-LPS facilities who have successfully completed the BHS training and testing approved by the Director of BHS related to the WIC Sections 5150 and 5585.50 detention process can write 5150 holds[1].

c) An Urgent Care sharing a facility/building with an LPS Inpatient Unit may be designated as an LPS Urgent Care, as long as it has the documented capability to provide all required emergency care for LPS clients.

d) A community program may be designated as long as it meets all applicable LPS regulations as referenced within these guidelines.

e) Involuntarily detained patients shall be treated in areas other than the mental health unit only if their medical condition requires it.

f) Appropriate mental health staffing, assessments, programs and treatment shall be provided to all involuntarily detained patients regardless of their physical location within the facility.

g) Patients under the jurisdiction of the Department of Justice, Department of Corrections, or detained primarily pursuant to the jurisdiction of state or federal law enforcement shall be housed separately from the civilly detained or voluntary behavioral health patient population.

h) All rights guaranteed to mental health patients by statutes and regulations are observed for all individuals with specific exceptions (WIC Section 5326) for patients under the jurisdiction of the Department of Justice, Department of Corrections, or detained primarily pursuant to the jurisdiction of state or federal law enforcement. In order to ensure access to mental health services to patients under the jurisdiction of the Department of Justice, Department of Corrections, or detained primarily pursuant to the jurisdiction of state or federal law enforcement, the Director of BHS has adopted the following conditions under which certain rights may not be guaranteed:

- For patients from a Federal Detention facility under the jurisdiction of the Department of Justice, Department of Corrections, or imprisoned primarily pursuant to the jurisdiction of state or federal law, the Departments of Justice and Corrections or federal and state law enforcement shall have the authority to

[1] "5150" refers to provisions in California's *Welfare and Institutions Code* §5150 permitting qualified staff to detain and transport or cause the detention and transport of a person meeting certain criteria, for up to 72 hours, to an LPS-designated facility to determine whether further mental health evaluation and treatment is necessary.

determine if the right to make and receive phone calls, to receive visitors, to write or receive mail, or to access personal property may be allowed in the LPS facility. The grounds for such an abridgement of rights must be documented in the patient file given to the hospital and the removal of rights must be noted in the patient's hospital record.

- The rationale for denial of any rights, including those noted above that have been removed by the Department of Justice or the Department of Corrections, shall, in all cases, be entered into each patient's treatment record.

i) All rights to administrative and judicial review to which patients may be entitled, including but not limited to certification hearings, medication capacity hearings, and writs of habeas corpus, shall be properly initiated, implemented, and conducted.

j) Seclusion and restraints shall not be used to compensate for inadequate staffing, lack of program or building security. Use of seclusion and/or restraints shall comply with all Title 9, Title 22, Health and Safety Code, Centers for Medicare & Medicaid Services (CMS), and The Joint Commission (TJC) standards.

k) The involuntary treatment provisions of the LPS Act shall not be used to authorize or deliver medical treatment. Consent to medical treatment must be obtained as otherwise provided in law.

6. The facility ensures that, of the time patients spend in a non-designated medical facility emergency department to which they have come for medical treatment and wherein identified staff believe there is a need for 5150 evaluation, any detention time from the time that the person has been detained on the 5150 and is awaiting placement to a designated facility is deducted from the subsequent 72-hour detention period, pursuant to Health and Safety Code Section 1799.111.
7. Prior to admitting a person to a designated facility pursuant to WIC Section 5150, the professional person in charge of the facility or his or her designee shall assess the individual in person to determine the appropriateness of the involuntary detention, as per WIC Section 5151.
8. Once a facility accepts the patient for treatment, it shall assume the responsibility for seeing the case through to its appropriate disposition (i.e. the clinically indicated, available, and legally allowable treatment, referral or placement that best meets the patient's clinical needs and desires).
9. The facility shall ensure that information and services, rights, notifications, and advertisements are communicated in a language and modality accessible to the patient. The facility shall make arrangements for interpreters or for use of other mechanisms to ensure adequate communication between patients and personnel, if any language or communication barriers exist between facility staff and patients.

10. The facility shall allow BHS to review the facility for initial designation and for site reviews which will occur every 3 years.
11. The facility shall allow the County of San Diego Patients' Rights Advocate access to all staff and patients at all times to conduct investigations to resolve specific complaints. Patients shall be allowed access to the Patients' Rights Advocate at any time.
12. The facility shall allow the Director of BHS or designee and the County of San Diego Patients' Rights Advocates access, upon request, to all treatment records, logs, policy and procedure manuals, contracts, credentials files and/or personnel records of staff empowered to initiate 72-hour holds, and other professional staff in order to conduct investigations and assess compliance with LPS and Patients' Rights statutes and regulations.
13. The facility shall abide by the procedures established by the Superior Court and BHS for all mental health-related court hearings that are facility-based (including but not limited to certification review [probable cause] hearings, medication capacity ["Riese"] hearings, inpatient admission of persons 14 – 17 year old [Roger S.] hearings and clinical reviews), and court-based hearings (including writs of habeas corpus, medication capacity appeals, and all conservatorship proceedings).
    a) The facility is responsible for transport and escort of patients to and from, and supervision at, all mental health-related court hearings.
    b) The facility provides adequate space and staff to ensure that all facility-based hearings are conducted without interruption and in an atmosphere that affords privacy and ensures confidentiality and safety.
14. The facility shall abide by all Patients' Rights Conditions of Participation as set forth by CMS in 42 CFR part 482 inclusive of seclusion and restraint requirements and ensures that a physician or qualified nursing staff perform face-to-face assessment of the patient within one hour of initiation of seclusion and/or restraint. The order of the treating physician details the date, time, and method of seclusion and/or restraint and the specific behavior supporting good cause for the intervention. The time limits of orders for restraint or seclusion are within CMS and TJC specifications. Staff shall continually assess, monitor, and evaluate patients in seclusion and/or restraints to ensure release at the earliest possible time. Facilities must abide by Title 22, Health and Safety Code (Div. 1.5 commencing with Section 1180-1180.6) requirements regarding seclusion and restraint. The facility's policies and procedures for using seclusion and/or restraints with mental health patients shall adhere to the following principles and practices.
    a) The use of seclusion and/or restraint is limited to those behavioral emergencies wherein a person's behavior presents an imminent danger of serious harm to self or others and property.

    b) Documentation supports staff awareness of patient's expressed preferences regarding de-escalation techniques and alternatives to seclusion and/or restraint, why patient preferences were not appropriate, and that seclusion and/or restraint was the least restrictive method available to prevent injury to patient or others.
    c) The original physician order for seclusion and restraint, if renewed for another period of time, does not exceed the time limits established in Title 22, Health and Safety Code (Div. 1.5 commencing with Section 1180-1180.6).
    d) There is documentation for each incident of use of seclusion and/or restraint of all rights denied.
    e) There is documentation, for each incident of use of seclusion and/or restraint, of all applicable rights having been restored after seclusion and/or restraint have ended.
15. The facility shall have a system and procedures in place to ensure the confidentiality, security, integrity, and accessibility of patient health information, inclusive of a contingency plan for the storage and protection of filed medical records against unauthorized intrusion and/or damage.
16. The facility shall submit required quarterly reports to the Director of BHS regarding involuntary detentions, patients' rights denials, and electroconvulsive treatment administered, as required by WIC 5326.1, 5326.15, and CCR, Title 9, Section 866, and Title 22. Critical incidents are reported to appropriate Licensing, State, and County agencies, as needed.
17. The facility shall notify BHS of any changes that may significantly affect the facility's conformance with the criteria for designation, including change of ownership, modification of physical structure, number of beds, demographic or diagnostic aspects of patient population, therapeutic services, or policies or procedures concerning staffing, program, or operations. Based on receipt and analysis of such information, the Director of BHS may require successful completion of a focused review as a condition of continued facility designation. The focused review will occur within 6 months of the change.
18. The facility shall indemnify, and hold harmless the County of San Diego BHS, County of San Diego Board of Supervisors, and the State Department of Health Care Services (DHCS), and their officers, agents and employees, from and against any and all claims, losses, liabilities, or damages arising out of, or resulting from the facility's or its designees' exercise of County-granted LPS authority to detain and treat patients on an involuntary basis.

STAFFING GUIDELINES

A. The facility shall have adequate 24-hour professional supervision to meet the clinical needs and ensure the safety of patients judged to be dangerous to themselves or others or gravely disabled.

B. Staff shall hold current and valid California professional licenses where required and, upon request, copies will be available onsite.

C. All staff involved in the evaluation and treatment of involuntary patients shall be fully conversant with the involuntary detention statutes (WIC, Section 5150 et seq.), with patients' rights statutes, (WIC, 5325 and 5325.1), and related regulations (CCR Section 860 et seq.), inclusive of residents, attending physicians and psychologists, allied health professionals, and clinical employees.

1. The facility shall make available for review required documentation of attendance of staff at in-service training concerning LPS and patients' rights statutes and regulations during orientation, at the time of hire, and at least annually thereafter.

POLICIES AND PROCEDURES

A. The facility shall have acceptable policies and procedures, plans, and contracts (without compensation or inducement for referring patients) which comport to WIC, CCR, and the California Business and Professions Code related to the legal, ethical, fiscally sound, and clinically appropriate psychiatric treatment of both voluntary and involuntary patients. These policies and procedures, plans, and contracts shall be made available for review and must include, but are not limited to, the following:

1. ADMISSIONS POLICIES AND PROCEDURES

a) To ensure that 5150 forms received by the facility contain documentation of a specific factual basis in support of each 5150

b) To ensure safe and orderly transfer of physical custody of the person from law enforcement

c) To ensure that a qualified professional conducts a face-to-face assessment of the person presented and makes the determination whether to admit pursuant to 5150, admit voluntarily, or refer for other services

d) For disposition of persons brought in by law enforcement or otherwise presented for evaluation and treatment who are not admitted, including those who decline alternative services

e) For establishing validity of conservatorship and obtaining approval for admission

f) To ensure that persons assessed and admitted, voluntarily or involuntarily, receive an evaluation as soon as possible after admission

g) To ensure that persons admitted receive whatever treatment and care his or her condition requires for the full period that he or she is hospitalized

h) Regarding release before the end of a 72-hour hold

i) To ensure documentation of patient's concerns, needs, limitations, and physical health needs (including assessment and documentation of pre-existing injuries), and

determination of appropriate bed assignment (i.e. need for private room, proximity to nurse's station, factors affecting roommate selection, safety issues)

j) To ensure documentation of patient's needs and preferences regarding the use of seclusion/restraint, including triggers and/or precipitants to aggressive behavior, patient's preferred de-escalation techniques, pre-existing medical conditions, limitations, or disabilities that constitute risk factors and history of trauma, physical or sexual abuse

k) Regarding obtaining informed consent from the patient or conservator for psychotropic medication including explanation of type and dosage of medication, therapeutic effects, and potential side effects

l) Regarding emergency administration of medication

m) Regarding patient advisement of legal status

n) To ensure receipt of state mandated patients' rights handbook and other patients' rights notifications and advisements

o) Detailing methods for ensuring that treatment information and services, patient rights, due process (including procedures relating to rights, certification hearings, writs of habeas corpus, and medication capacity) notifications, advisements, are communicated in a language and modality accessible to the patient

p) Regarding Department of Justice firearms prohibition, notification, and filing of paperwork

q) Regarding patient consent for release of information, including circumstances requiring consent, information given to patient, documentation required, and method of ensuring patient receives copy of all signed consents

r) Regarding inventory and safeguarding of all patient property upon admission

s) Regarding filing of requests for Riese hearings

t) To ensure documentation of good cause for all incomplete advisements and procedures for ensuring that the required subsequent attempts to advise are made and documented

u) Regarding documentation of denials of patients' rights including documentation of good cause, appropriateness of denial as least restrictive, the time limit(s) of denial, and the end time of the denial period

v) Providing evidence that rights regarding receiving visitors, making and receiving phone calls, and sending and receiving mail and/or access to personal property are not to be earned by the patient or subject to limitation by parent, guardian, or conservator. For patients from a Federal Detention facility under the jurisdiction of the Department of Justice, Department of Corrections, or imprisoned primarily pursuant to the jurisdiction of state or federal law, the Departments of Justice and Corrections or federal and state law

enforcement shall have the authority to determine if those rights may be allowed in the LPS facility

w) Providing evidence that trained staff is available at all times to inform involuntary patients requesting release of right to file writ of habeas corpus, including providing and assisting with appropriate paperwork and ensuring timely filing

x) To ensure signed psychotropic medication consents are kept in the patient's chart

y) Detailing that, absent judicial determination of incompetence to consent, patients on 72-hour or 14-day holds or temporary conservatorship who refuse to give consent are medicated only in an emergency as defined in Section 853 of CCR

z) To ensure medications are not used in quantities that interfere with the patient's ability to routinely participate in the treatment program

aa) To ensure that, for any disclosure of records or information, the facility has appropriate documentation including: the date, circumstance under which disclosure was made, to whom disclosure was made and specific information disclosed

bb) Regarding separate consents to treatment including, but not limited to, psychiatric medications, voluntary treatment, voluntary ECTs, and medical treatment

cc) Regarding room searches and search of patients

2. FACILITY PRACTICES POLICIES AND PROCEDURES

a) Regarding facility code of ethics and conflict of interest; resolving patient complaints, grievance and appeal processes, and Advance Directives

b) Regarding criteria for identifying potential abuse, procedures for management of alleged physical and sexual abuse, mandated abuse reporting

c) Detailing program services and schedules and addressing staffing plans based on patient care

d) Regarding mobile assessment team including member names, professional licenses, proof of 5150 training, scope of authority, staffing schedules and procedures to ensure review of 5150s written by mobile assessment team

e) Regarding medication dispensing and control

f) Regarding internal monitoring, review and auditing of medical records on an ongoing basis

g) Regarding Utilization Review

h) Regarding identification, reporting and management of critical incidents

i) Detailing safety and disaster plans

j) Regarding 5150 training and list of designated staff

k) To ensure timely notification to court and to clients of hearings

l) Regarding elopement

m) Regarding safeguarding of patient belongings throughout hospitalization and during transfer and discharge

n) Regarding usage of the Tarasoff procedure

3. SECLUSION AND RESTRAINT POLICIES AND PROCEDURES

a) Reflecting that the use of seclusion and/or restraint is limited to those behavioral emergencies wherein a person's behavior presents an imminent danger of serious harm to self or others and property

b) Addressing practices staff must follow to obtain an order for the use of seclusion and/or restraint when the physician is not on site

c) To ensure documentation supports staff awareness of patient's expressed preferences regarding de-escalation techniques and alternatives to seclusion and/or restraint, the reasons why patient preferences were not appropriate in each instance, and that seclusion and/or restraint was least restrictive method available to prevent injury to patient or others

d) To ensure that a physician or qualified nursing staff performs a face-to-face assessment of the patient within one hour of initiation of seclusion and/or restraint

e) Describing necessary details to be included on the physician order for seclusion and/or restraint

f) To ensure that staff continually assess, monitor, and evaluate patients in seclusion and/or restraints to ensure release at the earliest possible time

g) Regarding debriefing following incidents of use of seclusion and/or restraint

4. AFTERCARE/DISCHARGE POLICIES AND PROCEDURES

a) To ensure that discharge planning begins upon a person's admission to the facility

b) Regarding an assessment of present level of functioning, including the person's capacity to self- provide food, clothing, and shelter

c) Regarding diagnosis, including treatment initiated, medications, and dosage schedules

d) Describing the specific programs and services required so the person can minimize future confinement and receive the treatment in the least restrictive setting

e) Regarding the identification of the mental health personnel responsible for the aftercare needs

f) To ensure referral and assistance in contacting providers of public social services, legal aid, educational, and vocational services

g) To ensure that if the patient is homeless, arrangements have been attempted for the voluntary placement of the person in a living environment suitable to his or her needs

h) To ensure the facility makes a copy of the written plan available to the patient
i) Describing discharges pursuant to court hearing or discharges Against Medical Advice (AMA)
j) Regarding routine discharge activities (i.e. return of property, transportation, follow-up care scheduling)

5. POLICIES AND PROCEDURES RELATED TO MINORS

a) Specification of educational or training needs, provided these needs are necessary for the minor's well-being
b) Facility obtains the necessary legal consents for admission, medication, medical treatment, etc., from the legally responsible adult
c) Facility adheres to and demonstrates a knowledge of administrative and legal procedures for admission of minors to acute care psychiatric hospital treatment
d) The facility makes every effort to notify the minor's parent or legal guardian as soon as possible after the minor is detained and to involve them in the clinical evaluation and treatment
e) When additional treatment is determined to be necessary, a written mental health treatment plan is completed which identifies the least restrictive placement alternative in which the minor can receive the necessary treatment
f) The facility consults with the minor's family, legal guardian, or caretaker to obtain further needed consents and consults regarding discharge planning and aftercare
g) Clinical evaluations include a psychosocial evaluation of the family and living environment
h) Notification of proper authorities and disposition of minor if the minor's parent, legal guardian or caretaker is unwilling or unable to accept physical custody of the minor upon release
i) Emancipated minors, married minors, and minors who are or have been in armed services are treated as adults
j) Responsible party may not limit the minor's exercise of rights including phone calls and visitors with noted exceptions for minors under the jurisdiction of the Department of Justice, Department of Corrections, or detained primarily pursuant to the jurisdiction of state or federal law enforcement

PHYSICAL ENVIRONMENT

A. All behavioral health units shall be maintained in a manner that ensures patient areas are safe, clean, and comfortable while meeting the clinical and physical needs of the patients.

B. The physical plant shall meet the structural standards provided in Title 24, as evidenced by the latest approval from State Licensing.
C. The facility shall provide a safe, accessible, and secure outdoor area for patient use.
D. Each behavioral health unit shall have at least one room specifically designated for the use of patient seclusion and/or restraints.
E. The facility's plant shall have a fire clearance (CMS 482.41).
F. The facility's physical plant shall allow for individual indoor storage space for each patient.
G. Telephones shall be available for patient use in locations and for periods of time that allow patient access and ensure confidential conversations.
H. The patient bathrooms shall ensure the maximum amount of patient privacy and dignity while ensuring patient safety.
I. The facility shall provide space for patients to receive visitors in an atmosphere that affords privacy but allows for patient safety.
J. A facility treating minor patients shall ensure they are housed in a separate unit away from the adult population (WIC, Section 5585.55 and 5751.7).
K. The facility shall provide adequate space and staff to ensure that all facility-based hearings can be conducted without interruption, in an atmosphere that affords privacy and ensures confidentiality and safety.
L. Patients' Rights posters shall be in visible and prominent places in the facility (WIC, Section 5325).

DOCUMENTATION AND TREATMENT GUIDELINES

The designated facility participates in quality improvement activities, including documentation, data collection, and quarterly reporting, using approved State-mandated forms, as specified by BHS.

A. Data Collection
    1. Monthly seclusions and restraints data for contracted LPS facilities is transmitted to BHS on a quarterly basis
    2. Denial of Rights/Seclusion and Restraint Monthly Report
        a) Number of patients denied each specified right or placed in seclusion or restraints, the number of days each type of right was denied or seclusion and/or restraint used
    3. Quarterly Report on Services Provided to Persons Detained in Jail Facilities
        a) Number of admissions to local inpatient services for evaluation and treatment
        b) Number of admissions to an LPS jail inpatient mental health program
        c) Count of persons receiving outpatient services provided within a jail facility
        d) Number of emergency screenings
    4. Quarterly Report on Involuntary Detentions
        a) Admissions for 72-hour evaluation and treatment

b) Certifications for 14-day treatment
c) Additional 14-day intensive treatment for suicidal persons
d) Certifications for 30-day intensive treatment
e) Number of 180-day post-certification treatments

5. Electroconvulsive Therapy Treatments Administered – Quarterly Report
   a) Number of patients receiving
   b) Total treatments given
   c) Complications attributable to treatment
   d) Requests for, and Review Committee decision on, excessive treatment
6. Mental Health Rehabilitation Center (MHRC) license reports
   a) Denial of Rights—County Summary
   b) List of Facilities by type and bed capacity
   c) Number of patients denied rights and days each right denied
   d) Total number of patient days
   e) Percentage frequency of denial of rights

B. The facility shall ensure that initial assessments of referred patients are completed regardless of ability to pay.

C. Psychiatric assessments of voluntary and involuntary patients shall include documentation substantiating the need for current treatment and level of care and shall be completed within 24 hours by the attending practitioner.

D. Authorized members of the professional staff who initiate involuntary detentions shall participate in the care and treatment of the patients for whom they initiate 72-hour holds (inclusive of participation in treatment planning), pursuant to WIC, Section 5150 and CCR, Section 823.

E. The facility shall ensure that patients are appropriately involved in planning their care and treatment, as evidenced by documentation of patient participation in treatment planning.

F. The facility shall ensure that patients' medical problems are identified, addressed, and documented in treatment plans.

G. The facility shall meet BHS requirements for application and referral of clients to petition for establishment of LPS conservatorships.

H. The facility shall ensure that the attending practitioners are present and testify at all legal hearings for which their attendance is required by the Court (e.g., writs, LPS conservatorship hearings, and medication capacity hearings), and that treating physicians meet all expectations related to communication with, and testimony in, San Diego Superior Court.

I. The facility shall ensure that, upon discharge, patients receive appropriate referrals to community agencies and suitable placement, as evidenced by documentation in the Discharge and Aftercare Plans. Uninsured, non-Medi-Cal patients who need further psychiatric medication shall be discharged with prescriptions for

psychiatric medications that are available through BHS uninsured formulary and consistent with the parameters for prescription of psychiatric medication.

J. The facility shall have a mechanism to review medical records on an ongoing basis for completeness and timeliness of information and shall take action to improve the quality and timeliness of documentation that impacts the care of voluntary and involuntary patients.

K. The facility shall establish and maintain a process for appropriately resolving complaints, grievances, and appeals.

L. The facility's professional staff shall establish and maintain a mechanism for proctoring and conducting an ongoing peer review of the knowledge base and competencies of designated professional staff members on involuntary detention procedures and 5150s. Criteria and outcomes of monitoring shall be made available for review by the Director of BHS upon request.

M. The facility notifies BHS of all serious incidents, including adverse drug reactions, suicide attempts and suicides, homicides, medication errors resulting in serious adverse outcomes, use of physical restraints, deaths, sexual assaults, and serious physical injuries involving psychiatric patients by appropriately transmitted documents within the timeframe set forth in the Inpatient Operations Handbook.

N. The facility shall establish and maintain a process for determining patient perception of the quality of the clinical treatment process and the satisfaction of individuals served. Data on patient perceptions and satisfaction shall be made available for review by the Director of BHS upon request.

II. DESIGNATION TO TAKE INDIVIDUALS INTO CUSTODY PURSUANT TO LPS ACT

GENERAL GUIDELINES RELATED TO DESIGNATED INPATIENT FACILITIES

A. Facility administration shall maintain a current roster and current credential files of professional staff members who have been privileged and authorized to initiate 72-hour detentions. The foregoing shall be made available on request to representatives of BHS.

B. Continuation of the designation status of the facility shall require that all professional staff of the facility comply with all applicable LPS requirements. These requirements include the limitation of involuntary detention to those individuals who meet LPS criteria and are taken into custody only by members of the professional staff with involuntary detention authority.

C. The facility shall ensure that all designees, whenever exercising or otherwise communicating either orally or in writing about their designation authority or related services, clearly identify their facility affiliation and wear the mandated identification badge in face-to-face interactions.

D. The facility shall ensure that the completed original 5150 detention form is present in the medical record of each involuntarily detained patient. A completed form shall contain, in legible fashion, the signatory's professional discipline, and the facility affiliation under whose authority the involuntary detention was initiated.

E. The facility shall ensure that the involuntary detention authority granted to a member of the professional staff of the designated facility is exercised at that facility only and is in relation to the professional staff member's responsibilities at that facility. In instances where an evaluation for possible involuntary detention is conducted off the facility premises, the authorized professional staff member with mobile response responsibilities shall:

1. Be an employee or a formal contractor of the designated facility (Exception: Designated Physicians).
2. Dress and travel in a manner that does not inappropriately attract attention to the individual being assessed.
3. Complete a face-to-face assessment of the client prior to initiating an involuntary detention for that client.
4. Conduct and document an assessment that considers the full range of available treatment modalities, sites, and providers, and results in the care that best meets the client's specific needs. Assessment of need is based upon condition, treatment needs, geography, and current fiscal and treatment relationships with providers. The care should be rendered without regard to profit or gain by the designee's parent facility.
5. Have available a comprehensive and current referral source list and be well versed in all relevant treatment resources in the client's area.
6. Honor the preference of the client and/or the parent of a minor, conservator, or legal guardian for the type and location of the desired treatment facility if administratively feasible and clinically appropriate.
7. Unless prohibited by specific circumstances, seek information from and involve the client's current providers of mental health care in order to support continuity of care.
8. Represent themselves to the public as affiliated with the facility from which they derive their designation authority.
9. Strongly consider the proximity of the designated facility to the patient's own community, family and support system. Alternatives to taking a patient to a more distant facility should be considered and documented on the off-site assessment form.
10. Ensure that proper interventions and/or treatment are provided to the client for whom they have initiated LPS evaluation until appropriate disposition is effected (e.g. one-to-one monitoring, removal of contraband.)

11. Give detainment advisements to each client in a language or modality that the client can understand, pursuant to WIC, Section 5157, inclusive of the name of the facility to which the client is being taken, and notification that the person is not under criminal arrest but is being taken for examination by mental health professionals.
12. Follow all statutory requirements regarding client confidentiality.
13. Maintain an accurate log of all requests for the facility staff's off-premises services. Such log shall be available for inspection by the Patients' Rights Office and/or other designees of the Director of BHS and shall include:
    a) Date and time of both request and response
    b) Referral source
    c) Name of client
    d) Time of intervention and departure
    e) Completion of a written assessment of client, including consideration of less-restrictive alternatives
    f) Services provided and/or referrals made
    g) Disposition of the client
    h) Name of staff involved
    i) A copy of the 72-hour hold if initiated
    j) Source of payment
14. Take reasonable precautions to preserve and safeguard the patient's property, pursuant to WIC, Sections 5156 and 5211.
15. Initiate 72-hour holds only within the boundaries of San Diego County, unless special written designation authority or an exception has been granted by the County Mental Health Directors involved allowing for cross-county designation privileges.
16. Initiate involuntary detentions only for persons who, based on the authorized staff member's professional assessment, are believed to be dangerous to self or others or gravely disabled because of a mental disorder.
17. Abide by all provisions in the WIC, Division 5, and accompanying regulations, and Mental Health Services policies regarding treatment, evaluations, patients' rights, and due process.
18. When the client does not meet criteria for involuntary detention, provide the client with information, referral to appropriate community services, and/or other intervention as appropriate to his/her circumstances.
19. Report conditions of abuse or neglect at residential facilities, such as suspected or possible unsafe and unsanitary living conditions, involving elder or dependent adults and children, to the appropriate agencies per WIC, Section 15630(a)-(h).

F. The facility shall have at least one privileged professional staff member, who can be a Qualified Medical Professional (QMP), with 5150 authority present within one hour for on-site assessment of individuals considered for involuntary detention and/or admission.

G. The facility shall have the ability to safely detain an individual pending 5150 assessment for up to one hour on-site pending the arrival of an authorized professional staff member.

III. INITIAL FACILITY DESIGNATION

PROCEDURES

A. The facility requesting designation notifies the Director of BHS who notifies his appointee, the LPS Designation Review Coordinator (LPS Coordinator) of BHS. The LPS Coordinator then sends an informational packet to the facility delineating the criteria and procedures for LPS designation, along with an application and agreement to be signed by the facility Director of BHS, which stipulates that the facility agrees to abide by all designation guidelines and criteria set forth by the County.

B. Once the facility Medical and/or Administrative Director receives the packet from BHS and believes that the facility meets the LPS designation guidelines, he or she submits the application and agreement to the LPS Coordinator and arranges for an on-site survey visit.

C. Representatives of County of San Diego BHS, including Patients' Rights Advocates and BHS Quality Management staff, shall conduct an on-site review of the facility (including the physical plant, staffing, policies and procedures, and credentials files) for compliance with the LPS designation guidelines and criteria. If the facility is already accepting patients, the assessment also includes an examination of treatment charts selected by the representatives and voluntary interviews with selected patients and staff. The representatives also review mental health facility licensing reports, patient complaint logs and the facility's denial of rights, seclusion and restraint, involuntary holds reports, and grievance logs on file with BHS . At the time of the visit (or prior to the visit, if so requested), the facility provides the survey team with a copy of their current operating license, staffing plans by discipline, patient-to-staff ratios, Fire Marshal clearance, governing body and medical staff bylaws, Performance Improvement and Utilization Review Plans, a verification of 24-hour admitting capacity, type of staff and management (directly operated or by contract), treatment schedules, and program descriptions. At the time of the visit, the facility also provides the survey team with access to appropriate meeting minutes, manuals (Administrative, Nursing, Program, Safety/Risk Management), in-service records, and contracts/agreements related to off-site mobile response individuals and/or teams.

D. If the facility's physical plant has not yet opened at the time of the on-site review, conditional LPS designation authority may still be granted based on physical plant, staffing, licensure, policies and procedures (inclusive of Bylaws, Manuals and Plans), and credentials evaluations. However, in this instance, reassessment shall be

conducted three (3) months after commencement of the facility's operation and encompasses examination of treatment records, patient and staff interviews, in-service records, contracts with off-site mobile response individuals and/or teams, minutes, and logs and reports on file with the Patients' Rights Office.

E. If the facility is found to be in compliance with the LPS guidelines and criteria, the LPS Coordinator shall submit a written report to the Director of BHS with the recommendation that the facility be designated.

F. When the Director of BHS finds, based on all available information, that the facility meets all guidelines and criteria specified for LPS designation, the Director of BHS may, as delegate of the San Diego County Board of Supervisors, designate the facility for 5150 purposes. The Director of BHS shall relay this recommendation to DHCS.

G. The Director of BHS or designee notifies the Facility Director in writing of the designation decision.

H. If LPS Survey Team members find that a facility is not in compliance with LPS guidelines and criteria, they shall inform the facility and the Director of BHS and make specific recommendations for compliance. A return on-site visit is scheduled once the facility notifies the LPS Coordinator that the recommendations have been implemented.

I. If the LPS Survey Team determines that the facility is not in compliance with the LPS designation criteria and the facility disagrees, the facility may, if it chooses, present information and/or arguments directly to the Director of BHS.

J. Prior to the facility's exercising its designation authority, all individuals involved in the involuntary detention process shall have made application for approval to initiate involuntary evaluation and detention (5150). The application shall be accompanied by a signed attestation by the professional person clinically in charge of the facility that applicant has received San Diego County-approved training on LPS statutes and County policies and procedures concerning involuntary detention, as well as information on patients' rights and achieved a passing score on the written examination.

K. LPS facilities that change ownership shall be required to have a review within 6 months of change of ownership to ensure that designation will be continued. To facilitate transitions in ownership, the facility will retain a Conditional LPS status until the LPS review is completed.

L. LPS facilities which change location shall be required to have a review within 6 months of change of location to ensure that designation will be continued.

LENGTH OF DESIGNATION

A. Initial designation is provisional for six months but is revocable at any time should the facility fail to comply with the designation guidelines.

B. The facility is monitored by the contracted Inpatient Patient Advocacy Program during the six months provisional period. If found to be in compliance, the facility is designated from the time of the LPS review, unless such designation is subsequently suspended or withdrawn.

IV. FACILITY PERIODIC REVIEW

Each San Diego County LPS site will be routinely reviewed during a three year period to ensure that all LPS requirements continue to be met. County of San Diego Behavioral Health does not have a Redesignation Process per the December 6, 1994 (11), San Diego County Board of Supervisors resolution enabling each LPS facility to retain LPS designation baring exigent circumstances.

PROCEDURES

A. The LPS Coordinator sends an information packet to each facility being reviewed in a single Fiscal Year, delineating the criteria and procedures for LPS review and requesting an on-site visit.

B. The Facility Director and LPS Coordinator arrange for an on-site visit.

C. Under the auspices of the Director of BHS, the LPS Designation Review Committee conducts a review of each designated facility to assess compliance with LPS designation guidelines and criteria. Such review may encompass a tour of the patient units, survey of open and closed treatment charts selected by the reviewers, voluntary interviews with clients, review of facility vehicle for allowing clients to provide anonymous feedback, examination of policies, procedures, manuals, plans, minutes, and contracts, and discussion with facility staff. In preparation for the visit, the reviewers may examine: recommendations from the prior LPS designation survey(s); the facility's denial of rights, seclusion and restraint, 72-hour holds, minors' due process hearings, ECT administration (if any) monthly and quarterly data collection; TJC Accreditation Survey and Licensing reports; and any other relevant reports on file with the Patients' Rights Office regarding the facility.

D. The reviewers apprise facility staff of their findings orally at the conclusion of the visit and in writing within three months thereafter (via a preliminary draft and a final report), citing specific areas of compliance and noncompliance and making recommendations for remedial action where indicated. Reviewers may also ask for a specific plan of correction to address areas of noncompliance, to be submitted within 30 days of report receipt or as otherwise directed.

E. If the reviewers are unable to support continued designation, they may elect to conduct a repeat on-site visit upon their determination that sufficient time has elapsed for the facility to correct identified deficiencies. Gross violation(s) of clinical practice, patients' rights, and/or safety practices relevant to the class of persons for whom designation applies can result in temporary suspension and/or discontinuance of the designation.

F. If the facility fails to correct identified deficiencies, the Director of BHS takes appropriate remedial action up to and including termination of the facility's designation.

G. The facility is notified in writing of the above action. Temporary suspension of a designation or placement of the facility on conditional designation status is a departmental administrative action requiring no action by outside parties.

V. WITHDRAWAL OF DESIGNATION, CONDITIONAL DESIGNATION AND REINSTATEMENT OF DESIGNATION

CIRCUMSTANCES UNDER WHICH THE COUNTY OF SAN DIEGO, DIRECTOR OF BEHAVIORAL HEALTH SERVICES MAY WITHDRAW DESIGNATION OF A FACILITY

A. Gross violation and/or ongoing violations of clinical practice, patients' rights, quality of care, and/or safety precautions relevant to the class of persons to whom designation applies.

B. Failure to comply with the terms and ethical provisions of law and BHS policies regarding constitutional, statutory, regulatory and decisional law, including but not limited to WIC, Division 5; CCR, Titles 9 and 22; and the Business and Professions Code, Section 650, concerning compensation for referrals.

C. Repeated failure to verify and submit for authorization only fully qualified individuals; failure to assure that LPS designated staff are appropriately monitored and supervised; and/or that its representatives exercise the involuntary detention and treatment authority in accordance with established BHS guidelines and legal requirements.

D. Failure to allow the Director of BHS or designees to review the facility for designation or complaint resolution processes, including access to specified patients, staff, and records to establish compliance with San Diego County LPS guidelines and regulations.

E. Failure to correct circumstances within specified timelines that previously led to conditional designation.

F. Failure to truthfully disclose the material support provided to members of the authorized professional staff concerning off-site evaluation and detention activities or to ensure the support is in accordance with all applicable designation regulations.

G. Closure, loss of licensure, or loss of applicable facility accreditation.

H. Designation of the facility may be withdrawn/cease if the facility has not detained patients on an involuntary basis pursuant to the WIC Section 5150 and/or 5152 for a period of three years.

I. When, in the judgment of the Director of BHS, withdrawal of designation is required by community needs.

CIRCUMSTANCES UNDER WHICH THE COUNTY OF SAN DIEGO, DIRECTOR OF BEHAVIORAL HEALTH SERVICES MAY PLACE A DESIGNATED FACILITY ON CONDITIONAL DESIGNATION STATUS

A. Failure to submit a timely or acceptable corrective action plan as requested in writing for cited deficiencies.

B. Failure to ensure that all rights guaranteed to mental health patients by statutes and regulations are adhered to, including proper initiation and implementation of rights to administrative and judicial reviews, hearings, and writs.

C. Improper use of seclusion or restraint, including failure to routinely utilize preventive alternative interventions and/or to follow Title 22, or Health and Safety Code (Div. 1.5 commencing with Section 1180-1180.6) requirements for seclusion and restraint orders, use, and monitoring.
D. Occurrence of significant quality of care or safety issues or critical incidents requiring BHS investigation and prompt corrective action by the facility.
E. Failure to meet documentation and treatment guidelines by established deadlines.
F. Failure to notify BHS of an adverse event(s) or to submit reports as required by BHS within 30 days after end of reporting period.
G. Failure to provide whatever mental health treatment, care, and referrals involuntarily detained persons require for the full period that they are held.
H. Failure to notify BHS of any changes that may affect its conformance with the criteria for designation.

PROCEDURES FOLLOWING THE WITHDRAWAL OF THE LPS DESIGNATION OF A FACILITY

A. Except as described below in respect to emergencies, the Director of BHS shall notify the facility of his or her intention not less than 30 days in advance of taking the action. The notification will specify the reasons for which the action is being taken.
B. The facility may submit to the Director of BHS a written request for review within 14 days of receiving the notice of intention. In support of its written request, the facility may submit written documentation or other proof contradicting the specification made in the notice of intention. If the facility wishes to make an oral presentation or present witnesses to controvert the specifications in the notice of intention, its written request may also include a request for a meeting at which such oral presentation can be made.
C. If a request for a meeting or an oral presentation is made, the meeting shall be held not less than five or more than ten days from the date on which the facility requested the review. In no event shall the meeting take place more than 25 days after the notice of intent to withdraw the designation was received by the facility.
D. The meeting at which the facility makes its oral presentation shall be attended by the Director of BHS or designee and such other representatives as designated by the Director of BHS; the names of such representatives will be given in writing to the facility administrator. The meeting may be attended by the facility administrator and Chief Medical Officer and such others as they designate in writing to the Director of BHS. The facility may make oral presentations that are pertinent to the specifications contained in the notice of intent. A reasonable period of time, as determined by the Director of BHS or designee, shall be permitted for the facility's oral presentation.
E. The Director of BHS shall consider all written, oral and other information submitted by the facility. The Director of BHS shall notify the facility in writing of his or her final decision not later than 29 days from the facility's receipt of the BHS notice of intention.

SUSPENSION OF A FACILITY'S LPS DESIGNATION

A. If, in the judgement of the Director of BHS, an emergency or threat of harm to consumers exists, the authority of the facility to involuntarily detain or treat under the LPS Act or the approval of a designated facility's designation of an individual may be suspended.
B. Such a suspension may be made while the notice of intention to apply for LPS designation is in process, as described above, or for such periods of time during which the Director of BHS judges the emergency or threat to exist.
C. The facility may request a review immediately or within 14 days of receiving the written notice of emergency suspension, such review to be held within three working days from the date on which the facility requested the review, unless another mutually agreeable time, not to exceed 14 days from the date on which the facility requested the review, is set.

PROCEDURES FOLLOWING AN LPS DESIGNATED FACILITY'S REQUEST TO OPT OUT VOLUNTARILY FROM LPS DESIGNATION

A. The LPS designated facility shall notify the Director of BHS of their intention not less than 60 days in advance of taking the action. The notification will specify the reasons for which the action is being taken.
B. The Director of BHS will review the request within 15 days and will notify the facility that he or she has received the request.
C. The Director of BHS shall consider all written, oral and other information submitted by the facility. The Director of BHS shall notify the facility in writing of his or her final decision not later than 29 days from the Director's receipt of the notice of intention.

ITEM 11: UPDATE ON ADVANCING THE BEHAVIORAL HEALTH CONTINUUM OF CARE

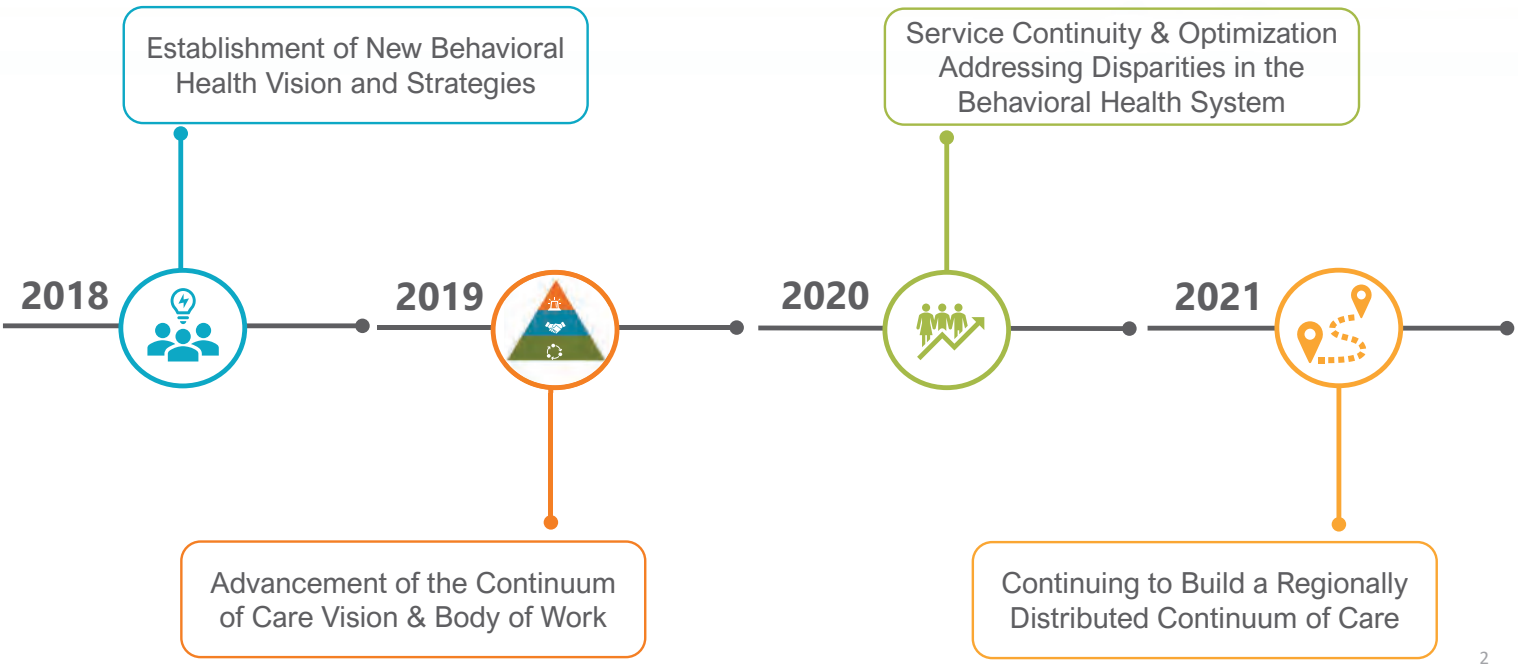
Dr. Luke Bergmann, Director, Behavioral Health Services
Health and Human Services Agency

May 4, 2021

LIVE WELL SAN DIEGO

1

Transformation of the Behavioral Health System



2

Advancing Behavioral Health

- High Hospitalization Rates
- 911 Calls
- Mental Health in Jails

Advancing Behavioral Health

Advancing Behavioral Health

Continuing to Build a Regionally Distributed Continuum of Care

Behavioral Health Services Guiding Framework

Population Health
Measure the distribution of health outcomes within a population and patterns of health determinants with the goal of improving health equity

Key Metrics
Invest in enhancement of key metrics to better measure program impacts, in alignment with nationally recognized best practices

Triple Aim
Improve the health of the population, enhance the experience and outcomes of individuals, and reduce per capita costs of care

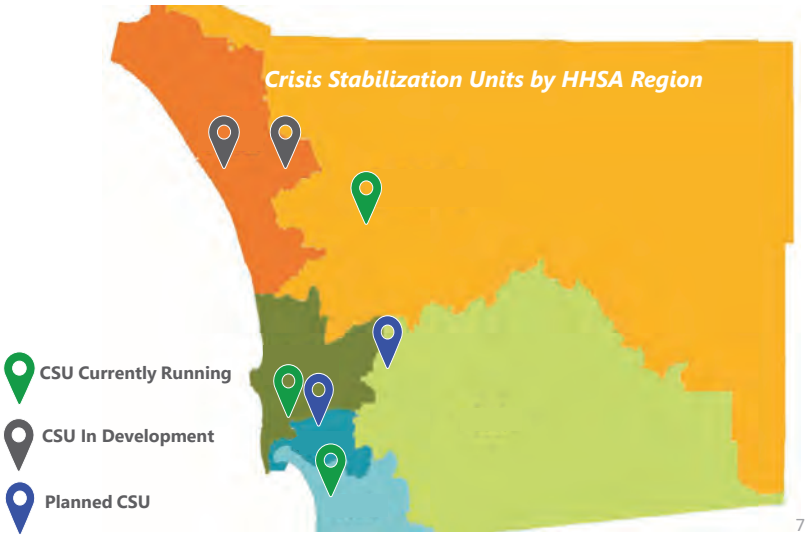
Services Across the Continuum of Care

CRISIS AND DIVERSIONARY SERVICES

INPATIENT AND LONG-TERM CARE

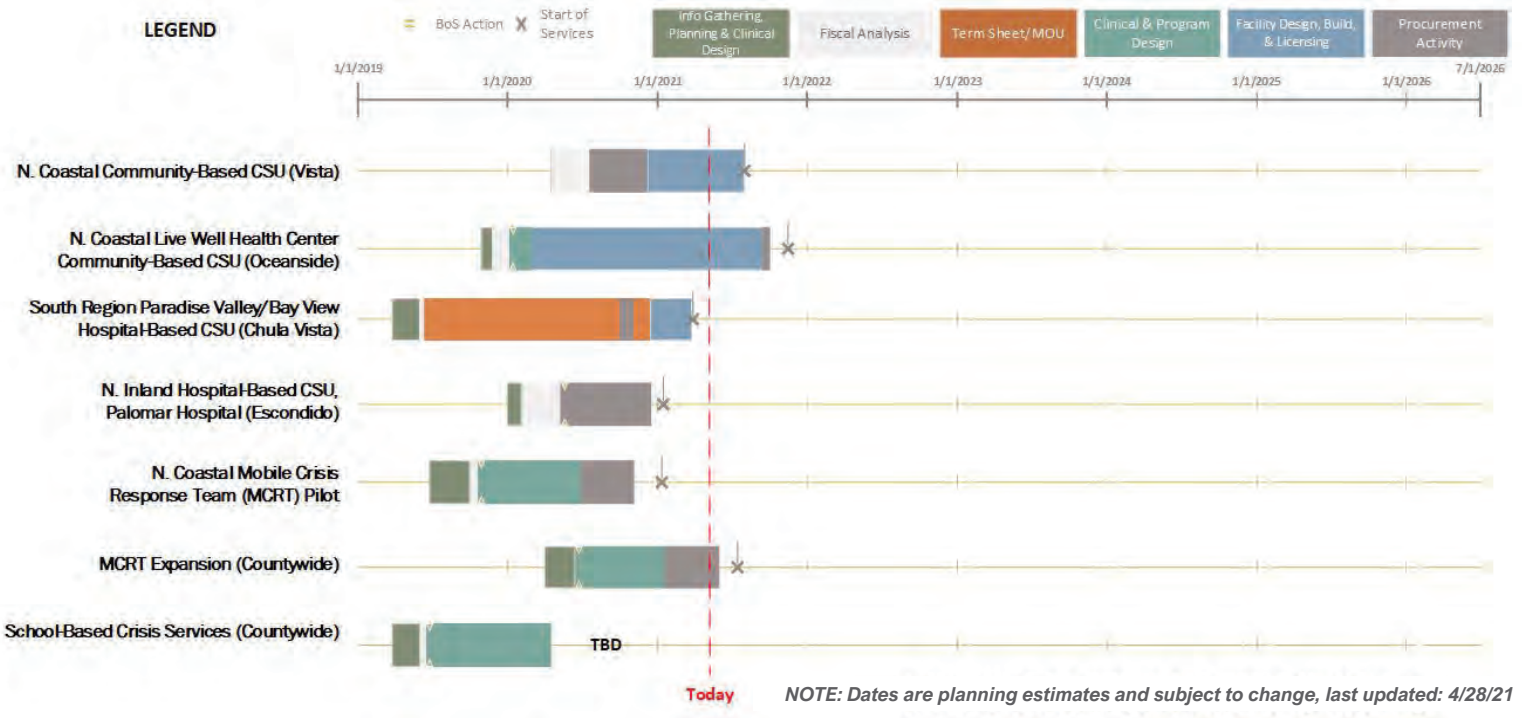
BH HUBS AND CARE COORDINATION

Crisis & Diversionary Services



7

Crisis & Diversionary Services

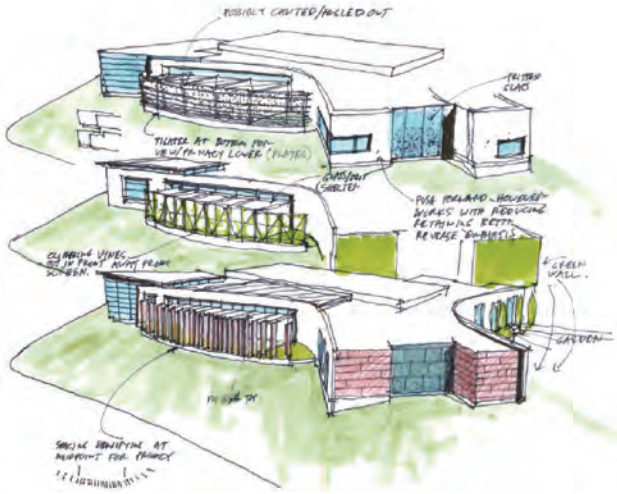


NOTE: Dates are planning estimates and subject to change, last updated: 4/28/21

Inpatient, Residential, & Long-Term Care

LIVE WELL SAN DIEGO

Tri-City Psychiatric Health Facility



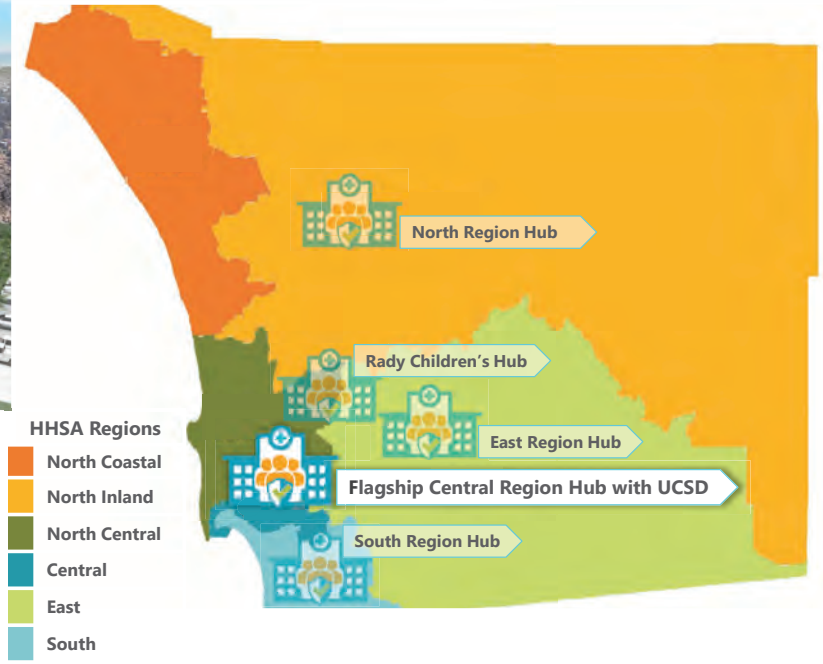
Tri-City Medical Center

Inpatient, Residential, & Long-Term Care

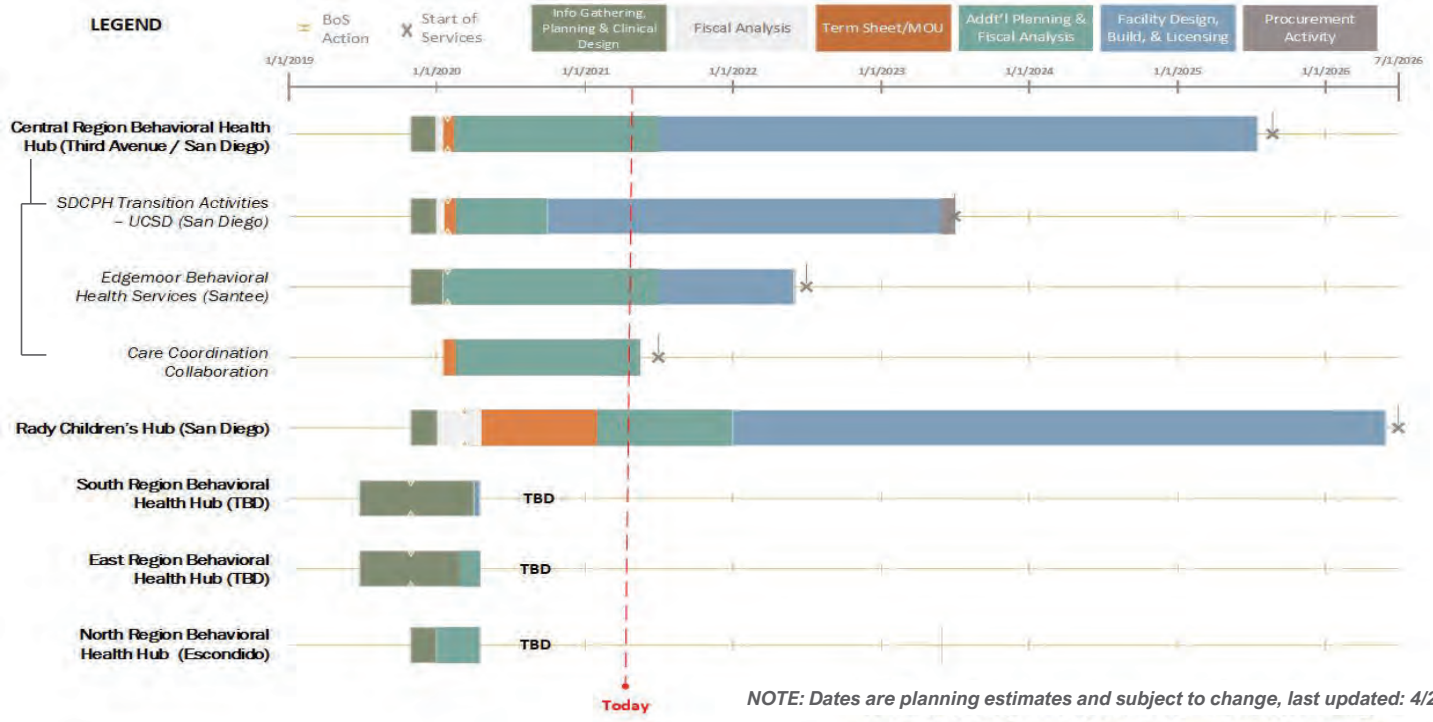
LIVE WELL SAN DIEGO

NOTE: Dates are planning estimates and subject to change, last updated: 5/3/21

Hubs & Care Coordination Services



Hubs & Care Coordination Services



NOTE: Dates are planning estimates and subject to change, last updated: 4/28/21

Key Projects to Advance Behavioral Health

Behavioral Health Equity Index

- Establish a process for identifying and addressing unmet behavioral health need
- Carefully developed areas of work and innovative data integration approach

Recommended Actions

Recommendation #1: Receive an update on Advancing the Behavioral Health Continuum of Care.

Recommendation #2: Direct the Chief Administrative Officer to sunset select time-certain reporting, and to shift reporting for the Behavioral Health Continuum of Care to coincide with significant developments.

Recommendation #3: Adopt the updated Lanterman-Petris-Short (LPS) Designation Guidelines and Processes for Facilities within San Diego County, revised to expand eligibility to all programs that meet applicable State and local requirements.

NATHAN FLETCHER
CHAIR
SUPERVISOR, FOURTH DISTRICT
SAN DIEGO COUNTY BOARD OF SUPERVISORS

AGENDA ITEM

24

DATE: May 4, 2021

TO: Board of Supervisors

SUBJECT
SUPPORTING H.R. 1280, THE GEORGE FLOYD JUSTICE IN POLICING ACT (DISTRICTS: ALL)

OVERVIEW
On May 25, 2020, George Floyd was brutally murdered on a Minneapolis, Minnesota street by Minneapolis police officer Derek Chauvin. The murder of George Floyd, an unarmed Black man, at the hands of police, and the events surrounding his death captured and highlighted the fear and deep distrust that Black, Indigenous, Latino, Asian American Pacific Islander, and all people of color have of law enforcement and the racial inequities and disparities that exist across the United States.

George Floyd's murder was a catalyst for a movement of people across the world demanding an end to police brutality, systemic racism and calling for substantive reforms. To address the deep-rooted reforms needed within law enforcement, shortly after the murder in 2020 Representative Karen Bass of California, Representative Jerrold Nadler of New York, Senator Cory Booker of New Jersey and then-Senator Kamala Harris of California introduced H.R. 7120, the George Floyd Justice in Policing Act. The George Floyd Justice in Policing Act seeks to hold police accountable, end racial profiling, change the culture of law enforcement, and build trust between law enforcement and communities by addressing racism and bias. While H.R. 7120 did not move in the 116th Congress, the bill was reintroduced as H.R. 1280 in February 2021 in the 117th Congress and passed the United States House of Representatives in March as the trial of Derek Chauvin was set to begin.

Today's action will direct the Chief Administrative Officer to express the County's support for H.R. 1280, the George Floyd Justice in Policing Act, consistent with Board Policy M-2.

SUBJECT: SUPPORTING H.R. 1280, THE GEORGE FLOYD JUSTICE IN POLICING ACT (DISTRICTS: ALL)

RECOMMENDATION(S)
CHAIR NATHAN FLETCHER
1. Direct the Chief Administrative Officer to express the County's support for H.R. 1280, the George Floyd Justice in Policing Act, consistent with Board Policy M-2.

FISCAL IMPACT
N/A

BUSINESS IMPACT STATEMENT
N/A

ADVISORY BOARD STATEMENT
N/A

BACKGROUND
On May 25, 2020, George Floyd was brutally murdered on a Minneapolis, Minnesota street by Minneapolis police officer Derek Chauvin. The murder of George Floyd, an unarmed Black man, at the hands of police, and the events surrounding his death captured and highlighted the fear and deep distrust that Black, Indigenous, Latino, Asian American Pacific Islander, and all people of color have of law enforcement and the racial inequities and disparities that exist across the United States.

George Floyd's murder was a catalyst for a movement of people across the world demanding an end to police brutality, systemic racism and calling for substantive reforms. To address the deep-rooted reform needed within law enforcement, shortly after his murder Representative Karen Bass of California, Representative Jerrold Nadler of New York, Senator Cory Booker of New Jersey and then-Senator Kamala Harris of California introduced H.R. 7120, the George Floyd Justice in Policing Act. The George Floyd Justice in Policing Act seeks to hold police accountable, end racial profiling, change the culture of law enforcement, and build trust between law enforcement and communities by addressing racism and bias. While H.R. 7120 did not move in the 116th Congress, the bill was reintroduced as H.R. 1280 in February 2021 in the 117th Congress and passed the United States House of Representatives in March as the trial of Derek Chauvin was set to begin.

Specifically, the George Floyd Justice in Policing Act would establish a national standard for the operation of police departments, mandate data collection on police encounters, reprogram existing funds to invest in transformative community-based policing programs, streamline federal law to prosecute excessive force, and establish independent prosecutors for police investigations. Additionally, the bill would prohibit federal, state, and local law enforcement agencies from racial, religious, and discriminatory profiling. It would also ban chokeholds, carotid holds, and no-knock warrants at the federal level and condition state and local law enforcement funding on compliance with these program changes.

State and local governments and law enforcement agencies also responded to George Floyd's death by implementing changes to curb violence and address racial inequities and disparities. Within a few weeks of George Floyd's murder, 15 San Diego County Police Agencies, including San Diego

SUBJECT: SUPPORTING H.R. 1280, THE GEORGE FLOYD JUSTICE IN POLICING ACT (DISTRICTS: ALL)

County Sheriff's Department, banned the use of the chokehold restraint. The State of California also passed bills prohibiting the use of chokeholds and allowing the state Department of Justice to investigate police shootings.

While reforms have been made, the racial disparities and injustice that existed when George Floyd was killed still exist today. Since George Floyd's murder one year ago, there have been many more Black lives lost at the hands of police. It is clear more needs to be done. By advocating for the George Floyd Justice in Policing Act, the County of San Diego will be making it clear that supporting reform and justice for all is a legislative priority.

The timeliness of the current legislation is underscored by the recent guilty verdict convicting Derek Chauvin on all counts in the murder of George Floyd. While the trial and guilty verdict has passed, the pain and anguish experienced by so many has not. The trial laid bare the critical need for policy reform in policing, and H.R. 1280, while not a panacea, would hold law enforcement accountable and help build trust between law enforcement and local communities. Black lives must matter, and H.R. 1280 is part of George Floyd's legacy.

I urge your support.

LINKAGE TO THE COUNTY OF SAN DIEGO STRATEGIC PLAN
Today's proposed action to express the County's support for H.R. 1280, the George Floyd Justice in Policing Act, supports the Safe Communities Initiative in the County of San Diego's 2021-2026 Strategic Plan by promoting racial justice and protecting San Diegans through substantive law enforcement reform.

Respectfully submitted,

CHAIR NATHAN FLETCHER
Supervisor, Fourth District

ATTACHMENT(S)
N/A

County of San Diego

NICK MACCHIONE, FACHE
AGENCY DIRECTOR

HEALTH AND HUMAN SERVICES AGENCY
BEHAVIORAL HEALTH SERVICES
3255 CAMINO DEL RIO SOUTH, MAIL STOP P-531
SAN DIEGO, CA 92108-3806
(619) 563-2700 • FAX (619) 563-2705

LUKE BERGMANN, Ph.D.
DIRECTOR, BEHAVIORAL HEALTH SERVICES

March 25, 2021

TO: The Behavioral Health Advisory Board (BHAB)

FROM: Luke Bergmann, Ph.D., Director, Behavioral Health Services (BHS)

BEHAVIORAL HEALTH SERVICES DIRECTOR'S REPORT – April 2021

ACTION ITEM: REPORT BACK ON COMPREHENSIVE COUNTY SUBSTANCE USE HARM REDUCTION STRATEGY

On January 26, 2021 (13), the San Diego County Board of Supervisors (BOS) approved overturning prior Board direction opposing harm reduction programs including the December 9, 1997 resolution entitled "Resolution to Oppose Needle Exchange Programs". The Board further directed the Chief Administrative Officer to:

- Create an Action Plan to realize a Syringe Services Program to meet the needs of San Diego County's population, including identification of necessary resources, and program partnerships; and in accordance with findings and recommendations in the January 14, 2021, Health and Human Services Agency (HHSA) memo and accompanied the Family Health Centers of San Diego (FHCSD) and San Diego State University's Institute for Public Health (IPH) study, *Environmental Assessment on People Who Inject Drugs*, and report back to the Board with regular updates; and

- Return within 90 days to the Board with a comprehensive County Substance Use Harm Reduction Strategy including immediate, intermediate and long-term actions that broadens the existing "Opioid and Prescription Drug Misuse" strategy to bring a harm reduction approach to all substance use interventions across the County.

On May 4, 2021, Behavioral Health Services and Public Health Services will return to the BOS with a recommendation to receive the report back on this direction, noting that the Syringe Services Action Plan is a component of the Harm Reduction Strategy.

It is THEREFORE, staff's recommendation that your Board vote to support the authorizations and approvals needed to advance the recommendation in this Board Letter.

***LIVE WELL SAN DIEGO* UPDATES / SPECIAL EVENTS**

Upcoming Events

May Is Mental Health Month 2021
Planning continues in preparation for May Is Mental Health Month, with this year's theme being *Hope for Change*. Once again, activities in recognition of the month will be held virtually. Additional plans include a webpage with an events calendar, list of activities, resources, and a special "5 Trails Challenge" to highlight the importance of mental and physical health and was created in collaboration with the County of San Diego's Park and Recreation department.

Providers, faith-based organizations, and community organizations are encouraged to submit planned activities in recognition of May Is Mental Health Month to Nancy Page (Nancy.Page@sdcounty.ca.gov) for inclusion on the events calendar.

Children and Youth Mental Health Awareness Day Celebration - May 7, 2021
The BHS Children, Youth, and Families (CYF) System of Care unit is partnering with NAMI San Diego to recognize the importance of children and youth mental health with a special virtual gathering that will use art to engage children and youth who are living with serious challenges and their families. This event is to serve as a reminder that we can be physically distanced and remain socially connected. Visit https://cyfliaison.namisandiego.org/may-event-2020/ to view last year's event and artwork.

UPDATES FROM THE ADULT AND OLDER ADULT (AOA) SYSTEM OF CARE

Advancing the Behavioral Health Continuum of Care

Expansion of Regional Crisis Stabilization Units

Palomar Health
On August 4, 2015, the San Diego County Board of Supervisors (BOS) approved a contract with Palomar Health to provide specialized services for crisis stabilization. On July 1, 2020, Palomar Health moved into their new modular building next to their hospital in Escondido, CA. The modular building is a state-of-the-art facility located directly outside the emergency room at Palomar Hospital. The two-story building accommodated eight additional recliners increasing the total number of recliners to 16 by the end of 2020. Crisis stabilization services are designed to prevent clients from being admitted to a more intensive inpatient setting, which can be disruptive to one's life. By June 2020, Palomar was able to divert 86.9% of their clients from admitting into their inpatient program. The service is designed to last 24 hours and provide intensive assessment, medications, monitoring, peer support and case management services. Additionally, Palomar provides clients with one-time funding for housing or other basic needs.

Paradise Valley
On August 4, 2020, the BOS approved a contract with Paradise Valley to provide specialized services for crisis stabilization. This newest crisis stabilization unit (CSU) will be housed at the Bay View Hospital, serving the south region. This site will accommodate 12 recliners and will provide 24-hour crisis stabilization. Services will include psychiatric assessments, monitoring, medications, peer support, case management, and care coordination. The CSU is scheduled to open in April 2021.

North Coastal Live Well Health Center
The North Coastal Live Well Health Center CSU will be an outpatient program operating 24 hours a day, to provide community-based, crisis stabilization services in a comfortable, welcoming environment. The program will assist in de-escalating the severity of a person's level of distress and/or reducing the need for urgent care associated with substance use or serious mental illness, while providing support in a recovery-oriented setting. This CSU will be located at the North Coastal Live Well Health Center at 1701 Mission Avenue in Oceanside, where an array of other behavioral health services are co-located. Additionally, there will be a care coordination component to ensure clients are connected to ongoing behavioral health and community support services. This program will serve both as a walk-in assessment center for 5150 clients and provide voluntary stabilization services.

North Coastal Pilot Mobile Crisis Response Team Procurement
On November 3, 2020, the North Coastal Mobile Crisis Response Team (MCRT) pilot contract was awarded to Exodus Recovery, Inc. On January 11, 2021, the MCRT launched with a soft opening providing field-based, non-law enforcement, crisis intervention services. Working in tandem with the Access and Crisis Line, teams consisting of a clinician and a peer respond to individuals experiencing a behavioral health crisis in the field with the goal of de-escalating the crisis and diverting the client from more costly levels of care. After the MCRT team mitigates the immediate crisis, the enhanced care coordination component allows for care coordinators to assist clients further, linking them with appropriate and ongoing services.

COVID-19 BHS Response
In response to the COVID-19 pandemic, BHS partnered with Public Health Services and other Health and Human Services Agency (HHSA) departments to ensure the behavioral health needs of individuals impacted by COVID-19 were addressed.

Mental Health Systems, Inc. (MHS)/Convention Center
Effective April 1, 2020, several contracts with MHS, Inc. were amended to deploy to the Convention Center in partnership with the City of San Diego, San Diego Housing Commission (SDHC), County of San Diego (County) Public Health Services and Medical Care Services, homeless service providers, and additional community service agencies to ensure establishing a temporary shelter space that would allow for physical distancing, COVID-19 testing, and connection to services. MHS, Inc. provides on-site crisis intervention, medication management, individual counseling services, and referrals to additional behavioral health services. As of March 1, 2021, MHS, Inc. has provided over 8,000 contact/service encounters to guests at the convention center. Services at the Convention Center will cease effective March 24, 2021, due to demobilization efforts led by the City of San Diego in partnership with other providers.

As part of the clinical intervention at the Convention Center, MHS, Inc. supported clients in developing an artwork display that is reflective of their experiences and trauma. MHS, Inc. is working with SDHC and the City of San Diego to capture the "history of this unique experience at the Convention Center" by creating a permanent display of the residents' artwork. It's been proposed that the artwork becomes a mobile art display that travels to locations around the region.

Telecare Tesoro/Convention Center
On May 1, 2020, Telecare Tesoro was co-located at the Convention Center to accept referrals for individuals who met eligibility criteria for Assertive Community Treatment (ACT) and project-based

housing vouchers through the SDHC. Up to 25 housing vouchers were made available along with treatment appointments for guests on site. Telecare Tesoro will cease services at the Convention Center effective March 24, 2021, as part of the Convention Center demobilization process but will continue to provide ongoing care and support to the enrolled ACT program clients.

Public Health Lodging Sites
Effective April 1, 2020, several contracts with Telecare were amended to deploy staff to the public health lodging sites in partnership with the Public Health Services to provide on-site behavioral health services for COVID-19 positive individuals requiring safe isolation. Telecare provides 24/7 support to the public health lodging site to include crisis intervention, case management, treatment/safety planning, coordination with external providers, and discharge planning for services. As of March 1, 2021, Telecare had provided services to over 3,000 guests at the public health lodging site.

Housing and Homeless Services

Local Government Special Needs Housing Program (SNHP)
BHS and Mental Health Services Act (MHSA) development partners have begun the lease-up process for two new housing developments with dedicated MHSA units: Ivy Senior Apartments and Trinity Place. Both will serve seniors (55+) with serious mental illness who are experiencing homelessness, and both will provide clients access to project-based housing vouchers through the SDHC.

Ivy Senior Apartments (Ivy) is a new construction development that will be located in the Clairemont area of San Diego and will have seven units dedicated to MHSA-eligible senior tenants. Trinity Place is also a new construction development that will be in the Grantville area of San Diego; the development will include 18 MHSA-dedicated senior units. The SNHP provides funding to affordable housing developers to create permanent supportive housing units for MHSA-eligible clients. Trinity Place and Ivy will be the fifth and sixth developments to become operational that were funded, in part, by SNHP. Funded by $20 million in MHSA funds allocated by the BOS, SNHP will ultimately lead to the creation of 128 supportive housing units, as well as the augmentation of Capitalized Operating Subsidy Reserves (COSR) to maintain the affordability of existing MHSA units.

Eligible MHSA tenants are scheduled to move into Trinity Place and Ivy beginning in August and October 2021, respectively. The lease-ups will bring the total number of operational MHSA permanent supportive housing units to 389.

No Place Like Home (NPLH)
Valley Senior Village, to be located in Escondido, is the sixth development countywide to receive a conditional funding and services commitment through the NPLH program. NPLH provides loans to affordable housing developers to create permanent supportive housing units for individuals with a serious mental illness (SMI) or severe emotional disturbance (SED) diagnosis who are at risk or experiencing homelessness or chronic homelessness. Like SNHP, supportive services for the NPLH units will be provided by BHS. Unlike previous MHSA-funded housing programs, NPLH loans are administered locally by County Housing and Community Development Services (HCDS). Valley Senior Village joins five other developments with NPLH commitments; the other developments will be in Downtown San Diego, San Ysidro, Carlsbad, and Chula Vista. The six developments combined will contain a total of 172 NPLH-funded units and will be deed-restricted to serve this

population for 55 years. The first NPLH developments are scheduled for completion beginning in 2022.

The 2nd Round NPLH Notice of Funding Availability is currently open, and additional NPLH funding is still available.

Housing Convention Center Resources
In response to the COVID-19 pandemic, BHS has partnered with the SDHC to direct BHS associated housing resources to eligible individuals with behavioral health needs who are sheltered by Operation Shelter to Home in the City of San Diego, including the Convention Center. In December 2020, the SDHC awarded 80 additional sponsor-based subsidies to the BHS-contracted Alpha Project Home Finder program to connect individuals to permanent supportive housing. The Home Finder program serves clients enrolled in services at BHS outpatient mental health clinics in the Central and North Central Regions. Since December, more than 40 clients have already been connected to these new subsidies.

The 80 subsidies are in addition to 100 subsidies that were awarded to Home Finder in September 2018, more than 40 of which were also issued to BHS clients sheltered at the Convention Center.

Drug Medi-Cal Organized Delivery System (DMC–ODS) Updates

Residential: The Way Back
The Way Back, a residential DMC program serving ASAM LOC 3.1 and 3.5, has modified operations to ensure compliance with the Center for Disease Control (CDC) requirements for congregate care facilities. The measures taken to ensure the safety of clients and staff include hiring additional maintenance staff to sanitize and clean on a more frequent basis, socially distancing beds, and chairs in the facility.

During the COVID-19 pandemic, the program has maintained 80% occupancy of the 22 contracted beds to serve clients in need of high intensity substance use residential services.

Outpatient: Union of Pan Asian Communities
Union of Pan Asian Communities (UPAC) Substance Use Outpatient Treatment Program made an impressive transition from February 2020 to April 2020 from no telehealth services to offering most of their services via telehealth. As of December 2020, 80% of all services were completed utilizing telehealth.

While most of UPAC's client population have access to technology, those who do not or need assistance accessing services can visit the clinic and use a laptop that is provided in a sanitized area for therapeutic services via telehealth.

UPAC Outpatient Clinic has increased DMC services by 28% compared to data from February 2020 to December 2020.

Opioid Treatment Program: SOAP MAT
The following updates highlight recent accomplishments of the SOAP MAT program:

- Take home exceptions have been submitted and approved for patients per DHCS, DEA, and SAMHSA guidelines to reduce possible exposure and infection of COVID-19. Currently

  76% of active patients have take-home medications approved, reducing clinic visits from five days a week to once a month.

- Curbside dosing has been offered and implemented for all patients who suspect possible exposure/infection or have reported symptoms of COVID-19.

- Telehealth services are being utilized frequently to reduce contact among patients at high risk for infection. Telehealth services include intakes, doctor consults with patients, counseling, and case management sessions.

- The number of services at SOAP MAT have remained consistent during the COVID-19 pandemic. There was less than a 3% variance in the number of services available when comparing data from February 2020 and August 2020.

- In response to the increase of opioid and fentanyl use, SOAP MAT initiated an outreach program at Tri-City Hospital. The program provides information regarding access and availability of Opioid Treatment Program (OTP) services.

- SOAP MAT delivered school and art supplies, cleaning products, Personal Protective Equipment (PPE) masks and gloves, kitchenware, milk, and miscellaneous goods to Project HOPE, a homeless shelter in Vista.

- The program has launched social media campaigns amid the COVID-19 pandemic on various platforms with the intention to deliver education on OTPs to a wide audience and promote the use of Medication Assisted Treatment.

Medication Assisted Treatment: ACTION East
The ACTION East Program provides supportive housing services integrated with SMI and substance use disorder (SUD) treatment services for homeless individuals in East Region. ACTION East operates two treatment program tracks: (1) Short-Doyle/Medi-Cal MHSA Full-Service Partnership (FSP) ACT and recovery services; and (2) DMC-certified Alcohol and Other Drug (AOD) treatment and recovery services.

ACTION East began offering medication assistance treatment (MAT) services in May 2020, adhering to all applicable federal, state, and local guidelines in the administration of FDA-approved medications for SUD, including the utilization of long-acting injectable naltrexone. The addition of this service has increased care coordination and supports clients in remaining connected to on-site care.

Supported Employment

Five-Year Strategic Employment Plan
Maximizing employment opportunities has been a key goal for the County Behavioral Health Services and the new Five-Year Strategic Employment Plan: Fiscal Year 2020 to 2024 (Plan) which outlines a clear vision for continued expansion of employment opportunities for people with behavioral health issues, including investing in evidence-based and evidence-informed practices that are effective in increasing employment.

The Plan was developed through in-depth consultation with key community, consumer, and business partners, including focus groups and interviews over a three-month period. The Plan provides an overview of the County's investments in behavioral health and employment services and the highly prioritized work stemming from the initial Five-Year Strategic Employment Plan which launched the "Work Well" initiative in San Diego. In addition, the Plan provides an overview of the evidence based best practice of the Individualized Placement and Support (IPS) Model of Supported Employment and how it is being implemented locally. As part of the Plan road map, it was crucial to include an analysis of priority and emerging sectors and employment opportunities in San Diego, outlining key opportunities for employment for people living with behavioral health

issues. The Plan also identifies gaps that must be addressed and potential resources in achieving these efforts.

The Plan recommends clear goals, objectives, and strategies which form the foundation to maximize employment opportunities and act as key drivers of positive change and greater employment outcomes in the coming years. The goals over the next five years are to:

- Expand access to IPS model of supported employment,
- Engage employers as key partners in the Work Well initiative,
- Enhance data collection and analysis,
- Champion peer employment and advocacy to increase peer involvement, and
- Identify and pursue funding opportunities.

Two components of the Plan are in progress. In February 2021, BHS in collaboration with contracted partners San Diego Workforce Partnership (SDWP) and Corporation for Supportive Housing (CSH), instituted the plan for data collection through Tableau, a business analytics platform. This shift in real time data collection, directly from providers, will enable real time review and analysis of program and systemwide performance. The pilot test begins in April 2021 and is expected to be fully implemented by July 2021.

Effective March 3, 2021, the ability to expand access to IPS Model of Supported Employment was activated through a SDWP Supported Employment / Work Well website that includes links to the IPS Model, provides information on the local Work Well initiative and the Plan, and directs individuals to the local support services of SDWP.

Justice Involved Services - Collaborative Courts Programs

Drug Court
Drug Court contracted BHS SUD treatment program works in collaboration with justice partners including a Judge, District Attorney, Public Defender, City Attorney, Probation, and Sheriff to provide an 18-month, highly structured and monitored treatment program for persons who have committed a non-violent drug-related crime and who are at high risk for recidivism and at high need for SUD treatment. These programs serve approximately 110 individuals in each court at any given time. Emphasis is placed on sobriety, housing, employment, education, and family re-unification. Criminal charges may be reduced or dismissed upon successful completion of the program. Drug Courts have participated in DMC-ODS since December of 2019.

Re-entry Court
Based in the Central Region, Re-entry Court operates similarly to the Drug Court program structure in collaboration with BHS contracted service providers and justice partners. This program serves up to 60 individuals at a time who have engaged in behavior that has violated their community supervision (Probation) and who have been assessed as having a SUD. Some participants also suffer from co-occurring mental health disorders. Emphasis is placed on sobriety, housing, employment, education, and family re-unification. Successful program completion may result in early termination of Probation.

Behavioral Health Court
Based in the Central Region, Behavioral Health Court (BHC) applies the Collaborative Court model for persons who are diagnosed with a SMI and who have engaged in criminal behavior in the community. The program was recently augmented with funding from the Department of State Hospitals (DSH) and now serves 90 individuals at a time, including 30 "diversion" clients. BHC

provides intensive mental health treatment with concurrent emphasis on sobriety, stable housing, linkage to benefits and/or employment, re-unification with family, and employment/education when appropriate. Successful program completion may result in the reduction or dismissal of charges.

Other Diversion Programs

Serial Inebriate Program
Serial Inebriate Program (SIP) is a collaborative effort involving a BHS contracted service provider, courts, police, emergency medical services, and hospitals to provide services to "chronically homeless inebriates". The program provides outpatient SUD treatment and housing as an alternative to custody for persons who have been sentenced. SIP serves 56 individuals in transitional housing with another 65 clients in permanent supportive housing. The SIP program also provides case management services for another 100 homeless individuals who are referred to case managers by the SDHC.

Inebriate Sobering Center
Provides a safe alternative to custody for "public inebriates" who need sobering services in lieu of arrest. This includes individuals who are under the influence of alcohol and other intoxicants. The program keeps persons transported and dropped off by law enforcement for a minimum of 4 hours. Persons receiving these services are provided counseling and linked to treatment resources in the community once they regain functioning. Multiple contacts in one month result in a mandated referral to SIP, described above.

Psychiatric Emergency Response Team (PERT)
PERT is a collaboration between BHS and law enforcement agencies around the County and pairs a licensed mental health clinician with a uniformed law enforcement officer in the field. The PERT clinician provides crisis interventions to individuals experiencing a behavioral health crisis. Interventions include a mental health and substance use consultation, case coordination, and referrals to individuals who come in contact with law enforcement. PERT can transport individuals to a hospital or other treatment as appropriate. There are currently 70 PERT teams allocated Countywide. PERT is also participating in a pilot that pairs a licensed clinician with an Emergency Services Technician to respond to and provide outreach and engagement with individuals who are high utilizers of the EMS system. There are currently two PERT EMS teams in Central San Diego.

Justice Involved ACT Programs

Center Star ACT
Utilizes the ACT model of care which provides comprehensive, multi-disciplinary, field-based mental health services. Center Star ACT provides these services for homeless, justice-involved clients who are diagnosed with SMI and co-occurring disorders. This program operates County-wide and serves approximately 200 persons at a time with the ability to "step clients down" to a lower level of care within the program utilizing a strengths-based case management approach. The program has both transitional and long-term housing resources and is funded with MHSA funding.

Vida ACT
Utilizes the ACT model of care, as described above, to serve clients who are diagnosed with SMI, are homeless, may have co-occurring disorders, and who are re-entering the community directly from custody. Vida ACT specializes in assessing for criminogenic need and ensuring these needs are addressed in the treatment plan along with SMI, SUD, and housing needs.

AB109 Contracted Mental Health Providers

Telecare PROPS ACT
Utilizes the ACT model of care, as described above, to serve clients diagnosed with SMI and co-occurring disorders, who have been adjudicated under AB109 and who are supervised by local Probation (PRCS/MS). Telecare PROPS ACT has funding for transitional housing along with comprehensive mental health services. This program is funded with AB109 re-alignment funds and serves 60 clients at any point in time.

Exodus Strengths-Based Case Management
Provides outpatient mental health services including medication management and strengths-based case management. This program has flex funds to cover various needs including temporary housing. Participants in this program are referred by Probation and are under supervision as AB109 offenders. The program serves adults 18 years and older and serves a minimum of 465 clients annually.

In-Reach Programs

Project In-Reach
BHS has partnered with the Sheriff's Department on the Project In-Reach to engage and serve persons who are diagnosed with a SMI and co-occurring disorders and are in custody at County jails. The Sheriff identifies persons in need of these services, submits a referral to the program, and services begin 30-60 days prior to release into the community. Services include physically assisting the client with moving from custody into community-based services. The program continues to monitor and support the client for up to 90 days. Emphasis is on the successful transition from custody to community and reduction in recidivism.

Wellness Ministry
Wellness Ministry follows a similar program model to Project In-Reach, with the added element of pairing a religious pastor with a mental health clinician providing these services. This program serves the same population as described above with the same outcome objectives. Emphasis is placed on meeting spiritual needs and linking clients with community religious organizations of their choice.

Other BHS Programs with Justice Intersections

Public Defender Unit
Public Defender Unit is a collaboration between the Office of the Public Defender and BHS. BHS provides funding for clinicians to screen and assess clients needing services for SMI as identified and referred by defense attorneys. Embedded clinicians identify the level of mental health need and link clients with services in the community, such as ACT and Outpatient Mental Health Clinics.

In-Home Outreach Team
In-Home Outreach Teams (IHOT) serve as the starting point of a treatment continuum with the goal of linking and connecting individuals with SMI to appropriate services, and if eligible, referring individuals to Assisted Outpatient Treatment (AOT). Referrals may come from hospital staff, family members, HHSA's Homeless Outreach Teams, PERT, law enforcement, crisis residential centers, jails, etc. Field-based teams generally consist of a licensed clinician, case manager, family support specialist, and a peer specialist who work to engage the individual in need in a comfortable setting, which allows the team an opportunity to build a relationship of trust. Although this coordinated

approach is typically successful in linking individuals to treatment and other services, there are some participants who remain resistant to engagement and may meet the nine criteria under Laura's Law. IHOT may refer an individual for a Laura's Law evaluation by an AOT Clinician (embedded in the IHOT program) if, after several attempts, engagement efforts are unsuccessful. The evaluation will determine if the path to court-ordered treatment via AOT is appropriate.

- IHOT Success Story: M was referred by her parents after experiencing acute psychotic symptoms, including delusional beliefs, and significant sexual trauma with a history of suicide attempts. Upon referral, M met criteria for Laura's Law as she had more than four hospitalizations. During the first several weeks of outreach and engagement, the IHOT staff worked on building rapport with M, as well as providing education and support to family members. Post-discharge from a recent hospitalization, M continued to present as too symptomatic to successfully connect to an existing behavioral health program and was re-hospitalized. Following that unsuccessful connection, IHOT was able to coordinate care and successfully refer the client to AOT services. Currently, M is safe and has been connected to treatment, housing, Supplemental Security Income (SSI), and a payee service. She has also started the process of strengthening her family relationships.

Assisted Outpatient Treatment
Once the AOT clinician from the IHOT program has determined an individual appears to meet the nine criteria for AOT, they are referred to the AOT program which is a Full-Service Partnership (FSP) ACT program. This FSP/ACT program provides a continuum of services with the goal of improving the quality of life of participants and supporting them on their path to recovery and wellness, as well as preventing decompensation and cycling through acute services (i.e., psychiatric hospitalization) and incarceration. Following IHOT involvement, a participant who continues to be resistant to treatment may enter the AOT program either voluntarily or through a court process, which may include opting to enter voluntarily (via a settlement agreement) or by an AOT court-order. Regardless of the way in which an individual is referred, the program relies on a highly collaborative, field-based team to provide intensive services to prevent further decompensation.

StrengTHS (Therapeutic Healing Services) Central East Regional Recovery Center
Clients are referred by the Central Court(s) to receive an in-person screening while at the court by an In-Court Liaison. Linkage is provided to behavioral health and case management services for individuals with a primary substance use disorder or co-occurring mental health condition(s) and who have committed an offense impacted by Proposition 47.

Respectfully submitted,

LUKE BERGMANN, Ph.D., Director
Behavioral Health Services

cc: Dean Arabatzis, Acting Agency Director
Cecily Thornton-Stearns, Assistant Director and Chief Program Officer
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County of San Diego

NICK MACCHIONE, FACHE
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HEALTH AND HUMAN SERVICES AGENCY
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LUKE BERGMANN, Ph.D.
DIRECTOR, BEHAVIORAL HEALTH SERVICES

April 28, 2021

TO: The Behavioral Health Advisory Board (BHAB)

FROM: Luke Bergmann, Ph.D., Director, Behavioral Health Services (BHS)

BEHAVIORAL HEALTH SERVICES DIRECTOR'S REPORT – May 2021

ACTION ITEM: REPORT BACK ON COMPREHENSIVE COUNTY SUBSTANCE USE HARM REDUCTION STRATEGY
On January 26, 2021 (13), the San Diego County Board of Supervisors (Board) voted to find prior Board direction opposing harm reduction programs, including the December 9, 1997 resolution entitled "Resolution to Oppose Needle Exchange Programs," to no longer be in effect. The BOS further directed the Chief Administrative Officer to: The BOS further directed the Chief Administrative Officer to:

- Create an Action Plan to realize a Syringe Services Program to meet the needs of San Diego County's population, including identification of necessary resources, and program partnerships; and in accordance with findings and recommendations in the January 14, 2021, Health and Human Services Agency (HHSA) memo and accompanied the Family Health Centers of San Diego (FHCSD) and San Diego State University's Institute for Public Health (IPH) study, *Environmental Assessment on People Who Inject Drugs*, and report back to the Board with regular updates; and

- Return within 90 days to the BOS with a comprehensive County Substance Use Harm Reduction Strategy including immediate, intermediate, and long-term actions that broadens the existing "Opioid and Prescription Drug Misuse" strategy to bring a harm reduction approach to all substance use interventions across the County.

On June 8, 2021, Behavioral Health Services and Public Health Services will return to the BOS with a recommendation to receive the report back on this direction, noting that the Syringe Services Action Plan is a component of the Harm Reduction Strategy.

It is THEREFORE, staff's recommendation that your Board vote to support the authorizations and approvals needed to advance the recommendation in this Board Letter.

***LIVE WELL SAN DIEGO* UPDATES / SPECIAL EVENTS**

Upcoming Events

National Prescription Drug Take Back Day
On Saturday, April 24, 2021, several locations throughout the county participated in the DEA's semi-annual National Prescription Drug Take Back Day which provides a safe way to dispose of expired, unused, or unwanted prescription drugs safely and anonymously.

This year's event also encouraged the community to consider disposing of unused animal medications. District Attorney Summer Stephan spoke at a media event on April 19, 2021 to encourage the community to safeguard animal medications and dispose of them safely when no longer needed.

May Is Mental Health Month 2021
Since 1949, there has been a national movement in May to raise awareness on mental health and provide resources to the community with the goal of reducing stigma for those experiencing mental health conditions. This year's theme, "Hope for Change", draws our attention to the present moment, allows us to reflect on the growth we've experienced, and move toward the future. The County of San Diego, along with the larger community who support loved ones with mental health conditions, will once again focus on raising awareness, offering support, and sharing local resources.

To maintain safety and comply with public health orders, all events this year will continue to be virtual. Many activities will be on social media where participants can all meaningfully connect. Visit the BHS May Is Mental Health Month (MIMHM) webpage (www.sandiegocounty.gov/content/sdc/hhsa/programs/bhs/mimhm_resources) for activity ideas, resources, and a calendar that includes information on community events. Providers and community organizations are encouraged to submit planned activities in recognition of MIMHM for inclusion on the events calendar. Submissions can be sent to Nancy Page (nancy.page@sdcounty.ca.gov).

Children and Youth Mental Health Awareness Day Celebration - May 7, 2021
The BHS Children, Youth, and Families (CYF) System of Care unit is partnering with the National Alliance on Mental Illness (NAMI) San Diego to recognize the importance of children and youth

mental health with a special virtual gathering that will use art to engage children and youth who are living with serious challenges and their families. This event is to serve as a reminder that we can be physically distanced and remain socially connected.

For registration and other information on the event, visit the BHS May Is Mental Health Month webpage (www.sandiegocounty.gov/content/sdc/hhsa/programs/bhs/mimhm_resources) and click on the calendar.

UPDATES FROM THE SAN DIEGO COUNTY PSYCHIATRIC HOSPITAL (SDCPH)

Medical Leadership Excellence

Dr. Ariana Nesbit-Bartsch: In December 2020, San Diego County Psychiatric Hospital welcomed Dr. Ariana Nesbit-Bartsch as the new Medical Director. Dr. Nesbit-Bartsch attended the University of Vermont College of Medicine, where she won awards for her research and outstanding academic achievement and was inducted into the Alpha Omega Alpha Honor Medical Society. After medical school, Dr. Nesbit-Bartsch completed a psychiatry residency at Harvard Medical School's Cambridge Health Alliance Program, where she spent her third year working at an integrated specialty clinic for individuals with serious and persistent mental illness. During residency, she also graduated from Harvard Medical School's Master of Bioethics program and was named a Rappeport Fellow by the American Academy of Psychiatry and the Law. She then received specialty fellowship training in forensic psychiatry at the University of California, Davis.

Dr. Nesbit-Bartsch has co-authored multiple textbook chapters on psychiatric ethics and forensic psychiatry. She has also written about and presented on a variety of topics including involuntary psychiatric treatment, antisocial personality disorder, schizophrenia, violence risk assessment, and malingering. She has historically worked at multiple correctional facilities and as a Forensic Psychiatric Consultant at Napa State Hospital. She is a Councilor of the American Academy of Psychiatry and the Law (AAPL) and co-chairs AAPL's Early Career Development and Peer Review of Psychiatric Testimony Committees. Additionally, Dr. Nesbit-Bartsch is a consulting member of the ethics committee of the American Psychiatric Association.

Dr. David Folsom: SDCPH is delighted to host Dr. David Folsom, the prior Medical and Training Director of St. Vincent DePaul's Federally Qualified Health Center, and prior Clinical Director for UCSD's Department of Psychiatry. In his role at SDCPH, Dr. Folsom has been working on the front lines in the Emergency Psychiatric Unit (EPU), Crisis Recovery Unit (CRU), and attending SDCPH clinical leadership activities. SDCPH has benefited immensely from Dr. Folsom's wealth of expertise and experience, and he has been instrumental in bolstering connections to the University of California San Diego (UCSD) clinical services for SDCPH patients in need.

Psychiatric Management of Patients in a Pandemic

The length and severity of the pandemic has required SDCPH to be creative and flexible with an ongoing approach to combine effective infection control and active psychiatric treatment. In December, as COVID-19 cases were increasing in our community and in the hospital, SDCPH

pivoted to dedicate one of the units at the hospital to specifically treat COVID-19 positive patients. This afforded many clinical benefits, including opportunities for outdoor programming including meetings with patient treatment teams, reduced isolation among COVID-19 positive patients, and better infection control.

Additionally, aware of our mission as community partner and as a public safety net hospital, SDCPH has played a critical role in serving as a resource to our partners and thereby reducing pressures on local hospital systems as they experienced the impacts of COVID-19.

Over the past month, SDCPH has been working with our partners at County Public Health Services to provide COVID-19 vaccines to patients in our hospital. SDCPH nurses have been trained on how to administer these vaccines, which has helped support efforts to offer vaccines to our longer-term patients.

Enhanced Care Coordination

SDCPH, in collaboration with BHS Case Management and NAMI Next Steps, is excited to launch a new pilot project for enhanced care coordination. Informed by the Whole Person Wellness, the goal is to identify clients at the hospital who are experiencing cumulative clinical and social difficulty due to mixed behavioral health and primary/specialty care needs, compounded by homelessness. A new enhanced care coordination team will begin working with these clients to connect them to the various clinical resources and community supports needed for improved outcomes. IT infrastructure will be developed to assist with tracking client outcomes and the advanced clinical oversight. This pilot will then inform broader efforts to transition patients from Whole Person Wellness into the new CalAIM structure, which will include Enhanced Care Management.

UPDATES FROM EDGEMOOR DISTINCT PART SKILLED NURSING FACILITY (Edgemoor)

COVID-19 Update

The COVID-19 pandemic continues to be at the forefront of operations at Edgemoor. Edgemoor continues to follow and implement the guidance of various local, state, and federal health organizations. Some of the precautions implemented include visitor restrictions; residents quarantined to the facility and connecting patios; entrance screenings which include temperature checks; masking; on-going staff education; communication with resident and families/responsible representatives; and testing of residents, staff, and contractors.

COVID-19 Vaccine Distribution

Edgemoor partnered with CVS Pharmacy to administer COVID-19 vaccinations on-site as part of the Centers for Disease Control (CDC) Pharmacy Partnership Program for skilled nursing facilities. Vaccination clinics were held on January 4, January 5, January 25, January 26, February 15, and February 16. During these clinics, Edgemoor was able to fully vaccinate approximately 74% of staff and 94% of residents with the Pfizer vaccine.

Facility Improvements
Edgemoor's solar installation project is complete and the facility is currently partially powered by solar energy.

UPDATE FROM THE ADULT AND OLDER ADULT (AOA) SYSTEM OF CARE

Vista Crisis Stabilization Unit (CSU)
On March 26, 2019, the BOS approved a recommendation to enhance the existing Walk-in Urgent Center in the city of Vista, which is operated by Exodus Recovery Inc., to provide specialized community-based, crisis stabilization services.

On November 17, 2020, the BOS approved the execution of an agreement between the County of San Diego, the City of Vista, and Exodus Recovery, Inc. which upon agreement of all parties, grants Exodus a special use permit to operationalize a Crisis Stabilization Unit (CSU) in the city of Vista.

The CSU is a community-based urgent care center for psychiatric emergency services with a length of stay under 24-hours. The CSU provides crisis intervention, psychiatric assessments, medication services, care coordination and peer support with the goal of stabilizing clients in the community. The CSU will collaborate with law enforcement in the region, as appropriate. Services at the Vista CSU are anticipated to begin by summer 2021.

Respectfully submitted,

LUKE BERGMANN, Ph.D., Director
Behavioral Health Services

cc: Nick Macchione, Agency Director
Cecily Thornton-Stearns, Assistant Director and Chief Program Officer
Aurora Kiviat, Assistant Director and Chief Operations Officer

Legal Aid Society San Diego, INC.

Supplemental Security Income for Children with Disabilities

Legal Aid attorneys and advocates provide free services for children with qualifying disabilities who:

- Are U.S. Citizens, asylees, or refugees;
- Reside in San Diego County;
- Are currently receiving care from a medical professional;
- Are not working **or** are earning less than $1,**310**/month; and
- Meet certain income and resource requirements

We can help with all stages of the SSI Application Process:

● Initial Appeal ● Reconsideration appeal
● Administrative law judge hearing ● Appeals Council appeal
● Federal District Court appeal ● Termination

Examples of Qualifying Disabilities:

ADHD

Autism Spectrum Disorder

Depression

Bipolar disorder

Anxiety

Oppositional defiant disorder

Mood dysregulation disorder

PTSD

Eating disorder

Intellectual disorder

Global developmental delay

Cerebral Palsy

Epilepsy

All our services are free. For more information, call: (844) 774-5463

COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY | LIVE WELL SAN DIEGO

Program funded by the County of San Diego

DEEMING ELIGIBILITY CHART FOR CHILDREN IN CALIFORNIA FOR 2021

Gross monthly income ***below*** the dollar amounts shown means a disabled child may be eligible for SSI benefits.

Amounts given are general guidelines only.

	All income is **earned**		All income is **unearned**	
Number of ineligible children in household	One parent in household	Two parents in household	One parent in household	Two parents in household
0	$3,257	$4,041	$1,606	$1,998
1	$3,649	$4,433	$1,998	$2,390
2	$4,041	$4,825	$2,390	$2,782
3	$4,433	$5,217	$2,782	$3,174

*Examples of earned income include wages and net earnings from self-employment.

**Examples of unearned income include unemployment compensation, state disability, pensions, Social Security retirement benefits, and interest income.

Legal Aid Society San Diego, Inc.

Seguridad de Ingreso Suplementario para Niños con Discapacidades

Los abogados y defensores de Legal Aid proveen servicios GRATUITOS para **niños** hasta la edad de 18 quienes:

- Cumplan con ciertos requisitos de ingreso y recursos,

Y

- Hayan sido diagnosticados con ciertas discapacidades mentales o físicas, y
- Están recibiendo tratamiento de un **medico** profesional.

AL PRESENTE ESTAMOS EVALUANDO A PERSONAS QUE CALIFIQUEN PARA LOS BENEFICIOS DE SSI Y TAMBIÉN ESTAMOS REALIZANDO ENTREVISTAS TELEFÓNICAS

Podemos ayudarle con todas las etapas del Proceso de Solicitud de SSI:

● Solicitud Inicial ● Apelación de Reconsideración ● Audiencia ante un Juez de Ley Administrativa ● Apelaciones de la Solicitud del Consejo para Revisión ● Revisión de Continua Discapacidad ● Redeterminación

Ejemplos de Discapacidades Aceptables:

ADHD

Trastornos del Espectro Autista

Depresión

Trastorno Bipolar

Ansiedad

Trastorno de Oposición Desafiante

Trastorno de Desregulación del Estado de Ánimo

PTSD

Trastorno de la Alimentación

Trastorno Intelectual

Retraso Global del Desarrollo

Todos nuestros servicios son gratuitos. Para mayor información, llame al: (844) 774-5463

COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY | LIVE WELL SAN DIEGO

Programa financiado por el Condado de San Diego

GRÁFICA DE ELEGIBILIDAD CONSIDERADA PARA NIÑOS EN CALIFORNIA POR EL 2021

El ingreso bruto mensual ***por debajo*** de las cantidades mostradas indica que un niño(a) discapacitado(a) quizás sea elegible para los beneficios de SSI.

Las cantidades dadas son sólo guías generales.

	Todo el ingreso es de **trabajo**		Todo el ingreso **no es de trabajo**	
Número de niños no elegibles en el hogar	Un padre en el hogar	Dos padres en el hogar	Un padre en el hogar	Dos padres en el hogar
0	$3,257	$4,041	$1,606	$1,998
1	$3,649	$4,433	$1,998	$2,390
2	$4,041	$4,825	$2,390	$2,782
3	$4,433	$5,217	$2,782	$3,174

CAYEN

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The California Youth Empowerment Network (CAYEN) was formed to develop, improve and strengthen the voice of Transition Age Youth (TAY) in local and state-level policy.

CAYEN engages youth and young adults who been touched in some way by the mental health, juvenile justice or foster care systems. They are passionate people – consumers, family members and friends of people living with a mental illness.
We are firm believers that their personal experience,education and employment give them a credible, passionate and true voice to the challenges and successes of the TAY population. Through CAYEN they receive the support, training and skills to bring their voices to policy and program discussions.

We believe that Transition Age Youth (TAY) must have their voices heard because:

- Their experience matters
- They help create better systems
- They bring passion and dedication
- They are experts in the youth experience

Join the CAYEN Action Network

Through our Action Network mailing list we will let you know about pieces of legislation that impact youth and young adults, send you advocacy alerts, and will provide templates of letters for you to send to your legislators. We will help you figure out when and how to make your voice heard in the Capital and in other advocacy forums!
Also, when issues arise in mental health policy and CAYEN is going to take an official advocacy stance, we often poll the Action Network to get feedback on the issue. Through participating in our occasional survey, you will have the opportunity to ensure that CAYEN is representing your voice! Join the CAYEN Action Network…

For more information on CAYEN: https://ca-yen.org/

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Beyond the ACE score: Examining relationships between timing of developmental adversity, relational health and developmental outcomes in children

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Neurosequential Model

ABSTRACT

Background: The association between developmental adversity and children's functioning is complex, particularly given the multifaceted nature of adverse experiences. The association between the timing of experience and outcomes is underresearched and clinically under-appreciated. We examine how the timing of both adverse (including potentially traumatic) events and relational poverty are associated with developmental outcomes.

Method: Clinicians using the Neurosequential Model of Therapeutics (NMT), an approach to clinical problem solving, reported on the timing of children's developmental experiences, their degree of current relational health, and current functioning in key brain-mediated domains (N = 3523 6- to 13-year-old children). A regularized hierarchical model produced stable and generalizable estimates regarding associations between the timing of experiences across four developmental periods: Perinatal (0–2 mos), Infancy (2–12 mos), Early Childhood (13 mos to 4 years), and Childhood (4 to 11 years) and current functioning.

Results: Perinatal developmental experiences were more strongly associated with compromised current functioning than such experiences occurring during other periods. Perinatal relational poverty was a stronger predictor than perinatal adversity. During subsequent developmental periods, the influence of relational poverty diminished, while the influence of adversity remained strong throughout early childhood. Current relational health, however, was the strongest predictor of functioning.

Conclusion: Findings expand the understanding of the association between the timing of adversity and relationally impoverished experiences and children's functioning. Although early life experiences are significantly impactful, relationally enriched environments may buffer these effects.

Introduction

In 1998, a landmark epidemiological study, the Adverse Childhood Experiences (ACEs) Study, was published (Felitti et al., 1998). While associations between maltreatment in childhood and a range of detrimental outcomes were well known in clinical and academic communities, the ACE study helped to catalyze a broader public and systemic awareness of the detrimental impact of 'adversity' on physical health, mental health, social functioning, health risk behaviors, and life expectancy. Awareness of "ACEs" has been a central component of 'trauma-informed' policy, program development and practice changes. Screening for childhood adversity, often using the 10–12 question ACE inventory, is more prevalent now than a decade ago, across a wide range of human service providers (Burke Harris, Silvério Marques, Oh, Bucci, & Cloutier, 2017). One of the features of the ACE study that makes public engagement effective is the simplicity and clarity of the dose-dependent correlations seen between the number of adversities in childhood and risk for negative outcomes in adult life (Anda et al., 2006). This simplicity, however, can lead to misunderstanding. Correlation and causality become conflated as ACE 'awareness' spreads into

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non-academic and lay audiences, including those making practice, program and policy decisions in child-serving systems (e.g., medical, education, social services, mental health). Public awareness about the potential impact of adversity and trauma on development is important, yet knowing that these matter is only the first step in the informed creation of programs, practice and policy to address the physical, social and emotional morbidity associated with developmental adversity.

A primary challenge is that human development is not simple; the current emotional, social, cognitive and physiological functioning of each individual is influenced by myriad factors ranging from genetics to developmental experiences and context. Clinically relevant questions persist regarding the ways in which developmental experience shapes functional outcomes. Going beyond the ACE score is essential to inform practice, programs and incorporate what is known about: 1) the timing of adversity; 2) the pattern of developmental stress and distress; and 3) the presence of attenuating and resilience-related factors. Further, it is imperative to continue more granular examinations of the complex effects of development on experience.

Babies are born experience-dependent. They require developmental experience to express underlying genetic potentials in all brain-mediated domains of functioning. Decades of research indicate that disruptions in typical development are associated with negative experiences such as chronic (Felitti et al., 1998) or severe (Jackson, Gabrielli, Fleming, Tunno, & Makanui, 2014) trauma and adversity (henceforth adversity), and with a range of negative outcomes, including behavioral, emotional, social, and cognitive (Bos, Fox, Zeanah, & Nelson, 2009; McDermott et al., 2013; Schatz, Smith, Borkowski, Whitman, & Keogh, 2008). In contrast, attentive attuned and responsive caregiving paired with cognitive and social enrichment is associated with positive outcomes in these domains (Masten & Coatsworth, 1998). Similarly, positive relationships, or social support, appear to buffer the effects of developmental adversity (Dai et al., 2016; Ludy-Dobson & Perry, 2010). Yet, the complexities of development, the timing, nature and pattern of adversity, the relational context in which adversity is experienced, and the heterogeneity of responses to adversity create theoretical and methodological challenges to understanding the myriad effects of developmental adversity.

Developmental psychopathology suggests that multiple dimensions of adversity, including type, timing, severity, frequency, chronicity, and the child's developmental status when the adversity occurs, are interrelated and uniquely meaningful for developmental outcomes (Cicchetti & Toth, 1995; Claessens et al., 2011). An infant whose caregivers are not attuned and attentive, but instead unpredictable or even threatening in their response to their child's cries during the first year after birth may have significantly different outcomes than an adolescent who is sexually abused by a stranger, but otherwise lives (and has lived) in a relationally-enriched environment. Though there are multiple dimensions of adverse experiences, timing appears to be a key – and under-researched – dimension that may influence the types of adverse experiences most likely to disrupt typical developmental trajectories, and the types of positive experiences most likely to promote optimal development.

Organizational theories of development suggest that children's current functioning is highly influenced by experiences during early developmental periods (Perry, 2001; Sroufe & Rutter, 1984). Developmental trajectories negatively impacted by adversity in early life jeopardize functions emerging later in life that will be constructed on these poorly organized developmental systems (Dunn, Nishimi, Powers, & Bradley, 2017). Consequently, experiences occurring early in life, particularly during the first year, can be devastating or protective (Schore, 2001). Evidence for this is seen in both animal and human research. Studies examining grooming behaviors of mouse and rat dams toward their pups suggest that maternal behaviors (licking/grooming and arched-back nursing) in the first weeks of a pup's life can alter pup DNA expression (Bedrosian, Quayle, Novaresi, & Gage, 2018; McGowan et al., 2009). Studies of institutionalized children are perhaps the most recognizable examples of the idea that early adversity, characterized by a profound lack of developmentally stimulating experience in the first year(s) of life, can have a lasting impact in cognitive, affective, and social/emotional domains (McDermott et al., 2013; Zeanah, Smyke, Koga, Carlson, & The Bucharest Early Intervention Project Core Group, 2005).

The notion that the timing of developmental experience matters is not new. Studies show that child maltreatment occurring during the first few years of life is associated with the severity of internalizing and externalizing problems during middle childhood (Manly, Kim, Rogosch, & Cicchetti, 2001). Adversity during the first five years of life is more predictive of maladaptive outcomes during adulthood, including risk for depressive or posttraumatic stress disorders (Dunn et al., 2017) and the severity of posttraumatic stress disorders (Ogle, Rubin, & Siegler, 2013), than is adversity occurring later in life.

There are, however, limitations to the available research on the timing of adversity. On one hand, the examination of timing has not been fine-grained, especially with regard to experiences very early in life. This is problematic because the rate of development is greatest during the first few months of life, sharply declining as a child ages in a logarithmic fashion (Johnson, 2001). Research collapsing trauma occurring during the first five or even three years of life still yields imprecise results regarding exactly when exposure to adversity or lack of developmentally positive experiences is most detrimental. Clearly, adversity during any developmental period can be detrimental, including adolescence (Crane & Clements, 2005), another time of rapid organizational change in the brain (Paus, 2005). Little research has been conducted on the relative impact of adversity or relational poverty during the first months of life compared to adversity occurring during later developmental periods. As such, it is unclear, for example, how the outcomes of children whose adversity occurs later in childhood, but not during infancy, compares to children whose adversity occurs during infancy, but not later in childhood.

The timing of relationally healthy experiences may also have implications for children's functioning due to the relative importance of certain types of positive caregiving experiences during infancy as opposed to childhood. The first few years of life are sensitive periods for children's acquisition of healthy attachment relationships (Zeanah, Smyke, Koga, & Carlson, 2005). Children require consistent, patterned, nurturing experiences with caregivers to form relationships that serve as templates for psychosocial functioning throughout development. Moreover, attuned caregiving during infancy provides the context in which affiliative, self-regulatory and ultimately higher-order cognitive capacities, such as the ability to plan, reason, and judge, form.

Not only can a lack of relational health, (i.e., 'connectedness'; essentially the presence of attuned caregivers, family members, mentors, teachers, and community members), itself be considered adversity, but when trauma occurs in the context of relational poverty, or an overall lack of attachment or otherwise meaningfully supportive relationships, the negative consequences for children can be amplified. Conversely, the effects of adversity are likely attenuated in relationally-rich environments. One study linking the severity of childhood maltreatment to the severity of posttraumatic stress symptoms (PTSS) in adulthood (Evans, Steel, & Dilillo, 2013) found that high levels of perceived familial social support buffered the development of PTSS among those whose maltreatment severity was low or moderate. A study examining social support among inner-city adult victims of interpersonal trauma found that high levels of social support buffered the "cumulative impact" of interpersonal victimization occurring in both childhood and adulthood (Schumm, Briggs-Phillips, & Hobfoll, 2006). The association between exposure to adversity and mental and physical health problems in adulthood is attenuated when individuals report having at least one consistently available adult throughout childhood (Bellis et al., 2017).

Outcomes typically explored when examining how and when adversity may pose risk include DSM diagnoses, or derivatives of common

diagnoses, such as “internalizing and externalizing problems” (Dunn et al., 2017; Ogle et al., 2013). While there is nothing inherently wrong with either approach, adversity notably leads to heterogeneous outcomes (Toth & Cicchetti, 2013). Reliance on any one diagnostic category or symptom subset may restrict identification of the various ways that trauma, adversity, and relational poverty influence development. Study of these complexities in human populations requires very large samples.

To explore these issues, a large dataset collected for clinical purposes by clinicians using the Neurosequential Model of Therapeutics (NMT) was utilized (Perry, 2009; Perry & Dobson, 2013; Perry & Hambrick, 2008). The NMT examines the nature, timing and severity of both adverse experiences (AE) and relational health (RH), as well as a child's current functioning in multiple central nervous system-mediated developmental domains (e.g., clinician-rated sleep, arousal, concrete cognition) and the current degree of “connectedness” (Section 0 contains description about the NMT & NMT Metrics). Given the specifications of AE and RH clinicians provide across several developmental stages, and the number of metrics available (approximately 30,000), this dataset provided a unique opportunity to evaluate associations between the timing of developmental experience and current functioning.

We hypothesized that profound AE occurring perinatally (0 to 2 months) and during infancy (2 to 12 months) would account for more variance in the current functioning of 6- to 13-year-olds than profound AE occurring during early childhood (13 months to 4 years) or childhood (4 to 11 years). Further, we predicted that a profound lack of RH would be most detrimental during the perinatal period than during any other period, a time when a child's optimal growth and development are heavily reliant on external regulation and touch (Beeghly, Perry, & Tronick, 2016). On the other hand, we expected profound AE to be highly detrimental during infancy and early childhood - a time when children become more capable of discerning stressors in their environment, yet are still forming the foundations for emerging developmental capacities.

Method

Study design

Data collected by clinicians using the Clinical Practice Tools (NMT Metrics, see Measures section) associated with the NMT (Perry, 2009), were used. De-identified NMT Metric data were downloaded from the web-based repository of data tracked by the ChildTrauma Academy (NMT developers) as part of their quality improvement initiatives. The Institutional Review Board at the (blinded for review) deemed this study “Not Human Subjects Research.” Below is a brief description of the NMT to contextualize the data.

The NMT is an approach to clinical problem solving that allows clinicians to catalogue the child's developmental history and current functioning using the web-based Clinical Practice Tools (NMT Metrics). The output report provides clinicians with information for intervention planning including: 1) historical and current Adverse Experiences, Relational Health and Developmental Risk; 2) current central nervous system functioning; and, 3) five functional domains of sensory integration, self-regulation, relational, cognitive, and cortical modulation ratio. The NMT has been named an “emerging practice” by the National Quality Improvement Center for Adoption/Guardianship Support and Preservation (QIC-AG.org). More information on the NMT and the use of the Metrics has been detailed in previous publications (Perry, 2014; Perry & Hambrick, 2008).

To complete the metrics, clinicians must report on the timing, severity, and type of a child's AE across several developmental periods, from the prenatal period through the current age of the index client being assessed. The developmental periods relevant to this study are: Perinatal (birth to two months), Infancy (2 to 12 months), Early Childhood (13 months to 4 years), Childhood (4 to 11 years). Clinicians then report on the quality of RH in like manner. These developmental periods are not exhaustive, but were selected by NMT developers to balance two objectives: 1) ease of clinician Metric use (if clinicians cannot complete Metrics efficiently, the metrics will likely go unused), and 2) age groups that allow for the most specificity during very early development (i.e., the first three years of life), when child development proceeds almost logrithmically (Johnson, 2001).

Next, clinicians report on a child's current functioning in 32 brain- or CNS-mediated domains, spanning self-regulatory, cognitive, relational, and sensorimotor functioning. These domains are subsumed under the broad category “CNS Functioning”. Clinicians are provided with extensive training in metric use throughout the certification process (Phase I certification is approximately 150 h). NMT Trainers from the ChildTrauma Academy conduct biannual Fidelity Exercises, where Metric users are given hypothetical case-based data with which to complete the metrics. Clinician performance in the Fidelity Exercise yields a fidelity rating of None, Low, Acceptable, or High. This fidelity rating is a reflection of the degree of interrater reliability between the clinician and NMT developers. Clinicians whose metrics were included in this study were NMT Phase I Certified or in advanced stages of completing this certification process, and had achieved a rating of “acceptable” or “high” in the Fidelity exercises during the period of time from which study metrics were completed and included.

Participants

For this study, NMT Metric data from 3523 children ages 6 to 13 years old seeking behavioral health services with histories of developmental adversity were analyzed. Descriptive data regarding gender and race/ethnicity are in Table 1. Data were collected from clinicians across 190 diverse clinical “sites” across the US, Canada, Europe, and Australia. Because both sites and individuals can be certified in the NMT, the majority of the “sites” (approximately 100) were a single clinician, while other sites contained ratings from many clinicians. Each site provides their estimated ratio of client settings to the NMT developers. Most sites are primarily outpatient, while some are a mixture of outpatient and residential/inpatient. One site was comprised of metrics completed by the NMT developers. At all sites, a percentage

Table 1
Descriptives.

	Typical sample
CNS Functioning (M, SD)	297.09 (41.19)
N	425
	Clinical sample
CNS Functioning (M, SD)	231.53 (39.63)
Female (%)	33.6
White (%)	42.1
Asian (%)	1.2
Black (%)	15.7
Hispanic (%)	7.6
Native American (%)	1.6
Other (%)	16.0
N	3834

Note. CNS = central nervous system. Typical CNS Functioning scores were obtained from metrics completed on children and youth well known to the clinician who have no obvious or known cognitive, mental, social or motor problem requiring ‘clinical’ intervention. As part of the NMT certification process, clinicians are asked to complete metrics on “typical” individuals to learn how to navigate the web-based app, and learn more about the items and anchors of the metrics. “Typical” children, youth and adults may have had some developmental adversity.

of patients were child welfare involved, ranging from 10 to 100%. Exact clinician characteristics are unknown. However, all NMT-certificated clinicians must have a masters degree in a relevant clinical discipline (e.g., nursing, social work, educational psychology, psychology) and have an active license. Approximately 80% of NMT clinicians have masters degrees, while the remainder have more advanced (e.g, Ph.D., Psy.D., DNP, M.D.) degrees. The NMT certification process is 150 h long and includes specific training on how to understand the Part C (CNS functioning) descriptors and anchors used to score various CNS-mediated functions.

Measures

NMT Metrics

The NMT Metrics are divided into four parts: Part A (Developmental Adversity; AE), Part B (Developmental Relational Health; RH), Part C (Central Nervous System (CNS) Functioning: Current), and Part D (Current Relational Health). Although the metrics are only completed by clinicians, clinicians are instructed to use information from clinical interviews, child welfare case files, observations of child/family, medical records, psychosocial assessments, etc. while completing them.

In Part A (AE), clinicians report whether a child experienced a range of potentially traumatic and/or adverse experiences during the following periods: Perinatal (0 to 2 months), Infancy (2 to 12 months), Early Childhood (13 months to four years), and Childhood (4 to 11 years). The six experiences assessed per developmental period are quality of primary caregiving, caregiver drug/alcohol use, neglect, domestic violence, transitions/chaos and "other trauma (e.g., natural disaster, gun violence)." Clinicians rate the severity of each experience from 1 to 12, ranging from None/Minimal (1–3), Mild (4–6), Moderate (7–9), to Severe (10 − 12). When clinicians are uncertain about a child's experience, they are instructed to provide a "neutral" score (6 or 7), use clinical reconstruction to estimate if the score should be marked up (more severe) or down (less severe) by a few points given what is known about the overall nature of the child's early experiences, and ultimately to underestimate the potential risk. Given these scoring instructions, scores falling in the range of 10 to 12 are highly likely to reflect documented, profoundly severe adversities.

In Part B (RH), clinicians report on the quality of a child's relationships across the same developmental periods. The six experiences assessed per period are primary caregiver safety, primary caregiver attunement, consistency in primary caregiving, paternal (or partner) support, kinship support, and community support on a scale of 1–12 from Poor (1–3), Episodic (4–6), Adequate (7–9), to Positive (10–12). These items are meant to assess quality of caregiving and overall "social support" but also, particularly in early developmental periods, risk for attachment disruption. The same scoring instructions are used to complete Parts A (AE) and Part B (RH). Part B scores ranging from 1 to 3 are likely to indicate profound absence of RH. Although some items in the Part A and Part B scales are similar, clinicians use a different lens when completing each section. In Part A, they are indicating adversities, where in Part B, they are indicating poverty or strength in a child's relational health. Moreover, Part A is scored with a "deficits-based" view, and Part B with a "strengths-" or "lack of strengths"-based view.

Part C (CNS Functioning: Current) is clinician rating of a child's capabilities across several brain-mediated developmental functions spanning from basic autonomic regulation, such as cardiovascular regulation (heart rate), to sleep, feeding/appetite, fine motor skills, affect regulation, relational skills, arousal, ability to modulate reactivity/inhibit impulsivity, and abstract/reflective thinking skills. The rating clinicians are asked to review (when possible) medical records, and in gathering history from caregivers to ask about known medical conditions. In addition, many of the NMT-certified clinicians – particularly nurses and other medical professionals - obtain heart rate, heart rate variability and blood pressure data as part of their routine clinic visits. In addition, there are specific scoring "rules" that clinicians learn, such that clinicians should assume 'typical' cardiovascular regulation unless they obtain history or data that suggests otherwise. Clinicians rate whether a child's capabilities are "age typical" or whether they fall above or below age typical on the 32 items comprising the CNS Functioning checklist on a scale of 1–12, where 1–3 = Severe Dysfunction, 4–6 = Moderate Dysfunction, 7–9 = Mild Dysfunction, and 10–12 = Normal Range (for a fully-functioning adult).

The highest possible CNS Functioning score is 384, which represents the capacity of a "typical" adult. This score should not be interpreted like an IQ score. Instead, a score of 384 indicates a general lack of dysfunction in the measured brain-mediated capacities. As part of the NMT certification process, clinicians are asked to complete metrics on "typical" children and adults to learn how to navigate the web-based app, and to learn more about the items and anchors of the metrics. "Typical" children and adults may have had some developmental adversity; the selection of "typical" is based upon the clinician's impression that this individual's current functioning is within a non-clinical range. This set of typical metrics ($N = 1035$) provides a type of normative sample against which clinical scores can be compared.

Part D (Current RH) is clinician rating of the quality of a child's current relational context across nine different domains, including primary caregivers, siblings, extended family, school, peers, and community. Clinicians rate the quality of each of the child's current relational experiences from Poor (1–3), Episodic (4–6), Adequate (7–9) to Positive (10–12). Then, these nine items are summed to create a total Current RH score.

Evidence for the validity and reliability of the NMT metrics include the following. In a sample of children with fetal alcohol spectrum disorders, improvements in CNS Functioning following six months of NMT-guided intervention coincided with improvements in scores on the Battelle Developmental Inventory – 2nd Ed (BDI-2) and the Parenting Stress Inventory (PSI) (Zarnegar, Hambrick, Perry, Azen, & Peterson, 2016). The correlation between the BDI-2 and Part C (CNS Functioning) was 0.67 and the PSI and Part C was −0.38. Significant associations between Part C items and the Trauma Symptom Checklist for Young Children Posttraumatic Stress Total score include arousal ($r = -0.408$) and child ability to modulate reactivity/inhibit impulsivity ($r = -0.390$) (Jackson, Frederico, Hameed, Cox, & Kascamanidis, 2016). In an analysis using a subsample of the current dataset comprised of primarily child-welfare involved children, Cronbach's α was 0.95 for Part C, and was 0.84 for Part D (Hambrick, Brawner, & Perry, 2018).

In the current study, evidence of NMT Metric reliability include the following. Cronbach's α was 0.95 for Part C (CNS Functioning), and was 0.85 for Part D (Current RH). Cronbach's α was not computed for AE and RH scores, as this is an inappropriate statistic when an endorsement of one item does not necessarily increase the likelihood of an endorsement on other items (Bollen & Bauldry, 2011). In the statistical models, site bias of CNS Functioning ratings was roughly normally distributed around and statistically indistinguishable from the NMT developers' ratings (Fig. 1).

Data analysis

To create statistical indicators likely to represent documented occurrences of severe, profound adversity (AE) and relational poverty (RH), variables were created to indicate the number of experiences rated 10–12 (AE) or 1–3 (RH) per child, within each developmental period. Thus, ordinal variables were created for Perinatal – AE Severity (range 0–6, given that 6 possible adversities are assessed per developmental period), Perinatal – RH Severity (range 0–6), and so forth. These AE and RH severity scores, per developmental period, were independent variables. Part C scores were summed to create a broad indicator of a child's current developmental functioning, hereafter called CNS Functioning. The CNS Functioning score was our dependent variable. Part D scores were also summed to create a broad indicator of a

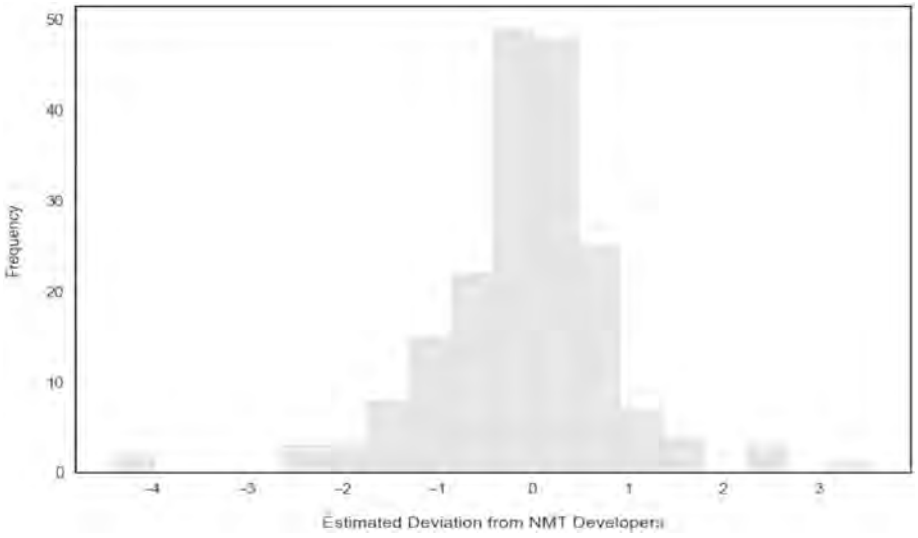

Fig. 1. Site bias in CNS Functioning scores.
Note. Distribution of the site intercepts in the regularized hierarchical model for the site indicators, where NMT developers are the reference category. Values represent deviations from the reference category in CNS Functioning scores.

child's current degree of RH. This score was also used as an independent variable.

We further controlled for degree of severity of intrauterine substance abuse (on a scale from 1 to 12, with 12 indicating the highest level of intrauterine substance use/abuse, and scores falling between 10 and 12 identified as "severe"). When completing Parts A (AE) and B (RH), clinicians are also asked to rate intrauterine experiences. Given the low degree of clinician-rated "confidence" in most intrauterine scores (other than the Part A item assessing degree of substance use/abuse), this was the only item that was included from the Part A intrauterine scale. Other controls included demographic attributes, including age (months), a binary indicator of gender (female = 1), binary indicators of race/ethnicity, and binary indicators for the 190 sites.

We also control for the "age category" a child was in (6 to 7 years, 8 to 10 years, and 11 to 13 years) at the time a Metric was completed. To promote ease of Metric use, clinicians are provided a different reference for what a "typical" score is expected to be on a given Part C (Current CNS Functioning) item per age category. Age category demarcations were roughly determined by considering the rate at which children's developmental functions are likely to change in a variety of CNS-mediated domains (e.g., most rapidly early in life, Johnson, 2001). Given this changing reference point per age category, we control for the scoring bias these reference points create. We restricted our analysis to children who were in these three age categories (6–7, 8–10, 11–13) at the time of Metric completion given that children in these three age categories all had the same developmental information (i.e., information regarding their experiences during the perinatal, infancy, early childhood, and childhood periods).

The analysis features a hierarchical linear model of CNS Functioning as a function of AE and RH severity scores for each of the developmental periods, and current RH. An important feature of the data is the correlation among the AE and RH scores, which produces a concern for collinearity. This collinearity is not surprising, because a child who lives in a chaotic, unpredictable, relationally depleted environment early in life is likely to live in a similar environment later in life. As evidence of this, the condition number, capturing the ratio of the largest and smallest eigenvalues in a matrix decomposition of the model inputs, was 22.69, indicative of unstable regression coefficients (Fox, 2008). To address this, we introduce a ridge penalty. Ridge regularization is commonly employed to reduce variance due to collinearity and improve the quality of inferences (Hastie, Tibshirani, & Friedman, 2016). In addition, in coordination with cross-validation, regularization helps prevent overfitting (Type I Errors). The value of the regularization parameter is chosen via generalized cross-validation.

The hierarchical component of the model is due to the nesting of individual observations within sites, among which we expect to observe variation. In the language of Gelman and Hill (2007), a linear model with no regularization and with estimated intercepts for each site is a hierarchical model with no pooling of the site intercepts. Such a model often inflates the estimated differences among sites, and Gelman and Hill instead suggest partial pooling of the intercepts, where site effects are assumed to follow a Normal distribution centered at zero. In our case, because linear regression with ridge regularization is equivalent to Bayesian regression with regularizing Gaussian priors, the model presented below is a hierarchical linear model with partial pooling of the site intercepts.

There are two consequences of regularization relevant for interpretation of regression estimates. First, analytical standard errors are not available, and therefore we evaluate uncertainty in the coefficient estimates using 95% accelerated bootstrap confidence intervals (Efron, 1987). Second, to penalize the terms in the model equally, all independent variables (IVs) are standardized to the same scale. Namely, unit changes in the standardized IVs correspond to one standard deviation, and estimates should be interpreted as the expected change in CNS Functioning due to a change of one standard deviation in the IV in question.

Results

Mean CNS Functioning was identified (Table 1). CNS Functioning scores in the clinical sample is presented alongside scores in age-matched typical peers, and indicate that clinical sample scores are approximately 2 SDs lower than typical scores. Descriptive statistics and bivariate correlations between predictors are in Table 2, and indicate correlations between most predictors.

Results from the Ridge Regression Model, assessing the association between severity of AE and RH per developmental period and CNS Functioning, indicated several significant associations (Table 3). A child's current degree of RH was the most significant indicator of a child's current CNS Functioning. The next strongest associations were RH and AE Severity scores, respectively, during the Perinatal period. AE Severity scores remained significant in Infancy and Early Childhood. RH Severity scores were only significant during the Perinatal period, and the AE score was no longer significant in Childhood.

Table 2
Bivariate Spearman correlations between predictor variables.

	M (SD)	CNS Functioning	Current relational health	Intrauterine drug abuse	AE Severity (Perinatal)	RH Severity (Perinatal)	AE Severity (Infancy)	RH Severity (Infancy)	RH Severity (Early childhood)	RH Severity (Early childhood)	AE Severity (Childhood)
CNS Functioning	231.53 (39.64)	–	–	–	–	–	–	–	–	–	–
Current relational health	59.14 (15.73)	0.338	–	–	–	–	–	–	–	–	–
Intrauterine drug abuse	0.216 (0.41)	−0.073	0.002	–	–	–	–	–	–	–	–
Perinatal - AE	0.944 (1.44)	−0.167	−0.013	0.446	–	–	–	–	–	–	–
Perinatal - RH	1.490 (1.70)	−0.196	−0.087	0.301	0.517	–	–	–	–	–	–
Infancy - AE	0.980 (1.54)	−0.171	−0.023	0.345	0.664	0.444	–	–	–	–	–
Infancy - RH	1.397 (1.63)	−0.175	−0.109	0.23	0.46	0.765	0.525	–	–	–	–
Early childhood - AE	1.181 (1.63)	−0.133	−0.111	0.197	0.372	0.252	0.5	0.341	–	–	–
Early childhood - RH	1.32 (1.6)	−0.136	−0.214	0.125	0.254	0.464	0.331	0.605	0.537	–	–
Childhood - AE	1.012 (1.50)	−0.01	−0.217	0.007	0.115	0.028	0.152	0.092	0.359	0.225	–
Childhood - RH	0.883 (1.23)	−0.117	−0.374	0.022	0.055	0.19	0.079	0.251	0.208	0.418	0.0382

Note. AE (adverse experiences) and RH (relational health) scores are ordinal indicators of the number of adversity or relational health indicators within the “severe” or “poor,” respectively, range.

Table 3
Hierarchical Ridge Regression Model: Severity of adversity and relational poverty per developmental period and CNS Functioning.

	Estimate	Confidence interval
Intrauterine drug/alcohol	−0.204	[−1.232 0.823]
Current relational health	**13.149**	**[12.083 - 14.152]**
Perinatal – AE	**−2.314**	**[−3.735 −0.96]**
Perinatal – RH	**−3.455**	**[−4.77 −2.235]**
Infancy – AE	**−3.28**	**[−4.687 −1.873]**
Infancy – RH	0.24	[−1.099 1.544]
Early childhood – AE	**−2.116**	**[−3.28 −1.081]**
Early childhood – RH	0.3171	[−0.86 1.563]
Childhood – AE	0.943	[−0.063 1.937]
Childhood – RH	−0.435	[−1.476 0.636]
Age in months	6.747	[5.663 7.933]
Female	2.489	[1.556 3.514]
Asian	−0.287	[−1.468 0.906]
Black	−0.51	[−1.532 0.422]
Hispanic	−0.145	[−1.101 0.9]
Native American	−0.857	[−1.897 0.199]
Other	0.293	[−0.645 1.2749]
Age category 8 to 10	2.746	[1.787 3.814]
Age category 11 to 13	5.587	[4.427 6.722]

Note. CNS = central nervous system. AE (adverse experiences) and RH (relational health) scores are ordinal indicators of the number of adversity or relational health indicators within the “severe” or “poor,” respectively, range. Site indicators are not represented here for brevity (190 site indicators), though their distribution is shown in Fig. 1. For ethnic/racial indicators, White is the reference category. For age category indicators, 6 to 7-year-olds are the reference category. Bolded are statistically significant findings.

To visually represent the potential functional impact of the major findings regarding the timing of negative developmental experiences, Fig. 2 shows a nonparametric local regression of the predicted developmental trajectory in CNS Functioning over time (0 to 18 years) across three groups: children with scores ranging from four to six on the AE Severity Perinatal variable but not the RH Severity Perinatal variable and vice-versa, and then children in the typical sample. Fig. 2 shows a widening gap over time in CNS scores for the typical and clinical samples, or evidence of a “developmental lag” that continues to widen over time in children with early life adversity – be it nodal adversities or lack of relational health.

Discussion

Previous research indicates that the timing of adversity likely matters for children's mental health, developmental, and psychosocial outcomes (Dunn et al., 2017). Yet, the association between timing and child outcomes has yet to be examined in a fine-grained manner. This study sought to promote a deeper appreciation of the complex association between the timing of adverse and relationally impoverished experiences and children's current functioning in 32 brain-mediated domains. Adversity and relationally healthy experiences throughout four developmental stages spanning from perinatal (birth to two months) to childhood (4 to 11 years) and children's current functioning were reported by clinicians using the NMT Metrics. We sought to determine the relative impact of adverse (AE) and relationally impoverished (RH) experiences on current functioning across these four developmental periods.

We found that children in our clinical sample had CNS Functioning scores significantly below the scores seen in age-matched samples of typically developing children (Table 1). This is not surprising, but perhaps a sobering realization of just how far from typical functioning significantly trauma-exposed children can, collectively, appear. Bivariate correlations showed correlations across predictors (Table 2). This was also unsurprising, given that children who live in chaotic, unpredictable, and relationally impoverished environments during the first months or year of life are likely to remain in such settings unless caregivers change significantly and/or the child is removed from their home and placed in a setting with quality caregivers. Therefore, these correlations across predictors identified a need to use regularized regression models to help determine which predictors, when considered together, were most influential for outcomes.

Results from the regularized regression indicated that a child's degree of current RH was the strongest predictor of outcomes (Table 3). This finding is consistent with a previous study conducted with a subset of the NMT Metric data comprised of child-welfare involved youth. This may be because many children entering therapy have been removed

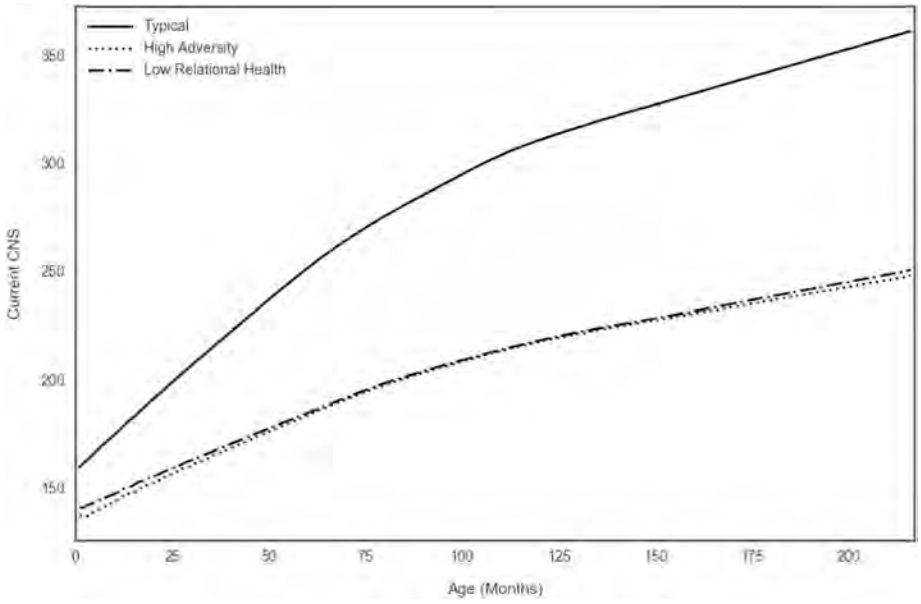

Fig. 2. Nonparametric Local Regression: Predicted trajectories of CNS Functioning given perinatal adversity and relational health.
Note. The High Adversity group is comprised of children across all age categories in the NMT Metric database ages 0 to 216 months (comprised of metrics of raters with "Acceptable" or "High" fidelity, N = 15,140) with scores ranging from four to six on the AE (adverse experiences) severity variable during the perinatal period (0 to 2 months), but not on the RH (relational health) severity variable during the perinatal period (n = 1433). The Low RH group is the opposite (n = 2440). The Typical group is comprised of individuals whom clinicians have deemed to have "typical" functioning on whom they completed metrics. "Typical" children and adults may have had some developmental adversity; the selection of "typical" is based upon the clinician's impression that this individual's current functioning is within a non-clinical range (n = 945).

from relationally impoverished environments, and their current more relationally positive context may be promoting their growth or providing a regulating environment. Impressively, despite children's adversity histories, RH later in life may have meaningful implications for functioning. Theories of developmental psychopathology posit that not only what happened matters, but the context in which it occurs matters (Cicchetti & Toth, 1995; Ludy-Dobson & Perry, 2010). Indeed, the relational context in which trauma occurs as well as the quality of subsequent relational environments may have powerful implications for children (Schumm et al., 2006). While this finding may provide a message of hope regarding ways to remediate developmental trauma, the current RH variable may be a proxy for several unmeasured variables, including a child's degree of relational adeptness, or their lack of behavioral concerns that make them easily relatable.

Despite the strength of the current RH finding, several of the indicators of developmental experience also evidenced strong associations with a child's degree of functioning. Both severe AE and extremely poor RH during the perinatal period were most strongly associated with negative outcomes, consistent with organizational theories of development (Cicchetti & Toth, 1995; Perry, 2001; Tronick & Perry, 2015) and research suggesting that the brain is most plastic during the few weeks following birth (Ishii et al., 2015; Paredes et al., 2016). Interestingly, severity of RH during the perinatal period was a stronger predictor of negative outcomes than severity of AE, the predictor variable that we used that is most similar to traditionally-utilized scales of "adverse childhood experiences." This suggests that the context and quality of early experiences (somatosensory, interactional, attunement, affective, safety, etc.) have a profound influence on subsequent development in multiple domains. The dependence of newborns on consistent, predictable caregivers to provide basic physical and emotional needs and thereby shape their developing stress response capabilities may contribute to this strong finding (Beeghly et al., 2016; Brandt, 2008). Although potentially traumatic events, such as domestic violence, are also impactful during this time, it is important to reflect on which developmental capacities are forming at a given time in development, and how these might dictate which types of experiences are most impactful. Newborns settle into their developmental context and are fully dependent on caregivers to regulate their temperature, relieve hunger, help regulate them, and soothe their primitive stress response systems. As a result, systems involved in reward, pleasure, safety, hunger, satiety, thermoregulation, transitions, organization of motor systems, state regulation, etc. are under development, and highly sensitive to and influenced by early experiences.

Following the perinatal period, the association between RH and outcomes significantly diminishes. This is not to say that connectedness does not continue to matter; indeed, we see that strong RH in a child's current environment matters greatly. Yet, holding all else equal – AE seem to take over in importance as a child ages, particularly in infancy and early childhood. The finding that AE are strong predictors of outcomes up until four years of age also fits with current understandings of the role of early life experiences in influencing outcomes. Infants are building a relational template that helps them determine if people are ultimately trustworthy and are working to determine if their world is safe (Narayan, Rivera, Bernstein, Harris, & Lieberman, 2018). Receipt of consistent messages that they are not safe during this sensitive developmental phase may result in significant neurodevelopmental alterations in attachment and in stress response systems that can have persistent implications.

We see evidence of this persistence, or what we informally call a "developmental echo" or lag in the current analysis. The idea that once a child is moved off of a typical developmental trajectory, they tend to appear further and further from age typical with time is not new (Font & Berger, 2015). A visual indication of this developmental echo is seen in Fig. 2, where we plot expected CNS Functioning over time in the sample of typical children, (ages 0 to 18) and in children whose perinatal experience included either significant AH or significant RH, and see an increasingly widening gap.

In sum, the current results are consistent with what researchers and clinicians have largely assumed: that early developmental experiences have a significant impact on development. Yet, the relatively more powerful impact of developmental disruptions in connectedness and adversity in the first two months of life is a striking finding with significant practice and policy implications. Other studies examining, for example, the impact of extreme early-life deprivation during the first three years of life have noted that deficits can persist into adulthood (Sonuga-Barke et al., 2017). And, emerging research also suggests that positive relational experiences, such as perceived family, peer, school, and community support, may buffer negative outcomes (Saeri, Cruwys, Barlow, Stronge, & Sibley, 2018; Sege et al., 2017).

Study strengths, limitations, and future research directions

Results must be interpreted in light of study strengths and limitations. One limitation was reliance on clinician report. Clinicians likely varied in the degree and quality of information available to them regarding a child's life experiences. Some clinicians may not have had

access to either child welfare records or a reliable reporter of the child's history. Use of retrospective reports of developmental histories in the study of how trauma influences functioning is a debated practice (Greenhoot, 2013) given that retrospective reports often differ from actuarial reports (Hambrick, Tunno, Gabrielli, Jackson, & Belz, 2014). Yet, aspects of NMT training may have mitigated the impact of retrospection on the current study.

Clinicians using the NMT Metrics have completed over 150 h of training, and have passed fidelity exercises to demonstrate competence and inter-rater reliability with these tools. When scoring, they are instructed to use all evidence available to them, including multiple reporters, case files, psychological assessments, and medical records. Allowing clinicians to use all information available to them may be a useful way to obtain the fullest picture possible about a child's developmental experience. Additionally, the scoring schema is designed to accommodate information gaps and neither add nor reduce risk beyond a neutral score to prevent a retrospective reporting bias. Clinicians are asked to only rate scores in the "severe" category if they have reports from child welfare documents, or reliable child, caregiver/case manager reports indicative of severe adversity during a specific developmental period. Regardless, prospective, longitudinal studies that track multiple dimensions of adverse experiences and their associations with functioning over time are needed.

Another study limitation was the monomethod, monoreporter design, which may have resulted in inflated correlations between variables (Podsakoff, MacKenzie, Lee, & Podsakoff, 2003). We sought to address this statistically. Ridge regularization in tandem with cross-validation is an effective method for addressing multicollinearity to learn generalizable and stable estimates from the data, while still permitting statistical inference.

Future research directions using the current dataset include evaluating which types of adversity or relational poverty are most associated with neurodevelopmental functioning, and which specific functional domains are most affected by various dimensions of adversity, including timing, type, frequency/chronicity, and severity. There are likely key domains, such as attention, arousal, sleep, and mood, that are affected by certain types of experiences during specific developmental periods. Interactions between risk trajectories and current functioning also need to be explored, when sample sizes are large enough, as does the association between the timing of various protective experiences and specific brain-mediated developmental functions.

We are aware that the utility of the current dataset will be vastly improved when it is linked to other indicators of children's functioning. Currently, we are scaling up clinical sites using the NMT to collect additional data, such as expanded demographic information (e.g., placement type, indicators of which sources were used to inform the developmental history reports, caregiver and clinician information), standardized measures of behavioral, social, cognitive, and neuropsychological function, and detailed information about the sequence and type of intervention children are receiving.

Conclusions

Findings indicate that the impact of highly traumatic and relationally impoverished experiences, particularly when occurring during the first few months of life, can be enduring. Conversely, relationally rich contexts at any point in a child's life may serve as a buffer. From either perspective, the potential for prevention and early intervention to address risk, reduce future morbidity, and enhance the lives of children is unmistakable.

Every provider coming into contact with pregnant women, or newborns and their families, can and should play a pivotal role in identification of families at risk and early intervention. Physicians, nurses, midwives, doulas, infant mental health specialists, home visitors, lactation consultants, etc. can inquire about the family's living conditions, adjustment to parenthood, stress levels, family violence, caregiver depression, substance use, economic stability, etc., and either intervene or provide a referral for support. They can provide anticipatory guidance regarding the the lasting effects of both early adversity and neglect, and the buffering impact of safety, protection, loving and attuned caregiving, and a developmentally rich environment. While the use of standardized screening and intervention tools may support this work, they cannot substitute for a conversation with a sincerely interested provider. Any program that decreases the isolation of caregivers during pregnancy and early childhood may significantly mitigate children's risk. Such efforts must also be paired with advocacy work to move local, state, and federal policies into greater alignment with these scientific findings.

Depending on the training, context and inclination of the provider, other preventive approaches can include simply observing the level of relational attunement and reciprocity of interactions between parent and newborn, and providing support or making a referral for a more advanced assessment by an infant mental health specialist if questionable patterns present (Brandt, Perry, Seligman, & Tronick, 2014; Weatherston, 2000). Professionals can also be trained in more advanced skills for supporting parents, such as: a) use of the Newborn Behavioral Observation (NBO), a clinical relationship-building approach for engaging parents in understanding their baby's unique language and behavioral repertoire, reducing parental anxiety, and enhancing parent-child interactions (Nugent, Keefer, Minear, Johnson, & Blanchard, 2007); and, b) the Parent-Child Interaction (PCI) Feeding and Teaching Scales that can be used starting at birth to identify dyads with potentially problematic interactional patterns, and pinpoint areas for intervention and support (Brandt, 2013; Oxford & Findlay, 2013).

Child medical providers typically see infants and their caregivers four times during the first two months of life and eight times during the first year (and even more so when children are preterm or have birth complications), and maternal medical providers typically have two postpartum contacts for checking in with the mother. These contacts afford multiple opportunities to build relationships, check in on family progress, and screen for relational challenges, including parental depression.

The findings reported here suggest the need for communities to organize coordinated efforts that embrace families with newborns and young infants in novel ways to prevent isolation, reduce stress, and promote safe and joyful parent-child relationships. Community based approaches for reduction of child risk include home visiting programs by nurses or other providers that focus on the parent-child relationship, risk reduction, and promotion of child safety and positive parental engagement (Doggett, 2013). The documented efficacy of home visiting programs targeting pregnant and post-partum mothers, such as Healthy Families America, Early Head Start Home Visiting, and Nurse Family Partnership (NFP) (DiLauro, 2012), may be due in part to the fact that the supportive services are provided during a time when we know that experiences, particularly relational experiences, are highly influential for the developing child. Other useful community programs may include lactation support organizations, faith-based congregations, and state and federal programs such as the Women, Infants, and Children (WIC) Supplemental Nutrition Program.

Even if a child's early experiences are poor, improving future relational contexts will likely improve outcome. To do so, however, we must think outside of traditional 50-minute therapy sessions toward ways to enrich a child's entire relational world every hour of the day, from the family context to friends, schools, and community settings. Certainly, these findings highlight the complex pathways through which developmental experience influences children's functioning. We must never underestimate how experiences can both hurt and heal, and how positive experiences early in life can optimize development and be preventive. Continuing to explore associations between experiences and outcomes will allow us to construct and promote clinical work that is more responsive to nuance, patient-centered, and increasingly effective.

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ACES Questions	CANS Trauma Module Item
1. Did a parent or other adult in the household often or very often… Swear at you, insult you, put you down, or humiliate you? or Act in a way that made you afraid that you might be physically hurt?	3. Emotional Abuse
2. Did a parent or other adult in the household often or very often… Push, grab, slap, or throw something at you? or Ever hit you so hard that you had marks or were injured?	2. Physical Abuse
3. Did an adult or person at least 5 years older than you ever… Touch or fondle you or have you touch their body in a sexual way? or Attempt or actually have oral, anal, or vaginal intercourse with you?	1. Risk Abuse
4. Did you often or very often feel that … No one in your family loved you or thought you were important or special? or Your family didn't look out for each other, feel close to each other, or support each other?	4. Neglect
5. Did you often or very often feel that … You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? or Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?	4. Neglect
6. Were your parents ever separated or divorced?	11. Disruption in Caregiving / Attachment Losses
7. Was your mother or stepmother: Often or very often pushed, grabbed, slapped, or had something thrown at her? or Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard? or Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?	6. Witness to Family Violence
8. Did you live with anyone who was a problem drinker or alcoholic, or who used street drugs?	10. Victim/Witness to Criminal Activity
9. Was a household member depressed or mentally ill, or did a household member attempt suicide?	9. Natural or manmade disasters
10. Did a household member go to prison?	12. Parental Criminal Behavior

Positive Childhood Experiences (PCE) Questions	CANS Strengths Item
1. Felt able to talk to their family about feelings	**Family Strengths**
2. Felt their family stood by them during difficult times	**Family Strengths**
3. Enjoyed participating in community traditions	**Community Life**
4. Felt a sense of belonging in high school	**Educational Setting**
5. Felt supported by friends	**Interpersonal**
6. Had at least two non-parent adults who took a genuine interest in them	**Natural Support**
7. Felt safe and protected by an adult in their home	**Family Strengths**

Advancing Cultural Responsiveness and Equity: this occurs at the program, policy and practice levels but nothing happens without personal commitment. Here are some examples how participants in the Children Youth and Families System of Care Council are showing their personal/professional commitment.

Examples from Council Members:

- ✓ Serve as an ambassador and advocate to ensure inclusion of individuals with lived experience and how they are powerful in making a difference in the system of care.
- ✓ Advocate for more integration of hiring/including individuals with lived experience. As someone with lived experience, use my voice more to bring new insights.
- ✓ Do more listening, reading and learning to help contribute and lead from a more informed and relevant perspective.
- ✓ Increase awareness of the impact language has on relationships and interactions.
- ✓ Expand my knowledge and awareness by continuing to learn about different cultures.
- ✓ Participate on committees that advance social and racial equity such as the Birth of Brilliance conference.
- ✓ Engage in difficult conversations with other leaders and take the risk of showing vulnerability as a leader to learn and grow.
- ✓ Devote time to learn, listen, and deepen my understanding of race, equity, and inclusion. Committed to raising these issues so that are incorporated in policy, practice, and program system change.
- ✓ Acknowledge that education contributes to disparity.
- ✓ Shift cultural competence training focus from information to action oriented and trauma informed.
- ✓ Integrate cultural responsive considerations when applying standardized interventions and techniques.
- ✓ Facilitate integration of racial, equity, and inclusion between programs and systems.
- ✓ Design structures that support multiple interventions for equitable and targeted support.
- ✓ Create a diverse group of Youth Ambassadors from various cultures & lived experiences into a positive Mental Health Youth team that speaks to other youth in our social media platforms.

Outreach and Engagement During the Pandemic-Best Practices

CYF Council Discussion – January 11, February 8, and March 8, 2021

Over a 3-month period the CYF SOC Council facilitated a hot topic discussion around outreach and engagement during the COVID-19 pandemic. The following is a collection of input and is meant to be a resource document to the council and community partners

SPECIAL POPULATION	TRADITIONAL PRACTICES AND NEW INNOVATIONS	
	OUTREACH Bringing new clients into care **NEW CLIENTS**	**ENGAGEMENT** Ensuring the right level of service provision **EXISTING CLIENTS**
Substance Use	▪ Shift in F2F – look to cross disciplinary partnerships to contact youth. ▪ Need broader community awareness – outreach with refugee community – need people who are trusted in the community to learn the language to talk about needs. ▪ Drive up outreach ▪ Partner with schools to distribute information ▪ Creative ways to meet with youth, provide PPE, fun activities for youth and families	▪ Creative ways to meet with youth, provide PPE, fun activities for youth and family's ▪ Drive up outreach; Particularly in Probation- resulted in more drug tests- put together curriculum bundles and drop-off at home ▪ Case management and outreach at home ▪ Teamed up with therapist and SUD counselor for visit; check-ins and taking family food ▪ No-cost drug test; Outreach to families who have historically been engaged in treatment
Mental Health	▪ "How-to Videos" about how different cultures understand the language of mental health from their culture ▪ SDUSD meeting with parent groups, resource guides for parents, resource guide for schools, ▪ Mailing out engagement letters when we are not able to communicate with new referrals and also after we have completed screenings to families that have not followed through with completing required Intake paperwork. Discussing barriers during screening process.	▪ How-to videos about how different cultures understand the language of mental health from their culture ▪ Need for home visits to connect and support the students and families. ▪ Many of us have learned that we need to support our teams (therapists, parent/peer partners, admin, etc.) so that they can best show up for the families we serve. Reflective supervision and infusing joy into their day has helped hold staff so that they can be emotionally present for those they are serving across - all populations ▪ Parents requesting specific strategies- Education trainings shifted to techniques/strategies that resonate with parents- district doing very large parent training; Adjust to age group ▪ Also working with staff trainings- cultivate resiliency and manage stress and anxiety; similar to parent strategies; also focus on next shift to hybrid and/or in-person learning ▪ Use of TAY youth partners in schools- for MH and SUD
Ages 0-5	▪ Referrals increased beginning in September ▪ Important to be F2F when possible	▪ Concern about child abuse rates, potentially gaps for young children needing mental health support ▪ May need to identify new pathways.

Outreach and Engagement During the Pandemic-Best Practices

CYF Council Discussion – January 11, February 8, and March 8, 2021

SPECIAL POPULATION	TRADITIONAL PRACTICES AND NEW INNOVATIONS	
	OUTREACH Bringing new clients into care **NEW CLIENTS**	**ENGAGEMENT** Ensuring the right level of service provision **EXISTING CLIENTS**
	▪ 3 to 4 sessions have really helped to build engagement then switching to virtual if necessary ▪ Important to support the caregiver ▪ Visits in community parks ▪ First 5 Warmline: 1-888-5First5	▪ Important to be F2F when possible ▪ Referral pathways are clear ▪ Utilizing a diversity-informed framework that allows for flexibility in use of EBPs. This includes strategies such as increasing the number of sessions to develop rapport with the family & pausing on integrating specific manualized interventions when needed to address the immediate need of the family, be it stabilization or case management supports
Ages 6-12	▪ In person sessions to build rapport ▪ Games with body movement – running, mini golf, ▪ Social stories about interacting ▪ Bringing them games ahead of time and have them open at virtual sessions ▪ Keep sessions shorter and spread them out during the week. ▪ Outreach to parents to ensure they have support and need met - food	▪ Important to be F2F when possible ▪ Increase # sessions to build rapport; meet the family where they are at and identifying needs and other supports ▪ Increased parenting groups from 1 a month to 3 a month; easier access online; families more connected to program when have extra offerings ▪ Looking at increase in youth groups ▪ Referral pathways are clear
Teens	▪ In the TRCs offered free drug test for parents to access for teens ▪ Schools have put together a portal on parent's page that shows resources and support to the parents about what could be happening with their child.	▪ Important to be F2F when possible ▪ Social media- avenue to connecting with teens; building this up as a means for engagement ▪ Groups online or live- hold a group on skill building; Bring teens together countywide- multiple region discussions and connections; success with ILS, mindfulness, yoga ▪ Service learning projects, plays, theater ▪ Leverage local popular social media influencers to deliver a message
Specialized Programs (i.e. CSEC, Homeless, LGBTQ)	▪ Schools leverage strength in student body population on how to speak to the youth and or parents on specific topics. Use peers to help peers (middle school and high school)	▪ Need to think about LGBTQ youth who are sheltering in place with family that may be having a hard time because of need for code switching, issues of safety. ▪ Online resources that can be accessed from the home are paramount for youth to be able to engage with a gender positive resource ▪ Asking teachers to add pronouns to their signature lines – shows they are safe and perhaps someone a youth can speak to.

Outreach and Engagement During the Pandemic-Best Practices

CYF Council Discussion – January 11, February 8, and March 8, 2021

SPECIAL POPULATION	TRADITIONAL PRACTICES AND NEW INNOVATIONS	
	OUTREACH Bringing new clients into care **NEW CLIENTS**	**ENGAGEMENT** Ensuring the right level of service provision **EXISTING CLIENTS**
		▪ Implement curriculum in 4 districts- online human trafficking training- parents, students and staff; also offered in Spanish
Families	▪ Caregiver and parent engagement is vital for young kids and teens ▪ Social media is very important to share resources and tools. ▪ Faith based communities are interested in supporting and offering resources but may not know how to connect or offer support ▪ First 5 Warmline: 1-888-5First5 provides First 5 resources and network connections	▪ Important to be F2F when possible ▪ Increase parenting groups ▪ Parenting groups in more threshold languages; reaching out in the manner that they would feel comfortable
Residential (SUD)	▪ Not applicable	▪ Gender responsive in SUD; Bring families in virtually and on the phone; acknowledge where teens are and the multitude of challenges that they are facing ▪ Family education throughout the process; capture the moment when the parents can be empowered with education and strategies for when youth comes back home
Residential (MH)	▪ Not applicable	▪ Family education throughout the process; capture the moment when the parents can be empowered with education and strategies for when youth comes back home
Education	▪ Schools leverage strength in student body population on how to speak to the youth and or parents on specific topics. Use peers to help peers ▪ SDCOEs Student Wellness and Positive School Climate Unit consolidated, created, and shared the mental health and wellness resources and virtual professional development opportunities through our multiple ListServs, SDCOE and outside partners' web-based platforms. SDCOE Communications Department designated a COVID-19 site for schools, caregivers, and students: https://covid-19.sdcoe.net/Parent-Resources ▪ The following are resources to support LGBTQ students during distance learning. ▪ A Checklist to Support LGBTQ Students During Distance Learning	▪ Training school staff on what to look for in zoom meetings for signs of distress/ needs ▪ Asking teachers to add pronouns to their signature lines – shows they are safe and perhaps someone a youth can speak to. ▪ Add link to parent resource guide on the grade page. ▪ PTA as a means for supporting schools to reaching out to students who aren't reporting to school regularly

Outreach and Engagement During the Pandemic-Best Practices

CYF Council Discussion – January 11, February 8, and March 8, 2021

SPECIAL POPULATION	TRADITIONAL PRACTICES AND NEW INNOVATIONS	
	OUTREACH Bringing new clients into care **NEW CLIENTS**	**ENGAGEMENT** Ensuring the right level of service provision **EXISTING CLIENTS**
	▪ Supporting LGBTQ Students During the Coronavirus Quarantine: A Tip-Sheet for School Counselors ▪ Supporting LGBTQ Students During the Coronavirus Pandemic: A Tip Sheet for School Social Workers	
Health Plans/ Primary Care/ FQHC	▪ Partnerships with PCP for referrals	▪ Physician offices are still seeing needs ▪ Drop off materials at clinic
Cultural Considerations	▪ Need to identify the language to how to ask for help ▪ Creating How to speak videos in specific cultures when addressing MH and SU	▪ When people are stressed, we need to realize people's cultural norms. We need to consider their culture and use that in a way to stay engaged with them. ▪ Cultural representation is also important to keep in mind.
Foster Youth	▪ Important to be F2F when possible	▪ Important to be F2F when possible ▪ Shorter, more frequent contacts ▪ CFT meetings and settings to host discussions with entre team to make adjustments to support as needed; bring in natural supports and family members as much as possible ▪ Educational liaisons in CWS regions (7); resource to PSWs and meetings ▪ Parent advocates reaching out; districts reaching out ▪ Working with birth parents to make most of in-person visits since not happening as frequently- work through mask-wearing and how to connect
Justice Involved	▪ Important to be F2F when possible	▪ Important to be F2F when possible
General Brainstorming	▪ Virtual consultations and follow-ups through texting, phone and video calls, e-mails, social media, Skype, or Zoom	▪ Wellness Calls for screening and informing of resources, when indicated ▪ Drive-Thru Check-ins for F2F contacts ▪ Appointment reminders- virtual touchpoints throughout care ▪ Mobile Applications for tracking wellness changes

Outreach and Engagement During the Pandemic-Best Practices

CYF Council Discussion – January 11, February 8, and March 8, 2021

SPECIAL POPULATION	TRADITIONAL PRACTICES AND NEW INNOVATIONS	
	OUTREACH Bringing new clients into care **NEW CLIENTS**	**ENGAGEMENT** Ensuring the right level of service provision **EXISTING CLIENTS**
Systemic Recommendations	▪ Important to be F2F when possible ▪ Creative ways to meet with youth, provide PPE, fun activities for youth and family's ▪ Drive-Thru Check-ins for face to face contacts ▪ Creating How-to videos in specific cultures when addressing MH and SUD	▪ Important to be F2F when possible ▪ Creative ways to meet with youth, provide PPE, fun activities for youth and family's ▪ Drive-Thru Check-ins for F2F contacts ▪ Appointment reminders ▪ Access other touchpoints for family drop off materials or F2F connection (school, physician's office, etc.) ▪ Training school staff on what to look for in zoom meetings for signs of distress/ needs ▪ Creating How to speak videos in specific cultures when addressing MH and SUD ▪ Outreach to parents to ensure they have support and need met – food ▪ Focus on pathways to connection ▪ Outreach to youth who are not logging in to zoom school ▪ Look at unique cultural strategies in SOC meeting ▪ How to break systemic racism- how to navigate the cultural differences and reduce systemic racism

CYF SOC Council's Summary Recommendations:

- Promote cross disciplinary solutions and connections.
- Continuously review and advance best practices, including evidence-based practices and community-informed best practices, to identify opportunities in today's changing environment and implement throughout program development and practice.
- Contractor's associations may also continue this discussion either through the association and/or in partnership with County BHS.
- Continued dialogue within County BHS CYF SOC Council meetings.

Join Us for a Virtual Input Session
Behavioral Health Services 5-Year Strategic Housing Plan

The County of San Diego Behavioral Health Services (BHS) is preparing to draft a new Behavioral Health Services 5-Year Strategic Housing Plan, facilitated by the Corporation for Supportive Housing (CSH). A series of Listening/Input Sessions are being hosted by CSH via Zoom to gather stakeholder information, input and feedback to inform the development of the Behavioral Health Services 5-Year Strategic Housing Plan. This effort is intended to obtain input on housing needs and goals in seeking to maximize a range of housing options (e.g. housing options/not licensed care) for people in San Diego County with behavioral health issues who have limited resources. We want to hear from you.

Input Session for Behavioral Health Services 5-Year Housing Strategic Plan
Stakeholder Group: All BHS Councils

May 14, 2021
1:00pm to 2:30pm

Join Zoom Meeting
https://zoom.us/j/93051106291

Meeting ID: 930 5110 6291
One tap mobile
8335480282,,93051106291# US Toll-free
8778535257,,93051106291# US Toll-free

We hope you will join us for this Listening/Input Session. CSH is committed on behalf of BHS to work with community partners in assisting BHS to develop a Strategic Housing Plan that maximizes housing options for people with behavioral health issues. If you have questions, please do not hesitate to contact Debbie.fountain@csh.org (Senior Program Manager, Corporation for Supportive Housing)

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