

California Mental Health Planning Council

Advocacy Committee
Wednesday, November 9, 2016

1000 "G" Street

4th Floor

Sacramento, Ca 95814

Conference Call Capability Available

Dial 1-866-742-8921 participant code 5900167

11:00 a.m. to 12:15 p.m.

Time	Topic	Presenter or Facilitator	Tab
11:00 am	Welcome and Introductions	Darlene Prettyman, Chairperson	
11:05	Agenda Review	Darlene Prettyman	
11:10	Work Plan Goal 2 : Draft RCF Paper to finalize	Darlene Prettyman and All	A
11:30	Work Plan Goal 3: Draft AB 109 Paper to finalize	Darlene Prettyman and All	B
11:50	Draft: Policy Platform to finalize	Darlene Prettyman and All	C
12:00	Legislative and Regulatory Updates related to Mental Health may be discussed, including but not limited to: election results	Darlene Prettyman and All	
12:05	Public Comment	Darlene Prettyman and All	
12:15 pm	Adjourn	Darlene Prettyman	

The scheduled times on the agenda are estimates and subject to change.

Committee Officers:

Chairperson: Darlene Prettyman

Chair Elect: Maya Petties

Members: Barbara Mitchell, Daphne Shaw, Monica Wilson, Arden Tucker, Steve Leoni, Adam Nelson, Carmen Lee, Amy Eargle

Staff: Dorinda Wiseman

If reasonable accommodations are required, please contact Chamenique Williams at (916) 323-4501 not less than five (5) working days prior to the meeting date.

A TAB SECTION

DATE OF MEETING 11/09/2016

MATERIAL
PREPARED BY: Wiseman

DATE MATERIAL
PREPARED 10/25/2016

AGENDA ITEM:	Work Plan Goal 2
ENCLOSURES:	Draft RCF Paper

BACKGROUND/DESCRIPTION:

The Committee members are to vote on and accept the draft paper for finalizations and presentation to the Council at the January 2017 meeting.



- **Advocacy**
- **Evaluation**
- **Inclusion**

Residential Care Facilities: What is going on?

**By: Dorinda Wiseman, MSW,
the Advocacy Committee
Members in consultation with
Lynda Kaufmann**

The California Mental Health Planning Council (Council) is under federal and state mandate to advocate on behalf of adults with severe mental illness and children with severe emotional disturbance and their families. Our majority consumer and family member Council is also statutorily required to advise the Legislature on mental health issues, policies and priorities in California. The Council has long recognized disparity in mental health access, culturally-relevant treatment and the need to include physical health. The Council has advocated for mental health services that will address the issues of access and effective treatment with the attention and intensity they deserve if true recovery and overall wellness are to be attained and retained.

This report is one of the Council's many functions as a federal and state mandated entity. This report is the beginnings of an effort to highlight a significant public health issue: the lack of residential care facilities as housing options for individuals with serious mental illness in California.

Welfare and Institutions Code 5772. The California Mental Health Planning Council shall have the powers and authority necessary to carry out the duties imposed upon it by this chapter, including, but not limited to, the following:

- (a) To advocate for effective, quality mental health programs;
- (b) To review, assess, and make recommendations regarding all components of California's mental health system, and to report as necessary to the Legislature, the State Department of Health Care Services, local boards, and local programs.
- (e) To advise the Legislature, the State Department of Health Care Services, and county boards on mental health issues and the policies and priorities that this state should be pursuing in developing its mental health system.
- (k) To assess periodically the effect of realignment of mental health services and any other important changes in the state's mental health system, and to report its findings to the Legislature, the State Department of Health Care Services, local programs, and local boards, as appropriate.

Residential Care Facilities: What is going on?

According to the California Department of Social Services (CDSS) website¹ on Residential Care Information, there are several categories of *residential care facilities* that are licensed by CDSS' Community Care Licensing Division (CCLD). Per the CCLD, the following are different types of care facilities. This report will focus on Adult Residential Facilities, Social Rehabilitation Facilities and Residential Care Facilities for the Elderly (RCFE). The facilities will be referred to as Residential Care Facilities (RCFs).

Foster Family Homes (FFH) provide 24-hour care and supervision in a family setting in the licensee's family residence for no more than six children.

Group Homes (GH) provide 24-hour non-medical care and supervision to children in a structured environment.

Small Family Homes (SFH) provide 24-hour care in the licensee's family residence for six or fewer children who are mentally disordered, developmentally disabled or physically handicapped and who require special care and supervision as a result of such disabilities.

Adult Residential Facilities (ARF) provide care for adults age 18-59, who are unable to provide for their own daily needs.

Adult Day Programs (ADP) provide care to persons 18 years of age or older in need of personal services, supervision, or assistance essential for sustaining the activities of daily living or for the protection of these individuals on less than a 24-hour basis.

Social Rehabilitation Facilities provide care in a group setting to adults recovering from mental illnesses who temporarily need assistance, guidance, or counseling.

Residential Care Facilities for the Chronically Ill (RCF-CI) provide care and supervision to adults who have Acquired Immune Deficiency Syndrome (AIDS) or the Human Immunodeficiency Virus (HIV).

Residential Care Facilities for the Elderly (RCFE) provide non-medical care to persons 60 years of age and over but also persons under 60 with compatible needs.

¹ [Website link to the CDSS CCLD website](#)

Individuals utilizing the services of Residential Care Facilities can and are diverse in their treatment needs, income status and level of family and/or community support. With the diversity in the individuals needing mental health treatment, should there not be variety/selection in the type of treatment and housing services available to them when discharged from institutional settings?

In response to a request of the California Mental Health Planning Council, the CCLD provided the following data to illustrate the number of facilities open and closed in the state during the 2004-2005 and 2015-2016 fiscal years. The data for FY 2015-16 was derived from FAS Management Reports – Internal Web Reports. The data for FY 2004-05 was derived from ITLB.

California Department of Social Services
Community Care Licensing Division
Adult and Senior Care Program - **Facility Count** (Division, 2016)

Fiscal Year 2004-2005	Facilities Operating at any time during FY 2004-2005		Facilities Closed during FY 2004-2005	
Facility Type	Facility Count	Total Capacity	Facility Count	Total Capacity
Social Rehabilitation Facility	85	1102	4	40
Grand Total	85	1102	4	40

Fiscal Year 2010-2011	Facilities Operating at any time during FY 2010-2011		Facilities Closed during FY 2010-2011	
Facility Type	Facility Count	Total Capacity	Facility Count	Total Capacity
Social Rehabilitation Facility	94	1207	3	51
Grand Total	94	1207	3	51

Fiscal Year 2015-2016	Facilities Operating at any time during FY 2015-2016		Facilities Closed during FY 2015-2016	
Facility Type	Facility Count	Total Capacity	Facility Count	Total Capacity
Social Rehabilitation Facility	113	1377	3	27
Grand Total	113	1377	3	27

Data for FY 10-11 & 15-16 from FAS Management Reports - Internal Web Reports.
Data for FY 04-05 from ITLB.

California Department of Social Services
 Community Care Licensing Division
 Adult and Senior Care Program – **Facility Closures** (Division, 2016)

Fiscal Year 2004-2005		
Closure Reason	Social Rehabilitation Facility	
	Facility Count	Facility Capacity
Closed, Licensee Initiated	2	22
Closed, Agency Initiated	0	0
Closed, Non-payment	0	0
Closed, Change of Ownership	0	0
Closed, Change of Location	2	18
Grand Total	4	40

Fiscal Year 2010-2011		
Closure Reason	Social Rehabilitation Facility	
	Facility Count	Facility Capacity
Closed, Licensee Initiated	3	51
Closed, Agency Initiated	0	0
Closed, Non-payment	0	0
Closed, Change of Ownership	0	0
Closed, Change of Location	0	0
Grand Total	3	51

Fiscal Year 2015-2016		
Closure Reason	Social Rehabilitation Facility	
	Facility Count	Facility Capacity
Closed, Licensee Initiated	3	27
Closed, Agency Initiated	0	0
Closed, Non-payment	0	0
Closed, Change of Ownership	0	0
Closed, Change of Location	0	0
Grand Total	3	27

Data for FY 10-11 & 15-16 from FAS Management Reports - Internal Web Reports.
 Data for FY 04-05 from ITLB.

California Department of Social Services
Community Care Licensing Division
Adult and Senior Care Program - **Facility Count** (Division, 2016)

Fiscal Year 2004-2005	Facilities Operating at any time during FY 2004-2005		Facilities Closed during FY 2004-2005	
	Facility Count	Total Capacity	Facility Count	Total Capacity
ADULT RESIDENTIAL	5278	42104	404	2943
RESIDENTIAL CARE ELDERLY	7531	148561	856	14192
RESIDENTIAL FACILITY CHRONICALLY ILL	25	354	0	0
Grand Total	13616	195350	859	10828

Fiscal Year 2015-2016	Facilities Operating at any time during FY 2015-2016		Facilities Closed during FY 2015-2016	
	Facility Count	Total Capacity	Facility Count	Total Capacity
ADULT RESIDENTIAL	5240	39834	267	1977
RESIDENTIAL CARE ELDERLY	7792	157263	542	8656
RESIDENTIAL FACILITY CHRONICALLY ILL	19	291	0	0
Grand Total	13051	197388	809	10633

California Department of Social Services
Community Care Licensing Division
Adult and Senior Care Program – **Facility Closures** (Division, 2016)

Closure Reason	Fiscal Year 2004-2005					
	ADULT RESIDENTIAL		RESIDENTIAL CARE ELDERLY		Total Facilities Closed	Total Facility Capacity
	Facility Count	Facility Capacity	Facility Count	Facility Capacity		
Closed, Licensee Initiated	225	1377	375	3910	600	5287
Closed, Agency Initiated	45	571	49	820	94	1391
Closed, Non-payment	1	6	6	35	7	41
Closed, Change of Ownership	78	631	385	9114	463	9745

Closed, Change of Location	55	358	41	313	96	671
Grand Total	404	2943	856	14192	1260	17135

Note: No Residential Care Facility for the Chronically Ill closed during this time period.

Fiscal Year 2015-2016						
Closure Reason	ADULT RESIDENTIAL		RESIDENTIAL CARE ELDERLY		Total Facilities Closed	Total Facility Capacity
	Facility Count	Facility Capacity	Facility Count	Facility Capacity		
Closed, Licensee Initiated	165	1055	323	2688	488	3743
Closed, Agency Initiated	25	197	57	798	82	995
Closed, Non-payment	0	0	1	32	1	32
Closed, Change of Ownership	49	562	153	5090	202	5652
Closed, Change of Location	28	163	8	48	36	211
Grand Total	267	1977	542	8656	809	10633

Note: No Residential Care Facility for the Chronically Ill closed during this time period.

The data shows a significant drop in the number of available placements for individuals needing a place to reside that provides continued structure and care, once they are discharged from a higher level of care. The purpose of this paper is to explain the need for residential care facilities and explore the growing shortage of community placements for individuals diagnosed with mental illness. This is a complex issue that involves agencies at the local, state and federal levels. While this paper will not be able to provide the keys to a solution, we hope this paper will generate a dialogue on the issue.

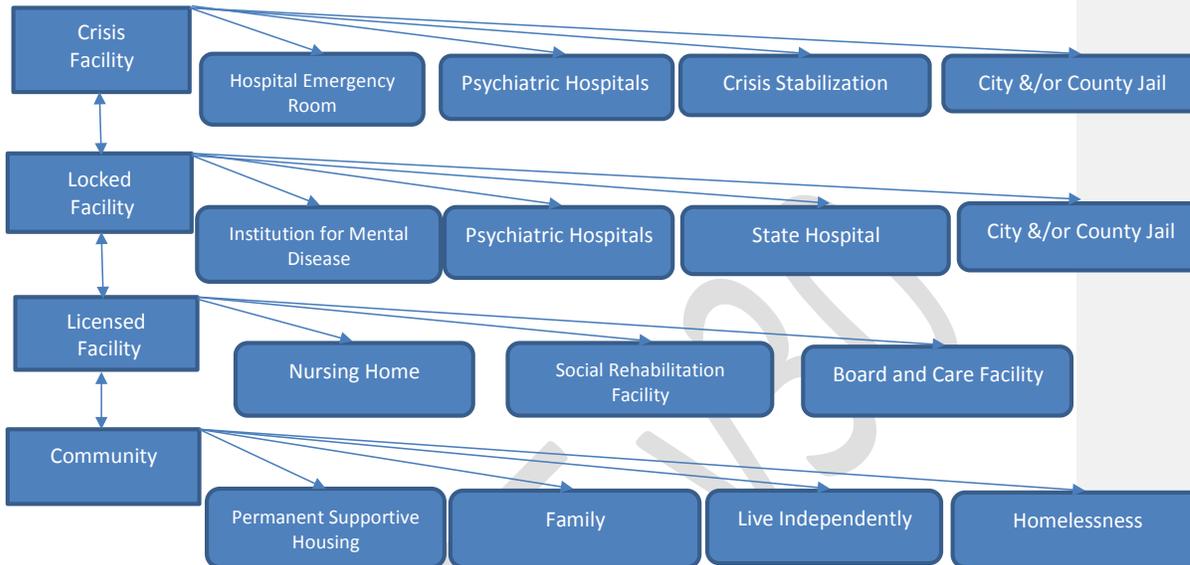
To understand the problem created by the decrease in the number of RCF beds, it is important to understand the flow or *transition* of individuals from one level of care to another. If there are no available beds for transitioning from a higher level of care to either a transitional setting or back to the community, what alternatives do individuals have once discharged from in-patient treatment back into the community?

What is the typical flow? As an example, an individual is engaged in their life and they experience a psychotic episode or severe depressive episode and/or attempt suicide. This individual may be placed in an Institution for Mental Disease (IMD) for a period of time. An IMD is a locked hospital, nursing facility, or other institution of 17 beds or more that is primarily engaged in providing diagnosis, treatment, or care of people with mental diseases, per federal definition in the Centers of Medicare and Medicaid Services' (CMS) Manual 4390 and Title 9, California Code of Regulations, Section 1810.222.1. The goal is to stabilize the individual so that they can reside outside of the secure, restrictive institutional environment. Once an individual is discharged from an IMD, they are usually transitioned to less restrictive settings. Often the RCF is an option utilized.

The terms 'residential care facility', 'licensed care' and 'board and care facility' are commonly interchangeable. The terms refer to the same type of facility licensed by the state. Residential Care refers to a system of non-medical custodial care. This care can be provided in a single family residence, a retirement residence, a nursing home or a care facility. The ultimate hope and desire is to assist stabilized individuals with mental illness into supportive housing or independent living situations, beyond care in residential facilities. Many of those diagnosed with severe mental illness would greatly benefit from ongoing care and support in RCFs. RCFs typically do not offer 24-hour nursing care. They do provide room, board and moderate levels of supervision. In these facilities, medication is centrally-stored and disbursed by facility staff, to the residents.

The numbers of Residential Care Facilities able **and** willing to serve individuals with severe mental illness continues to shrink. There are excessive waiting times in Emergency Rooms across the state of California, for individuals in crisis. The growing problem is that the numbers of individuals that receive crisis or acute care are then frequently discharged with no aftercare due to the unavailability of appropriate RCF housing options. Many are arrested and receive mental health stabilization and/or treatment as *incarcerated individuals*. The need for alternative options for residential treatment within the community is gravely unmet, yet necessary. The growing difficulty in the number and types of treatment services available at every point of the continuum cannot be explored within this report, as it is a vast and complex issue. However, the lack of provision and access does need to be addressed. With regard to RCFs, it would be beneficial to describe the facilities available at each level of care. The most critical apex would be the "**crisis**" level of care. The types of facilities that assist persons experiencing a psychosis or suicide attempt/ideation would be a hospital emergency room or a crisis stabilization unit (unfortunately we have to include a city or county jail facility here also). The next level of care would be your "**locked**" facility. This facility would admit an individual that necessitated continued stabilization treatment lasting longer than 72 hours. The types of facilities that assist individuals in this situation would be IMDs, psychiatric hospitals or a state hospital. The next level of care would be your state licensed facility (i.e. RCF). These would be nursing homes, social rehabilitation/residential care facilities and board and care homes. The least restrictive level of care would be "**community**," Once an individual's mental health challenge has been stabilized and they are able to live independently with supportive services, they should return to their community. The type of services that may be provided at this level would be permanent supportive housing, or supportive services while residing with family or living independently.

The Flow Between Levels of Care



According to Lynda Kaufmann (Kaufmann, 2015), Director of Government and Public Affairs for Psynergy Programs, Inc., "In fifteen years of working in community mental health I have never seen such a shortage... ever. We are losing community beds fast! I recently received a call from San Joaquin County that a 70 bed ARCF was at risk of being closed and asked if we could accept some of the clients. Unfortunately, we could not. This ARCF closure comes on the heels of the closure of Colonial Manor in Salinas (40 licensed beds) by the State and also the closure of Riveria EVP in San Jose (72 licensed beds) last December, and many others as well. Monterey County alone has lost 72 licensed beds just this year."

With the number of RCF closures, many individuals are not able to obtain appropriate housing with the next level of care following any type of in-patient treatment program (hospitalization or correctional setting). Therein lies the heart of the problem. No shelter, no treatment. If an individual suffering a mental health crisis has been stabilized, where should that individual receive their aftercare? Should it be in their community-of-origin or in the streets? Many individuals, with minimal or no social support or who are of low economic status, have little or no alternatives to maintain their treatment plan(s) or medication support, which results in a break in their continuity of care, which can undo their stabilization causing the cycle to start all over again.

California is making great efforts to shift away from institutional care towards care and support in an individuals' community. However, in order for individuals to remain in the least restrictive environments, within their communities, there needs to be available housing and support options. The RCFs are at the crux of this dilemma. Residential Care Facilities are an essential component needed to assist individuals in remaining as independent and unrestricted as possible with appropriate levels of services and supports, when living with severe mental illness. Further, as evidence that California is moving away from institutional care, include the implementation of Wrap-around services provided in Full Service Partnerships (FSPs); SB 82 grants for mobile crisis response (with 48 vehicles - nine in Los Angeles and 39 in eleven other counties); crisis residential facilities (836 beds – 560 in Los Angeles and 276 in 13 other counties); and crisis stabilization programs (217 beds – 54 in Los Angeles and 163 in 14 other counties) have been awarded since June 2013. However, there is a limited number of FSP spots and not every county was awarded grants, so the need continues. The focus of this paper is on the next level of care, after one is stabilized but unable to live independently, so where are they to go?

The California Mental Health Planning Council² (Council) is interested in shining a light on the decrease of available psychiatric out-patient treatment beds for individuals requiring care in a Residential Care Facility (RCF) and highlight a few programs currently providing innovative solutions. The Council is acutely aware of the need for expanded mental health treatment services including crisis response and crisis stabilization, however, an even greater need is for an increase in appropriate RCF to accommodate individuals released from acute psychiatric care. Historically, mental health treatment in California has undergone changes due to political and pharmaceutical incentives. According to PBS's Frontline Program, *Deinstitutionalization: A Psychiatric "Titanic"*³, "[de]institutionalization began in 1955 with the widespread introduction of chlorpromazine, commonly known as Thorazine, the first effective antipsychotic medication. The Mental Health System then received a major impetus 10 years later with the enactment of federal Medicaid and Medicare. Deinstitutionalization has two parts: the moving of individual with severe mental illness out of the state institutions, and the closing of part or all of those institutions. The former affects people who are already mentally ill. The latter affects those who become ill after the policy has gone into effect and for the indefinite future because those hospital beds have been permanently eliminated."

It is now 2016. How has California progressed in its ability to care for those who are severely mentally ill? There are numerous anecdotal stories across the state regarding the lack of *placements* for individuals needing psychiatric treatment and support post-

² [Website link to the California Mental Health Planning Council](#)

³ [Website link to Deinstitutionalization: A Psychiatric "Titanic"](#)

institutionalization. Why are these needed resources disappearing? According to the article, *Factors Associated with Increasing Nursing Home Closure* (Nicholas G. Castle, 2009), "...Policies that have likely influenced nursing home closures include Medicaid payment rates, Medicare Prospective Payment System, Home and Community-Based Services (HCBS) waivers, and report cards. [Note: 1915(c) waivers are one of the many options available to states to allow the provision of long term care services in home and community-based settings under the Medicaid program. (Medicaid.gov, 2016).] The types of facilities most likely to close include hospital-based facilities, those with high Medicaid census, low occupancy, and/or poor quality." (page 1107) "In 2005, there were 50,509 psychiatric beds available nationwide. By 2010, the number had shrunk to 43,318."

One argument for change to the residential care industry comes from the California Advocates for Nursing Home Reform special report, "[A New Model of Care is Necessary – One Size Does Not Fit All](#) (Reform, 2013)⁴." The special report cites the failure of the RCFE Act of 1985. The report indicated the Act was to "establish three levels of care within the RCFE regulatory structure to address the fluctuating health and care needs of older residents." However, the funding connected to the legislation "is subject to Budget Act appropriations and has never been implemented. Thus, for the past 28 years, CCL has maintained a "one size fits all" approach to residential care for elders, stretching the regulations to accommodate an ever-growing acuity level..." (page 4).

Along with the changes in acuity levels and lack of supply, the financial impact of caring for individuals with severe mental illness is becoming more of a challenge. Lynda Kaufmann stated, "There can be great gaps in funding sources between Supplemental Security Income (SSI), Medicaid (MediCal), Medicare, County General Funds (funds allocate by County BOS) MHSAs and private/personal funds. Psynergy Programs, Inc. uses a "braided funding" source to access many funding streams so no one agency is adversely impacted, if at all possible. There are many considerations when determining the income source to make housing and treatment appropriate, hospitality orientated, progressive, client centered, with a holistic approach. But it is not simple, nor is it easy.

County General Funds typically are used to pay for care in IMD's but can also be paid to RCF's in a form of payment called "Supplemental Rates" or "Patch" rates for RCF's that provide additional support and supervision. An example of an additional support and services may be a Bowel and Bladder plan, Colostomy bag care, Diabetic care monitoring with insulin dependency, 1:1 staff support during 15-18 hours a week and other restricted health care needs. Supplemental rates will always be a lower rate than Breakdown of SSI Monthly payment to board and care operator, demonstrated from 6beds.org (Wage and Hour Guide, 2016):

⁴ [Website link to Residential Care in California: Unsafe, Unregulated & Unaccountable](#)

MARCH 25, 2015 6BEDS, INC.

You do the math:

\$1,145 monthly govt. SSI/SSP paid to Care Home for each Resident
(\$733 Federal SSI + \$412 CA SSP)

From the \$1,145:

\$131 goes to Resident for personal & incidental needs

\$492 goes to Care Home for housing, meals, utilities, toiletries

\$522 goes to Care Home for 24x7 staff wages, taxes, insurance

\$522 monthly staff wage is equal to:

\$6,264 yearly wage (\$522/month x 12months) or

\$17.16 daily wage (\$6,264/year / 365 days/year) or

\$0.72 hourly wage (\$17.16/day / 24hours/day care & supervision)

Providing services, for an individual that has Serious Mental Illness (SMI), with the payment outlined above is near impossible." The *minimum* expenses that a board and care operator is responsible for are *food services*, *house furnishings (such as living room, bedroom, kitchen, linens, etc.)*, *cleaning and laundry supplies (or funds for a community laundrette)*, *hygiene items (such as shampoo, conditioner, soap, toothbrush/paste, razors, shaving cream, etc.)*, *office supplies*, *repairs (such as furnishings, building, equipment, etc.)*, *locksmith*, *employee wages*, *licensing fees*, *training*, *taxes (e.g. personal property, property, state and federal)*, *insurance (e.g. disability, health, liability, Workers' Compensation, dental, life, insurance bond, cyber can be optional)*, *utilities*, *program budget (e.g. outings, newspaper/magazines/books, transportation, art supplies, television, exercise equipment)*.

The aforementioned *minimum* responsibilities and anything above and beyond that would be considered an "extra." Let us build a generic budget for one month for a three-bedroom facility, serving six individuals with one employee.

Food (one cold and three hot meals per day for seven days a week) - \$600.00;

Cleaning and laundry supplies - \$400.00;

Hygiene - \$300.00;

Office supplies - \$200.00;

Repairs - \$500.00;

Employee wage - \$1120 (16 hour/day x \$10 = \$160 x 7 = \$1120);

Taxes - \$2000;

Insurance \$2000;

Utilities - \$1000;

Program budget - \$500

Grand total – \$8,620.00.

Thus, if a resident on Social Security has a maximum stipend of \$1145 per month for their board and care, what service and/or treatment will this individual have to sacrifice? The self-employed, sole proprietor has a budget of \$8,620 per month. Imagine in this scenario, providing support and supervision for a home with ten (10) severe mentally ill individuals. Of those individuals, three (3) are incontinent clients, one (1) is insulin

dependent diabetic client, and three (3) others are dually-diagnosed clients with substance use disorder. You are providing around the clock care management. The total income from Social Security benefits would total \$11,450. So when we subtract the generic budget of \$8620.00 from the \$11,450, we are left with \$2,830. In an environment with no medical or psychological crisis, this may be a viable budget. Remember, this generic budget has only ONE staff. There are ten individuals with varying degrees of illness, support and treatment need. With the aforementioned *minimal* expenses, many RCFs are struggling to maintain safe and appropriate facilities.

Commented [WD(1)]: This entire section is being REVAMPED!!!!!!

The above illustrates the reduction in residential care beds over the last decade and insight into the complex financial structure. The following news articles illustrate the plight of the Residential Care Facility. The Council found numerous newspaper and journal articles illustrating the disturbing trend in residential care facility closures:

[Hundreds of California Small Home Care Facilities Warn of Closures in 60 days article link](#)

This article delineates the human capital cost workers in the Residential Care Facility industry face.

[San Francisco homelessness Q&A: Frequently asked questions, answers article link](#)

This article answers some basic questions and debunks some myths often associated with homelessness.

[As nursing homes close, residents scramble to find alternatives article link](#)

This article discusses the trauma and anguish many families are facing when nursing homes close with few alternatives available. A prominent reason mentioned in the article makes a direct connection to the true cost of care and the Medicaid reimbursement rates.

[Nation's psychiatric bed count falls to record low article link](#)

This article discusses the decrease in psychiatric beds throughout the nation. It highlights “[a] three-year, \$75 million demonstration project begun as part of the Affordable Care Act, which suggests that certain policy changes can be part of the remedy, according to the study. The project allowed 10 states, plus the District of Columbia, to get Medicaid reimbursement for patients receiving mental health care in private psychiatric institutions.”

Although the current outlook for those living with mental illness may seem bleak, there are innovative ideas and programs in existence and on the horizon. Third Way Fresh Thinking published *Local Examples: Innovations in Recovery from Serious Mental Illness*⁵ on October 20, 2015. The author, Jacqueline Garry Lampert highlights several programs throughout the United States. Two programs from California were represented – MHA Village located in Los Angeles County and Telecare Corporation’s

⁵ [Website link to Local Examples: Innovations in Recovery from Serious Mental Illness](#)

operation of Steps Toward Recovery, Independent Dignity, Empowerment, and Success (STRIDES) in Alameda County.

“MHA Village is a program of Mental Health America of Los Angeles located in Long Beach. “The Village,” as its known, is not a residential program, but offers intensive twenty-four hours, seven days a week wraparound services including case management and rehabilitation services for individuals with severe mental illness, whom the Village calls ‘members’. The Village utilizes what it calls a “full service approach”⁶ – members are assigned to one of three “neighborhoods,” each of which has a director, assistant director, psychiatrist, financial planner, community integration specialist, and nine personal service coordinators. These personal service coordinators are not assigned a caseload, instead they serve all members in the neighborhood.” (Lampert, n.d.) The FSP was created around this service model.

The STRIDES Program is a “community treatment program focus[ing] on individuals with severe mental illness who, without the program, would require an institutional-level of care.” STRIDES⁷ has been in operation since 1994 and provides 120 members, some of whom have been with the program since 1994, with 24/7 access to a STRIDES team member. A four-year evaluation of STRIDES found these clients spent a total of 1,971 days in institutions, compared to 15,036 days spent in institutions by a comparison group. During the fourth year of the evaluation, STRIDES’ cost per client was \$11,035 compared to \$25,682 in the control group and, over the last four years, STRIDES has saved more than \$2.3 million.

The Substance Abuse and Mental Health Services Administration offers an Evidence-Based Practices Knowledge Information Transformation (KIT) titled, *Building Your Program: Permanent Supportive Housing*⁸ (Administration, 2010). The tool provides a general overview of “Understanding Permanent Supportive Housing,” provides tips for Mental Health Authorities and Agency Administrators and Program Leaders, provides potential funding sources, provides local and State housing plans and how to evaluate the housing market, along with the housing development phases. In 2007, the Mental Health Services Act (MHSA) Housing Program was implemented providing \$400 million for counties to establish permanent supportive housing units. As of April 2015, 1860 new housing units have opened for individuals who are homeless and have mental illness.

Another effective program, Psynergy Programs, Inc. incorporates a rigor of daily activities with educational and recreational choices. Psynergy’s housing alternative include comfortable, non-institutional shared rooms, small or large private rooms, and

⁶ [Web site link to MHA Village Full Service Approach](#)

⁷ [Website link to STRIDES](#)

⁸ [Website link to Permanent Supportive Housing: Building Your Program](#)

semi-independent private apartments. The clinical program encompasses on-site psychiatric and inter-disciplinary teams. Psynergy has locations in (Nueva Vista) Morgan Hill, (Cielo Vista) Greenfield, and Psynergy of Sacramento, California. Psynergy “continuously provides clients, and their families, a support team that assist in the process of recovery and community re-integration...Focusing on client care that is individually planned, and coordinated, our treatment team provides coping skills for the multiple symptoms and behaviors that client’s experience. We are committed to creating innovative options for individuals to move out of locked settings and into successful community living.” (Psynergy Programs, Inc., 2016)

The International Journal of Psychosocial Rehabilitation (Myra Piat, 2002) published a journal article titled, *Developing Housing for Persons With Severe Mental Illness: An Innovative Community Foster Home*⁹. The premise of the article was to report on a study that was conducted to “evaluate an innovative housing project that integrated a nursing assistant into a foster home for persons with a severe mental illness. The residents who were evaluated had tried to live in the community on numerous occasions, but their attempts had failed.” The study found that individuals that were unsuccessful in prior community housing attempts had increased success of remaining in the community while residing in the Community Foster Home, and therefore did not return to an institutional setting. “The overall time spent in the hospital by the residents one year pre- and post-evaluation differed greatly (in total 650 days before versus 124 days after placement). Supportive relationships were formed between the residents, nursing assistant and caregiver.”

A Place of My Own: How the ADA is Creating Integrated Housing Opportunities for People With Mental Illnesses is a report published by the Judge David L. Bazelon Center for Mental Health Law. This report discusses the effects of deinstitutionalization, key community integration principles and how the American with Disabilities Act and the *Olmstead* decision are making strides for a more robust supportive housing system in America. [Website link to A Place of My Own report](#)

When Opportunity Knocks...How the Affordable Care Act Can Help States Develop Supported Housing for People with Mental Illnesses is another report completed by the Bazelon Center for Mental Health Law. This report provides further rationale and examples of how the ADA can provide promising supports and financial assistance to individuals with mental illness. [Website link to When Opportunity Knocks report](#)

Workforce Implications of Models of Care for Older Adults with Mental Health and Substance Use Conditions (J. Eden, 2012) provides reviews of “nine models of care

⁹ [Website link to Developing Housing For Persons With Severe Mental Illness: An Innovative Community Foster Home](#)

delivery for older adults who have depression, substance use conditions, serious mental illness, or psychiatric and behavioral symptoms related to dementia.” The models for geriatric mental health and substance use disorder are as follows:

- Models for Managing Depression
 1. Improving Mood-Promoting Access to Collaborative Treatment (IMPACT)
 2. Kaiser Nurse Telehealth Model
 3. Program to Encourage Active and Rewarding Lives for Seniors (PEARLS)
- Models for Substance Use
 1. Screening, Brief Intervention, and Referral for Treatment (SBIRT)
 2. Primary Care Research in Substance Abuse and Mental Health for the Elderly (PRISM-E)
- Older Adults with Serious Mental Illness Models
 1. Helping Older People Experience Success (HOPES)
 2. Psychogeriatric Assessment and Treatment in City Housing (PATCH)
 3. Wellness Recovery Action Planning (WRAP)
- Psychiatric and Behavioral Symptoms Related to Dementia models
 1. Providing Resources Early to Vulnerable Elders Needing Treatment (PREVENT)
- MH/SU Care for Older Nursing Home Residents Models
 1. Consultation Model

The article goes on to provide the implications for the impact on workforce deficits and additional training needs to work effectively with the older public.

This paper is an effort to further shed light on the lack of Residential Care Facility options available for one of our most vulnerable populations – individuals living with severe mental illness. Some of the stark deficits were highlighted with the closures and economic shortfalls many facilities have faced within the last ten (10) years. There have also been some innovative programs that were highlighted that are doing exceptional work, in spite of the great challenges they face.

Improvements need to be made immediately. As a society, we cannot wait for another life to be lost, by wasting away in an institution. Local, state and federal initiatives, policies, regulatory and legislative changes can and should be demanded that would enable different types of residential care facilities to operate in a way that is fiscally viable. This would allow for the flow of individuals through each level of care and relieve the current bottleneck for individuals ready to step-down from locked or hospital settings. Additionally, is there means to assist struggling RCFs? Is there a way for RCFs to share best practices, in a cost efficient manner?

How can you as a consumer, stakeholder, professional, or concerned citizen, advocate for this change? Write to your local, county, state and federal representatives and demand:

- A. Data Collection: request systemic and coordinated efforts to obtain complete and concise information on what housing resources are available and why there are so many closures resulting in bottleneck situations.
- B. Continuity of Patient Care: demand that discharge treatment planning should begin while in treatment and continue beyond the 'warm hand-off' to the community.
- C. Accountability for RCF failures and closures: many closures of the RCFs that are failing the mentally ill, developmentally disabled and elderly continue in practices because of corporate giants; frequent name changes; are able to open shingles in multiple locations; fines do not deter the negative behaviors

In conclusion, individuals with severe mental illness are suffering from a medical condition. They are to be treated with respect and dignity, not as criminals or societal outcasts. Attention must be paid to provide housing and treatment options for these individuals. It is essential for this growing population to have access to appropriate residential care. The policies and regulations governing RCFs need to be revised to include more robust training for staff and owners to know how to work with this vulnerable population and how to maintain fiscal stability. No one deserves to be homeless or incarcerated due to a medical condition. By increasing the numbers of available Residential Care Facilities, many individuals living with severe mental illness will have long-term living options beyond locked institutions or facilities.

We hope to continue to shed light on this issue, with the intent on developing viable options to maintain RCFs. Lastly, we hope to work collaboratively with the appropriate stakeholders to introduce targeted policy changes to bolster the residential care industry in California.

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B **TAB SECTION**

DATE OF MEETING 11/09/2016

**MATERIAL
PREPARED BY:** Wiseman

**DATE MATERIAL
PREPARED** 10/25/2016

AGENDA ITEM:	Work Plan Goal 3
ENCLOSURES:	Draft AB 109 Paper

BACKGROUND/DESCRIPTION:

The Committee members are to vote on and accept the draft paper for finalizations and presentation to the Council at the January 2017 meeting.



- **Advocacy**
- **Evaluation**
- **Inclusion**

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AB 109

Implementation:

**A Follow-up look at how
four California Counties
continue to meet the
challenges of the 2011
Public Safety
Realignment Statute.**

By: Dorinda Wiseman, MSW and the Advocacy
Committee Members

The California Mental Health Planning Council (Council) is under federal and state mandate to advocate on behalf of adults with severe mental illness and children with severe emotional disturbance and their families. Our majority consumer and family member Council is also statutorily required to advise the Legislature on mental health issues, policies and priorities in California. The Council has long recognized disparity in mental health access, culturally-relevant treatment and the need to include physical health. The Council has advocated for mental health services that will address the issues of access and effective treatment with the attention and intensity they deserve if true recovery and overall wellness are to be attained and retained.

This report is a follow-up to determine what system changes, if any, that occurred in four counties in California, as a result of Assembly Bill 109 (AB 109) Public Safety Realignment (PSR) (Statutes of 2011).

The Council is committed to advocating for those living with mental illness and/or emotional disturbances and shining a light on positive changes to California's public mental health system. This report is an effort to revisit the four counties that were the subject of our prior AB 109 report, "Implementing AB 109: How Four California Counties Met the Challenge of the 2011 Public Safety Realignment in Their Communities." This report is one of the Council's many functions as a federal and state mandated entity.

Welfare and Institutions Code 5772(k) To assess periodically the effect of realignment of mental health services and any other important changes in the state's mental health system, and to report its findings to the Legislature, the State Department of Health Care Services, local programs, and local boards, as appropriate.

INTRODUCTION

According to the California Department of Corrections and Rehabilitation Fact Sheet distributed December 19, 2013, the 2011 Public Safety Realignment was “[t]he cornerstone of California’s solution to reduce prison overcrowding, costs, and recidivism.”¹ According to the Fact Sheet, the Realignment funding was “a dedicated and permanent revenue stream.”

In February 2013, the California Mental Health Planning Council (Council) published “Implementing AB 109: How Four California Counties met the Challenge of the 2011 Public Safety Realignment in Their Communities”. This report is being released to provide an update to what is happening now in the four counties.

The original report was the result of multiple face-to-face meetings that occurred in 2012 between the Council and representatives from the Sheriffs, Probation and Behavioral/Mental Health Departments in Los Angeles, San Mateo, Santa Clara, and Stanislaus Counties. The Council was interested in what the Public Safety Realignment (AB 109) implementation meant to the counties, what worked and what did not work.

The 2013 report illustrated the desire of the Counties to move progressively and positively toward increasing public safety, by decreasing crime rates and recidivism, as a result of AB 109. The Counties shared the frustration over the lack of consistent funding and the need for local discretion. In researching information for the 2013 report, we found the majority of AB 109 funding was spent on law enforcement and very little on needed support services for mental health and substance use. The 2013 Report noted the following,

“Counties that have minimal mental health services have no incentives to implement them, and, as the Legislative Analysts’ Office reported – the formula for funding to the counties essentially reward those that have the highest incarceration rates, not those that rely on preventative or rehabilitative measures. (Office, 2012)⁶ Counties are only required to report on outcomes, not methods, and that requirement is not attached to any consequence for noncompliance.”

The purpose of this report is to provide a follow-up four (4) years later to the AB 109 activities and practices discussed in the 2013 report and the Counties’ current perception on the status of the AB 109 implementation. It should be acknowledged that for the two reports, the methodology in obtaining information is different. The 2013 report utilized a standard set of questions and face-to-face discussions with the counties. This 2016 report focuses on research and reports obtained from the internet and one-on-one dialogues between Council Staff and representatives of the Sheriff, Probation and Behavioral Health/Mental Health Departments for Los Angeles, San Mateo, Santa Clara, and Stanislaus Counties. The hope is to a) obtain county

¹ California Department of Corrections and Rehabilitation Fact Sheet - [Link to website 2011 Public Safety Realignment](#)

perspective on the changes initiated by AB 109; b) learn about best-practices that have been shared beyond the four counties; c) obtain information on budgetary changes within the county-level systems; and d) any ongoing concerns for which the Planning Council may take up advocacy.

BACKGROUND: CALIFORNIA MENTAL HEALTH PLANNING COUNCIL & PUBLIC SAFETY REALIGNMENT (AB 109)²

California has had a statewide advisory board operating independently from the former State Department of Mental Health since the 1960s, providing public input into mental health policy development and planning for the public mental health system. Previously, as the California Council on Mental Health, the members helped develop and publish the 1st California Mental Health Master Plan in 1991. Key elements of system reform identified in the California Mental Health Master Plan were incorporated into the 1991 Realignment Legislation, including the need for county accountability and performance indicator language. In its present form -the California Mental Health Planning Council - was established in state statute in 1993, reflecting its increased responsibilities in monitoring the realigned mental health system, performance outcomes, and funding. The Council was designed to be an objective structure for public input, planning, and evaluation under realigned mental health programs. The Council published its initial findings – *Effects of Realignment on the Delivery of Mental Health Services* –in 1995. The Council also published the 2nd California Mental Health Master Plan in 2003 which informed many of the components of the Mental Health Services Act in 2004. The Council provides advocacy and review of the public mental health system and advises the Administration and Legislature on priority issues. Part of its mission is to educate the public and the mental health constituency about the current needs for public mental health services and ways to meet those needs.

AB 109: REALIGNMENT OF 2011

Unlike the 1991 Realignment which focused on community mental health systems, just one of the areas of focus of the 2011 Realignment is on Criminal Justice and Rehabilitative services. Both were facilitated by a weak economy. California has struggled for years with prison overcrowding, massive staffing and oversight issues, and lawsuits that have created even higher demands on an already precarious system. As the state limped through one of the worst recessions in the nation's history, the Budget Act of 2011 added to the existing 1991 Realignment funding formula an allocation for the AB 109 Realignment design. It also called for optimized rehabilitative services through leveraged resources, but created separate (protected) funding streams for each component. Per the California Department of Corrections and Rehabilitation (CDCR) Fact Sheet³,

² *The 2012-13 Budget: The 2011 Realignment of Adult Offenders—An Update* – Legislative Analyst's Office February 2012
A http://www.dhcs.ca.gov/services/MH/Documents/AB%20109%20Imp%20Feb%202013_FINAL.pdf

³ [California Department of Corrections and Rehabilitation fact sheet website link](#)

“AB 109 provides a dedicated and permanent revenue stream to the counties through Vehicle License Fees and a portion of the State sales tax outlined in trailer bills AB 118 and Senate Bill 89. The latter provides revenue to counties for local public safety programs and the former establishes the Local Revenue Fund 2011(Fund) for counties to receive the revenues and appropriate funding for 2011 Public Safety Realignment. This funding became constitutionally guaranteed by California voters under the passage of Proposition 30 in 2012.” (Page 1)

AB 109 PLANNING

Conservatively, the CDCR estimates that, of the prison population that has been evaluated, nearly 24% have been diagnosed with some form of mental illness. Nationally, six out of 10 inmates have substance use disorders, and it is likely that California’s inmates easily meet, if not exceed, that threshold.

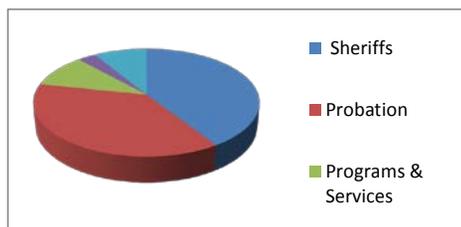
Council members felt that the funding formula of 11% for the intensive rehabilitative services would be insufficient to avoid recidivism in the counties - one of the key stated goals of the legislation. (A complete breakdown on how counties allocated the 2011 funds can be found in Appendix 3.) Due to its concern over the limited funding counties allocated to necessary rehabilitative and support services, the Council sent a letter to the Chief Probation Officer of each county encouraging the county to support, as fully as possible, and/or to expand the rehabilitative services that promote reintegration into their communities in order to meet the mandate (see Appendix 4).

The Legislative Analyst’s Office has reported that the counties appeared to be allocating funds in the following pattern:

- 38% to the sheriff’s department, primarily for jail operations
- 32% to the probation department, primarily for supervision and programs
- 11% for programs and services provided by other agencies, such as substance abuse and mental health treatment, housing assistance, and employment services
- 9% for other services, including district attorney and public defender costs

The Community Corrections Partnership (CCP) was part of Assembly Bill 117 (Chapter 39, Statutes of 2011) a companion bill to AB 109, was passed as part of the 2011-2012 budget. The statute required a “partnership between local public safety entities and the county to provide and expand the use of community-based supports for low-level offender populations. Each county’s Local CCP, as established in paragraph (2) of subdivision (b) of Section 1230, should play a critical role in developing programs and ensuring appropriate outcomes for low-level offenders.”⁴ The implementing language of AB 109 detailed the intent and types of services that the realigned dollars were to fund. However, while the mandating language stated that the funds “shall” be used for providing rehabilitative services, the language describing the *types* of services converted to the more discretionary “may include” the following:

***How CCPs allocated first-year AB 109 Funding:**



*Based on the 20 counties whose plans are on
[Web link to CalRealignment.org](http://CalRealignment.org) as of October 15, 2012

(3) Funds allocated to probation pursuant to this act shall be used to provide supervision and rehabilitative services for adult felony offenders subject to probation, and shall be spent on evidence-based community corrections practices and programs, as defined in subdivision (d) of Section 1229, which may include, but are not limited to, the following:

(D) Expanding the availability of evidence-based rehabilitation programs including, but not limited to, drug and alcohol treatment, mental health treatment, anger management, cognitive behavior programs, and job training and employment services.

California Penal Code: Section 1230 (3) (D)

The CCPs were created with the concept/framework of allowing local governments to develop correctional supervision programs, in order to allow for flexibility for each county’s individual need(s). Given the permissive phrasing of the California Penal Code Section 1230 (3)(D), the Council was very interested in knowing how the mental health and substance use disorders needs in these populations would be met, both in 2012 and in 2016.

2012: The AB 109 Forums

The Council held forums at their meetings in April and June of 2012. The first forum focused on Los Angeles County and a comprehensive overview of each department’s (Sheriff, Probation, and Mental Health Department) role and their implementation

⁴ Assembly Bill No. 117, Criminal Justice realignment, Chapter 39 (2011) [Web link to AB 117 text](#)

process. In an effort to get a broader cross section of county experiences, the Council invited three more counties to present at its June meeting -Santa Clara, San Mateo, and Stanislaus counties also provided representation from their Sheriff, Probation and Mental Health Departments. All participants were asked to respond to the following structured questions, followed by extemporaneous questions from Council members and the audience.

1. Please describe the successes/challenges of the collaboration process.
2. What is the perspective of what the Department envisions AB 109 to be like in five (5) years?
3. What/how have your County budgets shifted/adapted to the collaborative efforts?
4. What innovations/programs do you consider *successful*?
5. What surprised the Department about collaborating for this endeavor?
6. What would the Department like communicated to the legislature?

2016: The AB 109 Updates

For the update four years later, the original counties, Los Angeles, Santa Clara, San Mateo and Stanislaus, were requested to participate in conference calls and/or provide written responses to the same six questions. This process differed from the initial report in that there was no face-to-face contact with the Council.

This year, staff also obtained information provided by the Board of State and Community Correction (BSCC) regarding implementation of the 2011 Criminal Justice Realignment. The BSCC is legislatively mandated to provide an annual report to the Governor and Legislature regarding each county's CCP implementation plan. The BSCC has conducted surveys of the counties each year since 2012.

"Each county was asked to provide information about the implementation of its Fiscal Year (FY) 2014-2015 CCP Plan, progress in achieving outcome measures, programs and services, and funding priorities and plans for FY 2015-16 allocation of funds AB 93, Chapter 10, Statutes of 2015). All 58 counties responded to this survey providing varying detail on local goals, outcome measures, fiscal information, and local best practices.

Since Realignment, each county has taken a unique approach to developing its local public safety approach. Diverse approaches, include funding allocations, target populations, community stakeholders, and goals, are described throughout the report. The remainder of the report includes Individual County Profiles and an Appendix consisting of a Glossary of Terms and the FY 2015-16 CCP survey. ((BSCC), 2016)"

The BSCC published the [2011 Public Safety Realignment Act: Fourth Annual Report on the Implementation of Community Corrections Partnership Plans, July 2016 \(web link\)](#). The primary function of this report was to provide state leaders and the public with an understanding on how realignment allocations were utilized at the local level. This year's report covers "a range of topics, including CCP membership, Fiscal Year (FY)

2014-15 and FY 2015-16 Realignment allocations, and goals and objectives. For the first time, this year's survey included optional questions regarding the counties processes for determining program evaluation and local capacity to offer services." The BSCC report provides a "high-level overview" of implementation efforts at the local level. There are no conclusions explicitly made regarding pressing concerns or illumination of promising practices. The Council was able to glean concrete budget and service provision for each county represented in this report.

1. Please describe the challenges/successes of the collaboration.

The Counties were asked to provide insight on any barriers faced and successes achieved with implementation of AB 109. Many of the counties voiced challenges regarding employment, information gathering and sharing, service providers and quality of services and resources available to the AB 109 population. As in the 2012 report, the counties continue to see many of the individuals in this population having complex issues. The counties continue to state they work collaboratively with county and contracted support services to assist this population.

Employment - There is a lack of employment options for individuals with criminal histories. Los Angeles County Probation indicated, "We have an effort soon to try and remedy some of those barriers. We have a contract with Health Rite 360."

Data is not easily shared or accessible across county departments or within the state across jurisdictional lines. Los Angeles County Probation stated, "There is not a common data base about this population. The case management system does not exist at this time." Santa Clara County advised that a challenge from the beginning has been "data collection" and "the sharing of information" across agencies. Santa Clara County is looking "at San Diego's referral system" as a possible option. Santa Clara County also stated, the assessment tool Law Enforcement utilized was unfamiliar to those working in mental health. Thus, there was a learning curve for the Mental Health professionals to learn new jargon in order to make appropriate assessments, based on the Criminal Justice assessment tools.

Population – A CDCR Fact Sheet delineates the type of offender to participate in the AB 109 Realignment process. "AB 109 allows non-violent, non-serious, and non-sex offenders to serve their sentence in county jails instead of state prisons." The Counties resoundingly advised of the use of the *non-violent, non-serious* in many of their cases **only** pertained to the current offense for many offenders being released under the program. The Counties stated that many of those being released had significant criminal histories that would not be deemed as "non-violent" if the prior criminal offenses/convictions were used in the assessment.

Service Providers - The lack of service providers willing to deal with this population, including those completing their parole, is of great concern. The Counties acknowledged the limited number of services that are available to individuals while on parole. However, the Counties also advised of having success with many individuals and would like to see the successes go beyond parole. The continuity of care beyond the parole period is often in question as the number of providers in the community that willingly work with this population are not in abundance.

There were successes voiced during the discussions. The successes were varied, yet all counties indicated increases in communication and collaboration between county agencies. Additionally, there was the thread of commonality between the counties in their desire to provide *optimal* services that will result in successful outcomes for this population. Further, there is an ongoing need to provide consistent and accurate bi-directional information between Community-Based Organizations (CBOs), external county partners and the State Prisons. Communication was discussed as both an on-going barrier and a measure of success. The barriers continue when the counties discussed their inability to **directly** share information regarding an individual's complete health due to the Health Insurance Portability and Accountability Act (HIPAA). Some counties have developed Behavioral Health Teams within their criminal justice systems and have endeavored to work with their correctional counterparts within team-oriented settings. Many of these teams are co-located, both inside and outside of penal facilities.

Perception - The Los Angeles County Probation staff who were interviewed continually referred to "the individual" as opposed to 'parolee, felon or criminal' in their discussion of where their efforts have taken them. The significance of the use of such personalized language illustrates how the Department has made a commitment to view ex-offenders as members of the community, as opposed to 'criminals, parolees or felons.' Another tangible aspect of change and growth was evidenced by Santa Clara County's Probation and Sheriff's Department *requesting* the Mental Health Department to "support their clients." The shift in recognizing the value in bringing the mental health providers to serve this population was essential, as the inclusion of mental health did not occur prior to AB 109 implementation efforts.

Accountability - Another critical success mentioned, "There is a lot more accountability." This accountability is valued as a means to improve relationships, communication and perception both internally and externally in the counties in *how business is done*, not only with this population, but with all of its citizens.

Relationship - According to Javier Aguirre, Director of Re-Entry, Office of Re-Entry in Santa Clara County, the success can be measured in the "on-going relationships between departments" within the county. The total Santa Clara County budget is "leveraged with other funds, to include General Fund, Sales Tax, a two million grant from the state" and a supportive Board of Supervisors.

“Over the years, the percentage of Treatment Services funding has increased and the percentage to Sheriff and Probation has decreased.” Prior to AB 109 realignment implementation, the budget for law enforcement would have received the lion’s share of funding, in comparison to treatment services.

Duplication of Data collection – each county expressed issues of their efforts to collect data, issues with how duplicative much of their data collection efforts have become and/or the language translation needed with the various professions involved with data collection. One such example was the assessment tool. Dependent on which agency was the lead, the jargon of that profession was used. To address this, some counties chose to train the staff of the non-lead agency; other counties have attempted to work collaboratively on the assessment tool in order to meet evaluation and program needs.

2. What is the perspective of what the Department envisions AB 109 to be like in five (5) years?

The Los Angeles County participants stated they want “to continue with collaborative relationships.” There is also the desire to continue to see the mental health entities working with substance use and increasing “specialized programs for co-occurring treatment needs.” They would like to continue and to increase working with the Court and the Court Linkage Program; continued provider training for individuals and community providers working with this population; Jail In-Reach (Community Readiness Group) to increase the number of individuals participating prior to their release; continued “creative” innovative programs; and centralized access to care through Medicaid expansion, due to the Affordable Care Act (ACA).

According to San Mateo County’s Chief Probation Officer, Chief Keene, “Currently, there is a downward trend in the number of offenders released from state prison into their own communities, and it is anticipated that this trend will be sustained for a while. What we are looking at, as a Department, is the increase in those that commit crimes and reenter the criminal justice system, so even more transitional services such as housing and employment are needed. Also, with the continued rise in home prices in the bay area, more and more of our clients are becoming transient with no permanent place or keys to call home, which makes it difficult for the probation officers to supervise them. More attention should be focused on providing more affordable permanent, not just transitional, housing units to this population.” When this basic need is fulfilled, it provides a foundation upon which the rest of their successes can build.

Behavioral Health Director Tullys, of Santa Clara County, advised that AB 109 funding would remain an integral component to their behavioral health funding. She also indicated they hope to increase their Peer Support Workers “into our staffing mix. There will be a lot of strategic forward-looking thinking [funding], a lot of diversion programs” and engagement in the National STEP-UP Initiative. Director of Re-Entry, Aguirre advised their county was in the process of developing/conducting a five-year evaluation

of AB 109 efforts. It is anticipated that the results of the evaluation will inform planning for the next five years.

Los Angeles Chief Probation Officer Bingham advised that within five years, this will be the “new normal. This is embedded in the Criminal Justice model.” With every experience, connection and collaboration, the County, is “refining” how services are delivered. Additionally, he foresees a more “fine-tuned” approach. Chief Bingham advised that more legislation is moving us away from incarceration and toward, an increase in specialized service delivery and increased use of Evidence-Based practices.

3. What/how have your budgets shifted/adapted to the collaborative efforts?

Chief Keene, et al. advised, “In order to address client and collaboration needs, the Probation Department has increased the number of staff supporting the AB 109 unit by adding more Deputy Probation Officers, including a Senior Deputy Probation Officer as well as fiscal and data analyst staff. The Department has also implemented some evidence based programs such as journaling to assist clients in their successful reintegration into their communities.”

The Los Angeles County AB 109 efforts are reported on and provided to their Board of Supervisors on a continual basis. The Countywide Criminal Justice Coordination Committee submits their “Public Safety Realignment Implementation” report.⁵ The report summarizes the prior fiscal quarter and the activities of the Probation Department, Department of Public Health-Substance Abuse Prevention and Control (DPH-SAPC), Department of Mental Health (DMH), Department of Health Services (DHS) Sheriff’s Department-Parole Compliance Team (PCT), Sheriff’s Department-Custody Operations, District Attorney’s Office and Other Updates. The January 2016 Update included information on the Probation Department’s “Request for Services (RFS) solicitation to launch the AB 109 evaluation study.”

Santa Clara County advised their budgets were leveraged with other funds (e.g. General Fund, sales tax, \$2 million state grant, etc.) in their prior year AB 109 budgets. Director Tullys stated that there is new and other funding available “to create more treatment facilities.”

According to Michael Wilson, LMFT, Forensic Manager, Stanislaus County Behavioral Health and Recovery Services (BHRS), Stanislaus County began their AB 109 efforts “strong and we’ve continued to grow.” Mr. Wilson advised the mental health component has expanded by \$2 million per year. Stanislaus County seeks to continue improving their efforts and will utilize outcomes to determine best practices. The county has a crime analyst paid position and incorporates booking data from the Sheriff’s Department into their reports.

Commented [WD(1): “One correction would be that our budget is approximately 2 million per year, not growing by 2 million per year.” Mike Wilson
10/16/2016

⁵ [Countywide Criminal Justice Coordination Committee report January 2016 link](#)

4. What innovations/programs do you consider *successful*?

Ms. Marx of Los Angeles County advised there are Mental Health Teams that Probation has organized that “go out to Mental Health sites,” and there are four new Forensic Full-Service partnerships. Additionally, under SB 82, Los Angeles County has been awarded funding for four new Urgent Care and 35 Crisis Residential programs.

Per Chief Keene, et al., “In January 2015, the County re-opened the David Lewis Community Reentry Center in East Palo Alto. This Center serves as a hub for services focused on those coming from prison and back into their communities, in an area with the highest need in the County. Each service component offered in the Center is evidence-based or a best practice and shown to be important to changing lives and reducing recidivism.

Santa Clara County identified its Re-Entry Center and an “array of [outpatient] programs” that have been funded by AB 109 funding. Director Tullys advised there is a connection with faith-based organizations and there will be an expansion of services to faith-based centers within the next five years. Director Tullys lauded the partnerships, established by Behavioral Health, have made many of these collaborations possible. The county is leveraging AB 109 and Mental Health funding. Director Aguirre cited the success of entering into the jails and correctional facilities. This connection allows for access/contact with AB 109 participants, prior to release, further augmenting the potential for success.

In San Mateo County, multi-disciplinary team meetings coordinate these transitions. Emergency support and benefits enrollment will address immediate and pressing physical needs, such as food, shelter, clothing, etc. Employment services, health care, mental health and substance use treatment, housing, family reunification, cognitive therapies, and education will address the root causes and triggers of criminal behavior. Delivered and monitored in a unified system, they provide a strong foundation upon which county residents returning from incarceration can rebuild their lives. Staff from the San Mateo County Health System's Behavioral Health and Recovery Services Division are currently working with the California Department of Corrections and Rehabilitation to provide the same services mentioned to those on parole.

Stanislaus County is quite proud of their innovative programs. Mr. Wilson spoke of the working relationship with Probation that is quite positive and beneficial. He also mentioned the following as examples of success: Large Wrap-Around Program; Full Service Partnership; Housing First Model; and Monthly Restorative (Community) meetings.

5. What surprised the Department about collaborating for this endeavor?

Ms. Marx advised the Mental Health workers' interaction with Probation Officers have developed into “good working relationships with providers.” She also stated that this

effort has helped with bridging some of the community barriers of offering services 'outside-of-the-box.'

Chief Keene, et al. of San Mateo County indicated, "San Mateo County has always prided itself in its collaborative nature, even before the onset of AB 109. Departments within the county, as well as the community, have historically worked together to achieve solutions and bring resources to its neighborhoods. The onset of AB109 has only strengthened the collaborative nature of the County and we continue to learn from each other and share resources that will help our clients have the best results to become productive members of their own communities. We have gained more in-depth knowledge of other departments' programs, such as behavioral health and the human services agency and have implemented various Memorandums of Understanding to ensure that there is a continued delivery of services including counseling, health coverage and employment services."

Chief Bingham was asked if there was one thing to be done differently with AB 109, what would he suggest. He advised a "forewarning on the type of individuals and their illness" would have been helpful. He advised of a large population of individuals with respirators, who were medically fragile, or in wheelchairs, etc. that added additional complexities to the work to be done.

According to Director Aguirre, he was not surprised with the level of collaboration. "We have a strong Chief Operating Officer (COO)...brought everyone together." Due to the strong leadership, Director Aguirre believes there was "better understanding of who we were working with" when AB 109 efforts began. He did advise there was a learning curve from the Mental Health staff as they were not used to the same screening tool as their law enforcement colleagues. Due to the difference in jargon, there were some adaptations to be made with the screening tool.

Director Tullys further advised there are continuous improvements to be made. She advised that the "next big step" is dealing with the post-custody population and diversion programs. There are facilities that need to be "upgraded" to accommodate substance use residential and co-occurring residential programs. She advised their goal is to "keep people out of jail." The one issue that did surprise the county was the number, intensity and complexity of medical issues among the AB 109 population. This concern was voiced during the 2012 forums, as well as, by Los Angeles County four (4) years following the initial Council forum on the impact of AB 109 Realignment.

6. What would the Department like communicated to the Legislature?

Ms. Marx would like to see dedicated funding for beds. Due to the changes in the Criminal Justice System since 2010, there has been an increased demand on the resources that are impacted by non-AB 109 populations. For example, the Restore to Competency 1370/Conservatorship needs have dramatically increased; the IMD length of stay has increased as there are limited or no placements available for aftercare or

step-down services; the type and severity of issues has increased the complexity of needs for the population.

San Mateo County stated there needs to be “[m]ore technical and funding assistance for a larger data collection and analysis on this population. Since there is a need to provide a whole picture of how this population moves throughout our communities, there is a need to conduct a regional, if not statewide, study on how this population has done since their release from prison.”

Director Tullys of Santa Clara advised the “funding has changed lives and is meeting people’s behavioral health needs. Santa Clara County has an “extraordinary funding stream to do important work.” Director Aguirre advised the focus is on the “need for treatment.” There are barriers associated with treatment capacity, the housing market, permanent supportive housing, however the county is committed to providing integrated services for all of its citizens.

Stanislaus County advised there needs to be more “unified definitions for ‘recidivism’ and ‘homelessness status’”. If there were more “firm definitions and operational definitions,” there would possibly be less confusion. Mr. Wilson also mentioned if the State advised what it was looking for regarding outcome specifics that could appeal to broader research and national issues.

CONCLUSION

In the 2012 report, the Council wanted “to ensure that the Administration and counties do not lose sight of the primary goal of the Criminal Justice Realignment, which is to reduce recidivism, preferably by investing in rehabilitative services. (Murphy, 2012)” There was great concern that the efforts of the 2011 Realignment could further stigmatize individuals suffering with mental illness, as public misconceptions about mental illness and involvement with the criminal justice system has been exacerbated by numerous high-profile mass shootings⁶. The media continues to portray the perpetrators of such acts as violent criminals with mental illness, which thus caused them to act in heinous ways. As noted in a presentation by Amy Barnhorst, MD at the Forensic Mental Health Association of California Conference, 2016, people with mental illness are “more likely to be victims of crime than perpetrators” of a crime.

The Council’s 2012 report identified the following recommendations:

- Health Conditions: Physical, Mental, and Substance Use Disorder - The Administration needs to clarify permissible funding sources to counties so they can provide the services for this often aging and “high needs” population. The Council also cautions against an over-reliance on Medi-Cal and county Low Income Health Programs, whose

⁶ [Mass Shootings and the mental Health System - link](#)

needs assessments and service plans were based on numbers that preceded the Post-Release Supervision population.

- Training Needs for Community Partners - POST-Training should include educating street level police officers and first responders on available services for parolees. Additionally, school personnel should be trained on recognizing and referring for trauma services for children of incarcerated and post-release individuals.
- Related Supportive Services - Community Corrections Partnership panel should include a parolee who has successfully rehabilitated and a family member so that proposed services can be considered from informed perspectives.

Based upon the information gleaned and concerns expressed during the contact with the counties in 2016, there remains treatment and service continuity for individuals with complex health (physical, mental and/or substance use disorders) concerns. Additionally, there is an ever increasing population of geriatric individuals with complex needs associated with health and age. Due to the braiding of funding in many counties, there seems to be a reliance on federal and state grants/aid to fund various aspects of health treatment. Regarding the need for training community partners, there was specific attention given to first responders and school personnel. In speaking with the counties four years later, the community partners that are needing education are the service providers serving and treating this population. The experiences of incarcerated persons are vastly different from many other cultural groups. The 2012 report also included a recommendation for a parolee should be included on the Community Corrections Partnership panels. This paper did not focus on the Community Corrections Partnerships, however it appears the counties are working towards further integration of persons with lived experience to function in greater roles, in this endeavor to reduce recidivism, for those individuals with mental illness that also have criminal justice histories.

The overarching themes that emerged in this report, from the conversations with these four (4) counties, was a sense of hope, collaboration and a need for increased communication, data, as well as, sufficient financing.

Communication: many of the counties expressed the need for transparent and efficient communication between the State and counties, as well as, intra-county communications. Many individuals in this population are transient for varying reasons.

Data: many of the counties expressed a need to share important information regarding the client; however, HIPAA regulations have hindered many well-meaning efforts. Many county partners are finding ways to work through the barriers. There is also a desire to share information across county lines throughout the state, when necessary. Many clients move throughout the state and resources are inconsistent in availability and efficacy. Lastly, data needs to be collected with common data elements. There are many repetitive data collection efforts that increase the workload, and are obtaining redundant information. Can the data requests be streamlined?

Sufficient financing: there was a resounding request for sufficient funding for programs, to include transitional/supportive efforts, housing options, vocational, and educational services, etc. The overwhelming need for supportive services and treatment and housing cannot be met with the present funding levels, regardless of the source(s).

For a more concise snapshot of the counties highlighted in this white paper, please click on the link below to the [2011 Public Safety Realignment Act: Fourth Annual report on the Implementation of Community Corrections Partnership \(July 2016\)](#). The report contains information regarding County goals, objectives, budgets, programs and responses to survey questions. [Click for link to the BSCC 2011 Public Safety Realignment Act 2016 report](#)

Los Angeles County - pages 98-105 San Mateo County - pages 216-223
Santa Clara County - pages 230-240 Stanislaus County - pages 272-280

References

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Office, L. A. (2012, February). *The 2012-13 Budget: The 2011 Realignment of Adult Offenders - An Update*. Retrieved 2012

C TAB SECTION

DATE OF MEETING 11/09/2016

MATERIAL
PREPARED BY: Wiseman

DATE MATERIAL
PREPARED 10/25/2016

AGENDA ITEM:	Policy Platform
ENCLOSURES:	Draft Policy Platform

BACKGROUND/DESCRIPTION:

The Committee members are to vote on and accept the Policy Platform 2017 for finalizations and presentation to the Council at the January 2017 meeting.

CALIFORNIA MENTAL HEALTH PLANNING COUNCIL

POLICY PLATFORM

January ~~2016~~ Revised 2017

The California Mental Health Planning Council has federal and state mandates/duties to review State Plans, advocate for individuals with serious mental illness, children with severe emotional disturbance and other individuals with mental illnesses or emotional problems and to monitor the mental health services within the State.

The statements below are the Council's guiding principles.

1. Support proposals that embody the principles of the *Mental Health Master Plan*.
2. Support policies that reduce and eliminate stigma and discrimination.
3. Support proposals that address the human resources problem in the public mental health system with specific emphasis on increasing cultural diversity in efforts to reduce disparities and promoting the employment of consumers and family members.
4. Support proposals that augment mental health funding, consistent with the principles of least restrictive care and adequate access, and oppose any cuts.
5. Support legislation that safeguards mental health insurance parity and ensures quality mental health services in health care reform
6. Support expanding affordable housing and affordable supportive housing.
7. Actively advocate for the development of housing subsidies and resources so that housing is affordable to people living on Social Security Income (SSI).
8. Support expanding employment options for people with psychiatric disabilities, particularly processes that lead to certification and more professional status and establish stable career paths.
9. Support proposals to lower costs by eliminating duplicative, unnecessary, or ineffective regulatory or licensing mechanisms of programs or facilities.
10. Support initiatives that reduce and/or eliminate the use of seclusion and restraint.
11. Support adequate funding for evaluation of mental health services.
12. Support initiatives ~~that maintain or~~ can reduce disparities and improve access to mental health services, particularly to unserved, underserved populations, and maintain or improve quality of services.
13. Oppose bills related to "Not In My Back Yard-isms" "(NIMBYism") and restrictions on housing and siting facilities for providing mental health services.
14. Support initiatives that provide comprehensive health care and improved quality of life for people living with mental illness, and oppose any elimination of health benefits for low income beneficiaries, and advocate for reinstatement of benefits that have been eliminated.
15. Oppose legislation that adversely affects the principles and practices of the Mental Health Services Act.
16. Support policy that enhances the quality of the stakeholder process, improves the participation of consumers and family members, and fully represents the racial/cultural and age demography of the targeted population.

Commented [WD(1): Robert Blackford #1. When there are letters and Numbers AB 109 as an example- spelling out what it is would be very helpful (title versus number)
#2. I did not see anything where peers and peer services are listed as something to support etc.

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17. Support policies that require the increased use and coordination of data and evaluation processes at all levels of mental health services.

18. Support policies that promote appropriate services to be delivered in the least restrictive setting possible.

19. Support policies or legislation that promote the mission, training and resources for local behavioral health boards and commissions.

20. Support policies/initiatives that promote the integration of mental health, substance use disorders and physical health care services.

Commented [WD(2)]: Walter Shwe "17. Support policies that require the **increased use and** coordination of data and evaluation processes at all levels of mental health services."

The policies below are issues of interest to the Council.

1. Support proposals that advocate for blended funding for programs serving clients with co-occurring disorders that include mental illness.

2. Support proposals that advocate for providing more effective and culturally appropriate services in the criminal and juvenile justice systems for persons with serious mental illnesses and/or children, adolescents, and transition-aged youth with serious emotional disturbances, including clients with co-occurring disorders.

3. Support proposals that specify or ensure that the mental health services provided to Assembly Bill 109 (AB109) populations are paid for with AB 109 funding.

4. Support the modification or expansion of curricula for non-mental health professionals to acquire competency in understanding basic mental health issues and perspectives of direct consumers across the age spectrum and family members and those from cultural populations.

5. Promote the definition of outreach to mean "patient, persistent, understanding, respectful and non-threatening contact" when used in context of engaging hard to reach populations.

6. Support policies, legislation or statewide initiatives that ensure the integrity of processes at the local behavioral health boards and commissions.

7. Support the modification or expansion of curricula for Mental Health professionals to fully encompass the concepts of wellness, recovery, resiliency, cultural and linguistic competence, cultural humility, and perspectives of consumers, family members and members of cultural communities.