



REVISION

Posting Date: May 12, 2015

To: **CMHPC Advocacy Committee**

From: Andi Murphy, Staff

Subject: **Agenda for Advocacy Committee Meeting
Wednesday, May 13, 2015
11:00 a.m. to Noon**

Meeting location: 1501 Capitol Avenue, Suite 3001, Sacramento, CA 95814

Conference Call capability is provided: 1-877-951-3290

Participant Code: 8936702

AGENDA

Item	Time	Topic	Facilitator
1.	11:00	Introductions & Agenda Review	Adam Nelson, MD, Chair
2.	11:05	Approve Draft April minutes (Attached)	Kathleen Derby, Chair-Elect
3.	11:10	Revisit Issue Request from April Meeting (Attached)	Adam Nelson
4.	11:20	Other New Business	Kathleen Derby
5.	11:25	Discuss/Consider Work Plan modification	Adam Nelson
		<ul style="list-style-type: none">Option 1: <i>Explore AB 109 impact on IMD usage increase</i>	
		<ul style="list-style-type: none">Option 2: <i>The role of Board and Care homes as alternatives to IMDs</i>	
7.	11:50	Public Comment	Adam Nelson
8.	11:55	WWW/Next Steps	All
9.	Noon	Adjourn	

All agenda items are subject to action by the Planning Council. The scheduled times on the agenda are estimates and subject to change.

CHAIRPERSON
Cindy Claffin

EXECUTIVE OFFICER
Jane Adcock

➤ **Advocacy**

➤ **Evaluation**

➤ **Inclusion**

Members Present:		
Adam Nelson, MD, Chair	Kathleen Derby, Chair -Elect	
Carmen Lee	Steve Leoni	Barbara Mitchell
Maya Petties, PsyD	Darlene Prettyman	Daphne Shaw
Arden Tucker	Monica Wilson, PhD	
Staff Present:	Jane Adcock, E.O.	Andi Murphy, Staff
Presenter:	Mary Marx, LCSW	LA County DMH
Others Present:	Theresa Comstock	Napa County MHB

- Meeting Commenced at 8:40 a.m., members introduced themselves, and minutes were approved, (moved Shaw, 2nd Mitchell).

Item #	Issue	Discussion/Options	Action/Resolution	By Whom?	By When?
1.	New Business	CONREP in Ventura, NIMBYism, Pushback, economic and physical threats, people evicted; parents attacked. No place to provide services to mentally ill who have been released. The sites were in Residential neighborhoods and services were to be provided on-site.	Andi to send out synopsis to committee in order to discuss options at May meeting.	All	5/13/15
2.	Refresher: Legislative Process	What is the deadline for submitting proposing legislation? Are Gut and Amend bills sorted by author and available to use to propose legislation?	<ul style="list-style-type: none"> Andi to send out 2015 Leg Calendar and info on Gut and Amend. Create orientation packet specific to Advocacy committee and provide at each meeting. 	Andi	5/13/15 By June
3.	Review of Proposed Legislation	SB 614 Leno Peer Certification SB 11 (Beall) POST MH Training and	<ul style="list-style-type: none"> Support letter sent April 12 continue to monitor 		

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		SB29 (Beall) CEU	<ul style="list-style-type: none"> Support; request C/FM perspective be included in curriculum development and training. 		
	Review of Proposed Legislation (Con't)	<p>Ab 1193 (Eggman) Laura's Law AB 59 Waldon</p> <p>AB1194 – Allows past history to determine present danger when evaluating 5150. Intends to standardize across counties definition of "danger". Existing law, AB1424, requires prior history to be considered when deciding on 5150, but it still doesn't work because people aren't forwarding the information.</p> <p>AB 1300 – Ridley-Thomas, LPS and CHA – who can release from an ER hold, etc.</p>	<p>Oppose-Both Counties barriers have been removed already, there is no need to mandate it and based on loss of transparency and protective language of funds. AB 59 Removes protective funding.</p> <p>This law says "history must be considered" but AB1424 (2001) already does this, so oppose based on duplicativeness, and that it does not standardize the language.</p> <p>Lacks clarity on County Responsibility, CPA does not support this. WATCH</p>	Andi	Not stated
	Review of Proposed Legislation (Con't)	<p>AB 848 – Drug and Alcohol AB 858 – Same Day Billing AB 861 – Directs DHCS to apply for Matsui Mental Health grant program to increase Fed Medicaid match from 60 to 90% AB 1025 – Pilot project – Mental health for children in Elementary – multi-tier- 30 schools may be expensive.</p>	<p>Not really a platform issue – watch Support Same Day Billing Support AB 861 – (Check to see if it is for Rapid Rehousing?)</p> <p>Ask Monica N. about it.</p>	Andi	
	Info Only: Presentation,	Pursuant to previous discussion and	Consider investigating the correlation	All	Discuss

Item #	Issue	Discussion/Options	Action/Resolution	By Whom?	By When?
	LA County IMD Utilization Rates and Social Reinvestment	planning in respect to the committee work plan, the committee invited LA County to hear about their programs. (See Appendix for details).	between AB109 releases and increase of IMD usage - are the number the same?		at May meeting
5.	Discussion: Next Steps on Committee Work Plan	Our task may be beyond the scope of available committee members, and it may be able to use a consultant to gather the data; also DHCS may be able to assist Should the committee consider narrowing the focus further? Should the Committee focus on how many people in IMDs have had previous criminal justice backgrounds?	Discuss at May meeting	All	
6.	Public Comment	Dearth of Board and Care facilities for people on fixed incomes needing shelter and some level of assistance/care.	Send Board and Care report to commenter. Also send to committee members and discuss its inclusion in the overall work plan at the May meeting.	Andi All	May
7.	WWW/Plan For Next Meeting	May - send out Care Home report June: Invite County to talk about AB 109 and IMD beds.	(May) refine work plan, (June) Invite San Mateo.	All Andi	May

LACMHD COUNTY RESOURCES
Alternatives to IMDs
Mary Marx

PRESENTATION SYNOPSIS

LACDMH Continuum of Care

County Wide Resource management (created under MHSA) oversees 2300 beds a day in LA County. Services range from state hospitals to step-down programs and AB 109 clients. It serves as a single access point and gate to all level of care. They have staff of clinicians, psychiatrists, medical director, etc., who participate in a triage process for referrals to all levels of care as well as at the IMD side who consult and refer people back out when ready. 15,000 people annually transition through the service system.

Collaboration occurs between the LA county hospital and the urgent care center are co-located in order to coordinate efficiently. People can self-refer to Urgent Care too, and it does not automatically result in a 5150. They do not need to be Medi-Cal eligible. Another collaboration model is the Residential Bridges program, which includes 6 Peer "Bridgers" who work along with clinical staff to work with IMD step-down programs to identify lower levels of care that are appropriate for the individual.

Los Angeles has received 42 million dollars from SB 82 monies. The County Wide Resources management is responsible for implementing the SB 82 funded projects. Currently, 3 new urgent care centers, 35 crisis residential programs are in development.

Urgent Care centers are designed to offer Crisis Residential-type services; actual Crisis Residential centers are designed to have 30 day stays, Urgent care Centers 10 to 21 days, Crisis Stabilization 3 days. They are right down the street from the County Hospital. People can be dropped off by ambulance, or police, or self-refer. They may be referred from the Emergency room to Urgent Care and occasionally stay in the Crisis stabilization but not necessarily be 5150'd. The Urgent Care site sees about 60 people a day, 12 chairs(?) for adults, and an adolescent unit; about 10,000 people a year.

A recent project was implemented based on analysis of hospital campus and surrounding areas, developing a collaborative of 15 agencies, into a sort of one-stop, to provide multiple interventions on the individuals if desired, including SUD services. Similar to project 50, they demonstrated a cost savings of about \$4700 per person, based on reduction of ER use.

The LACDMH is presently applying for funding for a sort of Acute Diversion model, which diverts out of hospitals, provides longer term “urgent Care” of 10 to 21 days, (more than crisis stabilization, but less than standard Crisis residential or transitional housing).

A few hybrid residential care programs have been proposed for poly-morbid conditions (drug use, physical illness, mental illness) funded through the hospital fund, but has required a complicated licensing process to allow medical services to occur in the residential care homes.

IMD Usage and Alternatives

In 2008-09 LA’s IMD bed capacity was approximately 800, of which 45 to 50 beds a day were allocated to court diversion program. In 2010 beds were increased to 1254 and there is still a waiting list of 45 to 50. In 2015 IMDS bed capacity is averaging about 1024, with about a 150 people waiting in hospital beds. This may be partially attributed to the ACA and partially to AB 109 populations, who are screened upon release and referred to the appropriate level of services. Over the last few years, many Incompetent to Stand Trial (IST)s are diverted, through conservatorship, into IMDs with forensic capabilities. LACDMH has been trying to serve them at lower levels of care before resorting to IMDs, but it not always able to do that. For a time, LA County had a state hospital bed count as low as 190, from a high of 500. Now that AB109 has been enacted the number of beds has increased to 235.

Two different models of IMDS - MHRCs and SNF-STPs

LA County uses both MHRCs and SNF-STPs as IMDs. It had tried earlier to develop a program specifically for AB109 populations with high medical needs, and were not quite through the process when it was dropped. It has been resurrected now, due in part to ACA. It contracts with 8 IMDs, 2 in San Bernardino Riverside County, and 1 in San Diego county. The increase of AB 109 releases seems to anecdotally relate to increase of IMD beds, but there is no hard data at this point. LACDMH participates in the CBHDA Forensic committee activities, but nothing concrete has been developed yet in the area of AB 109 and IMD usage.

LA county population has increased by 3% between 2010 and 2014, and the IMD utilization has increased by 25%, - which is due to state hospitals as well as the prison systems. Stepdown Programs were developed – 240 beds initially with MHSA, and now there are about 650, and those step down programs provide very intensive mental health services and augmented supervision which helped reduce the use of IMD beds down to about 775.

For Advocacy Committee Consideration:

Submitted April 15, 2015

Ventura CONREP is a forensic conditional release program that is contacted through the Department of State Hospitals (DSH) to provide mental health services to clients deemed appropriate for outpatient treatment. Strict criteria for acceptance to the program must be met. Currently their efforts to service this population through treatment and supervision are being significantly impeded by social, financial, and physical means of intimidation. This is footage of an unprovoked assault on a consumer family member outside of the facility. <http://m.keyt.com/news/facility-used-to-treat-mentally-ill-opens-in-ventura/29788966>.

Social pressures from neighbors not to locate facility near them, financial from having business license revoked (i.e., it was an accident to issue an eviction notice).