

California Mental Health Planning Council

Advocacy Committee

January 15, 2015

Crowne Plaza Hotel
2270 Hotel Circle N
San Diego, CA 92108
(619) 297-1101

PACIFIC ROOM

8:30 a.m. to 12:00 p.m.

Time	Topic	Facilitator/Presenter	Tab
8:30 a.m.	Welcome and Introductions	Adam Nelson, Chair	
8:35 a.m.	Brief Orientation/Mentor Assignments	Adam Nelson	
8:45 a.m.	Agenda Review and/or Adjustments	Kathleen Derby, Chair-Elect	
8:50 a.m.	Council Requests/ New Business	Adam Nelson	
8:55 a.m.	2015 Work Plan Development	Adam Nelson	A
10:00 a.m.	Break		
10:15 a.m.	San Diego In-Home Outreach Team (IHOT) Presentation	Roselyna Rosado, LCSW; Program Administrator; In Home Outreach Team (IHOT) & Team	B
11:15 a.m.	Committee Discussion/Next Steps	Adam Nelson	
11:30 a.m.	Public Comment	Kathleen Derby	
11:45 a.m.	Develop Report-Out	Adam Nelson	
11:50 a.m.	WWW & Plan Future Meeting(s)	Kathleen Derby	
11:55 a.m.	Plus/Delta	Andi Murphy, Staff	
12:00 p.m.	Adjourn		

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

Committee Members:

Chair: Adam Nelson, MD

Chair-Elect: Kathleen Derby

Members:	Karen Bachand	Nadine Ford	Carmen Lee
	Steve Leoni	Barbara Mitchell	Maya Petties, PhD
	Darlene Prettyman	John Ryan	Daphne Shaw
Staff:	Andi Murphy	Arden Tucker	Monica Wilson, PhD

If reasonable accommodations are required, please contact Andi Murphy at (916) 323-4501 within 5 working days of the meeting date in order to work with the meeting venue.

California Mental Health Planning Council

Vision and Mission

Vision

The CMHPC envisions a mental health system that makes it possible for individuals to lead full and productive lives. The system incorporates public and private resources to offer community-based services that embrace recovery and wellness. The services are culturally competent, responsive, timely, and accessible to all of California's populations.

Mission

The CMHPC evaluates the mental health system for accessible and effective care. It advocates for an accountable system of seamless, responsive mental health services that are strength-based, consumer and family driven, recovery-oriented, culturally competent, and cost-effective. To achieve these ends, the Council educates the general public, the mental health constituency, and legislators.

CMHPC ADVOCACY COMMITTEE**Meeting Highlights****October 15, 2014**

Lake Natoma Inn

Folsom, CA 95630

1:30 – 5:00 p.m.**Present:**

Barbara Mitchell, Co Chair

Adam Nelson, Co-Chair

Kathleen Derby

Steve Leoni

Maya Petties

Daphne Shaw

Monica Wilson, Ph.D.

Staff: Andi Murphy**Presenters:** Sunshine Borelli,
Deputy Chief of Staff, Senator Jim
Beall's office (via phone)**Guests:** Karin Lettau, Lucinda
deRossi, Jaime Garcia, Jose
Oseguara, Adrienne Shilton**Welcome and Agenda Packet Review**

The meeting commenced on time with a brief mention by staff of the addition of updated meeting materials in packets that were distributed to committee members.

New Business

Adam Nelson was officially voted in as the chair for 2015 and Kathleen Derby was voted in as Chair-elect. Shaw moved, Leoni seconded.

Developing Legislative Proposals for Next Session

Sunshine Borelli, Deputy Chief of Staff for Senator Beall, phoned in to the meeting and provided advice on developing legislative proposals which included ways to prepare as well as what to watch out for. She made the following points in her overview:

This is a good time to develop proposals, create coalitions, and identify deal breakers. Prior to initiating a proposal, contact similar organizations to see what has and has not worked. Understand past legislative efforts and existing statutes. Identify potential funding sources. The big thing with legislation is understanding the land mines, because no legislator wants to back a lemon.

Investigate how the Governor's office feels about it, along with DHCS – understanding their feelings is key to effective marketing. Create a presence with coalition groups such as the Drug Medi-Cal task force – it builds support and avoids duplication of efforts. PARTICIPATE. Avoiding further fragmentation is a key component.

Understand the budget and legislative timeline. Legislators usually have their packet completed by January when bills are introduced. They are LOOKING for ideas right now. Develop relationships with legislators sympathetic to mental health and be sure to include members of the Health Committee, Budget subs for Health etc. It is best to meet with legislators during the off season and try to meet early. Don't pitch a bill until it is well researched. Make sure to include and work with committee staff too so that they fully understand the issue when they write their own analyses.

CMHPC ADVOCACY COMMITTEE**Meeting Highlights****October 15, 2014**

Lake Natoma Inn

Folsom, CA 95630

1:30 – 5:00 p.m.**Q & A**

- Q: What differences would come into play if you tried to include it into a trailer bill rather than regular legislation? What about the timelines?
- A: If you try to tack it onto a trailer bill you will really need to have the ear of Leadership. The Assembly develops their budget while the Senate develops their own. Ideally you would coordinate with them both; otherwise, find a key person to work with you on the Budget committee to include it as an item on the agenda. It would actually start right after the May revise, when the Budget committees start to develop their responses, and you would need to keep your item open so that it can become a budget item. Do not try to pressure the Governor's office to put it in the May Revise. The last two weeks of May and the first two weeks of July are the key times, but you need to be working with key players prior to that.
- Q: What if it is policy only?
- A: Start submitting toward the end of January when the session starts. Key dates are approximately between January 17 and January 24, the last day for policy to submit request to Leg Council.
- Q: What about a "spot bill"- and later a gut and amend? Or else it can be inserted into a similar bill as an amendment?
- A: It gets a little tricky there – there is a timeline when ALL bills have to go through Policy Committee. Spot bills have to be fully flushed out by then or they are basically dropped. The other important timeline is Appropriations Committee – dead lined at end of May.
- Q: What about Regulatory Changes?
- A: The Administration can do a regulatory change, but it is very difficult. Figures on why it is important, how many are impacted, what the expense is would be required. It can get very far in the process, but then be vetoed by the governor because the governor feels that departments should work it out without legislative mandate.

Discussion/Next Steps

- While not preferred, a single bill can contain several related issues, provided they are covered under the same Code section(s).
- It is possible to request that existing funding plans be diverted and reallocated but it typically creates conflict because of the other parties who are most likely counting on the funding, so it is not recommended.
- We should start with the lower level (i.e. Agency,) before we move forward with requesting Legislation.
- The Council approved the plan without all of the details but with the caveat that it be revisited in the future, so it cannot be modified now. OSHPD agreed to frontload the funding in order to avoid having it unspent in the five year cycle.

CMHPC ADVOCACY COMMITTEE

Meeting Highlights

October 15, 2014

Lake Natoma Inn

Folsom, CA 95630

1:30 – 5:00 p.m.

- The front –loaded funding went out as a regional RFA process and OSHPD appears to be redo-ing all of the work that has already been done. When challenged, OSHPD responds that it is not in statute.
- HHS and the Governor’s office should be consulted before we pursue legislation – it may just be a matter of interpretation of law and they may see it differently from OSHPD. If Agency is not willing to green light Peer Certification process, we should ask them to propose an alternative.
- Would it be worth it to MAKE it a regulatory issue? Should we promulgate regulation? The other thing that SB mentioned was bringing media attention to the issue. We are still facing a huge shortage of adequate mental health services.
- CMHPC should monitor how the funds are being expended. What if we push the issue and the funds are gone by the time it is approved?
- Should the committee send a formal letter to OSHPD stating the concern that the money is not being spent appropriately toward peer certification and ask them to provide the regulatory language they are following? It would be useful in sending it to agency to explain why we’d need their intercession. A letter should be sent to ALL of the entities involved so that everybody is on the same page. Nothing counts unless it is in writing.
- The letter should go to the Director of OSHPD.
- Although people are already billing under the rehab option, there are problems with job specifications and training are inconsistent, and peer support is very specific set of education and training. It must be recognized as a distinct and separate set of services.
- Educate the Legislators, prepare for the application process; and request deadlines for responses.
- Prepare the Legislative Proposal as a contingency plan. The information in the proposal will be useful when trying to inform HHS or the Governor’s office on the issue.

Advocacy Committee Work Plan

The committee reviewed the survey results, confirmed the non-quarterly meeting time is ok, and formalized Adam Nelson as the Chair starting in January, and Kathleen Derby as the Chair-elect for 2016. The following thoughts were put forth in regard to committee direction. There should not be limits to presentations during a meeting, but that depends most on what else is on the agenda.

- Advocacy committee does not need to confine itself to legislation.
- The mission /purpose is clear enough, but we could expand outside of legislation and do more advocacy related things.
- AB 109/AB 114 are still very much in the landscape – should we resurrect it for the work plan next year?
- The loss of the specialty population workgroups has affected the tenor of the work culture. For example, we no longer have an annual work product.
- Families have expressed that the people who are already in the system of care have been given short shrift relative to MHSA outreach PEI/Innovation etc.
- In State Hospitals, minimum requirements for therapy hours do not exist – it is up to the individual unit to make that determination.

CMHPC ADVOCACY COMMITTEE

Meeting Highlights

October 15, 2014

Lake Natoma Inn

Folsom, CA 95630

1:30 – 5:00 p.m.

- Staff safety at the Hospitals. In the last 24 months, one patient has taken out 17 staff. Medications for this individual were ineffective. The majority of the patients are from Corrections.

Suggested topics for a work plan for next year:

- Residential Care homes – Board and Care homes – how they are being utilized, how many are there, how many counties have none? Consumers were trying to get a bill passed requiring that Care homes expend a minimum number of funds for food etc.
- MIOCR has focused on post adjudication. How are the different counties dealing with this?
- Locked facilities that are the last stop. Santa Clara FSP 90. Do any other counties do that?
- Study of evaluations across the state. SAMHSA recommends that 10 or 15% be used for evaluation. Are counties spending this?
- Strategic Reinvestment – People exiting institutions need community services built up. MHSA was supposed to do that. Economy has stabilized –Look at what counties around the state are doing to help exit institutions.
- Figure out for future reports how to make them more usable, accessible. Let's make them more prominent.
- Mental Health courts and diversion; not post-sentencing.
- Cultural diversity in mental health services. Diversity at Patton has gotten worse. This must be true elsewhere.

Action Item: Write these up and schedule a meeting in November. Do a survey monkey with these options (ask for suggestions too) first and then discuss results in November meeting.

Legislative Platform Review

The Committee's charge is to review the legislative platform annually and suggest changes to the entire Council to vote on in January.

- Suggestion to move "Supporting Policy that enhances the quality of stakeholder process etc. involvement" be moved to mandatory planks from discretionary. (send email to inform of change)
- "Support initiatives that maintain or improve services, *particularly to underserved populations...*" (add)
- "Support adequate funding...." Move to mandatory?

PEI Revised Regulations Review

On September 30, OAC looked at public comments, and the commission voted to approve or modify the recommendations. There are two definitions in respect to mental illness- biological/developmental disability - that may raise a concern. There is already a separate funding stream for developmental disabilities and autism and this may result in a MHSA funding raised. This may also open a door for ill-trained providers being charged with the care of populations they are not prepared to care for. While this does not apply to the CSS funding, it will affect the pot of Prevention and Early Intervention dollars.

- There is a segment of the population that falls between the cracks if they are dually diagnosed with psychiatric and developmental disabilities or autism and they are refused services and shunted back and forth between providers.

CMHPC ADVOCACY COMMITTEE**Meeting Highlights****October 15, 2014**

Lake Natoma Inn

Folsom, CA 95630

1:30 – 5:00 p.m.

- The Advocacy Committee could recommend that the OAC amend the regulations provided that four committee members agree on the text of the modifications.

Plus/Delta

- Stick to the timetable and agenda.

Next steps: Staff to get meeting together for November to discuss Legislative Platform and work plan, and develop a January agenda.

Respectfully submitted,

Andi Murphy, Staff

**CMHPC
ADVOCACY COMMITTEE
CHARTER 2013**

Purpose: The purpose of the Advocacy Committee is to address public issues affecting the effectiveness of mental health programs and quality of life for persons living with mental illness. This includes increasing public mental health awareness through press and media, partnering with local consumer advocacy agencies for access and improved quality of care, and responding to proposed legislation, rule-making, and budget bills based on the CMHPC platform.

Mandate: WIC 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.
- (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.
- (j) To advise the Director of Health Care Services on the development of the state mental health plan and the system of priorities contained in that plan.
- (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.
- (l) To suggest rules, regulations, and standards for the administration of this division.

Guiding Principles: All advocacy efforts and proposed legislation shall be reviewed to ensure that the following best practices and principles are included.

Cultural Competence	Full Accessibility across the life span	Wellness & Recovery
Community Collaboration	Consumer & Family member driven or influenced	Integrated Services <i>End of description</i>

OBJECTIVES:

1. Review and respond to pending legislation, proposed code language, regulatory, and judicial actions that diminishes or adversely affects MHSAs programs and compromises the state mental health plan.
2. Inform a mental health system that incorporates public and private resources to offer community-based services that embrace recovery and wellness, and are strength-based, culturally competent, and cost-effective.
3. Develop talking points to use for education and commentary on mental health issues in the media.
4. Respond to and partner with Consumer agencies and family member organizations to support their activities when needed.

Roles and Responsibilities:

**CMHPC
ADVOCACY COMMITTEE
CHARTER 2013**

Regular attendance of committee members is expected in order for the Committee to function effectively. If a committee has difficulty achieving a quorum due to the continued absence of a committee member, the committee chairperson will discuss with the member the reasons for his or her absence. If the problem persists, the committee chair can request that the Executive Committee remove the member from the committee.

Members are expected to serve as advocates for the committee's charge, and as such, could include, but are not limited to:

- Attend meetings
- Speak - when authorized - at relevant conferences and summits when requested by the committee or the Planning Council
- Participate in the development products such as white papers, opinion papers, and other documents
- Distribute the committee's white papers and opinion papers to their represented communities and organizations
- Assist in identifying speakers for presentations

Materials will be distributed as far in advance as possible in order to allow time for review before the meetings. Members are expected to come prepared in order to ensure effective meeting outcomes.

Membership:

Name
<i>Adam Nelson, MD, Chair</i>
<i>Kathleen Derby, Chair-Elect</i>
<i>Karen Bachand</i>
<i>Nadine Ford</i>
<i>Carmen Lee</i>
<i>Steve Leoni</i>
<i>Barbara Mitchell</i>
<i>Maya Petties, PhD</i>
<i>Darlene Prettyman</i>
<i>John Ryan</i>
<i>Daphne Shaw</i>
<i>Arden Tucker</i>
<i>Monica Wilson, PhD</i>
<i>Staff: Andi Murphy (916) 324-0777 Andi.murphy@cmhpc.ca.gov</i>

**CMHPC
ADVOCACY COMMITTEE
CHARTER 2013**

General Principles of Collaboration:

The following general operating principles are proposed to guide the committee's deliberations:

- The committee's mission will be best achieved by relationships among the members characterized by mutual trust, responsiveness, flexibility, and open communication.
- It is the responsibility of all members to work toward the committee's common goals.
- To that end, members will:
 - Commit to expending the time, energy and organizational resources necessary to carry out the committee's mission
 - Be prepared to listen intently to the concerns of others and identify the interests represented
 - Ask questions and seek clarification to ensure they fully understand other's interests, concerns and comments
 - Regard disagreements as problems to be solved rather than battles to be won
 - Be prepared to "think outside the box" and develop creative solutions to address the many interests that will be raised throughout the Committee's deliberations

Decision Making:

The Committee will work to find common ground on issues and strive to seek consensus on all key issues. Every effort will be made to reach consensus, and opposing views will be explained. In situations where there are strongly divergent views, members may choose to present multiple recommendations on the same topic. If the Committee is unable to reach consensus on key issues, decisions will be made by majority vote. Minority views will be included in the meeting highlights.

Meeting Protocols:

The Committee's decisions and activities will be captured in a highlights document, briefly summarizing the discussion and outlining key outcomes during the meeting. Viewpoints will be recorded, but not be attributed to a specific member. The meeting highlights will be distributed to the Committee within one month following the meeting. Members will review and approve the previous meeting's highlights at the beginning of the following meeting.

Media Inquiries:

In the event the Committee is contacted by the press, the Chairperson will refer the request to the CMHPC's Executive Officer.

CA Mental Health Planning Council State Statutes

5514. There shall be a five-person Patients' Rights Committee formed through the California Mental Health Planning Council. This committee, supplemented by two ad hoc members appointed by the chairperson of the committee, shall advise the Director of Health Care Services and the Director of State Hospitals regarding department policies and practices that affect patients' rights. The committee shall also review the advocacy and patients' rights components of each county mental health plan or performance contract and advise the Director of Health Care Services and the Director of State Hospitals concerning the adequacy of each plan or performance contract in protecting patients' rights. The ad hoc members of the committee shall be persons with substantial experience in establishing and providing independent advocacy services to recipients of mental health services.

5771. (a) Pursuant to Public Law 102-321, there is the California Mental Health Planning Council. The purpose of the planning council shall be to fulfill those mental health planning requirements mandated by federal law.

(b) (1) The planning council shall have 40 members, to be comprised of members appointed from both the local and state levels in order to ensure a balance of state and local concerns relative to planning.

(2) As required by federal law, eight members of the planning council shall represent various state departments.

(3) Members of the planning council shall be appointed in a manner that will ensure that at least one-half are persons with mental disabilities, family members of persons with mental disabilities, and representatives of organizations advocating on behalf of persons with mental disabilities. Persons with mental disabilities and family members shall be represented in equal numbers.

(4) The Director of Health Care Services shall make appointments from among nominees from various mental health constituency organizations, which shall include representatives of consumer-related advocacy organizations, representatives of mental health professional and provider organizations, and representatives who are direct service providers from both the public and private sectors. The director shall also appoint one representative of the California Coalition on Mental Health.

(c) Members should be balanced according to demography, geography, gender, and ethnicity. Members should include representatives with interest in all target populations, including, but not limited to, children and youth, adults, and older adults.

(d) The planning council shall annually elect a chairperson and a chair-elect.

(e) The term of each member shall be three years, to be staggered so that approximately one-third of the appointments expire in each year.

(f) In the event of changes in the federal requirements regarding the structure and function of the planning council, or the discontinuation of federal funding, the State Department of Health Care Services shall, with input from state-level advocacy groups, consumers, family members

and providers, and other stakeholders, propose to the Legislature modifications in the structure of the planning council that the department deems appropriate.

5771.1. The members of the Mental Health Services Oversight and Accountability Commission established pursuant to Section 5845 are members of the California Mental Health Planning Council. They serve in an ex officio capacity when the council is performing its statutory duties pursuant to Section **5772**. Such membership shall not affect the composition requirements for the council specified in Section **5771**.

5771.3. The California Mental Health Planning Council may utilize staff of the State Department of Health Care Services, to the extent they are available, and the staff of any other public or private agencies that have an interest in the mental health of the public and that are able and willing to provide those services.

5771.5. (a) (1) The Chairperson of the California Mental Health Planning Council, with the concurrence of a majority of the members of the California Mental Health Planning Council, shall appoint an executive officer who shall have those powers delegated to him or her by the council in accordance with this chapter.

(2) The executive officer shall be exempt from civil service.

(b) Within the limit of funds allotted for these purposes, the California Mental Health Planning Council may appoint other staff it may require according to the rules and procedures of the civil service system.

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.

(c) To review program performance in delivering mental health services by annually reviewing performance outcome data as follows:

(1) To review and approve the performance outcome measures.

(2) To review the performance of mental health programs based on performance outcome data and other reports from the State Department of Health Care Services and other sources.

(3) To report findings and recommendations on programs' performance annually to the Legislature, the State Department of Health Care Services, and the local boards.

(4) To identify successful programs for recommendation and for consideration of replication in other areas. As data and technology are available, identify programs experiencing difficulties.

- (d) When appropriate, make a finding pursuant to Section 5655 that a county's performance is failing in a substantive manner. The State Department of Health Care Services shall investigate and review the finding, and report the action taken to the Legislature.
- (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.
- (f) To periodically review the state's data systems and paperwork requirements to ensure that they are reasonable and in compliance with state and federal law.
- (g) To make recommendations to the State Department of Health Care Services on the award of grants to county programs to reward and stimulate innovation in providing mental health services.
- (h) To conduct public hearings on the state mental health plan, the Substance Abuse and Mental Health Services Administration block grant, and other topics, as needed.
- (i) In conjunction with other statewide and local mental health organizations, assist in the coordination of training and information to local mental health boards as needed to ensure that they can effectively carry out their duties.
- (j) To advise the Director of Health Care Services on the development of the state mental health plan and the system of priorities contained in that plan.
- (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.
- (l) To suggest rules, regulations, and standards for the administration of this division.
- (m) When requested, to mediate disputes between counties and the state arising under this part.
- (n) To employ administrative, technical, and other personnel necessary for the performance of its powers and duties, subject to the approval of the Department of Finance.
- (o) To accept any federal fund granted, by act of Congress or by executive order, for purposes within the purview of the California Mental Health Planning Council, subject to the approval of the Department of Finance.
- (p) To accept any gift, donation, bequest, or grants of funds from private and public agencies for all or any of the purposes within the purview of the California Mental Health Planning Council, subject to the approval of the Department of Finance.

5820. (a) It is the intent of this part to establish a program with dedicated funding to remedy the shortage of qualified individuals to provide services to address severe mental illnesses.

(b) Each county mental health program shall submit to the Office of Statewide Health Planning and Development a needs assessment identifying its shortages in each professional and other occupational category in order to increase the supply of professional staff and other staff that county mental health programs anticipate they will require in order to provide the increase in services projected to serve additional individuals and families pursuant to Part 3 (commencing

with Section 5800), Part 3.2 (commencing with Section 5830), Part 3.6 (commencing with Section 5840), and Part 4 (commencing with Section 5850) of this division. For purposes of this part, employment in California's public mental health system includes employment in private organizations providing publicly funded mental health services.

(c) The Office of Statewide Health Planning and Development, in coordination with the California Mental Health Planning Council, shall identify the total statewide needs for each professional and other occupational category utilizing county needs assessment information and develop a five-year education and training development plan.

(d) Development of the first five-year plan shall commence upon enactment of the initiative. Subsequent plans shall be adopted every five years, with the next five-year plan due as of April 1, 2014.

(e) Each five-year plan shall be reviewed and approved by the California Mental Health Planning Council.

5821. (a) The California Mental Health Planning Council shall advise the Office of Statewide Health Planning and Development on education and training policy development and provide oversight for education and training plan development.

(b) The Office of Statewide Health Planning and Development shall work with the California Mental Health Planning Council and the State Department of Health Care Services so that council staff is increased appropriately to fulfill its duties required by Sections 5820 and 5821.

Federal Public Law (PL) 106-310- the MHPC should perform the following functions:	Council Activity	Deliverable
<ul style="list-style-type: none"> Review the State mental health plan required by PL 106-310 and submit to the State any recommendations for modification 	Annual review of CA SAMHSA BG application	Yes
<ul style="list-style-type: none"> Review the annual implementation report on the State mental health plan required by PL 106-310 and submit any comments to the State 	Annual review of CA Implementation Report	Yes
<ul style="list-style-type: none"> Advocate for adults with serious mental illness, children with a severe emotional disturbance, and other individuals with mental illnesses or emotional problems 	Legislative advocacy, Participation on HCR and other issue-specific committees,	No
<ul style="list-style-type: none"> Monitor, review, and evaluate annually the allocation and adequacy of mental health services within the State. 	Workbook Project w/ Local MH Boards	Yes
<p>California Welfare and Institutions Code (WIC) 5514- There shall be a 5-person Patients' Rights Committee formed through the CMHPC. This committee, supplemented by two ad hoc members appointed by the chairperson of the committee, shall advise the Director of Health Care Services and Director of State Hospitals regarding department policies and practices that affect patients' rights.</p>	None yet, new requirement in FY 2012-13 TBL	
<p>WIC 5771- Pursuant to PL 102-321 the Planning Council shall be responsible to fulfill those mental health planning requirements mandated by federal law.</p>		
<p>WIC 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:</p>		
<ol style="list-style-type: none"> To advocate for effective, quality mental health programs. 	Legislative testimony, Participation on HCR and other issue-specific committees	No
<ol style="list-style-type: none"> 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. 	SAMHSA BG Peer Reviews, Council Meeting to showcase model programs, Legislative testimony	No
<ol style="list-style-type: none"> To review program performance in delivering mental health services by annually reviewing performance outcome data as follows: 	Workbook Project w/ Local MH Boards, SAMHSA BG Peer Reviews,	Yes
<ul style="list-style-type: none"> To review and approve the performance outcome measures. 		

<ul style="list-style-type: none"> To review the performance of mental health programs based on performance outcome data and other reports from the State Department of Health Care Services and other sources. 		
<ul style="list-style-type: none"> To report findings and recommendations on programs' performance annually to the Legislature, the State Department of Health Care Services, and the local boards. 		
<ul style="list-style-type: none"> To identify successful programs for recommendation and for consideration of replication in other areas. As data and technology are available, identify programs experiencing difficulties. 		
4. When appropriate, make a finding pursuant to Section 5655 that a county's performance is failing in a substantive manner. The State Department of Health Care Services shall investigate and review the finding, and report the action taken to the Legislature.		
WIC 5772 - continued	Council Activity	Deliverable
5. 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.		
6. To make recommendations to the State Department of Health Care Services on the award of grants to county programs to reward and stimulate innovation in providing mental health services.		
7. To conduct public hearings on the state mental health plan, the Substance Abuse and Mental Health Services Administration block grant, and other topics, as needed.		
8. In conjunction with other statewide and local mental health organizations assist in the coordination of training and information to local mental health boards as needed to ensure that they can effectively carry out their duties.	Coordinate training needs with CiMH and CALMHBDC	No
9. To advise the Director of Health Care Services on the development of the state mental health plan and the system of priorities contained in that plan.		
10. 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.		
11. To suggest rules, regulations, and standards for the administration of this division.		
12. When requested, to mediate disputes between counties and the state arising under this part.		
13. To employ administrative, technical, and other personnel necessary for the performance of its powers and duties, subject to the approval of the Department of Finance.		

14. To accept any federal fund granted, by act of Congress or by executive order, for purposes within the purview of the California Mental Health Planning Council, subject to the approval of the Department of Finance.		
15. To accept any gift, donation, bequest, or grants of funds from private and public agencies for all or any of the purposes within the purview of the California Mental Health Planning Council, subject to the approval of the Department of Finance.		
WIC 5820 - Each OSHPD five-year WET plan shall be reviewed and approved by the Planning Council.	Participate in OSHPD WET Advisory Committee; Coordinate Council review of 5-Yr Plan	
WIC 5821 - The Planning Council shall advise the OSHPD on education and training policy development and provide oversight for the department's education and training development.	Participate in OSHPD WET Advisory Committee	

CALIFORNIA MENTAL HEALTH PLANNING COUNCIL

LEGISLATIVE PLATFORM

March 2014 (**DRAFT REVISION NOVEMBER 2014**)

Mandatory Planks

- Support any proposal that embodies the principles of the *Mental Health Master Plan*.
- Support policies that reduce and eliminate stigma and discrimination.
- Support any proposal that addresses the human resources problem in the public mental health system with specific emphasis on increasing cultural diversity and promoting the employment of consumers and family members.
- Support any proposal that augments mental health funding, consistent with the principles of least restrictive care and adequate access, and oppose any cuts.
- Support legislation that safeguards mental health insurance parity and ensures quality mental health services in health care reform
- Support expanding affordable housing and affordable supportive housing.
- Actively advocate for the development of housing subsidies and resources so that housing is affordable to people living on SSI.
- Support expanding employment options for people with psychiatric disabilities, particularly processes that lead to certification and more professional status and establish stable career paths.
- Support any proposal to lower costs by eliminating duplicative, unnecessary, or ineffective regulatory or licensing mechanisms of programs or facilities.
- Support any initiatives that reduce or eliminate the use of seclusion and restraint.
- Support adequate funding for evaluation of mental health services.
- Support initiatives that maintain or improve access to mental health services, particularly to underserved populations, and maintain or improve quality of mental health services.
- Oppose all bills related to “NIMBYism” and restrictions on housing and siting facilities for providing mental health services.
- 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.
- Oppose any legislation that adversely affects the principles and practices of the Mental Health Services Act.
- Support policy that enhances the quality of the stakeholder process, improves the participation of consumers and family members, and fully represents the racial/cultural demography of the targeted population.
- Support any policy that requires the coordination of data and evaluation processes at all levels of mental health services.

Discretionary Planks (Require Deliberation & Discussion)

- *Support any proposal that advocates for blended funding for programs serving clients with co-occurring disorders that include mental illness.*
- *Support any proposal that advocates for providing more services in the criminal and juvenile justice systems for persons with serious mental illnesses or children, adolescents, and transition-aged youth with serious emotional disturbances, including clients with co-occurring disorders.*
- *Support any proposal that specifies or ensures that the mental health services provided to AB109 populations are paid for with AB 109 funding.*
- *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 and family members.*
- *Promote the definition of outreach to mean “patient, persistent, and non-threatening contact” when used in context of engaging hard to reach populations.*

1. For items that are on the “automatic” approval planks of the platform and/or are **non-urgent** (more than seven days of response time):
 - Contact staff directly via email, with a cc to the Executive Officer, requesting action, and define the level of urgency of the request, informing staff of the deadline (and nature of the deadline i.e., which Legislative committee? How close to a final vote etc.) and suggested points that should be made in the letter.
 - *Staff performs analysis and presents the information, synopsis, and recommendation, and draft support/oppose letter to the Advocacy Committee for response and recommendation with the caveat that “approval is assumed if not contested within 7 days”.*
 - *If Advocacy Committee reviews the information and has comments, its recommendation /amendments/ approval is returned to staff with a cc to the Executive Officer and Executive Committee, including Leadership, **within 7 days**. The recommendation may be developed by a workgroup **within** the LRFC with expertise in the legislation’s subject area that is available and willing to do it within the time frame.*

2. If the item IS urgent (requires response in LESS than seven days):
 - *Request for action/analysis is addressed **to Executive Officer and staff, who will ensure that the information is forwarded to Leadership, Advocacy and Executive Committee***
 - *Staff performs analysis, and presents information, synopsis, and recommendation, with accompanying draft support/oppose letter, to **Leadership & Executive Committee, with a cc to Advocacy.***
 - *Leadership approves/amends recommendation and support/oppose letter, with input from Advocacy and Executive committees (if requested and time permits).*

3. Items that are NOT on the “automatic” approval planks should be vetted by **Leadership, by way of the Executive Officer or staff, who will also inform Executive Committee and Advocacy.** Request should include the same information as above – the action requested, the reason for its urgency, and the nearness of the vote. Staff may wish to perform preliminary analysis, but no document will be produced unless approved by Leadership. The final document will be distributed to the Advocacy and the Executive Committee.

Copies of Bills and/or existing Analyses may be requested from: Tracy Thompson

Tracy.Thompson@cmhpc.ca.gov (916) 552-8665 or Andi.Murphy@cmhpc.ca.gov (916) 324-0777

Requests for analyses or support/oppose letters should be directed to Jane.Adcock@cmhpc.ca.gov (916) 319-9343 for “non-automatic” items with a cc to Andi Murphy.

_____ INFORMATION

TAB SECTION A

X ACTION REQUIRED

DATE OF MEETING 1/15/2015

MATERIAL
PREPARED BY: Murphy

DATE MATERIAL
PREPARED 12/09/2015

AGENDA ITEM:	2015 Work Plan Development
ENCLOSURES:	Survey Results IMD Chart
OTHER MATERIAL RELATED TO ITEM:	CMHPC Draft Legislative Platform and Advocacy Committee Charter (at front of this packet).

ISSUE:

In October, Advocacy Committee members were asked to respond to a process survey in respect to the Advocacy committee functions and work structure. Part of the discussion entailed suggestions for a work plan topic for the upcoming year. Due to time constraints, a questionnaire was developed asking members to vote on the suggestions made at the quarterly meeting and requesting additional ideas, and the results were to be discussed at the November monthly meeting.

In November, based on suggestions that numbers 5 and 7 of the questionnaire be blended (see attached Survey results), participants decided those two items should serve as a base for the 2015 Work Plan. These included "Evaluation of county utilization rates of locked facilities and available options for alternatives" and "Evaluation of counties' Strategic Reinvestment Practices, i.e., what types of services are offered to help people achieve independence upon exiting institutions?" It was also suggested that the Joe Mortz Commendation could be awarded to organizations that work actively to divert from institutions by offering alternatives.

For the January meeting, committee members are being asked to articulate these two related topics into a cohesive objective for this committee to work toward. To that end, we need to ask:

- What populations are included and/or excluded in this review?
- What institutions are included and/or excluded in this review? (See IMD Chart)
- What are the indicators for assisting or assessing independence?
- How will the Utilization rates for data be obtained?
- What indicates successful diversion or rehabilitation?
- How will this work-plan relate to our Charter and Legislative Platform?

Results of Survey on Potential Work Plan for 2015	1st Choice –	2nd choice –	Total
1. Examination of statewide utilization rates of Residential/Board and Care homes by individual counties.	0.00% (0)	0.00% (0)	0
2. Evaluation of sufficiency of culturally diverse mental health workforce that is reflective of the populations it serves, particularly in institutions.	66.67% (2)	33.33% (1)	3
3. Examination and comparison of county budget commitment to mental health program evaluation and reporting.	0.00% (0)	0.00% (0)	0
4. Comparison of county utilization of Mental Health Courts and diversion programs to Post-adjudication services.	0.00% (0)	100.00% (1)	1
5. Evaluation of county utilization rates of locked facilities and available options for alternatives.	100.00% (3)	0.00% (0)	3
6. Examination of MIOCR grant deliverables – what types of services are counties proposing to provide and report on?	0.00% (0)	0.00% (0)	0
7. Evaluation of counties' Strategic Reinvestment practices – what types of services are offered to help people achieve independence upon exiting institutions?	0.00% (0)	100.00% (2)	2
8. Examination of county reporting requirements on Laura's Law – do the performance indicators reflect the MHSA principles of recovery, wellness, and social connectedness?	0.00% (0)	100.00% (1)	1
9a. Other: My suggestion/choice for a topic would be...(Please specify below)	0.00% (0)	0.00% (0)	0

Do you think any of the topics should be combined into one study or report?

- Answered: 5
- Skipped: 0

Answer Choices –	Responses –	Comments (3)
Yes	60.00% 3	5&7 My choices of 5 and 7 relate to one another 4 and 7
No	40.00% 2	No additional comments
Total	5	

Facilities and Programs Defined as Institutions for Mental Diseases (IMDs) 2014

Please note that this list is not exhaustive, nor does this list relieve county mental health departments of any responsibility to check federal definitions to ensure there are not additional IMDs within their jurisdiction.

Legend:

AP	Licensed by Dept. of Public Health
CRTS	Licensed by Dept. of Health Care Services
MHRC	Licensed by Dept. of Health Care Services
PHF	
STP	Skilled Nursing Facility (SNF) Licensed by Psychiatric Program Dept. of Public Health Certified by
DHCS	
*	

Facility	Address	Program	Licensed Beds	STP Beds
7th Avenue Center	1171 Seventh Avenue, Santa Cruz, CA 95062	MHRC	99	N/A
Alpine Treatment Center	2120 Alpine Boulevard, Alpine, CA 91901	MHRC	113	N/A
Alvarado Parkway Institute BHS	7050 Parkway Drive, La Mesa, CA 91942	AP	66	N/A
Atascadero State Hospital	PO Box 7001, Atascadero, CA 93423	AP	1275	N/A
Aurora Behavioral Healthcare Santa Rosa, LLC	1287 Fulton Road, Santa Rosa, CA 95401	AP	95	N/A
Aurora Charter Oak	1161 East Covina Boulevard, Covina, CA 91724	AP	134	N/A
Aurora Las Encinas Hospital, LLC	2900 East Del Mar Boulevard, Pasadena, CA 91107	AP	118	N/A
Aurora San Diego	11878 Avenue of Industry, San Diego, CA 92128	AP	80	N/A
Aurora Vista Del Mar Hospital	801 Seneca Street, Ventura, CA 93001	AP	87	N/A
BHC Alhambra Hospital	4619 Rosemead Boulevard, Rosemead, CA 91770	AP	97	N/A
BHC Fremont Hospital	39001 Sundale Drive, Fremont, CA 94538	AP	96	N/A
BHC Heritage Oaks Hospital	4250 Auburn Boulevard, Sacramento, CA 95841	AP	125	N/A
BHC Sierra Vista Hospital	8001 Bruceville Road, Sacramento, CA 95823	AP	120	N/A

Facility	Address	Program	Licensed Beds	STP Beds
California Psychiatric Transitions	9226 North Hinton Avenue, Delhi, CA 95315	MHRC	98	N/A
Canyon Manor Rehabilitation Center	655 Canyon Road, Novato, CA 94947	MHRC	89	N/A
Canyon Ridge Hospital	5353 G Street, Chino, CA 91710	AP	106	N/A
College Hospital	10802 College Place, Cerritos, CA 90701	AP	187	N/A
Community Care Center	2335 South Mountain Avenue, Duarte, CA 91010	SNF/STP	167	120
Cordilleras Mental Health Center	200 Edmonds Road, Redwood City, CA 94062	MHRC	68	N/A
Country Villa Merced Behavioral Health Center	1255 B Street, Merced, CA 95343	SNF/STP	96	96
Country Villa Riverside Healthcare Center	4580 Palm Avenue, Riverside, CA 92501	SNF/STP	120	120
Crestwood Behavioral Health Center	6700 Eucalyptus Drive, Suite A Bakersfield, CA 93306	MHRC	55	N/A
Crestwood Behavioral Health Center	1425 Fruitdale Avenue, San Jose, CA 95128	MHRC	98	N/A
Crestwood C.E.N.T.E.R.	295 Pine Breeze Drive, Angwin, CA 94508	MHRC	54	N/A
Crestwood Center - Sacramento	2600 Stockton Boulevard, Sacramento, CA 95817	MHRC	54	N/A
Crestwood Manor - Vallejo*	115 Oddstad Drive, Vallejo, CA 94589	STP	99	37
Crestwood Recovery and Rehabilitation		MHRC	60	N/A
Crestwood Wellness Recovery Center		SNF/STP	99	99
Crestwood San Diego MHRC		MHRC	42	N/A
Del Amo Hospital		AP	166	N/A
Department of State Hospital - Coalinga		AP	1500	N/A
Edgemoor Geriatric Hospital		AP	192	N/A

Facility		Program	Licensed Beds	STP Beds
Gateways Hospital and Mental Health Center		AP	55	N/A
Gladman		MHRC	40	N/A
Golden Living Center (San Jose Care and Guidance)		SNF/STP	110	110
John Muir Behavioral Health Center		AP	73	N/A
Kedren Community Mental Health Center***		AP	72	N/A
La Casa Mental Health Rehabilitation Center		MHRC	190	N/A
La Paz at Paramount		SNF/STP	173	136
Landmark Medical Center		SNF/STP	95	95
Langley Porter Psychiatric Institute		AP	67	N/A
Laurel Park		STP	43	43
Loma Linda University Behavioral Medicine Center		AP	89	N/A
Meadowbrook Manor		SNF/STP	77	77
Metropolitan State Hospital		AP	1254	N/A
Morton Bakar Center		SNF/STP	97	97
Napa State Hospital		AP	1362	N/A
Newport Bay Hospital***		AP	34	N/A
Ocean View Psychiatric Health Facility (Collaborative Neuroscience Network,		PHF	20	N/A
Olive Vista Behavioral Health		SNF/STP	120	120
Pacific Shores Hospital***		AP	30	N/A
Patton State Hospital		AP	1287	N/A
Penn Mar Therapeutic Center DBA San Gabriel Valley Penn Mar		SNF/STP	45	45

Facility		Program	Licensed Beds	STP Beds
Resnick Neuropsychiatric Hospital at UCLA		AP	74	N/A
Royale Health Care Center, Inc.		MHRC	80	N/A
Sacramento County Mental Health Treatment Center		PHF	50	N/A
San Diego County Psychiatric Hospital		AP	109	N/A
San Francisco Mental Health Facility		MHRC	47	N/A
Shandin Hills Behavior Therapy Center		SNF/STP	65	65
Sharp Mesa Vista Hospital		AP	149	N/A
Sierra Vista Hospital		SNF/STP	116	116
St. Joseph's Behavioral Health Center		AP	35	N/A
St.Helena Hospital Center For Behavioral Health		AP	61	N/A
Sutter Center For Psychiatry***		AP	73	N/A
Sylmar Health and Rehabilitation Center		SNF/STP	208	208
Tarzana Treatment Center		AP	60	N/A
The Pathway Home		CRTS	34	N/A
View Heights Convalescent Hospital		SNF/STP	163	99
Villa Fairmont Mental Health Center		MHRC	99	N/A
Vista Behavioral Hospital		AP	68	N/A
Vista Pacifica Center		SNF/STP	108	108
TOTALS		Total Beds	12787	1791

X INFORMATION

TAB SECTION B

ACTION REQUIRED

DATE OF MEETING 1/15/2015

MATERIAL
PREPARED BY: MurphyDATE MATERIAL
PREPARED 12/12/14

AGENDA ITEM:	In-Home Outreach Team (IHOT) Presentation
ENCLOSURES:	<i>IHOT Overview</i> , Telecare Corp.
OTHER MATERIAL RELATED TO ITEM:	<i>Review of Services for Individuals with Serious Mental Illness Who Are Resistant to Treatment</i> ; San Diego County, HHS; July 30, 2013

ISSUE:

The In-Home Outreach Team (IHOT) program has been of strong interest to the Council as a positive example of outreach and engagement. IHOT has proven effective at promoting and facilitating voluntary access to services and is a legitimate alternative to Assisted Outpatient Treatment, which has been steadily gaining ground in California counties and nationally.

Three individual IHOT teams serve the Central, East, South county regions of San Diego. They work with individuals living with severe mental illness and who may also be dually diagnosed with a substance use disorder or drug dependency. Quite often, the contact is initiated by family members, and they are included in the outreach from the outset. However, and contacts with the individual are protected by confidentiality and information is not shared unless specifically authorized. IHOT teams consist of a Peer Specialist, family member, personal service coordinator and team lead. The program was approved as a three-year pilot project beginning in January 2012.

In the 2013, the San Diego HHS report (attached) stated that:

“The current annual cost of IHOT services and evaluation in x regions is \$1.4 million. During the first 12 months of implementation, 402 individuals were screened for eligibility and 174 people were accepted for outreach services. The average cost per individual receiving outreach services is \$8,100.”

These costs are much lower than the annual cost per individual in a Full Service Partnership (\$20,000 including housing) and Assisted Outpatient Treatment (\$34,000). Staff ratios are similarly proportionate: IHOT = 1:25 staff to client ratio; FSP and AOT each have a 1:10 staff to client ratio,

The three-year pilot project also includes robust outcomes measurement and evaluation system provided through a contract by the University of San Diego.



Telecare In-Home Outreach Team (IHOT) is a centralized program offering three mobile teams to provide in-home outreach to adults with serious mental illness (SMI) who are reluctant or resistant to receiving mental health services. IHOT also provides support and education to family members and/or caretakers of IHOT participants. Three individual teams serve the Central, East, and South County regions of San Diego, California. Eligible individuals may have a co-occurring substance abuse diagnosis, in addition to a diagnosis of a serious mental illness.

Team staff includes a peer specialist, family coach, personal service coordinator (case manager), and team lead. Peer specialists and family coaches offer personal-lived experience to their work with participants, family members and/or caretakers.

Address:

1660 Hotel Circle North, Suite 314
San Diego, CA 92108

Contact Information:

Roselyna Rosado, LCSW
619-961-2120
619-961-2168 (fax)

Hours:

Monday-Friday: 8am – 5pm

Crisis Services:

IHOT offers on-call crisis management support after hours and during weekends. Enrolled participants and their family members can call 619-961-2120 and be connected to an IHOT team member.

Just the Basics

Members: Teams serve a combined 240-300 consumers per year (80-100 per team)

Population Served: Adults with SMI and resistant to mental health treatment, family members, and caretakers

Funded by: San Diego County Behavioral Health Services, Mental Health Services Act (MHSA), and Innovation Funds

Services

Services include, but are not limited to:

- behavioral health screening
- outreach and engagement
- crisis management
- transitional case management
- support and educational services
- linkage to community resources, such as medical and mental healthcare, National Alliance on Mental Health (NAMI), food banks, clubhouses, etc.



Referral Process

Participants may be referred by family members, PERT clinicians, hospital social workers, jail/corrections personnel, NAMI, APS and other community support providers, as is appropriate.

Admission Criteria

- Adults ages 18 years or older
- Reside in North Coastal, Central, or East Regions of the San Diego County Health and Human Services Agency
- Be identified as having a serious mental health problem (may include a diagnosis of serious mental illness) and declines mental health services and/or be an identified person with mental illness who has had sporadic contact with mental health treatment, but is not currently engaged in on-going treatment or who has discontinued recommended treatment services
- Be an identified person with serious mental health symptoms that contribute to serious functional impairment in activities of daily living, social relations, and/or ability to sustain housing or be an identified person that has had one or more previous episodes consisting of any of the following events in the past year:
 - psychiatric hospitalization
 - emergency room visit
 - police/PERT involvement
 - incarceration
- Identified person may also have a history of co-occurring substance use/substance abuse and mental illness (not a disqualifier). Also, if primary residence is in an eligible region, the location of incarcerations, hospitalizations, or ED/EPU contacts are not disqualifiers.

Contacting A Family Member

Family members are typically the ones contacting IHOT to make a referral to our program for their loved one(s) struggling with mental illness who may be living in or outside of their home and who are resistant to receiving mental health treatment. Thus, contact with family is usually established right at the outset. If a referral is made through a community provider, we usually request that the community provider (who may already be working with the family) give family our contact information to call IHOT or ask if IHOT may contact them directly. If we begin to work with the identified individual with mental illness, we guarantee that individual confidentiality of meeting content, etc., even if they have been referred to us by their family. IHOT does require written authorization to share information about individual participants, even if they were referred by a family member.

What Makes Us Different?

Our program is unique in that our target population is those with serious mental illness who are resistant to receiving mental health services. IHOT is the only mobile outreach program in San Diego performing this type of service at this time. Included in our service delivery is a strong support and education component to the identified participant's family member(s) if desired by the family. We are also unique in that we are not a billable service and use a very person-centered, non-coercive, non-agenda setting approach to engage with our participants. We meet participants where they are and work collaboratively with them to achieve their goals; often doing whatever it takes to help engage and connect with them to assist them in meeting their stated needs and desires.



What Others Say

Below is an excerpt from a letter written by a family member of an IHOT participant:

May 17, 2012

To Whom It May Concern:

I want to thank the establishment of Telecare for helping my family through a very hard situation. I am very thankful this program was available to help my son and our family deal with his schizophrenia and heroin drug addiction.

My son was in denial of his mental condition and with the help of Stacey from Telecare, he began to accept his condition and started taking medication regularly. Stacey also played a huge role in helping my son to get help for his addiction. I feel because of Stacey's support my son started accepting himself more, which helped him move forward in getting the help he needed.

Debbie from Telecare was instrumental in helping me start taking care of myself and setting boundaries.

Words can't express my gratitude for this program and the incredible staff team members who made such a huge difference in our lives.

Thank you, Debbie and Stacey, for helping my family regain structure and balance! This was truly a blessing and a gift from God.

Sincerely,

Kristine



Why This Program Was Started

IHOT began as an alternative to Laura's Law (also known as Assisted Outpatient Treatment/AOT), which is a process that allows courts to compel individuals with severe mental illness and a history of arrest or violence to stay in treatment as a condition for living in the community. San Diego County has opted not to implement Laura's Law and utilize a voluntary approach that will be evaluated for its effectiveness, but to instead implement the IHOT program model to help connect individuals with severe mental illness who are resistant to treatment with the support and resources they need. This is done by physically reaching out and meeting the needs of people in their own environment.

Desired outcomes include reducing psychiatric hospitalizations and incarcerations, helping families feel more educated and connected to resources related to mental illness, and reducing the need for forced outpatient or inpatient commitments. Forced treatment, although sometimes necessary, can lead to unpredictable results including arrests, trauma, violence, and even death. At IHOT we believe that change that comes from within through self-motivation has lasting results. Overall the hope is to reach out to underserved populations that are difficult to engage, support or treat via traditional interventions (i.e., walk-in clinics) and to help increase their access to community supports and help them become more productive members of the community.

Outcomes

The IHOT program was designed by the San Diego County Behavioral Health Services to address an increasing number of serious incidents committed by untreated and underserved mentally ill individuals.

Being an innovative program, IHOT has an evaluation component being implemented by UCSD (University of California, San Diego) to help determine its effectiveness in serving the stated population. Outcome data will be available in the coming year (2013-2014), as information is collected on an on-going basis in a number of client life domains.

Though IHOT is a unique pilot program, still very new, it has been implemented with a good deal of success.



**COUNTY OF SAN DIEGO
HEALTH AND HUMAN SERVICES AGENCY**

***REVIEW OF SERVICES FOR
INDIVIDUALS WITH SERIOUS
MENTAL ILLNESS WHO ARE
RESISTANT TO TREATMENT***

July 30, 2013



**LIVE WELL
SAN DIEGO**

Report to San Diego County Board of Supervisors

Table of Contents

Executive Summary	3
Introduction	4
Differences and Similarities Between In-Home Outreach Team (IHOT) and Laura’s Law	5
<ul style="list-style-type: none"> ➤ Services ➤ Staffing ➤ Projected Costs 	
Analysis of Proposed Laura’s Law Legislation	10
<ul style="list-style-type: none"> ➤ Active Legislation ➤ Inactive Legislation 	
Efforts to Close Identified Gaps between IHOT and Laura’s Law	11
Quarterly Updates	12
Attachment A – Assisted Outpatient Treatment Flow Chart	13

Executive Summary

The County of San Diego is committed to enhancing services and seeks to ensure that it has a robust tool kit to meet the needs of residents. A comprehensive continuum of care for mentally ill individuals must include effective tools to assist in serving those that are severely mentally ill and resistant to treatment. On March 19, 2013 (5), the San Diego County Board of Supervisors directed that an analysis be conducted on the differences and similarities between the County of San Diego's In-Home Outreach Team (IHOT) program and Laura's Law; along with a review and analysis of related legislation; and recommended next steps for closing service gaps.

As a result of the Board's direction, the Health and Human Service Agency (HHS) convened a multi-disciplinary team comprised of representatives across the County enterprise, including the HHS, Office of Strategy and Intergovernmental Affairs, and the Public Safety Group (PSG), with participation from the Sheriff's Department, the Office of the District Attorney and the Public Defender and Probation Departments. Additionally, representatives from the Superior Court, the San Diego Police Department, and Patients Rights Advocacy services collaborated on the analysis and review of program and legislation, which is contained in this report.

This report is the culmination of the analysis and review conducted. In addition to the analysis of IHOT and Laura's Law, this report contains a detailed review of; available services, such as Full Service Partnership (FSP) programs; staffing and costs; and a complete review of current legislation impacting Laura's Law.

Based on the analysis contained within this report, it is recommended that the existing mental health system be expanded to serve additional individuals who are mentally ill and have been resistant to treatment. The overall enhancement could include:

- Expansion of the IHOT program countywide;
- Increased capacity of Full Service Partnership Programs; and
- Increased utilization of the Conservatorship Office.

Additionally, building on this preliminary expansion, a move towards the implementation of Laura's Law will take place upon further review of data, and contingent upon availability of funding and attainment of legislative remedies.

Introduction

The Health and Human Services Agency (HHS) provides many services to help county residents lead healthy, safe, and thriving lives. This includes protective services, preventive health care, publicly funded health care coverage, self-sufficiency services, and mental health and substance abuse programs. The Behavioral Health Services (BHS) division within HHS provides a range of mental health, alcohol and other drug programs, promoting recovery and well-being through prevention, treatment and interventions.

Through the Behavioral Health Services Division and the Conservatorship Office, an array of services is available to adults, including those with severe mental health needs. Services available include acute care psychiatric hospitals, crisis residential treatment programs, intensive case management programs, outreach and engagement services and conservatorship.

In 2002 the California Legislature passed AB 1421, also known as Laura's Law. Laura's Law was created as an additional tool to serve the mentally ill through court-ordered treatment. These individuals must have a history of refusing to accept treatment and have recent psychiatric hospitalizations, incarcerations, or threats or attempts of serious violence towards self or others. Unfortunately, the present law falls short in meeting its intent in effectively serving treatment resistant individuals. The law does not include any form of involuntary or locked treatment, it does not specify any intervention by law enforcement, beyond what is currently available in Welfare and Institutions Code 5150, which governs the detention of Mentally Disordered Persons for evaluation and treatment, and does not permit the use of existing funding sources.

To strengthen the effectiveness of Laura's Law, and become a viable tool, changes are necessary to the enforcement process of the judicial order. Additionally, changes to current law are needed to allow the use of funding sources, such as the Mental Health Services Act (MHSA), that are not currently an option.

Given the limitations on the current law, on September 27, 2011 (7) the Board of Supervisors approved the implementation of a pilot program, In-Home Outreach Team (IHOT), as an alternative to Laura's Law. IHOT, a three-year pilot program, was implemented on January 1, 2012, in three of the six HHS geographical service regions - North Coastal, Central and East. Using mobile teams, the goal of IHOT is to support and educate treatment-resistant individuals and their families to engage in appropriate services available in the community.

On March 19, 2013 (5), the San Diego County Board of Supervisors directed that an analysis be conducted on the differences and similarities between the County of San Diego's IHOT program and Laura's Law, complete a review and analysis of related legislation and provide recommended next steps, and quarterly reports. This report contains the review and analysis requested by the Board.

Differences and Similarities Between In-Home Outreach Team (IHOT) and Laura’s Law

San Diego’s diverse mental health treatment system is designed to provide a comprehensive array of interventions for individuals with a serious mental illness. For those who are the most seriously mentally ill, San Diego currently offers multiple services based on level of need and care. For the most severe need there is an array of countywide services that include acute care psychiatric hospitals, alternatives to psychiatric hospitalization such as the Crisis Residential Treatment programs, intensive case management programs like the Full Service Partnerships, outreach and engagement services such as the IHOT program, and Conservatorship.

Services

For purposes of this analysis, the existing IHOT and Full Service Partnership programs are described below along with the Assisted Outpatient Treatment as defined in Laura’s Law.

In-Home Outreach Teams (IHOT)

Recognizing the challenges that family members and loved ones face when an adult with serious mental illness declines or refuses any intervention and treatment, the County of San Diego established the IHOT program. The IHOT program provides intensive outreach and engagement, mental health screening, in-home intervention, family education and support and linkage to treatment for this hard to engage population. The IHOT program does not provide on-going mental health treatment, but provides outreach and engagement with the goal of engaging individuals in accepting treatment and services over time, thus linking them to services available in the community.

The IHOT program was established as a pilot program in January 2012, in three regions of the county. In the North Coastal, Central, and East regions, the IHOT program offers mobile, intensive outreach to adults with serious mental illness who are reluctant or “resistant” to receiving mental health services. In addition, extensive support and education is provided to family members who are dealing with the mental illness of a loved one within their family. Services include

Case Example: “Tom”

IHOT helped Tom, a 22 year old male, with a history of Psychotic Disorder and heroin dependence. Tom was initially hospitalized and then transferred to inpatient treatment for four months. After a relapse, IHOT continued to work with Tom and determined that he needed to be hospitalized again, leading to placement at a locked long-term residential treatment facility. He then transitioned into an unlocked residential treatment program specializing in services for young adults with co-occurring mental health and substance abuse issues. He has been fully engaged in the residential program since January 2013. He recently was released from conservatorship and is now being transitioned to a Full Service Partnership program for community-based mental health treatment while he pursues part time employment opportunities.

behavioral health screening, outreach and engagement, crisis management, transitional case management, support and educational services, and conservatorship as needed. The program provides individualized and culturally competent services five days a week, during regular business hours. The primary goal of the program is to engage resistant individuals by developing a relationship built on trust and enhanced awareness so they can more readily accept services that will meet their unique needs, and to provide support for family members and loved ones.

Full Service Partnership (FSP)

While the focus of the IHOT program is intensive outreach and engagement services for individuals who are seriously mentally ill and have resisted treatment, the focus of Full Service Partnerships is the provision of community-based intensive case management, mental health treatment, rehabilitation, and recovery services in addition to outreach and engagement. Programs collaborate as necessary with the justice system. In contrast to IHOT, the FSP programs provide comprehensive, individualized, integrated, and culturally competent services 24 hours per day, 7 days per week, using a “whatever it takes” approach. Services include support in employment, education, housing, and transportation, and assisting the individual in establishing health services and peer relationships, and conservatorship services as needed.

Case Example: “Sally”

Sally was referred to one of the FSP-ACT programs through San Diego’s Vulnerability Index Survey. Sally was a hoarder and paid for several storage sheds rather than paying rent, because she could not bear to give up the prized possessions of those she loved that were no longer with her. Sally lived in an old car, and did not trust anyone. In addition, she was drinking heavily. The FSP-ACT staff worked with Sally, and she slowly started to engage and allowed the program to help her reduce the number of storage units, so she could afford her own apartment. Sally credits the FSP-ACT program with giving her renewed hope and she grins from ear to ear every time she comes to the office. She has now reconnected with her children and found employment as a house cleaner.

In San Diego County, the FSP program adheres to the evidence-based Assertive Community Treatment (ACT) model using a treatment team approach. The ACT model consists of comprehensive, community-based psychiatric treatment, rehabilitation, and support through a team of professionals providing mobile and site based services that include: outreach and engagement, initial and ongoing behavioral health assessments; psychiatric, rehabilitation and recovery services; supportive employment and supportive housing assistance; family support and education; and other services and supports critical to an individual's ability to live successfully in the community.

Clients served by San Diego’s FSP-ACT programs are individuals with serious and persistent mental illness, with severe functional impairments, and who have avoided or not responded well to traditional outpatient mental health care and psychiatric rehabilitation services co-

existing problems such as primary health conditions, homelessness, substance use disorders, and involvement with the justice system.

Laura's Law (Assisted Outpatient Treatment)

Laura's Law authorizes court-ordered outpatient treatment pursuant to Welfare & Institutions Code (WIC) 5345-5349.5, for individuals who have a history of untreated

1. *Be at least 18 years of age*
2. *Be mentally ill as defined in W&I Code*
3. *Be clinically determined unlikely to survive safely in the community without supervision*
4. *Have a history of treatment non-compliance for one of the following:*
 - *Two occurrences of hospitalization, or incarceration in prison or jail within the last 36 months: - OR -*
 - *One occurrence of serious or violent behavior within the last 48 months*
5. *Refused or did not engage in prior opportunities for treatment*
6. *Have a condition that is deteriorating*
7. *Assisted Outpatient Treatment must be the least restrictive placement to ensure the person's recovery and stability*
8. *The treatment must be deemed to prevent a relapse or deterioration that would likely result in involuntary mental health treatment through 5150*
9. *The person is expected to benefit from the Assisted Outpatient Treatment.*

mental illness and meet all nine of the following criteria stipulated in the Code:

Assisted Outpatient Treatment (AOT) was not designed as a replacement for the involuntary evaluation and treatment provisions of Welfare and Institutions Code 5150-5157. Laura's Law specifically stipulates that in the event a person fails or refuses to comply with court-ordered AOT, continued involuntary services must be pursuant to Sections 5150 et seq. The Lanterman-Petris-Short (LPS) Act of 1967, as codified in Sections 5150 et seq. provides a procedure for the involuntary detention for evaluation and treatment of persons who, as a result of a mental disorder, constitute a danger to themselves or others or are gravely disabled. Individuals who are not compliant with AOT may *only* be involuntarily held pursuant to 5150, which is currently in place throughout San Diego's adult mental health system of care. Laura's Law does not allow for involuntary medication without a separate court order.

The AOT program specifies an Assertive Community Treatment model, as is in place through the existing FSP-ACT programs, including services that use community-based, mobile, multidisciplinary mental health teams that provide outreach services, coordination and access to medications, psychiatric and psychological services, substance abuse services, supportive housing or other housing assistance, vocational rehabilitation, and veteran's services. Mirroring the FSP-ACT program, the services provided via the AOT program must be individualized, comprehensive, and culturally

appropriate meeting the unique array of service needs of the individual. Attachment A, *Assisted Outpatient Treatment Flow Chart*, provides a visual description of this process.

Staffing

In-Home Outreach Team

The IHOT program incorporates a 1:25 staff to client ratio. This contracted service utilizes a team approach led by a clinician and includes a case manager, family coach and peer support.

Full Service Partnership/Assertive Community Treatment

The FSP/ACT programs follow a 1:10 staff to client ratio, using a multidisciplinary team approach. The team consists of a psychiatrist, nurse, case manager, therapist, housing specialist, job developer/employment specialist, peer support, and substance abuse counselor. Depending upon the needs of the individual, additional clinicians or case managers may be involved as necessary. All members of the team work closely together to provide a comprehensive approach to services.

Conservatorship

Expansion of IHOT countywide and potential implementation of Laura's Law (Assisted Outpatient Treatment) is expected to increase the utilization of evaluations requested of the Conservatorship Office. Based on initial referrals from the IHOT pilot, it is projected that an increase of up to three Mental Health Public Conservator Clinicians could be necessary due to increased demand.

Laura's Law (Assisted Outpatient Treatment)

The Assisted Outpatient Treatment (AOT) model requires a 1:10 staff to client ratio. Each individual works with a Personal Services Coordinator (synonymous with the role and function of a case manager) who is responsible for assuring needed services are provided through a complete assessment and linkage with all appropriate community services and ensuring services meet the individual's needs. The Personal Services Coordinator may be part of the required community-based, mobile multidisciplinary mental health team working with the individual.

In addition to contracted treatment staff and increased county staff in the Conservatorship Office, it is anticipated that up to four additional staff positions could be added within Behavioral Health Services to implement Laura's Law. These positions include one Mental Health Program Manager, one Legal Support Assistant II, and two Psychiatrist Specialists.

Projected Costs

In-Home Outreach Team

The current contracted provider for IHOT is Telecare. The University of California, San Diego (UCSD) conducts the evaluation under contract. The current annual cost of IHOT services and evaluation in x regions is \$1.4 million. During the first 12 months of

implementation, 402 individuals were screened for eligibility and 174 people were accepted for outreach services. The average cost per individual receiving outreach services is \$8,100. If the program were expanded countywide, the total program costs would increase to \$2.8 million, which is an increase of \$1.4 million from current costs.

Full Service Partnership-Assertive Community Treatment (FSP-ACT)

The FSP-ACT program is contracted to various community treatment programs, including Telecare, Mental Health Systems, Inc., Community Research Foundation, and Providence. FSP-ACT provides services countywide and currently receives referrals from IHOT. If IHOT was expanded countywide, it is anticipated that FSP-ACT would realize an increase of approximately 20 additional clients annually. The average cost per client is \$20,000, including housing, for an increased cost of \$400,000.

Conservatorship

If San Diego were to expand the existing IHOT program countywide and/or implement Laura's Law, that action is projected to increase the number of evaluations requested of the conservatorship office. Based on the number of evaluations conducted for individuals who were referred to IHOT within the initial 12 months of the pilot, it is projected that the expansion could result in significant increases in annual evaluations. The cost associated with this increase could be up to \$500,000 annually.

Laura's Law (Assisted Outpatient Treatment)

If San Diego implemented Laura's Law, the expected annual cost would be \$34,000 per client. This cost includes the anticipated contracted treatment and evaluation costs, along with new County costs that would be incurred by the Adult Forensic Unit. Minimal additional costs are anticipated for Office of County Counsel and the Public Defender Department associated with conducting required hearings. The Superior Court has also estimated a potential cost impact associated with required hearings.

Cost Avoidance

Cost avoidance refers to actions that may cause future spending to be modified, but does not necessarily result in system-wide savings. Assisted Outpatient Treatment may result in cost avoidance within the criminal justice system. The actual costs avoided depend on many variables, but the primary costs avoided will be for reduced future use of jail days, either served in a San Diego County jail or one of the county's alternative custody options.

Additionally, in the past, actions of seriously mentally ill individuals have occasionally resulted in major incidents or SWAT responses. Accordingly, component costs potentially avoided include:

- \$31 for the marginal cost for every day of jail avoided
- \$78 for every day of alternative custody avoided
- \$10,000 average (nationally) for a SWAT response avoided

Analysis of Proposed Laura's Law Legislation

Five bills have been introduced in the California State Legislature relating to Laura's Law during this legislative session which began on December 3, 2012. The bills are all subjected to the legislative process which includes hearings in all committees relevant to the bill. Bills that did not make it through the legislative process by the respective deadlines are considered inactive, or "a 2-year bill".

Active Bills

- SB 585 (Steinberg). This bill clarifies that Mental Health Services Act (MHSA) funds and all other current mental health funding streams may be used for implementation of AOT under Laura's Law. This bill is significant as it would allow more funding streams to be available for the implementation of Laura's Law.

Status: The bill passed out of the Senate and is now awaiting hearing in the Assembly Appropriations Committee.

- SB 364 (Steinberg). This bill amends the Lanterman-Petris-Short (LPS) Act relating to involuntary commitment under Section 5150 of the Welfare & Institutions Code. This bill states that the intent of the Legislature is to provide consistent standards for protection of the personal rights of persons who are subject to involuntary detention and to provide services in the least restrictive setting appropriate to the needs of the person. The bill assigns several tasks to local County Mental Health Departments in terms of training and providing information. This bill would have minimal impact to Laura's Law, but as amendments to this legislation may affect section 5150, staff will continue to monitor.

Status: This bill passed out of the Senate and on to the Assembly. The bill is awaiting its first hearing in the Assembly.

Inactive Bills

- AB 1265 (Conway). This bill would have increased the AOT initial treatment period from 6 months to 12 months, and would eliminate the requirement that the patient be re-evaluated at the end of that time.

Status: The bill failed passage in its first committee and is now a 2-year bill.

- SB 664 (Yee). Under current Laura's Law provisions, to implement the AOT program, the county Board of Supervisors is required to, by resolution, authorize the program and make a finding that no voluntary mental health program serving adults, and no children's mental health program, may be reduced as a result of the program's implementation. This bill would have removed the requirement for a county to authorize the program by resolution and make those findings to implement the program, and would also authorize a county to limit the number of persons to whom it provides assisted outpatient treatment services. The bill failed to pass the Senate Appropriations Committee.

Status: This bill is no longer moving, and is now a 2-year bill.

- AB 1367 (Mansoor). This bill would have amended the Mental Health Services Act to specify that MHSA funds may be utilized for AOT under Laura's Law, and that MHSA funding could also be used to fund school-based programs.

Status: The bill was never acted upon and is no longer moving.

Efforts to Close Identified Gaps between IHOT and Laura's Law

Laura's Law was created as an additional tool to serve the mentally ill through court-ordered treatment. Unfortunately the present law falls short in meeting its intent in effectively serving treatment resistant individuals. The law does not include any form of involuntary or locked treatment, it does not specify any intervention by law enforcement, beyond what is currently available in Welfare and Institutions Code 5150, which governs the detention of Mentally Disordered Persons for evaluation and treatment, and does not permit the use of existing funding sources. Therefore, to strengthen efforts and support public safety, Laura's Law needs enhancements.

The County is committed to enhancing services for mentally ill clients and seeks to ensure that it has a robust tool kit to meet the needs of residents. A comprehensive continuum of care for mentally ill individuals must include effective tools to assist in serving those that are severely mentally ill and resistant to treatment. The effectiveness of Laura's Law will be strengthened by changes in the enforcement process of the judicial order. Additionally, changes to current law are needed to allow the use of funding sources, such as the Mental Health Services Act (MHSA), that are not currently an option.

Based on the analysis contained within this report, it is recommended that the existing mental health system be expanded to serve additional individuals who are mentally ill and have been resistant to treatment. The overall enhancement could include:

- Expansion of the IHOT program countywide;

- Increased capacity of Full Service Partnership Programs; and
- Increased utilization of the Conservatorship Office.

Additionally, building on this preliminary expansion, a move towards the implementation of Laura's Law will take place upon further review of data, and contingent upon availability of funding and attainment of legislative remedies.

In the upcoming Fiscal Year, the expansion of the IHOT program countywide and increases to the capacity of existing Full Service Partnership-Assertive Community Treatment programs will allow for enhanced access to outreach and engagement services for those who have been resistant to treatment, and establish capacity of intensive treatment and rehabilitation programs.

Staff will continue to review data and identify relevant and appropriate revenues for the implementation of Laura's Law. In addition, legislative remedies will be identified to ensure the effectiveness of a court-ordered outpatient treatment program.

Pending legislation, such as SB 585, would authorize the use of Mental Health Services Act (MHSA) funds to support the implementation of Laura's Law. Contingent upon the availability of MHSA revenue, if SB 585 is enacted, it may provide opportunities for additional funding that is not currently a viable source.

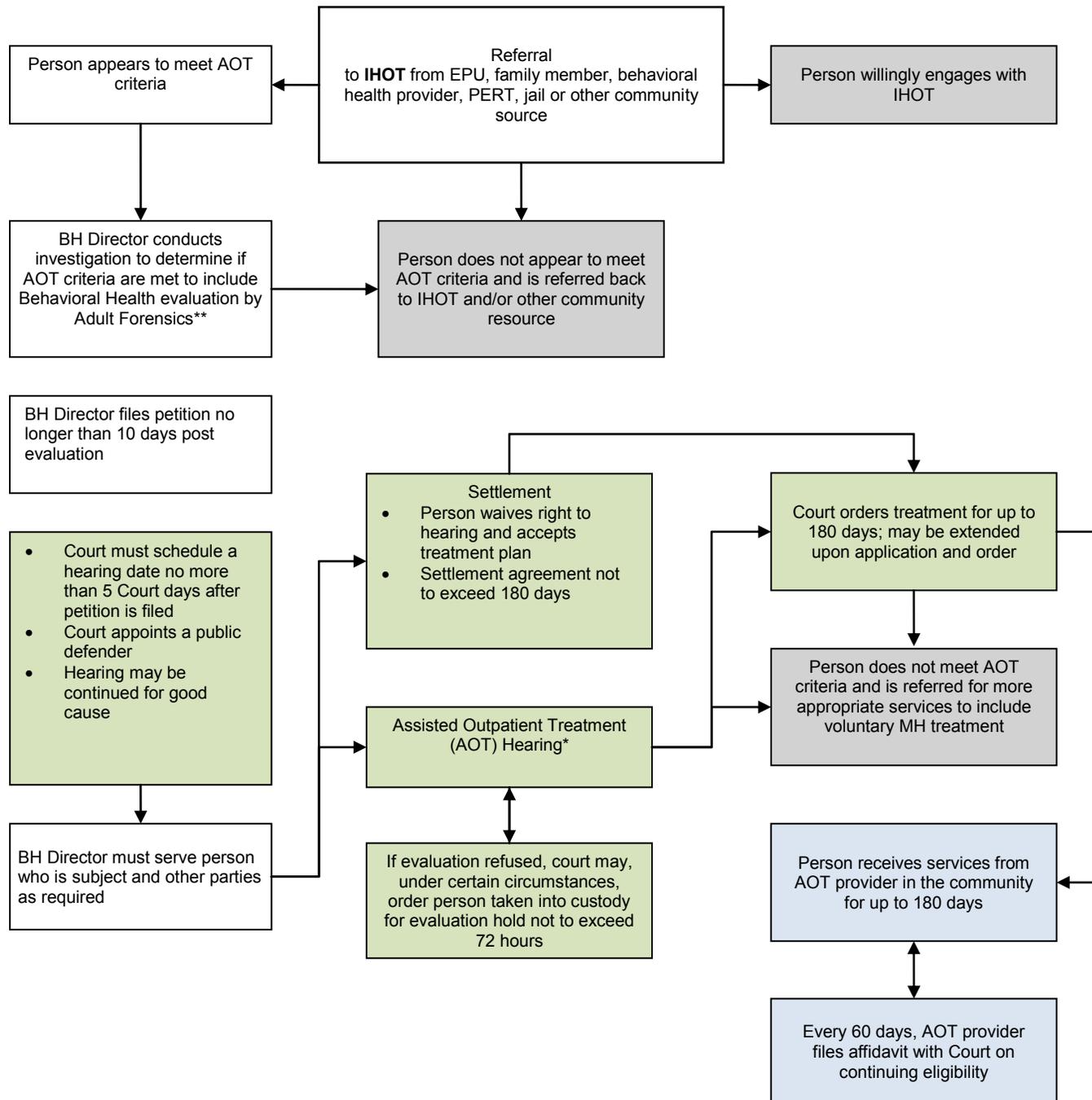
MHSA regulations require a community input process regarding the use of the funds. If the funds are used to expand the existing IHOT program, or if SB 585 passes and the County chooses to implement Laura's Law through MHSA funding, a community input process is required. In addition, approval from the Mental Health Services Oversight and Accountability Commission is required if MHSA Innovation funds are used. Recognizing that additional revenue will be necessary if the Board chooses to expand IHOT and/or implement Assisted Outpatient Treatment, it is further recommended that HHS conduct a community input process regarding the use of MHSA funds for these activities.

Quarterly Updates

In accordance with the Board's direction, results of progress made towards implementation of Laura's Law will be provided to the Board in the IHOT quarterly updates. These reports will include:

- Updates of preliminary IHOT expansion,
- Continued evaluation of data, and
- Legislative remedies that moves Laura's Law to becoming an effective option, through:
 - secured funding, and
 - strengthened effectiveness of the Court Order

Attachment A Assisted Outpatient Treatment Flow Chart



* At any point, person may file a writ of habeas corpus with Court to challenge AOT eligibility.

** BHS anticipates that some potential AOT participants will not consent to a behavioral health evaluation and has identified a process within the W&I code to complete the requirements.