

## Advocacy Committee

Thursday, April 16, 2015

Doubletree San Pedro  
2800 Via Cabrillo-Marina  
San Pedro, CA 90731  
(310) 514-3344

**Portofino Room**  
**8:30 a.m. - Noon**

| Time      | Topic   | Facilitator/Presenter       | Tab      |
|-----------|---|-----------------------------|----------|
| 8:30 a.m. | Welcome and Introductions   | Adam Nelson, MD, Chair      |          |
| 8:35      | Agenda & Packet Review  | Kathleen Derby, Chair-Elect |          |
| 8:40      | Council Requests/New Business   | Adam Nelson                 |          |
| 8:45      | Refresher: The Legislative Process  | Kathleen Derby              | <b>A</b> |
| 8:55      | Review of Proposed Legislation  | Adam Nelson                 | <b>B</b> |
| 9:50      | Break   |                             |          |
| 10:10     | Mary Marx, LCSW; Mental Health Clinical District Chief, LA County Mental Health, <i>IMD Utilization Rates and Social Reinvestment</i> | Adam Nelson                 | <b>C</b> |
| 11:10     | Discussion & Next Steps on Committee Work Plan  | Kathleen Derby              |          |
| 11:35     | Public Comment  | Kathleen Derby              |          |
| 11:45     | Develop Report Out  | Adam Nelson                 |          |
| 11:50     | WWW/ Plan for Future Meetings   | Andi Murphy, Staff          |          |
| 11:55     | Plus/Delta  | Kathleen Derby              |          |
| Noon      | Adjourn   |                             |          |

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

**Committee Members:**

**Chair: Adam Nelson, MD**

**Chair-Elect: Kathleen Derby**

|                 |                    |                    |                           |
|-----------------|--------------------|--------------------|---------------------------|
| <b>Members:</b> | Nadine Ford        | Carmen Lee         | Steve Leoni               |
|                 | Barbara Mitchell   | Maya Petties, PsyD | Darlene Prettyman         |
|                 | John Ryan          | Daphne Shaw        | Arden Tucker              |
|                 | Monica Wilson, PhD |                    | <b>Staff: Andi Murphy</b> |

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

|                                |  |   |
|--------------------------------|--|---|
| <b>Cultural Competence</b>     | <b>Full Accessibility across the<br/>life span</b>           | <b>Wellness &amp; Recovery</b>                          |
| <b>Community Collaboration</b> | <b>Consumer &amp; Family member<br/>driven or influenced</b> | <b>Integrated Services</b><br><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 MHS 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:**

|   |
|---|
| <b>Name</b>   |
| <i>Adam Nelson, MD, Chair</i>   |
| <i>Kathleen Derby, Chair-Elect</i>  |
|   |
| <i>Nadine Ford</i>  |
| <i>Carmen Lee</i>   |
| <i>Steve Leoni</i>  |
| <i>Barbara Mitchell</i>   |
| <i>Maya Petties, PsyD</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</i><br><i>(916) 324-0777</i><br><i>Andi.murphy@cmhpc.ca.gov</i> |

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**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"> <li>Review the State mental health plan required by <b>PL 106-310</b> and submit to the State any recommendations for modification</li> </ul>  | Annual review of CA SAMHSA BG application   | Yes         |
| <ul style="list-style-type: none"> <li>Review the annual implementation report on the State mental health plan required by <b>PL 106-310</b> and submit any comments to the State</li> </ul>  | Annual review of CA Implementation Report   | Yes         |
| <ul style="list-style-type: none"> <li>Advocate for adults with serious mental illness, children with a severe emotional disturbance, and other individuals with mental illnesses or emotional problems</li> </ul>  | Legislative advocacy, Participation on HCR and other issue-specific committees,           | No          |
| <ul style="list-style-type: none"> <li>Monitor, review, and evaluate annually the allocation and adequacy of mental health services within the State.</li> </ul>  | Workbook Project w/ Local MH Boards   | Yes         |
| <p><b>California Welfare and Institutions Code (WIC) 5514-</b> 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><b>WIC 5771-</b> Pursuant to <b>PL 102-321</b> the Planning Council shall be responsible to fulfill those mental health planning requirements mandated by federal law.</p>   |   |             |
| <p><b>WIC 5772 -</b> 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"> <li>To advocate for effective, quality mental health programs.</li> </ol>  | Legislative testimony, Participation on HCR and other issue-specific committees           | No          |
| <ol style="list-style-type: none"> <li>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.</li> </ol>   | SAMHSA BG Peer Reviews, Council Meeting to showcase model programs, Legislative testimony | No          |
| <ol style="list-style-type: none"> <li>To review program performance in delivering mental health services by annually reviewing performance outcome data as follows:</li> </ol>   | Workbook Project w/ Local MH Boards, SAMHSA BG Peer Reviews,                              | Yes         |
| <ul style="list-style-type: none"> <li>To review and approve the performance outcome measures.</li> </ul>   |   |             |

|  |  |                    |
|--|--|--------------------|
| <ul style="list-style-type: none"> <li>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.</li> </ul>   |  |                    |
| <ul style="list-style-type: none"> <li>To report findings and recommendations on programs' performance annually to the Legislature, the State Department of Health Care Services, and the local boards.</li> </ul>   |  |                    |
| <ul style="list-style-type: none"> <li>To identify successful programs for recommendation and for consideration of replication in other areas. As data and technology are available, identify programs experiencing difficulties.</li> </ul>   |  |                    |
| 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.                                |  |                    |
| <b>WIC 5772 - continued</b>  | <b>Council Activity</b>                          | <b>Deliverable</b> |
| 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. |   |  |
| <b>WIC 5820</b> - 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 |  |
| <b>WIC 5821</b> - 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](mailto:Tracy.Thompson@cmhpc.ca.gov) (916) 552-8665 or [Andi.Murphy@cmhpc.ca.gov](mailto:Andi.Murphy@cmhpc.ca.gov) (916) 324-0777

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

**CMHPC**  
**Advocacy Committee**  
**MEETING SUMMARY**

Crowne Plaza Hotel  
 2270 Hotel Circle N  
 San Diego, CA 92108

**January 15, 2015**

**Present:**

**Members:**

|                             |                    |
|-----------------------------|--------------------|
| Kathleen Derby, Chair-Elect | Maya Petties, PsyD |
| Nadine Ford                 | Darlene Prettyman  |
| Steve Leoni                 | Daphne Shaw        |
| Barbara Mitchell            | Arden Tucker       |
| Adam Nelson, MD, Chair      |                    |

**Presenters:**

Roselyna Rosado, LCSW  
 In-Home Outreach Team of  
 San Diego, CA

**Staff:**

Andi Murphy

**Welcome and Introductions**

Meeting commenced at 8:30 a.m.; committee members introduced themselves, and new members Maya Petties, Darlene Prettyman, and Arden Tucker were welcomed.

**Brief Orientation/Mentor Assignments**

Dr. Nelson provided a brief overview of the packet contents and its relation to the overall mission of the Advocacy Committee. Mentor assignments were as follows:

Maya Petties – Monica Wilson  
 Kathleen Derby – Daphne Shaw  
 Darlene Prettyman – John Ryan  
 Arden Tucker – Darlene Prettyman

**Agenda Review and/or Adjustments**

The request for 15 minutes to discuss recommendations for Peer Certification paper was granted and scheduled for later in the meeting.

**Council Requests/ New Business** – there were none.

## 2015 Work Plan Development

- Peer Certification can be “homed” at Advocacy as part of the effort to support and liaison between community stakeholders and legislators.
- Peer Certification should be included in this year’s work plan since things are heating up through the Darrell Steinberg Institute.

In respect to alternatives to institutions:

- We need to distinguish between hospitals and IMDs, which are predominantly contractor run.

There are currently efforts to have DHCS write an amendment to the State Plan that lifts the IMD exclusion in respect to Alcohol and Drug detox facilities.

1. Is there a risk of IMD exclusion extending to all mental health issues/facilities?

There was general discussion surrounding the topic and development of a work plan for the year ahead. Much of the discussion centered on culturally competent and racially representative workforce but it was not conclusive. It was ultimately decided to table the task until the February meeting. The following items were brought up as things to consider when drafting the work plan:

- Compare counties - good to bad, in respect to locked facilities. (I.e., Santa Clara, FSP 90?), Look at who has the highest lock up rates? Is it the same county that has the highest utilization of rehab services?
- What is available from county to county?
- How do criteria for institutionalization differ from county to county?
- What types of step-down services are provided, and what happens to the vacated bed?
- Synergy has a good program.
- Where are they being discharged to?
- Who are in these locked beds and why? To what extent do medical needs or physical issues play into it?
- Stick with IMDs, MHRC, and Hospitals?

## San Diego In-Home Outreach Team (IHOT) Presentation

The committee heard a presentation on the In-home outreach team program in San Diego. This is a person-centered program based on establishing trust, empathetic listening, and strength based planning that addresses the most pressing need first (such as potential eviction). The team works closely with both the individual and family members. Successful outcomes include accessing and maintaining treatment and medication; reconnecting with family or social supports; obtaining safe and stable housing; employment assistance; obtaining medical care and benefits; enhanced boundary and limit setting; Improved family communication skills; connecting the family to support services (NAMI); and educating on the best way to access emergency services if needed without fear of arrest.

This program has been embraced by the San Diego County Board of Supervisors as a viable alternative to AOT referral. It was originally approved for three regions in San Diego, but has now expanded to six. The IHOT team works with family members, NAMI, Jails, PERT, hospitals, and other mental health providers.

Copies of the PowerPoint and outcomes will be provided separately.

### **Committee Discussion/Next Steps**

- Monthly meeting will be held February 11, 2015 from 11:00 am to noon.
- The IHOT results should be captured, described and disseminated to other counties.
- Look at counties who are using alternatives to AOT and compare them to their incarceration rates.
- Ask people who have experienced AOT what their experience has been.

There was discussion as to whether the committee should track implementation of Laura's law but concluded that the OAC is doing it so we may decide to weigh in on OAC's report.

### ***February meeting planning:***

Continue discussion on work plan development - sort out resources, narrow down questions, and establish priorities.

**Public Comment** – There were no comments from the public.

### **WWW & Plan Future Meeting(s)**

For the April meeting – determine what type of information DHCS tracks in each county regarding institutionalization. How many IMD beds, how many acute care beds, etc. are available in each county. If there is a lack of information, highlight that fact.

- Send a letter to DHCS asking about Utilization rates

### **Peer Certification paper recommendations**

The following recommendations resulted from the committee discussion on the Peer Certification paper:

- Recommend that the Administration identify a State Department to take the lead on establishing a certifying body.
- Suggested language: “We recommend that OSHPD be given the authority to pursue the establishment of a certifying body”.
- Include language that directs readers to Inspired at Work or WWT for more in-depth information on peer certification.
- Suggest that somebody propose Legislation to make it happen – i.e. “We support a legislative approach to establishing....”
- Modify the language from “Peer Specialists don’t...” to “The certification would not include...”

**Adjourn – 12:00 p.m.**

February 11, 2015  
Brief Meeting Summary (Rev. 2/20/2015)

- Peer Certification paper still not accurate – edits did not go far enough to clarify capabilities and responsibilities of the classification – the language is still limiting.
- The work plan will be narrowed down to following parameters:
  - Locked facilities only (IMDs/MHRCs)
  - State Hospitals are excluded
  - Long-term care – more than 30-day placements only.
  - Adults only
- Committee members will preliminarily query on five or six items (listed below) to their local county mental health department in charge of institutionalized care placements (i.e., a very small sample).
  - Those items may be tweaked if the answers cannot be answered as asked – the purpose of the sample is to test viability of questions.
  - *Start with “The following questions regarding adults with SMI (including age appropriate TAY and older adults) and do not pertain to acute hospitalization or state hospitals.”*
    - What was the total number of placements in IMDs or MHRCs in 2014?
    - What was the total number of bed-days in IMDs or MHRCs in 2014?
    - How many adults with SMI are served in your county in 2014 regardless of whether placed in IMD's/MHRC's or not?
    - What was the number of placements, bed days, and SMI served in 2009?
    - Has Obamacare affected utilization?
    - What is the demography of long-term care placement? Race/age group/gender
    - Please describe any community programs/services intended to provide appropriate community placements or situations allowing the shortening of IMD/MHRC stays or the replacing of such stays altogether for some.
      - Types of services
      - Who provides them
      - How they are funded - MHSA funded and/or funded through reinvestment from no longer utilized IMD/MHRC bed-days?
      - What is the cost of these services?
      - Have they expanded, declined, or stayed the same since 2009.
- If the sample of Mental health departments are unable to answer these questions are written, they will be modified to what CAN be answered.

- Once they are modified, they will be distributed to ALL county mental health departments (potentially through CBHDA, and/or survey monkey).

***These meetings need to occur by March 9<sup>th</sup> meeting so the results can be reviewed and discussed at the March 11<sup>th</sup> meeting.***

It was also suggested that the committee may wish to ask about the number of residential care beds available in each county – possibly as a side bar project. This question would not be out of place in context of step down programs, etc.

X   INFORMATIONTAB SECTION     **A**       ACTION REQUIREDDATE OF MEETING   **4/16/15**MATERIAL  
PREPARED BY:   MurphyDATE MATERIAL  
PREPARED       **3/17/15**

|  |   |
|--|---|
| <b>AGENDA ITEM:</b>                    | Refresher Course: Review of the Legislative Process   |
| <b>ENCLOSURES:</b>                     | <i>Life Cycle of a Bill</i> – California State Assembly flow chart<br><i>Overview of the Legislative Process and Assembly Clerk’s Office</i><br><i>Q &amp;A</i> – California Mental Health Planning Council<br><i>What Does Suspense File MEAN anyway?</i> – various contributors |
| <b>OTHER MATERIAL RELATED TO ITEM:</b> |   |

**ISSUE:**

This year marks the start of a new two-year legislative session. Prior to reviewing the pending legislation for the new session, the committee may wish to re-review the process for the passage of legislation. This brief review will provide a better understanding of the timelines, opportunities for comment and participation and constraints as the Advocacy Committee considers potential activities or actions.

The *Life Cycle of a Bill* illustrates the flow of the process and the *Overview of the Legislative Process* provides more details of the different basic steps shown by the illustration.

The *Q and A* was a written response to questions submitted to staff by an interested party in the legislative process and specifically, how the Advocacy Committee responds to Legislation and why.

*What Does Suspense File MEAN anyway?* was patched together by staff from various blogs and contributors which contained some information and definitions not necessarily contained in the other documents.



## **Overview of Legislative Process**

The process of government by which bills are considered and laws enacted by the California State Legislature is commonly referred to as the legislative process. The California State Legislature is made up of two houses: the Senate and the Assembly. There are 40 Senators and 80 Assembly Members representing the people of the State of California. The Legislature maintains a legislative calendar governing the introduction and processing of the legislative measures during its two-year regular session.

### **Idea**

All legislation begins as an idea or concept. Ideas and concepts can come from a variety of sources. The process begins when a Senator or Assembly Member decides to author a bill.

### **The Author**

A legislator sends the idea for the bill to the Office of the Legislative Counsel, where it is drafted into bill form. The draft of the bill is returned to the legislator for introduction. If the author is a Senator, the bill is introduced in the Senate. If the author is an Assembly Member, the bill is introduced in the Assembly.

### **First Reading/Introduction**

A bill is introduced or read the first time when the bill number, the name of the author, and the descriptive title of the bill are read on the floor of the house. The bill is then sent to the Office of State Publishing. No bill except the Budget Bill may be acted upon until 30 days have passed from the date of its introduction.

### **Committee Hearings**

After introduction, a bill goes to the rules committee of the house, where it is assigned to the appropriate policy committee for its first hearing. Bills are assigned to policy committees according to subject area. For example, a Senate bill dealing with health care facilities would first be assigned to the Senate Health and Human Services Committee for policy review. Bills that require the expenditure of funds must also be heard in the fiscal committees, Senate Appropriations and Assembly Appropriations. Each committee is made up of a specified number of Senators or Assembly Members.

During the committee hearing the author presents the bill to the committee, and testimony may be heard in support or opposition to the bill. The committee then votes on whether to pass the bill out of committee, or that it be passed as amended. Bills may be amended several times. It takes a majority vote of the committee membership for a bill to be passed and sent to the next committee or to the floor.

Each house maintains a schedule of legislative committee hearings. Prior to a bill's hearing, a bill analysis is prepared that explains the intended effect of the bill on current law, together with background information. Typically the analysis also lists organizations that support or oppose the bill.

**Second and Third Reading**

Bills passed by committees are read a second time on the floor in the house of origin and then assigned to third reading. Bill analyses are also prepared prior to third reading. When a bill is read the third time it is explained by the author, discussed by the Members, and voted on by a roll call vote. Bills that require an appropriation, or that take effect immediately, ordinarily require 27 votes in the Senate and 54 votes in the Assembly to be passed. Other bills generally require 21 votes in the Senate and 41 votes in the Assembly. If a bill is defeated, the Member may seek reconsideration and another vote.

**Repeat Process in Other House**

Once the bill has been approved by the house of origin it proceeds to the other house where the procedure described above is repeated.

**Resolution of Differences**

If a bill is amended in the second house, it must go back to the house of origin for concurrence, meaning agreement on those amendments. If the house of origin does not concur in those amendments, the bill is referred to a two-house conference committee to resolve the differences. Three members of the committee are from the Senate and three are from the Assembly. If a compromise is reached, the bill is returned to both houses for a vote.

**Governor**

If both houses approve a bill, it goes to the Governor. The Governor has three choices: sign the bill into law, allow it to become law without his or her signature, or veto it. A governor's veto can be overridden by a two-thirds vote in both houses. Most enacted bills go into effect on the first day of January of the next year. Urgency bills, and certain other measures, take effect immediately after they are enacted into law.

**California Law**

Each bill that is passed by the Legislature and approved by the Governor is assigned a chapter number by the Secretary of State. These chaptered bills are statutes, and ordinarily become part of the California Codes. The California Codes are a comprehensive collection of laws grouped by subject matter.

The California Constitution sets forth the fundamental laws by which the State of California is governed. All amendments to the California Constitution come about as a result of constitutional amendments approved by the voters at a statewide election.

## Q & A

### 1. Could you describe the process of a state bill being passed from start to finish?

The idea for a law is formed through a suggestion or request from a constituent, current events, etc.. If it is from somebody outside the legislature, a legislator in that person's district might be approached with the request to "carry" the legislation, and be its author (basically the shepherd – taking it from floor to committees and pitching it – and amending it as needed it to get it to the next committee).

Each amendment is published – which is why it is important to track legislation- before it advances to the next committee.

If the bill is found to cost the State more than \$50K in General Funds and \$150K of any other funds, it is automatically "suspended" until after the budget bill is decided because there is basically no sense in wasting time on a bill that the state may not be able to afford.

Advocates can signal their approval or opposition to bills at any point in the process. However, either position tends to be more effective when delivered prior to the next committee hearing. **If you wish your position to be included in the analysis, you MUST submit your letters by 5:00 p.m. on the Thursday before the committee meets.** Sometimes the author's office will reach out to organizations that are on record as supporting or opposing and request that they signal their position to the next committee's members and staff in order to bolster its chances.

Bills have to pass through both sides of the House, so if a Senator authors it, the bill goes through all of the Senate Committees that pertain to its content, before it advances to the Assembly side. Typically the author will identify a counterpart on the Assembly side who will serve as the bill's "shepherd."

Any amendments that are made on the "other" side of the house cause the bill to be routed back through the author's side again in order to gain consensus on its content.

Once both the Assembly and Senate agree on the content of the bill, it is presented to the Governor for signature. The Governor may either:

- sign it outright, and send it forward to be enrolled and chaptered, or
- Veto it, which gives the Legislature 60 days to override it by amassing a 2/3 vote by BOTH the Assembly and the Senate, or a
- line-item veto, where the intent of the legislation is approved but the appropriation is reduced.

### 2. What is a trailer bill, and how does it go through legislation?

If the Budget Bill has provisions that require changes to existing law, separate bills that implement those changes — “Trailer Bills” — are introduced and voted on, generally at the same time as the Budget Bill. For example, SB 1009, the legislation that officially dissolved the DMH and ADP, was legislation that “trailed” a budget bill. The Budget Bill called for the actions (in this case as a cost saving measure), and the Trailer Bill provided the details (decided which agencies would house the various functions of the dissolved departments). You can follow the development of the Trailer bill on the Department of Finance Budget website:

[http://www.dof.ca.gov/budgeting/trailer\\_bill\\_language/health\\_and\\_human\\_services/documents/](http://www.dof.ca.gov/budgeting/trailer_bill_language/health_and_human_services/documents/)

### 3. What strategies do you use to impact legislation?

Write letters and attend hearings. Make sure you send the letters in before the hearing you attend. Sometimes testify. In some respects, testifying is communicating the points you make in your letters but in another sense, it is an opportunity to bring a perspective that legislators may not have considered. For example, a support letter for mental health parity – it’s important because it makes things fair, but when you testify to that effect, you might want to add something about the State’s federal funding for mental health hinging on the state’s efforts to enforce parity or something. This might be useful if part of the committee is not that interested or knowledgeable about mental health, because everybody understands a potential loss of money. Or, make it personal, and recount how this legislation would impact you personally. Putting a face on something can be pretty powerful, even for people who don’t think they care that much about a subject.

When we send letters, we include a long list of cc’s – that includes the author’s staff, the Committee consultants, the author’s office, sometimes the governor, Department of Finance, sometimes our colleagues at CMHDA, NAMI, or DHCS, MHA etc. The letter is always addressed to the chair of the committee that the bill is scheduled to be heard at if the bill is in the process already. When it is introduced but hasn’t been assigned to a committee yet, we’ll address it to the author. CMHPC letters are always signed by the Chair, not staff (i.e., me or even our Executive Officer, Jane Adcock).

***Any time you send a letter to Committee staff ahead of a committee hearing, it MUST be received by 5:00 p.m. the Thursday before the hearing in order to be included in the Staff analysis.*** If you miss that deadline, the staff will include it in materials for the legislators, but it is better to have it acknowledged in the analysis if possible (even if it is only to say “opposed by” or “supported by”).

Other methods include organizing or attending rallies, getting colleagues in similar organizations to also send letters or call; writing letters to the editor or an op-ed piece in the local paper. (So far, the Council hasn’t done these, but they are all on the table). Emulate other groups. Some of the best “lobbyists” out there are the In-Home Health Support Services groups – they show up everywhere, they always testify, they make noise, they educate everybody. It is not that they have such high numbers, but they have a very strong presence and they are able to influence.

**4. Do you have relationships with legislature and/or their offices? If so, what was your experience building those relationships?**

Not really. Not yet. Some legislative staff are starting to recognize our name, and they (the staff) will reach out to us to request support for legislation they are carrying if they know we have already gone on record as supporting it but it is not to us specifically. I think it is a matter of timing. They are so busy with legislation and budget when they are here it is hard to get their time (although things are pretty slow in February). It is probably easier to develop a relationship with their staff.

**5. What is the scope of your legislation committee?**

It is basically to represent the Council's interests in terms of what is spelled out on our Legislative Platform. This means that we will weigh in on the Budget and any regulations that are being formulated in respect to mental health services in addition to proposed legislation. We have a charter that spells out our mission and goals which are themselves based on the Council's vision and mission statements.

The Advocacy committee is to review the Legislative platform annually to see if it reflects current priorities and issues and recommend adjustments, which the entire Council must agree to and vote on. Having an approved platform allows me, (staff) to send letters of support or opposition without going through a group consensus and approval process.

There are Mandatory planks (based on our mandate in federal and state statute) – which are “automatic” /no-brainers.

Then there are the “Discretionary” planks – which DO require a review process and input prior to mailing the letter. We strive for consensus but don't always achieve it, in which case we allow for a minority dissent to be on record.

Here is a handy site for access to the Assembly Rules, Senate Rules, Joint Rules, the California Constitution, California Codes of Regulations, California Codes, etc.

<http://clerk.assembly.ca.gov//clerk/BILLSLEGISLATURE/PARLIAMENTARY.HTM>

## **Suspense File**

The committee, by a majority of the members present and voting, shall refer to the Suspense File all bills that would have a fiscal impact in any single fiscal year from the General Fund or from private funds of \$50,000 or more. Bills that establish a pilot project or program shall be referred to the Suspense File if the statewide implementation of the project or program would result in a fiscal impact of \$50,000 or more in any single fiscal year from the General Fund or private funds.

The committee, by a majority of the members present and voting, shall refer to the Suspense File all bills that would have a fiscal impact in any single fiscal year from any account(s) or fund(s) of \$150,000 or more. Bills that establish a pilot project or program shall be referred to the Suspense File if the statewide implementation of the project or program would result in a fiscal impact of \$150,000 or more in any single fiscal year from any account(s) or fund(s).

For purposes of the above paragraphs, "fiscal impact" shall include cost increases, cost pressures, revenue decreases, increases in appropriations subject to limitation that are restricted in their use and result from increases in tax proceeds, and reductions in the State's appropriations limit.

This provision shall not apply to deficiency or supplemental appropriations bills authored by the chair of the Senate or the Assembly Budget Committee or claims or judgments and settlements bills authored by the chair of the Senate or the Assembly Appropriations Committee.

Upon two days' notice in the Senate File, the chair may place before the committee a bill on the Suspense File.

A bill placed on the Suspense File may only be moved to Second Reading by an action of the committee.

The California State Assembly also has a suspense file, for which the rules in the Appropriations Committee are similar:

## **SUSPENSE FILE**

All bills with a fiscal impact in any fiscal year of \$150,000 or more will, by a majority of members present and voting, a quorum being present, move to the Suspense File. "Fiscal impact" includes all fund sources.

Authors should present all witnesses and testimony at the time of the bill's first hearing, even if the bill's provisions indicate a likely referral to Suspense. Authors may waive their right to presentation.

Suspense bills will be heard at a hearing that normally follows passage of the budget bill. When the bills are placed on the committee's agenda as "From Suspense File – For Vote Only," no testimony will be taken and the authors need not be present.

In each house the suspense file as a collection of bills that would cost the state more than \$50,000 from the General Fund, or \$150,000 from any source. At a future meeting of the Appropriation Committee, all bills in the suspense file are then voted on by the committee member one after another, quickly going through the possibly hundreds of bills in the file. Typically, the suspense file is revisited after the budget is passed, so the Senate can know which funds are available to implement new programs.

So the status "suspense file" is real and it does not mean that the bill is suspended or dead.

## Appropriations Committee Rules

Subject to the Joint Rules of the Senate and the Assembly, the Rules of the Assembly shall govern the conduct of all committee meetings. Committees may adopt additional rules not in conflict with the Assembly Rules or the Joint Rules.

### BILL SETTING

Upon receipt of a bill by the committee secretary, it will be set for hearing. It is not necessary to call the committee to set bills. No bills will be set "pending referral."

Bills set for hearing will appear in the Daily File. Notice will be sent to authors. The deadline for setting bills is 2:30 p.m., seven days prior to the hearing.

Please notify committee staff as soon as possible if a bill is to be taken off calendar. Bills taken off calendar will be reset for the next hearing unless arrangements are made by the author and approved by the Chair. A bill may be set for hearing in Appropriations only three times in accordance with Joint Rule 62(a).

### AMENDMENTS

#### Author's Amendments

To assure that bills are in print and analyzed the deadline for accepting author's amendments is 2:30 p.m., seven days prior to the hearing. They must be in Legislative Counsel form. Twelve copies of amendments, including the signed original, are required by the committee secretary.

Extensive and substantive amendments may require that a bill be put over to the following meeting. If major policy amendments are offered, the bill may be re-referred by the Chair to a policy committee.

#### Committee Amendments

Appropriations Committee staff is responsible for preparing amendments adopted in committee.

### PILOT PROJECTS

Bills establishing pilot projects will not be heard unless they specify measurable goals, objectives and time frames.

### SUSPENSE FILE

All bills with a fiscal impact in any fiscal year of \$150,000 or more will, by a majority of members present and voting, a quorum being present, move to the Suspense File. "Fiscal impact" includes all fund sources.

Authors should present all witnesses and testimony at the time of the bill's first hearing, even if the bill's provisions indicate a likely referral to Suspense. Authors may waive their right to presentation.

Suspense bills will be heard at a hearing that normally follows passage of the budget bill. When the bills are placed on the committee's agenda as "From Suspense File – For Vote Only," no testimony will be taken and the authors need not be present.

### CONSENT CALENDAR

The Chair will, with concurrence from the Vice Chair, prepare a proposed consent calendar for each hearing for noncontroversial bills with no significant costs that received no dissenting votes in the Assembly.

The consent calendar will be available at the hearing. Any committee member may remove a bill from consent or register a "No" vote with the secretary. If a bill is removed from the consent calendar during the hearing, the author will be notified by the Sergeants to present the bill.

## **COMMITTEE ANALYSES**

Authors will receive a copy of their bill analyses the day before the hearing, or no later than the morning of the hearing.

In accordance with Assembly rules, a limited number of committee bill analyses will be available to the public in the hearing room immediately prior to the meeting.

## **AUTHOR ORDER**

Authors are taken in sign-up order. Sign in with the Sergeants (Members only). An author may take up all of his or her bills at the same time.

## **TESTIMONY**

Please limit presentations to fiscal implications.

## **ROLL CALL VOTES**

Bills may be passed by substituting the consent calendar vote or a previous roll call. Additions or changes to the roll will only be permitted immediately prior to, or just after, adjournment of the committee and only provided the outcome of the vote is not changed.

When the roll on a bill is called, members who are silent will be recorded as not voting.

Members will not be included on the roll as voting unless they have been in attendance at the committee at some point during its deliberations.

X   INFORMATION

TAB SECTION        B

\_\_\_\_\_ ACTION REQUIRED

DATE OF MEETING    4/16/2015

MATERIAL  
PREPARED BY:    MurphyDATE MATERIAL  
PREPARED        3/16/2015

|  |   |
|--|---|
| <b>AGENDA ITEM:</b>                        | Review of Proposed Legislation                          |
| <b>ENCLOSURES:</b>                         | Bill Synopses – Capitol Track<br>Condensed Leg Analyses |
| <b>OTHER MATERIAL<br/>RELATED TO ITEM:</b> | No other materials.                                     |

**ISSUE:**

Several new bills have been proposed for this session and should be reviewed. The bill synopses as well as the preliminary reviews are attached. In many cases the bills have not been heard yet or revised as of the date this meeting packet has been put together.

If support or oppose letters are to be submitted, the document will need to reflect the points the committee would like to make that have been agreed upon by consensus.

**Please note these bills may have been amended since this packet was put together. If more up-to-date information is desired, please visit the Leg Info page at: <http://leginfo.legislature.ca.gov/faces/billSearchClient.xhtml>**

Staff will endeavor to bring the most up-to-date versions to the meeting electronically as well.

## Current Legislation for Consideration to date

[AB 690](#)

**(Wood D) Medi-Cal: federally qualified health centers: rural health clinics.**

**Current Text:** Introduced: 2/25/2015 [pdf](#) [html](#)

**Introduced:** 2/25/2015

**Summary:** Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid Program provisions. Existing law provides that federally qualified health center services and rural health clinic services, as defined, are covered benefits under the Medi-Cal program, to be reimbursed, to the extent that federal financial participation is obtained, to providers on a per-visit basis. "Visit" is defined as a face-to-face encounter between a patient of a federally qualified health center or a rural health clinic and specified health care professionals. This bill would include a marriage and family therapist within those health care professionals covered under that definition.

**Due Date**

[AB 741](#)

**(Williams D) Medi-Cal: comprehensive mental health crisis services.**

**Current Text:** Introduced: 2/25/2015 [pdf](#) [html](#)

**Introduced:** 2/25/2015

**Summary:** Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid Program provisions. Existing law provides for a schedule of benefits under the Medi-Cal program, which includes early and periodic screening, diagnosis, and treatment for any individual under 21 years of age. This bill would add to the schedule of benefits comprehensive mental health crisis services, including crisis intervention, crisis stabilization, crisis residential treatment, rehabilitative mental health services, and mobile crisis support teams, to the extent that federal financial participation is available and any necessary federal approvals have been obtained.

**Due Date**

[AB 848](#)

**(Stone, Mark D) Alcoholism and drug abuse treatment facilities.**

**Current Text:** Introduced: 2/26/2015 [pdf](#) [html](#)

**Introduced:** 2/26/2015

**Summary:** Existing law requires the State Department of Health Care Services to license adult alcoholism and drug abuse recovery or treatment facilities, as defined. Existing law provides for the licensure and regulation of health care practitioners by various boards and other entities within the Department of Consumer Affairs, and prescribes the scope of practice of those health care practitioners. This bill would authorize a facility to allow a licensed physician and surgeon or other health care practitioner, as defined, to provide incidental medical services to a resident of the facility at the facility premises under specified limited circumstances. The bill would require the department to conduct an evaluation of that program, and, on or before January 1, 2019, to report that evaluation to the appropriate fiscal and policy committees of the Legislature. The bill would also make related findings and declarations.

**Due Date**

[AB 861](#)

**(Maienschein R) Mental health services: patients' rights.**

**Current Text:** Introduced: 2/26/2015 [pdf](#) [html](#)

**Introduced:** 2/26/2015

**Summary:** Existing law directs the State Department of State Hospitals and the State Department of Health Care Services to ensure that mental health laws, regulations, and policies on the rights of recipients of mental health services are observed and protected in state hospitals and in licensed health and community care facilities. Existing law requires departments to contract with a single nonprofit entity for protection and advocacy services for persons with mental disabilities and requires the prescribed training of county patients' rights advocates to be provided by that contractor. This bill would make a technical, nonsubstantive change to these provisions.

**Due Date**

[AB 1025](#)

**(Thurmond D) Pupil health: multitiered and integrated interventions pilot program.**

**Current Text:** Introduced: 2/26/2015 [pdf](#) [html](#)

**Introduced:** 2/26/2015

**Summary:** Existing law establishes a system of public elementary and secondary schools in this state, and provides for the establishment of school districts and other local educational agencies to operate

these schools and provide instruction to pupils. Existing law requires the Superintendent of Public Instruction, among his or her other duties, to serve as the chief executive officer of the State Department of Education. This bill would require the State Department of Education to establish a 3-year pilot program to encourage inclusive practices that integrate mental health, special education, and school climate interventions following a multitiered framework in 3 schools in 10 school districts, as specified. The bill would require the State Department of Education to select schools where at least 60% of the student body is eligible for a free or reduced-price meal program and whose applications provide an estimate for the amount of funding being requested for start up and evaluation and detail a model approach that targets the behavioral, emotional, and academic needs of pupils with multitiered and integrated mental health, special education, and school climate interventions. The bill, contingent on the enactment of an appropriation for this purpose, would require the department to provide startup and evaluation funding to each school participating in the pilot program, and would require the schools to provide certain information to the State Department of Education in accordance with a comprehensive evaluation plan developed by the State Department of Health Care Services and the State Department of Education to assess the impact of the pilot program and disseminate best practices. The bill would require the State Department of Education to submit a report to the Legislature evaluating the success of the pilot program at the end of the 3-year period.

**Due Date**

**AB 1193 (Eggman D) Mental health services: assisted outpatient treatment.**

**Current Text:** Introduced: 2/27/2015 [pdf](#) [html](#)

**Introduced:** 2/27/2015

**Summary:** Existing law, the Assisted Outpatient Treatment Demonstration Project Act of 2002, known as Laura's Law, until January 1, 2017, authorizes each county to elect to offer certain assisted outpatient treatment services for their residents. Existing law authorizes participating counties to pay for the services provided from moneys distributed to the counties from various continuously appropriated funds, including the Mental Health Services Fund when included in a county plan, as specified. This bill would delete the provisions that authorize a county to elect to participate in the program, and instead would require each county to implement the provisions of Laura's Law unless the county elects not to participate in the program by enacting a resolution passed by the county board of supervisors. The bill would extend the January 1, 2017, repeal date of those provisions until January 1, 2022. This bill contains other related provisions and other existing laws.

**Due Date**

**AB 1194 (Eggman D) Mental health: involuntary commitment.**

**Current Text:** Introduced: 2/27/2015 [pdf](#) [html](#)

**Introduced:** 2/27/2015

**Summary:** Existing law, the Lanterman-Petris-Short Act, provides for the involuntary commitment and treatment of persons with specified mental disorders for the protection of the persons so committed. Under the act, when a person, as a result of mental health disorder, is a danger to others, or to himself or herself, or gravely disabled, he or she may, upon probable cause, be taken into custody by a peace officer, member of the attending staff of an evaluation facility, designated members of a mobile crisis team, or other designated professional person, and placed in a facility designated by the county and approved by the State Department of Social Services as a facility for 72-hour treatment and evaluation. Existing law requires, when determining if probable cause exists to take a person into custody, or cause a person to be taken into custody pursuant to the provisions described above, any person who is authorized to take or cause that person to be taken into custody to consider available relevant information about the historical course of the person's mental disorder, as specified, if the authorized person determines that information has a reasonable bearing on the determination described above. This bill would provide that for purposes of determining whether a person, as a result of a mental health disorder, is a danger to others, or to himself or herself, danger constitutes a present risk of harm that requires consideration of the historical course of a person's mental health disorder and shall not be limited to imminent or immediate risk of harm to others or to himself or herself. This bill contains other related provisions and other existing laws.

**Due Date**

**AB 1300 (Ridley-Thomas D) Mental health: involuntary commitment.**

**Current Text:** Introduced: 2/27/2015 [pdf](#) [html](#)

**Introduced:** 2/27/2015

**Summary:** Under existing law, when a person, as a result of mental disorder, is a danger to others, or to himself or herself, or gravely disabled, he or she may, upon probable cause, be taken into custody by a peace officer, member of the attending staff of an evaluation facility, designated members of a mobile crisis team, or other designated professional person, and placed in a facility designated by the county and approved by the State Department of Health Care Services as a facility for 72-hour

treatment and evaluation. This bill would authorize counties to designate one or more persons to act as a local or regional liaison to assist a person who is a patient in an emergency department of a defined nondesignated hospital and who has been detained, or who may require detention, for evaluation and treatment, as specified. The bill would reorganize and make changes to the provisions relating to the detention for evaluation and treatment of a person who may be subject to the above provisions, including specifying procedures for delivery of those individuals to various facilities; evaluation of the person for probable cause for detention for evaluation and treatment; terms and length of detention, where appropriate, in various types of facilities; and criteria for release from defined designated facilities and nondesignated hospitals. The bill would authorize a provider of ambulance services to transfer a person who is voluntarily transferring to a designated facility for evaluation and treatment. The bill would also make changes to the methods by which law enforcement is notified of the release of a person detained for evaluation and treatment.

**Due Date**

**SB 11**

**(Beall D) Peace officer training: mental health.**

**Current Text:** Amended: 2/26/2015 [pdf](#) [html](#)

**Introduced:** 12/1/2014

**Last Amend:** 2/26/2015

**Summary:** Existing law requires specified categories of law enforcement officers to meet training standards pursuant to courses of training certified by the Commission on Peace Officer Standards and Training (POST). Existing law requires POST to include in its basic training course adequate instruction in the handling of persons with developmental disabilities or mental illness, or both. Existing law also requires POST to establish and keep updated a continuing education classroom training course relating to law enforcement interaction with developmentally disabled and mentally ill persons. This bill would require POST to include in its basic training course an evidence-based behavioral health classroom training course to train law enforcement officers to recognize, deescalate, and refer persons with mental illness or intellectual disability who are in crisis. The bill would require that this evidence-based behavioral health classroom training course be 20 hours long and be in addition to the basic training course's current hour requirement. This bill contains other related provisions and other existing laws.

**Due Date**

**SB 29**

**(Beall D) Peace officer training: mental health.**

**Current Text:** Amended: 2/26/2015 [pdf](#) [html](#)

**Introduced:** 12/1/2014

**Last Amend:** 2/26/2015

**Summary:** Existing law requires specified categories of law enforcement officers to meet training standards pursuant to courses of training certified by the Commission on Peace Officer Standards and Training (POST). Existing law requires POST to include in its basic training course adequate instruction in the handling of persons with developmental disabilities or mental illness, or both. Existing law also requires POST to establish and keep updated a continuing education classroom training course relating to law enforcement interaction with developmentally disabled and mentally ill persons. This bill would require POST to require field training officers who are instructors for the field training program to have 40 hours of evidence-based behavioral health training, as specified. The bill would also require POST to require the field training program to include a 20-hour evidence-based behavioral health training course relating to law enforcement interaction with persons with mental illness or intellectual disability. This bill contains other related provisions and other existing laws.

**Due Date**

**SB 296**

**(Cannella R) Medi-Cal: specialty mental health services: documentation requirements.**

**Current Text:** Introduced: 2/23/2015 [pdf](#) [html](#)

**Introduced:** 2/23/2015

**Summary:** Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services, including specialty mental health services. The Medi-Cal program is, in part, governed and funded by federal Medicaid Program provisions. In order to facilitate the receipt of medically necessary specialty mental health services by a foster child who is placed outside of his or her county of original jurisdiction, existing law requires the department to create a standardized set of documentation standards and forms. This bill would require the department, in consultation with specified stakeholders, to develop a single set of service documentation requirements for the provision of specialty mental health services by March 31, 2016, for use commencing July 1, 2016, and would require the department to update the documentation requirements no less than every 2 years. The bill would generally prohibit counties from requiring additional documentation requirements for Medi-Cal specialty mental health services that go beyond the documentation requirements developed by the department.

**SB 614 (Leno D) Medi-Cal: mental health services: peer and family support specialist certification.****Current Text:** Introduced: 2/27/2015 [pdf](#) [html](#)**Introduced:** 2/27/2015

**Summary:** Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income persons receive health care benefits. The Medi-Cal program is, in part, governed and funded by federal Medicaid provisions. Existing law provides for a schedule of benefits under the Medi-Cal program and provides for various services, including various behavioral and mental health services. This bill would require the State Department of Health Care Services to establish, by July 1, 2016, a statewide peer and family support specialist certification program, as a part of the state's comprehensive mental health delivery system. The bill would include 3 certification categories: adult peer support specialists, family peer support specialists, and parent peer support specialists. The certification program's components would include, among others, defining responsibilities and practice guidelines, determining curriculum and core competencies, specifying training and continuing education requirements, and establishing a code of ethics and certification revocation processes. This bill contains other related provisions and other existing laws.

Due Date

**Total Measures: 12****Total Tracking Forms: 12**

## Condensed Analysis Sheet

|   |  |   |                |                |                                      |                                |             |
|---|--|---|----------------|----------------|--------------------------------------|--------------------------------|-------------|
| <b>Author</b>   | <b>Introduced</b>  | <b>Revisions:</b>   | <b>Date</b>    | <b>Date</b>    | <b>Loc/Status</b>                    | <b>Next hearing/committee:</b> | <b>Date</b> |
| <b>Wood</b>   | 2/25/2015  | 1 <sup>st</sup> :   |                |                | A-Health, to be heard on Apr 7, 2015 |                                |             |
| <b>Bill #</b><br><b>AB 690</b>  | <b>Description:</b>  |   |                |                |                                      |                                |             |
| <b>Staff Recommendation:</b>  | Current law provides that federally qualified health center services and rural health clinic services, as defined, are covered benefits under the Medi-Cal program, to be reimbursed, to the extent that federal financial participation is obtained, to providers on a per-visit basis. "Visit" is defined as a face-to-face encounter between a patient of a federally qualified health center or a rural health clinic and specified health care professionals. This bill would include a marriage and family therapist within those health care professionals covered under that definition. |   |                |                |                                      |                                |             |
| <b>Support</b>  |  |   |                |                |                                      |                                |             |
|   |  |   |                |                |                                      |                                |             |
| <b>What prompted it? (What problem is this addressing?)</b>   |  |   |                |                |                                      |                                |             |
| Difficulty in attracting licensed mental health professionals to rural areas or to FQHC's.                            |  |   |                |                |                                      |                                |             |
| <b>How will this bill address the problem?</b>  |  |   |                |                |                                      |                                |             |
| It will widen the pool of acceptable and qualified practitioners.   |  |   |                |                |                                      |                                |             |
| <b>Platform Issue? Which one(s)?</b>  |  | <i>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.</i> |                |                |                                      |                                |             |
| <b>How will it be funded if it passes? Are cost estimates available? Describe source &amp; \$\$ amounts if known:</b> |  | Federal participation, but the rest TBD. It will require a fiscal committee review.   |                |                |                                      |                                |             |
| <b>Supporters:</b>  |  |   |                | <b>Oppose:</b> |                                      |                                |             |
| <b>How do our colleagues stand on this bill?</b>  |  |   |                |                |                                      |                                |             |
| <b>CMHDA</b>  |  | <b>Disability Rights California</b>   |                |                | <b>NAMI</b>                          |                                |             |
| <b>Date</b>   | <b>Stance:</b>   | <b>Date:</b>  | <b>Stance:</b> | <b>Date:</b>   | <b>Stance:</b>                       |                                |             |
|   |  |   |                |                |                                      |                                |             |
| <b>Reason:</b>  |  | <b>Reason:</b>  |                |                | <b>Reason:</b>                       |                                |             |
|   |  |   |                |                |                                      |                                |             |

## Condensed Analysis Sheet

|   |   |   |                                     |                |                |                         |                |
|---|---|---|-------------------------------------|----------------|----------------|-------------------------|----------------|
| <b>Author</b>   | <b>Introduced</b><br>2/25/2015  | <b>Revisions:</b><br>1 <sup>st</sup> :  | Date                                | Date           | Loc/Status     | Next hearing/committee: | Date           |
| <b>Williams</b>   |   |   |                                     |                |                |                         |                |
| <b>Bill #</b><br><b>AB 741</b>  | <b>Description:</b> This bill would add to the schedule of Medi-Cal benefits comprehensive mental health crisis services, including crisis intervention, crisis stabilization, crisis residential treatment, rehabilitative mental health services, and mobile crisis support teams, to the extent that federal financial participation is available and any necessary federal approvals have been obtained |   |                                     |                |                |                         |                |
| <b>Staff Recommendation:</b><br><br><b>Support</b>  |   |   |                                     |                |                |                         |                |
| <b>What prompted it? (What problem is this addressing?)</b>   |   |   |                                     |                |                |                         |                |
| There is an urgent need to provide more crisis care alternatives to hospitals for individuals experiencing mental health crises. The problems are especially acute for children who may have to wait for days for a hospital bed and who may be transported, without a parent, to the nearest facility hundreds of miles away. In 2012, the California Hospital Association reported that two-thirds of the people taken to a hospital for a psychiatric emergency did not meet the criteria for that level of care but the care they needed was not available. SB 82 encouraged counties to provide more crisis programs, but they cannot accommodate children. There is currently no state licensing category for crisis residential programs for children. |   |   |                                     |                |                |                         |                |
| <b>How will this bill address the problem?</b>  |   |   |                                     |                |                |                         |                |
| Existing law provides for a schedule of benefits under the Medi-Cal program, which includes early and periodic screening, diagnosis, and treatment for any individual under 21 years of age. This bill would add to the schedule of benefits comprehensive mental health crisis services, including crisis intervention, crisis stabilization, crisis residential treatment, rehabilitative mental health services, and mobile crisis support teams, to the extent that federal financial participation is available and any necessary federal approvals have been obtained.  |   |   |                                     |                |                |                         |                |
| <b>Platform Issue? Which one(s)?</b>  |   | Support initiatives that maintain or improve access to mental health services, <i>particularly to underserved populations</i> , and maintain or improve quality of mental health services (Mandatory)   |                                     |                |                |                         |                |
|   |   | Support any initiatives that reduce or eliminate the use of seclusion and restraint. (Mandatory)  |                                     |                |                |                         |                |
| <b>How will it be funded if it passes? Are cost estimates available? Describe source &amp; \$\$ amounts if known:</b>   |   | <i>The department (DHCS) shall seek approval of any necessary state plan amendments to implement this subdivision. This subdivision line 14 shall be implemented only to the extent that federal financial participation is available and any necessary federal approvals have been obtained.</i> |                                     |                |                |                         |                |
| <b>Supporters:</b>  |   |   |                                     | <b>Oppose:</b> |                |                         |                |
| <b>How do our colleagues stand on this bill?</b>  |   |   |                                     |                |                |                         |                |
| <b>CMHDA</b>  |   |   | <b>Disability Rights California</b> |                |                | <b>NAMI</b>             |                |
| <b>Date</b>   | <b>Stance:</b>  | <b>Date:</b>  | <b>Stance:</b>                      | <b>Date:</b>   | <b>Stance:</b> | <b>Date:</b>            | <b>Stance:</b> |

## Condensed Analysis Sheet

| Author  | Introduced   | Revisions:   | Date | Date           | Loc/Status                           | Next hearing/committee: | Date |
|---|--|--|------|----------------|--------------------------------------|-------------------------|------|
| <b>Chau</b>   | 2/25/2015  | 1 <sup>st</sup> :  |      |                | Referred to A-Health;<br>no date set |                         |      |
| <b>Bill #</b><br><b>AB 745</b>  | <b>Description:</b><br>Would require the Speaker of the Assembly to appoint an additional member to the Mental Health Services Oversight and Accountability Commission who has experience providing supportive housing to persons with a severe mental illness. The bill would state the findings and declarations of the Legislature that this change is consistent with and furthers the intent of the Mental Health Services Act. |  |      |                |                                      |                         |      |
| <b>Staff Recommendation:</b>  |  |  |      |                |                                      |                         |      |
|   |  |  |      |                |                                      |                         |      |
| <b>What prompted it? (What problem is this addressing?)</b><br>Not stated   |  |  |      |                |                                      |                         |      |
| <b>How will this bill address the problem?</b><br>Add a position to the OAC   |  |  |      |                |                                      |                         |      |
| <b>Platform Issue? Which one(s)?</b>  |  | <ul style="list-style-type: none"> <li>• Support expanding affordable housing and affordable supportive housing. (mandatory)</li> <li>• Actively advocate for the development of housing subsidies and resources so that housing is affordable to people living on SSI.</li> </ul> |      |                |                                      |                         |      |
|   |  |  |      |                |                                      |                         |      |
| <b>How will it be funded if it passes? Are cost estimates available? Describe source &amp; \$\$ amounts if known:</b> |  | Not stated. The position is a volunteer position, so the fiscal impact should be minimal. However, a review by the Fiscal committee is required.   |      |                |                                      |                         |      |
|   |  |  |      |                |                                      |                         |      |
| <b>Supporters:</b>  |  |  |      | <b>Oppose:</b> |                                      |                         |      |

## Condensed Analysis Sheet

| Author  | Introduced  | Revisions:        | Date | Date           | Loc/Status                             | Next hearing/committee: | Date |
|---|---|-------------------|------|----------------|--|-------------------------|------|
| Maienschein   | 2/26/2015   | 1 <sup>st</sup> : |      |                | Policy Committee<br>3/29/2015 possibly |                         |      |
| <b>Bill #</b><br><b>AB 861</b>  | <b>Description:</b><br>Current law requires the State Department of State Hospitals and the State Department of Health Care Services to contract with a single nonprofit entity for protection and advocacy services for persons with mental disabilities and requires the prescribed training of county patients' rights advocates to be provided by that contractor. This bill would make a technical, nonsubstantive change to these provisions. |                   |      |                |  |                         |      |
| <b>Staff Recommendation:</b><br><b>Support</b>  |   |                   |      |                |  |                         |      |
| <b>What prompted it? (What problem is this addressing?)</b><br>Appears to be a clarification in terms or expectations of contractor – clarifies that “Training shall be directed at ensuring that all county patients’ rights advocates possess <i>all of the following</i> ” |   |                   |      |                |  |                         |      |
| <b>How will this bill address the problem?</b><br>Makes the clarification that appears to be needed.  |   |                   |      |                |  |                         |      |
| <b>Platform Issue? Which one(s)?</b>  | <ul style="list-style-type: none"> <li>• Support initiatives that maintain or improve access to mental health services, particularly to underserved populations, and maintain or improve quality of mental health services.</li> </ul>  |                   |      |                |  |                         |      |
| <b>How will it be funded if it passes? Are cost estimates available? Describe source &amp; \$\$ amounts if known:</b>   |   |                   |      |                |  |                         |      |
| No fiscal committee review required, it appears to be cost neutral.   |   |                   |      |                |  |                         |      |
| <b>Supporters:</b>  |   |                   |      | <b>Oppose:</b> |  |                         |      |
|   |   |                   |      |                |  |                         |      |
|   |   |                   |      |                |  |                         |      |
|   |   |                   |      |                |  |                         |      |

## Condensed Analysis Sheet

| Author   | Introduced   | Revisions:        | Date | Date           | Loc/Status | Next hearing/committee: | Date |
|--|--|-------------------|------|----------------|------------|-------------------------|------|
| <b>Wood</b>  | 2/26/2015  | 1 <sup>st</sup> : |      |                |            |                         |      |
| <b>Bill #</b><br><b>AB 858</b>   | <b>Description:</b>  |                   |      |                |            |                         |      |
| <b>Staff Recommendation:</b><br><br><b>Support</b>   | Existing law allows an federally qualified health center (FQHC) or rural health clinic (RHC) to apply for an adjustment to its per-visit rate based on a change in the scope of services it provides. This bill would provide that a maximum of 2 visits, as defined, taking place on the same day at a single location shall be reimbursed when either after the first visit the patient suffers illness or injury requiring additional diagnosis or treatment or the patient has a medical visit, as defined, and another health visit, as defined, or both.   |                   |      |                |            |                         |      |
| <b>What prompted it? (What problem is this addressing?)</b>  |  |                   |      |                |            |                         |      |
| Not permitting same day billing for people in rural areas or who are economically disadvantaged impedes access to their health care services. Requiring people to return to a health care site, which may be some distance from their residence, or require uncompensated time off from work, or who are generally resistant to being seen, is an extreme hardship for those who must endure it. It also creates an unnecessary delay in reimbursement and additional time preparing the billing for those services. |  |                   |      |                |            |                         |      |
| <b>How will this bill address the problem?</b>   |  |                   |      |                |            |                         |      |
| It will enable clinics to function more efficiently by addressing more than one issue in a day.  |  |                   |      |                |            |                         |      |
| <b>Platform Issue? Which one(s)?</b>   | <ul style="list-style-type: none"> <li>• 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.</li> <li>• Support initiatives that maintain or improve access to mental health services, particularly to underserved populations, and maintain or improve quality of mental health services.</li> </ul>   |                   |      |                |            |                         |      |
| <b>How will it be funded if it passes? Are cost estimates available? Describe source &amp; \$\$ amounts if known:</b>  | <p>The bill would require an FQHC or RHC that currently includes the cost of encounters as a single visit to apply for an adjustment to its per-visit rate by January 1, 2017. After the rate adjustment has been approved by the department, this bill will require the FQHC or RHC to bill a medical visit and another health visit that take place on the same day at a single location as separate visits.</p> <p>This bill would require the department, by January 15, 2016, to submit a state plan amendment to the federal Centers for Medicare and Medicaid Services reflecting the changes described above</p> |                   |      |                |            |                         |      |
| <b>Supporters:</b>   |  |                   |      | <b>Oppose:</b> |            |                         |      |

## Condensed Analysis Sheet

| Author   | Introduced  | Revisions:        | Date | Date | Loc/Status | Next hearing/committee: | Date |
|--|---|-------------------|------|------|------------|-------------------------|------|
| <b>Thurmond</b>  | 2/26/2015   | 1 <sup>st</sup> : |      |      |            |                         |      |
| <b>Bill #</b>  | <b>Description:</b>   |                   |      |      |            |                         |      |
| <b>AB 1025</b>   | Would require the State Department of Education to establish a 3-year pilot program to encourage inclusive practices that integrate mental health, special education, and school climate interventions following a multitiered framework in 3 schools in 10 school districts, as specified. The bill would require the State Department of Education to select schools where at least 60% of the student body is eligible for a free or reduced-price meal program and whose applications provide an estimate for the amount of funding being requested for start up and evaluation and detail a model approach that targets the behavioral, emotional, and academic needs of pupils with multitiered and integrated mental health, special education, and school climate interventions. The bill would require the State Department of Education to submit a report to the Legislature evaluating the success of the pilot program at the end of the 3-year period |                   |      |      |            |                         |      |
| <b>Staff Recommendation:</b>   |   |                   |      |      |            |                         |      |
| <b>Support</b>   |   |                   |      |      |            |                         |      |
| <b>What prompted it? (What problem is this addressing?)</b>  |   |                   |      |      |            |                         |      |
| Current funding practices fail to adequately incentivize schools to invest in front-end preventative measures that would reduce overall cost of special education. Students with stressors such as economic disadvantage, emotional disturbance, or being in the foster care system have lower rates of graduation.  |   |                   |      |      |            |                         |      |
| <b>How will this bill address the problem?</b>   |   |                   |      |      |            |                         |      |
| This bill creates a three year pilot program in six schools to focus on the development and delivery of an inclusive multitiered system of behavioral and academic supports such as targeted interventions for pupils with identified social-emotional, behavioral, and academic needs in a supportive climate that adopts bully-prevention actions and fosters a student sense of well-being. |   |                   |      |      |            |                         |      |
| <b>Platform Issue? Which one(s)?</b>   | <ul style="list-style-type: none"> <li>• Support policies that reduce and eliminate stigma and discrimination. (Mandatory)</li> <li>• Support initiatives that maintain or improve access to mental health services, particularly to underserved populations, and maintain or improve quality of mental health services. (Mandatory)</li> </ul>   |                   |      |      |            |                         |      |
| <b>How will it be funded if it passes? Are cost estimates available? Describe source &amp; \$\$ amounts if known:</b>  |   |                   |      |      |            |                         |      |
| Upon the enactment of an appropriation in the annual Budget Act for the purpose of implementing this section, the department shall provide startup and evaluation funding to each school participating in the pilot program in the following amounts:  |   |                   |      |      |            |                         |      |
| <ul style="list-style-type: none"> <li>(1) Two hundred fifty thousand dollars (\$250,000) in year one.</li> <li>(2) Two hundred thousand dollars (\$200,000) in year two.</li> <li>(3) One hundred fifty thousand dollars (\$150,000) in year three. (I heard it would be funded through PEI though).</li> </ul>   |   |                   |      |      |            |                         |      |

## Condensed Analysis Sheet

|  |   |  |                |                |                   |                                |                |
|--|---|--|----------------|----------------|-------------------|--------------------------------|----------------|
| <b>Author</b><br><br>Eggman  | <b>Introduced</b><br><br>2/27/2015  | <b>Revisions:</b><br>1 <sup>st</sup> : | <b>Date</b>    | <b>Date</b>    | <b>Loc/Status</b> | <b>Next hearing/committee:</b> | <b>Date</b>    |
| <b>Bill #</b><br><b>AB 1193</b>  | <b>Description:</b> Would delete the provisions that authorize a county to elect to participate in the Assisted Outpatient Treatment Demonstration Project Act of 2002 (Laura's Law), and instead would <u>require</u> each county to implement the provisions of Laura's Law unless the county elects not to participate in the program by enacting a resolution passed by the county board of supervisors. The bill would extend the January 1, 2017, repeal date of those provisions until January 1, 2022. This bill contains other related provisions and other existing laws.<br><b>It also increases the number of people who may request that outpatient treatment be supplied to a person (i.e., a judge).</b>   |  |                |                |                   |                                |                |
| <b>Staff Recommendation:</b><br><b>TBD/ Oppose, or Oppose unless amended?</b>  |   |  |                |                |                   |                                |                |
| <b>What prompted it? (What problem is this addressing?)</b> This is not addressed in the text of the proposed legislation -  |   |  |                |                |                   |                                |                |
| <b>How will this bill address the problem?</b> Unknown at this time.   |   |  |                |                |                   |                                |                |
| <b>Platform Issue? Which one(s)?</b>   | (This may be debatable): <i>"Oppose any legislation that adversely affects the principles and practices of the Mental Health Services Act."</i> (Mandatory plank)<br><br><i>"Promote the definition of outreach to mean "patient, persistent, and non-threatening contact" when used in context of engaging hard to reach populations."</i> (Discretionary plank)   |  |                |                |                   |                                |                |
| <b>How will it be funded if it passes? Are cost estimates available? Describe source &amp; \$\$ amounts if known:</b>  | "may pay for the provision of services under Sections 5347 and 5348 using funds distributed to the counties from the Mental Health Subaccount, the Mental Health Equity Subaccount, and the Vehicle License Collection Account of the Local Revenue Fund, funds from the Mental Health Account and the Behavioral Health Subaccount within the Support Services Account of the Local Revenue Fund, funds from the Mental Health Services Fund when included in county plans pursuant to Section 5847, and any other funds from which the Controller makes distributions to the counties for those purposes. Compliance with this section shall be monitored by the State Department of Health Care Services as part of its review and approval of county performance contracts. |  |                |                |                   |                                |                |
| <b>Staff Concerns/observations/questions:</b> 1) Strikes out language that no voluntary adult's or children's mental health services may be reduced as a result of this action; and<br>2) Does County BOS Resolution require public hearing? There was already language that it could be adopted through the budget process, which the Council has argued in the past meant it might lack transparency (and violates MHSA principles). |   |  |                |                |                   |                                |                |
| <b>Supporters:</b>   |   |  |                | <b>Oppose:</b> |                   |                                |                |
| <b>How do our colleagues stand on this bill?</b>   |   |  |                |                |                   |                                |                |
| <b>CMHDA</b>   |   | <b>Disability Rights California</b>    |                |                | <b>NAMI</b>       |                                |                |
| <b>Date</b>  | <b>Stance:</b>  | <b>Date:</b>                           | <b>Stance:</b> | <b>Date:</b>   | <b>Stance:</b>    | <b>Date:</b>                   | <b>Stance:</b> |
| <b>Reason:</b>   |   | <b>Reason:</b>                         |                |                | <b>Reason:</b>    |                                |                |

## Condensed Analysis Sheet

|   |  |  |                                     |                          |                   |                                |                |
|---|--|--|-------------------------------------|--------------------------|-------------------|--------------------------------|----------------|
| <b>Author</b>   | <b>Introduced</b>  | <b>Revisions:</b>  | <b>Date</b>                         | <b>Date</b>              | <b>Loc/Status</b> | <b>Next hearing/committee:</b> | <b>Date</b>    |
| <b>Eggman</b>   | 2/27/2015  | 1 <sup>st</sup> :  |                                     |                          |                   |                                |                |
| <b>Bill #</b><br><b>1194</b>  | <b>Description:</b><br>Would provide that for purposes of determining whether a person, as a result of a mental health disorder, is a danger to others, or to himself or herself, danger constitutes a present risk of harm that requires consideration of the historical course of a person's mental health disorder and shall not be limited to imminent or immediate risk of harm to others or to himself or herself. This bill contains other related provisions and other existing laws |  |                                     |                          |                   |                                |                |
| <b>Staff Recommendation:</b><br><br><b>Watch</b>  |  |  |                                     |                          |                   |                                |                |
| <b>What prompted it? (What problem is this addressing?)</b><br>The reason stated for the need for this bill was that often times when somebody in crisis is looked in on, they present as "okay" and in no immediate danger to themselves or others, but that if previous history is allowed to be considered, it may result in treatment sooner. |  |  |                                     |                          |                   |                                |                |
| <b>How will this bill address the problem?</b><br>Allow responders and officials to consider previous history as a context for current concern when evaluating the need to put a person on a 5150 hold.   |  |  |                                     |                          |                   |                                |                |
| <b>Platform Issue? Which one(s)?</b>  |  | Not specifically – Seclusion and restraint possibly – but that is usually once a person is admitted.   |                                     |                          |                   |                                |                |
| <b>How will it be funded if it passes? Are cost estimates available? Describe source &amp; \$\$ amounts if known:</b>   |  | Not stated explicitly: " <i>This bill would provide that, if the Commission on State Mandates determines that the bill contains costs mandated by the state, reimbursement for those costs shall be made pursuant to these statutory provisions.</i> " Fiscal committee review required. |                                     |                          |                   |                                |                |
| <b>Supporters:</b>  |  |  |                                     | <b>Oppose:</b>           |                   |                                |                |
| <b>How do our colleagues stand on this bill?</b>  |  |  |                                     |                          |                   |                                |                |
| <b>CMHDA</b>  |  |  | <b>Disability Rights California</b> |                          |                   | <b>NAMI</b>                    |                |
| <b>Date</b>   | <b>Stance:</b>   |  | <b>Date:</b>                        | <b>Stance:</b>           |                   | <b>Date:</b>                   | <b>Stance:</b> |
|   |  |  |                                     |                          |                   |                                |                |
| <b>Progress:</b>  |  | <b>Assembly Approval:</b>  |                                     | <b>Senate Approval :</b> |                   | <b>Gov. Approval:</b>          |                |
| Letter Sent:  |  |  |                                     |                          |                   |                                |                |

## Condensed Analysis Sheet

|  |   |   |                                     |              |                                    |   |             |
|--|---|---|-------------------------------------|--------------|------------------------------------|---|-------------|
| <b>Author</b><br>Beall   | <b>Introduced</b><br><br>12/1/2014  | <b>Revisions:</b><br>1 <sup>st</sup> :<br>2/26/15 | <b>Date</b>                         | <b>Date</b>  | <b>Loc/Status</b><br>Public Safety | <b>Next hearing/committee:</b><br>Public Safety on 4/7/2015<br>9:30 a.m., Room 4206 | <b>Date</b> |
| <b>Bill #</b><br>SB 11   | <b>Description:</b><br><i>This bill would require POST to include in its basic training course an evidence-based behavioral health classroom training course to train law enforcement officers to recognize, deescalate, and refer persons with mental illness or intellectual disability who are in crisis.</i>                      |   |                                     |              |                                    |   |             |
| <b>Staff Recommendation:</b><br><br><b>SUPPORT</b>   |   |   |                                     |              |                                    |   |             |
| <b>What prompted it? (What problem is this addressing?)</b>  |   |   |                                     |              |                                    |   |             |
| Interactions between law enforcement and civilians in mental distress has increasingly become more violent and injurious to the civilian There have been several incidents where these interactions have resulted in death or severe bodily injury to the civilian and additional mental trauma. In addition to the pain and suffering this causes, it also creates a hostile and mistrustful environment which is not conducive to law enforcement and public safety.               |   |   |                                     |              |                                    |   |             |
| <b>How will this bill address the problem?</b>   |   |   |                                     |              |                                    |   |             |
| <i>The bill would require that this evidence-based behavioral health classroom training course be 20 hours long and <b>be in addition to the basic training</b> course's current hour requirement and that the trainer have a minimum of 40 hours training. The bill would also require POST to establish and keep updated an evidence-based behavioral health training course as part of its perishable skills training under its continuing professional training requirement.</i> |   |   |                                     |              |                                    |   |             |
| <b>Platform Issue? Which one(s)?</b>   | <p>"Support policies that reduce and eliminate stigma and discrimination." (Mandatory)</p> <p>"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". (Discretionary)</p> |   |                                     |              |                                    |   |             |
| <b>How will it be funded if it passes? Are cost estimates available? Describe source &amp; \$\$ amounts if known:</b>  |   |   |                                     |              |                                    |   |             |
| TBD: "...the bill would impose a state-mandated local program." "...reimbursement to local agencies and school districts for those costs shall be made pursuant to Part 7 (commencing with Section 17500) of Division 4 of Title 2 of the Government Code."  |   |   |                                     |              |                                    |   |             |
| <b>Supporters:</b>   |   |   |                                     |              | <b>Oppose:</b>                     |   |             |
| <b>How do our colleagues stand on this bill?</b>   |   |   |                                     |              |                                    |   |             |
| <b>CMHDA</b>   |   |   | <b>Disability Rights California</b> |              |                                    | <b>NAMI</b>   |             |
| <b>Date</b>  | <b>Stance:</b>  | <b>Date:</b>                                      | <b>Stance:</b>                      | <b>Date:</b> | <b>Stance:</b>                     |   |             |
| <b>Reason:</b>   |   | <b>Reason:</b>                                    |                                     |              | <b>Reason:</b>                     |   |             |



## Condensed Analysis Sheet

| Author   | Introduced   | Revisions:                     | Date | Date | Loc/Status             | Next hearing/committee:      | Date |
|--|--|--------------------------------|------|------|------------------------|------------------------------|------|
| <b>Beall</b>   | 12/01/2014   | 1 <sup>st</sup> :<br>2/26/2015 |      |      | Policy, referred to PS | Public Safety, April 7, 2015 |      |
| <b>Bill #</b><br><b>SB 29</b>  | <b>Description:</b><br>Would require the Commission on Peace Officer Standards and Training (POST) to require field training officers who are instructors for the field training program to have 40 hours of evidence-based behavioral health training, as specified. The bill would also require POST to require the field training program to include a 20-hour evidence-based behavioral health training course relating to law enforcement interaction with persons with mental illness or intellectual disability. This bill contains other related provisions and other existing laws. |                                |      |      |                        |                              |      |
| <b>Staff Recommendation:</b><br><br><b>Support</b>   |  |                                |      |      |                        |                              |      |
|  |  |                                |      |      |                        |                              |      |
| <b>What prompted it? (What problem is this addressing?)</b><br>Increasing incidents of officer-involved beatings/shootings/killings of individuals who are experiencing a crisis or psychotic episode by officers who feel threatened or may feel the person poses an imminent threat to others.   |  |                                |      |      |                        |                              |      |
| <b>How will this bill address the problem?</b><br>This bill will require evidence based behavioral health training for officers to distinguish between developmentally disabled, mentally ill, or substance use disordered; how to respond and de-escalate situations; understanding the resources that are available for referral; the perspective of family members and those living with a mental illness; appropriate language, etc. in order to be more informed and prepared for those situations. |  |                                |      |      |                        |                              |      |
| <b>Platform Issue? Which one(s)?</b>   | <ul style="list-style-type: none"> <li>• Support policies that reduce and eliminate stigma and discrimination. (mandatory plank)</li> <li>• 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. (Discretionary Plank)</li> </ul>   |                                |      |      |                        |                              |      |
|  |  |                                |      |      |                        |                              |      |
| <b>How will it be funded if it passes? Are cost estimates available? Describe source &amp; \$\$ amounts if known:</b>  | Funding source is not cited yet, but reimbursement to counties will be required:<br><i>“This bill would provide that, if the Commission on State Mandates determines that the bill contains costs mandated by the state, reimbursement for those costs shall be made pursuant to these statutory provisions”.</i>  |                                |      |      |                        |                              |      |

X   INFORMATION TAB SECTION C

\_\_\_\_\_ ACTION REQUIRED DATE OF MEETING 4/16/15

MATERIAL PREPARED BY: Murphy DATE MATERIAL PREPARED 3/18/15

|  |  |
|--|--|
| <b>AGENDA ITEM:</b>                    | <b>IMD Utilization Rates and Social Reinvestment Strategies in Los Angeles County</b>  |
| <b>ENCLOSURES:</b>                     | <b>Advocacy Committee Questions to Mental Health Departments<br/>LACDMH/CRMB Alternative Crisis Services Criteria and Requirements</b> |
| <b>OTHER MATERIAL RELATED TO ITEM:</b> | Listing of services provided through the Countywide Resource Management Branch   |

**ISSUE:**

The 2015 Work Plan for the Advocacy Committee will compare the rates of IMD and Long Term Mental Health Rehabilitation Center placements throughout the state. To that end, the committee will hear from the Los Angeles County Department of Mental Health (LACDMH) Countywide Resource Management Branch (CRMB) about its efforts to reduce IMD usage and promote social reinvestment/ reintegration services in Los Angeles. We will also receive feedback on questions the committee developed (attached) for its statewide survey of mental health departments on IMD usage and alternatives.

The LACDMH/CRMB performs the following functions:

- Provide overall administrative, clinical, integrative, and fiscal management functions for the Department's indigent acute inpatient, long-term institutional, and crisis, intensive, and supportive residential resources, with a daily capacity for approximately 1,400 persons;
- Provide coordination, linkage, and integration of inpatient and residential services throughout the system to reduce rates of re-hospitalization, incarceration, and the need for long-term institutional care, while increasing the potential for community living and recovery.

In respect to reducing IMD usage, the Alternate Crisis Services (ACS) provides a comprehensive range of services and supports for mentally ill individuals. For those meeting the specified criteria (see attached), these services are designed to provide alternatives to emergency room care, acute inpatient hospitalization and institutional care, reduce homelessness, and prevent incarceration. These programs are essential to crisis intervention and stabilization, service integration and linkage to community-based programs, e.g. Full Service Partnerships (FSP) and Assertive Community Treatment Programs (ACT), housing alternatives and treatment for co-occurring substance abuse. A listing of the program types is attached.

## Potential Questions for Statewide IMD Utilization Survey of Mental Health Departments

1. What was the total number of placements in IMDs or MHRCs in 2014?
2. What was the total number of bed-days in IMDs or MHRCs in 2014?
3. How many adults with SMI are served in your county in 2014 regardless of whether placed in IMD's/MHRC's or not?
4. What was the number of placements, bed days, and SMI served in 2009?
5. Have the changes due to the Affordable Care Act affected utilization?
6. What is the demography of long-term care placement? Race-Ethnicity/age group/gender
7. Please describe any community programs/services intended to provide appropriate community placements or situations allowing the shortening of IMD/MHRC stays or the replacing of such stays altogether for some.
  - Types of services?
  - Who provides them?
8. How they are funded - e.g. MHSA funded and/or funded through reinvestment from no longer utilized IMD/MHRC bed-days?
9. What is the cost of these services?
10. Have they expanded, declined, or stayed the same since 2009?

**COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH**  
**COUNTYWIDE RESOURCE MANAGEMENT**  
**Alternative Crisis Services**

**IMD Step-Down Facilities (Enriched Residential Facilities/Augmented Board & Cares/ Intensive Residential Services):**

- Provide supportive on-site mental health services at selected licensed Adult Residential Facilities, assisted living, congregate housing or other independent living situations.
- Accommodate persons discharged from an IMD, acute psychiatric inpatient units or intensive residential facilities or those at risk of being placed in these higher levels of care who are appropriate for this service.
- One facility provides services to clients with forensic histories, however charges must be resolved.
- Clients conserved, preferred.

**Admission Criteria:**

- Must be 18-54 years of age.
- Must have a primary DSM IV psychiatric diagnosis and Axis I of any major psychotic disorders. May have Axis II diagnosis of substance abuse.
- No registered sex offenders.
- No fire setting history.
- Ambulatory.
- No serious or life-threatening medical problems.
  - No need for frequent nursing monitoring
  - No need for parenteral medication administration by others (other than dept antipsychotic medications)

**Clients must not require treatment in a locked setting, as evidenced by:**

- No assaultive behavior within the last 30 days
- No self-destructive behaviors within the last year for swallowing foreign objects and within the last 60 days for other self-destructive behaviors
- Clients must have applied for SSI and there exists a strong likelihood for benefit establishment.

**Clients must require the intensity of services provided by this level of care as evidenced by:**

- Risk of discontinuing treatment, including medication compliance
- Inability to provide basic living necessities without intensive support and supervision
- Inability to access mental health treatment, benefits establishment, physical healthcare, self help and peer support groups, money management, and treatment for co-occurring substance abuse

## **Los Angeles County Alternate Crisis Services Programs**

### **Urgent Care Centers (UCC)/Crisis Resolution Services (CRS)**

#### **Urgent Care Centers**

- Provide intensive crisis services to individuals who otherwise would be brought to emergency rooms;
- Provide up to 23 hours of immediate care and linkage to community-based solutions;
- Provide crisis intervention services, including integrated services for co-occurring substance abuse disorders;
- Are geographically located throughout the County;
- Focus on recovery and linkage to ongoing community services and supports that are designed to impact unnecessary and lengthy involuntary inpatient treatment.

#### **Crisis Resolution Services**

Services include:

- Clinical Triage
- Clinical and Case Management Assessments
- Mental Health Crisis Intervention to divert utilization of inpatient services
- Rapid psychiatry medication evaluation and prescription services
- Resource coordination and linkage for housing, employment, benefits establishment
- Mental Health Services including brief crisis intervention, and short-term mental health interventions using EBPs such as CBT, Motivational Interviewing, etc.
- Peer and Family Intervention and Support Services
- Clinical Outreach Services in collaboration with the PMRT as needed
- Linkage/Access/Follow-up to additional Community Based Services
- Currently operating in Downtown Los Angeles
- Planned sites: Long Beach MHC, Palmdale MHC, Rio Hondo, MHC, Santa Clarita MHC, and West Valley MHC

#### **Residential and Bridging Services**

- Provide DMH program liaisons and peer advocates to assist in the coordination of psychiatric services and supports for individuals being discharged from County Hospital Psychiatric Emergency Services, UCCs, Institutions for Mental Disease (IMD), and crisis residential, supportive residential, substance abuse, and other specialized programs;
- Promotes the expectation that individuals must be successfully reintegrated in their communities upon discharge and that all care providers must participate in the individual's transition to the community.

- Mental Health Peer Advocates facilitate self-help and substance abuse groups in IMD and IMD Step-Down Programs. In addition, Advocates provide education and information about recovery and wellness to clients, families, and providers.

### **Supportive Residential Programs (Enriched Residential and IMD Step-Down).**

- Provide supportive on-site mental health services at selected licensed Adult Residential Facilities, and in some instances, assisted living, congregate housing, or other independent living situations;
- Serve persons being discharged from IMD, acute psychiatric inpatient units or intensive residential facilities, or those who are at risk of being placed in these higher levels of care;
- Target individuals in higher levels of care who require on-site mental health and supportive services to transition to stable community placement and prepare for more independent living;
- Designed to break the cycle of costly emergency and inpatient care and promote successful community reintegration.

This information was taken from the LA County DMH website.