

AGENDA
CALIFORNIA MENTAL HEALTH PLANNING COUNCIL
January 20, 21, 22, 2016
Crowne Plaza San Diego
2270 Hotel Circle North
San Diego, CA 92108

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

Wednesday, January 20, 2016

COMMITTEE MEETINGS

Time	Event	Room
8:30 a.m.	Executive Committee Meeting	Peacock I
10:00 a.m.	New Member Orientation Meeting	Peacock II

PLANNING COUNCIL GENERAL SESSION

Kona Coast Room

Conference Call 1-877-951-3290

Participant Code: 8936702

Time	Topic	Presenter or Facilitator	Tab
1:30 p.m.	Welcome and Introductions	Cindy Claflin, Chairperson	
1:40 p.m.	Opening Remarks	Alfredo Aguirre, Director, San Diego County Behavioral Health Department	
2:00 p.m.	Election of Chair-Elect and Changing of the Officers	Arden Tucker, Chair of the Nominating Committee	
2:05 p.m.	Approval of Minutes from October 2015 meeting	Jo Black, Chairperson	G
2:10 p.m.	Review and Approval of Proposed Changes to the Workforce Education and Training Five-Year Plan	Linda Onstad-Adkins, Brent Houser and John Madriz, Office of Statewide Health Planning and Development	H
3:10 p.m.	Public Comment		
3:15 p.m.	Break		

California Mental Health Planning Council

3:30 p.m.	Updates from the Substance Abuse and Mental Health Services Administration (SAMHSA)	Jon T. Perez, Ph.D. CAPT, USPHS Regional Administrator, HHS Region IX, SAMHSA, U.S. Department of Health and Human Services	
4:20 p.m.	Report from CA Behavioral Health Director's Association	Noel O'Neill, Director, Trinity County	
4:40 p.m.	Public Comment		
5:00 p.m.	Recess		

Thursday, January 21, 2016

COMMITTEE MEETINGS

Time	Event	Room	Tab
7:30 a.m.	Children's Caucus	Hotel Restaurant	
8:30 a.m.	Advocacy Committee	Peacock I	
8:30 a.m.	Continuous System Improvement	Peacock II	
8:30 a.m.	Health Care Integration Committee	Paradise Room	
12:00 p.m.	LUNCH (on your own)		

PLANNING COUNCIL GENERAL SESSION

Kona Coast Room

Conference Call 1-877-951-3290

Participant Code: 8936702

Time	Topic	Presenter or Facilitator	Tab
1:30 p.m.	Welcome and Introductions	Jo Black, Chairperson	
1:40 p.m.	Public Comment	Jo Black, Chairperson	
1:45 p.m.	Jail Diversion Programs in San Diego County	Piedad Garcia Ed.D., LCSW, Deputy Director for Adult and Older Adult System of Care, Health and Human Services Agency, Behavioral Health Services	I
3:00 p.m.	Break		
3:15 p.m.	Overview of Levels of Residential Care and Usage by the Counties	Lynda Kaufmann, Director of Gov't and Public Affairs, Psynergy Programs, Inc.	J
4:15 p.m.	Review and Approval of 2015 Council Reports	Jo Black, Chairperson	K

California Mental Health Planning Council

4:45 p.m.	Executive Officer's Report	Jane Adcock, Executive Officer	
4:50 p.m.	Public Comment	Jo Black, Chairperson	
5:00 pm	Recess		

Mentorship Forum for Council members, including Committee Chairs and Chair-Elects, will occur immediately following the recess of Thursday's General Session.

Friday, January 22, 2016

PLANNING COUNCIL GENERAL SESSION

Kona Coast Room

Conference Call 1-877-951-3290

Participant Code: 8936702

Time	Topic	Presenter or Facilitator	Tab
8:30 am	Welcome and Introductions	Jo Black, Chairperson	
8:40 am	Opening Remarks	Assembly Member Rocky Chavez	
9:10 am	Report from the California Association of Local Behavioral Health Boards/Commissions	Larry Gasco, Ph.D., LCSW, President	
9:30 a.m.	Committee Reports – Continuous System Improvement and Patients' Rights	Lorraine Flores, Chair CSI and Daphne Shaw, Chair PR	
10:00 am	BREAK		
10:15 a.m.	Committee Reports Cont. – Health Care Integration and Advocacy	Terri Lewis, Chair HCI and Darlene Prettyman, Chair Advocacy	
10:45 a.m.	Executive Committee Report	Jo Black, Chairperson	
11:00 a.m.	Public Comment	Jo Black, Chairperson	
11:10 a.m.	Council Discussion of Integration of Substance Use Disorders	Integration Steering Committee Members and All	
11:40 a.m.	New Business and Council Member Open Discussion	Jo Black, Chairperson	
11:55 a.m.	Evaluation of the Meeting	Jo Black, Chairperson	
12:00 p.m.	ADJOURN		

All items on the Committee agendas posted on our website are incorporated by reference herein and are subject to action.

California Mental Health Planning Council

If Reasonable Accommodation is required, please contact Chamenique Williams at 916.552.9560 by January 5, 2016 in order to work with the venue to meet the request.

2016 MEETING SCHEDULE

January 2016	January 20, 21, 22	San Diego	Crowne Plaza San Diego, 2270 Hotel Circle North, San Diego, CA 92108
April 2016	April 20, 21, 22	San Francisco	Holiday Inn Golden Gate 1500 Van Ness Avenue San Francisco, CA 94109
June 2016	June 15, 16, 17	Ontario	Ontario Airport Hotel 700 N Haven Ontario, CA 91764
October 2016	October 19, 20, 21	Sacramento	Lake Natoma Inn 702 Gold Lake Drive Folsom, CA 95630

2017 MEETING SCHEDULE

January 2017	January 18, 19, 20	San Diego	To Be Determined
April 2017	April 19, 20, 21	Oakland	To Be Determined
June 2017	June 14, 15, 16	Orange	To Be Determined
October 2017	October 18, 19, 20	Sacramento	To Be Determined

California Mental Health Planning Council

Executive Committee

Wednesday, January 20, 2016

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

Peacock I
8:30 to 10:30 a.m.

Time	Topic	Presenter or Facilitator	Tab
8:30	Welcome and Introductions	Cindy Claflin, Chairperson	
8:35	October and November 2015 Executive Committee Minutes	Cindy Claflin	1
8:40	FY 2015-16 Council Budget and Expenditures	Jane Adcock, Executive Officer	2
8:50	Discuss Executive Committee Membership	Jane Adcock, Executive Officer	3
8:55	Discuss Implementation of 2016-17 Area of Focus: Children and Youth	Cindy Claflin and All	
9:15	Review Strategic Planning Recommendations and Determine Next Steps	Cynthia Burt, Consultant and All	4
9:35	Determine Exec Officer Annual Evaluation Criteria for 2016	Cindy Claflin, Cynthia Burt and All	5
9:55	Liaison Reports for CALMHB/C and CCMH	Susan Wilson and Daphne Shaw	
10:05	Public Comment	Cindy Claflin	
10:10	**CLOSED SESSION** Review and Finalize 2015 Evaluation of Executive Officer	Cindy Claflin	
10:30	Adjourn		

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

California Mental Health Planning Council

Executive Committee Members:

Officer Team	Cindy Claflin	Jo Black	Monica Wilson
Advocacy Cmte	Adam Nelson	Darlene Prettyman	
CSI Cmte	Susan Wilson	Lorraine Flores	
HCI Cmte	Steven Grolnic-McClurg	Terry Lewis	
Liaisons	Daphne Shaw, CCMH	Susan Wilson, CALBHB/C	Noel O'Neill, CBHDA
At Large	Walter Shwe, Consumer		
Executive Officer	Jane Adcock		

If reasonable accommodations are needed, please contact Chamenique at (916) 552-9560 at least 5 working days prior to the meeting date.

California Mental Health Planning Council

Advocacy Committee

Thursday, January 21, 2016

Crowne Plaza
2270 Hotel Circle North
San Diego, CA 92108

**ROOM: Peacock I
8:30a.m. to 12:00p.m.**

Time	Topic	Facilitator/Presenter	Tab
8:30 a.m.	Welcome, Introductions and Changing of Officers	Adam Nelson, Chair	
8:35	Agenda Review	Darlene Prettyman, Chairperson	
8:37	Approval of October and November Minutes	Darlene Prettyman, Chairperson	A
8:40	Council Requests/New Business	All	
8:45	2016 Legislative Platform Revisions	All	B
10:00	Break	Adam Nelson	
10:15	Lynda Kaufmann, Director of Gov't and Public Affairs, Psynergy Programs, Inc. re: IMDs and other locked residential care		C
11:00	Next Steps – Work Plan Discussion	Darlene Prettyman	D
11:30	Legislative Issues/Updates (tentative)	All	
11:40	Public Comment	Darlene Prettyman	
11:45	Develop Report-Out	Darlene Prettyman	
11:50	WWW/ Plan for Future Meetings	Committee Staff	
11:55	Plus/Delta	Darlene Prettyman	
Noon	Adjourn		

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

Committee Roster:

Chair: Darlene Prettyman

Chair-Elect: Maya Petties

Members:	Nadine Ford	Carmen Lee	Adam Nelson
	Barbara Mitchell	Linda Naranjo	
	Arden Tucker	Daphne Shaw	
	Monica Wilson	Steve Leoni	Staff:

If reasonable accommodations are required, please contact the CMHPC at (916) 323-4501 no less than 5 working days prior to the meeting date.

**California Mental Health Planning Council
Continuous System Improvement Committee
2270 Hotel Circle North, San Diego, CA 92108
January 21, 2016 – Peacock 2
8:30am – 12:00pm**

Time	Topic	Presenter or Facilitator	Tab
8:30am	Planning Council issue requests	All members	
8:35am	Welcome and Introductions	Lorraine Flores, Chair Walter Shwe, Chair-elect	
8:40am	Review/approve December minutes	All members	A
8:45am	Data Notebook 2016: Planning and design of questions.	Linda Dickerson	
9:30am	2016 Work Plan review	Lorraine Flores, Chair	B
10:15am	Panel presentation: LGBT Youth Mental Health Services	TBD	
11:30am	Public comment		
11:40am	Evaluate meeting/Develop agenda for next meeting	Lorraine Flores, Walter Shwe	

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

Committee Members:

Chair: Lorraine Flores

Chair-Elect: Walter Shwe

Members:

Patricia Bennett, Kathleen Casela, Amy Eargle, Karen Hart, Celeste Hunter, Esmeralda Liberato, Raja Mitry, Monica Nepomuceno, Noel O'Neill, Susan Wilson

If reasonable accommodations are needed, please contact the CMHPC at (916) 323-4501 no less than 5 working days of the meeting date.

California Mental Health Planning Council

Healthcare Integration Committee

Thursday, January 21, 2016

Crowne Plaza San Diego

2270 Hotel Circle North

San Diego, CA 92108

Room: Paradise

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

Time	Topic	Presenter or Facilitator	Tab
8:30 a.m.	Planning Council Member Issue Requests		
8:35 a.m.	Welcome and Introductions and Changing of Officers	Steven Grolnic-McClurg, LCSW, and Terry Lewis	
8:40 a.m.	Review and Approve October and November Meeting Highlights		A
8:45 a.m.	Brief Recap of October Meeting	Cindy Claflin	
9:00 a.m.	Presentation and Update: Mild to moderate health needs and data around utilization and hospitalization rates for those in the health plans with mild to moderate health needs	Catherine Teare, Associate Director, California Health Care Foundation, <i>Invited</i> Steven Grolnic-McClurg, LCSW	B
10:00 a.m.	Questions/Comments	All	
10:30 a.m.	Break		
10:45 a.m.	Work Plan Review and Discussion	Terry Lewis, Chairperson	
11:10 a.m.	Committee Discussion: Choose a 2016 Chair Elect	All	
11:30 a.m.	Public Comment		
11:40 a.m.	Next Steps/Develop Agenda for Next Meeting	Terry Lewis, Chairperson	
11:50 a.m.	Wrap up: Report Out/ Evaluate Meeting	Terry Lewis, Chairperson	
12:00 p.m.	Adjourn Committee		

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

Committee Members:

Chair: Terry Lewis **Chair-Elect:**

Members:	Josephine Black	Robert Blackford
Cindy Claflin	Deborah Pitts	Dale Mueller
Gail Nickerson	Peter Schroeder	Robbie Powelson
Jeff Riel	Cheryl Treadwell	Melen Vue
Steven-Grolnic McClurg	Staff: Tracy Thompson	Daphyne Watson

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

G TAB SECTION

DATE OF MEETING 1/20/16

MATERIAL
PREPARED BY: Adcock

DATE MATERIAL
PREPARED 12/14/15

AGENDA ITEM:	Approval of Minutes from October 2015 meeting
ENCLOSURES:	Draft Minutes of the October 2015 meeting

BACKGROUND/DESCRIPTION:

Attached are the draft minutes from the October 2015 meeting of the California Mental Health Planning Council for Council review and approval.

CALIFORNIA MENTAL HEALTH PLANNING COUNCIL MEETING MINUTES

October 14, 15, 16, 2015
Lake Natoma Inn
702 Gold Lake Drive
Folsom, CA 95630

CMHPC Members Present:

Cindy Claflin, Chair	Noel O'Neill
Josephine Black, Chair-Elect	Gail Nickerson
Patricia Bennett	Maya Petties
Amy Eargle	Deborah Pitts
Karen Hart (teleconference)	Jeff Riel
Celeste Hunter	Joseph Robinson
Steve Leoni	Daphne Shaw
Carmen Lee	Walter Shwe
Esmeralda Liberata	Arden Tucker
Barbara Mitchell (teleconference)	Melen Vue
Raja Mitry (teleconference)	Daphyne Watson
Dale Mueller	Monica Wilson
Adam Nelson	Susan Wilson

Staff Present:

Jane Adcock, Executive Officer	Tracy Thompson
Tom Orrock	Chamenique Williams

Wednesday, October 14, 2015

1. Welcome and Introductions

Chair Claflin welcomed everyone to the meeting. The Planning Council members, staff, and audience introduced themselves.

2. Opening Remarks

Don Ashton, Director of the El Dorado County Health and Human Services Agency, began with an overview of the demographics of El Dorado County. It is considered a small rural county; providing services to the north part of the county is a challenge because of its remoteness.

About five years ago, the county's Mental Health Division went bankrupt and required a \$5 million loan from its General Fund. The Mental Health Division made cuts and repaid the loan three years ago. Since then they have been trying to build up their services.

- The county has a Psychiatric Health Facility.
- The county has adopted Laura's Law for outpatient treatment.

- The Board approved a resolution allowing the Mental Health Division to administer psychotropic meds in the jails.
- The Board approved a contract with a remote service provider who will travel to homes to provide Full Service Partnership (FSP) and Katie A. services, as well as traditional mental health outpatient services for children.

Questions and Discussion

Mr. O’Neill asked if Mr. Ashton could share the Penal Code section that his Board adopted in regard to the jail treatment. Mr. Ashton agreed.

Ms. Lee asked about the Native American population. Mr. Ashton replied that the Shingle Springs Tribe resides in the county; they have a joint collaborative that focuses on the kids in the foster system. One of the challenges is getting the tribe to trust public agencies. The tribe has one of the nicest health clinics in the county. Mr. Ashton explained it is a Federally Qualified Health Centers (FQHCs), which receive a higher reimbursement rate for Medi-Cal and indigent people.

Mr. Leoni asked about the difficulty of getting providers in the county, and about the “bare minimum” services that the Mental Health Division had kept during its budget crisis. Mr. Ashton replied that the Mental Health Services Act (MHSA) program had suffered the most; they had focused on spending the funding on locked treatment facilities. They now have a Transition House program with 30 beds, in which clinicians visit and meet with the clients.

Regarding the difficulty of obtaining service providers, Mr. Ashton said that he had no good answer. The county had been able to recruit two full-time psychiatrists which they were very pleased about.

Ms. Dickerson pointed out that there were two rural health clinics in El Dorado County that can also see Medi-Cal patients.

Ms. Mueller asked about the aging population in the county and about health care benefits for the minimum wage casino workers. Mr. Ashton replied that the South Lake Tahoe area is one of the highest populations of Medi-Cal. Regarding the aging population – there are many “pioneer families” that have been there since 1850. Also, the county is very senior-friendly which has impacts on services such as ambulances.

Ms. Liberato asked about services for the Spanish community. Mr. Ashton answered that they do their best to hire Spanish speakers.

(4.) Alternatives to Locked/Involuntary Placements

Mr. Ashton stated that El Dorado County’s Transition House program consists of the county renting homes for the mentally ill population, who are independent enough to not live in a locked facility, but not independent enough to live on their own.

- With a maximum of six beds they don’t have to deal with zoning requirements.
- One of the South Lake Tahoe homes is specifically for the offending population.
- A clinician visits all the houses twice a day.

- Residents are encouraged to come to the Wellness Center in the afternoons.
- At the Transition House in South Lake Tahoe for the offender population, clinicians visit 24/7. It was a collaborative grant effort.
- Another program resulting from a grant is pre-trial release for people who have already offended. They are immediately put into substance abuse or mental health services. The challenge with the program is the conservative nature of the county toward people who commit crimes.
- Eligibility workers (Medi-Cal enrollment staff) work in the jails, as do substance abuse and mental health clinicians.
- A partnership with community corrections searches for employment for people released from jail.
- A partnership with the Office of Education works to get newly released people a high school diploma or GED. Outcomes have been very positive.

Ms. Shaw asked about the pre-trial diversion; Mr. Ashton said that the individuals do not have to plead beforehand. She asked about the six-bed transition homes; he replied that the residents run the houses independently.

Mr. O'Neill asked about the Restoration to Competency program in the jail; Mr. Ashton answered that they do not yet have it.

Mr. Ashton explained the *Doubt of Competency* term used by Public Defenders before a judge. Competency restoration can take up to three years – it gets very expensive.

Mr. Ashton agreed with Mr. Leoni on the dilemma that residents of the Transition Houses would receive more robust services if they were living in the community. Mr. Ashton is working with the County Administrative Officer to get Medi-Cal Administrative Activities (MAA) back in the county.

Mr. Ashton informed Ms. Shaw that the Transition Houses serve between 25–30 people. The Institutions for Mental Disease (IMDs) are all outside the county. The county does have enough beds for acute care under a 5150.

3. Approval of Minutes from June 2015 Meeting

Mr. Leoni requested the addition on page 11 of the phrase “in substance abuse” to the sentence beginning “He added that the 1115 Waiver...”

Motion: The approval of the June 2015 Meeting Minutes was moved by Steve Leoni, seconded by Josephine Black. Motion carried with two abstentions.

(Unscheduled)

Ms. Adcock introduced Captain John Perez, Ph.D., of the Substance Abuse & Mental Health Services Administration. He spoke about the appropriations process in terms of block grants, as well as legislation – particularly that pertaining to “Murphy’s bills.”

A continuing resolution was passed on the last day of the federal fiscal year that prevented another government shutdown. It is temporary, continuing until December 11.

Instead of having the full budget outlaid, it comes piecemeal, including block grants and discretionary programs. The budget will be funded at a stationary level from the last fiscal year; no money will be taken away.

Dr. Bennett asked if this impacts SAMHSA and other offices issuing RFPs. Dr. Perez explained that we have to be more conservative with projections. Those who are already SAMHSA grantees have priority, but we cannot properly plan for the year.

Dr. Perez informed Ms. Adcock that this will not impact the October awards to the 25 states that might get certified community behavioral health planning grants.

Dr. Perez continued that the legislative picture for behavioral health over the next year is important but murky. Over 30 bills are pending in Congress.

The original Murphy bill was introduced in the last session of Congress and called for reorganization of behavioral health services leadership at the federal level. It mandated the Assisted Outpatient Treatment (AOT) in the states, which became a divisive issue.

Representative Tim Murphy has continued his advocacy for significant change in the mental health system. The current bill makes AOT optional; however, there are “carrots” they can offer states that choose to go with an AOT.

The bill calls for the elimination of SAMHSA as an agency. Its functions would come underneath the Assistant Secretary for Mental Health and Substance Use – this would elevate mental health to an Assistant Secretary level. This position could reach out and have some influence at the Department of Health and Human Services in mental health.

The bill would direct funding far more toward safety nets and would decrease discretionary ability.

Senator Chris Murphy’s bill also calls for an Assistant Secretary of Mental Health and Substance Use. Under Tim Murphy’s bill, this person could only be a licensed physician/psychiatrist or a licensed psychologist.

Dr. Perez said that the language of Chris Murphy’s bill is not completely written. He encouraged interested Council Members to contact their advocacy groups. He felt that we will see some kind of legislation before the end of next year.

Questions and Discussion

Dr. Nelson commented that a large part of the basis for the proposal is the drive toward “evidence-based practices,” an area that has been cited as one of the most significant factors in inefficient cost and wasteful spending in medical care and mental health care.

Dr. Bennett asked if Dr. Perez had heard that the people behind the proposed legislation were trying to reduce the presence of people with lived experience as “experts” in behavioral health. Dr. Perez responded that there may indeed be a trend in this direction.

Ms. Shaw commented that Chris Murphy’s bill does expand to allow a Ph.D. level Social Worker. She also noted that the advisory committees are at least 50% providers, psychiatrists, and psychologists; the emphasis is moving toward these areas of expertise.

Mr. Leoni voiced doubts about the value of evidence-based practices. He noted that some Advisory Councils under these new bills would require only one person with lived experience, and that person would have to be someone currently in treatment with a psychiatrist or psychologist; however, the voices of those in recovery need to be heard in some way. Mr. Leoni expressed concern that these bills will move in the opposite direction from where California has been trying to go.

Ms. Adcock reported that the Department of Health Care Service (DHCS) has received notice that SAMHSA is coming out to do a program review the first week of December.

Dr. Bennett asked if CMHPC has a position as a council on the legislation. Ms. Adcock responded that the Planning Council had sent a letter of opposition regarding Tim Murphy's bill.

Dr. Perez informed Ms. Shaw that the National Association of State Mental Health Program Administrators and the National Association of Substance Abuse Directors had also compared the two bills. (He said he would check on the organization titles.)

Public Comment

Michele Curran, a Peer Program Specialist with the State of California, commented that many mental health organizations and agencies throughout the nation have taken an opposed position. She felt that both bills are neither harmless nor progressive.

Mr. Leoni stated that the bill should receive opposition not from weak minor bills that make tweaks here and there in response, but from something bold in the direction of recovery and understanding.

Dr. Perez stated that we do not have to look at repealing the entire legislation to be able to influence and modify it. A more powerful tool for the legislators to work with is to go in with options, stating what we don't like and what we would like instead.

Ms. Shaw had looked up the California congressmen who had signed on – this can indicate which representatives we might be able to influence.

Karin Lettau of the California Association of Mental Health Peer-Run Organizations (CAMHPRO) spoke against the Murphy bill: it would be a travesty for people with disabilities and for the human rights of people with mental health challenges.

(4.) Early and Periodic Screening, Diagnosis and Treatment – Performance Outcome System Indicators

Dionne Maxwell of the Fiscal Systems and Outcomes Reporting Branch, Mental Health and Substance Use Disorders, DHCS, gave the presentation.

- The presentation fulfills CMHPC's Welfare and Institutions Code (WIC) mandates to review and approve indicators.
- The population for the reports is children and youth under the age of 21, who are eligible to receive Medi-Cal specialty mental health services.
- Ms. Maxwell listed the objectives of the Performance Outcomes System (POS).

- She listed the POS domains – the areas they chose to study in terms of what is happening with this population.
- They looked first at demographic characteristics including Race/Ethnicity, which is troublesome as it is not measured as most current usage is understood to measure it (for example, the Census Bureau). Demographic characteristics enable understanding of the population, particularly important for penetration rates.
- Age and Gender were the other demographic characteristics included.
- Access Indicators were:
 - Penetration rates for youth receiving one or more billable service in a fiscal year
 - Penetration rates for youth receiving five or more specialty mental health services in a fiscal year – showing engagement issues
 - Time to step-down services after patient discharge
 - Snapshot report, which looks at whether children are remaining in the system, leaving, or coming in
- Ms. Maxwell listed the types of specialty mental health services used. She also listed the measures used for each type.
- All of these Indicators are available on the POS web page within the DHCS website.
- Ms. Maxwell listed the new POS Indicators, all of which were drawn from the Consumer Perception Survey.
- Reporting on the new Indicators is done by Domains, each with its own questions.
- Currently, only three Indicators are reflected from the POS:
 - Client/caregiver perceptions of accessibility of service
 - Children/caregiver perceptions of collaborative service delivery
 - Services are culturally competent and respectful of the culture of children and their families
- Of the three reports that will be given out, the individual county reports will be the most useful, as the counties will be able to see how they are performing.

Ms. Adcock stressed that by mandate, the Planning Council is to review and approve Performance Indicators as designed by DHCS. For two years, staff member Linda Dickerson participated in the DHCS workgroups. The Planning Council's Ad Hoc Workgroup worked directly with Ms. Maxwell to have a deeper understanding of the elements of the Performance Outcome System.

Questions and Discussion

Ms. Maxwell answered Mr. Mitry that the age ranges will be split if the findings persist over the counties, because they were meaningful.

Dr. Bennett asked if the term “penetration” had included retention. Ms. Maxwell answered that it had not; it needs to be measured separately.

Mr. O’Neill asked if the data on the Consumer Perception Survey had been available to counties in the past. Ms. Maxwell said she would find out; she knew the data has been reported to SAMHSA. Mr. O’Neill noted that in 20 years he had never seen any analysis of the data.

Mr. O’Neill asked how long it typically takes DHCS to analyze the POS data. Ms. Maxwell responded that there is always a lag; the most recent DHCS report is for ’13-14, and that is incomplete. It is not the timeliest data. Mr. O’Neill commented that the External Quality Review Organization (EQRO) data is very helpful to his small county.

Ms. Mitchell asked if the surveys can be incentivized; Ms. Maxwell responded that they try to incentivize the counties by letting them add three questions at the end. She would ask about incentives for the consumers.

Mr. Leoni commented that the process seemed rushed; there is an issue as to how well the Planning Council can do in fulfilling this function. He also suggested that for the Access Indicator of *Penetration Rate for 5+ Contacts*, they might want to look at the length of time over that year. In addition, for the Access Indicator of *Time to Step Down Services Post Inpatient Discharge*, he commented that some sense of the acuity and stability of the person when they leave should be considered.

Ms. Maxwell stated that a significant limiting factor is that currently the only database sufficient for reporting is the Short-Doyle/Medi-Cal II Claiming System, which is worked around service dates and billing data. It doesn’t capture things like first contact.

Mr. Leoni asked what had happened to the Client System Information (CSI). Ms. Maxwell replied that some of the counties were not submitting valid data. DHCS is engaged with the counties in data cleanup, and is hoping that by the end of 2016, they can start using CSI for reporting.

Ms. Adcock stated that because the state law was passed that directed DHCS – with specific timelines – to design and implement this particular POS for children’s services, it has happened this quickly. DHCS will continue to build, expand, and improve the data that is being collected; Ms. Adcock asked for patience from the Planning Council.

Ms. Adcock encouraged the Planning Council to talk with the Ad Hoc Committee about what they have learned and concerns they may have.

Dr. Nelson asked if hearing recommendations from someone on the Ad Hoc Committee would be worthwhile.

Ms. Tucker asked about outreach to the deaf and hard-of-hearing community. Ms. Maxwell responded that it would be a meaningful category to include, and she would bring it up with the subject matter experts.

Ms. S. Wilson stated that Ms. Maxwell had been very responsive to the workgroup's suggestions and comments, and they had come to consensus on approval of the new parameters.

Motion: Acceptance of the proposed Performance Outcome System Indicators for the Early and Periodic and Screening, Diagnosis and Treatment (EPSDT) Children and Youth Mental Health Performance Outcome System was moved by Susan Wilson; seconded by Dr. Adam Nelson.

Mr. Leoni stated that at this point he would recommend a “no” vote. He had seen very little in the presentation that rises to what he would call outcomes. Ms. Adcock stressed that the CMHPC was looking to approve what they had designed *thus far*. The system can be expanded to include much more information. Ms. S. Wilson termed the upcoming vote a “vote of confidence.” Mr. Leoni withdrew his recommendation.

Mr. Mitry recognized the importance of including the deaf and hard of hearing community. Chair Claflin responded that it would come with the continuing development of the process.

Ms. Maxwell clarified for Mr. O’Neill that the proposal applied only to youth and children receiving specialty mental health services (a subset of EPSDT benefits).

Dr. Bennett stated that the proposal was the foundational part of using data to figure out outcomes.

Call the Question: Unanimously accepted.

Vote: Motion passed with one abstention.

Mr. Leoni commented that he had abstained in good conscience because to him, the motion did not read as a vote of confidence.

Ms. Maxwell continued with the second part of the presentation.

- The Metrics Workgroup was comprised of county representatives and DHCS working to meet the special terms and conditions of the 1915(b) waiver.
- Upcoming Indicators address quality of care being received; they all revolve around the notion of face-to-face contacts. The problem is that there is no easy measure available for it.
- All Indicators are tentative – they need to be explored with data. Ms. Maxwell explained the Indicators.

(5.) The Statewide Plan to Promote Health and Mental Health Equity

Dante Allen, Senior Communications Officer at the Office of Health Equity (OHE), CDPH, stated that OHE was established by legislative mandate in 2012. Last August they released to the public the first Strategic Plan to promote health and mental health equity.

- OHE’s mission: *“To promote equitable social, economic, and environmental conditions to achieve optimal health, mental health, and well-being.”*

- The physical burden of disparity and inequities ends lives too soon, and causes illness and decreased quality of life for large swaths of people.
- Studies place the cost of inequity at about \$1.2 trillion every three years, looking at both direct health care costs and productivity costs.
- The implications of this illness and despair are huge – beyond what we know.
- Mr. Allen noted that the element of socioeconomic factors – where we live, work, play, pray – can account to up to 50% of health outcomes.
- Mr. Allen indicated with a map of income within California’s 58 counties that the more money you make, the more healthfully you are able to live.
- OHE’s method to develop its Strategic Plan involved coordination with the Health in All Policies Task Force – a coalition of 29 government agencies, offices, and departments and an Advisory Committee.
- Guiding questions throughout the process have been:
 - Do we have the right information?
 - Are we connected to the right people, systems, and institutions to make a difference?
 - Can we provide solutions?
- Mr. Allen explained a chart showing the age-adjusted death rate per 100,000 in populations.
- He explained a chart showing that about one third of single mothers and their children live below the poverty line.
- He explained a chart showing the rates that California’s populations lack health insurance.
- One in four children do not have enough food to eat.
- The hot spots on a map showing crime compared with environmental warning signs (such as chronic disease) are almost identical.
- The rate of suicidal thoughts is higher among bisexual, gay, and lesbian adults. If we know this to be true, are we offering the kind of culturally and linguistically competent health care services that this population needs?

Mr. Allen outlined OHE’s approach to the plan.

- They proposed three major elements of focus: *Assessment*, *Communication*, and *Infrastructure*.
 - *Assessment* answers the question: Where are there gaps in the data?
 - *Communication* is comprised of two elements:
 - We need to put this information in front of the right people – those who are making decisions about health and outcomes.

- We need to enlist the support of people who can help in this effort.
 - *Infrastructure*: Where are we investing? How can we make improvements in the way we are investing?
- OHE has planned a major overhaul of how we collect and collate information, and make it accessible for the public.
- OHE is the facilitating arm of the Health in All Policies Task Force.
- The California Reducing Disparities Project is an example of the Infrastructure investment.
- The test of OHE's progress is not whether they add more abundance to those who have much, but whether they provide enough to those who have too little.

Questions and Discussion

Dr. Bennett asked how the fundamental causality of poverty shapes OHE's work. Mr. Allen responded that OHE is teaming to do some technical assistance services with California housing; they are looking at opportunities to reduce food insecurity; they are paying attention to the school-to-prison pipeline.

Ms. Tucker asked about the Communication component – many people living below the poverty line may not have access to computers. Mr. Allen responded that being present, the gatherings, and the release of information are all important. OHE has developed materials that do not require Internet access.

Public Comment

Ms. Lettau commented on the problem of people being warehoused in board and care facilities, rather than being transitioned to independent living and tracked.

Announcement Prior to Recess

Ms. Shaw had brought a copy of *Robert's Rules of Order*, revised in 1951, for Ms. S. Wilson.

Thursday, October 15, 2015

1. Welcome and Introductions

Chair Claflin welcomed everyone to the second day of the meeting. Those present introduced themselves.

2. Behavioral Health Issues, Priorities and Future

Ms. Maggie Merritt, Executive Director of the Steinberg Institute, gave a presentation on the work of that organization.

- The Steinberg Institute is dedicated to advancing sound public policy, primarily by working with academics, researchers, and data collectors who are giving feedback and research.
- We feel the importance of consumers, family members, stakeholders, and researchers to inform our legislation.
- A major activity is to engage and bring people together to find focal points to champion together.
- Such as addressing the problem of people having a mental health crisis who wait for hours in the Emergency Department, the Steinberg Institute is working with all primary stakeholders in creating a system of care serving everyone who needs it.
- Darrell Steinberg feels that mental health is the unattended issue of our time. It is a civil rights issue that needs to be addressed immediately as a priority – thus he established the Steinberg Institute.
- The Steinberg Institute has a partnership with the UC Davis Behavioral Health Center of Excellence, which has provided free office space and a staff member. Ms. Merritt listed the Steinberg Institute staff and described its formation.
- The Steinberg Institute helped sponsor legislation on mental health services for soldiers who have served our country.
- AB 1006 (Levine) addresses the issues of the criminalization of mental illness, lack of care during incarceration, and lack of knowledge on this issue.
- The Steinberg Institute has been working with advocates on AB 1299. This bill will ensure that when foster children or youth are moved from one county to another, their mental health services follow them.
- SB 11 and 29 speak to the issue of first responders and police officers needing training. Both bills have been signed.
- The Steinberg Institute worked with the California Behavioral Health Directors Association (CBHDA) in doing an evaluation of FSPs and their impact.
- To address homelessness, the Steinberg Institute is proposing to use about \$130 million per year from Prop 63 to service a \$2 billion bond to create supportive housing across the state.
- The top three priorities that the Steinberg Institute will be talking about for the next year are:
 - System of care for psychiatric crisis
 - College student mental health
 - Homelessness

Questions and Discussion

Mr. O'Neill noted that SB 82 has been a very successful project. Rural counties are interested in having it include peer respite as an intervention. Ms. Merritt responded that the Steinberg Institute has been keeping this in mind, and is in communication with the California Health Facility Finance Authority (CHFFA). The Steinberg Institute has been a strong supporter of SB 614. Mr. O'Neill said that SB 75 has set aside \$3 million for peer respite; it will be up to CHFFA to decide in the next few months whether they want to put out an RFP.

Mr. Leoni pointed out the need for more research on anti-psychotics. Further, research results can be fraught with errors and should be used with care. Ms. Merritt agreed and commented that this is why the Steinberg Institute is working with a wide variety of coalitions and stakeholder groups.

Ms. Watson asked Ms. Merritt about work being done to ensure that services are culturally relevant. She responded that staff had just met with Dr. Sergio Aguilar-Gaxiola and his team about their work. Steinberg Institute staff is spending a lot of time with people who can inform and guide their actions to move forward in this area of cultural disparity.

Ms. Shaw voiced the Advocacy Committee's concern that federal legislation could be enacted (for example, the Murphy bills) that undoes the work that has been done in California at the state level.

Ms. M. Wilson referred to mental health of students younger than college age. Is the Steinberg Institute doing anything about prevention in the earlier years? Ms. Merritt responded that the Steinberg Institute is making a start with college campuses, and hopes to address the larger issue in time.

Ms. Liberata asked about services for college students. Ms. Merritt responded that at UC Davis, for example, there is one psychiatrist for 30,000 students. The Steinberg Institute is working on a pilot project there to increase significantly the number of mental health professionals at all levels, and to provide some training for faculty and staff to recognize signs. The Steinberg Institute is also working with the CSU, UC, and community colleges to move forward with ensuring that all campuses have the care they need, with not only Prop 63 dollars, but also matching funds by the colleges. The Steinberg Institute is also working with the Affordable Care Act and Medi-Cal in reimbursement issues for mental health professionals.

3. Workforce Education and Training, 5-Year Plan Budget Revision Discussion

Ms. Adcock stated that in January 2016, the Office of Statewide Health Planning and Development (OSHPD) will come back to the Planning Council to revisit the allocations of the Workforce Education and Training (WET) 5-Year Budget. This fall OSHPD is conducting a number of stakeholder and advisory group meetings to seek input on the budget.

Ms. Adcock stated that input from the Planning Council on the 5-Year Plan was important. OSHPD was present today to report on the activities for which the money has been spent so far, and the outcomes and functions that are occurring as a result of those expenditures.

Linda Onstad-Adkins, Acting Deputy Director for the Healthcare Workforce Development Division and the Health Professions Education Foundation at OSHPD, was present to seek feedback from the Planning Council regarding needs for any modifications, and to hear any recommendations.

John Madriz, WET Program Acting Chief, began the presentation with an update on the implementation of WET. He explained the background and initial funding for the first and second WET programs.

Mr. Madriz summarized the efforts to date of the second WET 5-Year Plan which began in 2014.

- \$10 million was allocated for the Mental Health Loan Assumption Program (MHLAP).
- For FY 14-15, MHLAP awarded \$9.4 million to 1,085 individuals across 54 counties. Of those individuals, 590 speak at least one language other than English.
- The FY 15-16 application cycle has been extended to November 30.
- OSHPD provided stipends for a variety of mental health professions.
- OSHPD awarded four organizations to expand the capacity of psychiatrists across four counties.
- OSHPD awarded four organizations to expand the capacity of psychiatric mental health nurse practitioners across seven counties.
- OSHPD funded five WET regional partnerships to develop and implement regional issues and needs. Mr. Madriz listed the programs.
- OSHPD awarded a total of \$250,000 for the WET mini-grant program for under-represented and disadvantaged youth in mental health careers.
- OSHPD funded six organizations \$153,000 for California's Student/Resident Experiences and Rotations in Community Health (CalSEARCH) program.
- OSHPD awarded six organizations to engage in activities to help retain public mental health workforce as part of the Public Mental Health Recruitment and Retention Program.
- OSHPD formed the Consumer and Family Member Employment Advisory Committee to provide input to OSHPD.
- OSHPD funded two organizations for the Local Organizational Support and Development Network.
- OSHPD funded nine organizations a total of \$1.3 million to provide services that engage and support individuals with lived experience who are currently employed or volunteering in the public mental health system.

- OSHPD awarded UC San Diego Health Services Research Center, in partnership with Harder+Company, to conduct a comprehensive assessment of California's consumer/family member/parent caregiver workforce.
- OSHPD awarded Mental Health America of Northern California \$1.2 million to engage in various activities that aim to increase consumer and family member employment across the state.
- OSHPD has been implementing peer personnel programs connected to SB 82.
- In August 2015, OSHPD released an RFA that funds an organization to engage in research and compile and assess county-administered MHSA WET activities going back to 2008.

Questions and Discussion

Ms. Watson commented on the lack of culturally-appropriate workforce development. Brent Houser, WET Manager, responded that all of the programs have culturally and linguistically responsive needs addressed in each of the RFAs. It is a key component. Ms. Watson requested a clearer reference to it, and asked who is tracking it. Mr. Houser replied that it is a part of the progress reports that contractors must submit.

Mr. Leoni commented that the numbers given in the presentation lacked meaning without a context. It was difficult to assess where the various programs should be larger or smaller. Mr. Houser responded that WET staff would be sharing more information as the process continues.

Ms. Liberato asked if the programs cover the needs of Hispanic people. Mr. Houser replied that ethnicity is one of the cultural aspects they look into.

Mr. Houser provided information on the WET budget reassessment.

- In 2013 OSHPD conducted a robust stakeholder engagement process to identify needs; it culminated in the development of the second 5-Year Plan. The Planning Council approved it in January 2014.
- For the first two fiscal years, approximately \$63.8 million was allocated for WET programs. OSHPD has encumbered about \$54 million, leaving a balance of \$9.1 million moving forward.
- Mr. Houser showed how the numbers align with the specific programs.
- The purpose of the current reassessment is to identify how to allocate the remaining balance of \$61 million for the last two fiscal years. OSHPD is now conducting research, engaging stakeholders, and meeting with the WET Advisory Committee.

Questions and Discussion

Mr. Leoni clarified the arrangement of the fiscal years pertaining to budget. He also pointed out that the MHSA dollars for WET planning disappear at the end of the 5-Year Plan. This may affect how we play out the last couple of years of opportunity. He asked

where that may leave us for 2019-20 in terms of WET activities. Mr. Houser confirmed that OSHPD is unsure of funding commitments after the end of the 5-Year Plan.

Mr. Houser presented questions for Planning Council feedback. Responses to the questions were as follows.

Mr. Leoni: SB 82 may alter programs such as Crisis Residential – there may be less need for some of the professions staffing hospitals if people are diverted.

Mr. Leoni: If it passes, Peer Certification will lead to a ramping up of the use of peers.

Ms. Watson: With the influx of Syrian refugees into the San Diego area, mental health will be a part of their needs. Is there any opportunity to develop a workforce that could address these specialty needs? (Ms. Onstad-Adkins mentioned that people from the MHLAP program are already working with these populations in different counties.)

Mr. Leoni: The Affordable Care Act may have put us deeper in the hole in terms of not having the workforce we need. That, and the changing profile of the people coming in, may lead to some alterations that need to be made.

Mr. Houser informed Mr. Leoni that in the next round of stakeholder meetings, the WET staff plans to show a draft budget with reasons for any changes included.

Dr. Bennett: Our entire mental health system would benefit from a look at how people in management have the skills and supports they need to engage their workforce successfully.

Mr. O’Neill: Is there a provision for Occupational Therapists to receive some kind of educational support? Mr. Houser answered that they are eligible for MHLAP, should that profession be deemed eligible. Also, in Southern California that profession is eligible for a Retention Grant.

Ms. Vue: Have you considered the California Reducing Disparities Project’s (CRDP’s) roll-out into your plan? Mr. Houser: we are paying attention to it but are not taking an active role in that plan.

Mr. Leoni: There is a problem getting people in rural counties to work in mental health. Are there any activities that could be developed to get those people, after training, to get where they are needed? Mr. Houser answered that the coordinators from the rural counties have developed programs such as the Roving Supervisor to meet this issue. Part of the county MHSA evaluation RFA can evaluate such programs to better inform where to place resources down the road. Ms. Onstad-Atkins added that in the stipend contract, there is a stipulation for the institutions to try to work with counties perceived as having a greater need.

Mr. Leoni: we should reinstate the last two years of funding for Consumer and Family Members (Peer Certification).

Mr. Houser encouraged the Planning Council members to contact him.

4. Public Comment

Ms. Lettau pointed out that \$5.6 million of the \$9 million left over from 2014 through 2017 was actually from the Consumer and Family Member employment piece. For SB 614, we are concerned that the money not go to fund DHCS for lawyers and staff members, but rather to community-based programs once the bill passes.

5. Excellence in Mental Health: Certified Community Behavioral Health Clinics, Overview of California's Application

Brenda Grealish, Assistant Deputy Director of Mental Health and Substance Use Disorders, DHCS, spoke about the Certified Community Behavioral Health Clinics (CCBHC) grant.

- CCBHCs came out of federal legislation – the 2014 Excellence in Mental Health Act, a \$1.1 billion investment.
 - Phase 1 is the planning grant application; DHCS submitted one on August 5. The planning phase will last for one year.
 - Phase 2 is the demonstration grant application. It will show what California has done to certify these community behavioral health clinics. At that point, SAMHSA will select up to eight states to implement CCBHCs.
- The vision of the CCBHCs is *“To improve overall health by providing improved community-based mental health and substance use disorder treatment.”*
- Ms. Grealish listed key dates for the Planning Council.
- Minimum standards covered in the Phase 1 application were: staffing for CCBHCs, access of services, care coordination, scope of services, quality, data reporting, and organizational authority structure.
- DHCS envisions a focus on super-utilizers as the population of focus.
- Care coordination requires physical health care to be a major component.
- Care is to be “whole person.” The Health Home project and the CCBHC project are looking to tackle the same kind of issue, with the former coming from a physical perspective and the other coming from a behavioral health perspective.
- Ms. Grealish described how DHCS envisions the planning year.

Questions and Discussion

Dr. Bennett commented that the Summary Sheet reads initially as if it is all about substance abuse. Ms. Grealish assured her that it is about both; the Needs Assessments for both mental health and substance abuse are in the application.

Mr. Leoni asked if super-utilizers might be crowded out of a clinic, or if they might limit the capacity of a clinic to handle other users going there because they can't get services anywhere else. He also asked how the CCBHC model fits in with Full Service Partnerships (FSPs). Ms. Grealish responded that both questions will have to be thought through during the planning year.

Mr. O'Neill asked about the scope – how many counties will be participating? Ms. Grealish answered that the counties are waiting to see what happens in the planning process; it hasn't been operationalized yet.

Ms. Vue asked what DHCS's goals will be around cultural competency, should they be awarded the demonstration grant. Ms. Grealish answered that in the application DHCS discussed the different populations and how it would address cultural competence. As it builds clinics, we will have to know the populations in the area and the ways to provide service and access.

Mr. Leoni stated that if we start thinking creatively and demonstrating some outcomes, possibly using some MHSA dollars, this could percolate up to the federal government, influencing them to consider what else they might make available under Medicaid.

Ms. Vue mentioned the diversity of the Asian community – are there any plans of breaking out that demographic? Ms. Grealish answered that SAMHSA will decide; DHCS is doing what SAMHSA says to do. She hadn't seen much on demographics – SAMHSA is looking more for physical, mental health, and substance use and disorder outcome information.

Ms. Grealish stated that DHCS had received approval of the 1915(b) Waiver so they operate their mental health system under the carve-out from the Managed Care system. They are approved for a five-year waiver. In return, they agreed to some Special Terms and Conditions that have to do with making data and information available. DHCS is working closely with the Centers for Medicare and Medicaid (CMS) to keep them informed.

6. Public Comment

Ms. Lettau asked how we can ensure that Peer Support Specialists and Family Support Specialists are integral in implementing CCBHC. Ms. Grealish responded that she sees it coming out in the Care Coordination Workgroup – that is where peer services will be leveraged. It is definitely on the radar and was part of SAMHSA's RFP.

7. Report from California Behavioral Health Directors Association

Adrienne Shilton, CBHDA Director of Intergovernmental Affairs, provided an update on that organization.

- The new Executive Director is Kirsten Barlow, MSW. She had previously been the Director of Legislative Affairs at CBHDA.
- Dr. Marvin Southard is retiring in November from the Los Angeles Department of Mental Health. Many other Directors are retiring now as well.
- CBHDA is having a Strategic Planning meeting next month. Four issues will be addressed:
 - Expanding the capacity for individuals who need behavioral health crisis services.

- Expanding California’s capacity to treat individuals with Substance Use Disorders (SUDs).
- Expanding affordable housing opportunities for individuals with behavioral health needs.
- Integration of behavioral health with the larger health delivery system.
- A priority regarding legislation is the CBHDA sponsorship of SB 614 (Leno). It has been made into a two-year bill; Senator Leno wants to get it moving early in the next session and get it to the Governor’s desk in March, where it will be signed possibly in April. The bill is the result of decades of research which laid the framework for what the counties are carrying forward. Ms. Shilton acknowledged the important work of the Planning Council in this effort.
- Another priority is overseeing the implementation of SB 82. CBHDA recently provided a comprehensive overview of accomplishments to date. Counties have really stepped up to the need for crisis capacity systems. CBHDA recently met with Diane Stanton, Executive Director of California Health Facility Finance Authority (CHFFA), to get an idea of the fourth round of grants.
- When the Steinberg Institute was presenting, CBHDA worked very hard for the inclusion of peer respite in a trailer bill for CHFFA to consider.
- CBHDA was pleased to see that CMS approved the Drug Medi-Cal Waiver. It is a real opportunity to build out a system that has been significantly underserved and underfunded for quite some time. The phase-in will consist of five phases.
- It was an active year for mental health bills in the Legislature, with children’s mental health particularly active.
- Mr. O’Neill spoke regarding the organized Drug-Medi-Cal system delivery: because the mental health and the drug/alcohol organizations really have integrated at the ground level. Many consumers truly want both services.

Questions and Discussion

Ms. Adcock asked if counties are planning to opt in and participate in the phased approach. Ms. Shilton replied that the majority of counties are planning to opt in to the Waiver. The Bay Area counties will be first in the phase-in.

Ms. Lee asked how CBHDA is addressing the affordable housing crisis. Ms. Shilton responded that the government organization California Housing Finance Agency (CalHFA) was administering the \$400 million statewide housing program; CalHFA is setting up a continuation of that for counties that wish to dedicate additional funding. In addition, CBHDA is thinking about a regulatory or legislative fix for people not enrolled in an FSP who are trying to transition out of intensive services, but cannot receive rental subsidies.

Ms. Adcock addressed the issue that Ms. Lee had raised: landlords in pockets around the state realize that fair market value for their rent has really gone up, so they are no longer using Section 8. The federal government is prohibited from augmenting the dollar

amount that the Section 8 voucher is worth. When these people are evicted they will become homeless. Ms. Adcock was interested in having Planning Council members try to devise ways to address this growing issue.

Ms. Adcock raised another issue: OSHPD had just presented the current budget. The category of Consumer and Family Member Employment had been front-loaded: \$5 million for the first year and the second year. The second year has not yet been obligated. OSHPD is now getting input on how to adjust it. Ms. Adcock suggested for the Planning Council to send a letter to CBHDA requesting to have that \$5 million obligated to the SB 614 Peer Certification effort.

Mr. Leoni stated that he would object because the money in OSHPD was originally put there to develop, train, and retain peers in the workforce. DHCS is now assigned the oversight of the peer certification program – it is not OSHPD’s responsibility. Given the fact that once this program is set up there may be a bump in people working in peer situations, we will need that money for the development of that workforce.

8. Executive Officer’s Report

Ms. Adcock reported on the following.

- A number of public forums were conducted around the state that focused on specific cultural populations: Hmong, Native American, LGBT, and Cambodian. These forums will continue in the coming year; Ms. Adcock encouraged Planning Council members to attend. The forums are conducted in the native languages.
- The Mental Health Services Oversight and Accountability Commission (MHSOAC) has created a workgroup around children and youth crisis services. They hold regular meetings and anyone is welcome. The expectation is to develop recommendations that may lead to policy, funding, and programming in the state.
- UC Davis and others held a symposium on first-break psychosis. There is a disconnect between researchers and policy makers that needs to be addressed.
- Staff member, Andi Murphy, is retiring in December.

Ms. Vue asked if the communities for the next forums have been selected already. Ms. Adcock answered that they have not; she had hoped to focus on the Latino and Afghan populations. Any interested community can host a forum.

Ms. Tucker asked how many forums will be held. Ms. Adcock answered that it depends on the availability of staff at the various times of year.

Ms. Lee expressed fond appreciation for Ms. Murphy.

Ms. Liberato appreciated having the upcoming Latino forum being held in Spanish.

Ms. Watson suggested forums for the African-American and African immigrant communities.

Ms. Tucker asked about giving suggestions for focus groups. Ms. Adcock responded that she needs to know where they are, and to have a contact – some of the communities are guarded, and negotiating to come in is delicate. She needs a cultural broker at times.

Friday, October 16, 2015

1. Welcome and Introductions

Chair Claflin greeted everyone attending the Friday morning session. Members of the Planning Council and audience introduced themselves.

2. Report from the California Association of Local Mental Health Boards/Commissions

Dr. Larry Gasco, President of the California Association of Local Mental Health Boards/Commissions (CALMHB), provided a report.

- CALMHB members attended a meeting of the Health Integration Committee a few months ago. The topic – consumers accessing managed care services provided by the counties – is now on everyone’s radar.
- Regardless of the size of the counties, they basically face many of the same issues.
- Particularly during the last quarter, CALMHB discussed issues of infrastructure, funding, and potential for more diversified funding.
- CALMHB has changed its name to California Local Behavioral Health Boards and Commissions.
- CALMHB greatly appreciates the support of the CMHPC. The two groups had met yesterday to discuss any stressors and differences.
- In the future, CALMHB members probably will not be able to join CMHPC for the Friday morning meetings because of cost.

Dr. Gasco introduced the new Executive Committee: David Wood, First Vice-President; Julie Crouch, Second Vice-President; May Sherman, Secretary; Beryl Nielsen, Treasurer; and Cary Martin, Past President.

Ms. Adcock stated that the Planning Council has a new representation for a fast-growing population: Aging. Gail Nickerson is representing the California Council on Aging.

Ms. Nickerson addressed the Planning Council with messages from her fellow Commissioners.

- Schools of Social Work have received MHSA funds to produce stipends for MSW students interested in pursuing mental health. These funds are to cease within the next year or two. Advocacy is needed for the continuation of MHSA funds for higher education to train social workers, counselors, and nurses to serve elders who have mental health issues.

- We need more MHSA funds directed to home field-based services for sick and isolated older adults. Health plans need to use MSWs who are going for their hours to provide counseling with supervision. Evidence-based practices are nice but do not work in all communities; we need more flexible cultural outreach and engagement.
- It would be beneficial if Marriage and Family Therapists could be paid for by Medi-Care.

3. SUD Integration Update

Ms. Adcock introduced Bruce Emery from the Advocates for Human Potential, the Technical Assistance Consultant from SAMHSA. Mr. Emery has begun to draft the areas for consideration regarding the integration. The document will be expanded and edited over time. Areas of it will be brought to the full Planning Council for decision-making. A Steering Committee is working with Mr. Emery and all are welcome to join.

Mr. Emery spoke about the following.

- The State Technical Assistance Project delivers technical assistance to state planning councils.
- Where and how the CMHPC takes its integration is completely up to the members. There are no rules and SAMHSA has no directives.
- Mr. Emery presented two goals for today:
 - Decide on the level of integration in general.
 - Give some guidance to the Steering Committee for the integration: how, how far, and how fast.
- Mr. Emery described the three levels of state Planning Councils. The largest group is the moderate level of integration with Substance Abuse.
- A middle ground would be mental health and co-occurring SUDs. 60-75% of the people in the public systems have co-occurring disorders.
- Most state councils now call themselves State Behavioral Health Planning Councils, even those that are only moderately integrated.
- In terms of service systems: Planning Councils look at them, and at needs of populations; then they try to get a sense of where the gaps are. If a council is not really integrated, it will focus on mental health agencies. Fully integrated councils will look at how mental health agencies, mental health/substance abuse agencies, and addictions agencies – all the public systems – operate.
- A planning council that is already large in size must consider the number of members to represent substance abuse.
- Planning Council agendas can tell a lot about the level of integration. Looking at the CMHPC agenda, Mr. Emery could see that the organization is already moderately integrated.

- A Planning Council that is not very integrated is only looking at mental health revenue. As systems of care integrate and as revenue becomes more diverse, there are fewer and fewer mental health-only funding streams.
- The majority of state block grant applications are now combined – both mental health and substance abuse.
- Assessing the adequacy of resources allocation around the state is a task that produces a gap analysis. This is where the strength of Planning Councils lies.

Questions and Discussion

Mr. Emery asked the members at which level of integration they want the Steering Committee to aim.

Ms. Lee asked if the full integration level would encompass everyone who has a substance abuse, not just those who are also diagnosed with a mental illness. Mr. Emery replied that it is completely up to the Planning Council.

Mr. Leoni ascertained with Mr. Emery that at this point, the Planning Council was not deciding ultimate destinations, but instead where to move right now.

Mr. O'Neill recollected with Ms. Lee and Mr. Leoni that the Steering Committee had suggested to move in a moderate direction. This was practical, as there would be no financial or membership adjustments – yet it would allow the Planning Council to stretch a bit.

Mr. Emery felt that next steps included deciding what the Steering Committee can do and what areas to look at. In the next few months the Steering Committee can start to develop a Transition Strategic Plan to give the Planning Council a road map.

Mr. Emery had advised the Steering Committee to keep the plan simple, direct, manageable, and practical. The Steering Committee can look at revising the Bylaws as a first step.

Ms. Shaw pointed out that the Planning Council has state legislative mandated duties that need to be examined; are any legislative changes necessary?

Mr. Emery noted that more and more states have their roles and functions mandated in statute.

Mr. Emery mentioned the *Behavioral Health IQ*, a tool for helping a council decide how integrated it is. The CMHPC could have the Steering Committee complete it.

Dr. Bennett suggested performing a Planning Council survey to discern the number of members now working in the field of co-occurring disorders. She also suggested looking at the current committee structure to see how it might change their agendas.

Ms. S. Wilson pointed out that last year, the Continuous System Improvement Committee had used the California Outcomes Measurements System (CalOMS) data for the Data Notebook; the CalOMS data came from the SUD portion of DHCS. We have already tried to integrate some of it.

Mr. Shwe felt that integrating co-occurring disorders and SUDs into the committee Work Plans would be a good idea.

Mr. Leoni suggested for the Planning Council to discern the number of members with lived experience with substance abuse, including family members. Mr. Leoni also suggested that the Planning Council add members from primary care and the Department of Managed Health Care.

Ms. Watson commented on her experience during the integration in San Diego: there was much work that had to be done in relationship building, and in understanding the focus of the two groups. It took some time to work through the issues.

Mr. Leoni referred to the management and allocation of block grants. Currently, the mental health grants come through the CMHPC while the substance abuse grants have been entirely an administrative function. He also pointed out that historically, the mental health community in the state has largely taken on the dual diagnosis issues. It is not actually too much of a stretch to add in the dual diagnosis.

Ms. Lee liked Mr. O'Neill's idea of putting it on the table formally. It would be a real issue with co-occurring mental illness and formally recognized as such.

Mr. Emery stated that he saw his job as helping the Steering Committee take the morning's input, organize its thinking, and help to facilitate a decision on how to proceed. They would now begin the initial stages of putting a draft Transition Plan together.

Ms. Adcock reviewed the Planning Council's will thus far.

We will aim for moderate integration, blending in co-occurring.

Priorities for the Steering Committee are to look at membership and legal/legislative needs.

Mr. O'Neill suggested doing the *Behavioral Health IQ*.

Ms. S. Wilson felt that the Steering Committee should start looking at the financial aspects.

Ms. Adcock pointed out that staff has been providing information to augment Planning Council member knowledge regarding substance use delivery systems in California. We have had presentations and materials. Today, a summary of the Statewide Needs Assessment and Planning Report is included in the meeting materials. DHCS just did their substance abuse block grant; Mr. Orrock compiled it into a snapshot summary.

Ms. Adcock added that staff will create a substance abuse library on the website, and will start posting these documents.

Mr. Emery pointed out that because the state substance abuse authority is required to conduct a Needs Assessment (in California, every two years), that may benefit the mental health side. Generally, the substance abuse data system Needs Assessment tends to be more expansive and better organized; a number have states have requested to expand the survey to include the people they are interested in. It gives the mental health side a better tool to do its work. There may be great benefit to this Planning Council reaching out to

other substance abuse state groups to see if they can help do some of the work that CMHPC is already charged with.

Ms. Lee suggested having someone from Santa Clara County speak at the January meeting on their innovative system of care for SUD. Ms. Adcock suggested holding off for the April meeting in San Francisco, a closer location.

Mr. Leoni pointed out that Karen Baylor had said that they are going to set county standards for substance use data; that could provide a framework for some of the counties to roll some of their data systems over. Mr. Leoni also noted that a concern in the Needs Assessment was youth access to tobacco products – a subject far afield from what the Planning Council usually would discuss.

Ms. Adcock stated that in January, CMHPC staff will have a summary document of the Organized Delivery System – the new Waiver for Substance Use services in California.

Public Comment

Michael Helmick of the Racial and Ethnic Mental Health Disparities Coalition (REMHDCO) stated that there are unique inequities that currently exist within both mental health and SUDs. He urged the Planning Council to keep these racial, ethnic, and socioeconomic inequities in mind as they consider the integration of its membership.

Lavinia Jones, a family member from Alameda County, stated that she would like to see data on consumers who have been stuck in the older adult system.

Ms. Lettau stated that as a person with lived experience, she was very glad to see the upcoming integration.

Dr. Asaid from Imperial County expressed concern that many mentally ill patients are not receiving the care they should be getting; providers should be monitored.

Ken Bonner of Santa Barbara County spoke about the depressed areas of California where mental health of the homeless is a problem. He has started his own organization in the community called Rebuild Outreach.

4. Report from Mental Health Services Oversight and Accountability Commission

Brian Sala, the new Deputy Director for Evaluation and Program Operations at the MHSOAC, provided the report.

- He provided his background, which is in public policy analysis. He was brought on to the MHSOAC to help the organization work through its business processes and think about what it is trying to get done. He will be helping to better integrate the evaluation staff with the program staff.
- The MHSOAC is in a re-evaluation phase. It is dealing with significant staff turnover, including the evaluation team; In addition, the consulting psychologist, Dr. Deborah Lee, will be retiring at the end of the year.
- The Office of Administrative Law recently issued two sets of regulations from the MHSOAC, having to do with Innovative Programs and Prevention and Early

Intervention (PEI). The regulations create a new set of obligations for the counties regarding data reporting for a variety of programs. The MHSOAC is developing strategies for working with the counties in Technical Assistance and Training, to help them understand what the regulations mean for their data collection and reporting requirements.

- It is a high priority of Mr. Sala's to integrate his evaluation staff with the program staff, so that they have effective training materials produced. Then they can move rapidly to put technological solutions in place for receiving data and putting it into a form ready for descriptive and substantive analysis, feeding it back quickly to the counties.
- Mr. Sala hopes to work closely and collaboratively with the counties, so he can provide value to them and the consumers.
- Mr. Sala's group is working rapidly to improve the MHSOAC's ability to track and share high-level descriptive fiscal information about the system. There aren't easy tools readily available for exploratory data analysis.
- They are building tools on the website to allow the public to explore the innovative programs component as well as revenue, expenditures, etc. on all the components. This will provide a high-level view of how money is being spent.
- Regulation/Implementation is another major area of emphasis. They are working collaboratively with CBHDA and the counties to develop and implement data collection tools and strategies.
- Another important area is working with the Client Services Index (CSI) and Data Collection and Reporting (DCR) data – a shared interest with the Planning Council.
- They have been engaged in early discussions with the Department of Justice to identify potential data linkage projects. Mr. Sala is interested in exploring opportunities to do validity testing. For example, they have a direct measure of involvement in the criminal justice system: arrest data.
- They are thinking about focused policy projects. The first is on crisis services for children and youth; two task force meetings have been held so far, and they are also conducting site visits.
- Another MHSOAC initiative is talking about how stakeholder contracts are done and building in an evaluation component.

Questions and Discussion

Ms. S. Wilson mentioned the value of the collaborative relationship among staff and members regarding data collection. She also mentioned the Data Notebook: the Planning Council wants it to have good and valid data, good return on data, and usefulness. Mr. Sala noted that they do not want to inundate the counties with overlapping data requests – it is important for the two organizations to work closely to coordinate and share data.

Dr. Bennett noted that arrest data varies by jurisdiction in its quality. Mr. Sala responded that he was aware of data challenges across the board.

Mr. O'Neill mentioned the great technical support that Trinity County has received from the MHSOAC on their two initiatives: a triage grant and an innovative project. He expressed concern with the upcoming regulations and data collection. It will be critical for the MHSOAC to frontload that project: counties can only collect data that their software systems handle. Small counties do not always have software expertise; they will be looking to the MHSOAC for support. Mr. Sala responded that he intends to visit counties to discuss the challenges they face in modifying their systems. The bottom line is to find a path to get to the consumer outcomes we care about. The regulations have put some strong expectations in place about understanding our effectiveness in reaching out to underserved communities in particular.

Mr. Leoni commended the MHSOAC for the leadership role it has been taking on these issues. He appreciated the MHSOAC's direction toward using data for quality improvement, for counties, consumers, providers, and so on. Mr. Sala responded that although he is not a mental health expert, he really does not want to see his staff creating burdens for the service providers, the counties, and the consumers. They need to be net contributors to success – this will be their continued focus.

5. Committee Reports – Patients' Rights, Health Care Integration, Continuous System Improvement and Advocacy

Patients' Rights Committee

Ms. Adcock reported in place of Committee Chair Daphne Shaw.

- The committee met with representatives from the California Office of Patient Rights. The committee has two projects on its Work Plan one is directed towards county patient right advocates, the other to the state hospitals. The California Office of Patient Rights serves both. The committee will continue working with them.
- The committee has begun to address the issue of the ratio of Patient Rights Advocates to the population. The committee will be advocating to DHCS, seeking either policy or legislative action regarding that ratio.

Health Care Integration Committee

Chair Claflin reported in the absence of Committee Chair Steve Grolnic-McClurg.

- The committee is collaborating with CALMHB in trying to obtain information regarding health care reform in the counties.

Continuous System Improvement Committee

Committee Chair Susan Wilson gave the report.

- The committee focused on adults with mental health diagnoses in permanent supportive housing. They were given a presentation from two different

permanent housing organizations who brought clients with them – resulting in a complete view of the needs, both met and unmet.

- Since the last Data Notebook has gone out, the committee has received back 39 reports representing 41 counties. 14 are still coming, but will not make it to the report. Only two or three counties were not able to complete the Data Notebook.
- The committee hopes to focus on children during the coming year. The committee will also have questions regarding the Planning Council's focus during the coming year.
- The committee is looking forward to a new and developing relationship with the CBHDA.
- The committee spent time with CALMHB; they indicated that they would like more input into committee work.
- The committee sought long-term input from the Planning Council on how and where to disseminate the report. Right now the plan is to return the compiled reports to each county.
- Mr. Orrock is in the process of writing a report that goes along with the presentation on Housing Issues for Adults with Mental Health Disorders.

Advocacy Committee

Committee Chair Dr. Adam Nelson provided the report.

- The committee was experiencing some liabilities: it has lost its Chair-Elect and its staff support person; it also has no real Work Plan.
- The committee met with Megan Sussman, a representative from Doris Matsui's office. She discussed in detail the Excellence in Mental Health application for beginning the planning process to look at certified community behavioral health clinics. Ms. Sussman also discussed the two Murphy bills.
- The committee is in the process of reviewing its legislative platform – an annual obligation. The committee will present its recommendations in January.
- The committee is considering how to adjust its legislative platform to reflect the Planning Council's expanded mission as an integrated care organization.
- Mr. Leoni added that he felt it important to look at the two Murphy bills. Although the committee usually does not look at federal legislation, California has a lot of clout at the national level, and these two bills could undermine much of the direction we have decided to take in California.

Executive Committee

Ms. Adcock reported on the following.

- The Executive Committee has been working with a consultant on a series of questions regarding the work of the Planning Council. She is working to identify its roles and functions, as well as avenues for improvement in its visibility,

relevance, and efficiencies. After talking with members, she has made five recommendations to the Executive Committee.

1. A retreat for Planning Council staff should be held to delve into the mission, vision, goals, and objectives.
 2. A retreat for the Executive Committee should be held to work on Planning Council efficiencies, strengthen its vision, and prepare for current and future leaders.
 3. Bring in outside consultant support to committees on an as-needed basis.
 4. Develop a communication plan to facilitate the distribution of Planning Council work products and increase visibility and impact.
 5. Continue to guide the Planning Council with its alignment to mandates, and to use those mandates as a touchstone for work and activities.
- The consultant also designed a process and timeline for an annual evaluation of the Executive Officer. The committee adopted a procedure for the coming years. For the 2015 evaluation, members will be getting a surveymonkey to provide input on Ms. Adcock's performance. Responses are anonymous.

6. Public Comment

Mr. Helmick suggested that the Planning Council look further into the community health workers – if SB 614 passes, community health workers can be an appropriate model for communities of color.

Ms. Lettau confirmed that the Data Notebook will be posted on the CMHPC website. Also, for the Advocacy Committee, she hoped to see a statement included on the support of harm reduction measures as part of SUD. In addition, Ms. Lettau hoped to see support of alternatives to forced treatment.

7. Member Suggestions for 2016 Area of Council Focus

The members offered suggestions for areas of focus for 2016.

Ms. S. Wilson: for the Data Notebook to focus on children and youth.

Ms. Nickerson: for an additional focus on the aging population.

Ms. Lee: first steps for the integration with Substance Abuse.

Mr. Leoni: how to accomplish strategic shifting of clients from IMDs to community programs.

Mr. O'Neill: comprehensive reports in the Data Notebook on numbers of FSP children and Katie A. children; numbers of counties working with their Office of Education to provide treatment to Special Ed children; psychotropic medication for children.

Dr. Nelson: the population that has the combination of behavioral disorders plus developmental challenges.

Ms. Black: a presentation on this topic from someone from the Department of Developmental Services. Also, use of the Olmstead Decision in getting people de-institutionalized.

Ms. Watson: the problem of alcohol abuse accompanying aging. Also, mental health as it is connected to racial and ethnic disparities.

Mr. Leoni commented that the federal government is beginning to lean on states to fully implement the Olmstead Act. He also clarified the wording of his former suggestion: *“Strategic shifting of populations from IMDs to community.”*

Ms. Vue: Care coordination among mental health and physical health – the CCBHCs that DHCS applied for.

8. Meeting Evaluation

Ms. S. Wilson commented that it is shocking that the Planning Council must work so hard to achieve a quorum.

Ms. Liberato felt that the meeting was a good start.

Mr. O’Neill acknowledged the wonderful facilitation of the Chair.

9. ADJOURN

Chair Claflin adjourned the meeting at approximately 11:45 a.m.

H TAB SECTION

DATE OF MEETING 1/20/16

MATERIAL
PREPARED BY: Adcock

DATE MATERIAL
PREPARED 12/14/15

AGENDA ITEM:	Review and Approval of Workforce Education and Training Five-Year Plan Revision
ENCLOSURES:	

BACKGROUND/DESCRIPTION:

In January 2014, the Planning Council approved the proposed Workforce Education and Training Five-Year Plan developed and implemented by the MHSA WET team at the Office of Statewide Health Planning and Development (OSHPD). At that time, the Council requested that the team return in two years to revisit the budget in order to have the ability to make adjustments should the workforce needs and/or opportunities change during the five year span.

OSHPD has conducted a robust stakeholder engagement process to receive input from interested and involved parties regarding any proposed adjustments to the 5-Year Plan.

At the January meeting, the team at OSHPD is returning to the Planning Council with a revised budget for the Council's review and approval. We have an ad hoc workgroup working closely and directly with the team, they include Cindy Clafin, Dale Mueller, John Ryan, Monica Wilson, Darlene Prettyman and Steve Leoni.

The current 5-Year Plan can be found at this link:

<http://www.oshpd.ca.gov/HWDD/pdfs/WET/WET-Five-Year-Plan-2014-2019-FINAL.pdf>

I TAB SECTION

DATE OF MEETING 1/21/16

MATERIAL
PREPARED BY: Adcock

DATE MATERIAL
PREPARED 12/14/15

AGENDA ITEM:	Alternatives to Locked Facilities
ENCLOSURES:	<ul style="list-style-type: none">• Criminal Division: Community Court Program• Rehab vs. Jail: How It Works• Jail Diversion Programs for Persons With Mental Illness: An Emphasis on Pre-Booking Diversion And Other Early Diversion Models• Excerpts from San Diego County Behavioral Health Services Website

BACKGROUND/DESCRIPTION:

Pursuant to the Council's focus for 2015-16, counties around the state will present to the members on programs they have established which provide: 1) prevention services to catch folks before a need arises; 2) diversion programs when someone finds themselves at the doorway; and/or 3) reintegration activities to assist in the transition out of a facility back into the community. The facilities include hospitals and jails.

San Diego County is presenting on its Jail Diversion Programs.

To further enhance the Council's understanding of these types of programs, additional information is provided and can be found at the following web links:

<http://www.sandiego.gov/cityattorney/divisions/criminal/commcourt.shtml>

<http://www.jaildiversionprogram.com/san-diego/>

<http://www.mhac.org/pdf/jail%20diversion%20information.pdf>

It is anticipated that an annual report will be prepared which will discuss the focus topic and present information on effective programs implemented throughout the state.



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Criminal Division Community Court Program

San Diego Community Court Program is a post-plea diversion program for offenders who commit low-level misdemeanors. It allows them to get their case dismissed if they pay their debt to society by completing conditions that include two days of community service.

Community Court provides swift consequences for individuals who commit lesser crimes, but without the lasting stain of a criminal conviction. Crimes that qualify include "quality of life" offenses that affect communities, such as disturbing the peace, petty theft, minor vandalism, illegal lodging, trespass and public intoxication.

Through this program, many first-time offenders have been given a second chance to get their lives on track. Participants have paid their debts to society by planting trees, recycling waste products, painting out graffiti, clearing neighborhoods of illegally dumped trash, and helping to provide services to the homeless.

The visible results have been less-crowded courtrooms and jails, and a higher quality of life for San Diegans.

San Diego Community Court is facilitated through the City Attorney's Criminal Division. The Criminal Division participates in problem-solving courts which use restorative justice principles to address quality-of-life crimes.

Note: Do not contact the City Attorney's Office about receiving a Community Court offer for yourself or another. Offers are made only through defense counsel during court proceedings.

Here's how the program works:

- The City Attorney's Office, upon reviewing a case, may elect to offer Community Court to individuals charged with low-level misdemeanors. The offer is made during a defendant's first court appearance, which is usually arraignment.
- If the offer is rejected, the case proceeds as it normally would. There will be no subsequent offer.
- If the offer is accepted, the defendant enters a guilty plea and is referred to a non-profit service provider – either Alpha Project or Urban Corps of San Diego County – to complete 16 hours of supervised community service within 60 days. Participants must pay a \$120 administrative fee; indigent slots are available at no cost.
- Once all conditions are met, the case is dismissed by the City Attorney's Office. The participant does not have to return to court, and the charge never appears on the participant's record.
- Participants who fail to meet the conditions must return to court in 90 days for sentencing of two or five days in jail.

In addition to keeping their records clear, the program helps participants by exposing them to the services offered by Alpha Project and Urban Corps, which include job referrals, education centers and treatment programs.

This potential for early intervention and fresh direction in the lives of young or first-time offenders is one reason the City Attorney's Office is as inclusive as possible in making Community Court offers.

However, it retains discretion over who receives offers, and certain types of offenses – including DUI, domestic violence, sex offenses, child and elder abuse, and arson – warrant automatic exclusion.

Community Court reduces courthouse crowding and costs by limiting the number of court hearings, reduces jail crowding and costs by lowering inmate levels, and reduces law-enforcement costs by removing the need for police officers to testify.

As a result, our courts and jails are able to focus resources on more serious crimes and the criminals who commit them, and our law-enforcement personnel are spending more time on the streets.

In addition to Alpha Project and the Urban Corps, partners in the program include the Public Defender's Office, the Sheriff's Department and the San Diego court system. The American Civil Liberties Union has praised the program for taking "a common-sense approach to handling misdemeanor offenses."

More information on the program can be found here:

- [Community Court Program Having Dramatic Success](#)
- [San Diego Community Court Brochure](#)

JAIL DIVERSION PROGRAM

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How It Works

Jail diversion makes it possible for defendants

How does Jail Diversion work?

After being booked, defendants are screened for eligibility in pre-trial. In court, the judge explains the jail diversion program to the defendant and makes it clear what treatment is required. This includes:

- duration of the treatment
- expectations for the defendant
- requirements for successful discharge of case
- any other stipulations

Those who refuse or withdraw early from the jail diversion program are sent back to criminal court where a conviction usually involves jail time.

Choosing a qualified jail diversion treatment facility after sentencing

Court systems offer a great deal of discretion and flexibility when sentencing non-violent drug offenders and other eligible defendants to treatment. In alternative sentencing, State sanctioned facilities are required, but the choice of residential treatment programs is up to the individual.

Courts monitor offender's progress in treatment

Though not behind bars, jail diversion participants are under close scrutiny. Courts utilize computer applications to keep track of urinalysis and treatment reports. If the offenders are not following their treatment programs, the judge and court system are notified of this immediately.

Successful completion of drug program in alternative sentencing

When clients successfully complete the required jail treatment program and no longer need further monitoring:

- Counsel recommends the case be discharged by the judge
- Both the defendant's counsel and the judge will examine an offender's overall recovery

- At the final court appearance, the case is dismissed and the client will be released from supervision
- Upon graduation from a treatment program, qualified clients will also have the opportunity to file and expunge their arrest record.
- If record is expunged, offenders are able to officially answer that they have never been arrested or convicted on a drug charge on any official questionnaire.

Further information on Jail Diversion and alternative sentencing

Jail Diversion is not for every case and alternative sentencing may not always be offered. Call Capo By The Sea for a free consultation at 888-503-3185 or complete the contact us form for more information.

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JAIL DIVERSION PROGRAMS FOR THOSE WITH MENTAL ILLNESS: AN EMPHASIS ON PRE-BOOKING DIVERSION AND OTHER EARLY DIVERSION MODELS



MEMORANDUM

DATE: January 2009

TO: Mental Health and Criminal Justice System Leaders

FROM: Rusty Selix, Executive Director

RE: Jail Diversion Programs

This report is a detailed paper studying various criminal justice diversion programs that is a culmination of work done by Rachel Scherer a recent law school graduate, who is now an attorney, who collected this research information over the past year. The paper is an excellent one and was originally conceived of as documenting recommendations on pre-booking criminal justice diversion and contrasting that with mental health courts while providing recommendations on both.

However, after reading the report what it really does more than anything is document that there are at least 10 stages of involvement of the criminal justice system for which there can be diversion through coordinated efforts between law criminal justice and mental health officials.

What emerges is that police departments, sheriffs, district attorneys, judges, and County mental health officials should be working together to match the full continuum of strategies to each situation.

The ten strategies can be summarized as follows:

1. Proactive efforts by outreach teams to homeless and other places for those at high risk of criminal justice system contact to provide services before a crime has been committed.

A corollary to this type of proactive pre-crime commitment was brought to my attention after this paper was prepared by a San Bernardino City police officer named Marci Atkins who indicated that she is now teaching classes to mental health consumers about how to respond to the police that is the flip side of CIT training for police officers. In other words while it is important to train police officers in terms of how respond to a situation involving someone with a mental illness it is equally important to train those who have severe mental illnesses and may again be in situations where they are confronted by law enforcement and to help them better understand law enforcement and how they can respond in a more constructive way that serves them better.

2. Police officers direct diversion at the commission of a crime that is considered minor or for which the officer does not file charges and directly transfers the individual to mental health services.

3. Same as number 2 except officer threatens the filing of charges and individual only cooperates after threat is made.
4. Police response (often accompanied by mental health officials) through CIT programs responding to 911 calls or other situations and making the referral to treatment instead of taking the person into court and also an alternative to taking a person to the hospital for a 51/50.
5. Taking the individual into custody and filing charges and transferring the individual to a mental health treatment program with legal action initiated but not court action.
6. After the filing of charges a diversion at the time of arraignment or the initial pleading of the case but before there has been a trial.
7. After trial mental health court determination in lieu of entering a conviction.
8. The more common form of the mental health court which is an alternative sentencing approach after there has been a conviction.
9. Not guilty by reason of Insanity Plea bargain
10. Incompetent to Stand Trial (debatable as to whether this is really diversion versus delay but when initiated it does result in treatment instead of incarceration and could lead to one of the other forms of diversion)

The continuum would seem to be based upon the severity of mental health symptoms the magnitude of the crime and the individual's willingness to enter treatment without threats of punishment.

Critical to all of these programs is the availability of mental health services that has to be known to the law enforcement officials involved so that they can confidently make a referral knowing there are slots available.

Additional copies are available online at www.mhac.org. We recommend that this be distributed broadly to mental health and law enforcement community leaders and encourages meetings of representatives of all the organizations affected by this to promote a broader range of criminal justice diversion strategies than the two that are widely understood, the CIT training for response to crisis situations and the mental health court after conviction.

The document also should be viewed still as a continuing document subject to adding additional material and editing. We post this on our website with an expectation that it will be updated over time reflecting additional information learned and corrections from those who know more about this than we do.

JAIL DIVERSION PROGRAMS FOR THOSE WITH MENTAL ILLNESS: AN EMPHASIS ON PRE-BOOKING DIVERSION AND OTHER EARLY DIVERSION MODELS *

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* Rachel Scherer, Mental Health Association in California, September 2008.

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I. INTRODUCTION

Jail diversion programs that target mentally ill offenders have been sprouting up all around the country for roughly the last twenty years.¹ This report focuses primarily on analyzing pre-booking diversion programs and some early intervention post-booking diversion programs because they identify and begin the diversion process at early stages in the criminal process. Thus, contact with the criminal system as a result of a mental illness is substantially reduced, and in some cases almost entirely prevented. In order to understand why pre-booking diversion and other early intervention post-booking programs are such an important component in the criminal process to place our time and energy on expanding, it is important to first understand the generalized and objective differences between pre-booking and post-booking jail diversion programs.

II. BACKGROUND

A. *The First Step: Understanding the Booking and/or Arrest Process*

One of the most important steps toward understanding the differences between pre-booking and post-booking jail diversion programs is to identify and understand the booking and/or arrest process itself. In doing so, the specific rationales for selecting and creating a mental health diversion program at any of several points along the continuum of the booking and/or arrest process emerge. Some basic definitions will help.

1. *Booking*

Black's Law Dictionary defines "booking" as the process that occurs when a police officer records "the name of a person arrested in a sequential list of police arrests, with details of the person's identity (usually including a photograph and a fingerprint), particulars about the alleged offense, and the name of the arresting officer."² Booking typically takes place at the police department. In order to be booked, an individual needs to *first be arrested* for a particular offense.

2. *Arrest*

Black's Law Dictionary defines an arrest as the "taking or keeping of a person in custody by legal authority, especially in response to a criminal charge"³ Generally (for purposes of this report), a person is under arrest for a particular crime when an officer escorts him or her in a police car to the station for booking.

Arrest is often the most damaging moment for a person with a mental illness. First, in many cases, it is confrontational, accusatory, and humiliating, as the individual is being criminalized for a behavior they often can't control. Second, once an arrest is made, booking as well as the more formal court processes begin, which further criminalizes the illness.

¹ CMHS NAT'L GAINS CTR. & CMHS GAINS TAPA CTR. FOR JAIL DIVERSION, PRACTICAL ADVICE ON JAIL DIVERSION: TEN YEARS OF LEARNINGS ON JAIL DIVERSION FROM THE CMHS NATIONAL GAINS CENTER 7 (2007). "Seven percent of U.S. Counties have one or more jail diversion programs." Henry J. Steadman, *What Can We Say About the Outcomes of Jail Diversion Programs*, Power Point, NASMHPD's Forensic Division Annual Meeting, Sept. 12, 2005.

² BLACK'S LAW DICTIONARY (Brian A. Garner, ed., 2004).

³ *Id.*

However, the unwritten rule about an arrest is that an officer has some discretion as to whether to make an arrest in the first place (depending on the crime).⁴ This is true regardless of whether a formal diversion program is in place. For example, for minor offenses, an officer might give a verbal warning, never initiating the arrest or booking process at all.⁵

3. *The Citation*

Some lower level crimes, such as those governed by municipal codes, do not require the costly and timely process of arrest and booking at all. Instead, issuing a citation regarding the charged crime is appropriate.

Black's Law Dictionary defines "citation" as a "police-issued order to appear before a judge on a given date to defend against a stated charge"⁶ Thus, a citation may be a substitute for what could otherwise be an arrest resulting in booking.

Initially, it appears that someone who is issued a citation for a charged crime is never arrested or booked. But in practice, this is hardly ever the case, particularly for homeless individuals suffering from mental illness.⁷ This is because these individuals often "fail to appear" in court pursuant to the date on the citation.⁸

If an individual fails to appear at court pursuant to a citation for a minor infraction, a bench warrant will be issued for that individual's arrest. Then, the criminal cycle of arrest and booking begins due to a simple "failure to appear" charge resulting from the missed court date. Thus, failing to appear in court pursuant to a citation for a minor municipal crime, such as loitering or panhandling, could ultimately end in arrest and booking upon future contact with a police officer.

4. *Summary*

In summary, there are two key ways in which an individual might be arrested and booked for a crime. First, as is most common, arrest and booking takes place for higher level offenses and crimes, including some misdemeanors and all felonies in which the officer is required under law to make the arrest. However, for some misdemeanors and municipal crimes, the arrest and booking process might never be initiated due to the officer's discretion not to make the arrest. In the alternative, if a citation alone is issued for a municipal crime—and the individual appears in court regarding the charge—a bench warrant will not be issued and the arrest and booking process will be avoided. The second way in which arrest and booking typically takes place is for minor municipal crimes and/or infractions when an individual fails to appear for a court date on the original minor offense or citation.

B. The Second Step: Understanding the Criminal Process an Individual Faces Post-Booking

⁴ *E.g.*, Interview with Officer Marci Atkins, Homeless Advocate Officer, San Bernardino Police Department, San Bernardino, CA, Aug. 8, 2008.

⁵ *Id.*

⁶ BLACK'S LAW DICTIONARY (Brian A. Garner, ed., 2004).

⁷ Interview with Officer Marci Atkins, Homeless Advocate Officer, San Bernardino Police Department, San Bernardino, CA, Aug. 8, 2008.

⁸ *See e.g.*, Superior Court of California—County of Shasta, Criminal Division, www.shastacourts.com/menu/php?page=criminal (last visited Sept. 19, 2008). In addition to failing to appear, such individuals may also have difficulty paying fines associated with minor citations due to lack of finances causing a bench warrant to be issued.

In order to appreciate any future contacts with the criminal system that might be avoided under a pre-booking or other early diversion program, it is important to identify some basic stages of the post-booking criminal process. There are six major points of contact with the criminal system after booking has been completed: 1) arraignment, 2) the pre-trial hearing, 3) the preliminary hearing, 4) trial, 5) sentencing, and 6) possible jail or prison time if convicted.⁹ At each of the stages of trial, the defendant may be represented by counsel. The issue then turns to whether the time, cost, punishment, and resources used by the criminal system at each of these stages are a useful investment for our society to make when the root cause of the behavior has been determined to be a mental illness.

1. Arraignment—The Court Process Begins

For most crimes, the first step after booking is arraignment, usually occurring within one or two days of booking. Black's Law Dictionary defines arraignment as "the initial step in a criminal prosecution whereby the defendant is brought before the court to hear the charges and enter the plea."¹⁰ At arraignment, the defendant, or counsel on behalf of the defendant, usually pleads not guilty. If the defendant pleads guilty he or she can be convicted without a trial at this early stage.

A pre-booking diversion program avoids this stage of the criminal process altogether, thereby avoiding any time waiting in jail for the arraignment. Instead, this time will be spent linking the offender to key community mental health services and supports.

On the other hand, a virtue of some post-booking diversion programs is that they might begin the diversion process at this early stage in the criminal process. Thus, while the diversion is technically post-booking or post-arraignment, it still avoids the other stages of criminalization of mental illness, including the following: pre-trial hearing, preliminary hearing, trial, sentencing, and possible jail or prison time. The inherent disadvantage, however, is that the defendant is still criminalized for his or her mental illness and potential wasteful tax dollars are spent to pay judges, bailiffs, and police officers involved in the criminal process through arraignment.

2. Pre-Trial Hearing

After arraignment, a pre-trial hearing may take place during which time information is exchanged between the prosecution and the defense. During this time, the prosecutor may offer a plea agreement to the defendant and the defense attorney may file motions, such as that to suppress evidence.¹¹

While a plea agreement sounds diversionary to some degree, it can often be as damaging as a conviction on the original charge. For example, if a mentally ill individual is charged with a felony, he or she might agree to plead guilty to a lesser charge or related misdemeanor. But a conviction for a misdemeanor can still be highly damaging to the individual when he or she attempts to obtain employment later down the road. Additionally, focusing on the plea

⁹ See Los Angeles Superior Court-Criminal, General Information, *available at* www.lasuperiorcourt.org/Criminal/main.htm (last visited Sept. 8, 2008).

¹⁰ BLACK'S LAW DICTIONARY (Brian A. Garner, ed., 2004). The defendant need not be present in court for arraignment of a misdemeanor crime if represented by counsel. Nonetheless communications regarding each of these proceedings will be communicated to the defendant.

¹¹ See e.g., Superior Court of California—County of Shasta, Criminal Division, www.shastacourts.com/menu/php?page=criminal (last visited Sept. 19, 2008).

agreement as a way to avoid a harsher penalty does nothing to ensure linkage to lasting mental health treatment.

A pre-booking diversion program and some early intervention post-booking programs avoid this criminally-based negotiations process altogether and instead link the individual directly to treatment. Additionally, such programs circumvent the tax dollars being spent to pay judges, prosecutors, defense attorneys, police officers, and bailiffs during this time, instead directing such costs to community treatment.

3. Preliminary Hearing

After the pre-trial hearing, for felony charges only, the next step is the preliminary hearing.¹² The alternative to a preliminary hearing is for the District Attorney to seek an indictment from a grand jury, but this is far less common.¹³

Black's Law Dictionary defines a preliminary hearing (also known as a probable cause hearing) as "a criminal hearing (usually conducted by a magistrate) to determine whether there is sufficient evidence to prosecute an accused person."¹⁴ "If sufficient evidence exists, the case will be set for trial"¹⁵

While the preliminary hearing itself may not be terribly damaging to the defendant, the costs in time and labor associated with paying the judge, court staff, prosecutor, and public defender are factors to consider. Again, the question should be asked as to whether it is worth the time and cost of all these judicial parties to be involved in the matter if the root cause of the behavior is a mental illness that could have been identified and addressed at an earlier stage. While a preliminary hearing often occurs within a couple days of booking, it may also be the case that the mentally ill individual waits in jail during those few days, which can be damaging to the individual's condition, even if he or she is receiving some type of mental health treatment through the jail.

4. Trial

Generally, trial takes place within one or two months of arraignment. This can be a critical and lengthy period of time for persons with mental illness. Under California law, trial usually takes place within sixty days of arraignment for charges involving felonies.¹⁶ For misdemeanors, trial usually takes place within thirty to forty-five days, depending upon whether the individual has been held in jail during that time.¹⁷

It is important to note the length of time being spent between the time charges are filed and the trial, because often during this time, if there is no diversionary program in place, very little or nothing is done to address the mental illness that led to the criminal behavior. If the individual waits in jail this entire time, although likely receiving some type of mental health care in the jail under California law, jails are not first and foremost mental health facilities and are not

¹² See Los Angeles Superior Court-Criminal, General Information, *available at* www.lasuperiorcourt.org/Criminal/main.htm (last visited Sept. 8, 2008).

¹³ See BLACK'S LAW DICTIONARY (Brian A. Garner, ed., 2004). "If a grand jury decides that evidence is strong enough to hold a suspect for trial, it returns a bill of indictment charging the suspect with a specific crime." *Id.*

¹⁴ *Id.*

¹⁵ *Id.*

¹⁶ See Los Angeles Superior Court-Criminal, General Information, *available at* www.lasuperiorcourt.org/Criminal/main.htm (last visited Sept. 8, 2008).

¹⁷ *Id.*

designed to be a therapeutic or rehabilitative environment. Thus, while care may be obtained, it is not necessarily the most beneficial toward long-term recovery or reducing recidivism. Likewise, if the individual is released to the community while awaiting trial, he or she may not be receiving mental health care and could wind up with another similar charge during that time. A pre-booking or other early diversion program avoids the time and money spent dragging a criminal case out when at an early stage it can be determined that a mental illness was the root cause of the criminal behavior.

5. *Sentencing Hearing*

If the jury or fact-finder finds the defendant guilty at trial, a sentencing hearing will take place to determine the defendant's punishment. This may be a stage at which a post-conviction mental health court intervenes, however, many mental health courts will intervene earlier at any point post guilty plea. In a post-plea mental health court, the defendant might plead guilty as early as arraignment and be diverted to treatment, or alternatively, plead guilty as late as trial and still be diverted. Some courts, discussed further throughout the report, will even intervene pre-guilty plea.¹⁸

6. *Jail or Prison Time*

One of the most damaging aspects of the criminal system to mentally ill offenders can be a sentence to jail or prison. For misdemeanor crimes, the defendant can be sentenced to jail time for up to one year. For felony crimes, the defendant can be sentenced to prison for over one year. While mental health treatment will be provided in jail or prison under California law, persons with mental illness often deteriorate due to the general harsh conditions of incarceration. Additionally, they are less likely to follow rules compared to other prisoners and therefore may suffer harsher consequences. Further, they are susceptible to being both physically and mentally victimized by other prisoners.

7. *Summary*

In summary, as illustrated through the six key steps of the criminal process above, it is possible that a defendant could wait in jail from the time of booking and arrest all the way through trial and sentencing. In most cases, this might take between one and two months.

However, for many low level offenses it is often not practical or cost-efficient to have such individuals wait in jail for such a lengthy period of time. Due to overcrowding of the jails, defendants may be "site released" shortly after booking and/or arraignment.¹⁹ Upon being site-released (generally, with no treatment plan in place), such individuals (and/or counsel) are expected to appear for future court/hearing dates, including the preliminary hearing and trial. While site release ensures the person with mental illness does not wait in jail or prison, it does not end the criminal process by which he or she is subjected. Further, with no treatment program in place, the individual is more likely to reoffend while on release in the community, further exacerbating the problem.²⁰

A pre-booking diversion or other early diversion program eliminates incarceration as a source of punishment, as well contact with the criminal system at many or all of the stages of the

¹⁸ *See infra* Section V.B.2.

¹⁹ *E.g.*, Interview with Officer Marci Atkins, Homeless Advocate Officer, San Bernardino Police Dep't, San Bernardino, CA, Aug. 8, 2008.

²⁰ Additionally, irrespective of site-release, if a judge sets bail for either a felony or misdemeanor charge, the defendant may also be released by posting bond. But again, with no treatment in place, the individual is more likely to re-offend.

criminal process identified above. Early diversion programs focus on linkages to treatment to address the root problem of the criminal behavior instead of perpetuating punishment for that behavior through the generalized criminal system.

C. The Third Step: Identifying the Two Main Types of Criminal Diversion Programs, Pre- versus Post-Booking Diversion

There are several terms often used interchangeably to describe criminal diversion programs. The most common terms are pre-booking and post-booking. But within each of these two major overarching categories there are multiple if not hundreds of different variations upon which a pre-booking or post-booking program might function. Therefore, the terms alone fail to denote a specific type of program, but rather a point or moment in the criminal process in which some type of diversion is being accomplished. The National GAINS Center²¹ and the Bazelon Center for Mental Health Law²² use the terms “pre-booking” and “post-booking” to describe and evaluate a variety of mental health diversion programs around the country. This report will also use these terms to make an important policy distinction among many types of jail diversion programs. But other organizations, such as the Criminal Justice Mental Health Consensus Project, eliminate use of the terms pre-booking and post-booking altogether opting simply to refer to all such programs as “jail diversion.”²³

1. Pre-Booking Diversion

As mentioned in detail in Section I of this report, a diversion program that is pre-booking in nature seeks to divert the individual from booking and arrest altogether. The focus is on early diversion to treatment in order to address the root cause of the criminal behavior, eliminating virtually all subsequent contacts with the criminal system. Thus, at a minimum, a pre-booking program diverts the individual from the following stages of the ordinary criminal process discussed in Section II: arrest, booking at the station, arraignment, the pre-trial hearing, the preliminary hearing, trial, sentencing, and possible jail or prison time.

The GAINS Center describes two main types of pre-booking diversion programs. The Mental Health Association in California (“MHAC”) has identified a third type of pre-booking diversion that will be discussed last.

²¹ “The National GAINS Center in the Justice System is committed to the goal of transforming the nation’s fragmented mental health system and developing a recovery-oriented, consumer-driven system of care as described in the report of the President’s New Freedom Commission. The GAINS Center is uniquely poised to help states forge collaborations among the mental health, substance abuse, and criminal justice systems.” The GAINS Center, <http://gainscenter.samhsa.gov/html/about/default.asp> (last visited Aug. 19, 2008).

²² The Bazelon Ctr. for Mental Health Law, Fact Sheet #6, Pre-Booking Diversion, *available at* www.bazelon.org/issues/criminalization/factsheets/criminal6.htm; The Bazelon Ctr. for Mental Health Law, Fact Sheet #7 Post-Booking Diversion, *available at* www.bazelon.org/issues/criminalization/factsheets/criminal7.htm (last visited Sept. 8, 2008).

²³ “Some visitors to this website will be more familiar with terms associated with jail diversion (for example, “pre-booking” and “post-booking”). Though these terms aren’t used here, you can find content on these types of diversion programs throughout the site.” Council of State Governments, Criminal Justice Mental Health Consensus Project, *Jail Diversion*, *available at* <http://consensusproject.org/issue-areas/jail-diversion/> (last visited Sept. 18, 2008).

The first type of pre-booking diversion is the Crisis Intervention Training (“CIT”) police officer model.²⁴ In this model, a police officer is the first responder to a 911 call directed to him or her because of specialized training in handling crisis mental health situations. The officer as first responder assesses the mental health situation and determines whether to link the individual to services or alternatively to make an arrest. Through CIT training “officers [are] encouraged to consider, when appropriate, linkage and referral for care to the mental health system as a preferable alternative to arrest.”²⁵

The second type of CIT is the co-responder model, which includes an officer “co-responding” with the assistance of a clinician or social worker to help assess the mental health needs of the client and determine what linkages and services might be appropriate.²⁶ These are often called crisis intervention *teams*, and the acronym CIT is also used to identify them.

As stated by the GAINS Center,

Most pre-booking programs are characterized by specialized training for police officers and a 24-hour crisis drop-off center with a no-refusal policy for persons brought in by the police. The most recognized program model is the Crisis Intervention Team (CIT) developed in Memphis, TN. Other models of pre-booking diversion involve collaboration between police and specially-trained mental health service providers who co-respond to calls involving a potential mental health crisis.²⁷

The third type of pre-booking diversion that MHAC has identified need not involve a crisis or emergency situation. Further, it need not involve a police officer responding to a 911 call. However, a police officer may be a key ingredient in the program as it involves a duty to patrol and may include proactive outreach seeking out persons who may be in need of services. Through such programs,²⁸ officers might do regular patrol of downtowns and other neighborhoods, where there are commonly people who are homeless. Alternatively they may proactively do outreach to homeless camps, and abandoned areas for persons who might be in need of mental health services. Such officers will then provide appropriate linkages to services needed. Often the persons targeted through this type of diversion program may be in need of multiple services, only one of which is mental health treatment. Usually, when the officer identifies these types of individuals, the individual has been involved in minor crimes related to their homelessness, such as trespassing, disorderly conduct, petty theft, public intoxication, loitering, or panhandling.

The proactive outreach is often before commission of a crime. A social worker or an outreach team (with or without a police officer) may patrol the same areas to enroll people in

²⁴ The GAINS Center for Mental Health Services, www.gainscenter.samhsa.gov/html/tapa/jail%20diversion/types.asp (last visited Aug. 19, 2008).

²⁵ Jennifer L.S. Teller, et al., *Crisis Intervention Team Training for Police Officers Responding to Mental Disturbance Calls*, 57 PSYCH. SERVS. 232, 233 (2006).

²⁶ The GAINS Center for Mental Health Services, www.gainscenter.samhsa.gov/html/tapa/jail%20diversion/types.asp (last visited Aug. 19, 2008).

²⁷ The GAINS Center for Mental Health Services, www.gainscenter.samhsa.gov/html/tapa/jail%20diversion/types.asp (last visited Aug. 19, 2008).

²⁸ One prominent such program is discussed in detail in Section IV.B (describing the program Officer Marci Atkins and the San Bernardino City police department created).

community mental health programs as was the model in AB 34 (1999) and AB 2034 (2000). Pre booking diversion only to the situations when an arrest could have otherwise been made.

2. Post-Booking Diversion

As described in Section I, post-booking diversion can occur at any stage in the criminal process after arrest and booking. This is the most prevalent type of diversion program in the U.S., and it includes two further subtypes, jail-based and court-based diversion programs.²⁹

Court-based diversion programs are most prevalent and are often known as mental health courts. In such a court the criminal charge or conviction leads to treatment rather than to a jail or prison sentence. In many mental health courts the charges are dropped or the conviction is reversed upon successful completion of the program.³⁰ Although mental health courts are the most prevalent type of post-booking diversion program, often occurring on a post-conviction or post guilty plea basis, post-booking court diversion may take place at earlier stages in the criminal process, as briefly mentioned in Section II.B. Such an early intervention model mental health court might intervene at arraignment or before a guilty plea is given, which could be at a number of stages in the trial process. Early diversion mental health courts may be ideal diversion models when used to target felony or elevated misdemeanor offenses that are directly result of or caused by mental illness. This is because the severity of the charged crime makes it unlikely that such individuals will be diverted on a pre-arrest or pre-booking basis.

Jail based diversion, the other type of post-booking diversion, is somewhat similar content-wise to court based diversion, except that it avoids the use of a formal court altogether.³¹ Jail based diversion might occur after booking but at jail after a consultation with a clinician upon intake. If the clinician determines that the individual is suffering from a mental illness that directly led to the criminal behavior, he or she might recommend that law enforcement and the district attorney defer charges upon the condition that the individual obtain treatment in the community. If treatment is completed, then charges will be dropped.³²

3. Summary

The GAINS Center has identified five major points at which a post-booking diversion program typically operates, which include relevant key stages in the two jail based and court based options: 1) “at or immediately after booking into jail, before the formal filing of charges”; 2) “release from pretrial detention [in jail], with the condition of participation in treatment”; 3) “prior to disposition [of the case at trial], for example, upon the prosecutor’s offer or deferred prosecution”; 4) “at disposition or sentencing; this may include deferred sentencing or release on

²⁹ CMHS NAT’L GAINS CTR. & CMHS GAINS TAPA CTR. FOR JAIL DIVERSION, PRACTICAL ADVICE ON JAIL DIVERSION: TEN YEARS OF LEARNINGS ON JAIL DIVERSION FROM THE CMHS NATIONAL GAINS CENTER 12-13 (2007), *available at* http://gainscenter.samhsa.gov/pdfs/jail_diversion/PracticalAdviceOnJailDiversion.pdf (last visited Aug. 27, 2008).

³⁰ For more information about CA mental health courts, see *infra* Section V.

³¹ *E.g.*, CMHS NAT’L GAINS CTR. & CMHS GAINS TAPA CTR. FOR JAIL DIVERSION, PRACTICAL ADVICE ON JAIL DIVERSION: TEN YEARS OF LEARNINGS ON JAIL DIVERSION FROM THE CMHS NATIONAL GAINS CENTER 13 (2007), *available at* http://gainscenter.samhsa.gov/pdfs/jail_diversion/PracticalAdviceOnJailDiversion.pdf (last visited Aug. 27, 2008).

³² See Patricia A. Griffin, *The Use of Criminal Charges and Sanctions in Mental Health Courts*, 53 PSYCHIATRIC SERVS. 1285, 1286 (2002).

probation with conditions which include participation in treatment”; and 5) “when at risk of, or following, a violation of probation related to a prior conviction.”³³ Because there are so many points at which an individual might be diverted post-booking, one can begin to see the myriad of post-booking programs that exist and could potentially be created.

One final minor point regarding the linguistics at work in jail diversion programs needs to be made. The word “pre” alone or with some other term does not mean it is a *pre-booking* diversion program. Some programs are *pre-trial*, *pre-conviction*, or *pre-sentencing*, and it is important to note that these are all *post-booking* diversion programs. This is part of the flaw with the pre- and post-booking terminology. The key is to focus on the term “booking” or any other point of entry into the criminal system and see whether diversion is aimed before or after that point.

III. WHY PRE-BOOKING DIVERSION OR OTHER EARLY DIVERSION PROGRAMS ARE A KEY AREA TO FOCUS CALIFORNIA RESOURCES, TIME, AND ENERGY

“The vast majority of *detainees and inmates in U.S. jails and prisons* with co-occurring mental health and substance abuse disorders are nonviolent, low-level offenders who repeatedly cycle through the criminal justice system”³⁴ Further, nearly half of the mentally ill persons *incarcerated in state prisons* nationwide are there because they committed a non-violent crime.³⁵ Even more, “Half of all *arrests* of people with mental illnesses are for nonviolent crimes such as trespass or disorderly conduct.”³⁶

While pre-booking diversion or other early diversion programs may not be appropriate for some persons who are criminally minded that just so happen to have a mental illness unrelated to the criminal behavior, diversion programs are a critical step toward addressing why so many persons with mental illness are incarcerated for non-violent crimes. Pre-booking diversion is most appropriate for those who commit very minor, non-violent offenses as a result of a mental illness. Early intervention post-booking diversion alternatives, on the other hand, may be appropriate for higher level offenses, including felonies, when the mental illness has caused the criminal behavior. In either case, incarcerating such a high number of persons with mental illness for non-violent and/or minor crimes does little to reduce recidivism. Additionally, it clogs the courts, jails, and prisons with problems that should be dealt with in the mental health system rather than the criminal system.

A. *Types of Crimes Typically Associated with Pre-Booking Diversion*

³³ The GAINS Center for Mental Health Services, www.gainscenter.samhsa.gov/html/tapa/jail%20diversion/types.asp (last visited Aug. 19, 2008).

³⁴ SAMHSA, *Jail Diversion: Knowledge Development and Application Program* (emphasis added).

³⁵ COUNCIL OF STATE GOVERNMENTS, THE CONSENSUS PROJECT, THE ADVOCACY HANDBOOK: A GUIDE FOR IMPLEMENTING RECOMMENDATIONS OF THE CRIMINAL JUSTICE/MENTAL HEALTH PROJECT, *available at* http://consensusproject.org/advocacy/step1_1/ (emphasis added).

³⁶ THE BAZELON CTR., *THE ROLE OF MENTAL HEALTH COURTS IN SYSTEM REFORM*, *available at* http://www.bazelon.org/issues/criminalization/publications/mentalhealthcourts/#_ftn1 (last visited Aug. 27, 2008) (emphasis added).

One of the first distinctions that tends to arise between a pre-booking and post-booking diversion program is the type of offense for which pre-booking diversion is most appropriate. Typically, offenses diverted through a pre-booking program are low level misdemeanors and infractions for which a citation might be appropriate.³⁷ Currently, these tend to be offenses for which a police officer has general discretion with regard to whether to make an arrest. These types of offenses such as trespassing, loitering, disorderly conduct, public intoxication, petty theft, and nuisance; are sometimes referred to as “survival” or crimes.³⁸ Because nearly half of all arrests of persons with mental illness are for non-violent crimes, pre-booking diversion programs are ideal for two key reasons: 1) to address the underlying illness as soon as possible and 2) to divert the individual from entering (or re-entering) the criminal system.

B. Post-Booking Diversion Programs that Emphasize Diversion at Early Stages

Both jail-based and early intervention court-based diversion programs are important to develop and bolster for the general two reasons identified above with respect to pre-booking diversion programs. One key practical difference with respect to the need for both pre-booking and early intervention post-booking diversion programs is that higher level offenses are not likely to be diverted through the pre-booking stage. Thus, when higher level offenses related to a mental illness are at issue, early diversion post-booking diversion programs are critical aspects of jail diversion that should be bolstered.

A mental health court is a practical model to divert charges associated with higher level offenses, particularly felonies or cases where the individual is more resistant to treatment. Whether intervening at sentencing or at an earlier stage in the criminal process, the judge and a mental health court team—including prosecutors, public defenders, clinicians, and probation officers—work with the individual to obtain treatment for a set period of time in exchange for avoiding incarceration. Often treatment through a mental health court is conditioned on a guilty plea or conviction for the crime charged. In some cases, the conviction is dropped if treatment is completed successfully.³⁹ Less frequently, treatment programs through a mental health court may be obtained on a pre-plea basis.⁴⁰ When treatment in a pre-plea court is successfully completed, charges are then dropped.

Many argue that dragging a mentally ill individual through the criminal process of a mental health court in order to ultimately enter a treatment program is coercive and not likely to last in the long-run as treatment seldom results in recovery without the active willing participation and engagement of the client. However, there appear to be many stories of success with such courts. Since mental health courts are still new and developing, more data needs to accumulate before specific questions regarding long-term recidivism patterns can be answered.⁴¹

³⁷ See *infra* Section IV for a detailed discussion of why this tends to be the case.

³⁸ *E.g.*, Interview with Officer Marci Atkins, Homeless Advocate Officer, San Bernardino Police Dep’t, San Bernardino, CA, Aug. 8, 2008.

³⁹ The Orange County W.I.T. court operates this way. Interview with Honorable Judge Wendy S. Lindley, Orange County Superior Courts, Orange County, California, Nov. 26, 2007.

⁴⁰ See *infra* Section V.B.2 discussing San Francisco’s Pre-Plea Mental Health Court.

⁴¹ The National Council on State Governments cautions that “Understanding the mental health court concept means recognizing that not only are multiple options available for improving the courts’ response to defendants with mental illness, but that there are numerous ways to design and implement a mental health court.

Short-term data on these courts suggest that they are having a great impact in reducing recidivism and enhancing recovery.⁴²

. . . .
Program planners should . . . *be aware of the limited evidence base for mental health courts*. While these programs show great promise, their long-term viability depends on empirically documented results. *More research is needed* to better understand mental health court processes, to identify the specific categories of defendants who benefit the most from a mental health court, and to isolate the components of the mental health court model most responsible for its effectiveness.

BUREAU OF JUSTICE ASSISTANCE, COUNCIL ON STATE GOVERNMENTS, A GUIDE TO MENTAL HEALTH COURT DESIGN AND IMPLEMENTATION v (2005) (emphasis added).

⁴² Outcome data from the San Francisco Behavioral Health Court (“BHC,” a mental health court) revealed the following: “By 18 months after graduation, the estimated risk of being charged with any new offense was about 40% lower for BHC graduates than that of similar detainees who did not participate in the program. The risk of BHC graduates being charged with a new violent crime was about 54% lower than that of other comparable detainees.” SUPERIOR COURT OF CALIFORNIA, COUNTY OF SAN FRANCISCO, OFFICE OF COLLABORATIVE JUSTICE PROGRAMS, SAN FRANCISCO BEHAVIORAL HEALTH COURT (2008) *available at* http://www.sfgov.org/site/uploadedfiles/courts/BHCFactSheet_Final.pdf. The study was principally aimed at determining whether the recidivism rate was being reduced for felony as opposed to misdemeanor offenders. In the authors’/researchers’ words, it was concluded that “it appears possible to expand the mental health court model beyond its original clientele of persons charged with nonviolent misdemeanors in a way that public safety is enhanced rather than compromised” Dale E. McNeil & Renee L. Binder, *Effectiveness of a Mental Health Court in Reducing Criminal Recidivism and Violence*, 164 AM. J. PSYCHIATRY 1395, 1402 (2007).

In comparison, outcome data from a study of the Santa Barbara Mental Health Treatment Court concluded that participants in the mental health court had fewer days in jail (though not significantly reduced recidivism rates) than traditional court. MERITH COSDEN, JEFFREY ELLENS, JEFFREY SCHNELL, & YASMEEN YAMINI-DIOUF, UNIV. CAL. SANTA BARBARA GERVITZ GRAD. SCHOOL OF EDUC., EVALUATION OF THE SANTA BARBARA COUNTY MENTAL HEALTH TREATMENT COURT WITH INTENSIVE CASE MANAGEMENT ix (2004). Somewhat alarmingly, however, the study found that the two populations—those in mental health court versus those with treatment as usual in the criminal system—had comparable outcome rates in most instances. *Id.* at 22. Those receiving “treatment as usual” pursuant to a regular criminal court, however, were uniquely connected to services, including a case manager with referrals to relevant county treatment programs. *Id.* at 15 tbl.3. The study cautioned that mental health courts need to be particularly sensitive to the period after participants graduate from the courts, when linkages to specialized treatment may abruptly end. “A concern among some of the graduates was that the supports, including their close contacts with their case managers, ended after 18-months. This led some clients to slip back into old problems and habits of treatment non-compliance.” *Id.* at 73. The study concluded by stating the following:

Overall, the utility of mental health treatment courts will depend on the collaboration of the criminal justice and mental health systems, and on the range and quality of services available to qualifying criminal offenders.

C. Effective Programs Need to Have Available Capacity In Mental Health Programs

While pre-booking diversion or other early intervention diversion programs may sound great in theory, one key element to an effective program is that there be a guaranteed slot in county mental health programs to divert persons in need of treatment into.⁴³ To illustrate the problem, a police officer may wish to divert someone with a mental illness into a treatment program, but upon arriving with the individual at a local facility, may be told that there is no room available in the program as capacity is full. Further, even if there are some guaranteed slots, the program may develop a waiting list, only being able to support so many individuals due to limited funding.⁴⁴ In order to create effective pre-booking diversion or other early diversion models, California counties need to set aside or reserve slots in their programs so that persons in need of treatment are not turned away once the program is started. California counties can seek to create this change by expanding their county mental health plans with funding from the Mental Health Services Act.⁴⁵ Funding issues will be further discussed in Section VI.B.

IV. MODEL PRE-BOOKING DIVERSION PROGRAMS

Crisis intervention training (“CIT”) has become a critical method by which pre-booking diversion programs are created. More often, CIT is the backbone of any pre-booking diversion program. Thus, pre-booking outreach diversion programs always involve a police officer, and may or may not include another “co-responder,” such as a mental health provider.

As previously mentioned, the primary reason that police officers receive CIT training is to improve response to a 911 call. The call might be from a commercial establishment complaining that a homeless person is continually loitering near the premises, the call might be from a family member concerned about a loved one with a mental illness who may be in crisis (which could involve a threat to another family member that could be charged as a crime.) When the call is received, the 911 operator dispatches the call to officers with CIT training. Thus, due

Many of the criminal offenders seen in these programs needed long-term, perhaps life-long, mental health care. Work is needed to develop and implement programs that can provide treatment options for this population.

Id.

⁴³ For example, the Orange County “Whatever It Takes” mental health court has 100 reserved slots for its program. Interview with Honorable Judge Wendy S. Lindley, Orange County Superior Courts, Orange County, California, Nov. 26, 2007. *See also* County of Orange, Mental Health Services Act, Community Services & Supports Three-Year Plan, Approved as of April 1, 2006, at 293.

⁴⁴ E-mail Attachment from Bruce Gurganus, Marin County Mental Health Director, Sept. 3, 2008. The program currently has 75 participants, but “[c]urrently there are twenty individuals on the waiting list [for the STAR program] who would qualify for the program if there were enough staff and resources available.” *Id.*

⁴⁵ *See also* Appendix 3, County of Orange, Mental Health Services Act, Community Services & Supports Three-Year Plan, Approved as of April 1, 2006, at 287-309.

to the nature of the 911 call, it is a police officer (rather than someone from the public mental health sector) who is the “first responder” to a mental health offense or crisis situation.⁴⁶

One caveat, as mentioned earlier, is that CIT training may be used in such a way that ultimately the program is not responding solely to 911 call crisis situations. Instead, through the program and the training skills learned from CIT, officers proactively reach out to persons in need of mental health treatment and divert them to it.

A. *Review of Key Elements in Pre-Booking Diversion Programs at a National Level*

A review of 14 prominent pre-booking diversion programs⁴⁷ reveals the following elements or options that may be present in a pre-booking diversion program:

- A well defined target population
 - Often, best accomplished through collaboration among all key parties: law enforcement, jail personnel, judges, prosecutors, public defenders, and other stakeholders.⁴⁸ Additionally, strategic planning and gradual isolation of a problem area or group is important.⁴⁹
 - For example, one pre-booking diversion program has targeted persons who are homeless and mentally ill.⁵⁰ Other programs might target persons who have committed misdemeanors or non-violent offenses.⁵¹ Even more, a program might simply target women with children if that is a group that is in need of special attention in the community.⁵²
- 40 hour CIT training for patrol officers⁵³
 - Patrol officers are often carefully screened and selected for the program based on their willingness to be there
 - Officers enter the program on a voluntary basis
 - Officers may receive incentive pay for their work
 - Some new police recruits are now *required* to attend CIT post-academy training

⁴⁶ Interview with Officer Marci Atkins, Homeless Advocate Officer, San Bernardino Police Department, San Bernardino, CA, Aug. 8, 2008.

⁴⁷ E-mail Attachment from Latrease Moore, Project Assistant, Criminal Justice Division, Policy Research Associates, *GAINS Ctr., Pre-Booking Jail Diversion Programs 2003*. The fourteen programs identified by the Policy Research Associates are 1) Akron, Ohio, 2) Albuquerque, N.M., 3) Athens, GA, 4) Athens, OH, 5) Hillsborough, County FL, 6) Houston, TX, 7) Kansas City, MO, 8) Miami Dade County, 9) Long Beach, CA, 10) Phoenix AZ, 11) Tucson, AZ, 12) Memphis, TN, 13) San Diego, CA, and 14) Kings County, WA. *Id.*

⁴⁸ For further information about getting started in creating a pre-booking diversion program, see CMHS NAT’L GAINS CTR. & CMHS GAINS TAPA CTR. FOR JAIL DIVERSION, *PRACTICAL ADVICE ON JAIL DIVERSION: TEN YEARS OF LEARNINGS ON JAIL DIVERSION FROM THE CMHS NATIONAL GAINS CENTER 23-30 (2007)* [hereinafter *PRACTICAL ADVICE ON JAIL DIVERSION*], *available at* http://gainscenter.samhsa.gov/pdfs/jail_diversion/PracticalAdviceOnJailDiversion.pdf (last visited Aug. 27, 2008).

⁴⁹ *Id.*

⁵⁰ San Bernardino Homeless Advocate Officer Model.

⁵¹ *PRACTICAL ADVICE ON JAIL DIVERSION*, *supra* note 49, at 29.

⁵² *Id.* at 31.

⁵³ *Id.*

- 40 hour training may be divided so that it is not all “classroom” time: ex. 20 hours in the classroom, 8 hours taking field trips to mental health facilities or other service centers, and 12 hours role-playing⁵⁴
- CIT Refresher courses
 - 6 minute training models to the entire department on a regular basis⁵⁵
 - Two-day annual trainings⁵⁶
- CIT training for 911 operators who receive, interpret, and dispatch the calls
 - One program requires a 2 hour CIT training course for operators⁵⁷
- Officers in CIT programs are usually in uniform when dispatched on a CIT call
- Officer Employee Shifts and/or Coverage of mental health calls
 - Some programs have CIT officers who respond to mental health calls, but are not always able to do so quickly if other emergency calls associated with their general patrol duties are ahead on the dispatch list
 - Other programs designate certain on-call hours for CIT officers; thus there is always an available officer to immediately respond to a mental health call. One program, for example, has CIT shifts that rotate every 2 hours, 7 days a week⁵⁸
- Who is the first responder? (Single Officer v. Co-Responder Models)
 - Some first responders include a single CIT police officer
 - Others include the CIT police officer with another mental health provider, such as a social worker or clinician⁵⁹
 - Other programs incorporate a fuller team, often called a mobile crisis team, with a peer advocate, (such as a former homeless person with a mental illness now in recovery through treatment) licensed clinician or social worker, crisis counselor, registered nurse, and police officer.⁶⁰ In some cases, the police officer returns to duties after the team takes over.
- Linkage to Lasting Treatment in the Community
 - Partnership with mental or behavioral health services is critical
 - Community based services often include mental health outpatient services, substance abuse outpatient services, housing, medical assistance, benefits assistance, and employment assistance
 - Some officers have agreements with facilities that if they bring an individual to the center, that individual will be accepted even if near full capacity
- Linkage to Voluntary or Involuntary Treatment?
 - Typically treatment linkages are made on a voluntary basis⁶¹

⁵⁴ *Id.* (describing the program in Tucson, Arizona).

⁵⁵ *Id.* (describing the program in Tucson, Arizona).

⁵⁶ Jennifer L. S. Teller, et al., *Crisis Intervention Team Training for Police Officers Responding to Mental Disturbance Calls*, 57 PSYCH. SERVS. 232, 233 (2006).

⁵⁷ *Id.* (describing the program in Houston, Texas).

⁵⁸ *Id.* (describing the program in Memphis, Tennessee).

⁵⁹ *Id.* (describing the Long Beach, CA MET program)

⁶⁰ *Id.* (describing the Hillsborough, County, Florida program).

⁶¹ See Jennifer L. S. Teller, et al., *Crisis Intervention Team Training for Police Officers Responding to Mental Disturbance Calls*, 57 PSYCH. SERVS. 232, 235 (2006).

- But some CIT programs focus on emergency situations during which a 72 involuntary hour hold is actually part of the goal of the program⁶²
 - A recent 2006 study showed that 95.2% of the linkages to treatment by CIT trained officers were voluntary; prior to the CIT program, however, 89.4% of the linkages were allegedly voluntary⁶³
 - Follow Up Post-Crisis Call
 - One program has designed a Special Investigation Unit to follow up with CIT cases⁶⁴
 - Special detectives may be designated to investigate CIT calls and issues⁶⁵
- B. Variations of the Pre-Booking Diversion Model in California*

1. San Bernardino City's Homeless Advocate Officer Program⁶⁶

In 2005, the City of San Bernardino decided to create a program that would directly address the root problem of the homeless mentally ill in their city. Homeless persons with mental illness were identified as the target population for the program because such persons typically wind up in the police and criminal system for minor offenses such as trespass, loitering, panhandling, or failure to appear in court pursuant to a citation. The City decided that continuing to re-arrest and re-book these individuals was not cost-effective, and it was also not solving the problem of getting such individuals off the streets and out of the cycle of criminal survival behaviors. While the program might not have been thought of as a “pre-booking diversion” program when it was created—as it was more specifically created to address a problem of the homeless mentally ill who continued to re-offend on the same charges—this is exactly what it is.

a. Brief Description and Advantages of Having a Full Time Specialized Officer

Through the program, a single officer—the Homeless Advocate Officer—takes on several roles. Officer Marci Atkins is the founding and current Homeless Advocate Officer of the San Bernardino City program.⁶⁷

⁶² Some aspects of the Los Angeles SMART and San Diego PERT programs work this way.

⁶³ Jennifer L. S. Teller, et al., *Crisis Intervention Team Training for Police Officers Responding to Mental Disturbance Calls*, 57 PSYCH. SERVS. 232, 235 (2006).

⁶⁴ *Id.* (describing the program in Albuquerque, New Mexico).

⁶⁵ *Id.* (describing the program in Albuquerque, New Mexico, where there are “four full time detectives supervised by a sergeant to review CIT reports and identify people at high risk for contact with law enforcement . . .”).

⁶⁶ Nearly all the information obtained to write this section of the report is derivative of conversations with Officer Marci Atkins of the San Bernardino City Police Department in August 2008. Citation to her for each idea or sentence has been omitted in lieu of providing a citation to her here. MHAC is grateful for the time she took in explaining all the details of her program so that we could report them to you here.

⁶⁷ Initially, counties and agencies might think that creating such a program with a single officer is not worth it because it is only one position—and how much impact could one police officer make? But Officer Atkins and the Homeless Advocate Officer Program have made a significant impact in the lives of countless homeless persons suffering from mental.

First, the Homeless Advocate Officer is designated to address 911 calls related solely and specifically to homelessness issues. Second, even absent a 911 call about an issue related to homelessness, the designated Homeless Advocate Officer is expected to patrol the City to look for people who might be homeless and in need of linkages to services. About 90% of the time, appropriate services include linkages to mental health services.⁶⁸ Additionally, the Homeless Advocate Officer is not required to take any general patrol officer 911 calls that are not related to homelessness or mental health. This is critical because many CIT officers who juggle both types of calls and corresponding duties may wind up putting mental health/homelessness calls on the backburner because they are non-emergency calls.

For example, calls about loitering or panhandling are typically non-emergency calls dealt with after higher emergency calls by the typical patrol officer. But these calls may also often involve an underlying mental health issue. Under the Homeless Advocate Officer model, the Homeless Advocate Officer will be dispatched immediately to the “non-emergency” call because this is the specialized goal of the program. Without the Homeless Advocate Officer position, however, a general patrol officer might wait several hours before arriving to the “non-emergency” panhandling or loitering call because he or she must first address “emergency” calls. By this time, the individual who was panhandling or loitering may have left the scene. One strength in having a single officer or multiple officers on call to address issues related to a target population—such as crimes related to homelessness—is that there is almost always an immediate response to the call.

Further, the Homeless Advocate Officer is effectively on-call for all homeless issues during a full-time shift each week (unlike many other CIT programs in which all officers remain on duty for general patrol issues or may rotate CIT responses). Having one or more full time officers devoted to the program ensures that an officer will be a first responder at or near the moment of the crisis situation and that this officer has the specialized knowledge to provide proper linkages to services if needed.

Another advantage to having one or two officers specialize in the program, effectively taking it on full-time, is that sometimes general patrol officers are reluctant to spend too much time on non-emergency calls for fear that persons in their department might view them as lazy or wasting time on unimportant “non-police” matters. Having one or more officers who are devoted to the program ensures that adequate time is spent in assessing each person and offering linkages to potential mental health treatment or other services.

Officer Atkins has previously participated in CIT training through her police department, as have other officers in her department. But as a single officer dedicated solely to the program, another advantage is that Officer Atkins has built a strong reputation in the homeless community as being the officer who is present to help and not necessarily to make an arrest.⁶⁹ Additionally, Officer Atkins has also developed relationships with the key service centers and organizations in the city, and is able to link individuals to services based on their individual needs. Many police departments overlook the importance of educating officers about specific mental health services available in the community; this knowledge is critical in order to implement an effective pre-booking diversion program.

⁶⁸ Statement by Officer Atkins.

⁶⁹ Officer Atkins described once meeting a homeless woman who, after Atkins introduced herself, started crying because she had heard about Atkins through word of mouth on the street and knew she finally had a chance to get help.

b. Emphasis on Voluntary Treatment

Arguably, what may be most important to the success of the San Bernardino program is Officer Marci Atkins' positive and non-paternalistic attitude about mental health treatment. If homeless individuals are willing to and desirous of getting out of homelessness, Officer Atkins is there to help them find a way to make this a reality. Officer Atkins does not spend her time trying to help persons who are resistant to treatment because she knows and believes that the process is already so hard for those who are willing to accept it voluntarily. Additionally, her time is limited, and she wants to assist those who are desirous of help and change because there is more likely to be a long lasting impact for such individuals.

c. Avoiding Arrest: The Pre-Booking Diversion Process of Linking Homeless Mentally Ill Persons to Voluntary Treatment

1) Introductions

The process by which Officer Atkins meets with a homeless and/or mentally ill individual is as follows. Upon dispatch to a 911 homelessness/mental health call or arrival at an area where she believes an individual is in need of her assistance, Officer Atkins' first step is to approach the individual in a non-threatening and conversational manner. Although Officer Atkins is in uniform, her first job is to introduce herself by name, identify her role as the Homeless Advocate Officer, and then explain that her role is to help and not necessarily to arrest.

2) The Questionnaire

Officer Atkins then tries to get to know the individual and learn about his or her individual needs, goals, and desires. She has developed a Homeless Assessment Questionnaire for this purpose (see Appendix 3 for a copy). Some of the questions include the following: How long have you been homeless? What event caused you to become homeless? Do you have a job/income? What are your skills? Do you have a Driver's License? What hurdles have you run up against while being homeless? Are you under the care of a Doctor? Have you ever been diagnosed with a mental illness? Are you a Veteran? Are you on parole/probation? Asking these questions allows her to form a bond with the individual and learn about how to connect him or her to the services he or she needs.

3) Education about Crime and Services Available

After completing the Questionnaire, Officer Atkins then takes the time to educate the individual about the likely crimes an officer might arrest him or her for if he or she chooses to remain homeless.⁷⁰ Additionally, this presents an opportunity for Officer Atkins to educate the individual about available treatment or services choices.

As a result, most of the time Officer Atkins finds herself in conversations with homeless persons about whether or not they are ready for change in their lives: Do they want a job? If so, what kind? Do they want housing? Do they have any other goals in their life? Are they resistant to access mental health services because they dislike medications? Does failing to access mental health treatment interfere with one or more life goals they have? Officer Atkins makes sure they know change will not be easy, but if they are ready for the challenge, she is willing to help them get there. If individuals are receptive to the idea of voluntarily accessing

⁷⁰ This is yet another effective and preventive aspect of pre-booking diversion: education about the types of crimes likely to lead to arrest.

treatment, she will connect them to mental health services in addition to other supportive services.

4) Transportation and Linkage to Community Services

Officer Atkins then transports such individuals (in her police car) to the intake office at the Mentally Ill Homeless Program. At this facility, individuals in need of services meet with a clinician at intake to determine whether a mental illness is present. Then, if a mental illness is present, the individual will meet with a case manager to determine their needs for services.⁷¹ (For this particular program services will only be provided if a mental illness is present.) Furthermore, through linkage with the Mentally Ill Homeless Program, individuals might also be eligible for the Homeless Court Program, which operates right next door. Through Homeless Court, persons who have outstanding warrants issued for their arrest may have them expunged from their record provided they are participating in a mental health program.⁷²

d. Outline: Core aspects of the San Bernardino Pre-Booking Diversion Program

Listed below are some of the core aspects of the pre-booking diversion program Officer Atkins and the City of San Bernardino's Police Department have developed:

- *A Policy Not To Arrest but to Develop Relationships with the Homeless Mentally Ill that may overtime lead to effective services linkages*
 - Homeless Advocate Officer must have good communication skills
 - Patience and focus on small steps toward help accessing services
 - Sometimes Officer Atkins merely hands out her business card; weeks or months later receives a call that the individual needs help
- *Education about the Law and How Not to Get Arrested if such Individuals Wish to Remain Homeless*
 - Education about prevalent crimes such as loitering, panhandling, trespass, etc.
 - If such persons know the elements of the crimes, they are less likely to commit them and therefore less likely to be arrested
 - Officer Atkins also goes to outpatient clinics to educate persons with mental illness about why police officers might seem harsh or demanding sometimes
 - She calls this "reverse CIT training" because in regular CIT training the officers are taught to step into the shoes of someone with a mental illness, and in the reverse CIT training, she encourages persons with mental illness to step into the shoes of police officers to better understand why they act the way they do
- *Once a Relationship is Established, Officer Atkins Makes Sure that Persons Enter the Program on a Voluntary Basis*
 - Open and honest discussion about the individual's choice to remain homeless and untreated and the consequences versus obtaining housing and/or treatment
- *How Clients Are Linked to Services*
 - Most often through the County of San Bernardino Behavioral Health Mentally Ill Homeless Program

⁷¹ As a side note, Office Atkins has never been turned away from a county facility that provides services, possibly because of the strong relationships she has built with them.

⁷² County of San Bernardino, Homeless Court Program Pamphlet. See *infra* Section V.B.1 for a discussion about the difference between a mental health court and a homeless court.

- Criteria for admission: must be between the ages of 18-64, have a mental disorder, be currently homeless, have ability to take medication without assistance, and is otherwise without funds
 - Services Available: “temporary housing and food, assistance in securing permanent housing, assistance with transportation to and from needed services, referrals for health care [including mental health], referrals for job search and placement, assistance in SSI & Medi-Cal Applications, and referrals for V.A. Services.”
 - 90 days duration to provide linkage to other programs that may provide longer lasting services
 - Outstanding warrants may be cleared through linkage with and participation in the Homeless Court Program (post-booking diversion)⁷³
 - “Clients with warrants and failures to appear for anything but felonies can have these issues resolved . . . even if charges go back many years.”⁷⁴
 - “Clients may have been arrested or received citations for misdemeanors or infractions such as open containers, petty theft, loitering, public intoxication, urinating in public and other legal problems of this nature including traffic violations. . . . Clients accepted into homeless court must also be participating in a mental health and/or substance abuse program.”⁷⁵
 - Bi-Monthly court sessions
- *Officer Atkins still follows up after linkages are made*
 - Whether by phone call or dropping by their new residence to see how they are doing,⁷⁶ Officer Atkins maintains a relationship with persons she has helped, making sure that such persons still know they can contact her for help
 - Many persons have complaints about board and care facilities. These facilities are sometimes fraudulent, and so Officer Atkins can also provide education to persons in this situation about their tenant rights.

⁷³ See *infra* Section V.B.1 for a discussion about the difference between a mental health court and a homeless court.

⁷⁴ Homeless Court Program Pamphlet, County of San Bernardino.

⁷⁵ *Id.*

⁷⁶ During the ride-along in which I accompanied Officer Atkins for a day to learn about the program, we visited the apartment residence of a formerly homeless couple who Atkins had gone to great lengths over a long period of time to help connect to services and housing. Officer Atkins was working on helping them get a fridge to store food, but had also managed to get them a bed and a chair for their apartment. We also drove the woman to and from Goodwill that day, and Atkins gave her vouchers to buy clothing and other items that they needed for the apartment (such as bed sheets). This couple was at first very resistant to her offers for help. Officer Atkins initially met them while responding to a 911 call that they were loitering near a business. Officer Atkins gave them her card, but eventually met them when she was patrolling the city and discovered the camp where they were living. Upon this later encounter, the couple seemed ready to make a change. Among many other aspects of linking the couple to services, Atkins also managed to find a temporary shelter for their beloved dog while they stayed at a temporary room and board before finally moving into their own apartment.

- *General Distinction between patrol officer's responses and homeless advocate officer's options/responses*
 - General Patrol Officer
 - Give a warning
 - Issue citation or arrest
 - Run name of individual in system and look for a warrant for their arrest, if there is one arrest will be made
 - Homeless Advocate Officer
 - All the above options plus . . .
 - Spending more time with the person to learn the root of the problem and try to think of a way to address it
 - Provide linkages to services
- *Officer Atkins' ideas to improve programs like hers in the future*
 - 24 hour services center linkage needed (currently does not exist in San Bernardino)
 - From the beginning find someone to help with data collection
 - Find a way to keep track of clients, whether by photo or other identifying info, so that other officers might be able to easily learn whether or not the client has a mental health problem

2. *San Diego's Psychiatric Emergency Response Team ("PERT")*

The mission of the PERT program, which has been in existence for twelve years, is to prevent unnecessary hospitalizations and to reduce the incarceration of persons with mental illness.⁷⁷ The most critical aspect of the PERT program that makes it different from San Bernardino is that a full time clinician accompanies the designated police officer on-call for mental health issues 40 hours a week. Thus, when a PERT team arrives to a crisis situation, there is one uniformed officer and one plain clothed clinician to help the person in crisis, as well as any affected family members. The program is available from 6 AM until 3 AM, staffed most heavily from 2 PM until midnight, as this is the time when most calls are received.

The PERT program's co-responder model does not necessarily include the police officer who may be the first responder to the 911 call.⁷⁸ If the patrol officer at the crisis situation believes there is a psychiatric emergency, he or she will contact the PERT team, which will rapidly arrive to provide assistance to individuals with mental illness in crisis. The program is designed so that the police officer on general patrol duty returns to work as soon as possible.

In the alternative, the 911 operator might dispatch the PERT team directly to a crisis in which the operator believes a mental health emergency is at issue. Upon dispatch by the 911 operator or the police officer who is the first responder, "[t]he PERT team will do an evaluation and assessment, and if appropriate [provide] a referral to a community-based resource or treatment facility."⁷⁹

⁷⁷ Information in this Section came from a phone conversation with Jim Fix, the Director of the PERT program, September 2008.

⁷⁸ San Diego County Sheriff's Department, Psychiatric Emergency Response Team (PERT), www.sdsheriff.net/vista/services_pert.html (last visited Sept. 2, 2008).

⁷⁹ *Id.*

Additionally, the PERT team has gained such a positive reputation in San Diego, particularly with NAMI members, and as a result, members of the community might dial 911 and specifically ask for a PERT team to be dispatched to their residence if a family member with a mental illness is in crisis.

The target population the PERT team addresses is persons who have a mental illness and are in a crisis situation. The crisis may involve a danger-to-self-or-others emergency situation, requiring an involuntary 72 hour commitment hold. But it is estimated that roughly 80% of the time, the crisis at issue involves assisting the person in obtaining voluntary mental health services through linkages to services with the county department of behavioral health.⁸⁰ Further, in many cases, it is often the case that no criminal offense has been committed. Thus, the program is diversionary in that members of the community are accessing PERT arguably even earlier than when a crime has taken place. Yet, the essence of the program is that a 911 call is made in order to dispatch the team.

The PERT team currently works with 21 different law enforcement offices and was recently expanded geographically and by increasing hours of availability via Mental Health Services Act funding.

3. *Los Angeles Law Enforcement Teams*

Los Angeles County has several CIT based emergency response teams, including the following: 1) Los Angeles Police Department's Systemwide Mental Assessment Response Team ("SMART"); 2) Long Beach Police Department's Mental Evaluation Team ("MET"); 3) Pasadena Police Department Homeless Outreach Psychiatric Evaluations (Project HOPE); 4) Los Angeles County Metropolitan Transit Authority Crisis Response Unit (MTA-CRU); and 5) Los Angeles County Sheriff's Department Mental Evaluation Team ("MET").⁸¹

Like San Diego's PERT program, each of these teams consists of a trained deputy sheriff or police officer and a mental health clinician.⁸² These teams may either be called in by a patrol officer on duty at the scene of a crisis or by a 911 operator. Typically, upon arrival at the scene, the original patrol officer is relieved of further duties and can return to normal patrol. The L.A. programs are very similar in function to San Diego's PERT program. Like PERT, dispatch of a SMART team or other law enforcement co-responder team usually occurs in a crisis or emergency situation and arrests are avoided if possible. SMART officers are encouraged to provide linkage to treatment and avoid making an arrest.⁸³

L.A. County does have Homeless Outreach Teams ("HOT"), which are similar to Officer Atkins' Homeless Advocate Officer position.⁸⁴ The main difference, however, is that the HOT team is comprised of Department of Mental Health Staff and not an officer. But much of the diversionary and educational model is the same: "HOT serves to increase the likelihood of

⁸⁰ Phone Interview with Jim Fix, Director, PERT program, Sept. 2008.

⁸¹ County of Los Angeles, Network of Care for Behavioral Health, <http://losangeles.networkofcare.org/mh/emergency.cfm> (last visited Sept. 3, 2008).

⁸² *Id.*

⁸³ "The objective [of SMART] is to provide intervention, referral, or placement for a mentally ill person, allowing field officers to quickly return to other field duties." *SMART Helps the Mentally Ill*, Los Angeles Police Beat, Office of the Chief of Police, Feb. 2000, at 1.

⁸⁴ County of Los Angeles, Network of Care for Behavioral Health, <http://losangeles.networkofcare.org/mh/emergency.cfm> (last visited Sept. 3, 2008).

effective outcomes for the homeless mentally ill in situations when he or she encounters law enforcement personnel.”⁸⁵

Additionally, similar to San Bernardino, L.A. has a Homeless Court Program in which persons with a mental illness who are in treatment may have the opportunity to have outstanding warrants related to homelessness cleared from their record.⁸⁶ To be eligible for the Court, the offense must have been committed within L.A. County; the individual must either be homeless or at risk of becoming homeless; the individual must have completed 90 days of satisfactory participation in a rehabilitation program; the individual may not have any citations or arrests in the last six months, have any open felony warrants, or be in violation of probation or parole.⁸⁷ Homeless Courts, however, are a post-booking diversion program discussed later in this report.⁸⁸

C. National and International Examples

1. CIT in Akron, Ohio

“In 2000, the Akron Police Department became the first in Ohio to start a CIT program.”⁸⁹ This program, like other “Crisis Intervention Team programs across the country help[s] direct persons with mental illness into treatment instead of inappropriate incarceration.”⁹⁰ The backbone of the program is the 40 hours of free CIT training for police officers that is put together by the “mental health community, providers, consumers, and family members.”⁹¹ One of the goals of the Akron program, like many other CIT programs, is to provide CIT training to 25% of its patrol officers to ensure that at least one CIT officer is on duty 24 hours a day, seven days a week.⁹² In this pre-booking diversion program, the officers remain on their regular patrol duties and incorporate CIT calls into their daily routine.⁹³

2. Australia’s Mental Health First Aid

“Mental Health First Aid is a 12-hour training course designed to give *members of the public* key skills to help someone who is developing a mental health problem or experiencing a mental health crisis.”⁹⁴ The concept of the program is to provide general mental health crisis training tools similar to that of general CPR knowledge, which members of the public are often

⁸⁵ *Id.*

⁸⁶ Public Counsel, The Los Angeles Homeless Court Handout. For information about the homeless court, see www.publiccounsel.org “Homelessness Prevention Law Project.”

⁸⁷ Public Counsel Handout obtained at Transformation Through Advocacy Conference in Los Angeles, Spring 2008.

⁸⁸ For more information about Homeless Courts see Section V.B.

⁸⁹ Ohio Criminal Justice Coordinating Center of Excellence, Crisis Intervention Team, <http://www.neoucom.edu/CJCCOE/cit.html> (last visited Sept. 2, 2008).

⁹⁰ *Id.*

⁹¹ E-mail Attachment from Latrease Moore, Project Assistant, Criminal Justice Division, Policy Research Associates, *GAINS Ctr., Pre-Booking Jail Diversion Programs 2003*

⁹² Ohio Criminal Justice Coordinating Center of Excellence, Overview of CIT, <http://www.neoucom.edu/CJCCOE/support/citoverview.pdf> (last visited Sept. 2, 2008).

⁹³ *Id.*

⁹⁴ Nat’l Council for Community Behavioral Healthcare, Press & Public, Mental Health First Aid, available at http://www.thenationalcouncil.org/cs/pressroom/mental_health_first_aid (last visited Sept. 8, 2008) (emphasis added).

aware of for physical health emergencies.⁹⁵ “The evidence behind the program demonstrates that it makes people feel more comfortable managing a crisis situation and builds mental health literacy — helping the public identify, understand and respond to signs of mental illness.”⁹⁶ “Although the training is generally geared to average citizens and does not typically offer the level of expertise needed by police departments . . . [some police departments, such as one in Rhode Island] . . . use Mental Health First Aid as a supplement to other training police receive.”⁹⁷ The National Council for Community Behavioral Healthcare has introduced Mental Health First Aid to the U.S. and offers trainings on the program throughout the country.⁹⁸ Mental Health First Aid might be thought of as a pre-booking diversion program to the extent that it is used to train officers and members of the public to divert persons with mental illness who are in crisis.

V. EARLY DIVERSION POST-BOOKING PROGRAMS

A. Jail Diversion Program in San Rafael, Marin County

San Rafael does not currently have a pre-booking diversion program, but it operates a post-booking diversion program called the Support and Treatment After Release (“STAR”), also known as the Mentally Ill Offender Crime Reduction Program, that aims to assist persons with severe mental illness get treatment shortly after they have been booked and are taken to jail.⁹⁹ Diversion takes place at jail, after booking, but often before or shortly after arraignment. The program currently has 75 offenders and is funded through the Mentally Ill Offender Crime Reduction Act as well as the Mental Health Services Act.¹⁰⁰ The County also has a mental health court, but it operates on a post-conviction basis in which a guilty plea is required in order for the treatment program to be initiated.¹⁰¹

1. Santa Barbara Plans to Replicate the San Rafael Model

Santa Barbara is in the process of building a pre-booking or other early diversion program.¹⁰² Currently, homeless outreach advocates meet once a month with members of the police department to discuss problem areas and ways they might divert minor offenders in the

⁹⁵ *Tragic Events Involving Police in R.I. Spur Mental Health Training Initiatives*, MENTAL HEALTH WEEKLY, July 28, 2008, at 7.

⁹⁶ Nat’l Council for Community Behavioral Healthcare, Press & Public, Mental Health First Aid, available at http://www.thenationalcouncil.org/cs/pressroom/mental_health_first_aid (last visited Sept. 8, 2008) (emphasis added).

⁹⁷ *Tragic Events Involving Police in R.I. Spur Mental Health Training Initiatives*, MENTAL HEALTH WEEKLY, July 28, 2008, at 1, 7.

⁹⁸ Nat’l Council for Community Behavioral Healthcare, Press & Public, Mental Health First Aid, available at http://www.thenationalcouncil.org/cs/pressroom/mental_health_first_aid (last visited Sept. 8, 2008).

⁹⁹ Phone Conversation with Bruce Gurganus, Director, Division of Mental Health, Marin County, Sept. 3, 2008.

¹⁰⁰ *Id.*

¹⁰¹ *Id.*

¹⁰² Phone conversation with Annemarie Cameron, Executive Director of the Mental Health Association of Santa Barbara, Sept. 3, 2008.

future. The program is small and collaborative, but it is being modeled after early post-booking diversionary programs in San Rafael.

B. Early Diversion Mental Health Courts

1. Mental Health Courts Defined and Distinguished from “Homeless Courts”

Post-booking diversion programs often involve court-diversion programs known as specialty courts. Mental health courts are one type of specialty court, and are in some ways distinctive from general homeless courts, even though mental health issues are often involved in homeless court.

A United States Council of State Governments Report, defines the key characteristics of a “mental health court”¹⁰⁴. A mental health court is any specialized court docket with a problem-solving focus that has a team of court staff including mental health professionals who design and implement community treatment mental health programs to divert mentally ill persons from incarceration, which often include incentives and sanctions for good and bad behaviors at regular judicial hearings, and culminate in graduation from the court program.¹⁰³

The unique aspect of a homeless court, even though to some degree it fits this definition of mental health court, is that often the individual comes to the court already having completed a term of rehabilitation or mental health treatment for a certain period of time.¹⁰⁴ This is a critical policy distinction. In a homeless court, arguably, no or very little coercion is involved in linking the individual to treatment—this is because to be eligible, the treatment has already been completed. For example, in the Los Angeles Homeless Court, one must have successfully participated in a rehabilitation program that lasted at least 90 days.¹⁰⁵ The court itself then seems to act in a non-threatening or non-coercive manner in that it only rewards those individuals who have already voluntarily completed or are enrolled in treatment. Thus, upon demonstrating commitment to treatment and toward recovery, the court steps in to clear the individual’s record for minor offenses, including fines or bench warrants often issued due to the failure to appear in court. In theory, a post-booking Homeless Court has a feel similar to a pre-booking diversion or other early intervention diversion programs because little to no coercion is involved in its structure.

¹⁰³ BUREAU OF JUSTICE ASSISTANCE, IMPROVING RESPONSES TO PEOPLE WITH MENTAL ILLNESS: THE ESSENTIAL ELEMENTS OF A MENTAL HEALTH COURT vii (Draft 2007).

¹⁰⁴ Orange County, however, has a model that blends both the mental health court and homeless court model—it is called the Orange County Outreach Court. COLLABORATIVE COURTS UNIT, ORANGE COUNTY SUPERIOR COURT, 2006 ANNUAL REPORT 137-40 (2006). The court focuses on resolving misdemeanor cases that often affect homeless persons and requires participation in treatment for at least one-and-a-half years. *Id.* The top ten charges that prompted entry into the court (in order from highest to lowest) are as follows: 1) violation of vehicle code for failure to provide proof of financial responsibility; 2) failure to register vehicle; 3) running a red light, stop sign, or pedestrian cross walk; 4) violation of the penal code for failure to appear on written or non-written promise to appear; 5) driving without a safety belt; 6) public intoxication; 7) drinking an alcoholic beverage in public; 8) driving without a valid license; 9) driving while driver’s license is suspended or revoked; 10) unsafe speed for prevailing conditions. *Id.*

¹⁰⁵ Public Counsel Handout obtained at Transformation Through Advocacy Conference in Los Angeles, Spring 2008.

More formal mental health courts, on the other hand, offer treatment for those who are likely not already receiving it but are suffering from a mental illness as an alternative to incarceration. These diversionary courts generally take place at any of three general adjudicatory stages: pre-plea, post-plea or post-conviction, and probation-based.¹⁰⁶ As seen from the discussion in Section II.B regarding the stages of the criminal process, one can see that a mental health court could take place at a variety of stages. In a post-plea court, an individual might plead guilty after arraignment, as part of a plea agreement in the pre-trial stage, or at some point during trial. Additionally, though less common, some mental health courts might operate post-conviction, possibly after a full adjudicatory trial. For a pre-plea court, however, the prosecution would likely delay pressing charges until successful completion of the treatment program. Specific California examples of these different types of courts will be described in detail in the next few sections.

Further, mental health courts, like homeless courts, often restrict eligibility based on the criminal charge. Many mental health courts decline to admit felonies, particularly those involving violence. The most prevalent mental health courts today deal with both misdemeanors and some non-violent felonies on a case-by-case basis. Homeless courts, however, typically deal with infractions, citations, and fines.

2. *San Francisco's Pre-Plea Mental Health Court*

San Francisco's mental health court is called "Behavioral Health Court" in order to reduce the stigma for participants associated with being labeled a "mental health court" participant. The court has been in existence since 2003.¹⁰⁷ It operates on a pre-plea basis.

Clients are not required to plead guilty to criminal charges to enter [] the program and access mental health services. [The] court operates on the premise that clients in BHC would not be in the criminal justice system if they had been adequately and appropriately treated in the community mental health system. Often, clients in [the] court have viable mental health defenses to charges, but opt for mental health treatment instead of proceeding to a jury trial. To insist that clients plead guilty to such charges just to access treatment would be fundamentally unfair and would further criminalize people with mental illness.¹⁰⁸

In order to be eligible for Behavioral Health Court, the individual must be in custody and a referral must be made by a judicial officer, prosecutor, defense attorney, or Jail Psychiatric

¹⁰⁶ "In preplea cases, prosecution is generally deferred and charges are dismissed after successful completion of treatment. . . . [I]n postplea cases [adjudication occurs], but the sentence is deferred. Probation-based cases include a conviction with probation and sometimes a suspended or deferred jail sentence." Patricia A. Griffin, *The Use of Criminal Charges and Sanctions in Mental Health Courts*, 53 *PSYCHIATRIC SERVS.* 1285, 1286 (2002).

¹⁰⁷ See Dale E. McNeil & Renee L. Binder, *Effectiveness of a Mental Health Court in Reducing Criminal Recidivism and Violence*, 164 *AM. J. PSYCHIATRY* 1395, 1396 (2007).

¹⁰⁸ E-mail from Lisa Lightman, Director of the Office of Collaborative Justice Programs, San Francisco Superior Court, Jan. 15, 2008.

Services.¹⁰⁹ In the referral process, jail screening for an Axis I mental illness (this includes all of the major categories of mental illness such as schizophrenia, bipolar disorder, depression, and anxiety disorders such as obsessive compulsive disorder, post traumatic stress disorder, and attention deficit disorder.) is undertaken to determine whether the individual would medically qualify for the court.¹¹⁰ In order to be eligible, the defendant must have an Axis I Mental Disorder and further, be charged with a felony or misdemeanor. “Defendants charged with the following offenses are not eligible without the District Attorney’s consent: sex offenses, domestic violence offenses, homicide, weapons offenses, offenses involving great bodily injury, and other ‘serious felonies’ as defined by Penal Code 1192.7(c).”¹¹¹

Once a defendant has been accepted into the program, an individualized community-based treatment plan is devised.¹¹² Participants must remain in the treatment program for a minimum of one year, while they attend regular court sessions that meet on a regular basis (in some cases this may be on a weekly basis).¹¹³ The purpose of the court session is to inquire with the individual about his or her treatment progress and make any adjustments to the plan if necessary. In order to graduate from the court, the treatment program must be completed successfully. Upon graduation charges are resolved “in a way that takes into account the seriousness of the charges and the seriousness of the mental illness.”¹¹⁴ Thus, not all cases or charges are dismissed at the end of the program.

a. Compare to Orange County’s Post-Conviction/Post-Plea Mental Health Court

Unlike San Francisco’s Behavioral Health Court, Orange County operates one specialty mental health court, called the “Whatever It Takes” (“WIT”) Court that operates on a post guilty plea or post-conviction basis.¹¹⁵ Thus, the program operates from a different premise than the San Francisco Court, in that it requires the defendant admit to guilt and be convicted for the crime in order to take responsibility for his or her actions and to serve as further incentive to complete the treatment program.¹¹⁶ However, upon graduating from the court and having successfully completed treatment, a participant “may be given the opportunity to withdraw [the] plea and [the] case may be dismissed or reduced to a misdemeanor.”¹¹⁷ The program requires a

¹⁰⁹ SUPERIOR COURT OF CALIFORNIA, COUNTY OF SAN FRANCISCO, OFFICE OF COLLABORATIVE JUSTICE PROGRAMS, SAN FRANCISCO BEHAVIORAL HEALTH COURT (2008) available at http://www.sfgov.org/site/uploadedfiles/courts/BHCFactSheet_Final.pdf.

¹¹⁰ *Id.* “A mental health evaluation is conducted by Jail Aftercare Services (JAS) to determine client diagnostic suitability for BHC. If deemed appropriate, JAS staff present the case to the BHC team. The BHC legal team reviews the case to make the final decision regarding transfer into the program.” *Id.*

¹¹¹ *Id.*

¹¹² *Id.*

¹¹³ *Id.*

¹¹⁴ E-mail from Lisa Lightman, Director of the Office of Collaborative Justice Programs, San Francisco Superior Court, Jan. 15, 2008.

¹¹⁵ Interview with Honorable Judge Wendy S. Lindley, Orange County Superior Courts, Orange County, California, Nov. 26, 2007.

¹¹⁶ *See id.*

¹¹⁷ Orange County Whatever It Takes Program, W.I.T. Court Participant Handbook 11 (2006).

minimum commitment of eighteen months of treatment.¹¹⁸ While the core individualized treatment plans are very similar to that of San Francisco, the Orange County Court diverts offenders at a later stage in the criminal process: post-plea or post-conviction.¹¹⁹

b. Santa Barbara's Mixed Pre-Plea and Post-Adjudication Mental Health Court

The Santa Barbara Mental Health Court, also known as the Mental Health Treatment Court accepts persons diagnosed with serious mental illnesses who have been charged with either a felony or misdemeanor and have at least one previous booking. However, most notably,

Offenders . . . [can] enter the program either pre-plea or post-adjudication.

Pre-plea participants could have no prior offenses that involved serious acts of violence. Post-conviction participants could have some violent activity in their past, if the . . . team members determined that they no longer posed a threat of danger to others.

...

For pre-plea offenders, graduation from the program result[s] in their charge being dropped, while post-conviction offenders ha[ve] a reduction in their terms of probation.¹²⁰

The advantage to having a mixed pre-guilty plea and post-conviction model is that diversion services are more closely tailored to the crime committed, and thus, may be more widely accepted in the community.

3. Causes For Concern With Mental Health Courts

One cause for concern in operating post-booking diversion mental health courts (not necessarily homeless courts), is that they become a mechanism by which coerced treatment is obtained. Technically, in every mental health court, the participant "voluntarily" agrees to

¹¹⁸ Interview with Honorable Judge Wendy S. Lindley, Orange County Superior Courts, Orange County, California, Nov. 26, 2007.

¹¹⁹ Nevada County also has a mental health court that operates on a post-conviction basis. The court accepts persons with both felony and misdemeanor convictions on an individualized basis, however, the court is moving toward accepting more offenders with violent felony convictions that present significant mental health problems. Interview with Nevada County Mental Health Court Team, Nevada County, California, Dec. 7, 2007. Currently, the following offenses are presumptively ineligible: 1. Any felony or misdemeanor which demonstrates that the defendant presents a substantial risk to health and safety of others; 2. Any "serious" felony under P.C. § 1192.7(c); and 3) Any crime subject to the Three Strikes sentencing law. NEVADA COUNTY MENTAL HEALTH COURT, NEVADA COUNTY MENTAL HEALTH COURT POLICIES AND PROCEDURES 16 (2003).

Additionally, San Bernardino County has a post-conviction mental health court that accepts persons who have convictions for felonies. "San Bernardino has a fixed duration of three years [treatment with the court] for felony cases." Patricia A. Griffin, Henry J. Steadman & John Petril, *The Use of Criminal Charges and Sanctions in Mental Health Courts*, 53 PSYCHIATRIC SERVS. 1285, 1287 (2002).

¹²⁰ MERITH COSDEN, JEFFREY ELLENS, JEFFREY SCHNELL, & YASMEEN YAMINI-DIOUF, UNIV. CAL. SANTA BARBARA GERVITZ GRAD. SCHOOL OF EDUC., EVALUATION OF THE SANTA BARBARA COUNTY MENTAL HEALTH TREATMENT COURT WITH INTENSIVE CASE MANAGEMENT 5-6 (2004).

accept treatment,¹²¹ but many argue that the choice between incarceration and treatment is too coercive to be entirely voluntary as indicated by the views of officer Atkins in San Bernardino, it is enough of a challenge for a willing individual to have successful recovery so it is more difficult for those who only willingly agree to do so in order to avoid jail.

Additionally, another cause for concern is that mental health courts will become the primary entry/diversion point to access mental health services, as opposed to other less coercive or earlier intervention models. If police officers become aware of and accustomed to this entry point into the mental health system for minor violations, the concern is that officers will no longer use pre-booking diversion tactics to begin with. One study on this issue in Akron, Ohio, where both CIT and a mental health court were available, discovered that officers were more inclined to make arrests of persons with mental illness when they knew of the existing local mental health court diversion program.¹²² The study noted the following:

The apparently higher rate of arrest by CIT-trained officers was unanticipated. Mental health systems support CIT programs in part because they view the programs as prearrest diversion programs. Police agencies, on the other hand, embrace the CIT program of enhancing officer and community safety. Through CIT training, officers may learn when referral to the mental health system is most effective and when arrest may be preferable. . . . Furthermore, it is likely that Akron arrest rates are influenced by officers' knowledge of the Mental Health Court postarrest diversion program. . . . Knowledge of the program and the fact that it may help individuals who may otherwise be resistant to treatment to live successfully in the community may result in CIT-trained officers' choosing arrest in selected cases. The interaction of prearrest diversion programs such as the CIT program and postarrest programs such as the mental health court should be the subject of future research.¹²³

Thus, it is all the more important that in areas where post-booking diversion programs are well established, including mental health courts, that pre-booking diversion programs are also strengthened.

VI. STEPS NECESSARY TO INCREASE THE NUMBER OF PRE-BOOKING DIVERSION PROGRAMS IN CALIFORNIA

A. Creation of Programs

There are many published and detailed how-to guides that lay out the critical steps involved in creating a pre-booking diversion program. Two guides we recommend are 1) the

¹²¹ *E.g.*, ORANGE COUNTY WHATEVER IT TAKES PROGRAM, W.I.T. COURT PARTICIPANT HANDBOOK 1 (2006). "The program is voluntary and is your personal choice. The Judge, the court staff and the treatment team will guide and assist you, but the final responsibility is yours." *Id.*

¹²² Jennifer L. S. Teller, et al., *Crisis Intervention Team Training for Police Officers Responding to Mental Disturbance Calls*, 57 PSYCH. SERVS. 232, 236 (2006).

¹²³ *Id.*

Bureau of Justice Assistance’s “Improving Responses to People with Mental Illness: The Essential Elements of a Specialized Law Enforcement-Based Program;” and 2)The CMHS National GAINS Center and TAPA Center for Jail Diversion’s “Practical Advice on Jail Diversion: Ten Years of Learnings on Jail Diversion from the CMHS National GAINS Center.”

The first guide highlights the ten essential elements of a pre-booking diversion program: 1) Collaborative Planning and Implementation; 2) Program Design; 3) Specialized Training; 4) Call-Taker and Dispatcher Protocols; 5) Stabilization, Observation, and Disposition; 6) Transportation and Custodial Transfer; 7) Information Exchange and Confidentiality; 8) Treatment, Supports, and Services; 9) Organizational Support; and 10) Program Evaluation and Sustainability.¹²⁴ The guide “provide[s] practitioners and policymakers with a common framework for program design and implementation that will promote positive outcomes while being sensitive to every jurisdiction’s distinct needs and resources.”¹²⁵

The second guide is much longer and more detailed, discussing practical advice in creating and implementing jail diversion programs. The guide is broken down into the following sections: 1) Why Develop a Jail Diversion Program?; 2) What is Jail Diversion Really?; 3) Making Jail Diversion Happen in Your Community; 4) Getting Started; 5) Putting the “Action” in Your Action Plan; 6) Planning for Sustainability; and 7) Data 101.¹²⁶ Six steps identified in this guide for success in developing a diversion program are as follows: 1) interagency collaboration; 2) active involvement with stakeholders; 3) cross-system staff; 4) leadership; 5) early identification and screening; and 6) specialized case management.¹²⁷

B. Funding: Accessing and Applying for Proposition 63 or Mental Health Services Act Funds

California county mental and behavioral health departments must work with local city police departments to provide funding through MHSA to create pre-booking diversion programs. Several county diversion programs mentioned in this report have already done this. For example, San Diego’s PERT program has been expanded and improved with MHSA funds. And mental health court programs in Orange County are also using MHSA funds. The first step in accessing MHSA funding is to collaborate with the county mental health department to develop a diversion plan and eventually submit a proposal to carry out that plan.

Other potential funding sources for jail diversion projects, which several county programs mentioned in this report, have used are the federal Mentally Ill Offender Crime Reduction Act (“MIOCRA”) and grants from the Substance Abuse and Mental Health Services Administration

¹²⁴ THE COUNCIL OF STATE GOVERNMENTS, BUREAU OF JUSTICE ASSISTANCE, IMPROVING RESPONSES TO PEOPLE WITH MENTAL ILLNESS: THE ESSENTIAL ELEMENTS OF A SPECIALIZED LAW ENFORCEMENT-BASED PROGRAM (2008).

¹²⁵ *Id.*

¹²⁶ CMHS NAT’L GAINS CTR. & CMHS GAINS TAPA CTR. FOR JAIL DIVERSION, PRACTICAL ADVICE ON JAIL DIVERSION: TEN YEARS OF LEARNINGS ON JAIL DIVERSION FROM THE CMHS NATIONAL GAINS CENTER (2007), *available at* http://gainscenter.samhsa.gov/pdfs/jail_diversion/PracticalAdviceOnJailDiversion.pdf (last visited Aug. 27, 2008).

¹²⁷ *Id.* at 14.

("SAMHSA").¹²⁸ Cities should also be willing to offer their own resources since these programs free up officers time. The pre-booking diversion Homeless Advocate Officer program in San Bernardino is currently funded through the police department and with matching funds from other sources?¹²⁹

VII. CONCLUSION

California counties should use MHSA funding to create and/or enhance early intervention jail diversion programs. Both pre-booking diversion and other early intervention post-booking diversion models should be expanded.

Pre-booking diversion programs are ideal for minor offenses and/or infractions and for small target populations that have been identified as a problem area (such as homeless persons with mental illness or single mothers who have a mental illness). As discussed in the report, pre-booking diversion often includes a CIT trained officer, but may also include a co-responder model with a licensed clinician. Both types of CIT should be expanded and implemented. This report shows that while co-responder models may be ideal in theory, specialized law officers (such as the Homeless Advocate Officer Program developed in San Bernardino) may also have a great impact and should not be overlooked if resources are limited.

However, pre-booking diversion is not always the most realistic diversion method. For greater offenses, including misdemeanors and felonies genuinely committed as a result of a mental illness, early intervention post-booking diversion programs should be bolstered. Four key moments in which post-booking diversion might still be considered early intervention are as follows: first, after an individual is taken into custody but before charges are filed; second, after charges have been filed but before arraignment; third, through a pre-guilty plea early intervention mental health court; and fourth, in post-guilty plea mental health court that emphasizes obtaining the plea at the earliest stage possible.

When both are established pre-booking and post-booking diversion programs would serve different populations. Therefore, both programs should be bolstered so that there are fewer gaps in the system.

While our jails have become a primary stop for mental health services and mental health clients, the criminal system should not continue to be a place for *perpetual* stops for persons with mental illness. Currently, persons with varying degrees and types of mental illnesses continue to cycle in and out of the criminal system, sometimes for decades, without ever receiving lasting or meaningful treatment. Early intervention programs, such as pre-booking diversion and early intervention post-booking programs are critical for counties to develop in order to proactively address this problem from reoccurring in the future. In doing so, court, jail, and prison costs will also be reduced and redirected to mental health treatment programs. Studies have demonstrated

¹²⁸ San Diego's PERT program is currently funded by about 50% through the Mental Health Services Act, the other 50% of its funding come from non-MHSA sources such as SAMHSA. Phone Interview with Jim Fix, Director, PERT program, Sept. 2008.

¹²⁹ Interview with Officer Marci Atkins, Homeless Advocate Officer, San Bernardino Police Department, San Bernardino, CA, Aug. 8, 2008.

that in the long run “[i]t is less expensive to provide mental health treatment in communities than in correctional facilities.”¹³⁰

Further, another key aspect for counties to keep in mind when developing these types of early intervention diversion programs is that ample planning and thought should go into the voluntary mental health services attached to the diversion programs so that they have a long-lasting effect and genuinely reduce recidivism. This includes being sensitive to capacity issues and ensuring that slots in treatment programs for persons to be diverted are reserved.

APPENDIX 1: Key Resources that Will Be Helpful to California Counties or Agencies Seeking to Establish a Pre-Booking or Other Early Diversion Program

1. CMHS Nat’l GAINS Ctr. & CMHS GAINS TAPA Ctr. for Jail Diversion, *Practical Advice on Jail Diversion: Ten Years of Learnings on Jail Diversion from the CMHS National GAINS Center* (2007), available at http://gainscenter.samhsa.gov/pdfs/jail_diversion/PracticalAdviceOnJailDiversion.pdf (last visited Aug. 27, 2008).
2. TAPA Ctr. of the GAINS Ctr., Melissa Reuland & Jason Cheney, *Enhancing Success of Police-Based Diversion Programs for People with Mental Illness* (2005).
3. The Council of State Governments, Bureau of Justice Assistance, *Improving Responses to People with Mental Illness: The Essential Elements of a Specialized Law Enforcement-Based Program* (2008).
4. The Council of State Governments, Bureau of Justice Assistance, *Improving Responses to People with Mental Illness: Strategies for Effective Law Enforcement Training* (draft 2008).
5. Bureau of Justice Assistance, Council of State Governments, *Improving Responses to People with Mental Illness: The Essential Elements of a Mental Health Court* (Draft 2007).
6. Bureau of Justice Assistance, Council of State Governments, *A Guide to Collecting Mental Health Court Outcome Data* (2005).

APPENDIX 2: Homeless Assessment Questionnaire, Officer Marci Atkins, San Bernardino City Police Department

On file with the Mental Health Association in California, available upon request.

APPENDIX 3: Orange County MHSA Plan Approved in 2006 to fund/create the “Whatever It Takes” mental health court

On file with the Mental Health Association in California, available upon request.

¹³⁰ Council of State Governments, Criminal Justice Mental Health Consensus Project, *The Advocacy Handbook*, available at http://consensusproject.org/advocacy/step1_2 (last visited Sept. 19, 2008).

Children, Youth & Families System of Care



Emergency and Crisis Services

If you are having a Behavioral Health emergency, please call 9-1-1.

According to Title 9 of the California Code of Regulations, an "Emergency Psychiatric Condition" is defined as a condition in which a person, due to a mental disorder, is an imminent danger to self or others or is immediately unable to provide for or utilize food, shelter or clothing. This situation indicates an immediate need for psychiatric inpatient hospitalization or psychiatric health facility assessment.

Crisis children's services are available at the Access and Crisis Line at **1-888-724-7240**. (TDD for the hearing impaired: **619-641-6992**.) Spanish speaking counselors are available most hours, and interpretation is accessible in over 140 languages through language interpreting services 24/7.

Emergency mental health services are available at the **Emergency Screening Unit (ESU)** for children and adolescents **under age 18** who are experiencing a mental health emergency or crisis.

Emergency Screening Unit (ESU): 619-421-6900

730 Medical Center Court
Chula Vista, CA, 91911
Telephone: (619) 421-6900

Please call in advance if possible.

The Emergency Screening Unit (ESU) provides emergency psychiatric evaluations, crisis intervention, crisis stabilization, brief outpatient counseling, case management and emergency medication management to children and adolescents under age 18.

Over 1,000 youth receive an emergency psychiatric assessment at the Emergency Screening Unit annually. The unit is open 24 hours/7 days a week, and serves the entire County. Patients are brought by parents/guardians, social workers, law enforcement or ambulance from their family residences or from shelters, Juvenile Hall, hospital emergency rooms, schools, foster homes, group homes, or residential facilities.

ESU serves the Medi-Cal population and those who do not have any medical coverage. Although those with private insurance can be seen at ESU, it is advised that the private insurance clients receive services at facilities and agencies authorized by the insurance company.

Clients are assessed as to the types of services they need, with integrated attention to mental health, physical health and substance-related issues. If hospitalization is not required, appropriate community referrals are made.

Adult/Older Adult System of Care



Adult Emergency and Crisis Services

If you are experiencing a Behavioral Health emergency, please call 9-1-1.

If you need information about how to handle a mental health crisis, you can talk to a trained counselor who can help with your specific situation. Call the Access and Crisis Line at **1-888-724-7240**. The toll-free call is available 24-hours a day, 7-days a week. (TDD for the hearing impaired: 619-641-6992.)

Operators at this line will talk to you about what services are available in your area, for all ages, including mental health services for those with Medi-Cal or no insurance, services for alcohol or drug abuse, suicide prevention, medication needs, and more.

Spanish-speaking counselors are available most hours, as well as language interpreters for 140 languages.

Walk-in emergency mental health services are available for adults and older adults who are experiencing a mental health emergency or crisis at the Emergency Psychiatric Unit located at:

San Diego Psychiatric Hospital

3853 Rosecrans Street
San Diego, CA 92110
Telephone: 619-692-8200

**PSYCHIATRIC EMERGENCY RESPONSE TEAM and HOMELESS OUTREACH TEAM:
SAN DIEGO POLICE DEPARTMENT
SUMMARY**

SCAN:

Five percent (5%) of the US population has a serious mental illness. In contrast, sixteen percent (16%) of the population in prison or jail has a mental illness according to the U.S. Department of Justice.

ANALYSIS:

In 2001, The San Diego Police Department put together a task force comprised of 71 community members and 66 members of the San Diego Police Department to examine Use of Force. Among its other recommendations, the task force recommended adopting and expanding the “Psychiatric Emergency Response Team” and the “Homeless Outreach Team.”

RESPONSE:

The Psychiatric Emergency Response Team, (PERT, Inc.) is a mobile crisis team specifically designed to meet the needs of un-served, underserved and inappropriately served San Diego county residents, including children, youth in transition, adults, and older adults. As an innovative program, PERT Units pair a San Diego Police Department Officer who has undergone special training with a mental health clinician, comprised of a registered nurse, a licensed clinical social worker, or a psychologist. By design, the Team integrates law enforcement with mental health workers for the purpose of crises response and alternatives to jail for those with serious mental illness. The Homeless Outreach Team is a mobile outreach team designed to target transient individuals. HOT Units work in teams of a PERT clinician, a San Diego Police Officer, and a San Diego County health and human services worker to collectively provide assistance and offer placement or programming to those without means.

ASSESSMENT:

In the first two years of operation, PERT handled an average of 3,000 cases. One percent of these cases resulted in incarceration. Other individuals were assisted through local mental health facilities, acute residential crisis facilities, and other programs as appropriate. Similarly, HOT increased the number of persons placed in community programs, thereby decreasing the number of transients on the street and decreasing the number of community complaints and patrol officer radio calls.

SCAN:

Five percent (5%) of the US population has a serious mental illness. In contrast, sixteen percent (16%) of the population in prison or jail has a mental illness according to the U.S. Department of Justice.

According to State Department, men with a history of mental illness in New York City are four times more likely to be incarcerated; women with a history of mental illness are six times more likely to be incarcerated.

The Los Angeles County Jail, the Cook County Jail (Chicago) and Riker’s Island (New York City) each hold more people with mental illness on any given day than any

psychiatric facility in the United States.

According to a 1999 Department of Justice report, at least 16 percent of the total jail and prison population, or nearly 300,000 people, have a serious mental illness – more than four times the number in state mental hospitals.

The costs of such incarceration are enormous. According to the Department of Justice (1996 Source Book: Criminal Justice Statistics), it costs American taxpayers a staggering \$15 billion per year to house individuals with psychiatric disorders in jails and prisons (\$50,000 per person annually; 300,000 incarcerated individuals with mental illness). Incarcerating individuals with severe psychiatric disorders costs twice as much as assertive community treatment programs – some of the most effective plans to treat the severely ill. While some jails and prisons provide adequate psychiatric services to ill inmates, many do not. And, many corrections officers receive very little training in the special problems of caring for psychiatrically ill inmates.

In 2005, California estimates that San Diego County has roughly 19,000 individuals eligible for mental health services, which, for some reason, have not been able to get the help that they need. Similarly, it is estimated that there are 1900 severely mentally ill homeless persons in San Diego County. Given these statistics, these individuals are at increased risk of further mental health decompensation as well as arrest and innumerable other costs our community.

ANALYSIS:

A disproportionately high percentage of individuals come to the attention of law enforcement and are suspected of having a mental illness. Statistics like the ones cited above lead to day-to-day events such as officer-involved-shooting, community resentment, officer-stress, and criminalization of the mentally ill.

Training law enforcement in the recognition of mental illness and appropriate use of force with this population has been the subject of numerous task forces assigned to tackle these issues. In 2001, The San Diego Police Department put together a task force comprised of 71 community members and 66 members of the San Diego Police Department to examine Use of Force. The Task Force focused on breaking down several problems which had arisen in the community, among them eliminating the “us vs. them” syndrome” that so often exists between the officers and the citizens they serve, particularly the mentally ill and homeless.

Among its other recommendations, the Task Force recommended adopting and expanding the “Psychiatric Emergency Response Team” and the “Homeless Outreach Team.”

RESPONSE:

Program Description: “PSYCHIATRIC EMERGENCY RESPONSE TEAM--PERT”

The Psychiatric Emergency Response Team, (PERT, Inc.) is a mobile crisis team specifically designed to meet the needs of un-served, underserved and inappropriately served San Diego county residents, including children, youth in transition, adults, and older adults. As an innovative program, PERT Units pair a San Diego Police Department

Officer who has undergone special training with a mental health clinician, comprised of a registered nurse, a licensed clinical social worker, or a psychologist. By design, the Team integrates law enforcement with mental health workers for the purpose of crises response and alternatives to jail for those with serious mental illness. In 2005, California estimates that San Diego County has roughly 19,000 individuals eligible for mental health services, which, for some reason, have not been able to get the help that they need.

PERT, Inc. is established as a separate entity, with its own board. PERT supervises the staff and coordinates billing for its client contacts. Clinician productivity is measured on a monthly basis and billing is entered according to the county-accepted format. In addition, there is Coordinating Council with representation from the Police Department (Captains) and the County Department of Mental Health. Law enforcement Supervisors (Lieutenants and Sergeants) meet with the PERT Executive Director regularly to discuss logistics and operations and an Advisory Board composed of mental health stakeholders and two police coordinators provide insight and accountability.

PERT's Executive Director, a forensic psychiatrist, provides yearly, monthly, and weekly seminars as training to the San Diego Police Department and other law enforcement agencies, upon request. The PERT Academy, currently a yearly event since 1998, runs 20 hours and "certifies" the officer/deputy to become a PERT-designated officer. Topics covered during the PERT Academy include:

- Mental Health Diagnosis, Medication, and Acute Interventions
- Suicide by Cop
- Mental Health Law and Weapons
- Involuntary Hospitalization and Treatment
- Elder Abuse
- "Hearing Distressing Voices" (a workshop which uses audiotapes and tasks to simulate the experience of schizophrenia.)

The PERT Academy is followed by a monthly training day, which is hosted by the Executive Director and focuses on topics pertinent to the clinicians as well as the officers and deputies.

Program Description: "HOMELESS OUTREACH TEAM—HOT"

PERT, Inc. also provides mental health clinicians for collaboration with San Diego Police Department's Homeless Outreach Teams, which specifically perform outreach services to persons who are homeless or at risk of homelessness. The City of San Diego's Homeless Outreach Team consists of four San Diego police officers, two County of San Diego social service representatives, and one one and three-quarter (1.75) psychiatric clinicians. The San Diego Police Department also provides a full-time Sergeant to over-see the daily operations of the team and coordinate with the City of San Diego homeless coordinator. HOT provides for the immediate needs of homeless individuals, including acute physical healthcare, food, clothing, showers, and shelter. Through previous grants and donations, it has been able to provide immediate vouchers for clients and has been able to advocate for them in court toward treatment rather than incarceration.

Funding: A county contract and local mental health system grants fund the mental health clinicians, the administrative office and the services furnished to the individuals diverted from arrest. Additional funding is provided by a community foundation and occasional donations.

ASSESSMENT:

Outcomes: In the first two years of operation, PERT handled an average of 3,000 cases. One percent of these cases resulted in incarceration. Other individuals were assisted through local mental health facilities, acute residential crisis facilities, and other programs as appropriate.

In FY 2003-2004, PERT Units made 3,582 contacts. It currently employs six full time clinicians and three administrative staff. Due to budgetary constraints, PERT has been unable to provide 24-hour crisis intervention services in the eight different divisions of the San Diego Police Department and the additional 11 different divisions in which it also has clinician teams. For example, San Diego Police Department Central Division, an area with an estimated homeless and mentally ill population of 1417 has but one clinician, four days per week, from six am to four pm. This schedule leaves San Diego's mentally ill citizens and police officers the busiest hours-- weekends, evenings, and Fridays—without additional and needed expertise, less restrictive treatment options and triage support. As a result, decisions regarding whether someone should be placed on an involuntary hold for psychiatric assessment due to “gray” areas such as grave disability are left to patrol units that little to no mental health training at all.

However, during the hours that the clinician-officer (PERT) unit is available, patrol is able to function more effectively, the mentally ill are assessed, transferred and triaged more efficiently, and communication between the County Mental Health System and law enforcement is improved. PERT Units are routinely dispatched to calls involving issues where mental health concerns are raised including suicide calls, welfare checks, domestic violence calls, and incidents involving reports of “bizarre behavior.” The teams have been so successful that this year the San Diego Psychiatric Society honored two of the PERT Officers as “Persons of the Year” for their contributions to mental health.

Populations Previously Underserved, Now Better Served by PERT and HOT:

- As stated previously, only 1% of PERT calls resulted in incarceration.
- Eighteen percent (18%) of PERT calls in the past year have been related to dementia or have been specifically placed in reference to older adults needing support.
- Fifteen percent (15%) of the calls were related to child and adolescent or youth-in transition contacts.
- For fiscal year 2004-2005, sixty-three percent (63.3%) of PERT's clients were uninsured. Thus, PERT was able to provide access to care for a population that previously had no means to care.
- Thirty-seven percent (36.7%) of PERT's clients had MediCal. (Medicaid)
- San Diego Police Department responded to several calls from children psychiatric

outpatient clinical services in the last three months alone. These calls were precipitated by reported concerns that youth-in-transition and their families, unable to afford health insurance, would be forced to pay for paramedic transport for inpatient psychiatric care.

- HOT client demographics for April fiscal year 2004-2005 noted 95 new contacts, ten percent (10%) of which were Hispanic and twenty-four percent (24%) of which were black.

- Twenty-five percent (25%) of the HOTA's April 2005 new clients were defined as older adults, ages 55 and above.

- Attached are specific chart indicating the HOTA Unit statistics and placements.

The need for police officer teams specially trained to deal with individuals with mental illness clearly exists. Clients report that the teams have "saved their lives." Communication and collaboration has opened the doors to direct admissions from the PERT Units to private psychiatric hospitals, thus providing additional avenues to provide the clients immediate and appropriate care and return patrol officers to their duties. (Prior to the PERT and HOTA units, San Diego Police Department was required to take all suspected mental ill clients to the only local county inpatient psychiatric hospital, thus significantly slowing processing times.)

Required Monitoring AND Areas of Improvement:

Data will need to be collected on an ongoing to basis to confirm that PERT's and HOTA's mission, to provide beneficial outcomes for individuals with mental illness that have come to the attention of law enforcement and return uniformed officers or deputies to patrol duties as quickly as possible, is being achieved. Additionally, limited funding of the programs has prohibited their ability to expand to 24-hour coverage, as initially recommended. Therefore, several areas and divisions of San Diego have seen suboptimal responses and acceptance of the program due, at least in part, to its limited availability in those areas.

J TAB SECTION

DATE OF MEETING 1/21/16

MATERIAL
PREPARED BY: Adcock

DATE MATERIAL
PREPARED 12/14/15

AGENDA ITEM:	Overview of Levels of Residential Care and Usage by the Counties
ENCLOSURES:	Synopsis of background information from the website of Psynergy Programs, Inc. Article from the Mercury News: Low hospitalization rate for California's mentally ill draws complaints (December 10, 2015)

BACKGROUND/DESCRIPTION:

Pursuant to the Council's focus for 2015-16, Alternatives to Locked Facilities, the Council has been hearing about programs around the state which provide: 1) prevention services to catch folks before a need arises; 2) diversion programs when someone finds themselves at the doorway; and/or 3) reintegration activities to assist in the transition out of a facility back into the community. The facilities include hospitals and jails.

It is important to understand the different kinds of residential services that are available in California, including the differing levels of care. Lynda Kaufmann will describe the different levels, which ones are locked and which ones offer voluntary services.

Lynda Kaufmann is the Director of Governmental and Public Affairs at Psynergy Programs, Inc.

Psynergy Program Inc.

About Us

Psynergy Programs, Inc. was founded on the philosophy that individuals experiencing mental distress have the potential to do better when everyone works together. Our vision of a future filled with personal and community transformation is one we strive to share with our clients and their families. Psynergy's licensed adult residential facilities provide a housing option for individuals who desire a home-like setting coupled with care and supervision. Clients at our facilities experience an atmosphere that celebrates hope, promotes personal growth, builds social networks, and helps individuals realize their full potential.

Our Company

Psynergy Programs operates with the shared belief that recovery happens, especially when a cohesive set of supports and services are available to support and sustain it. Based in Morgan Hill, California, our organization has grown from one facility to two over the last four years, with a third now in development. Each facility offers a slightly different mix of programs and services that allow Psynergy Programs to tailor treatment and environment to suit individual needs. This way, we can emphasize the best elements of a community-living experience for individuals facing a variety of mental health challenges.

Partners in Recovery

Psynergy's Integrated Dual Recovery focus offers a series of rehabilitation groups and structured activities designed to enhance each resident's ability to cope effectively with life challenges and to attain greater autonomy in community living. As residents participate in the program they gain awareness of their natural capabilities and develop practical skills. Residents learn to use these capabilities and skills to move in a positive direction in life and to satisfy basic needs. Graduates of Psynergy's "empowerment training" develop a greater sense of trust, self-confidence and self-control and growing ability to create a healthy lifestyle.

Group trainers and Residential Counselors provide coaching, guidance and assistance to participants on a daily basis. Participants are expected to meet with their counselor each week to discuss their progress. Participants are also expected to engage in dual recovery groups each week to develop the skills and abilities needed to overcome personal obstacles and to advance in the program.

The Psynergy therapeutic communities offer three “core groups” and five “elective groups” on a regular basis throughout the year. Residents must successfully complete a required number (minimum of 20) core group training sessions in order to graduate with honors from the program. Three clinical counselors offer core group training to residents on a weekly basis, Monday through Friday, from 10:00 a.m. to 11:00 a.m. Each core group is conducted over a 10-week period on a rotating basis throughout the year. The curriculum for each training group consists of a combination of psychoeducation, process work and skill building exercises. The main subject matter of each group training session is broken down into particular topics that are addressed on a weekly basis.

Core Group Training:

- 1) Health, Hygiene and Nutrition.
- 2) Keys to Success: Motivation, Planning and Problem Solving.
- 3) Making Connections: Active Listening and Constructive Communication.

Elective Group Training:

- 4) Feeling Good with Physical Fitness.
- 5) Money Management: Keys to Financial Freedom.
- 6) Everything You Need to Know about Medications.
- 7) Relaxation and Recreation: Ways to Manage Stress.
- 8) Household Management: Keys to Independent Living.

Psynergy is only one part of the Recovery Process...

Our Services

Psynergy Programs recognizes that clients understand and appreciate high standards of care, compassion, cuisine, and choice. This does not change simply because they are going through a crisis. When clients experience cooking and accommodations comparable to what they would receive in a home setting, it is easier for them to visualize going home, being active in their community, participating in their recovery, and fulfilling their dreams.

Psynergy Spectrum

Because the Psynergy Spectrum of Care delivers distinct levels of care in a single location, we help reduce acute hospitalization, eliminate subacute care costs, and increase community recovery. From Community Reintegration to Supported Accommodations, Psynergy can meet a comprehensive set of client, family and community needs.

Our Residences

Our licensed adult residential facilities provide a housing option for individuals that desire a homelike setting coupled with care and supervision. Psynergy creates an atmosphere that celebrates hope, promotes personal growth, builds social networks, and helps individuals realize their full potential. Based in the San Francisco Bay Area and California's Central Coast, Psynergy Programs Inc. takes full advantage of one of the most desirable environments in the world. Year-round outdoor activities, locally grown foods and fresh coastal air enhance the Psynergy Lifestyle.

Psynergy's housing alternatives include comfortable, non-institutional shared rooms, small or large private rooms, and semi-independent private apartments. Access to the TV room, WiFi access, Anytime Fitness in Morgan Hill and courtyard garden is included, as is an extensive roster of weekly recreational activities.

Psynergy Lifestyle

At Psynergy, the concepts of "living well" and "getting well" are closely intertwined. It's all part of a holistic approach to becoming a healthier person, increasing activity, and doing something positive with your day. We believe that daily exercise, appealing, appetizing food, attractive accommodations and caring, supportive staff add up to a lifestyle that sets the stage for recovery.

As clients recover and benefit from our programs, we encourage them to look beyond the Psynergy campus and take advantage of the resources our host communities of Morgan Hill / Greenfield have to offer. As a resident's orientation period ends nightly walks, weekly bike rides, visits to local festivals, the library, the zoo, and trips to restaurants all enhance the flavor of life in San Francisco's Bay Area / California's Central Coast and lead to optimism about the future. Respect for individual feelings and personality is also a major part of the equation, giving clients a preview of what it can be like to recover and rejoin the community.

Low hospitalization rate for California's mentally ill draws complaints

By Matthias Gafni mgafni@bayareanewsgroup.com

Updated: 06/14/2015 04:26:19 PM PDT

MercuryNews.com

MARTINEZ -- The vast majority of patients who arrive at California hospitals with a psychiatric emergency are not admitted, a situation that has prompted some mental health advocates to ask whether enough is being done to help those who may pose a threat to themselves or others.

The number of psychiatric beds in California hospitals has steadily shrunk over the years as the focus in treating mental illness has shifted toward less restrictive outpatient care. Many mental health professionals have argued that forced hospitalization in many cases can do more harm than good.



William Shultz, 18, of Discovery Bay

But the decision to send a patient with a psychiatric emergency home can also have tragic consequences, as occurred in Contra Costa County in April when a 9-year-old Discovery Bay boy was stabbed to death in his bed just hours after his admitted killer was taken to Contra Costa Regional Medical Center in Martinez. After speaking for a couple hours with a psychiatrist, William Shultz said in a jailhouse interview that he was diagnosed as being delusional, discharged from the Martinez hospital and sent home in a cab.

The hospital's handling of Shultz's case was not unusual. In 2014, the Contra Costa Regional Medical Center's psychiatric emergency services -- a locked facility separate from its general medical emergency room -- handled 10,566 visits, admitting 874 of those patients (8.3 percent) to its inpatient hospital with 23 beds. In 2013, the hospital admitted 947 of 9,860 visits (9.6 percent) to its inpatient facility. That percentage is only slightly below the statewide average of 11.1 percent, based on 2013 data, though other county hospitals in the Bay Area have higher admittance rates (15.8 percent at Alameda County's John George Psychiatric Hospital and 12.5 percent at Santa Clara Valley Medical Center's inpatient psychiatric care).

In addition to the 874 emergency patients admitted to its own facility last year, the Martinez hospital also sent a similar number to other hospitals for inpatient services, an official said, but most patients receive outpatient services.

Once in those Contra Costa Regional beds, mentally ill patients stayed an average of 8.6 days, compared with 13.9 days in Alameda County with its 80 psychiatric beds and 13.3 days in Santa Clara in its 50 beds, according to 2013 state data collected by the California Office of Statewide Health Planning and Development.

John Snook, executive director of Virginia-based Treatment Advocacy Center, said that only the most severe and dangerous cases are hospitalized because California has so few psychiatric beds.

"What you see is predictable. If there are only a few beds, facilities have to triage, and take only the most severe cases," Snook said. "People aren't very good at predicting when someone is imminently dangerous, and so they are let out and what happens is people continue to deteriorate.

"Those folks then find themselves in a much less therapeutic facility -- they're in jail."

In one of his agency's studies, researchers could not identify a single county in the nation where the county inpatient psychiatric hospital was holding as many mentally ill individuals as the county jail.

Family members of mental health patients have complained of the revolving door at Contra Costa's psychiatric emergency services department, where, they say, many mentally ill patients are seen but too few are admitted for short- or long-term care.

Dr. Kristine Girard, chief psychiatrist at the Contra Costa facility, said she understands families' frustrations but stressed that determining whether someone is a danger to themselves or others, which would provide the option to involuntarily hospitalize a patient, is not an exact science.

"That is a challenge. It's very difficult," she said. "No one with a professional kind of lens ... can accurately predict the future."

The Martinez hospital is conducting an analysis of Shultz's care the day before he stabbed to death 9-year-old Jordon Almgren, according to Contra Costa County Supervisor Mary Piepho, who lives in Discovery Bay. However, what exactly happened during Shultz's brief stay there is a mystery due to patient-confidentiality laws.

Piepho has also proposed a report on how other county law enforcement and medical teams handle similar cases compared with Contra Costa.

Shultz's attorney and the Almgren family lawyer declined to comment for this story. Shultz recently pleaded not guilty to murder.

One 49-year-old Antioch mother, whose 30-year-old son has been diagnosed with delusional psychosis, said Shultz's quick exit from the hospital is the norm. She said she struggled unsuccessfully to get her son hospitalized care for years.

During one period, she said, her son stopped eating, dropping from 210 to 135 pounds. Police took him to the Martinez facility, only to be sent home hours later, she said.

"He was killing himself, gravely disabled, a failure to thrive, and he was sent home in a cab," she said, asking for anonymity to protect her son's identity. Her son was eventually hospitalized, and she said that once inside the inpatient portion of the Martinez facility, he received great care.

Girard emphasized that "patients are entitled to the least-restrictive environment."

"We are committed to hospitalizing based on critical need and do that on a case-by-case basis," she said.

Public psychiatric beds in California have dropped from 6,285 in 2005 to 5,283 in 2010, down 16 percent, according to a Treatment Advocacy Center report. The state averages 14.2 beds per 100,000 population, ranking 22nd in the country. The study recommends 50 beds for every 100,000.

The dismantling of inpatient psychiatric care in favor of outpatient facilities began to catch hold in the 1960s in a "deinstitutionalization" movement. In 2010, there were 43,318 patients in psychiatric hospitals in the United States, down from 535,540 in 1960, and 135,134 in 1980.

The mass exodus from public mental hospitals was driven, according to a Treatment Advocacy Center report, by media reports on overcrowded facilities post-World War II, civil libertarian lawyers working to free patients, reductions in federal fiscal support, introduction of antipsychotic drugs, and literature and

movies such as "One Flew Over the Cuckoo's Nest" that portrayed hospitalization as part of the problem.

Santa Clara County Supervisor Joe Simitian is pushing for more psychiatric beds for juveniles in his county, which has none dedicated to minors. That causes nearly 20 minors per day to seek or be sent for treatment at hospitals outside the area for acute inpatient care, according to his office's recent report.

"There's a tension between need and desire to ensure beds are available, and concerns of overinstitutionalizing," Simitian said.

Pat McConahay, a spokeswoman for Disability Rights California, said there are alternatives to hospitalization, and outpatient care also needs funding.

"Situations like this are a major problem statewide in California; however, the answer is not hospital inpatient treatment necessarily," McConahay said. "What these people need is a crisis team to work with them, certainly not being sent home alone in a cab."

Staff writer Danny Willis contributed to this report. Contact Matthias Gafni at 925-952-5026. Follow him at [Twitter.com/mgafni](https://twitter.com/mgafni).

K TAB SECTION

DATE OF MEETING 1/21/16

MATERIAL
PREPARED BY: Adcock

DATE MATERIAL
PREPARED 12/15/15

AGENDA ITEM:	Review and Approval of 2015 Council Reports
ENCLOSURES:	Data Notebook 2015 Hope for the Homeless We're Listening: Community Forums of 2015 State and National Timeline of Mental Health

BACKGROUND/DESCRIPTION:

There are four reports prepared by CMHPC staff for member review and approval.



**STATEWIDE OVERVIEW REPORT 2015:
DATA NOTEBOOK PROJECT ON
BEHAVIORAL HEALTH IN CALIFORNIA**

Submitted By

Linda W. Dickerson, Ph.D.

and the

**Continuous System Improvement Committee of the
California Mental Health Planning Council**

December 15, 2015

Acknowledgements:

This project was developed by the California Mental Health Planning Council (CMHPC) through its Continuous System Improvement Committee, in collaboration with the California Association of Local Mental Health Boards and Commissions.

We express great appreciation for data, expert advice, and many other contributions from County Departments of Behavioral Health and Mental Health, without which it would not be possible for either the local advisory boards or the CMHPC to fulfill their respective mandated roles.

We also thank the research staff at the California Department of Health Care Services, Office of Applied Research and Analysis who prepared data related to substance use treatment and outcomes in the counties and provided expert advice regarding data on substance use disorders treatment and our interpretation of the material.

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**STATEWIDE OVERVIEW REPORT 2015:
DATA NOTEBOOK PROJECT ON BEHAVIORAL HEALTH IN CALIFORNIA**

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Introduction: Purpose, Mandates, and Data Resources

What is the “Data Notebook?”

The Data Notebook is a structured format for reviewing information and reporting on the behavioral health services in each county. For some questions, the Data Notebook supplied data for each county from public resources (e.g., mental health (MH) data from the External Quality Review Organization¹ and substance use disorders treatment reports from the Cal-OMS group at DHCS). For other questions, we requested that local mental health boards obtain information from their county behavioral health department because there was no public source.

The Data Notebook is designed to meet these goals:

- assist local boards to meet their legal mandates² to review the local county mental health services and report on performance every year
- function as an educational resource about mental health data for local boards
- enable the California Mental Health Planning Council (CMHPC) to fulfill its mandate³ to review and report on the public mental health system in our state.

Every year, the mental health boards and commissions are required to review data about the services for mental health in their county and to report their findings to the CMHPC. To facilitate the reporting, the CMHPC creates a structured document for receiving information. The Data Notebook is organized to provide data and solicit responses from the local advisory board regarding specific topics so that their information can be readily analyzed and synthesized into a report. This CMHPC report informs policy makers, stakeholders and the general public.

The CMHPC serves under the umbrella of the Department of Health Care Services (DHCS) and must fulfill certain legal mandates to report on the public mental health system every year. As part of our reporting mandate, we analyzed all Data Notebooks received in 2014 from the mental health boards and commissions. This information represented 41 counties that comprised a geographic area containing 83% of this state’s population.⁴ Our analyses produced the Statewide Overview Report for 2014 that is on the CMHPC website at:

<http://www.dhcs.ca.gov/services/MH/Documents/CMHPCCSIDataNBReport2015.pdf>

¹ See www.CALEQRO.com for county level data. Select the Archives folder containing reports for each county MH Plan, or check “New Reports” as available for the most recent year data.

² W.I.C. 5604.2, regarding mandated reporting roles of MH Boards and Commissions in California.

³ W.I.C. 5772 (c), requires annual reports from the California Mental Health Planning Council.

⁴ An additional six counties submitted their documents after our report for 2014 was completed, for a total participation rate of 84%, including 47 counties in partnership with their local advisory boards.

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Other recent reports from various committees of the CMHPC can be found at: <http://www.dhcs.ca.gov/services/MH/Pages/CMHPC-PlanningCouncilWelcome.aspx>

Our overall goal is to promote a culture of data-driven policy and quality improvement in California's behavioral health services and to improve client outcomes.

Data Resources for the Data Notebook

Some questions requested input from members of the local boards. Their experience and perspectives as stakeholders are valuable and that is one reason these boards exist. Most important, stakeholder input is taken into account by legislators, agency policy makers, and local governments when they designate funding and implement programs. Most other data and information for the Data Notebook was available from a variety of local county sources, such as:

- Director, Department of Behavioral Health or Mental Health
- Administrator for Alcohol and other Drug Programs
- Quality Improvement Coordinator
- Mental Health Services Act (MHSA) Coordinator
- Cultural Competence Coordinator or committee

Data about local specialty MH services could be found in reports from the external quality review organization (EQRO) (www.CALEQRO.com) in the "Archives" file for "Reports," by selecting the most recent "EQRO MHP Report" for a specific county. "Appendix D" of the county report provides detailed numbers about demographics of clients served and numbers who received different types of services. The "Information Systems Review" section may be consulted for an estimate of the percent of clients with serious mental illness (SMI) who also have substance use disorders (SUD).

Finally, we were able to obtain a new resource from DHCS for substance use disorders treatment data to share with the counties and their local advisory boards. These data were made available for publication by their research group at the Office of Applied Research and Analysis after review by the DHCS office charged with protecting patient privacy and HIPAA compliance.

We customized each Data Notebook report by placing the data specific to each county within the substance use disorders section, followed by discussion questions on this topic. Statewide reference data was presented so that it could be compared to the information for each county. We also included a county data page with a few basic statistics on specialty mental health, numbers of Medi-Cal eligible beneficiaries, and

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overall county population. These data were taken from the most recent EQRO reports that were publically available on April 23, 2015.

Strategies for Completing the Data Notebook 2015

California has made substantial strides in integrating mental health treatment with substance use disorder treatment. This Integration is still a work in progress in most counties. The data systems are largely separate entities as are the treatment and billing systems for mental health and substance use. However, a major statewide priority is to coordinate services for individuals across different systems of care.

Additionally, in terms of resources to meet the needs of individuals experiencing a mental health crisis, some counties have inpatient facilities and/or crisis response teams. Some counties have just one such resource available and some have none.

In consideration of the diversity among the counties, their resources and different systems of care, we presented topics covering two critical issues for review by the local advisory boards in this year's Data Notebook. The local advisory boards, in partnership with their respective county departments, were asked to discuss and answer questions for these topics:

- A. Strategies to Meet the Needs of Persons Experiencing Mental Health Crises: Treatment Options and Alternatives to Locked (Involuntary) Facilities
- B. Integrated Care: Treating Individuals with both MH and SU Disorders

We thank all the county departments of behavioral health who assisted the local advisory boards by providing data and key information about resources, programs and unmet needs in their local community. We also deeply appreciate the work and thoughtful discussion prepared by local advisory boards and commissions. Due to all these efforts, we achieved a total county response rate of just over 86%.

Methods for Development of Study Design, Data Collection and Analysis

The selection of topics and development of the Data Notebook arose from ongoing discussions with members of local advisory boards, the California Association of Mental Health Boards and Commissions, the Mental Health Planning Council members, and consultation with individual county Directors of Behavioral Health. These efforts built on the prior year's Data Notebook work group and stakeholder process. The data analysis for the "checkbox" survey items was comprised of descriptive summary statistics. However, analysis of the open-ended survey questions was devised after the fact and implemented in consideration of the variability of the data submitted, in that the responses represented the diversity of counties statewide.

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This year, a greater number of boards (and increased numbers of members) reported that they actively participated in reviewing their data and assisted in adding significant qualitative input, especially regarding local needs. Of the 50 reports received to date, 33 were completed mostly or completely by county staff and/or the Director. Another 4 reports were completed mainly or entirely by advisory board members. At least 22 local boards described a process that was largely collaborative in that board members worked with county staff. A few groups had input from county alcohol and drug treatment services and/or input from a separate alcohol and drug advisory board.

Of the 50 reports received, 29 had been placed on the agenda for discussion at the local MH/BH advisory board meeting and presented for final approval. Such review at the local board meeting is a minimum requirement for meeting state mandates for local MH boards to review data about local mental health needs and services.

This year, at least 12 local boards went beyond collaboration with their county departments in that they developed ad hoc committees or special work groups for this project. These groups subsequently presented their input and the final version of the Data Notebook to their executive leadership and their full board. We recognize these as exemplary practices that produced an excellent final product.

In summary, we received **50 Data Notebooks** that represent data from **52 counties**. These reports reflect information from a geographic area containing **99.4 %** of the state population. Counties that submitted Data Notebooks during 2015 are listed in Table #1 (next page), grouped by size of population. These counties comprise the data set analyzed for the synthesis presented in this Statewide Overview Report for 2015. All these Data Notebooks contribute meaningfully to our efforts to improve the quality and accessibility of services and to promote better behavioral health outcomes for all Californians.

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Table 1. Data Notebook 2015 Summary of Report Progress

Received Reports: (50 reports, covering 52 counties)⁵

Small⁶ population: (23 counties)	Medium:⁷ (15 counties)	Large:⁸ (14 counties)
Alpine	Butte	Alameda
Amador	Marin	Contra Costa
Del Norte	Merced	Fresno
El Dorado	Monterey	Kern
Glenn	Placer/Sierra	Los Angeles
Humboldt	San Luis Obispo	Orange
Imperial	San Joaquin	Riverside
Kings	Santa Barbara	Sacramento
Lake	Santa Cruz	San Bernardino
Lassen	Solano	San Diego
Madera	Sonoma	San Francisco
Mendocino	Stanislaus	San Mateo
Modoc	Tulare	Santa Clara
Mono	Yolo	Ventura
Napa		
Nevada		
Plumas		
San Benito		
Shasta		
Siskiyou		
Sutter/Yuba		
Trinity		

⁵ Sutter and Yuba counties are combined into one Mental Health (MH) Plan, as are Placer and Sierra counties.

⁶ Counties with populations less than 200,000.

⁷ Counties with populations between 200,000 and 749,999.

⁸ Counties with populations of 750,000 and greater on January 1, 2015.

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Strategies to Meet Needs of Persons Experiencing a Mental Health Crisis

Treatment Options and Alternatives to Locked (Involuntary) Facilities

While every effort is made to notify Californians of the availability of services and to encourage individuals to seek services early, sometimes a crisis occurs and immediate intervention is needed. In a worst case scenario, law enforcement is called to respond. However, in a better case scenario, a multi-disciplinary team, that includes a mental health professional and a peer, will meet with the individual in crisis. The toll and costs of hospitalizations and incarceration of individuals experiencing a mental health crisis are high on both the individual and public system. Many counties have implemented diversionary programs to help persons in crisis manage the situation, de-escalate their symptoms and recover without having to enter an institution. The strategies for MH crises, however, are not necessarily the same as for persons with an SUD-related crisis (including but not limited to overdoses). The urgency for immediate triage may vary with the person, the clinical situation, and other factors.

The Need to Provide Urgent Care for Serious Mental Illness in Our State

National statistics⁹ for the prevalence of serious mental illness show that in California, there was an average of 1,103,000 persons¹⁰ with severe mental illness per year during 2012 and 2013. A larger population is represented by those with “any” mental illness, which was 5,278,000 per year¹¹ during 2012 and 2013 in California, and includes those with mild to moderate as well as severe mental illness.

For comparison, in 2013 California’s public mental health system¹² served nearly 490,000 persons with serious mental illness (or serious emotional disorders, children<18) out of approximately 10.5 million Californians who received Medi-Cal.

While all of those numbers are very large, only a small fraction needed MH crisis services or psychiatric hospitalizations in any given year. At this time, statewide data on the numbers of Californians who experienced a MH crisis last year are not available.

⁹ SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2012 and 2012. For details on methods, see Section B of the “2011-12 NSDUH: Guide to State Tables and Summary of Small Area Estimation Methodology,” at <http://www.samhsa.gov/data/population-data-nsduh/reports?tab=33>.

¹⁰ 95% confidence interval: 942,000 – 1,290,000.

¹¹ 95% confidence interval: 4,902,000—5,676,000

¹² www.CALEQRO.com, data for CY 2013 (calendar year) from Appendix D tables of archived MH Plan reports for FY 2013-14. For general comparison, CA state population was 38,357,121 on Jan 1, 2014, according to CA Department of Finance tables.

We sought to identify resources and options that are available to promote treatment and services in the least restrictive environment that will help individuals experiencing a MH crisis to stabilize and move toward recovery. We bear in mind that the concept of MH recovery may be different than that for SUD treatment. The goal of this project was to highlight effective programs that meet this essential need on the continuum of services. Effective programs are an excellent way to reduce institutionalization and recidivism, reduce stigma and reduce costs allowing those savings to be used in other areas of the service system. By sharing information about programs with a promising track record, we seek to promote programs of quality, excellence and effectiveness.

Continuum of Care for Serious Mental Illness in our Communities

Psychiatric hospitalization services are sometimes necessary, but not all counties or communities have local access to such facilities for adults and even fewer have any type of psychiatric hospital services for children and youth under 18. In order to get a full picture of the services available in each county, we asked for information about the types of acute care psychiatric facilities as well as alternatives to hospitalization.

Some basic definitions of terms and common abbreviations¹³ may be helpful to here. Some of the entities and services described below may have partially overlapping functions but have different licensing or personnel requirements or designated funding sources.

IMD: refers to Institutions for Mental Diseases, an older term that implies longer term care for those with severe psychiatric illnesses and other mental health impairments.

PHF: Psychiatric Health Facility means a facility that provides therapeutic and/or rehabilitative services on an inpatient basis to clients who need acute psychiatric care and which meet specific criteria under the regulations.¹⁴ The client's physical health needs should be able to be met on either an outpatient basis or by a general acute care hospital which is affiliated with the PHF. The services of a PHF are different from those categorized as a "Psychiatric Inpatient Hospital."

Psychiatric Inpatient Hospitals provide acute inpatient services for clients who need a level of psychiatric care that is medically necessary to diagnose or treat a covered

¹³Many of these descriptions are defined in the Performance Outcomes System Measures Catalog: Methodology and Measures Definitions, Department of Health Care Services, February 17, 2015.

¹⁴"Psychiatric Health Facility" means a facility licensed under the provisions beginning with Section 77001 of Chapter 9, Division 5, Title 22 of the California Code of Regulations and which provide services to beneficiaries who need acute care under the criteria of Section 1820.205 of Chapter 11, Division 1, Title 9 of the California Code of Regulations.

mental illness. These facilities also provide administrative day services, which are inpatient hospital services provided to clients who are ready to move to a less intensive level of care but are awaiting residential placement options. Services at these facilities are covered under Short/Doyle Medi-Cal or Fee-for-Service Medi-Cal, or private insurance. Technically, state hospitals are also psychiatric inpatient hospitals but at the present time they are utilized less often for civil commitments than for forensic commitments (for clients having criminal system involvement).

SNF with PTP: Skilled Nursing Facility that also has the capacity to provide some limited psychiatric treatment program services for their clients.

Licensed adult residential facility for “Board and Care,” either with or without additional mental health-related services. There are a variety of other supported housing services with different licensing and funding sources, and include SLE, sober living environments for those recovering from mental health and substance use disorders.

Crisis Stabilization Unit (or Team) (CSU) provides services that last less than 24 hours, and are for a client that needs a more timely response than a regularly scheduled visit. Services may include assessment, therapy, or “collateral,” which addresses the client’s MH needs to ensure coordination with significant others and treatment providers.

Crisis Intervention Services (or Teams) (CIT) also provide services that last less than 24 hours for clients who require more timely response than a regularly scheduled visit. Services may include assessment, therapy, or “collateral,” which addresses the client’s MH needs to ensure coordination with the client’s designated support system. These services may be provided face-to-face or by telephone with the client, or with the client’s designated significant support system. Services may be provided anywhere in the community including the client’s place. In some communities the CIT may include a member of law enforcement who has been trained to participate in crisis intervention.

Crisis Residential Services (CRS) or Units (CRU): provide an alternative to acute psychiatric hospital services for clients who otherwise would need hospitalization. The CRS/CRU programs for adults provide normalized living environments integrated in residential communities. The services include case management and referrals to other social services, follow a psychosocial rehabilitation model (including milieu therapy), and may integrate aspects of emergency psychiatric care as needed. Generally these units are intended for adults, but some communities also have special crisis residential units designated for older adolescents and transitional-aged youth (young adults).

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Adult Residential Treatment Services: occur in a non-institutional residential setting to provide rehabilitative services for those clients who would be at risk of psychiatric hospitalization or other institutional placement if they did not receive such services. Services and programs are designed to restore, maintain, and apply interpersonal and independent living skills, and to access community support systems. Therapy, case management and linkage to other social services or to primary health care are provided.

Assisted Outpatient Treatment (AOT), “Laura’s Law”: provides outpatient medication and therapy under certain conditions to selected individuals. A variation on this type of program is IHOT, In-Home Outpatient Treatment, which is deemed less coercive and more respectful of an individual’s self-determination, by seeking voluntary cooperation and acceptance of the medication and therapy program.

Respite Care: A form of short-term crisis residential care for up to 14 days provided in a homelike setting for clients who can largely take care of themselves but need a temporary place of safety so that they can resolve an acute emotional crisis, perhaps by temporarily removing themselves from a precipitating situation in their customary home. In some cases a crisis stabilization unit or crisis residential unit may set aside one or more beds for such respite care.

Next, we list each of the questions asked of the local advisory boards and their departments of behavioral health in this year’s Data Notebook. After each question the responses are summarized in either tables or brief discussions. Some responses received under the “other” option fit the intent of categories listed in the question and were appropriately re-coded.

In those cases for which open-ended questions were asked, in addition to the brief summaries, county-specific information is listed in a related Data Appendices as a companion to this document. A copy of the Data Appendices can be requested but is not included with this report due to the size. Many or most counties have implemented great programs, often with local variations, but there are too many to describe adequately in a summary report. The Data Appendices are intended to provide access to the county-level information as a creative resource for stakeholders and staff in other communities. Such information may provide opportunities for regional-level collaborations and shared solutions.

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How Our Counties Meet the Needs of Persons in Mental Health Emergencies

1. Do you have these types of facilities in your county? Please check all that apply. Please mark ‘Other’ (and describe) if your county contracts for beds outside of your county.

The right-hand column shows the number of counties that selected a specific response.

<u>Types of Facilities or Services</u>	<u>#Counties</u>
Psychiatric hospital beds	33
IMDs (Institutions for Mental Diseases, used often for placement of MH clients who are under conservatorship and others)	26
PHFs (Psychiatric Health Facilities)	22
Skilled Nursing Facility (SNF) with Psychiatric Treatment Program	15
State Hospital beds	17
Other	10
None of the above	12

‘Other’ options offered by counties included:

- Mental Health Rehabilitation Facilities: 2
- Adult Residential Facilities: 1
- Residential Care Facilities for Elderly: 1.
- Out-of-county placements for children, adolescents, and/or TAY under 18: 2
- Unspecified as to type: “beds as needed”: 4

The note for only 2 counties listing outside contractors (mainly out of county) for children and youth under 18 is clearly an under-estimate, as there are few counties which have acute care psychiatric hospitalization facilities for this age group available within the county. The question did not ask respondents to differentiate between adults and minors, so the responses would be unlikely to provide a complete picture regarding children and youth under 18.

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2. If you do not have any of the above facilities in your county and you have a need that goes beyond crisis intervention, how do you handle a need for a longer term hospitalization (14-90 days)?

The right-hand column shows the number of counties selecting a specific response.

<u>Type of Service or Facility</u>	<u>#Counties</u>
Transport to out-of-county psychiatric care facility	30
Licensed adult residential facility (board and care home) that receive extra funding from the county (or placing agency) for additional MH-related services	16
Crisis intervention services (includes triage or mobile crisis teams)	14
Other	7
Does not apply	17

The responses under “not applicable” came from those counties whose options were listed previously for Question #1. The responses to “Other, please list” indicate that this question could have included some additional options.

- Finding treatment for children is a major concern, for large and small counties (children’s wait time for beds prolonged in Emergency Departments): 2.
- Board and Care (6-beds with one bed dedicated to respite care up to 14 days): 1.
- Although IMD, psychiatric and state hospital facilities are located within county, competition with other counties results in clients being sent out-of-county: 1.

3. What alternatives to a locked facility do you have for those experiencing an immediate MH crisis? Please check all that apply.

The far right-hand column shows the number of counties that selected a response.

<u>Crisis Service, Program, or Facility</u>	<u>#Counties</u>
Mobile Crisis Intervention Teams or other Crisis Intervention Program (have or currently developing)	33
Licensed adult residential facility (board and care home) that receives extra funding for additional MH-related services	28

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Crisis Stabilization Unit Services (23 hours)	27
Crisis Residential Treatment facility	27
Transport to another county for treatment	24
Assisted Outpatient Treatment (AOT) teams (Laura's Law type programs)	13
Transport to another state for treatment	4
Crisis Triage Teams, which may be embedded in Hospital Emergency Department, or homeless shelters/service centers, etc.	3
Other	24

A variety of options listed under "Other" included the following resources, services, and programs. Some may provide similar programs but under slightly different names or with different specifications to meet local needs and/or licensing requirements.

- MHSA FSP services for those individuals who qualify: 2
- Respite Housing options and/or peer-run respite center: 2
- Board and Care: 2 (one of which has a dedicated 14-day 'respite' bed)
- Trainings for CIT teams involving law enforcement and multiple agencies: 2
- Transitional Housing: 1
- Contracted agency for homeless services (housing) and recovery innovations (peer-run program): 1
- Outpatient Treatment alternative (RBEST) funded by MHSA: 1
- Crisis drop-in center for those not meeting 5150 criteria: 1
- Crisis Response Line (24-hr): 1
- Comprehensive Children and Family Support Services (CCFSS): 1 (includes a continuum of wrap-around services for children and youth).

4. Does your county have a MH court, jail diversion program, or similar mechanism to help individuals whose MH crisis or illness contributed to their involvement with the criminal justice system? Please check all that apply.

The right-hand column shows the number of counties that selected a specific response.

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MH/BH Alternatives in Criminal Justice System	#Counties
Re-entry programs with MH/BH services to assist persons released into the community after leaving a correctional facility (e.g. programs funded by AB 109, Proposition 47, or related services)	42
Drug Court (some counties have combined these into “problem-solving courts”), includes “co-occurring disorders court”	38
MH court	35
Jail diversion program (a court-ordered MH program where client avoids jail); includes “deferred entry of judgment” programs	21
Veterans Courts	3
None of these options	3
Other	19

“Other” resources and programs included variations on the already defined options, as well as some specific services or linkage to needed services.

- Full Service Partnership programs: 2
- County is developing Laura’s Law assisted outpatient treatment program: 2
- Probation Youth Reporting Centers (diversion day program): 1
- Commercially Sexually Exploited Children (CSEC) Court: 1
- MH clinician embedded in probation department to assist persons with connection to MH services: 1
- In-custody MH services for adult facility and 3 staff at Juvenile Hall, to provide medication support, individual and group counseling, crisis intervention and other support services including a bilingual jail discharge planner, and link those in need to ongoing MH treatment and to eligible services such as Medi-Cal, Social Security, or temporary housing, etc.
- Juvenile Justice MH Program that is stationed on the same campus as Juvenile Commitment Center; this program makes contact with minors in custody for evaluation and to ensure follow-up at release for those with MH issues.

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- Crisis Counselors in jails, (re-entry AB 109): 1
- Inmate Discharge Medication Program, which involves a social worker who focuses on jail discharge planning and arranges with a local grocery/pharmacy to partner with the Rx program for released persons.
- One county contracts with CIBHS for Moral Reconditioning Therapy (MRT) training and consultation, a specific type of cognitive behavioral therapy program for substance use treatment and criminal justice offenders. Training is attended by those who work in youth and young adult services, adult services, and the probation department. Also, rehabilitation technicians assist consumers with linkage to applicable services: shelter, clothing, food baskets, SSI/SSA benefits, Section 8 housing, referrals to substance use treatment, physicians, dentist, driver's license and/or immigration paperwork.

5. Creative Solutions. Does your county have an innovative program or another way to address needs for inpatient care or emergency MH services, other than what has been listed above?

The numbers below indicate the number of counties that selected a specific response. A summary of some programs described under "yes" option is provided below. Detailed answers for 'yes' are shown in the Data Appendices.

No	16
Yes	33

Every county has approached MH crisis services a little differently, but the common theme is commitment to meeting the client's needs "wherever the client is", meaning not only the client's location, but at whatever stage of recovery the individual is experiencing. No summary can do justice to the variety of programs and strategies implemented by many counties. Details are listed in the Data Appendix for those counties who supplied their information. Upon review, it appears that a number of counties which answered "No" to this question actually had developed fairly innovative approaches as described in their answers to prior questions.

Crisis Teams and MH Triage Workers

Many counties have implemented mobile Crisis Response Teams. Some have Crisis Intervention Teams that incorporate a member of law enforcement specially trained to assist in a psychiatric emergency along with the MH personnel. And some crisis teams

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include trained peer specialists or peer mentors. A number of counties place a MH Triage worker in local emergency departments or in a walk-in clinic that may be part of a Wellness Center or Behavioral Health clinic (e.g., Lake County, San Bernardino County).

Respite Care

Some counties, such as Trinity County, have created respite care units, which may have designated beds that are part of, or associated with, a crisis stabilization unit or crisis residential facility. A different variation on respite care was developed by San Francisco as The Hummingbird Place, a peer-designed and managed respite care facility with a home-like setting and feel. A number of counties specifically mentioned funding from SB 82 helped them develop their own strategies to assist clients in crisis.

MHSA and other State-funded Programs

Other counties cited MHSA funding for Full Service Partnerships (FSP), Innovation programs, or Prevention and Early Intervention programs. Some, such as Shasta County, are using Full Service Partnership services to assist individuals as they transition from crisis stabilization or hospitalization to community living, or to avoid hospitalization altogether. One program in Placer-Sierra counties was designed as a co-occurring disorders FSP program. A few counties listed MH care and assessment in Jail or Juvenile Detention for youths and others, as part of a pre-release program to link individuals to the MH and SUD treatment services, physical health care, or social services, as needed (AB 109 funded programs).

Crisis Needs of Children and Youth Served Separately from Adults

San Joaquin County described several strategies to assist children and youth in crisis. They have separate adult and juvenile mobile crisis stabilization teams, a Crisis Bed program for juveniles with MH crises and who have run away or are at risk, in-home therapy and other services to juveniles, and a 24-hr crisis line. Also, the county is building a voluntary CSU with facilities for children and youth as well as adults.

San Bernardino also has implemented a Crisis Residential treatment program for transition-aged youth, developed with MHSA Innovation funds.

Regional Collaboration Between Counties

Some programs seemed especially innovative in the way they developed collaborative relationships with other agencies or counties. Madera County entered into a partnership with four other central valley counties to develop crisis residential beds in Merced through funding from SB 82.

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Inter-Agency Collaborations to address a County's Homeless Problems

Through the collaboration of at least nine county agencies and several faith-based and private industry groups, Yolo County implemented an ambitious Bridge to Housing (B2H) Program to assist 71 long-term homeless persons move from a river encampment to temporary housing (including their 47 dogs and 22 cats). Residents were provided with 90 days of short-term housing, assistance with job training, health insurance, disability benefits applications and one year's free cell phone service. Links to various services were designed to help these clients transition to longer-term housing. Yolo County is also in the process of developing a Homeless Court for problem-solving similar to MH and Drug Courts.

6. Prevention. Does your county have any programs implemented specifically as alternatives to locked facilities that haven't been addressed above?

This is an open question that could include MHSA-funded programs designed to assist individuals in crisis, or to prevent first-break psychosis. Such programs could include local implementation of a program for more MH triage workers (funded by SB 82). Other strategies could engage public and private partnerships, regardless of funding source.

The right-hand column shows the number of counties that selected a specific response. Some of the responses for 'Yes' answers are discussed in the summary which follows. A detailed listing of county-level information is provided in the Data Appendices.

No	5
Yes	44

The types of programs described in response to this question tended to overlap with those listed for the previous question. However, few counties listed the same program(s) twice in response to this second question, but instead described additional programs or services.

The responses generally focused more on Prevention and Early Intervention programs, increased numbers of Wellness Centers, and more FSP programs. More counties specifically described outreach to groups historically underserved based on race/ethnicity, or persons for whom English is not their primary language, and an emphasis on outreach and services for transition-aged youth (TAY).

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Again, no summary can do justice to the rich variety of programs and strategies implemented by the counties who supplied information for this question. Details are listed in the Data Appendix for each county who answered in the affirmative.

Diverse Approaches for Prevention and Early Intervention Programs

At least 25 counties described some type of prevention and early intervention program (PEI) for psychosis, under various names: MHSA-funded PEI programs, Mental Health Block Grant or SAMHSA-funded First Episode Psychosis (FEP) treatment programs, Prevention and Recovery in Early Psychosis (PREP) programs, and the Portland Identification and Early Referral (PIER) Model, an evidence-based treatment program.

- Sacramento and Placer-Sierra Counties are using the UC-Davis EDAPT or Sac-EDAPT model programs that involve training to recognize signs and symptoms associated with major mental illnesses in young populations. Those programs link individuals to Turning Point Community Programs, which is contracted to provide early intervention and treatment for those identified as being at high risk.
- Del Norte County's new perinatal program provides services to new mothers and families at risk of crisis.

Mobile Teams and Crisis Workers

A variety of other resources play important roles in counties' efforts to help those in crisis avoid hospitalization and to remain in their communities. At least 13 counties described having Mobile Crisis teams, CIT teams or new MH Triage workers that are funded by SB 82, The Investment in MH Wellness and Recovery Act of 2013.

Housing Supports, Longer-Term Residential Treatment, and Coordination with FSP

Another 5 counties listed housing supports or long-term residential treatment. FSP program services were listed as part of several counties' strategies to help adults and youth in crisis and provide support to those who were homeless or at risk of becoming homeless.

- One example is the Odyssey Team of Marin County that serves those who are homeless or at risk of becoming homeless, one of several FSP teams. Another county team, "Support and Recovery after Release" (STAR) team helps those at risk for incarceration or re-incarceration. Two other FSP teams focus on the needs of Transitional Aged Youth.
- Amador County and many others have developed a permanent supportive housing program with funding provided by the MHSA.

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- Nevada County runs the Odyssey House, a 10-bed adult residential program that is staffed 24/7, another example of a program supporting better client outcomes.

Expanded Role for Wellness and Recovery Centers

More wellness centers were added or more services were offered at existing wellness centers to assist clients in crisis in at least six counties.

Some small-population counties use specialized approaches to reach out and engage potentially underserved groups.

- Lake County has four Peer-Guided Wellness and Recovery Centers (Native American, Latino, Adult, and TAY) to assist community members with wellness and recovery programs and referrals to reduce the possibility of crisis and for post-crisis services. These community centers are in addition to mobile crisis workers, PEI services, suicide prevention task force, and outreach crisis workers that go into the community.
- Glenn County also has different wellness centers to serve adults, TAY, a center for Week-end Wellness, and a Transitions Learning Center.
- Lassen County has opened the Renaissance Center for Transitional-Aged Youth to prevent first-break psychosis.

What Resources are the Top Priorities to Address Unmet Urgent Needs?

- 7. Unmet needs. Please describe any specific unmet needs for children, transition-aged youth, adults or older adults in your county for either MH-related hospitalization or community-based crisis treatment services.**

Compilation of answers for each of the three age groups listed, plus an “all populations” option for needs which apply to several groups.

Unmet Needs for Children and Youth <18:

Difficult to find psychiatric inpatient facilities or psychiatrist services.

Lack of group home Residential Care Level 14 facility in-county.

Increase child psychiatrists, increase local inpatient beds, increase MH staff.

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No crisis facility or hospital in county, also need more Spanish bilingual staff.

Increase use of Evidence-Based Practices and work with CiBHS to increase Evidence-Based clinical services for children and families.

Increase child psychiatry, increase local inpatient beds, increase MH staff .

All 5150 evaluations occur in our sole hospital ED; but for children and TAY we do our best to rally their natural supports and then provide support to those systems.

Children inpatient psychiatric hospital beds; now they go out-of-county.

CSU for children to meet urgent needs.

Need psychiatric beds for children under 12.

Identification and treatment of sexually exploited children, with ongoing collaboration of CPS, courts, and probation department.

Lack of any 5150 placements, including PHFs or IMDs in-county which accept juveniles.

Crisis residential treatment.

Crisis Stabilization Unit to meet the unique needs of this age group.

No psychiatric inpatient beds in county.

No local acute hospital options for minors.

In-county hospital treatment lacking.

Unmet Needs for Transitional-Aged Youth (age group 16-25)

Youth need a less dramatic environment to go to for a hospitalization than the PHF. Need better skills/training than county FSP teams have for working with youth; also could use an intensive treatment program like EDAPT for early onset thinking disorders.

Safe and affordable housing for TAY.

Lack housing and supportive services for emancipated foster youth or problem youth ages 18-25. Lack of safe and affordable housing is major barrier for TAY population who need supports for their recovery.

Supportive housing options.

Limited number of programs (only 5) in N. CA for Board and Care or transitional living.

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Increased demand for TAY services in county.

Crisis Stabilization Unit to meet the unique needs of this age group.

Crisis residential placements for youth.

Increase crisis stabilization services and crisis residential for TAY; increase capacity.

More effective outreach to teens & TAY for our great programs.

Acute need for crisis residential and respite services for youth < 18.

Psychiatric bed shortage, clients sent out-of-county; need 23hr crisis stabilization unit & crisis residential facility; both would help to avoid hospitalization and assist with step-down services post-hospitalization.

No crisis unit or psychiatric hospital in county, also need more Spanish bilingual staff.

Lack of youth crisis residential treatment programs, lack of group home RCL level 14 facility in-county, lack of youth psychiatric hospital beds.

Difficult to find psychiatric inpatient facility, or psychiatrist services, also need a CSU.

Need to develop a supported housing plan and also address needs for persons under the influence who need a "sobering crisis station" as in some other counties.

Identification and treatment of sexually exploited youth, with ongoing collaboration of CPS, courts, and probation department.

Unmet Needs for Adults:

Crisis help for people experiencing emotional instability that does not result in suicidal or homicidal tendencies but are still fraught with anxiety, depression, mania, and/or obsessive thoughts. In our county, only physical safety is addressed.

Lack of adult Crisis Residential treatment programs, lack in-county IMD or state hospital beds, lack SNF beds, lack field crisis mobile teams, shortage of county psychiatric adult hospital beds.

Difficult to find psych services, need a CSU or respite center to avoid hospitalization; would consider developing a regional resource for a CSU.

Need to develop a new housing plan for supported housing; also our county currently has no services for people under the influence and is exploring "sobering crisis stations" as in other counties.

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No crisis facility or psychiatric hospital in-county; the ER is for temporary 5150 holds until transport out-of-county. Need more Spanish-speaking bilingual staff for our large Latino population.

All 5150 evaluations occur in our one hospital ED; depending upon which ED doctor is on duty, meds can sometimes be administered to adult patients who are willing.

No inpatient psychiatric facility or IMD in our county, no mobile crisis, no CSU, no transitional housing for released offenders with BH issues. (These apply across all adult and youth age categories).

Need for integration of response to 5150 assessment between our Mobile Crisis Response Team and ED. Also, significant unmet need for comprehensive treatment of psychotic disorders in all age categories in our community, need a program like the SacEDAPT program at UC Davis (from a northern county not adjacent to Sacramento).

More culturally-competent outreach within communities about MH & SUD treatment services available.

Current unmet need for crisis serve to increase hospitalization rates and ER use.

Transportation in hospitalization; respite care as alternative to hospitalization.

In-county shortages of PHF beds for adults and of Board and Care beds.

Shortage of inpatient beds in county; large homeless population but insufficient services, such as forensic psychiatry for “incompetent to stand trial” (IST) population and services for released offenders with MH issues.

Safe and affordable housing for adults, both female and male.

Need a peer respite facility.

Outpatient case management; supportive housing; additional Crisis Stabilization Unit and Crisis Residential Unit should be available to other regions of county besides the county seat.

Unmet Needs for Older Adults:

Needs for the increasing number of elderly adult mentally ill plus homeless population. Available resources are extremely limited. Services needed include food, clothing, shelter, medical care, benefits assistance and linkage to community services.

Lack of transitional housing, long wait time and lack of beds in county, and no crisis residential treatment or 23-hr crisis stabilization services locally.

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Need to contract with a hospital to open a geriatric psych unit for elderly psychiatric hospitalization, especially for those who also have medical needs.

Lack of in-patient beds in-county for older adults with co-occurring dementia or significant physical health needs.

Need in-county resources for psychiatric beds/hospitalization, further development of our crisis drop-in center, and need to work more closely with Law Enforcement. We have very limited resources with our 2 ERs in a rural county.

Community-based crisis treatment for older adults who are isolated, depressed, and at-risk of suicide.

Problem with opioid dependence in seniors; need treatment for those with dual diagnosis or co-occurring disorders.

Peers for seniors with MH issues and outreach to seniors, especially 'shut-ins.'

No geriatric specialty MH inpatient services in county.

Elderly Medicare clients are sometimes not accepted into local Psychiatric Hospital because beds are occupied by out-of-county clients—hence, a lack of capacity.

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8. If you could ask for any specific resource, program, or facility to meet serious, urgent MH needs in your community, what would be your top three priorities?

Priorities listed may apply to one age group, several groups, or to all stages of the lifespan. These priorities included many of the needs identified under the responses for Question #7.

<u>Priority Resource Needed</u>	<u>#Counties</u>
PHFs, psychiatric hosp. beds, IMD beds, SNF, MH Urgent Care	13
Crisis Residential Services/ Facilities	10
Crisis Stabilization Unit Services (23-hour)	9
Supportive housing of any type, including Sober Living Environments (SLE).	9
Respite Care, Peer-respite care and/or Drop-in centers (24 hr)	6
More case management services and/or 'wrap-around', transitional assistance, services to help homeless.	5
Mobile Crisis Unit and/or PERT (Psychiatric Emergency Response Team)	4
Increased number of psychiatric appointments/services	4
MH personnel, all types including RNs, psychiatrists, peers.	4
More training of MH staff to be qualified to treat AOD disorders	3
Detoxification (medical) unit/facility and temp. sobering stations	3
Dual Diagnosis residential treatment programs	2
Assisted Outpatient Treatment (Laura's Law) or AOT	2
MH Triage Teams	2
More bilingual MH staff or clinicians	2
Eliminate exclusions of IMDs and limitations by managed care for geographic regions	2
More FSP programs or "FSP-like" services.	1

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Integrated Care: Treating Individuals with both MH and SU Disorders¹⁵

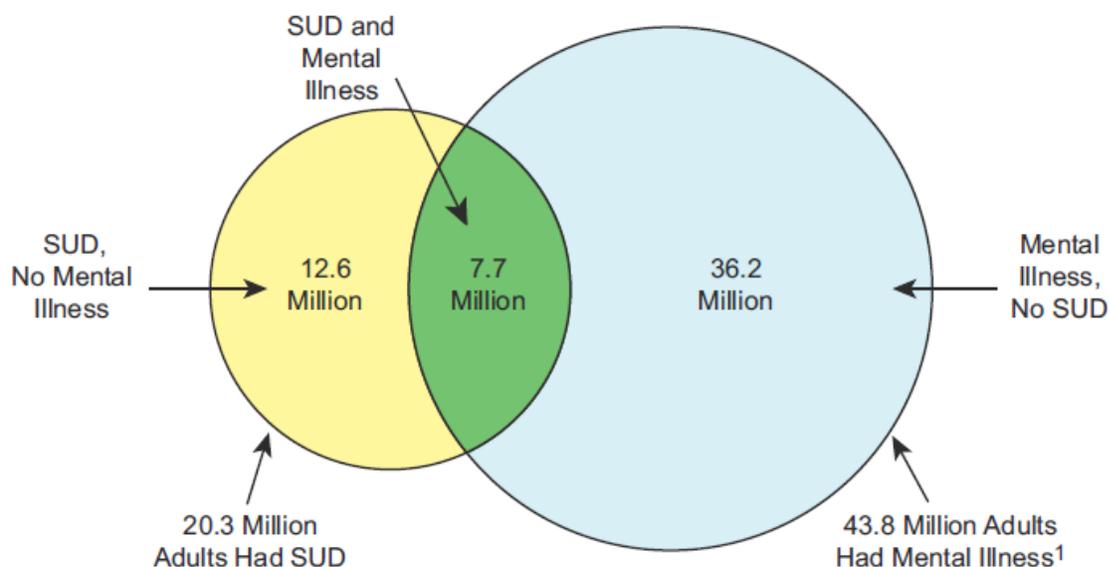
Understanding the Scope of the Problem using National Statistics

We show examples of national data from the NSDUH¹⁶ survey to give perspective on the mental health and substance use data for our state. Many experts believe these data are an under-estimate of the true scope of the problem. All figures in this section are from the NSDUH survey report. We ask: how many people are affected by these disorders?

The report describes adults who had any mental illness, or a substance use disorder, or both problems in the U.S. during 2013, the most recent year for which there are reports.

- A total of 43.8 million adults had a mental illness. Of that group, 7.7 million (17.5 percent of total) also had a substance use disorder. But, in contrast, only 6.5 percent of adults without any mental illness had a substance use disorder.
- Among the 20.3 million adults with substance use disorder, 7.7 million (37.8 percent) also had a mental illness.

Figure 1. Past Year Substance Dependence or Abuse Co-Occurring with any Mental Illness among Adults Aged 18 or Older in the U.S., 2013.



SUD = substance use disorder.

¹⁵ SU = substance use. SUD= Substance use disorders, referring to problems with abusing drugs, alcohol, or both. Drugs refer to both illegal substances and prescription drugs used for purposes other than those legally prescribed or intended. See www.drugabuse.gov for more information.

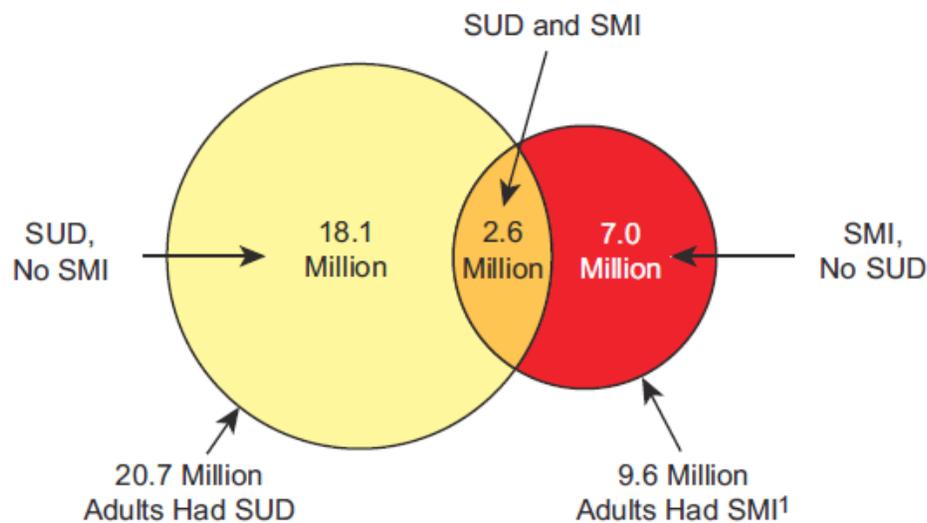
¹⁶ **NSDUH:** The National Survey on Drug Use and Health (NSDUH) is the primary source of information on the prevalence and patterns of alcohol, tobacco, and illegal drug use and abuse and mental disorders in the U.S. population. See "Results from the 2013 NSDUH: Mental Health Findings," at: <http://www.samhsa.gov/data/sites/default/files/NSDUHmhfr2013/NSDUHmhfr2013.pdf>

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The problem is even more serious as we consider the risks for those with serious mental illness (SMI), a subset of those with “any” MH disorder shown above. So let us focus on the seriously mentally ill sub-group of the overall mental health population.

The following data are also taken from the NSDUH report cited above. For the 20.7 million adults in the U.S. who had a substance use disorder, 2.6 million (12.6 percent) also had serious mental illness (SMI). (The numbers for total persons with SUD and SMI differ slightly between this figure and the preceding one due to statistical modeling and the effects of rounding on estimates).

Figure 2. Serious Mental Illness and Past Year Substance Abuse or Dependence Among Adults Aged 18 and Older in the U.S., 2013.



SMI = serious mental illness; SUD = substance use disorder.

Who received treatment and what kind? In the co-occurring disorder population we hope for better recovery outcomes for clients who receive treatment for both disorders. However, such integrated treatment may be difficult to obtain or access. Let us consider the data for all affected persons with “any” mental illness, as well as SMI.

For the 7.7 million adults with co-occurring disorders in 2013, how many received treatment in the last year for MH disorders, SUD, both, or neither?

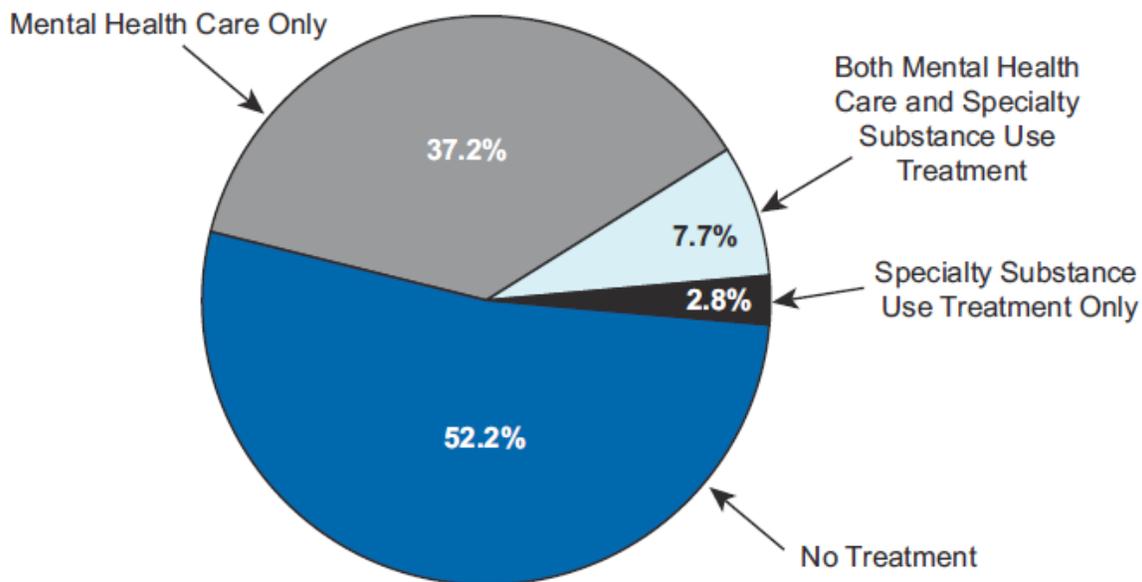
The NSDUH (2013) reports that: 47.8 percent received some kind of treatment for either SUD or mental illness during the past year, however:

- 37.2 percent received MH care only
- 2.8 percent received SUD treatment only, and
- just 7.7 percent received treatment for both disorders.

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But more than half, or 52.2 percent, received no treatment at all for either disorder. Those findings may be surprising. Examine what that data looks like in the next figure.

Figure 3. Past Year Mental Health Care and Treatment for Substance Use Problems among Adults Aged 18 or Older who had Both a Substance Use Disorder and Any Mental Illness in the U.S., 2013.



7.7 Million Adults with Co-Occurring
Mental Illness and Substance Use Disorders

Note: Mental health care is defined as having received inpatient care or outpatient care or having used prescription medication for problems with emotions, nerves, or mental health. Specialty substance use treatment refers to treatment at a hospital (inpatient only), rehabilitation facility (inpatient or outpatient), or mental health center in order to reduce or stop drug or alcohol use, or for medical problems associated with drug or alcohol use.

Many will be surprised that such a large percentage, over 52%, who have both SUD and MH disorders do not receive any treatment within a given year. We focus on the co-occurring disorder population for a number of reasons in this report.

If instead, we examine the data for all persons with substance use disorders (most of whom have not been diagnosed with mental illness), the numbers paint a much more alarming picture. Within any given year, typically **more than 95%** of those with substance use disorders do NOT seek treatment. Put another way, **only 5%** of those who need substance use treatment each year actually seek/receive treatment.

The larger number of persons who have a substance use disorder (but most of whom do not have a major mental illness) would likely exceed the capacity of all treatment resources available. Many experts believe that, as a society, we cannot “treat our way”

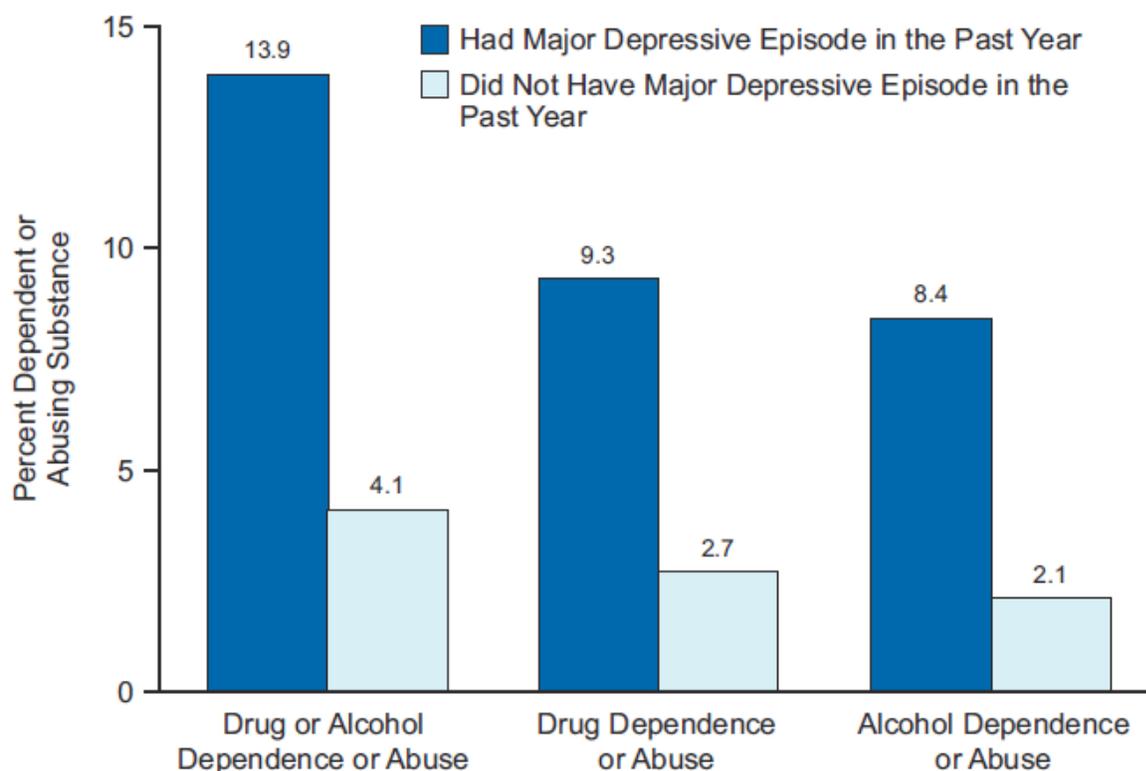
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out of this problem. Investing in effective prevention is essential. Later in this report, we discuss strategies used by counties to address substance use education and prevention programs, especially those efforts targeted for children and youth. Next, we focus on youth under 18 in order to understand how frequently co-occurring SUD and MH disorders occur in this vulnerable group.

Risks for Children and Youth with Co-occurring MH and SU Disorders

Children and youth under 18 who had a major depressive episode were three times more likely to engage in alcohol or drug abuse (or both), compared to members of their same-age peer group who did not have depression.¹⁷ Experiencing a major depressive episode more than doubled the risk for abusing each of the major illicit drugs (see data in next figure, from the 2013 NSDUH survey). Such episodes of depression may be an early indicator of risk for more severe emotional disorders later in life.

Figure 4. Youths Aged 12-17: Past Year Substance Abuse or Dependence by Major Depressive Episode in the Past Year in the U.S., 2013.



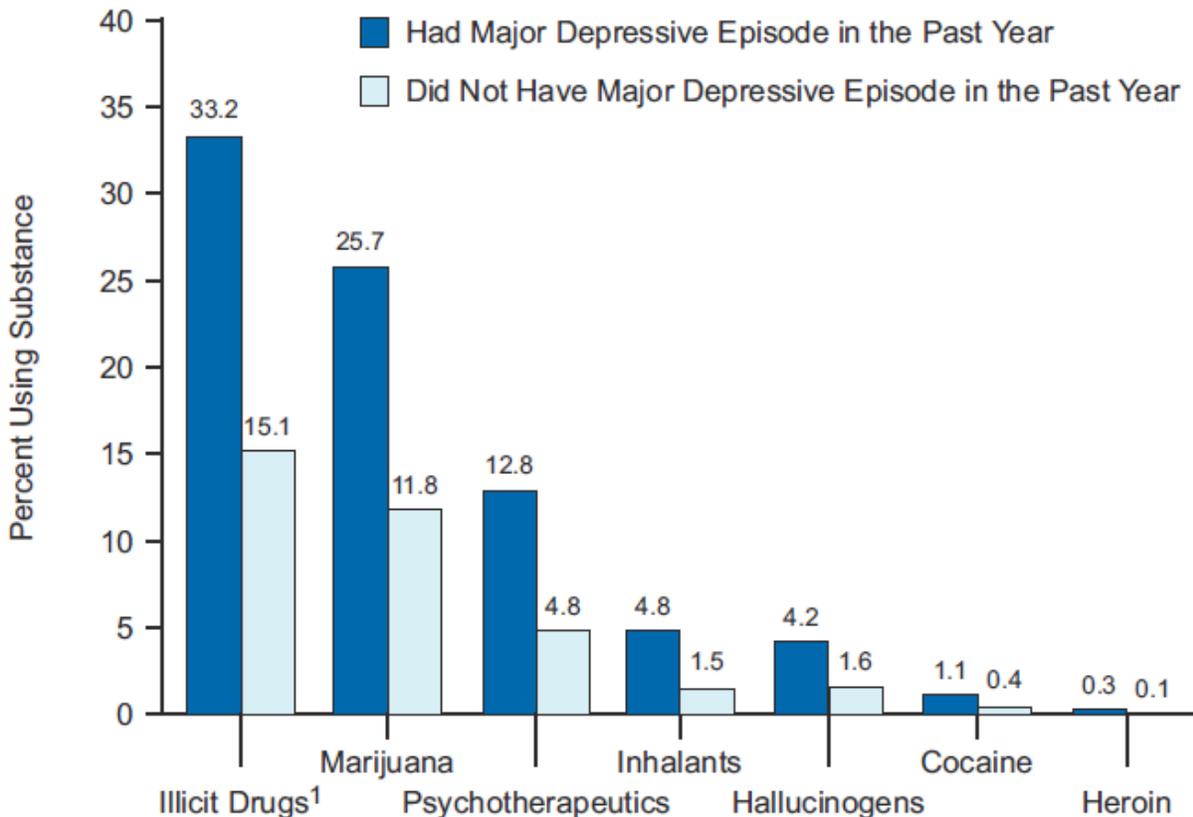
¹⁷ Results from the 2013 National Survey on Drug Use and Health: Mental Health Findings, at: <http://www.samhsa.gov/data/sites/default/files/NSDUHmhfr2013/NSDUHmhfr2013.pdf>

The data above, shown for youths in the U.S. aged 12-17, resembles a very similar profile of risk for substance abuse in adults who had a major depressive disorder in the prior year (data not shown). These data highlight the importance of recognizing and seeking treatment for depression and for health care providers to initiate depression screening.

The NSDUH report also found that youth with a major depressive episode had an increased risk for use of any type of illicit drug. A related but very serious concern is the increased risk for abuse of prescription drugs (when taken for non-prescribed uses).

The data for youth shown below are very similar to those for adults who had depression, except that adults' use of cocaine was greater than that of hallucinogens, inhalants, or heroin (the least frequent choice).

Figure 5. Youths Aged 12-17: Type of Illicit Substance Use and Relation to Having a Major Depressive Episode in the Past Year in the U.S., 2013.



¹ Illicit Drugs include marijuana/hashish, cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used nonmedically.

State Level Impact: Prevalence Data for Co-occurring Disorders in California

Our major concern in this overview report is to understand the scope of the problem, need for treatment and resources in the state of California and our communities. Now that we have considered some of the scope and prevalence of the problems presented by SU and MH disorders, we next turn our attention to the data for treatment and services within our state. Some resources for statewide data are available.¹⁸ We will be examining only a subset of the overall data in order to get a basic foundation for understanding our system of care and treatment outcomes. As we examine these data, we keep in mind the perspectives gained from the national data and consider how that may compare to California's data.

Data: Who Receives SUD Treatment in California and Treatment Outcomes

The next few pages show statewide information supplied by researchers in the Office of Applied Research and Analysis at the Department of Health Care Services (DHCS). The data are from fiscal year 2013-2014 and represent counts of individuals admitted to publically-monitored alcohol and other drug treatment programs. The data are for unduplicated individuals and only for the first admission to any treatment program during that treatment year regardless of what came before or after that year's initial service.

Access: Who Receives Services? The first section presents data for the demographics of those admitted for SUD treatment and the type of service admissions. Demographics include age, gender, major race/ethnicity groups, and county of service. Service types included in this dataset are outpatient, detoxification, or residential treatments. Not broken out are perinatal programs or narcotic treatment programs (NTP, medication-based maintenance programs such as methadone or buprenorphine).

What are the Client Outcomes? The second section contains a snapshot of statewide data regarding client outcomes at time of discharge from outpatient drug-free programs. This represents the most common type of treatment program. Discharge outcomes are measured for the 30 days immediately following discharge and include:

- return to substance use
- arrests
- employment

¹⁸ Here is the most recent data source for state-level estimates for prevalence of MH and SUD disorders and population with co-occurring disorders, and some estimates of patient access to treatments. <http://www.samhsa.gov/data/sites/default/files/NSDUHsaeTotals2013/NSDUHsaeTotals2013.pdf>

- housing situation (homeless vs. stable housing of any type)
- social supports within the last 30 days (includes 12-step programs as well as general social support activities, more than 4 or fewer than 4 per month).

There is a certain percentage of data assigned as “not collected,” which otherwise might be described as missing data. These are not redacted (hidden) numbers. “Data not collected” indicates the numbers of clients for which no further data were obtained by the treatment program. Some clients were no longer reachable by program staff or were otherwise lost to follow-up. However, with such a large percentage (e.g. 43.5 %) not collected, increased efforts are needed to collect more data so that unbiased outcome statistics for all treatment clients can be developed and used.

Finally, as stated earlier, please examine the county data reference pages in the Data Appendices. We live in a highly diverse state and so your county data may or may not resemble the statewide data. However, these data are worth review and discussion as we consider advocacy and policies regarding demographic disparities in service access and unmet needs.

CALIFORNIA State Data. Totals include all counties.

ACCESS: Who Receives Services and in What Type of Program?

Demographics for Unique Clients, FY 2013-2014 Admissions to Treatment

Service Type:

Outpatient	Detox Treatment	Residential	Total
89,071	19,904	24,763	133,738
66.60%	14.88%	18.52%	100%

Age at Admission:

Under 18	18 - 25	26 - 35	36 and Older	Total
14,957	23,614	38,042	57,125	133,738
11.18%	17.66%	28.45%	42.71%	100%

Gender:

Male	Female	Total
84,615	49,123	133,738
63.27%	36.73%	100%

Race/ Ethnicity:

American Indian or Alaska Native	Asian or Pacific Islander	African American, not Hispanic	Hispanic or Latino	Multiracial/ Other Race, not Hispanic	White, Not Hispanic	Total
1,612	2,984	16,926	49,352	5,070	57,794	133,738
1.21%	2.23%	12.66%	36.90%	3.79%	43.21%	100%

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CALIFORNIA State Data. Totals include all counties.

CLIENT OUTCOMES: Key Indicators of Client Recovery for the 30 Days preceding Discharge from Outpatient Drug-Free Programs for FY 2013-2014.

Substance Use at Discharge from Program (as reported by clients):

No Substance Use	Substance Use Documented	Use Data Not Collected	Total
28,093	9,533	29,016	66,662
42.14%	14.33%	43.53%	100.00%

Arrests:

No Arrests	1 or More Arrests	Arrest Data Not Collected	Total
36,486	1,160	29,016	66,662
54.73%	1.74%	43.53%	100.00%

Employment:

Employed	No Employment	Employment Data Not Collected	Total
10,596	27,050	29,016	66,662
15.90%	40.58%	43.53%	100.00%

Housing Situation

Stable Housing	Homeless	Housing Data Not Collected	Total
34,479	3,167	29,016	66,662
51.72%	4.75%	43.53%	100.00%

Social Support Participation (SSP), days per month

4+ SSP days	<4 SSP days	SSP Data Not Collected	Total
19,306	18,340	29,016	66,662
28.96%	27.51%	43.53%	100.00%

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Meaning and Limitations of County-Level ‘Snapshot’ Data for SUD Treatment

Comparable data summaries for individual counties were also released and are displayed in the Data Appendices. These are the numbers that were presented in the Data Notebooks prepared for each individual county. When examining the county data, some data cells may not have any numbers, but instead are marked by an asterisk, “*” which means that the numbers were redacted (hidden) to protect patient privacy because the total number is too small. Counties with small populations may see many such asterisks, with the result that only limited data can be seen.

The statewide and county-level data are presented for review and discussion to promote increased access to services and more evidence-based programs. The overall goal is to identify what leads to more successful client outcomes. The data show that a major continuing challenge is shown by substantial, persistent disparities by demographic in service access and unmet needs for all counties and including small-population counties with large land areas and limited resources.

For a better understanding of SUD treatment in our state, please consult the Data Appendix describing the list of SUD Treatment providers in each county. What becomes evident is that substantial numbers of small-population counties have no narcotic treatment programs available and very few have residential substance use treatment programs. Of the other types of programs listed, some counties with physically large land areas but small populations have only one outpatient SUD treatment program, usually an abstinence or drug-free program.

The lack of specific types of treatment programs (e.g. Residential, Intensive Outpatient, NRT) explains the data seen in the Admissions to Treatment tables (Appendix 1 and Appendix 2) for small-population counties—the presence of multiple “zeroes” suggests that certain programs may not exist in that county. The “Summary of SUD Treatment Programs Available” (shown in Appendix 3) may be consulted to confirm program availability or lack thereof for a given county.

Finally, the substantial travel distances necessary to access treatment and other transportation-related issues present significant barriers to SUD treatment in at least 29 counties, as shown by other data presented later in this report summarizing responses to question #10 of the Data Notebook.

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The Impact of Substance Abuse on the MH System of Care in your County

9. This next question was intended to help define the nature and scope of substance use in each county, a first step that is essential for each community to assess needs and develop strategies for addressing the problems of alcohol and substance abuse.

What substances are the most commonly abused in your county? Please select the top three drug categories below (and indicate estimated percentage if known).

The far right-hand column shows the number of counties that prioritized these specific responses.

<u>Major Substances Abused</u>	<u>#Counties</u>
Alcohol	46
Amphetamines, methamphetamine, prescription stimulants (ADHD drugs)	42
Marijuana, hashish or synthetic marijuana-like drugs (e.g. 'spice', 'bath salts')	35
Opioids (heroin, opium, prescription opioid pain relievers)	30
Cocaine, 'crack' cocaine	4
Club Drugs (MDMA/Ecstasy, Rohypnol/ flunitrazepam, GHB)	1
CNS depressants (prescription tranquilizers and muscle relaxants)	1
Dissociative Drugs (Ketamine, PCP/ phencyclidine/ angel dust, Salvia plant species, dextromethorphan cough syrup)	1
Other: "Polysubstances"	1
Hallucinogens (LSD, Mescaline/ peyote/ cactus, Psilocybin/ mushrooms)	0
Inhalants (solvents, glues, gases, nitrites/ laughing gas)	0

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The results shown above, and further supported by the following table (showing percentages), indicate that the top four substances abused statewide are (1) Alcohol, (2) Amphetamines and related stimulants, (3) Marijuana/Hashish, and (4) Opioid class drugs, including both heroin and prescription narcotic pain relievers. Note that some substances received few or no responses, but that does not mean that these drugs are not problems in our communities. These other substances are well-documented elsewhere as important concerns in our society. They simply were not perceived as being in our top list of substances abused.

The next table below shows data for those counties that supplied percentages for type of substance used. Some variations are apparent among different counties and regions of the state. Note that some counties provided data for those substances which are a problem in their general population, but others supplied data regarding substances for which clients were most often seeking treatment ("seek Tx"). A few counties volunteered data for youth<18. Note that the choice of substance(s) abused by youth tends to differ from those of adults. Generally, the percentage numbers for each county will not add up to 100% due to the way the question was framed regarding the top three or four substances abused.

<u>County</u>	<u>Substance Abused</u>	<u>Seek Tx</u>	<u>Youth <18</u>	<u>Alcohol</u>	<u>Marij./hash</u>	<u>Amph/meth</u>	<u>Cocaine/crack</u>	<u>Opioids</u>
Contra Costa	X			19.9	15.1	31.1	6	9.1
Imperial	X			19	7	74		
Imperial			X	9	87	4		
Kings	X			21.4	35.7	37.9		
Los Angeles		X		16.0	17.6	24.8		30
Madera	X			20	25	43		
Marin	X			37.6	9	21.5	5	26.2
Mendocino	X			75	50	50		
Mono	X			70				30
Monterey	X			19	8	36	5	27
Napa	X			50	10	40		
Placer-Sierra	X			24		30		30
Riverside	X			18	8	50		19
Riverside			X	8	85	10		<3
Sacramento	X			23		41		20
San Bernardino	X			19		48		13

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San Diego	X			23	20	36		
San Francisco			X	25	25			5
San Joaquin		X		8		16		51
San Mateo	X			33.72		28.3		13.08
San Mateo			X	11.4	83.0		1.8	
Santa Barbara	X				17	28		29
Sonoma	X			42	9.6	25.6	0.9	21
Santa Clara	X			24.9	16.7	44.2		
Ventura		X		12		36		38
Yolo				13	21	33		

10. With respect to SUD treatment in your county, what are the main barriers to access and engagement with treatment?

The most striking result of this question indicates that there are marked changes in client motivation and participation in Drug Courts following recent changes in law. Drug court is a way to reduce criminal penalties for some crimes in exchange for the client engaging in treatment for substance use and successful completion. However, Proposition 47 reduced penalties for some substance use crimes, thus individuals now may choose not to apply for drug court/supervision of their case.

The right-hand column the shows number of counties that selected a specific response.

<u>Barriers to SUD Treatment</u>	<u>#Counties</u>
Client not ready to commit fully to stopping use of drugs and/or alcohol	41
Reduced motivation of clients due to changes in court-required drug treatment programs post-Proposition 47	29
Transportation	29
Failure to complete treatment program	24
Lack of treatment programs or options locally	19
Stigma and prejudice regarding diagnosis or participation in treatment	19

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Lack of workforce licensed/certified to treat co-occurring MH and SUD disorders	17
Wait list to enter treatment	17
Language and/or cultural issues	10
Safe housing needed while clients work to be clean and sober or for dual diagnosis clients, but funding streams are limited	8
Insufficient funding for SUD programs and treatment, and/or limited financial resources of clients	5
Lack of Dual Diagnosis programs for co-occurring disorders	4
Different factors are more significant barriers for adolescents and TAY, so need more programs specific to their needs and outreach	3
Other	10

Compilation of “Other” Answers for each key barrier itemized.

A variety of items were deemed to be among the most significant barriers to treatment for substance use disorders. Some responses were sufficiently frequent that they were grouped into additional categories created above. Following is a partial selection of additional responses to “other.”

- Homeless population has difficulties accessing services and environmental stress impedes full engagement and recovery: 2.
- Need more transitional long-term recovery programs: 1.
- Too much reliance on ‘abstinence’ model: 1.
- “The unbridled availability of methamphetamines in our county:” 1

11. What could be done to increase successful outcomes for SUD recovery in your county? Choose the top three priorities.

This question resulted in responses that represent the vision of an ideal approach, in the sense that we are asking what COULD be done for clients to help improve their chances of success and recovery. One important option which was not listed, but which emerged as quite important in subsequent discussions, is “Collecting and using program performance and service recipient outcome data to help inform service improvement decisions.” This is one important perspective as we consider the choices offered and responses gathered in the table below. Options listed in the table below

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may, or may not, be used in the responding county at present. (A subsequent question will address what programs or services actually are being offered currently).

The right-hand column shows the number of counties that selected a specific response.

<u>Perceived Ideal Ways to Improve SUD Outcomes</u>	<u>#Counties</u>
Ongoing case management, including connecting individuals to other services and longer-term support, 'wrap-around' services	44
Medication services	30
Vocational training and support, including employment readiness classes, and more employment options	20
Support individuals to make necessary changes in social patterns (new neighborhood; change routes to home, school or work; change circle of friends); including court-approved relocation	19
Family treatment/education and engagement	17
Onsite access or referrals for primary health care screening and treatment	14
Housing supports, including Sober Living Facilities for females as well as males or "dry" shelter options	10
More residential treatment beds, co-occurring disorders treatment medical 'detox' services and/or funding for these	5
Health and nutrition classes	4
Parenting classes	3
Transportation of clients (e.g. funding for bus passes, and other)	3
Other	8

The following items or comments were listed in response to the "other" option. Some respondents listed multiple items under "other."

- Treatment facilities within county and/or geographically accessible services: 2.
- Individualized treatment: provide appropriate treatment at the appropriate time: 2.
- More sober recreational activities, especially family-oriented: 2.

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- Collecting accurate baseline data for measuring outcomes: 1
- Different approaches needed by adolescents: 1
- Engagement before release for consumers that are incarcerated: 1
- Screening, Brief Intervention, and Referral to Treatment (SBIRT): 1
- Increase knowledge of SUD system by Medi-Cal Managed Care Plans (MCP): 1
 - especially for complex care management of medically fragile and psychiatrically complex individuals: 1
- Shift to more Evidence-Based Practices: 1.

12. Have any SUD treatment strategies been shown to be especially successful in your county?

The right-hand column shows the number of counties that selected a specific response.

No, none	2
Yes	47

If 'yes,' please describe.

Nearly all respondents indicated that there were successful SUD treatment strategies being employed in their county and cited them. Many counties listed several successful programs. Some of the successful programs are described below with the goal of sharing with other communities what programs and services are being found most successful in each county. Some counties engage in regional collaborations, so it may be useful to know what is working well in nearby communities. Detailed listing of programs by county is available in the Data Appendix for this question.

The most common type of program that was considered successful are those associated with problem-solving courts of all types, i.e., modeled on Drug Courts and MH Courts, including Veterans Courts, Homeless Courts, and “Deferred entry of judgment” programs. This finding takes on more importance with the perceived negative changes to client engagement in treatment following the enactment of Proposition 47—which has resulted in unforeseen outcomes.

One important observation was that Motivational Interviewing and Motivational Enhancement therapies can be very effective, but they need to be offered with careful fidelity to best practices. Practitioners need to be well-trained to be effective.

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The following substance use treatment strategies were most frequently cited as helping clients succeed in their treatment:

<u>Program or Treatment Strategy</u>	<u># Counties</u>
Drug Courts and other Problem-solving Courts	14
Motivational Enhancement and Motivational Interviewing	12
Trauma-informed Therapy, including “Seeking Safety”	10
Cognitive Behavioral Therapy, Dialectical Behavior Therapy, or Moral Reconciliation Therapy (for justice-involved clients)	9
Coordinated MH and SUD Treatment	8
Case management, may be intensive or long-term	7
Drug-assisted Narcotic Treatment Programs (Methadone, Suboxone, Buprenorphine, Vivitrol, etc).	6
Perinatal Treatment Programs, including those with intensive case management	5
Matrix Therapy—may be coordinated with 12-step programs	4
AB 109 funded programs for in-custody or released offenders	3
Sober Living Environments	3
Red Road to Recovery based programs (also: “Right Road”)	3

13. (a) How does your county support individuals in recovery to increase their rates of success? Please check all that apply in your county.

(b) In your opinion, which of the above are the four factors most essential to client success in SUD recovery?

Program and treatment strategies are listed in the left column. The numbers in the middle column below indicate how many counties indicated that strategy is currently used in their county.

The numbers in the far right column indicate choices within the top four factors that were deemed most essential to recovery.

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<u>Strategies Used to Promote SUD Recovery in your County</u>	<u># of Counties Use This</u>	<u>Deemed Most Essential</u>
Motivational interviewing	43	19
Linkage to primary care clinic for health tests and treatment	40	10
Facilitate a change in the person's culture, to build new relationships, routines, patterns <u>not</u> linked to alcohol or drug use.	38	23
Peer support, mentors or sponsors in the community	37	13
Teaching about activities of daily living	35	4
Transportation to outpatient treatment and therapy appointments	33	12
Case management/ aftercare/ follow-up services and referrals	32	30
Parenting classes	30	2
Medication services	31	13
Job readiness training, vocational services, GED/ college classes, or supported employment	28	14
Classes about nutrition, cooking, exercise, and care of one's own health	27	1
On-site health testing and treatment	26	1
Family treatment and/or family education	24	11
Smoking cessation classes or treatment	21	0
Services more like FSP ¹⁹ or wrap-around services	20	8
Supported housing and recovery residences, SLE	2	9
Collaboration between caregivers and/or having	N/A	6

¹⁹ Full Service Partnership mental health services, programs funded by the Mental Health Services Act.

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co-occurring services under the same roof, including primary care		
Other	17	28

In the second part of this question, respondents were asked to identify the four most important factors for client recovery, of the options listed in the table. Besides those choices, we received a number of responses under the “Other” option, listed below.

- Enhanced services for pregnant and postpartum women with SUD, including childcare and parenting training: 2
- For youth, add family treatment and/or education: 1
- Strength-based approaches: 1
- Appropriate level of care placement: 1
- Complexity-capable services: 1
- Positive genuine engagement with clinic/counselor: 1
- Understanding health concerns with respect to substance use: 1
- Community efforts to provide stigma reduction via law enforcement and medical providers: 1
- Access to alcohol or other drug (AOD) services: 1
- Matrix model: 1
- 12-Step program attendance: 1

In summary, recurring themes cited in the responses to Questions 11, 12, and 13 included “adopting a harm reduction approach with the goal of achieving sobriety in contrast to requiring immediate sobriety,” and a non-punitive “client-centered approach” that meets the client where he/she is on the road to recovery, rather than a rigid “one size fits all” approach.

Finally, we agree with the following perspective in one county’s response to the question about which factors are most essential to client success:

“All of the factors listed. Our belief is that all of the items checked above are essential to success in SUD recovery. The factors that are chosen depend on the individual client’s needs.”

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Prevention Strategies: Coordination of Mental Health and Substance Use Prevention Programs

14. **Prevention.** This last question is about coordinating prevention efforts between different agencies and groups. We believe that prevention and education activities are important to help reduce the number of persons using drugs or abusing alcohol, especially for youth under 18 and young adults.

The evidence shows that prevention efforts are much more effective when coordinated across multiple service systems. Currently, funding for MH efforts have a different source than that for substance abuse prevention²⁰ and therefore must be devoted to mental health. This results in most programs being separate or ‘siloed’ which risks producing fragmented, patchwork efforts and less than optimal outcomes for consumers.

Does your county implement coordinated programs to address prevention of both SUD and mental illness in children, transition-aged youth and young adults?

The numbers below indicate the number of counties that selected a specific response.

No	8
Yes	41

To date, eight counties answered in the negative. However, as some of these respondents included large counties which are well-known to have both SUD prevention programs and MHSA programs for PEI, it appears that the negative response is to “coordination” of prevention programs from the two different systems. A strict view of coordination takes into account the different cultures and targeted approaches for SUD and MH prevention, and the restrictions arising from the different funding sources. Many of those responding took care to emphasize that MHSA funds were not used for non-mental health purposes to assure compliance with regulations.

An example of a thoughtful response to this issue came from Alameda County.

“While there is definite benefit to have coordinated programs, currently [Alameda] BHCS does not jointly fund any MH/SUD prevention programs. The main reason for this is that the definition for ‘prevention’ is different depending on which

²⁰ Examples of programs funded from different sources could include MHSA Prevention and Early Intervention programs or the substance Abuse Prevention and Treatment Block Grant. You may know of others in your community.

funding stream (MH/SUD) you look at. On the SUD side, prevention is defined more narrowly as only 'primary' prevention, meaning services can only be provided to those not in need of treatment, whereas on the MH side, prevention is defined more broadly, e.g. preventing a mental illness from becoming severe or disabling as well as increasing access to underserved populations.

[Alameda] BHCS recognizes that SUD and MH issues may come hand-in-hand, so we have taken the approach in SUD prevention of looking at the risk factors for substance use experimentation, which include many mental health issues such as depression, anxiety and bullying. Because of this approach, BHCS SUD prevention providers are able to weave in MH issues into their programming. Similarly on the MH side, education around SUD issues are also addressed since we know substance use can be a coping mechanism/self-medication tool. So even though BHCS does not fund blended prevention programs (at the moment) the communities we serve do receive both MH and SUD prevention.”

14. (Continued.) If 'yes,' please provide a brief description of the program, target audience, and activities.

The responses below demonstrate that there is a considerable variety of programs and strategies to address prevention for both BH and SUD issues. It is evident that there is an overall commitment to providing coordination of programs and services where possible and practical, and especially to provide integrated care even when coordinated prevention strategies may not yet be feasible.

Here are some of the most common prevention programs²¹ presented by counties in our state. Where possible, the purpose and targeted group are described.

Recovery Assistance for Teens (RAFT)

- Target Population Category - Indicated Youth
- Services- Screening and Referral, Educational Groups

Description- RAFT offers an educational-based approach to work with youth that have had academic, legal, or social consequences for drug involvement but do not meet the criteria for treatment. Youth are placed into weekly educational groups which cover information centered around how to change behavior over an 8 week period.

²¹ Some of these descriptions were taken from Data Notebook reports by Merced, Stanislaus, San Joaquin, Imperial, Orange, San Bernardino and Orange Counties.

Friday Night Live Mentoring (SAPT)/ Middle School Mentoring (MHSA PEI)

- Target Population Category - Selective Youth
- Services- Screening, Alternative Activities, Educational Groups

Description- FNLM is an afterschool mentoring program that uses older youth to mentor younger youth who are struggling in a variety of areas. This program uses the evidence-based curriculum, "Project ALERT!" for its educational purposes.

Club Live

- Target Population Category - Universal
- Services- Alternative Activities, Environmental Prevention

Description- Club Live offers afterschool enrichment activities that provide opportunities for leadership, team building, and community service projects. As a part of the Friday Night Live programs, Club Live is based in the evidence based practice of youth development and follows the Friday Night Live Standards of Practice.

Strategic Prevention Framework State Incentive Grant to Reduce Underage Drinking (SPF SIG)

- Target Population Category - Universal
- Services- Community Mobilization, Environmental Prevention

Description- SPF SIG is a grant-funded operation which brings together community-based service providers, law enforcement and local government agencies to address the core issues in the community that lead to underage drinking. This includes increased enforcement, community social norms, visibility and training.

Prevention Community Wide

- Target Population Category- Universal
- Services- Community-Based Process, Information Dissemination, Education, Screening and Referral, Alternative Activities

Description- This program provides an array of services depending on the needs of the community/agency/family that is requesting assistance and/or support. The Prevention Unit offers workshops, speaking engagements, trainings, program development, consultation and many other services that may assist an agency or community address their concerns with AOD use.

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Strengthening Families Program:

This is a national evidence-based curriculum for youth and caregivers. The aim is to reduce initiation of alcohol in 9th graders and reduce or prevent binge drinking in 11th graders. These primary prevention programs are aimed at youth alcohol use patterns that are part of the population health alcohol prevention strategy that includes healthier neighborhood, stores, etc.

Too Good For Drugs Program:

This program is delivered to middle and high school campuses. Students learn about depression, the relationship between alcohol, drugs, and suicide, as well as learn about their feelings and how to share them.

The Committed Program Model (also, 'Athletes Committed'):

This program blends youth development principles with innovative youth-led environmental prevention strategies and school climate initiatives. The goal is to build leadership skills, broaden young peoples' social network, and implement youth-led projects to reduce youth access to alcohol.

Behavioral Health Promotoras:

SUD and PEI have begun to partner on training support and coordinated efforts for BH *promotoras* to provide education and information to the community about drug and alcohol use, treatment, and prevention efforts.

.....

Finally, other Prevention programs focus on stigma reduction, student mental health, and suicide prevention, and enforcement of laws prohibiting local stores from selling alcohol to minors. In summary, we know from other statewide reports that 54 out of 58 counties have a current substance use prevention plan. Twenty-six counties refer individuals for additional services directly from primary prevention settings to further screening and treatment.

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Summary and Conclusions

Programs funded by SB 82 and AB 109 are making an impact. MHSA-funded PEI and Innovation programs continue to contribute to improved access to services and outreach to underserved communities and improve outcomes for many individuals. In particular, Full Service Partnerships provide the type of intensive support for adults, children and youth that is needed by many with the most severe mental illness or emotional disorders. Supported Permanent Housing programs are helping to reduce homelessness, but it is important to note that the stability and safety of having a place to live also contribute substantially to the affected client's ability to recover from MH and SUD challenges.

The results of the 2015 Data Notebook indicate the most significant areas of need to be facilities for inpatient care and more alternative programming to serve individuals experiencing a mental health crisis especially in the small-population counties. Limited funding, workforce shortages and burnout of the few providers available combine with transportation challenges to limit access to needed treatment by their residents, whether MH treatment, crisis services, or SUD treatment of any type. The rising suicide rates and rates of overdose deaths in many small-population counties are but two measures of the hidden suffering and unmet need. There is an imperative to advocate for sustained state funding to help meet locally-informed solutions and provide sustainable support for facilities such as crisis stabilization units and crisis residential treatment. Additionally, there are too few facilities, MH therapists, or psychiatrists specially trained to treat children, adolescents or TAY in all the counties.

What we see in the wide-ranging programs and services offered in counties across our state is evidence of a statewide behavioral health system in the process of enormous change. Regardless of category of resource or program, there are many, many more than just three years ago. And many counties are employing more programs that have creative or flexible approaches that meet the client where they are in their process or stage of recovery. A large number of programs cited funding from MHSA Innovation programs, MHSA Community Services and Supports, SB 82, and other governmental initiatives such as those for supportive housing of multiple types.

The challenges of integrating the systems of care for mental health and substance use disorders treatment have been considerable and yet we see substantial evidence of concerted, dedicated efforts to meet these challenges. The system of care is succeeding more often at providing integrated care or at least well-coordinated care across systems and provides robust linkages with primary health care. The data

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systems still face considerable hurdles to meet full integration and are constrained by a variety of technological and legal issues regarding HIPAA and privacy regulations.

We have endeavored to present an overview of the most critical needs for mental health and substance use disorders treatment. We see the ongoing needs in rural and small-population counties that still remain as challenges to be met. However, we see hopeful signs of regional collaborations on building and operating various facilities to meet acute MH needs, to grow their workforce and to provide more types of substance use treatment services. Our hope is that we have helped to promote improved services and more regional collaboration by presenting substantial detail about services and programs in each county under the different areas of inquiry posed in this year's Data Notebook project.

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FINAL NOTE OF ACKNOWLEDGEMENT:

Thank you to all who participated by preparing data, engaging in discussion, and completing reports for the Data Notebook project.

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Hope for the Homeless

Effective programs that provide help toward real change

A report from the California Mental Health Planning Council, December 2015

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Introduction:

In September of 2015, Los Angeles declared a “state of emergency” to address the city’s homeless population, the largest in the United States. Homeless counts have revealed that 26,000 people live on the streets of Los Angeles on any given night. City officials have asked for 100 million dollars to provide relief.¹ Before the funding has even been approved there is debate about how it should be spent. Critics say that with past funding the city has prioritized law enforcement efforts to issue citations and remove homeless encampments at the expense of providing more permanent supportive housing (PSH) which is a proven and more sustainable approach to the problem.

This report will highlight promising behavioral health efforts which serve the homeless population in California. Providing effective services such as adequate housing and behavioral health treatment is a significant part of the state’s goal to end homelessness by 2020. California is home to the largest number of homeless youth and adults in the nation. Many programs have been instituted over the past 50 years but the numbers can’t be ignored. Homelessness continues to elude our efforts, strain our healthcare resources, and infuse discouragement in our large cities, suburbs, and rural communities. This report will focus on programs that provide effective behavioral health services for youth and adults. These programs are some of the critical building blocks in the construction of a system that works to keep the most vulnerable sub-groups of homeless Californians safe, secure, and healthy.

In June and October of 2015 the California Mental Health Planning Council (CMHPC) conducted panel presentations involving advocates, consumers, and stakeholders who are connected to the issues of behavioral health and homelessness. The report highlights those discussions and builds upon them by providing examples of other efforts around California and the nation which appear to be promising components in ending homelessness for those with severe mental illness and substance use disorders.

Definition:

The federal government has an official definition of homelessness which was finalized in January of 2012. It states that a person or family is homeless if they fall into one of four categories. The categories are: **Literally homeless:** they lack a fixed, regular, nighttime residence which includes living in a car or temporary shelter program; **imminent risk of homelessness:** an individual who will lose their residence within 14 days; **homeless under other federal statutes:** unaccompanied adults, youth,

¹ World Socialist Website. *Los Angeles Officials Declare “state of emergency” over Homelessness*, September 2015.

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or families with children who have not had permanent housing for the past 60 days; **fleeing or attempting to flee domestic violence.**²

There is an effort underway to create a single definition of homelessness between government agencies. H.R. 5186 would create one definition of homelessness. The rationale for such action would be to ensure that families with children and unaccompanied youth who are at imminent risk of homelessness have the same access to Housing and Urban Development (HUD) funds as other defined homeless persons. In the past, homeless counts conducted by HUD compared with those conducted by the Department of Education show very different numbers. The Department of Education has a higher count of homeless children under their definition than under HUD's. A consistent definition would increase access to HUD funding for children and unaccompanied youth.

Homelessness Statistics:

While it is difficult to obtain an accurate count of the number of people in our country and state who are experiencing homelessness, it is estimated that in the United States 578,424 people lack permanent shelter on a given night. Up to 31% of the total number of homeless lacks any type of shelter or roof over their heads. California has the highest population of homeless at 114,000. This number represents 20% of the nation's homeless.³

Statistics gathered by the Substance Abuse and Mental Health Services Administration (SAMHSA) from January 2010 found that 26.1% of those being sheltered had a severe mental illness compared to 4-6% in the general population. Those with chronic substance use issues represent 34.7% of the homeless population.⁴ It is widely reported that up to 40 percent of homeless youth identify as LGBTQ. Youth typically move to the streets due to conflict with their families, disagreements with foster families, or because they have aged out of the foster care system. The National Alliance to End Homelessness estimates that each year 550,000 single youth and transition age youth have experienced a homeless episode of up to one week.⁵ California has the largest number of veterans experiencing homelessness at 12,096. This number makes up 24% of the nation's total number of homeless veterans.⁶

The statistics demonstrate California's unique challenge, but it also presents the opportunity to provide leadership in the effort to bring an end to homelessness for youth and those with mental illness or substance addiction.

² Housing and Urban Development. *Hunger and Homeless Coalition of Collier County*. January 2012. www.collierhomelesscoalition.org.

³ Housing and Urban Development. *Homeless Statistics: 23 Facts to Know Before You Sleep Tonight*. January 2014.

⁴ Substance Abuse and Mental Health Services Administration. July 2011.

⁵ National Alliance to End Homelessness, <http://www.endhomelessness.org/pages/youth>.

⁶ Department of Housing and Urban Development. *Annual Homeless Assessment Report to Congress*. October 2014.

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History of Homelessness:

According to John Foran of Praxis Housing we can find references to the homeless as far back as the book of Amos in the Old Testament. Most Western religions speak of the homeless and encourage followers to feed the hungry and clothe the naked. For the first 1300 years AD, the homeless were largely cared for by the church. But in 1349, the plague changed people's thinking about their interactions with the homeless for fear of becoming sick. It was at this time that people avoided those who wandered from town to town. This is when laws regarding the homeless came into effect and different definitions for the homeless emerged i.e. "unemployed, lusty rogues, shiftless beggars, jugglers, minstrels, and thieves." For the next 500 years the government took on the responsibility of helping the homeless. In England they had work houses which you read about in Dickens' books, Oliver Twist, and Hard Times. There were often small servings of food, poor conditions, and limited help for those housed there.

In the 1800s the United States became an industrialized nation until the 1970s. The time of heavy industry was economically strong but it was also unstable and there were several periods of economic depression and job loss which led to homelessness. In this period of time, homeless people with mental or developmental disabilities were hospitalized against their will. In 1967, California Governor Ronald Reagan signed into law the Lanterman-Petris-Short Act. This law ended commitment of the mentally ill to state hospitals except in the case of criminal sentencing. Some believe that this decision led to a sudden increase in homelessness for people with mental illness as state hospital staffing was drastically cut and no increase in funding for community-based programs occurred. Homeless persons were often blamed for their own plight. It wasn't until 1975 that people began to recognize that homelessness could happen to anyone. Although the phrase "pull yourself up by your own bootstraps" remained popular throughout the 1980's.⁷

As the United States moved from an industry economy to a service economy many people experienced unemployment. At this time, the homeless were introduced to drug use which became both a cause and result of homelessness as it is today. In 1975, journalist Geraldo Rivera investigated Willowbrook, a New York mental hospital for children and adults. The conditions were sub-standard and his report gained the attention of the American people. Hugh Carey, the NY state governor, took action and began to set up supportive housing in communities. While the idea was a good one, thousands of people were released from mental hospitals without secure housing. Implementation of the housing component was slow and resulted in 25,000 people becoming homeless.⁸

⁷ "Pulling Yourself Up By Your Own Bootstraps": An Etymology of an American Dream, May 2011.

⁸ Foran, John. Praxis Housing CEO. www.youtube.com. March 2008.

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The McKinney-Vento Homeless Assistance Program was enacted in 1987. The Act which was named after Representatives Stewart B McKinney and Bruce Vento includes a set of homeless programs administered through the Department of Housing and Urban Development (HUD). The McKinney-Vento Act was the first federal response to homelessness. The act was created after the public demanded that homelessness be acknowledged on a national level. The original Act included fifteen programs that addressed issues such as job training, emergency shelter, health care, and some permanent housing. The Act has been amended several times since 1987. In 1990 it was amended to include two vital programs, Shelter Plus Care which provides housing assistance to people with disabilities, and Projects for Assistance in Transition from Homelessness (PATH). In 2009, Congress passed, and President Obama signed, the Homeless Emergency Assistance and Rapid Transition to Housing Act (HEARTH) which amended and reauthorized the McKinney-Vento Act.⁹

In 2004, California voters passed Proposition 63, called the Mental Health Services Act (MHSA). This law has generated over 14 billion dollars since its inception. The funds are provided to enhance the mental health services in California. The MHSA program provides Permanent Supportive Housing to homeless persons who have serious mental health disorders. This report will highlight the MHSA Housing programs in California and how they benefit homeless people who have mental illness.

For the past 30 years there has been significant movement toward finding solutions for homeless youth and those with mental illness. However, the number of people experiencing homelessness in California is substantial and can no longer be ignored. Innovative and effective programs that target specific homeless populations will be highlighted here in order to further the conversation about what is working and what California could implement going forward.

Critical Components:

Programs that serve homeless youth and homeless persons with behavioral health disorders consist of four critical components that, when integrated, can produce effective results. These four components are prevention, outreach, permanent or transitional housing, and reintegration.

1. Prevention:

Can homelessness be prevented? According to the US Interagency Council on Homelessness, assistance with rental housing is the most direct and effective tool to prevent homelessness in adults with behavioral health issues and their families.¹⁰ Emergency Solutions Grants (ESG), through the HEARTH Act, provides funding to subsidize rent payments for no income or very low income individuals

⁹ National Coalition for the Homeless. McKinney-Vento Act. Fact Sheet. June 2006. www.nationalhomeless.org/publications/facts/McKinney.pdf

¹⁰ United States Interagency Council on Homelessness., *Explore the Solutions Database*. January, 2013.

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and families. Permanent supportive housing has been demonstrated as effective in reducing the number of people who return to homelessness by providing mental health and substance use services along with subsidized housing. For adults with behavioral health disorders, connection to Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI) is a critical service that can prevent chronic homelessness by providing a steady, albeit modest, income to individuals deemed to be disabled. In California it has been recognized that many homeless persons are not taking advantage of Medi-Cal eligibility which could improve their health through management of chronic diseases such as diabetes, asthma, or heart disease.¹¹ Connecting homeless individuals with these necessary financial and healthcare resources is an important step in improving the overall health of those who are homelessness.

“Teachers must be alert to the signs that a child is homeless, since these youth face a variety of challenges and experiences that put them at risk for a range of physical, mental, and academic problems.”

For homeless youth the most effective prevention method is family reunification services with on-going support. Runaway and homeless youth (RHY) ages 14-18 typically end homelessness by returning to their families. “Family conflict and abuse are consistently identified by unaccompanied homeless youth as the primary reason for their homelessness.”¹² Because of this, effective programs address these family systems issues and provide support to all family members in order to ensure that it is safe for youth to return. The primary goal is to return youth to their families or extended families before pursuing longer term youth housing programs.

Schools can play a vital role in early intervention efforts. “Teachers must be alert to the signs that a child is homeless, since these youth face a variety of challenges and experiences that put them at risk for a range of physical, mental, and academic problems.”¹³ For high risk homeless youth, those who are 18-24 years of age or who have serious behavioral health issues, the best methods to prevent chronic homelessness is to connect them with permanent supportive housing which can address their mental health, substance abuse, and life skills development in one location. According to the National Alliance to End Homelessness, “it would be important that these programs have limited barriers to entry and minimize rules that would result in ejecting youth from the program in order to keep them off of the streets.”¹⁴ This is a “harm reduction” strategy. The prevention of homelessness starts with getting and keeping youth off of the streets. If programs have a black or white, inflexible, or judgmental view towards drug use, youth who are using drugs will fail in these programs and not receive the help they need.

¹¹ California Healthline, “Many California Homeless Not Taking Advantage of Medi-Cal Eligibility”, March 2014.

¹² *Ending Youth Homelessness Before it Begins: Prevention and Early Intervention Services for Older Adolescents*, August 2009.

¹³ *Homeless Youth In Our Schools, Identifying and supporting a marginalized and victimized population*, Poland, March 2010.

¹⁴ National Alliance to End Homelessness. *An emerging Framework for Ending Unaccompanied Youth Homelessness*. March 2012.

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The California Fostering Connections to Success Act (AB12) went into effect in January 2012. The Act was designed to address the growing number of aged out foster youth who were experiencing homelessness at a much higher rate than other youth. This program allows foster youth to remain in extended foster care from 18-21 years of age if they are finishing high school, enrolled in college or trade school, working part time, in a program to train for work, or they have a medical condition that would not allow them to meet the criteria. This program prevents homelessness in former foster or probation youth by allowing them additional time to finish schooling or obtain the skills necessary for independence.

It is estimated that people with untreated psychiatric illnesses make up one-third of the homeless population.¹⁵ For people with serious mental illness, prevention efforts must begin at the first sign of psychosis. While schizophrenia or bi-polar disorder may not be avoidable conditions, it is possible to prevent deterioration in those who suffer with these diagnoses. If symptoms are recognized in the early stage, young people can be engaged in mental health support services which could prevent them from becoming homeless. Psychotic symptoms are generally first recognized in people between 18 and 22 years of age.¹⁶ For this reason, former Senate Pro Tempore Darrell Steinberg has recently shed light on the issue by encouraging more funding for mental health services in the UC, State, and community college systems.¹⁷ This is a good start and at some point it will be helpful to explore how employers, military personnel, and trade school representatives could be informed about the symptoms of early psychosis so that services could be delivered to the approximately 35% in this age group who are not in college but have gone to work, trade school, or the military.

2. Outreach:

“Outreach seeks to establish a personal connection that provides the spark for the journey back to a vital and dignified life.”¹⁸ For homeless adults with mental illness and youth who may have grown to mistrust others, outreach and engagement services may be difficult and perplexing. The following are just some of the components of successful outreach and engagement services to the homeless.

- Designed to treat the whole person
- Respect for the client is critical
- Relationship building is of utmost importance
- Respect for culture
- Meeting basic needs such as food, shelter, and clothing

¹⁵ Nieves.E. *Fed Up, Berkeley Begins Crackdown on Homeless*. New

Ohlemacher S. Study: 744,000 homeless in U.S. Associated Press archives, January 10, 2007, <http://www.ap.org/>, last accessed March 28, 2011. York Times, November 3, 1998, p. A19

¹⁶ NIH, News In Health. *Recognizing Schizophrenia*, May 2011.

¹⁷ Steinberg, D. *Time to adjust California's Mental Health Services Act*. September 2015 <http://www.sacbee.com/opinion/oped/soapbox/article36452658.html>

¹⁸ Bassuk, The Open Health Services and Policy Journal. *Definitions of Outreach and Engagement*. 2010.

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- Coordination of services
- Involvement of consumers or formerly homeless
- Safety, boundaries, and ethics
- Designed to serve people who have difficulty accessing services
- End goal is integration into the community¹⁹

Outreach takes place in many different settings i.e. emergency rooms, the streets, and homeless encampments. Workers typically move out in pairs to make initial connections and bring essentials like food, water, socks, sleeping bags, and information about local services. If done well, rapport is built over time and services are delivered in a respectful and non-judgmental way. It is important to consider the reasons why some homeless people with mental illness refuse any type of assistance with shelter. A review of several articles found varied reasons for shelter refusal:

- Psychosis which creates paranoia toward helpers
- They want to bring all of their belongings but are told they can't
- They see "home" as an unsafe place where they were previously abused or mistreated
- Past experiences of physical abuse in shelter programs
- Prevalence of theft in shelters
- Burdensome shelter rules
- Past experiences with sexual assault in a shelter
- They can't bring their animals
- They have a drug/alcohol dependence and think that the shelters won't allow it
- They prefer isolation
- The shelter itself represents the shame of their situation
- Contagious disease, bed bugs and lice in shelters
- There aren't enough beds available in local shelters
- Shelters become targets for drug sellers
- Too much fluorescent light
- They're treated like children by shelter staff
- People try to persuade them to adopt their religion
- They'll be separated from their homeless friends who support one another

In San Francisco, this issue was considered and the Navigation Center was launched. The goal of the Navigation Center was to create a different kind of shelter with fewer barriers. People are welcome to bring their "three Ps" with them; pets, personal belongings, and partners.²⁰ So far the plan is working.

¹⁹ Homeless Resource Center. *Assessing the Evidence: What We Know About Outreach and Engagement*. 2007.

²⁰ KQED. San Francisco Hopes New Shelter Program Impresses Tech Sector. July 2015 [ww2.kqed.org/.../san-francisco-hopes-new-homeless-shelter-impreses](http://www.kqed.org/.../san-francisco-hopes-new-homeless-shelter-impreses).

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Another hurdle to overcome in regards to service delivery is the criminalization of homelessness. Because the homeless have been arrested for sleeping or resting in public areas there exists a certain degree of mistrust and fear. Outreach is an important step in the effort to de-criminalize homelessness. Furthermore, the United States Interagency Council on Homelessness recommended that police officers be involved along with outreach workers in the effort to connect the homeless to services.²¹ Youth can be difficult to engage in outreach efforts because they fear being arrested for running away or eventually returned to a home that may have been abusive. For this reason youth outreach workers practice consistency and patience without judgement in order to see results. In September of 2015 the Department of Housing and Urban Development stated that they will now consider a community's efforts to prevent the criminalization of the homeless when they award \$1.9 billion in new homeless assistance grants later this year.

In fully integrated health care outreach, clinicians, physicians, nurses, and program staff are involved on the teams to bring critical health care services to the homeless. This model increases penetration rates for the homeless into health care programs. It is difficult to quantify outreach efforts. As a result, it becomes difficult to keep them funded. Highlighting the financial benefits of outreach would increase the feasibility of such programs and ensure that they remain a vital component of the larger plan to end homelessness.

3. Housing First and Permanent Supportive Housing:

Permanent Supportive Housing (PSH) programs provide disabled individuals and/or families with the rights of tenancy in a long term housing unit of their own. In other words they are free to stay as long as they want if they are able to fulfill the terms of their lease, i.e. paying their rent on time. The program includes supportive services which are voluntary and offered on site. This is a “housing first” approach which delineates itself from other programs that offer support services but do not offer housing. A housing first approach is defined as “an approach that centers on providing homeless people with housing quickly and then providing services as needed.”²²

The greatest challenge to a “housing first” approach is the lack of available supportive housing units. Waiting lists often require people who are homeless to call in each day to check in and secure their place on the list. For clients who experience severe mental illness or substance use disorders, this requirement can become too burdensome and can create a barrier to assistance. The “Housing First-San Diego” three year plan seeks to dramatically grow the number of affordable housing by renovating a 72 unit downtown hotel, awarding 30 million dollars to programs that will grow permanent supportive housing, and by utilizing 1,500 federal government vouchers for rental housing.²³ This type

²¹ United States Interagency Council on Homelessness. *Searching Out Solutions, Constructive Alternatives to the Criminalization of Homelessness*. 2012.

²² National Alliance to End Homelessness. What is Housing First? November 2006

²³ San Diego Housing Commission. Housing First-San Diego. November 2014. www.sdhc.org/Special-Housing-Programs.aspx?id=7616

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of plan has promise because if cities and counties have housing units available, they can successfully implement a “housing first” model.

The belief behind PSH is that people with behavioral health issues will not benefit from services until a safe, steady place to sleep each night is acquired. Once the basic needs of safety, warmth, and health care are met the important supportive services can begin. “The difference is that they can access, at their option, services designed to address their individual needs and preferences. These services may include the help of a case manager or peer counselor. They receive help in building independent living and tenancy skills, assistance with integrating into the community, and connections to community-based health care, treatment, and employment services.”²⁴ The use of peer counselors in these programs is vital to its effectiveness. When people recover, they are often times the most effective resources to provide outreach services and keep others engaged in recovery.

It costs \$16,282 per person in a housing unit year round. When all the costs of supportive housing and public services are considered, it costs the public only \$995 more a year to provide supportive housing to a mentally ill individual than it does to allow him or her to remain homeless. University of Pennsylvania

The cost of providing PSH units may seem exorbitant. However, the National Alliance to End Homelessness in a 2015 report cited a University of Pennsylvania study which found that PSH provided a major reduction in costs associated with caring for homeless persons with mental illness. “It costs \$16,282 per person in a housing unit year round. When all the costs of supportive housing and public services are considered, it costs the public only \$995 more a year to provide supportive housing to a mentally ill individual than it does to allow him or her to remain homeless.” Living on the streets deteriorates the physical and mental condition of homeless individuals and leads to the inefficient and costly use of public health, mental health, and law enforcement services.²⁵ In 2009, Michael Cousineau of the Keck School of Medicine of USC conducted the “Homeless Cost Study” which found that placing four chronically homeless persons in PSH saved taxpayers \$80,000 per year.²⁶ When the most vulnerable homeless are permanently housed, significant cost savings are found in the areas of health care, emergency room visits, overnight stays in hospital beds, and law enforcement expenditures. According to Daniel Flaming of the Economic Roundtable, “The key finding from our study is that practical, tangible public benefits result from providing housing and supportive services to vulnerable homeless individuals. Public costs are reduced by 79 percent and the quality of life for homeless persons is improved.”²⁷

²⁴ United States Interagency Council on Homelessness, *SAMHSA 2010 Annual Report*. 2010.

²⁵ National Alliance to End Homelessness, *Permanent Supportive Housing*, 2015.

²⁶ Lewit, M. *Sheltering Homeless Saves Money, Study Says*. 2009.

²⁷ Examiner.com. *Housing Homeless People reduces costs for Los Angeles taxpayers*. 2010.

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Housing for youth ages 16-24 requires a different approach. Homeless youth often reunite with families, but when they don't and they end up experiencing chronic homelessness, the housing approaches must adjust to meet the specific needs of youth. In the United States, 50,000 youth sleep on the streets for 6 months or more.²⁸ Effective youth housing programs not only house youth but also provide Positive Youth Development (PYD). For youth who are chronically homeless we can assume that they have no supportive family or friend network willing to take them in and lead them toward successful adulthood. Because of this, PYD provides much needed guidance in the areas of cooking, relationships, school attendance, paying bills, caring for children, and establishing goals. PYD is strength-based in that the programs don't focus on the problems a youth may have but on their unique abilities. PYD is trauma informed as it recognizes the significant emotional, social, and physiological effects of trauma on the lives of people and is aware of the high rate of trauma experiences in this age group. Successful programs not only recognize trauma, but have services available for depression, anxiety, drug and alcohol use, chronic health conditions, and past physical/emotional abuse.

Youth housing options are provided in steps, depending on the age and independence level of the youth. These housing level options are emergency shelter, community-based group home, shared houses, supervised apartments, and scattered-site apartments. At each level there is an effort to assess needs, provide services, and implement PYD approaches.²⁹ Within these layers of housing exists programs to assist transition age youth (TAY). These programs are called Transitional Housing Programs (THP) or Transitional Living Programs (TLP).

The more information we obtain about homeless youth the better we'll be able to address specific needs with the most effective approach. It wasn't until 2013 that HUD asked communities to count unaccompanied homeless youth. In their 2014 Annual Homeless Assessment report, a point-in-time snapshot count across the country found 194,302 homeless youth on a single night. 45,205 of those youth were unaccompanied and represented 8% of all homeless people on that night in January 2014.³⁰ It is likely that the reported number of unaccompanied homeless youth is lower than the actual number. This is because youth on the streets avoid police contact and find places to shelter i.e. friend's houses, and cars. A Government Accounting Office (GAO) report estimated that only 1 in 12 unaccompanied youth ever come into contact with a shelter system. Obtaining accurate reports will help us to design housing options for the most vulnerable homeless youth.

4. Reintegration:

Webster's defines reintegration as: "to integrate again into an entity, to restore to unity."

²⁸ National Alliance to End Homelessness, Youth, www.endhomelessness.org/pages/youth

²⁹ Ibid.

³⁰ Department of Housing and Urban Development. *Annual Homeless Assessment Report to Congress*. October 2014.

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Reintegration of people who are experiencing homelessness assumes that those people have been removed from an entity or community, and need to be re-connected to that community. This final component of reintegration is critical. If those who are homeless, and living with mental illness, have been separated out and are not reconnected back into their local communities, they run the risk of isolation while the community at large runs the risk of remaining uninformed about their potential contributions to the community.

“The obstacles and difficulties the mentally ill face builds courage, strength and endurance. It is the resilience of survivorship. This group remarkably and unexpectedly did well after the tragedy of 9/11 as compared to other groups. Its members exhibited remarkable strength and courage based on the very difficulties they have encountered because of their illness.”

Walder, N. *The Ghettoization of the Mentally Ill*. 2012.

For homeless people who are young or who have a serious behavioral health issue, reintegration is a thread that can run through the other critical components; prevention, outreach, and housing. The goal of effective reintegration efforts is to assist consumers as they recover and then re-enter the larger community. The Center for Reintegration describes it as “the process by which a person with a mental illness finds meaningful work, restores his or her relationships, and moves toward independent living”.³¹ Often times, relationship breakdown and loneliness precede homelessness. Whether a divorce, job loss, family conflict, or untreated mental illness, these events can become the catalyst to isolation and eventual homelessness. Loneliness and isolation can also be the cause of failed re-housing efforts. “Crisis”, a national charity for single homeless people, claims “Isolation and loneliness are also commonly experienced after people have been re-housed into permanent housing and are often linked to tenancy breakdown and repeated episodes of homelessness. One in four formerly homeless people find themselves unable to sustain a tenancy, with loneliness and isolation the main causes of this.”³²

The double stigma of having a mental illness and being homeless is difficult to overcome. However, if housing programs make it a priority to get consumers connected to others, outside of the mental health arena, they may fare better and end the cycle of homelessness. Job assistance, friendship development, and community living skills are an important piece in the step by step process of recovery.

Funding Streams:

The funding of homeless programs for youth and those with serious mental illness comes from several different sources. Non-profit organizations and churches benefitting the homeless receive funding through fundraising efforts, federal, state, and local grants; while states and counties receive funding

³¹ The Center for Reintegration. *Back to Work, Back to Life*, www.reintegration.com/center, 2003.

³² Crisis, “*Relationship Breakdown and Loneliness*.” www.crisis.org.uk/pages/relationship-breakdown-and-loneliness.html. 2012.

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from federal and state government programs. Some of the major funding streams are the Department of Housing and Urban Development (HUD), Projects for Assistance in Transition from Homelessness (PATH), Mental Health Services Act, (MHSA Housing), and Substance Abuse Mental Health Services Administration (SAMHSA).

HUD:

HUD expends the funding from the McKinney-Vento homeless grants which are the federal government's primary fiscal response to homelessness. This program consolidated three programs, Shelter + Care, Supportive Housing, and Section 8, into one Continuum of Care program. The program was reauthorized in 2009 through the Homeless Emergency Assistance and Rapid Transition to Housing Act (HEARTH). Shelter + Care is recognized as a promising program that works. In this model, people are not only sheltered, but they are provided with the support needed to find more permanent housing, employment, and benefits. Many homeless people with severe mental health issues do not have the skills necessary to complete forms, meet with landlords, and fully understand the rules and agreements around housing. Shelter + Care provides a warm hand-off to more permanent housing options while shelter is being provided.

The Homeless Prevention and Rapid Rehousing Program (HPRP) is also funded out of the HEARTH Act. "Rapid re-housing is a cost-effective strategy to help families successfully exit homelessness and maintain permanent housing by integrating three components: employment assistance, case management, and housing services."³³ Rapid re-housing programs provide assistance to individuals or families with move in expenses such as first and last month's rent, as well as rent subsidies which make housing affordable to low income families. The reauthorization simplified the fund matching requirements and consolidated the grant programs. Every year this funding serves one million people who are in emergency shelters, transition programs, or permanent supportive housing. In fiscal year (FY) 2014 California communities received 307.5 million dollars in HUD, Continuum of Care Homeless Assistance Grant funding.³⁴ In FY 2015 funding for the entire program was authorized at \$2.145 billion, and the FY-2016 proposed budget calls for \$2.48 billion.³⁵

PATH:

The California Department of Health Care Services (DHCS) administers the federal funding that comes through the SAMHSA/PATH formula grant. The PATH grant funds community outreach efforts, as well as mental health and substance abuse referral and treatment. It also funds case management services as well as housing services for the homeless who are mentally ill. In FY 12-13 42 California counties

³³ National Alliance to End Homelessness. 2012. Rapid re-housing: Successfully ending family homelessness. Retrieved from: <http://www.endhomelessness.org/library/entry/rapid-re-housing-successfully-ending-family-homelessness>.

³⁴ <https://www.hudexchange.info/onecpd/assets/File/2014-california-coc-grants.pdf>.

³⁵ HUD Exchange. HEARTH Act information. 2014. <https://www.hudexchange.info/homelessness-assistance/hearth-act>

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participated in the program which served 8,300 persons annually.³⁶ Not all counties elect to participate in the PATH Homeless grants.

MHSA:

The MHSA Housing Program is supported by two main funding streams within the Community Services and Supports portion of the act. The MHSA Housing funds offer permanent financing and subsidies toward the development of properties to be used for permanent supportive housing (PSH) programs. The support services such as case management, treatment, and peer support services are offered through the Full Service Partnership (FSP). FSP funds can also be used to fund outreach, engagement, and rent subsidies.

Since 2007, 400 million dollars has been provided to counties for the construction of permanent supportive housing units. Funding amounts received by counties was determined by population and represents the largest sum of money provided to California counties to successfully address the needs of the homeless who have a severe mental health challenge. Each county is provided additional MHSA funds each month for housing and support services.

PSH sites such as motels are redeveloped into several living units with community meeting rooms. The housing options are both rental and shared housing, and serve people who have serious mental illness, are homeless, or at risk of homelessness. Tenants must meet this MHSA Housing Program target population description. The program is administered by the California Housing Finance Agency (CalHFA) as well as DHCS under an interagency agreement. Other funding sources can be joined together with MHSA Housing funds to maximize funding and subsidies. This is especially helpful in difficult economic times when people struggle to find affordable housing. MHSA Housing had a goal for 2013 to produce 2,530 units.³⁷ As of March 2015, MHSA has funded 1,860 units.³⁸

The CMHPC talked with consumers, service providers, and developers of some of the MHSA programs which is discussed later in this report.

SAMHSA:

The Substance Abuse and Mental Health Services Administration's (SAMHSA's) Center for Substance Abuse Treatment (CSAT) provides Grants for the Benefit of Homeless Individuals-Services in Supportive Housing (GBHI-SSH). This fund supports the development of programs which treat drug and alcohol abuse as well as co-occurring disorders as a part of their overall homeless support services. It also funds permanent housing for veterans and other individuals who are experiencing homelessness. It is SAMHSA's goal to increase the number of individuals enrolled in permanent housing programs that support recovery from drug or alcohol abuse. Another goal is to support efforts to engage and connect

³⁶ California Department of Health Care Services. *PATH*, [www.dhcs.ca.gov/Services/Mental Health/Pages](http://www.dhcs.ca.gov/Services/MentalHealth/Pages) 2015.

³⁷ Mental Health Services Act Housing Program. www.dhcs.ca.gov/services/MH/Documents/MHSATermSheet.pdf. 2011.

³⁸ DHCS. MHSA Housing Program Semi-Annual Update. March 31, 2015.

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clients who experience substance use or co-occurring substance use and mental disorders to the resources available to them through health insurance, Medicaid, and other benefit programs like SSI/SSDI.³⁹ This is an important component for funding because many homeless individuals and young adults with mental illness are not enrolled in the Medi-Cal program. California Health Line reports that many homeless individuals do not enroll in or use Medi-Cal coverage because of discomfort with medical settings, lack of understanding about how to sign on, and the difficulty they have in providing the required paperwork.⁴⁰

Veterans:

Veterans make up 11% of the homeless adult population in the United States. In California, 63% of the state's homeless veterans were living in unsheltered locations based on HUD's 2014 Annual Homelessness Assessment report.⁴¹ California is one of only five states where the majority of homeless veterans live without shelter. San Jose had the highest rate of unsheltered veterans at 71%.⁴² According to the US Interagency Council on Homelessness, about half of homeless veterans have serious mental illness, typically PTSD or bi-polar disorder, and 70 percent have substance use disorders.⁴³

The good news is that homelessness among veterans has declined dramatically in California since 2009. This may be due in part to two programs which directly benefit veterans, the Veteran's Bond Act (VBA) and HUD's Veteran's Affairs Supportive Housing (HUD VASH). Past efforts such as the VBA attempted to assist veterans in purchasing homes of their own. However, this was implemented in 2008 when the economy was in major recession and few veterans were able to take advantage of the program. In 2013, Proposition 41 allowed the VBA to be restructured to fund multi-family housing units.⁴⁴ Supportive housing options and housing-first programs are proven methods for addressing homelessness for veterans with mental illness, but where to put these units becomes an issue in some counties such as Santa Clara where land is very expensive.

In October of 2014, Phase I of the Mather Veteran's Village broke ground. When completed, the project will provide housing and supportive services for up to 160 veterans. Phase II of the project received funding from the Veteran's Housing and Homeless Prevention Bond Act or Proposition 41.⁴⁵

³⁹ SAMHSA. *Grants for the Benefit of Homeless Individuals-Services in Supportive Housing*, 2015.

⁴⁰ California Healthline. *Many California Homeless not Taking Advantage of Medi-Cal eligibility*, 2014.

⁴¹ Department of Housing and Urban Development, *Annual Homeless Assessment Report to Congress*. 2014.

⁴² Ibid

⁴³ USICH. *Opening Doors: Homelessness Among Veterans*, 2011.

⁴⁴ Veteran's Housing and Homelessness Prevention Program. *Proposition 41 fact sheet*. Cal Vet. 2015.

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This project is unique in that it is being built within walking distance of the VA hospital at the former Mather Air Force Base. When all behavioral health support services are added, it will provide an integrated and comprehensive program to address the significant health needs of veterans who experience homelessness or at risk for becoming homeless.

In Phoenix, Arizona and Salt Lake City, Utah supportive housing programs for veterans have worked. In 2011, Phoenix counted 222 chronically homeless veterans with mental, physical or substance use disorders. In 2014, they announced that they had successfully housed the final 56 chronically homeless veterans in their city.⁴⁶ Salt Lake City followed shortly afterward declaring in December of 2014 that they had ended chronic homelessness for veterans. For these cities, the veteran population was the best place to start, considering that they often have co-occurring disorders, can draw from multiple sources of funding, and have significant public support, as most people find veteran homelessness unacceptable.

Older Adults:

Homelessness among older adults is rising and will continue to rise over the next 20 years due to a decrease in affordable housing and a growing elderly population. The population of homeless older adults in the United States is expected to double in size by 2050.⁴⁷ This often ignored population of homeless individuals will become more pronounced. Innovative approaches will become more necessary as we address the issue going forward. Research shows that when individuals lose their housing at an older age or have co-morbid conditions, they are far more likely to experience chronic homelessness.⁴⁸ When older adults become homeless, they experience significant health related challenges that often go unmet. “Older adults who are experiencing homeless have three to four times the mortality rate of the general population due to unmet physical health, mental health, and substance use treatment needs.”⁴⁹

For this reason, it will be important to consider three factors in the discussion of homelessness of older adults. First, prevention efforts such as rapid re-housing will need to be available to the elderly population when they are not able to maintain their current residences. Second, as more funding becomes available for permanent supportive housing, the significant health needs of the elderly will need to be addressed in these settings by providing support services that focus on physical health. It may be necessary to designate more PSH reserved for and serving only

⁴⁵ Sac County News. Mather Veteran’s Village Phase I Celebrated. www.saccounty.net/news/latest-news/Pages/Mather-Veterans-Village

⁴⁶ Phoenix Becomes First City to End Chronic Homelessness. Think Progress. Scott Keyes. December 2013. Thinkprogress.org/economy/2013/12/23/3099911/phoenix-homeless

⁴⁷ Homeless Research Institute. Demographics of Homelessness Series: The Rising Elderly Population. M William Sermons and Meghan Henry. April 2010.

⁴⁸ Older Homeless Adults. Can We Do More?. Margot Kushel MD, November 2011.

⁴⁹ Premature mortality in homeless population: A review of the literature. J. O’Connell. 2005. <http://www.nhchc.org/PrematureMortalityFinal.pdf>

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seniors. Lastly, providing PSH to older homeless adults could result in tremendous cost savings, above and beyond any other age group, and should be factored into the community discussions and planning efforts.

Promising Programs:

While we seem to be on the cusp of some promising ideas in resolving the problem of homelessness, there is still much to consider. The issue is complex and will require innovation among California's advocacy groups, consumers, mental health stakeholders, and legislators. Toward this goal, the California Mental Health Planning Council (CMHPC) held two separate panel discussions to identify what is working and to outline areas that need improvement. The panels consisted of the following representatives from non-profit organizations, county programs, and housing project members:

Ky Le, Director of Santa Clara County Office of Supportive Housing

Sparky Harlan, CEO of the Bill Wilson Center

Dr. Vitka Eisen, CEO of HealthRIGHT 360

Renee McRae, Personal Service Coordinator III from Turning Point

Richard Brown, Resident Services Coordinator from TLCS.

Holly Wunder-Stiles, Director of Housing Development, Mutual Housing of California

Michael Robinson, Turning Point/Wellspace MHSA Housing member

Regina Range, TLCS, MHSA Housing member

Santa Clara County Office of Supportive Housing

Mr. Le noted that there has always been a strong correlation between mental illness and homelessness. Some of the other major factors leading to homelessness are low income, no affordable housing and few supportive services. He has observed that many solutions and strategies have been tried but these strategies have failed because they don't focus on housing. He believes that resources are often directed to affordable housing but not supportive housing. He recommends that resources should fund three main strategies:

- Residential care, and other options for Permanent Supportive Housing
- Rapid re-housing using temporary income supports
- Homelessness prevention.

Mr. Le supports the idea of MHSA Housing funds being used to develop more supportive housing units and highlighted the importance of the mental health departments reserving them for the serious mentally ill by controlling the wait lists.

The Bill Wilson Center

Ms. Harlan stated that the focus and vision of the Bill Wilson Center is to prevent poverty and

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homelessness through support of youth and families. They accomplish this by connecting them to supportive services. She stated that it is often the case that different homeless populations such as chronically homeless adults, veterans, and youth have competing needs and that the limited resources create a need to prioritize efforts. The BWC is a national trainer for Family Advocacy Services (FAS), a homelessness prevention program that includes caseworkers placed at schools to help families at risk of losing their homes. Many of the families are immigrants, some monolingual speaking languages other than English. The program measures outcomes by how the children perform in school, since homelessness, or the threat of homelessness, is known to lead to low attendance and poor grades. The Bill Wilson Center has intentionally focused on winning the trust of the community through outreach efforts as well as a practice of hiring peers as mentors. This has led to many individuals and families self-referring for assistance. Peer counselors are a vital resource for service delivery to the homeless population.

HealthRIGHT360

Dr. Eisen is the CEO of HealthRIGHT360, an agency which encompasses several entities, including Walden House and the Haight Ashbury Free Clinic. But, before she was CEO she was a client in the program which now provides services in 7 counties: Santa Clara, San Mateo, San Francisco, Los Angeles, Orange, Imperial and San Diego. The focus is on integration of services for substance abuse treatment, mental health care, and primary care. The agency runs four Federally Qualified Health Centers where 70% of the clientele are homeless. HealthRIGHT360 houses approximately 1000 people statewide, and provides services in jails and prisons as well. Many of the 800 employees are consumers, who inspire the clients through their own experience. Volunteers run a hotline that receives over 30,000 calls per year, as well as a Teen Chat line.

Thirty years ago the CEO was herself a client who received residential treatment for two years through public funding until she was stabilized, had income, and housing. Dr. Eisen stated that in this program, no one was transitioned until all 3 conditions were met. Today she stands as a great example of the effectiveness of peers as supporters and advocates. Dr. Eisen advocates for those with drug dependence issues by highlighting that SUD has become criminalized, and as a result, those addicted to drugs are seeking treatment less often. This has led to clients becoming much more sick with chronic diseases, mental illness, unemployment, and are often incarcerated. While the Affordable Care Act has provided more people with Medi-Cal treatment, she believes that there is a major shortage of housing designed specifically to support those with SUD dependence.

Mutual Housing of California

Mutual Housing, the first organization in the state to apply for MHSA capital funding, developed Mutual Housing at the Highlands. This permanent supportive housing project has 33 studio and 1-BR apartments designated for people who have a mental illness and are homeless. The MHSA

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housing units are part of the larger apartment complex which has a total of 90 apartment homes. Holly Wunder-Stiles is the Director of Housing Development and shared information with the Council on the pre-opening planning process and the importance of ongoing communication between the property manager, property owner, social services coordinator, and tenant. The importance of this collaboration was said to be critical in the success of the program. Ms. Wunder-Stiles stated that *“Case management needs to learn about property management, and property management needs to learn about case management.”* The number of evictions due to behaviors stemming from mental illness are significantly decreased when there is on-going cross collaboration between these two entities. *“We don’t build housing and walk away.”* Property managers and case managers meet weekly to discuss any issues that may jeopardize the housing of a tenant.

The economics of permanent supportive housing must also be considered. Ms. Wunder-Stiles believes that the program is working because of three important functions. Proposition 63 allowed for funding to complete the build out of properties, maintain the properties through operating subsidies, and to help residents recover through supportive services. If apartment owners are not provided with the subsidies needed to maintain their properties, the program would not survive.

“Case management needs to learn about property management, and property management needs to learn about case management.”

TLCS:

Richard Brown, a Residential Services Coordinator with TLCS, remembers the struggle of opening the Folsom Oaks Apartments, an 18 unit complex with 5 MHSA designated apartments. *“Folsom didn’t want us here.”* But now, 5 years later, people come into the office to ask about renting an apartment. Richard has to explain to them that the complex is designated for the homeless. The CMHPC took a tour and quickly discovered why many would want to live there. The small complex has a playground for the children who live there, and large oak trees that canopy the property. One resident insisted that her apartment be toured, which was decorated with furniture and wall hangings donated from a local non-profit. While on the tour, another resident in her early twenties approached Richard and asked for some help because her car was acting up. He explained later that help with car trouble can be a big part of the “support” in permanent supportive housing. Transportation is an often overlooked need among his residents and has become an area of frustration when tenants need to get their children to school.

Regina Range is a tenant at Folsom Oaks. She became homeless six years ago after her mother died of cancer. She and her son lived in a car for months before she was referred to Folsom Oaks by an advocacy group in Sacramento. Regina raised a couple of important points before the Council. First, she felt that the local school district was not supportive to her children and grandchildren in that they

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were not taking their living conditions and past trauma into consideration. She has been frustrated hearing about her children's poor behavior or tardiness when she had no transportation and was just trying to survive. She believes that permanent supportive housing should come with support to homeless children as well, and that this support needs to come from the local school district. Secondly, Regina discussed how her LOCUS level has prevented her from receiving the help she has needed. LOCUS is the Level of Care Utilization System and it provides a measurement of needs in six areas, 1) Risk of Harm; 2) Functional Status; 3) Medical, Addictive and Psychiatric Co-Morbidity; 4) Recovery Environment; 5) Treatment and Recovery History; and 6) Engagement and Recovery status.⁵⁰ The concern for her was that the use of this system alone in determining her level of services has created what some call a "fail first model".

Turning Point/Wellspace:

Renee McRae is a Personal Services Coordinator at the Boulevard Court Apartments in Sacramento. TP/Wellspace coordinated with Mercy Housing to build the complex which used to function as a motel. Renee completes two important functions at the program. She delivers support services and connects residents to needed services outside of the program, when necessary. She also coordinates with the Mental Health Court to assist residents in meeting their obligations in order to avoid confinement in jail. For clients who come to the program with no financial supports in place, the Sacramento Multiple Agency Resource Team (SMART) program is utilized to connect them to SSI/SSDI benefits. This SMART program is recognized as a national best practice model, and is operated by Capitol Community Health Network in partnership with Sacramento County Department of Health and Human Services. "The program expedites SSI/SSDI enrollment services by connecting community members who are disabled and homeless or at-risk of becoming homeless to Benefits Advocates."⁵¹

Michael Robinson is on his way to recovery and is now volunteering in the program that he says saved his life. Michael grew up in San Francisco, graduated from college, and joined the Marine corp. After leaving the military he started to use drugs and ended up on the streets. He got sober but then lost his wife to a brain tumor. Homeless again, he lived in his car, sleeping in the parking lot at the UC Davis Medical Center. He attempted suicide and was taken to the crisis residential program in Sacramento. Time ran out for him there but he was still receiving behavioral health services. Michael was grateful but stated, "*I got all the help I needed there but there was one thing I didn't have and that was a roof over my head.*" He was eventually referred to Boulevard Court where he is now safe and sober. Michael expressed to the Council how exhausting it was to be homeless with nowhere to lay his head. He doesn't believe that he would have made it without this housing first approach.

⁵⁰ LOCUS. Level of Care Utilization System. 2010. www.dhs.state.il.us/page.aspx?item=32545

⁵¹ Sacramento Steps Forward: Ending Homelessness, Starting Fresh. Success Saturday. 2012. <https://sacramentostepsforward.wordpress.com/taq/homeless>

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When Michael arrived at the program he had been prescribed several medications. *“Renee would come into my apartment and at the end of my coffee table would be 12 or 13 bottles of medication I was taking, now I’m down to 3 medications.”* This is a striking example of just one area where supportive housing can bring real cost savings. Stable healthy people are able to reduce medications and stay out of the hospital.

Conclusion:

California has the highest number of homeless persons per capita in the United States. At 114,000 our homeless population is roughly the population of Fairfield, CA. They represent all ages, ethnicities, and backgrounds. Those who are homeless are five times as likely to have a mental health or substance use disorder. For generations we have made attempts to address the issue but the numbers keep growing. We are now beginning to understand that homelessness is not an issue of laziness or immorality, but an economic issue created by a lack of affordable housing. It is also an issue of civic responsibility to address the basic life needs of the most vulnerable in our communities. Homelessness, when coupled with a severe behavioral health issue, becomes nearly impossible overcome.

Several funding sources are available but there isn’t enough. Programs are often fragmented and hard to find when you’re mentally ill and living on the streets. Coordination is needed among programs to ensure that funds are being spent on the programs that have been proven to work. Throwing more money at the problem will not work if these funds are not dedicated to the most proven, evidence based approaches. For this reason several states have created an interagency council on homelessness to coordinate efforts, secure funding, and create better access to proven methods.

The Shelter + Care model is a paradigm that appears to work well in California, especially as it utilizes non-profit organizations with a consumer work force. Prevention efforts like rapid re-housing, Emergency Solutions Grants, school district coordination, and early detection of psychosis are very important tools. Outreach with the use of Peer Counselors offers an effective first step toward gaining the trust of the homeless. The reintegration and inclusion of those with mental illness into their communities helps to solidify the recovery process for those with mental illness and substance use disorders.

As with any life struggle, acknowledgement of a problem is the first step. California has a problem with homelessness. If we fail to address this issue with bold economic solutions, we run the risk of spending more capital on solutions that do not work. We will be economically stronger when we stop the revolving door of public expenditures that don’t resolve the problem.

Michael and Regina’s life stories inform us that recovery from mental illness, substance abuse and chronic homelessness is possible. As they told us about their path to recovery there was a strong

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sense of hope in the room. They have moved from hopelessness and dependence on expensive systems of care to becoming healthy contributors in their new communities. If California can increase its understanding of homelessness and mental illness, and adequately fund its systems of response, we will celebrate thousands of recovery stories across the state just like theirs.

Recommendations:

- Programs that house the homeless should collect data for staying or leaving behaviors and evaluate this data at the county level to help guide efforts to decrease unsuccessful leaving of programs.
- County Offices of Education should receive increased funding to ensure that a homeless liaison connects to all shelters, Permanent Supportive Housing, and Rapid Re-housing programs in their county to provide necessary supports to homeless children living with their parents in these programs.
- Counties should receive increased funding so that they can ramp up and streamline programs like SMART which assists disabled homeless adults and youth in obtaining SSI and SSDI benefits.
- California needs considerable new funding which should be used for Shelter + Care, bricks and mortar, and supportive services.
- Counties should receive additional funding to create street outreach teams to guide homeless people with serious mental health disorders to permanent supportive housing options.
- The California Interagency Council on Homelessness should be created to reduce fragmentation of service delivery and track federal funding opportunities.
- Counties should assess for barriers to shelter use noted on page 8 and attempt to increase utilization and access to shelter services through removal or limitation of such barriers.
- California should build the capacity and expertise of the homeless service workforce through passage of SB 614, the peer, family, parent, transition-age, support specialist certification program.



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We're Listening

A Community Dialogue on Mental Health

December 2015

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California Mental Health Planning Council

Community Forum Report 2015

Introduction

The California Mental Health Planning Council (CMHPC) is mandated by federal law (Public Law 106-310) and state statute (Welfare and Institutions Code (WIC) 5772) to advocate for children with serious emotional disturbances and adults and older adults with serious mental illness; to review and report on the public mental health system; and to advise the Administration and the Legislature on priority issues and participate in statewide planning.

In 2015, the CA Mental Health Planning Council endeavored to meet with and hear from a number of underserved communities including the Hmong, Native American, Cambodian and lesbian, gay, bisexual, transgender, queer and questioning (LGBTQ) communities. California's ethnic population reached new percentages in 2014, with the Caucasian population moving into the minority. This means that the majority of persons living in California are of other ethnic and racial groups, many of whom are foreign-born and many living in monolingual households. California's diversity calls for cultural and language competency in all of its systems including education, commerce, law enforcement/criminal justice, religious and spiritual, social services and healthcare. The latter is where mental health services fall.

As America is ever so slowly realizing, mental health, and its counterpart, mental illness, impacts every facet of daily life. The impact of untreated mental illness is felt in all of the systems mentioned above and erodes the stability of a society. Untreated mental illness most often exists within impoverished communities. In California, it is predominately the new majority populations or 'people of color' who are living in poverty.

In 2004, California voters passed the Mental Health Services Act (MHSA) to bring new funding, policies and vision to the public mental health system. The MHSA shed a spotlight on the numbers of unserved individuals and communities and on the effects of an underfunded system which have resulted in increased homelessness, school drop-out rates, out of home placements and more devastatingly, suicide. It also required that services, programs and stakeholder engagement be focused on un- and underserved communities.

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In 2013, the California Reducing Disparities Project (CRDP) released 5 reports focused on specific populations including African American, Asian/Pacific Islander, Native American, Latino and LGBTQ. From this list, one immediately notices that disparities do not exist only in ethnic groups, but in other cultural groups such as the LGBTQ communities. These reports highlight gaps in service, service needs, strategies for engagement and recommendations of best- or community-based practices which are to serve as guides to further work to reduce disparities in these populations in California. We have to think beyond skin color and include other populations that have a culture unto themselves such as veterans, persons with physical disabilities and those who are hearing impaired. It also includes our remote and rural communities and age groups such as older adults and our young adults (18-25 years).

It is widely acknowledged that there are many more underserved cultural communities in California and that these 5 reports are just the beginning. California receives numerous refugees from war torn, and often politically unstable, countries including, but not limited to, Cambodia, Laos, Viet Nam, Syria, and Afghanistan where horrific events and atrocities were suffered by their people. This suffering negatively impacts their mental health and they arrive in America and California traumatized, depressed and often suicidal. With these issues already a heavy burden, the refugees strive to adapt, assimilate, survive and thrive in a new country that is more foreign in its traditions, language, economy and politics than they ever imagined.

Additionally, right here in America we have cultural groups who experience trauma, isolation, and exclusion. Individuals whose sexual orientation or gender identity falls outside the norm of male/female heterosexuality are bullied, harassed, ignored, excluded and physically attacked. Rates of suicide among this group are rising at alarming rates. Despite coming so far in achieving their civil rights, there is so much more ground to cover for these individuals to have equity and acceptance.

But first, it is the hierarchy of needs that must be addressed. Food, shelter, and safety are paramount then a source of income to maintain those initial, basic needs. For many cultures, the next item in the hierarchy is their spiritual needs. Last is health, especially

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their mental health. Refugees who have lost loved ones, lost their homes, have left behind their roots, and traveled far to live in a land of safety and security often believe, “well, I survived all that so these voices in my head, or this pervasive sadness I am feeling is nothing compared to what I have endured before. So, I will just live with it, this is my lot in life’. The MHSA vision includes wellness, recovery and resiliency. People can and do recover from mental illness and go on to lead fulfilling lives. That means that no one should ‘just live with it’, because help is available. However, as the 5 reports indicate, the help must to be culturally competent and culturally relevant in order to achieve the desired outcomes of wellness, recovery, and resiliency for our citizens from other communities.

So what is cultural competency? Is it providing interpreters and written materials in native languages? It is that, but it also goes so much farther than that. It means knowing, accepting and understanding the history (good, bad and horrific) of the group. It means being able to be with, talk to, and listen to a person from the group without judgement, with acknowledgement of their suffering and their needs. It means providing help in ways that support their cultural values, traditions and perspectives. And most importantly, it means engaging with the people where they are rather than expecting them to come to us, to come to clinics filled with white walls, fluorescent lighting and paperwork, to fit into a medical model of services designed by the white majority for the white majority.

Meeting with and listening to the various cultural groups allows for a deeper understanding of the groups’ needs which in turn facilitates more informed and effective mental/behavioral health policies, programming, and services. One set of reports is not enough to mobilize the healthcare workforce and policy makers to move in the right direction. Ongoing dialogues, meetings, reports, and information sharing must occur to effect the necessary changes to meet the needs of California’s diverse population. Stigma and shame continue across ALL communities.

The Council obtained the services of cultural brokers to reach out to and engage the communities and to inquire whether the group would be comfortable talking with us. The venues for the forums were located within the neighborhood communities and in facilities that were already known and visited by members of the community. The forums were held

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in the native language of the community and interpreters were used for the Council's understanding rather than the community's understanding. Publicity and materials were tailored using language and visuals relevant to the community.

The following are summaries of the forums for each of the communities we visited in 2015. It was an honor and a privilege to be welcomed into the communities. CMHPC has developed a set of guiding questions that will provide a framework for discussion at this and future ethnic community forums. Opening up to strangers about their darkest moments and their cultural beliefs and perspectives are not actions that most of these cultures promote so for them to talk with us underscores the depth of their need.

Hmong Community

Community Forum facility provided by: The Fresno Center for New Americans Fresno County

This community forum was planned for the Fresno area which is home to one of the largest populations of Hmong immigrants in the state. Hosting and facility were provided by staff of Fresno Center for New Americans (FCNA), the largest Hmong community-based organization in Fresno County. The FCNA is implementing two culturally based mental health programs through Mental Health Services Act funding: the Living Well Program and the Holistic Cultural Education and Wellness Center.

Stakeholder Comments

What is the biggest barrier that keeps you/people you know from coming in for mental health services?

- For example, men? All the community members present were female and most were over 50 years old. Why don't men seek or participate in mental health services? Responses included that "men are not depressed like women are", men don't feel comfortable sharing their feelings, and men won't participate in groups where there are mostly women participants. [Both Fresno County BH and FCNA currently offer counseling groups for men.]
- Youth? Participants responded that young people really don't know about available mental health services for them. More outreach and education is needed to raise

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awareness of youth mental health issues, for both youth and their families. Advocacy is needed to create more services for youth. When asked about mental health services in schools, one student responded that she was aware of grief counseling groups, but not other services. There was some discussion of the importance of preventive mental health services for youth: more Hmong teens committed suicide in Fresno County in the late 1990's- early 2000's than in any other area.

For people you know who receive mental health services, anywhere, are the services meeting their needs?

- An informal poll of the participants revealed that the vast majority were receiving services at FCNA. The discussion centered on their favorite program, the Community Gardens. When asked why this program is effective for them, they responded that gardening provides a familiar activity that they know and have practiced all their lives. It reminds them of their former life in Laos. It is good exercise and physical activity, and helps to take their mind off their health concerns and family problems. Community gardens provide a means of connecting and socializing with other program participants. The women love to see the vegetables and herbs that are the results of their hard work. Gardening makes them feel productive, independent and useful. If anything, they feel that the program should be bigger and provide more space and water for more people to participate.
- Several women related their own life story, but their experiences are not unique. Women in their older age experienced trauma 40 years ago when their country was at war. They lost relatives, their homes, everything that was familiar. They experienced different trauma as they tried to adjust to the completely new world that they found in the U.S. They were uneducated, they felt inadequate, they were homesick and they had lost control over their life. Their marriages suffered, some were abandoned either physically or emotionally by their husbands. Their children acculturated to a social system that values youth and disrespects old age. Many women said they have lost the ability to communicate with their children and in

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any case the children don't listen to them. They are isolated in their homes, they can't drive to errands and appointments, and their income is very limited. These older women reported that they suffer major depression, with suicidal ideation. For them, therapy is having someone listen to them and the opportunity of activities that provide a brief respite from their daily cares and problems.

- Fresno County Behavioral Health reported that there are a total of 7 community garden projects that include one for Russian-speakers and one for Punjabi residents.

How do you know when services are really helping people? What results are we looking for? How do you know that the services are helping you to feel better?

- Before we felt sick, sad, crying often, even felt like committing suicide. Now we feel healthy, feel happier, and have more activities and interests in life.
- We know that it is helpful to have people who listen to us and offer advice about how to solve our problems.
- We didn't know any services were available to help us, and now we can receive many services from FCNA and we have more hope for our life here in the U.S.

Are there any services that are not available that you think would help people with mental health needs?

- Several people mentioned that more and better transportation is needed. [Lack of transportation is a reported problem across urban and rural areas in every county.]
- Outings to local destinations to get to know the surrounding area. People mentioned that they've never traveled much outside their neighborhoods. [Fresno County BH has a program that provides weekly outings for people who meet the eligibility criteria for specialty mental health services.]
- Exercise programs, perhaps with equipment and an instructor. Many people with mental illness also suffer from chronic diseases like diabetes and hypertension, and they recognize that they need more physical activity. Walking or jogging in some neighborhoods is dangerous, and people don't go out at night.

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- More one-on-one counseling, there are not enough providers for this service.
- 24-hour access to mental health services (in case of crisis or emergency).
- Youth services, such as a recreation center where teens can also access mental health education and services.
- A holistic focus that includes mental, spiritual and physical wellness. Inclusion of the entire family in services, and an emphasis on healthy relationships.
- Arts and crafts activities.
- Multiple services available at one location.

What is the best way to engage your community to discuss and plan mental health services?

- This question either was not fully understood, or not very well explained. The participants spoke about other subjects and didn't address the meaning of the question. [Note: FCNA operates a program called Equal Voice which "captures the voices and opinions of the Hmong community about their participation with private and public organizations, events and issues throughout Fresno", via surveys and focus groups.]

Nor Rel Muk Wintu Tribe: Native American Community

Community Forum facility provided by: Trinity County Behavioral Health Services

This community forum was planned for Trinity County. The Nor Rel Muk means "southward uphill people." Current Tribal members live in the vicinity of the Hayfork Valley and the Southern Trinity River and include large portions of Trinity County. Approximately half of the tribe's 1,000 members still live near their ancestral lands in Trinity and Shasta Counties. The Nor Rel Muk Wintu Tribe is not federally recognized but is seeking sovereign status and continues to petition the United States Government for Federal Tribal recognition as a distinct Indian community that has continuously remained an identifiable

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American Indian entity on a substantially continuous basis since the 1900s to the present times.

Stakeholder Comments

What is the biggest barrier that keeps you/people you know from coming in for services?

- The stigma of having a mental illness is a huge problem within the community.
- Those with substance abuse issues are much more willing to seek treatment because there is not as much stigma attached to substance abuse. The referral program for substance abuse is also easier.
- Historical Trauma is a huge issue. Many people do not trust the county (government) because of generational historical trauma.
- The Welfare Reform Act has caused tribes to feel they are not being serviced at the county level (Tribal TANF).
- Accessibility is also a big problem. People are not sure where to start or where to go to seek services; in part due to a lack of education on symptoms to identify what is happening and how to recognize mental illness.
- Psychiatrists do not understand historical trauma or do not take it seriously.
- The biggest stigma is that many Native Americans are not recognized for who they are. Becoming a federally recognized tribe is a long and grueling process and serves to reinforce historical trauma.
- The Native American people feel alienated.
- The recruitment of young people into the marijuana trade is a big problem.

What is the best way to engage your community to discuss/plan for services?

- The Nor Rel Muk Wintu tribe would like more spiritual connections and to awaken traditions.
- There is a stigma outside the community as well as inside the community.

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- It is so important for a person to get their identity back, have a trade, work in the community, and have a purpose.
- Education also opens the door to identity- it is instrumental in assisting people to achieve their goals and feel accomplished.
- Cultural sensitivity training is a must!
- The Native American people need the spiritual side of healing- this is an integral part of our identity and of who we are at the core. More activities to keep people busy such as hikes, field trips, etc. and more tribal family cultural activities would be welcomed.
- Becoming a “federally recognized tribe” will go a long way in obtaining and providing effective services for the people. Services will be provided by the Indian Health Center. There needs to be more funding for culturally-focused activities and services and to establish a communal location in which to hold the activities.

For you/people you know who receive mental health services, are the services meeting your/their needs?

- Alpine House (Licensed Residential Adult Facility) and Bonita House: Milestones in Trinity County are very important to the community and have provided a location where people can easily seek assistance. Bonita House, Inc., (BHI) is a private non-profit mental health agency offering a range of services for adults diagnosed with co-occurring serious psychiatric disabilities and substance use disorders, including intensive residential treatment, supported independent living programs, housing and supported employment, outpatient case management and clinic services. The outpatient day rehabilitation program works both with adults who have single mental health diagnosis as well as those who are dual-diagnosed. Alpine House is Trinity County’s new Licensed Residential Adult Board and Care Facility. Alpine House has provided the opportunity for those receiving care to be placed near family members within Trinity County.

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- Mostly these services work but we would like more Native American cultural activities within Trinity County.

How do you know when services are really helping? What results are you looking for?

- There is a decrease in the use of alcohol and drugs.
- Spiritual needs being fulfilled.
- Re-unification of families.

Are there any services that are not available that you think would help people with mental health needs?

- The community needs more cultural activities.
- Local services are very important. Many people do not have transportation to travel to other counties.

LGBTQ Community

Community Forum facility provided by: LGBT Center Orange County in Santa Ana

This community forum was planned for Orange County. The LGBT Center OC opened its doors in the 1970s and serves the growing LGBTQ population of Orange County. The center offers LGBTQ-friendly business referrals and service providers, computer and internet services, and mental health counseling and HIV services.

Stakeholder Comments

What is the biggest barrier that keeps you/people you know from coming in for services?

- There is a lack of resources for culturally knowledgeable providers.
- Lack of affordable and accepting housing (especially for Transgender community).
- Lack of LGBTQ focus in the community and in therapy. Psychiatrists are not knowledgeable about LGBTQ issues.

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- Lack of knowledge regarding transitioning. We need more medical professionals who specialize in transitioning.
- Lack of specialized practitioners for each of the groups collectively known as LGBTQ.
- Lack of awareness of services.
- Stigma, discrimination, bullying, isolation.
- Many times the treatment becomes JUST about transitioning and there is no focus on other issues, such as anxiety, depression, etc.

What is the best way to engage your community to discuss/plan for services?

- There needs to be more social programs geared towards LGBTQ and more programs specifically for families.
- Respect and dignity in events is very important.
- There needs to be more options for Transition Age Youth.
- More information out there on meeting spaces and locations. Locations are disconnected and remain so hidden.

How do you know when services are really helping? What results are your community members looking for?

- When a person accomplishes their life goals.
- When there is an equal opportunity to achieve the same goals as others in the community.
- When there is really good access to services that are easy to navigate.

For you/people you know who receive services, do the services meet your/their needs?

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- There is only one psychiatrist that the community feels has been an integral part of meeting the needs of LGBTQ. The community needs more psychiatrists who understand the LGBTQ issues, including transitioning.

Are there any services that are not available that you think would be helpful?

- For those in transition: hormones and Doctors should be part of the mental health treatment. We should not have to wait so long to have access to hormones either.
- There are inconsistent gatekeepers: professionals who have the power to deny hormones or treatment with doctors for those transitioning. This sets back mental health treatment and causes people to not seek services.

Community Forum facility provided by: EMQ FamiliesFirst Santa Clara County

This community forum was planned for Santa Clara County and the surrounding Bay Area. EMQ FamiliesFirst is a statewide nonprofit that helps children and families. The agency is one of the largest, most comprehensive mental health treatment programs in California. EMQ FamiliesFirst takes a state-of-the-art approach to children and adolescents with complex behavioral health challenges and helps them recover from trauma such as abuse, severe neglect, addiction and poverty.

What is the biggest barrier that keeps you/people you know from coming in for services?

- There are not enough specific services for the LGBTQ community.
- There is a major lack of outreach and workforce available to do outreach.
- Stigma is a huge issue.
- We need clinically supervised group therapy. Things can happen in a group however, so we need a professional to handle the group and do no harm.
- There is a lack of awareness of services. People think there is no place to get help.

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- Insurance and provider barriers are a problem. Insurance companies have too much power in denying care.
- The LGBTQ community is not included in decision making.

What is the best way to engage your community to discuss/plan for services?

- Caregivers need to go into the community and provide care where LGBTQ feel the most comfortable. Outreach should be orchestrated and more consistent with information made available in places LGBTQ youth hang out.
- Have providers make more of an effort to establish relationships and create some sort of continuity when it comes to care.
- There needs to be better bridges between the churches and mental health.
- Adapting the Mental Health First Aid training to be geared towards the LGBTQ community as well.
- Family inclusion is very important and needs to be a focal point.

For you/people you know who receive services, do the services meet your/their needs?

- The profession does not teach professionals about LGBTQ issues.
- There is a severe lack of knowledgeable workforce and peer providers to help individuals in the LGBTQ community.
- The LGBTQ community continues to feel like outsiders: we are neither appointed nor included in important decisions.

Are there any services that are not available that you think would be helpful?

- There needs to be much better data collection within counties to assist with outcomes for our community.

Cambodian Community

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Community Forum facility provided by: The United Cambodian Community of Long Beach,
Los Angeles County

This community forum was planned for Long Beach, which is home to the second largest population of Cambodian immigrants. The United Cambodian Community is a nonprofit social services agency that has served the Cambodian community in the greater Long Beach area since 1977. They offer health and human services to a diverse clientele, including elderly, youth, and women. Their mission is to bridge cultural, language, and generational gaps between first-, second- and third-generation Cambodian Americans.

What is the biggest barrier that keeps you/people you know from coming in for services?

- Many do not have any health insurance and very little money to see a Doctor.
- There is a language barrier and a need for more specialists who speak Khmer.
- Karma is also a barrier: many feel that Karma is to blame for their problems and that they must suffer through it. Because of this, many do not recognize that what they are experiencing is a mental health issue. Feelings of shame and stigma are obstacles.
- Many are afraid to seek services because they may be undocumented.
- Trauma: many feel that they have no right to feel anxious/sad/depressed after what they endured before coming to the States. It is better to forget their trauma in the past and not to re-live it.

What is the best way to engage your community to discuss/plan for services?

- More community gatherings at the Cambodian Center would be helpful. Familiar activities within the community such as dancing, music, and gardening.
- Reaching out to community members in places they frequent and feel comfortable in, such as community gardens, stores, churches, etc.
- Connecting with a local agency that the people trust.
- A local media announcement in the Khmer language.

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For you/people you know who receive services, do the services meet your/their needs?

- Do not want to be prescribed medications so quickly.
- Need more specialists who understand the trauma that was endured in the past and how it is affecting us now.

How do you know when services are really helping? What results are your community members looking for?

- A community healing center that serves all mental health and spiritual needs.
- Several people shared their own personal stories of trauma and suicide. There is a disconnect between parents and first generation children who may feel the repercussions of historical trauma but have not experienced that trauma. There is also a language barrier between parents and their children who have fully acclimated to life in the United States and either never learned to speak Khmer or have forgotten the language. Family is extremely important and for many women it is their identity. Non-traditional services such as community events that bring families together are highly desired.
- When struggling with trauma, depression, and anxiety, individuals tend to isolate themselves and not venture out of the home. When people are participating in events, going to the store, working in the garden, then they feel better and services are helping.

Are there any services that are not available that you think would be helpful?

- Would like more group activities.
- Classes on healthy food and diet.
- More physical therapy activity-related programs.
- There is a need for programs to reach children/young adults who are first generation in the United States but who are also affected by the family trauma.

Conclusion

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An understanding of each culture will lead to better services. Although each culture is unique, there are common threads that run through all of them. There is a need for more culturally sensitive and/or educated specialists across all cultural groups. The inclusion of spirituality was a big issue- even in the LGBTQ community. This seems to be a component that is lacking and should be an integral part of recovery. Discrimination is also a huge issue across all cultures. Sensitivity and the awareness of historical or past trauma are important for service providers. Providing care on their “turf” is essential: providing services in places where people hang out and feel comfortable in. The inclusion of family members in the recovery process is a must.

The California Mental Health Planning Council has a statutory responsibility to advise the Legislature, Department of Health Care Services, and county boards on mental health issues and priorities that the state should be pursuing in developing its mental health system. Establishing policies that encourage adaptation of service delivery/practices, recruitment of a workforce that is culturally competent and humble and that increases access for the diverse, unserved and underserved populations must be a priority. California will not achieve the outcomes and recovery for individuals that we strive for unless we embrace the cultural differences and lean in to do better in serving these individuals and families.

Because of the need to do better in serving California’s diverse population, the CMHPC will continue to hold public forums with more communities in 2016. The Council is committed to continuing the dialogue and information sharing to effect the necessary changes in workforce, funding, policies, and programming to fulfill the promise of recovery and resiliency for all.

MENTAL HEALTH POLICY AND FUNDING MARKERS AND MILESTONES

***NATIONAL LEVEL**

****STATE LEVEL**

At The Roots: 1880 to 1957

*1880	110 psychiatric hospitals are constructed due to the efforts of Dorothea Dix after she witnessed the housing and treatment of the mentally ill in a Cambridge, MA jail in 1841.
*1887	Nellie Bly writes the first expose of a women's "lunatic asylum" exposing the appalling care and abusive treatment endured by women in institutions.
*1907	Indiana begins a program of mass sterilization of psychiatric patients – by 1940 over 18,000 people were sterilized.
*1936	The first pre-frontal lobotomy is performed, culminating in a total of over 50,000 in the US by the late 1950s.
*1938	Electro-shock therapy is introduced.
*1946	The National Mental Health Act is signed by Harry Truman, eventually establishing the National Institute of Mental Health to conduct neuropsychiatric research in 1949.
*1955	Psychiatric hospital patients number 560,000 in the United States. Total U.S. population was just over 165.9 million.
**1956	The State of California is the sole provider for the care and hospitalization of the mentally ill at 8 hospitals, (plus 2 others serving the developmentally disabled and the mentally ill) throughout the state. Total state hospital population of mentally ill at the end of 1956-57 is 36,319. Total California population was just over 3 million.
**1957	California implements the Short-Doyle Act, providing financial assistance to local governments to establish and develop locally administered and controlled community mental health programs. State assumes 50 percent of cost.

The 1960s

**1962	Only 20 California jurisdictions have established Short-Doyle programs since its implementation in 1957.
*1963	The Kennedy Administration passes the Community Mental Health Services Act, which funds the construction of mental health centers to replace institutions as the first step towards deinstitutionalizing mental health services.

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MENTAL HEALTH POLICY AND FUNDING MARKERS AND MILESTONES

*NATIONAL LEVEL	**STATE LEVEL
**1963	California Legislators increase the scope of state reimbursable services and state funding participation to 75 percent for community mental health programs.
*1965	The United States Congress passes Title XVIII, the Medicare legislation for some disabled individuals and persons 65 years of age and over, and Title XIX, Medicaid legislation that provides federal matching funds to states that implement a comprehensive health care system for the poor. <i>The Institutions for Mental Disease (IMD) exclusion originates here.</i>
** 1966	California implements the Medi-Cal program. Federally reimbursed mental health services (i.e., “medically necessary”) included psychiatric inpatient hospital services, nursing facility care, and professional services provided by psychiatrists and psychologists,
**1967	California passes the Lanterman-Petris-Short Act, which further dis-incentivizes the use of institutionalized care and encouraged community-level supports and services for people living with mental illness and their families. State funding participation for community mental health programs is increased to 90 percent and a judicial hearing procedure is required prior to any involuntary hospitalization. All counties were covered by LPS. Many geriatric state hospital patients are moved from the hospitals to nursing homes, where the federal government pays one-half the cost in lieu of the state paying 100 percent of the state hospital cost.
**1968	The number of Short-Doyle programs in California increases to 41.
*1969	From 1965 to 1969, \$260 million in federal dollars were authorized for community mental health centers.

The 1970's

*1970	There are 525,000 psychiatric beds in the United States, 420,000 (80%) provided by state and county mental hospitals.
**1971	California adds Short-Doyle community mental health services into the scope of benefits of the Medi-Cal (SD/MC) program. This enables counties to obtain federal matching funds for their costs of providing acute inpatient hospital services, individual, group or family therapy delivered in outpatient or clinic settings and various partial day or day treatment programs
**1972	Despite Legislative intent for the budget savings from three closed hospitals to “follow the patient” into local programs, Governor Reagan vetoes the redirection of savings in 1972 and 1973.
*1973	Mental Health funding drops under the Nixon Administration with a total of only \$50.3 million authorized between 1970–1973.

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**MENTAL HEALTH POLICY AND FUNDING
MARKERS AND MILESTONES**

*NATIONAL LEVEL	**STATE LEVEL
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*1977	There are 650 community mental health facilities nation-wide serving 1.9 million patients a year.
**1978	Proposition 13 is passed in California capping property-tax rates, limiting hikes in assessed values and giving control of local property tax revenue allocation to the state. Many consider this to be the source of ongoing General Fund deficits that negatively impacted subsequent funding for social services, health, and education.

The 80's

*1980	President Carter signs the Mental Health Systems Act, which aims to revive and restructure the community mental health center program and improve services for people with chronic mental illness.
*1981	Under President Reagan, the Omnibus Budget Reconciliation Act revokes Carter's Mental Health Systems Act and establishes block grants for the states, ending the federal government's role in providing services to the mentally ill. Federal mental health spending decreases by 30 percent.
*1984	An Ohio-based study finds that up to 30 percent of homeless people are thought to suffer from serious mental illness.
*1985	Federal funding drops to 11 percent of community mental health agency budgets.
**1985	California's Bronzan-Mojonnier Act enacts significant provisions relating to the link between shortage of services and subsequent criminalization of the mentally disordered, the need for community support for homeless mentally disordered persons, vocational services, and seriously emotionally disturbed children.
**1989	California Welfare & Institutions Code is amended to include Section 5730, the "Mental Health Master Plan Development Act" assigning the development of the first Mental Health Master Plan to the <i>California Planning Council</i> (i.e., California Council on Mental Health) and requiring the plan's completion by October 1, 1991.

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MENTAL HEALTH POLICY AND FUNDING MARKERS AND MILESTONES

***NATIONAL LEVEL**

****STATE LEVEL**

The 1990's

*1990	More than 50,000 beds are provided through psychiatric units in general hospitals and 45,000 beds in private psychiatric hospitals.
**1991	California's Realignment program established through the Bronzan-McCorquodale Act (AB1288) is passed to help compensate counties for loss of property tax revenue due to Prop 13. Medi-Cal and indigent population costs are shifted to counties and funded through a formula of state sales tax and vehicle license fees. However, due to Mental Health services' status as a "non-entitlement" (covered under Titles VIII or IX), the funding is soon prioritized to Social Service and Health programs over mental health services.
*1992	The Substance Abuse and Mental Health Services Administration (SAMHSA) is established, providing a home base for mental health planning and funding for states trying to implement the vision of rehabilitative services.
**1993	The current iteration of the California Mental Health Planning Council is established and tasked with developing Performance Indicators for the Realignment Program.
**1995	The California Mental Health Planning Council (CMHPC) submits its report on the "Effects of Realignment on the Delivery of Mental Health services" to the Legislature.
*1999	Olmstead Act ("the Olmstead decision"): The Supreme Court construes Title II of the Americans with Disabilities Act (ADA) to require states to place qualified individuals with mental disabilities in community settings, rather than in institutions.
**1999	AB 34 (Steinberg) is chaptered. It authorizes grants totaling \$9.5 million for one-year pilot programs in up to three counties to provide services to severely mentally ill adults who are (1) homeless, (2) recently released from jail or prison, or (3) at risk of being homeless or incarcerated in the absence of services. Sacramento, Los Angeles and Stanislaus were awarded the first three grants.

The 21st Century

2000 – 2015

**2000	AB 2034 is chaptered into California law expanding the number of counties who initiate the prototype of the first "Full-Service Partnership" demonstrated under AB 34, a comprehensive services plan that addressed all major aspects of recovery and wellness.
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MENTAL HEALTH POLICY AND FUNDING MARKERS AND MILESTONES

*NATIONAL LEVEL	**STATE LEVEL
*2003	In July, the President's New Freedom Commission on Mental Health issues its report, " <i>Achieving the Promise: Transforming Mental Health Care in America</i> ", with 19 specific recommendations that center on a more integrated, comprehensive approach to providing services, including earlier recognition and intervention methods.
**2003	The CMHPC updates The Mental Health Master Plan of 1993, focusing on unmet needs, cultural competency, managed mental health care, age-based systems of care, and suggesting performance indicators for measuring and evaluating success in order to demonstrate and assure accountability in community mental health services.
*2004	Studies suggest approximately 16 % of prison and jail inmates – roughly 320,000 people -are seriously mentally ill, and the number of public and private hospital psychiatric beds number about 100,000, suggesting that there are more than three times as many seriously mentally ill people in jails and prisons than in hospitals.
**2004	California voters approve the Mental Health Services Act, (MHSA) which provides a dedicated source of funding for comprehensive mental health services demonstrated under AB 34/2034 and includes provisions for prevention, early intervention, innovation, and workforce development; funded through a 1% income tax for millionaires.
*2008	Mental Health Parity and Addiction Equity (MHPAE) is enacted to ensure that private insurance covers mental health and substance use disorders services at the same level and cost as primary care services.
*2009	The "official" end of the Great Recession has resulted in states being forced to cut \$4.35 billion in public mental health spending over the next three years, the largest reduction in funding since deinstitutionalization.
*2010	The Healthcare Reform/Affordable Care Act is enacted, with a projected full implementation date of 2014.
**2010	California's 1115 Waiver application, aka "the Bridge to Healthcare Reform" is approved and in effect for five years while the ACA is implemented. Mental health and substance use services are targeted for eventual inclusion.
**2012	California Department of Mental Health is eliminated, and the majority of community mental health functions transferred to Department of Health Care Services (DHCS). The Department of Alcohol and Drug Programs is also eliminated and all functions are transferred to DHCS, signaling the Administration's plan to fully integrate MH/SUD services into public healthcare.
*2014	The Affordable Care Act begins full implementation and includes certain levels of mental health and substance use disorder services as "essential health benefits" required under basic healthcare coverage for all enrollees.

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**MENTAL HEALTH POLICY AND FUNDING
MARKERS AND MILESTONES**

***NATIONAL LEVEL**

****STATE LEVEL**

****2015**

The Department of Health Care Services is approved for its 1115 Waiver renewal, which includes a more seamless integration of MH/SUD services into Primary Care, develops incentive systems, and strengthens partnerships between the state and counties.

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