Mental Health Services
Oversight & Accountability Commission

WELLNESS · RECOVERY · RESILIENCE

Victor Carrion, M.D.
Chair

1325 J Street, Suite 1700
Sacramento, California 95814

Tina Wooton
Vice Chair

Commission Meeting Agenda

September 22, 2016
9:00 A.M. – 4:15 P.M.
California African American Museum
600 State Drive
Los Angeles, CA 90037

Call-in Number: 866-817-6550; Code: 3190377

Public Notice

The public is requested to fill out a "Public Comment Card" to address the Commission on any agenda item before the Commission takes an action on an item. Comments from the public will be heard during discussion of specific agenda items and during the General Public Comment periods. Generally an individual speaker will be allowed three minutes, unless the Chair of the Commission decides a different time allotment is needed. Only public comments made in person at the meeting will be reflected in the meeting minutes; however, the MHSOAC also will accept public comments via email, and US Mail. The agenda is posted for public review on the MHSOAC website http://www.mhsoac.ca.gov 10 days prior to the meeting. Materials related to an agenda item will be available for review at http://www.mhsoac.ca.gov.

All meeting times are approximate and subject to change. Agenda items are subject to action by the MHSOAC and may be taken out of order to accommodate speakers and to maintain a quorum.

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Victor Carrion, M.D
Chair

AGENDA
September 22, 2016

Tina Wooton
Vice Chair

9:00 AM **Convene**

Chair Victor Carrion, M.D., will convene the Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission) meeting. Roll call will be taken.

9:05 AM **Action**

1A: Approve August 25, 2016, MHSOAC Meeting Minutes

The Commission will consider approval of the minutes from the August 25, 2016, Commission Meeting.

- Public Comment
- Vote

Information

1B: August 25, 2016 Motions Summary

A summary of the motions voted on by the Commission during the August 25, 2016, Commission Meeting.

1C: Evaluation Dashboard

The Evaluation Dashboard provides information on both executed and forthcoming MHSOAC evaluation and data strengthening efforts, including primary objectives, timelines, and deliverables.

1D: Calendar

The Calendar provides information on Commission and related meetings.

9:15 AM **Information**

2: Mental Health and Criminal Justice Commission Project Panel Presentations

Project Chair: Commissioner and Sheriff Bill Brown
Facilitator: Toby Ewing, Ph.D., Executive Director

Subject matter experts and stakeholders have been invited to participate in the following four presentations to support the Commissioners' understanding of local and state challenges and opportunities to reducing the number of adults with mental health needs in the criminal justice system, and improving outcomes for those who must remain in custody and are ultimately released into the community. Commissioner Brown will report out on the most recent public engagement meeting and site visit.

9:25 AM **Panel 1: Consumers, Family Members and Advocates**

- Harold Turner, Los Angeles County parent
- Mark Gale, Criminal Justice Chair, NAMI Los Angeles County Council

Invited panelists will share with the Commission their experience with the criminal justice and mental health systems, identify needs and gaps, and discuss how the Commission can support improved outcomes.

10:30 PM **Panel 2: Los Angeles County Mental Health and Public Safety Representatives**

Presenter: The Honorable Jackie Lacey, Los Angeles County District Attorney

- Robin Kay, Ph.D., Acting Director of Mental Health, Los Angeles County Department of Mental Health
- Mark Ghaly, M.D., Director of Community Health and Integrated Programs, Los Angeles County Department of Health Services
- Kelly Harrington, Assistant Sheriff, Los Angeles County Sheriff's Department
- Judge James Brandlin, Superior Court of Los Angeles County

District Attorney Jackie Lacey will present to the Commission on how Los Angeles County has focused on mental health diversion. Invited panelists will discuss challenges and solutions from their perspective.

12:00 PM **Panel 3: Statewide Challenges and Opportunities**

- Stephanie Welch, Executive Officer, Council on Mentally Ill Offenders (COMIO)
- David Meyer, J.D., Clinical Professor, Institute of Psychiatry, Law and the Behavioral Sciences, U.S.C. Keck School of Medicine

Executive Officer Stephanie Welch will present the mission and role of COMIO with regard to addressing the intersection of criminal justice and mental health, and the progress COMIO has made in pursuing its mission and role. David Meyer will present on the statewide challenges and opportunities to reducing the number of adults with mental health needs in the criminal justice system.

12:45 PM **General Public Comment**
Members of the public may briefly address the Commission on matters not on the agenda.

1:00 PM **LUNCH BREAK**

2:00 PM **Panel 4: Mental Evaluation Unit (MEU)**

Presenters:

- Brian Bixler, Lieutenant II, Los Angeles Police Department (LAPD)
- Detective Charles Dempsey, Admin-Training Detail
- Detective Paul Scire, Case Assessment and Management Program (CAMP)
- Detective Michael Morlan, Systemwide Mental Assessment Response Team (SMART)

Presenters will provide information on the Los Angeles Police Department (LAPD) Mental Evaluation Unit's (MEU) activities to address complex mental health needs within its jurisdiction.

3:00 PM **Action**

3: Orange County Innovation Plan

Presenter: Brian R. Sala, Ph.D., Deputy Director

County Presenter: Flor Tehrani Yousefian, Interim Administrative Manager for Innovative Projects

The Commission will consider approval of three Orange County Innovation Projects.

- Public Comment
- Vote

3:45 PM **Information**

4: MHSOAC Executive Director Report

Presenter: Toby Ewing, Ph.D., Executive Director

Executive Director Ewing will report out on projects underway and other matters relating to the work of the Commission.

4:00 PM **General Public Comment**

Members of the public may briefly address the Commission on matters not on the agenda.

4:15 PM **Adjourn**

MHSOAC
Mental Health Services
Oversight & Accountability Commission

Commission Packet

September 22, 2016

Commission Meeting

California African American Museum
600 State Dr
Los Angeles, CA 90037

Call-in Number: 1-866-817-6550
Participant Passcode: 3190377

AGENDA ITEM 1A

Action

September 22, 2016 Commission Meeting

Approve August 25, 2016 MHSOAC Meeting Minutes

Summary: The Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission) will review the minutes from the August 25, 2016 meeting. Any edits to the minutes will be made and the minutes will be amended to reflect the changes and posted to the MHSOAC Web site after the meeting. If an amendment is not necessary, the Commission will approve the minutes as presented.

Presenter: None

Enclosures: August 25, 2016 Commission Meeting Minutes.

Handouts: None

Recommended Action: Approve August 25, 2016 Meeting Minutes.

Proposed Motion: The Commission approves the August 25, 2016 Meeting Minutes.

State of California

MENTAL HEALTH SERVICES
OVERSIGHT AND ACCOUNTABILITY COMMISSION

Minutes of Meeting
August 25, 2016

MHSOAC Offices
Darrell Steinberg Conference Room
1325 J Street, Suite 1700
Sacramento, California 95814

866-817-6550; Code 3190377

Members Participating

Reneeta Anthony
Khatera Aslami-Tamplen
John Boyd, Psy.D.
John Buck
Itai Danovitch, M.D.
David Gordon
Gladys Mitchell
Larry Poaster, Ph.D.
Richard Van Horn

Members Absent:

Lynne Ayers Ashbeck
Senator Jim Beall
Sheriff Bill Brown
Victor Carrion, M.D., Chair
Assembly Member Tony Thurmond
Tina Wooton, Vice Chair

Staff Present

Toby Ewing, Ph.D., Executive Director
Norma Pate, Deputy Director;
Program, Legislation, and Technology
Brian Sala, Ph.D., Deputy Director;
Evaluation and Program Operations
Filomena Yeroshek, Chief Counsel;
Kristal Antonicelli,
Associate Governmental Program Analyst
Peter Best, Staff Services Manager
Cody Scott, Staff Services Analyst
Moshe Swearingen, Office Technician

CONVENE

Commissioner Poaster stated that neither the Chair nor the Vice Chair could attend today's meeting and called the meeting of the Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission) to order at 9:12 a.m. and welcomed everyone. Filomena Yeroshek, Chief Counsel, called the roll and announced that a quorum was present at 9:50 am. Because a quorum was not present when the

meeting was called to order the agenda items that required a quorum were postponed for later in the morning when a quorum could be established.

INFORMATION

1B: <u>July 28, 2016, Motions Summary</u>

1C: <u>Evaluation Dashboard</u>

1D: <u>Calendar</u>

INFORMATION

2: <u>MHSA Fiscal Reversion Panels</u>

<u>Panel 1: Law and History of Reversion Policy</u>

Presenters: Ben Johnson, Legislative Analyst's Office; Cynthia Burt, MHSOAC Staff

Commissioner Poaster stated the Commission established a work group in concert with the Financial Oversight Committee to look at the issue of reversion and put together three panels to help bring understanding on this issue.

Executive Director Ewing stated the purpose of the panels today is to provide context that will allow the Commission to consider the issues it needs to engage on in order to advise the Governor and Legislature on policy changes. The focus today is not about solving the problem as much as providing context and background and learning the issues that the Commission might need more information on moving forward.

Executive Director Ewing stated Mr. Johnson will present on the law, how fiscal incentives in policy can work, and tradeoffs. Ms. Burt will provide historical context of why the Department of Mental Health (DMH) put the reversion and fiscal policies in place and the challenges that the DMH was trying to address. Executive Director Ewing stated there seems to be a mismatch in the policy structure with how the money flowed to the counties initially, the rules that were put in place with regard to reversion at that time, and how the money flows to counties now. The problem is the policies and procedures have not been updated.

<u>Ben Johnson</u>

Ben Johnson, Fiscal and Policy Analyst, Legislative Analyst's Office, stated although the Mental Health Services Act (MHSA) does provide clear parameters for an MHSA reversion policy, no reversion policy is currently in place today due to the lack of regulations around MHSA reversion. Also, the state does not have a good understanding of county MHSA revenues and expenditures. Without good data on county financial situations, it will be difficult to implement a working reversion policy. He suggested that future Department of Health Care Services (DHCS) guidance should provide clear standards for reporting county financial conditions. A long disallowance period for Medi-Cal claims is an issue behind why counties are accumulating funds. Whether accumulating reserves to potentially pay down these disallowances is an appropriate use of MHSA funds may need to be assessed. He summarized his written responses to staff questions he provided in the meeting packet.

Commissioner Questions and Discussion

Commissioner Poaster asked if there is a maximum level of prudent reserves. Commissioner Van Horn stated 50 percent of the average three-year funding could be retained as a reserve fund.

Commissioner Buck asked if there are examples of reversion policies that can be used as a model. Mr. Johnson gave an example of the After School Education and Safety (ASES) Program, in which funds go out from the state on a continuous basis for use by local programs. If local after-school programs continually fail to meet performance targets, funding is reduced at the discretion of the California Department of Education (CDE). That model may be worth exploring further.

Commissioner Buck stated counties believe they can use reserves to cover Medi-Cal disallowances. He asked if there is legal precedent for this and if counties can use reserves to cover non-MHSA disallowances. Mr. Johnson stated the reversion policy in the MHSA requires that spending occur in accordance with counties' plans. He stated the extent to which counties are maintaining reserves for disallowances is not clear; he did not have sufficient information to answer that question.

Commissioner Danovitch stated the flow of funds as currently structured creates less of an incentive and more of a punishment, which creates fundamental challenges in how to incentivize counties. He asked what happens to the money and why it is so difficult to track. Mr. Johnson stated that is the unanswered question. One issue is the lack of information about how counties ultimately spend the funding. The state reporting mechanisms are not current and spending is not identified in a way that is consistent with counties' three-year spending plans.

Commissioner Danovitch asked what it would take to remedy that. Mr. Johnson suggested looking into what counties are being asked to report with regard to their expenditures and revenues to see if that is all the information needed to effectively make a comparison between county plans and actual expenditures.

<u>Cynthia Burt</u>

Cynthia Burt, MHSOAC staff, provided an overview, accompanied by a slide presentation. She reviewed the reversion language contained in Welfare and Institutions Code section 5892(h), discussed the historical backdrop of the DMH efforts to implement the MHSA and reversion, and legislative changes made to the MHSA that affected the ability for the State to tract reversion of funds.

Commissioner Questions and Discussion

Executive Director Ewing asked how the Commission could begin changing reversion from a punishment to an incentive. Ms. Burt stated the need to review the Annual Update and the Revenue and Expenditure Report (RER) side-by-side to avoid evaluating something written prospectively against something developed retroactively. She suggested linking the reports. Beyond that, there needs to be policy changes to address fiscal problems. Because of braided funding to support mental health services it will be hard to unbraid the MHSA funds.

Commissioner Mitchell stated this issue is overwhelming. It is difficult to understand how programs and counties can revert funds when there are great needs left unmet in communities. Programs and counties need to be held accountable. She stated the need to close that gap.

Commissioner Poaster asked about the magnitude of the problem and whether there is a problem that needs to be fixed. Executive Director Ewing stated part of the problem is media reports of hundreds of millions of unspent funds, yet the law says unspent funds revert so they can be used by other counties within three years. It is hard to reconcile money that counties have not spent for several years that has not become available to other counties. The presenters have demonstrated that this is a complicated issue. The Commission is trying to get to a point where the issue is simple and creates the right kind of incentive with clarity and consistency across counties.

Executive Director Ewing stated there are counties that have struggled to put their innovation (INN) plans together and complete the approval process in a timely manner. They have not spent their annual INN funds within three years, yet they have not reverted the funds. He stated the need to learn if the law is being followed and what the extent of the challenge is. He stated current practice makes it difficult for some counties because they are squeezed between a public clamor to spend the funds and operating under complicated rules.

Panel 2: Policy and Challenges of Reversion

Presenters: Brenda Grealish, Assistant Deputy Director, Mental Health and Substance Use Disorder Services, DHCS; Melissa Chilton, Budget Specialist, Humboldt County Department of Health and Human Services; and Kimberly Danner, Deputy Chief Fiscal Officer, Napa County

Executive Director Ewing thanked Adrienne Shilton, of the California Behavioral Health Directors Association, for putting staff in contact with Ms. Chilton and Ms. Danner, who agreed to be part of the panel today to discuss how reversion is working for their counties. He asked Ms. Grealish to outline the current steps the DHCS has underway to address the reversion issues.

Brenda Grealish

Brenda Grealish, Assistant Deputy Director, Mental Health and Substance Use Disorder Services, DHCS, stated the Department created a work group that has been collaborating with the Commission and counties to work through this issue. The DHCS has responsibility for developing regulations for the MHSA, including fiscal regulations, which include reversions. Fiscal regulations currently being developed will bring clarification to counties and communities. The DHCS plans to have draft fiscal regulations by the end of this year or early next year, which will begin the formal regulations process that takes approximately eighteen months. The goal is to have fiscal regulations in place by mid-2018.

Ms. Grealish listed several challenges throughout the steps of the reversion process that the work group is working on:

- Determining the total revenue – the DHCS is working on regulations to clarify this.

- Understanding the correct time to transfer funds from Community Services and Support (CSS) to Capital Facilities, Technological Needs, and prudent reserves.
- Determining the total expenditures, Federal Financial Participation (FFP) and how that is calculated, how it gets reported on the RER, and how that works with reversion.
- Working on the calculation of reversion, how it works, and if it is a first in, first out calculation.
- Working on how counties can recoup funds once reversion funds have been identified.
- Coming up with logical solutions that align with the MHSA and the law.

Commissioner Questions and Discussion

Commissioner Gordon stated "reversion" is the penalty to get people to do the right thing. He asked what the "right thing" is. Ms. Grealish stated the idea behind reversion is so that funding will not be stagnant and not put to good use. Prudent reserve is there to ensure services can be consistently maintained during down times.

Commissioner Aslami-Tamplen asked who is part of the work group and if community-based organizations are a part of it. Ms. Grealish stated the work group is made up of Department, MHSOAC, and county representatives. Providers are not yet part of the work group. Ms. Grealish stated the Department will consider what providers might have the subject matter expertise to be a part of the group.

<u>Melissa Chilton</u>

Melissa Chilton, Budget Specialist, Humboldt County Department of Health and Human Services, stated one of the biggest issues that counties have is using MHSA dollars for the federal match for direct services. Cost settlement and audit exceptions impact the utilization of those MHSA funds. Counties are unclear on how to account for the audit exemptions.

Counties have been operating under assumptions and information notices issued by the DMH and the DHCS. The key Information Notice from the DMH was issued in December 2011 and provides for the calculation of reversion. Counties have been operating off of that policy for the last several years. The Notice indicated that if counties spend sufficient dollars in Community Services and Supports (CSS) and Prevention and Early Intervention (PEI), then INN dollars would not be subject to reversion. That policy was rescinded in June of 2016 by the DHCS.

She suggested an open dialogue to address if the redistribution of reverted funds will negatively impact smaller counties, if there will be opportunities to enhance components across the spectrum, and how to formulate redistribution formulas.

Commissioner Questions and Discussion

Commissioner Anthony asked how many counties have reserves for capital improvements, which were intended to be used to develop new buildings for outdated or growing community needs, It would be helpful to know how much of the reserves are still

retained by the counties and have not been utilized, and how long the counties are going to keep those funds without starting something.

Commissioner Van Horn stated the goal is for counties to spend the funds as effectively as possible, but the process has become overly-complicated. The unresolved question is whether to provide a penalty, which is not producing desired results, or an incentive, which will produce desired results.

Kimberly Danner

Kimberly Danner, Deputy Chief Fiscal Officer, Napa County, agreed with all presenters that this issue is complicated. She agreed with Commissioner Van Horn and with the idea of blending, braiding, and melding of resources. The better this can be done, the better services can be provided. The Medi-Cal system needs to be discussed in order for that to be understood. The Medi-Cal system is one of the most complicated reimbursement systems in the nation, but its role is to leverage the MHSA so more can be done. It is important but it has inherent problems because the off-set is constantly moving. There are problems with interpretations of terms in that auditors sometimes interpret terms differently than how counties interpret.

Ms. Danner stated knowing the reversion policy is important because the lack of clarity holds counties back from developing programs.

Commissioner Questions and Discussion

Commissioner Danovitch asked about the size of the uncertainty on a percentage basis and if it varies by county and by type of service. Ms. Danner stated it varies by county depending on Medi-Cal issues and rules, the auditing of records, and the misinterpretation of regulations between auditors and counties.

Panel 3: Strategies for Improving Reversion Policy

Presenter: Mike Geiss, Geiss Consulting

Mike Geiss

Mike Geiss, Geiss Consulting, provided an overview, accompanied by a slide presentation, of reversion policy, reversion considerations, and opportunities for new policy. He stated reversion needs to be included in the overall context of behavioral health funding and the policies and reporting need to be applied consistently county-to-county, year-to-year.

He stated there is a host of reasons for reversion: a penalty for counties that are not doing things, a capacity issue, or a way to encourage and potentially identify deficiencies where there may be a need for technical assistance.

One thing that has not been discussed is that the volatility of this funding source makes planning and budgeting difficult, and counties often do not know the amount of funding they will receive until after the fiscal year.

It is important to understand why there are unspent funds and how much unspent funds there are in order to create a reversion policy. There is an opportunity to clarify issues

through the regulatory process, to develop a standardized RER, and to train counties on what the state expects to see in the RER.

Commissioner Questions and Discussion

Executive Director Ewing asked how to transform the intent of reversion away from a punishment and more toward an incentive for success.

Mr. Geiss stated the state is working toward figuring out the type of outcomes needed for programs such as the Full Service Partnership. It does not seem appropriate for counties to be penalized for trying to do the right thing. He suggested that counties that have a capacity issue report to the state that they will be unable to spend the funds so it will be made available to other counties. He suggested determining the expected outcomes, gathering information, standardizing reporting, getting more technical assistance to counties, and identifying best practices.

Commissioner Van Horn stated the funds received in year one must be spent before the end of year three. It should not be that difficult. Mr. Geiss stated the governor releases the budget for the next fiscal year in January and February with an estimate of MHSA revenues for the next fiscal year. Counties may set a budget on that, but it is predicated on an annual adjustment that is not known until March, which is sometimes off by millions of dollars. The volatility of the funding makes is difficult to plan. Also, the stakeholder process and coming to the Commission for approval of INN plans tend to draw things out.

Commissioner Poaster stated the timeclock starts when the Controller's Office funds the county for their INN plan, but if the county did not begin the stakeholder process because they did not know how much money they would get, this almost by definition means the county will run out of time.

Executive Director Ewing stated Commissioner Danovitch raised the question about calculating the margin of risk on disallowance. It seems there is a clash between the MHSA, which says innovate and take risks, and an accounting world, which says do not take risks because of volatility on the revenue and audit side. There is a challenge between the intent of the MHSA and the fiscal structure in which the MHSA is being administered. Mr. Geiss agreed. What compounds the audit part is that they are now auditing fiscal year 2009-10, so it is not just one year, but five years.

Commissioner Danovitch asked about other state or industry models. Mr. Geiss stated he was unsure that reversion is the way to do it versus looking at what the appropriate level of unspent funds is. While the money should come back in the case of noncompliance in implementing new programs, there needs to be a technical assistance step first.

Commissioner Mitchell asked if there are other state examples for dealing with this issue. Mr. Geiss stated he is not aware of any, but it would be worth taking a look if there are.

Commissioner Buck asked if Mr. Geiss is on the DHCS fiscal regulation work group. Mr. Geiss stated he is not, but there is state, DHCS, and county representation. With the added provider representation included, the work group will consist of those most impacted by the policies.

Commissioner Buck stated the Commission put together a subcommittee to work on reversion, but the DHCS work group is already meeting on a regular basis with all players working toward a common goal to get the funding out into the community. He asked if the Commission can see the minutes produced by the DHCS work group to track the product that will be unavailable until 2018.

Chuck Anders, Chief, Fiscal Management and Reporting Outcomes, Mental Health Services Division, DHCS, stated the work group has met twice so far and plans to meet on the first and last Wednesdays of each month. They have already worked through reversion and have come to an agreement on policies to move forward. There are still a few outstanding questions that county members have volunteered to continue to discuss and to bring proposals on how to address those issues back to the work group.

Deputy Director Sala stated there are no minutes to the meetings but the group has a working paper that is revised as input is gathered.

Commissioner Buck and Commissioner Van Horn encouraged Mr. Anders to include community members and providers on the work group.

Commissioner Aslami-Tamplen asked if the work group is open to the public. It is important for the community to have access to this issue that will ultimately impact them. Mr. Anders stated the work group is not open to the public at this time.

Executive Director Ewing asked if the goal for the DHCS is to put forward regulations that would allow the public to see how much money came in, was spent, and how much was left. Ms. Grealish stated that is the goal.

Deputy Director Sala stated the work group meetings are preliminary, staff-level discussions about the issues that need to be grappled with in the design of the draft regulations.

Public Comment

Poshi Walker, LGBTQ Program Director, NorCal MHA, thanked Ms. Danner for discussing Medi-Cal disallowances. She provided an example of how Medi-Cal disallowances negatively affect client and family member services. She suggested having a discussion on this topic in the future.

Michelle Violett, MHSA Coordinator, Nevada County, stated small county reversion issues that cause delay were not discussed, specifically small counties cannot find individuals to hire to implement the programs that are approved which causes delay in implementation.

ACTION

3: <u>El Dorado County Innovation Plans</u>

Presenter: Brian R. Sala, Ph.D., Deputy Director

County Presenter: Jamie Samboceti, MA, MFT, Deputy Director, El Dorado County Health and Human Services Agency

Deputy Director Sala provided an overview, accompanied by a slide presentation, of the El Dorado County INN summary, materials, regulatory criteria, and what OAC staff look for in the two proposed El Dorado County INN projects: (1)“Restoration of Competency in an Outpatient Setting” originally scheduled for two years and $727,010 but changed to three years and $651,572; and (2)“Community Based Engagement and Support Services”, for four years and $2,760,021.

Jamie Samboceti, MA, LMFT, HHSA, Deputy Director, El Dorado County Health and Human Services Agency, provided an overview, accompanied by a slide presentation. She highlighted the transformational activities the county has recently implemented, county challenges, and county strengths. She explained each of the Innovation projects, including, service implementation, evaluation, and budget. She stated, that due to a calculation error in the “Restoration of Competency in an Outpatient Setting” INN project they are able to do three years instead of two and for less money. She revised the County’s original approval request to reflect the change.

Commissioner Questions

Commissioner Aslami-Tamplen asked why there are no costs for evaluation for the Community Based Engagement and Support Services INN project. Ms. Samboceti stated evaluations are provided with in-kind services by First 5 Commission but there are administrative costs.

Commissioner Anthony asked what evaluation tools will be used on the young people. Ms. Samboceti stated the evaluation tools will mainly be for the parents, to determine if parents need mental health and substance use services. The evaluation tools for children will be for school readiness and health need identification.

Commissioner Gordon referenced the budget and asked about the $1.2 million in county staff costs and $1.3 for administrative costs. He asked why the administrative costs are so high relative to the staff costs. Ms. Samboceti stated the INN program will fund 100 percent of the administrative costs but .5 for public health nurses and advocates.

Commissioner Gordon asked why the administrative costs are so high for such a small county. Ren Scammon, Program Manager, El Dorado County, stated the county uses an indirect cost rate that is applied to the salaries of all staff. Additionally, the Utilization Review Unit will be doing a lot of the evaluation in-house, so those costs are added to the administrative costs.

Commissioner Anthony asked about the tools and approaches used to engage clients in the “Restoration of Competency in an Outpatient Setting” INN project. Ms. Samboceti stated there is no specific tool. The Trauma-Informed Care approach and the Adverse Childhood Experiences (ACEs) model are followed.

Commissioner Gordon asked how the huge administrative costs can be replaced if the program works well and the county wants to continue it. Ms. Samboceti stated some restructuring in services and staff will be needed. Ms. Scammon added that the county receives funding for Assembly Bill (AB) 109 services and has the ability to move staff between those programs.

Commissioner Anthony asked if peer support staff are built into this project. Ms. Samboceti stated the wellness center has a peer-driven and peer-run program and

some groups that are peer-driven. The INN projects will utilize county peer-support specialists in the everyday delivery of services.

Commissioner Aslami-Tamplen asked how many clients the "Restoration of Competency in an Outpatient Setting" INN project will serve. Ms. Samboceti stated the INN project will serve eight clients per year.

Public Comment

Heidi Strunk, Advocacy Coordinator, California Association of Mental Health Peer-Run Organizations (CAMHPRO), stated CAMHPRO has worked with peers at the wellness center in El Dorado County in continuing technical support. She strongly encouraged that the county provide paid peer employment in programs.

Michaele Beebe, Public Policy Director, United Advocates for Children and Families (UACF), asked what is in place for the rest of the family once the incarcerated adult returns home and what children's services, including housing resources are provided for homeless clients. Ms. Samboceti stated the counties encourage clients to have secured housing.

Commissioner Discussion

Commissioner Anthony voiced her extreme concern of the high administrative costs for the Restoration project. Deputy Director Sala stated the ratio is approximately 47.8 percent of the total cost.

Action: Commissioner Van Horn made a motion, seconded by Commissioner Gordon, that:

The MHSOAC approves El Dorado County's INN Projects as amended:

> *Name: Restoration of Competency in an Outpatient Setting*
> *Amount: $651,572*
> *Program Length: Three Years*
>
> *Name: Community Based Engagement and Support Services*
> *Amount: $2,760,021*
> *Program Length: Four Years*

Motion carried 8 yes, 0 no, and 0 abstain, per roll call vote as follows:

The following Commissioners voted "Yes": Commissioners Anthony, Aslami-Tamplen, Buck, Danovitch, Gordon, Mitchell, Poaster, and Van Horn.

GENERAL PUBLIC COMMENT

Ms. Walker read a statement from Susan Gallagher, Executive Director, NorCal MHA, about the MHSOAC's slip away from its fundamental purpose of oversight, particularly as it relates to its role as a funding entity. Ms. Gallagher urged the Commission to take seriously the charge of oversight and to do everything in its power to dispel the perceptions of favoritism, fraud, and corruption in the MHSA. The future sustainability of this funding depends on it.

ACTION

1A: <u>Approve July 28, 2016, MHSOAC Meeting Minutes</u>

Action: Commissioner Danovitch made a motion, seconded by Commissioner Anthony, that:

The Commission approves the July 28, 2016, Meeting Minutes.

Motion carried 6 yes, 0 no, and 1 abstain, per roll call vote as follows:

The following Commissioners voted "Yes": Commissioners Anthony, Danovitch, Gordon, Mitchell, Poaster, and Van Horn.

The following Commissioner abstained: Commissioner Aslami-Tamplen.

ACTION

4: <u>Nevada County Innovation Plan</u>

Presenter: Brian R. Sala, Ph.D., Deputy Director

County Presenter: Michele Violett, MHSA Coordinator, Nevada County Behavioral Health Department

Commissioner Buck recused himself from the discussion and decision-making with regard to this agenda item and was not in the room.

Deputy Director Sala provided a summary of the proposed five-year, $375,000 Nevada County INN project, titled "Integration of Rural Mental Health Services to Improve Outcomes." He noted that this INN project will work across county lines.

Ms. Violett provided an overview, accompanied by a slide presentation, of the overview of the Tahoe Truckee community, stakeholder process, goals, existing services, staffing, focus, learning objectives, and evaluation of the Nevada County INN project. She stated Nevada County will work with Placer County on the client-level outcome survey to be used. Currently, the counties collect different types of data elements.

Commissioner Questions

Commissioner Aslami-Tamplen asked if the data will align with PEI data collection requirements. Ms. Violett stated Nancy Callahan has separately contracted with Placer and Nevada Counties to do the PEI evaluations.

Action: Commissioner Gordon made a motion, seconded by Commissioner Danovitch, that:

The MHSOAC approves Nevada County's Innovation Project as follows:

Name: Integration of Rural Mental Health Services to Improve Outcomes
Amount: $375,000
Program Length: Five Years

Motion carried 7 yes, 0 no, and 0 abstain, per roll call vote as follows:

The following Commissioners voted "Yes": Commissioners Anthony, Aslami-Tamplen, Danovitch, Gordon, Mitchell, Poaster, and Van Horn.

ANNOUNCEMENT

Executive Director Ewing announced the retirement of Sheridan Merritt and thanked Mr. Merritt for his work with the Commission and especially his recent work on the Children's Crisis Service project.

ACTION

5: Additional Funding for Stakeholder Contracts

Presenter: Angela Brand, MHSOAC Staff

Angela Brand, MHSOAC staff, provided an overview, accompanied by a slide presentation, of the background, current contracts, and staff proposal for the additional funding for stakeholder contracts.

Commissioner Questions

Commissioner Mitchell asked about the criteria for the amount of additional funding. Executive Director Ewing stated that the Commission wanted no break in advocacy and the criteria will be what is needed to have no break. Staff will met with each contractor to discuss what would be required to fill the gap until the completion of the RFP process.

Public Comment

Delphine Brody, Sacramento Icarus Project, spoke in support of the proposed motion to provide bridge funding for existing contractors.

Stave Leoni, consumer and advocate, spoke in support of the proposed motion.

Ms. Walker stated she can philosophically see that sole-source funding has the potential to be problematic. She stated she has seen LGBTQ communities left behind too many times. She asked that, if the other groups receive short-term funding, LGBTQ also should receive short-term funding now that there is approved funding. The LGBTQ is the only stakeholder group not included in the proposed motion. She humbly requested that LGBTQ be added to the motion.

Nicki King, Ph.D., REMHDCO, spoke in support of the proposed motion.

Zima Creason, CEO, Mental Health Association in California (MHAC), California Youth Empowerment Network (CAYEN), spoke in support of the proposed motion. She stated the concern that the intent is to potentially not be $200,000. These contracts are not cost-reimbursement contracts but deliverable-based contracts. Just because there are dollars that have not been billed does not mean they have not already been spent. The bridge funding is for new work.

Laurel Benhamida, Ph.D., REMHDCO Steering Committee Member, Muslim American Society Social Services Foundation, spoke in support of the proposed motion.

Najeeb Kamil, REMHDCO Steering Committee Member, spoke in support of the proposed motion.

Meghan Stanton, CAMHPRO, spoke in support of the proposed motion. She stated the prior contract extensions were no-cost extensions – no additional funds were put into those contracts. Organizations have continued their work without additional funding to this point.

Sally Zinman, Executive Director, CAMHPRO, spoke in support of the proposed motion.

Janet King, REMHDCO, Native American Health Center, spoke in support of the proposed motion. She agreed with Ms. Walker that the LGBTQ community should be included.

Stacie Hiramoto, Director, REMHDCO, spoke in support of the proposed motion.

Rebecca Gonzales, REMHDCO Steering Committee Member, National Association of Social Workers (NASW), spoke in support of the proposed motion.

Commissioner Discussion

Commissioner Mitchell asked why the LGBTQ community is not included in the motion. Executive Director Ewing stated the original intent was to ensure that the representation of current contract organizations would continue with one exception. The Legislature had granted $1 million to add veterans and increase TAY and directed the Commission to begin immediately before the funding was available. The Commission asked permission to borrow from research funds to do two short-term contracts. The Legislature has now directed the Commission to allocate funds for stakeholder advocacy for LGBTQ, but they asked that the process be done competitively. Staff asked the Legislature and the Department of Finance (DOF) for 10 percent of the funds to sustain the work being done but did not ask to jumpstart the LGBTQ RFP.

Commissioner Van Horn stated, since there has never been an LGBTQ contract, there is no organization to give bridge funding to.

Executive Director Ewing stated there is nothing to prevent the organizations with which the Commission currently has a contract from beginning work with the LGBTQ community immediately. TAY organizations that did not win the TAY contract have an opportunity to participate in other RFPs such as Diverse Communities and LGBTQ. There may be opportunities to extend existing work in ways that pick up LGBTQ advocacy right away while the RFP process moves forward.

Commissioner Mitchell suggested that the LGBTQ be part of the bridge funding.

Commissioner Poaster stated there is no bridge funding because it will be something new, but something may be doable.

Commissioner Mitchell stated it is important to include all communities. She requested doing whatever the Commission can for the LGBTQ community.

Commissioner Buck spoke in agreement for all Commissioners.

Commissioners Aslami-Tamplen and Van Horn rescued themselves.

Action: Commissioner Anthony made a motion, seconded by Commissioner Mitchell, that:

The Commission authorizes the Executive Director to contract with current stakeholder contractors to provide short-term funding in an effort to ensure continued advocacy until the RFP process is complete.

Motion carried 4 yes, 0 no, and 2 abstain, per roll call vote as follows:

The following Commissioners voted “Yes”: Commissioners Anthony, Buck, Mitchell, and Poaster.

ACTION

6: <u>Request for Proposals (RFP) Stakeholder Contracts</u>

Presenter: Angela Brand, MHSOAC Staff

Ms. Brand provided an overview, accompanied by a slide presentation, of the background, initial RFP, budget changes for fiscal year 2016-17, new RFP, next steps, and projected timeline of the RFP for stakeholder contracts.

Commissioner Questions

Commissioner Aslami-Tamplen asked what will be learned in the process. Ms. Brand stated staff would like to bring all applicants together to discuss the process, proposals, scores, what worked, and what did not work.

Commissioner Mitchell asked why the minimum qualifications (MQs) for the LGBTQ contract did not mirror the veteran and diverse communities RFPs. Executive Director Ewing stated funding was not originally budgeted for a contract specific to the LGBTQ community. Staff went to the Legislature last year and was granted additional funding for this group. This is the first time the Commission will issue an RFP to support advocacy specific to the LGBTQ population. Staff proposes to mirror the more general criteria of a statewide organization with experience providing programs and services to that population, which is the criteria used for diverse communities and veterans.

Commissioner Van Horn asked why a board and staff of more than 51 percent of each population is not required for all advocacy contracts. Executive Director Ewing stated the concern that for some categories – for example, veterans’ organizations – viable organizations may not meet the technical requirements of 51 percent board and staff. The broader definition allows the merits of the proposals to be considered.

Public Comment

Ms. Creason stated the hope that community members will be included in reviewing and scoring the proposals. Stakeholder involvement lends credibility to the contract award process. She stated there is a problem with the current RFP process. Canceling all RFPs except the transition-age-youth (TAY) RFP and providing technical assistance (TA) to all other RFPs does not seem equitable. The TAY RFP is being treated differently.

Mr. Kamil agreed with the previous speaker. He stated the need for stakeholders to be involved in the RFP process to ensure that the process is transparent and fair and to bring legitimacy to the process. He does not interpret the Public Contract Code and the State Contracting Manuals the same way the Commission is interpreting and he thinks it can be interpreted to allow stakeholders. Private consultants can provide clarification or subject matter expertise.

Ms. Gonzales agreed with the previous speakers. She stated the need for the evaluators of the Diverse Communities RFP to be not only diverse but culturally competent and understand the work that REMHDCO is trying to do.

Dr. Benhamida agreed with the previous speakers. She questioned the RFP process. She suggested including street-credible stakeholder input in the process. It is important that contracts are awarded to organizations that have built relationships over the years with diverse communities.

Michael Helmick, Associate Director, REMHDCO, agreed with the previous speakers and added the following comments and suggestions:

- The contracts should be advocacy-focused and not program-focused
- The scorers should understand the difference between advocacy and program activities
- The proposal should be designed and scored so there is a level playing field, not giving additional scoring favor to larger organizations
- The RFP language should be written in a way that does not prescribe the activities for the proposer but leaves greater flexibility
- The evaluation committee should include stakeholders with experience and understanding of what advocacy means

Ms. King spoke about why an RFP for advocacy is important. It is important to understand the specialized mental health needs of people of color, but it is also important to have meaningful engagement of people of color. Oftentimes, they are abused, such as not being compensated for their time or travel to speak at conferences. This is why advocacy is important.

Ms. Walker thanked Commissioners for the LGBTQ stakeholder RFP. She stated her organization would not qualify if the requirement was for 51 percent LGBTQ board and staff; however, that does not mean the program her organization would run would not be 100 percent LGBTQ. She stated there are agencies that meet the 51 percent requirement but know nothing about mental health from the grassroots MHSA, Proposition 63 level. She agreed with previous speakers that it is important that the reviewers are from the community. Grassroots does not always match state protocol; what looks good on paper is not always what is good on the ground.

Ms. Stanton agreed with the previous speakers. She stated for statewide advocacy contracts in the Welfare and Institution Code, there is a parameter to use non-state employees as part of the process for selecting the contract. She echoed the advocacy needs to underserved and unserved communities. The advocacy contracts are paramount to getting any kind of meaningful involvement from stakeholders.

Ms. Zinman agreed with the previous speakers. She stated the Commission should take a sufficient amount of time to examine what failed in this RFP process and explore other RFP processes. She stated the importance of including individuals on the review teams with experience in statewide advocacy organizations who are experientially familiar with state and local advocacy and grassroots community work.

Ms. Brody reminded Commissioners that this is no ordinary RFP process; it is for statewide contracts for diverse organizations representing many grassroots communities who have not had much of a voice on the state level in mental health policy. As such, a

level playing field is crucial. Further steps can be taken in spite of the laws – in particular, with the scoring process, those state employees that the Commission has brought in to review can also work with community members rather than proceed as though they have expertise exclusively from their own lived experience. There is a difference between individuals who are struggling to survive on the grassroots level and individuals who work full-time within the system. Also, RFPs need to be made more accessible to low-income groups that may have little or no starting funds so they can compete with groups that have greater funding. She encouraged the Commission to make RFPs accessible to individuals who may have much in the way of knowledge, experience, and advocacy capabilities but cannot compete in terms of capacity.

Steven Kite, Deputy Director, National Alliance on Mental Illness (NAMI) California, agreed with the previous speakers. He asked that scorers' names be released to add to the transparency.

Beth Wolf, Director of Programs, NAMI California, agreed with the previous speakers.

Mr. Leoni echoed Ms. Zinman, Ms. Walker, and Ms. Brody's statements. He stated several speakers have asked for non-state personnel on review panels, but it would be against state law. He suggested looking at state legislation. The current contracting rules for competitive bidding are for individuals building roads, bridges, and tunnels, where dozens of contractors bid and have other contracts. The mental health community is very different – it is not the landscape that these rules are for. Not only is it the process but it is what can or cannot be considered in the process.

Dr. King encouraged the Commission to recognize that thirteen organizations put a lot of time into responding to the RFP process. The fact that twelve of them were noncompliant suggests that there is something that needs to be tweaked in terms of the process. She applauded the Commission for trying to do something that is as creative and innovative as a series of advocacy RFPs and contracts. She encouraged the Commission to look closely and think about how a process can be done that individuals who are experienced in doing what is requested can qualify.

Commissioner Discussion

Executive Director Ewing stated there have been internal conversations about looking for openings in the law to allow for more consultation. It is important to understand that staff took a tremendous amount of consultation from the community in terms of the design components and flexibility of the RFP. The Commission outlined the three broad areas for work to be done but left it open to the proposer to decide how to do the work.

Executive Director Ewing agreed with Mr. Leoni that there is a mismatch between the rules the Commission operates under and what the Commission is trying to get done. It is rare to have legislation that states funds shall be used to support community voice and engagement.

Commissioner Poaster expressed his appreciation that the RFP included local level training and technical assistance as well as local advocacy efforts.

Executive Director Ewing stated there are six separate RFPs. It was not a situation with 12 out of 13 students in a classroom did not pass the test. It was six different classrooms with one or two students in each room. There was one applicant for several of the RFPs

and one applicant did not get above the minimum threshold. There was a mismatch between the rules, the expectations, and the experience. Staff is earnest in wanting to improve the match between expectations and the proposals. However, there is no time to go back and revisit the law or the rules.

Executive Director Ewing, in response to public request for the names of the reviewers, stated he is extremely cautious about releasing the 22 names of the reviewers. Other state agencies have counseled against this. Each review panel had subject matter experts on them. Staff spoke with three attorneys, many consultants, and individuals who are in charge of contracting for all of the Department of General Services (DGS), who were all explicit that there could not be non-state employees for scoring.

Executive Director Ewing stated staff is trying to follow the law and address perception. The statewide contracting dollars went from $1.9 million to almost $5 million per year for three years. The Department of Finance, the Governor's office, and the Legislature want to provide support as evidenced by the growth in dollars but they have heard from many in the communities that these contract dollars have not been well-managed in the past. This is an almost $15 million investment and, if the Commission wants to go to the Legislature to ask for more funding, the quality of the investment needs to be defended. There are other groups that are not well-represented in the current contracts, such as older adults.

Executive Director Ewing asked everyone to put the process in the context of the Commission's efforts to grow the funds, increase the flexibility on behalf of the proposers for effective advocacy, and make the case both in reality and perception that this is an investment worth sustaining and growing over time.

Commissioner Van Horn stated he was told that there have been non-state employees who were reviewers on state-issued RFPs. Executive Director Ewing stated it is possible that it may have been non-competitive, or the law has changed since then, or the funds were not state funds. Executive Director Ewing asked Chief Counsel to read the relevant section from the Public Contract Code.

Ms. Yeroshek read Public Contracts Code section 10344(c) and the State Contracting Manual Volume 1, section 5.15. She stated, given those sections and the legal advice obtained, it was determined that in order to comply with the law, scorers had to be state employees.

Commissioner Anthony provided some advice regarding responding to future RFPs. The proposals must be clearly written to stand on their own. Proposers should assume that the scorers are not familiar with the proposers or any of their work.

Action: Commissioner Danovitch made a motion, seconded by Commissioner Van Horn, that:

The Commission authorizes the Executive Director to issue RFPs for the following populations:

- *Clients/Consumers (up to $670,000 per year / $2,010,000 total)*
- *Diverse Communities (up to $670,000 per year / $2,010,000 total)*
- *Families of Clients/Consumers (up to $670,000 per year / $2,010,000 total)*

- *LGBTQ (up to $670,000 per year / $2,010,000 total)*
- *Parents of Children and Youth (up to $670,000 per year / $2,010,000 total)*
- *Transition Age Youth (up to $710,000 total)*
- *Veterans (up to $670,000 per year / $2,010,000 total)*

Motion carried 6 yes, 0 no, and 0 abstain, per roll call vote as follows:

The following Commissioners voted "Yes": Commissioners Anthony, Aslami-Tamplen, Buck, Mitchell, Poaster, and Van Horn.

INFORMATIONAL

7: <u>MHSOAC Executive Director Report</u>

Presenter: Toby Ewing, Ph.D., Deputy Director

Executive Director Ewing presented his report:

<u>Staff Changes/Vacancies</u>

Executive Director Ewing introduced new MHSOAC employee Angelica, who is working in the Personnel Department.

Recruitment for a consulting psychologist is underway.

<u>Outreach</u>

There will be a preliminary viewing of a documentary on the mental health needs of veterans at the MHSOAC offices on August 29, 2016, at 1:00 p.m. Following the documentary, there will be a discussion about activities the Commission can support around the release date. The documentary will be released nationally and at the local PBS station on or around Veterans Day. Staff will work with the Legislature to host a viewing at the Crest or in the Capitol Building.

<u>Agenda/Meeting Calendar</u>

The next Commission meeting will be on September 22 in Los Angeles with a focus on mental health and criminal justice, with a full day of activities the day before, including a tour of the jail.

The October meeting will focus on mental health and the schools.

The November meeting is a teleconference meeting.

There will be no meeting in December.

<u>Community Forums</u>

Community forums in Stanislaus and Alameda Counties have been planned with a focus on the mental health and criminal justice theme.

<u>Crisis Services</u>

The work on crisis services will be presented later in the year.

Projects

Staff will work with Commissioner Buck to set up work group meetings on reversion to build on the work that the DHCS is doing.

Triage

The Commission runs a $32 million per year grant program to provide funds to counties to keep individuals out of the criminal justice system and emergency departments. Strategies are being put in place for counties to learn from each other. The goal is to use the funding to drive transformational change through collaborative learning processes. A new round of competitive funding will begin late next year.

Budget

The budget process is beginning and a new process for legislation towards the end of the year. Added to the list will be the issue of looking at policy change around the competitive procurement process.

Fellowships/Internships

Staff will meet with the Legislature to discuss sponsoring legislation to allow the Commission to offer a mental health fellowship program both at the psychiatry and peer levels.

Data and Analytics

Work continues to try to match mental health with employment data to study trends in employment.

Discussions continue with the DOF on how to track the administrative funding used, particularly the unspent administrative funds.

Legislation

The Commission took a support position for Senate Bill (SB) 614. The sponsors of the bill have pulled back the language and the bill is being used for something else.

The Commission sent a letter of support to the Legislature and the Governor for AB 2279 to increase transparency of the mental health funds.

The Commission is mentioned in AB 2017 to create a grant program for college-based mental health. The current version of the bill has the Commission running that program.

The Commission was given $3 million of the $30 million dedicated to crisis services for children for grants with the triage program.

GENERAL PUBLIC COMMENT

Robin Allen, Executive Director, California Youth Connection (CYC), introduced herself and stated the Commission's investment will be well-used and the CYC is excited to have a statewide reach.

Ms. Creason stated MHAC/CAYEN put in a public information request to see the TAY RFPs. She stated MHAC/CAYEN was awarded zero out of five points in the desired

qualifications self-certification category. The technical review document notes indicated that the proposer did not include an attachment and did not self-certify. However, the Compliance Review Sheet that accompanied the proposal noted that it was submitted and was in compliance. She stated there may be an unknown explanation, but if that was an error, there may have been more.

Ms. Creason suggested empowering advocacy groups to do specific work and questioned the catalyst that is moving the Commission to shift away from accountability and oversight. Great program work is happening, but maybe others should be empowered to do that work so the Commission can do oversight and accountability.

Tando Goduka, CAMHPRO, stated there was a conference in the spring that addressed the unmet needs of stakeholders to come together, network, share, and grow resources in social capital. It was the first time in seven years that California had a statewide consumer conference. She stated she is grateful for bridge funding but is concerned that it takes a lot of time to put on advocacy work. There needs to be strong momentum to make logistical plans to have the event, judge expected outcomes, look at measurable results, and identify best practices. Having this level of uncertainty in terms of bridge funding affects advocacy efforts, which trickles down with how needs are met with stakeholders from the grassroots MHSA level who are oftentimes and historically unserved and underserved.

Ms. Walker thanked Commissioners for their gracious, thoughtful discussion and for their willingness to explore the issues. She also gave her appreciation to staff.

ADJOURN

Commissioner Poster commended staff for their work during this difficult process. There being no further business, the meeting was adjourned at 4:05 p.m.

Mental Health Services
Oversight & Accountability Commission

WELLNESS • RECOVERY • RESILIENCE

Motions Summary

Commission Meeting
August 25, 2016

Motion #: 1
Date: August 25, 2016
Time: 12:14 p.m.

Text of Motion:

The MHSOAC approves El Dorado County's INN Projects as follows:

Name: Restoration of Competency in an Outpatient Setting
Amount: $651,572
Project Duration: 3 Years

Name: Community Based Engagement and Support Services
Amount: $2,760,021
Project Duration: 4 years

Commissioner making motion: Commissioner Van Horn
Commissioner seconding motion: Commissioner Gordon

Motion carried 8 yes, 0 no, and 0 abstain, per roll call vote as follows:

Name	Yes	No	Abstain
1. Chair Carrion	☐	☐	☐
2. Vice-Chair Wooton	☐	☐	☐
3. Commissioner Anthony	☒	☐	☐
4. Commissioner Ashbeck	☐	☐	☐
5. Commissioner Aslami-Tamplen	☒	☐	☐
6. Commissioner Beall	☐	☐	☐
7. Commissioner Boyd	☐	☐	☐
8. Commissioner Brown	☐	☐	☐
9. Commissioner Buck	☒	☐	☐
10. Commissioner Danovitch	☒	☐	☐
11. Commissioner Gordon	☒	☐	☐
12. Commissioner Mitchell	☒	☐	☐
13. Commissioner Poaster	☒	☐	☐
14. Commissioner Thurmond	☐	☐	☐
15. Commissioner Van Horn	☒	☐	☐

MHSOAC
Mental Health Services
Oversight & Accountability Commission

WELLNESS • RECOVERY • RESILIENCE

Motion #: 2
Date: August 25, 2016
Time: 1:23 p.m.

Text of Motion:

The Commission approves the July 28, 2016 Meeting Minutes.

Commissioner making motion: Commissioner Danovitch
Commissioner seconding motion: Commissioner Anthony

Motion carried 6 yes, 0 no, and 1 abstain, per roll call vote as follows:

Name	Yes	No	Abstain
1. Chair Carrion	☐	☐	☐
2. Vice-Chair Wooton	☐	☐	☐
3. Commissioner Anthony	☒	☐	☐
4. Commissioner Ashbeck	☐	☐	☐
5. Commissioner Aslami-Tamplen	☐	☐	☒
6. Commissioner Beall	☐	☐	☐
7. Commissioner Boyd	☐	☐	☐
8. Commissioner Brown	☐	☐	☐
9. Commissioner Buck	☐	☐	☐
10. Commissioner Danovitch	☒	☐	☐
11. Commissioner Gordon	☒	☐	☐
12. Commissioner Mitchell	☒	☐	☐
13. Commissioner Poaster	☒	☐	☐
14. Commissioner Thurmond	☐	☐	☐
15. Commissioner Van Horn	☒	☐	☐

Mental Health Services
Oversight & Accountability Commission

WELLNESS • RECOVERY • RESILIENCE

Motion #: 3
Date: August 25, 2016
Time: 1:45 p.m.

Text of Motion:

The MHSOAC approves Nevada County's INN Project as follows:

Name: Integration of Rural Mental Health Services to Improve Outcomes
Amount: $375,000
Project Duration: 5 Years

Commissioner making motion: Commissioner Gordon
Commissioner seconding motion: Commissioner Danovitch

Commissioner Buck recused himself.

Motion carried 7 yes, 0 no, 0 abstain per roll call vote as follows:

Name	Yes	No	Abstain
1. Chair Carrion	☐	☐	☐
2. Vice-Chair Wooton	☐	☐	☐
3. Commissioner Anthony	☒	☐	☐
4. Commissioner Ashbeck	☐	☐	☐
5. Commissioner Aslami-Tamplen	☒	☐	☐
6. Commissioner Beall	☐	☐	☐
7. Commissioner Boyd	☐	☐	☐
8. Commissioner Brown	☐	☐	☐
9. Commissioner Buck	☐	☐	☐
10. Commissioner Danovitch	☒	☐	☐
11. Commissioner Gordon	☒	☐	☐
12. Commissioner Mitchell	☒	☐	☐
13. Commissioner Poaster	☒	☐	☐
14. Commissioner Thurmond	☐	☐	☐
15. Commissioner Van Horn	☒	☐	☐

MHSOAC
Mental Health Services
Oversight & Accountability Commission

WELLNESS • RECOVERY • RESILIENCE

Motion #: 4
Date: August 25, 2016
Time: 3:05 p.m.

Text of Motion:

The Commission authorizes the Executive Director to issue RFPs for the following populations:

- Clients/Consumers (up to $670,000 per year / $2,010,000 total)
- Diverse Communities (up to $670,000 per year / $2,010,000 total)
- Families of Clients/Consumers (up to $670,000 per year / $2,010,000 total)
- LGBTQ (up to $670,000 per year / $2,010,000 total)
- Parents of Children and Youth (up to $670,000 per year / $2,010,000 total)
- Transition Age Youth (up to $710,000 total)
- Veterans (up to $670,000 per year / $2,010,000 total)

Commissioner making motion: Commissioner Danovitch
Commissioner seconding motion: Commissioner Van Horn

Motion carried 6 yes, 0 no, 0 abstain, per roll call vote as follows:

Name	Yes	No	Abstain
1. Chair Carrion	☐	☐	☐
2. Vice-Chair Wooton	☐	☐	☐
3. Commissioner Anthony	☒	☐	☐
4. Commissioner Ashbeck	☐	☐	☐
5. Commissioner Aslami-Tamplen	☒	☐	☐
6. Commissioner Beall	☐	☐	☐
7. Commissioner Boyd	☐	☐	☐
8. Commissioner Brown	☐	☐	☐
9. Commissioner Buck	☒	☐	☐
10. Commissioner Danovitch	☐	☐	☐
11. Commissioner Gordon	☐	☐	☐
12. Commissioner Mitchell	☒	☐	☐
13. Commissioner Poaster	☒	☐	☐
14. Commissioner Thurmond	☐	☐	☐
15. Commissioner Van Horn	☒	☐	☐

MHSOAC
Mental Health Services
Oversight & Accountability Commission

WELLNESS • RECOVERY • RESILIENCE

Motion #: 5
Date: August 25, 2016
Time: 3:44 p.m.

Text of Motion:

The Commission authorizes the Executive Director to contract with current stakeholder contractors to provide short-term funding in an effort to ensure continued advocacy until the RFP process is complete.

Commissioner making motion: Commissioner Anthony
Commissioner seconding motion: Commissioner Mitchell

Commissioner Aslami-Tamplen and Commissioner Van Horn recused themselves.

Motion carried 4 yes, 0 no, and 0 abstain, per roll call vote as follows:

Name	Yes	No	Abstain
1. Chair Carrion	☐	☐	☐
2. Vice-Chair Wooton	☐	☐	☐
3. Commissioner Anthony	☒	☐	☐
4. Commissioner Ashbeck	☐	☐	☐
5. Commissioner Aslami-Tamplen	☐	☐	☐
6. Commissioner Beall	☐	☐	☐
7. Commissioner Boyd	☐	☐	☐
8. Commissioner Brown	☐	☐	☐
9. Commissioner Buck	☒	☐	☐
10. Commissioner Danovitch	☐	☐	☐
11. Commissioner Gordon	☐	☐	☐
12. Commissioner Mitchell	☒	☐	☐
13. Commissioner Poaster	☒	☐	☐
14. Commissioner Thurmond	☐	☐	☐
15. Commissioner Van Horn	☐	☐	☐

AGENDA ITEM1C

Information

September 22, 2016 Commission Meeting

MHSOAC Evaluation Dashboard

Summary: The Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission) Evaluation Dashboard assists in monitoring the major evaluation efforts currently underway. The Evaluation Dashboard provides information, objectives, and the status of all current deliverables for internal and external evaluation contracts and projects. Below is a list of all changes/updates to all evaluation projects, which are highlighted in red within the Dashboard.

Changes/Updates: There are no changes or updates to evaluation projects at this time.

Enclosures: MHSOAC Evaluation Dashboard

Recommended Action: None

Presenter: None

Motion: None

MHSOAC Evaluation Dashboard September 2016

(updated 9/12/16)

Mental Health Services
Oversight & Accountability Commission

Current MHSOAC Evaluation Contracts and Deliverables

Mental Health Data Alliance (MHDATA)

Full Service Partnership (FSP) Classification Project

MHSOAC Staff: Brian Sala

Active Dates: November 2014 – June 30, 2017

Objective: The purpose of this evaluation effort is to assess Full Service Partnerships (FSPs) on a statewide level in order to classify them in a meaningful and useful fashion that should ultimately enable clients, family members, providers, counties, and the State to further understand the diversity of FSPs across California.

	Deliverable	Due Date*	Deliverable Cost	Status
1	Preliminary Statewide FSP Classification System Presentation Based on Focus Groups and/or Interviews	February 27, 2015	$52,650	Completed
2	Report of Proposed Statewide FSP Classification System Based on Stakeholder Input	August 31, 2015	$53,750	Completed
3	Report of Final Statewide FSP Classification System Based on Public Comment	October 30, 2015	$11,225	Completed
4	Report of Online Statewide FSP Classification System Website Version 1.0 Design Specification	February 29, 2016	$56,900	Completed
5	Online Statewide FSP Classification System Website Version 1.0	August 31, 2016	$119,900	Pending
6	Online Statewide FSP Classification System Website Administrator Training and Technical Assistance Report	October 31, 2016	$11,225	Pending
7	Online Statewide FSP Classification System Website User Training and Technical Assistance Report	October 31, 2016	$11,225	Pending
8	Online Statewide FSP Classification System Website Hosting and Cost Report	May 1, 2017	$10,438	Pending
Total Contract Amount			$327,313	

* Reflects the date that the deliverable is due to the MHSOAC for an internal review for compliance and approval.

MHSOAC Evaluation Dashboard September 2016

(updated 9/12/16)

MHSOAC
Mental Health Services
Oversight & Accountability Commission

The Regents of the University of California, University of California, San Diego

Recovery Orientation of Programs Evaluation

MHSOAC Staff: Ashley Mills

Active Dates: January 1, 2015 – May 31, 2017

Objective: To identify, describe, and assess existing measures and methods of evaluating the recovery orientation of programs and services, conduct an evaluation of the recovery orientation of direct and indirect services and/or programs provided within the Community Services and Supports (CSS) component (focused on the adult system of care), and use results from the evaluation to provide recommendations to providers, counties, and the State for achievement/promotion of recovery orientation in programs/services, as well as recovery and wellness of the clients that are served via these programs/services.

	Deliverable	Due Date*	Deliverable Cost	Status
1	Report on Existing Measures of Recovery Orientation	June 30, 2015	$50,000	Completed
2	Report of Proposed Research Design and Analytic Plan to Evaluate the Recovery Orientation of Programs and Services	July 15, 2015	$100,000	Completed
3	Technical Report of Evaluation Results, Data, Stakeholder Materials, and Dissemination Plan	September 30, 2016	$200,000	Pending
4	Resources for Evaluating Recovery Orientation and Dissemination Plan	January 15, 2017	$50,000	Pending
5	Resources for Promoting Practices that Encourage Recovery Orientation and Dissemination Plan	January 15, 2017	$50,000	Pending
6	Report of Policy and Practice Recommendations for Ensuring, Maintaining, and Strengthening the Recovery Orientation of Programs and Services	March 30, 2017	$50,000	Pending
Total Contract Amount			$500,000	

* Reflects the date that the deliverable is due to the MHSOAC for an internal review for compliance and approval.

MHSOAC Evaluation Dashboard September 2016

(updated 9/12/16)

MHSOAC
Mental Health Services
Oversight & Accountability Commission

The Regents of the University of California, University of California, Davis

Early Psychosis Evaluation

MHSOAC Staff: Ashley Mills

Active Dates: June 1, 2015 – June 30, 2017

Objective: To identify and analyze program costs (i.e., costs expended to implement the program), outcomes (e.g., decreased hospital visits), and costs associated with those outcomes (e.g., costs associated with hospitalization) related to providing early psychosis programs. This evaluation will use the data from the Early Diagnosis and Preventative Treatment of Psychosis Illness (SacEDAPT) program in Sacramento County to pilot a method to calculate the program costs, outcomes, and costs associated with those outcomes when providing the SacEDAPT program, and to identify appropriate sources of comparison data (e.g., costs and outcomes during the period preceding SacEDAPT implementation). The evaluation will also develop and implement a method for identifying and describing all early psychosis programs throughout the State, to include specifically, for example, the data elements that are collected by these programs and the various ways in which they are collected (e.g., via Electronic Health Records or EHRs); data elements will be used to provide insight regarding existing capacity to assess costs and outcomes for early psychosis programs statewide, as well as help to define methods for use during the Sacramento County pilot.

	Deliverable	Due Date*	Deliverable Cost	Status
1	Summary Report of Descriptive Assessment of SacEDAPT Early Psychosis Program	July 1, 2015	$75,000	Completed
2	Proposed Methodology for Analysis of Program Costs, Outcomes, and Changes in Costs Associated with those Outcomes in the SacEDAPT/Sacramento County Pilot	November 1, 2015	$35,000	Completed
3	Report of Research Findings from Sacramento County Pilot	July 1, 2016	$45,000	Completed
4	Proposed Plan to Complete the Descriptive Assessment of Early Psychosis Programs Statewide	October 1, 2016	$20,000	Pending
5	Summary Report of Descriptive Assessment of Early Psychosis Programs Statewide	March 1, 2017	$20,000	Pending
6	Proposed Statewide Evaluation Plan	May 1, 2017	$5,000	Pending
Total Contract Amount			$200,000	

The Regents of the University of California, University of California, Los Angeles

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MHSOAC Evaluation Dashboard September 2016

(updated 9/12/16)

Mental Health Services
Oversight & Accountability Commission

Assessment of System of Care for Older Adults

MHSOAC Staff: Brian Sala

Active Dates: June 1, 2015 – June 30, 2017

Objective: The purpose of this evaluation effort is to assess the progress made in implementing an effective system of care for older adults with serious mental illness and identify methods to further statewide progress in this area. This assessment shall involve gauging the extent to which counties have developed and implemented services tailored to meet the needs of the older adult population, including un/underserved diverse older individuals, recognizing the unique challenges and needs faced by this population. In order to bolster the State's ability to promote improvements in the quality of services for older adults, a series of indicators shall be developed focused specifically on older adults with mental health issues; these indicators shall be developed with the intention of incorporating them into future data strengthening and performance monitoring efforts. The Contractor shall also identify and document the challenges and barriers to meeting the unique needs of this population, as well as strategies to overcome these challenges. Lessons learned and resultant policy and practice recommendations for how to improve and support older adult mental health programs at the State and local levels shall be developed and presented to the Commission.

	Deliverable	Due Date*	Deliverable Cost	Status
1	Proposed Research Methods	September 7, 2015	$100,000	Completed
2	Recommended Data Elements, Indicators, and Policy Recommendations	June 30, 2016	$118,292	Completed
3	Summary and Analysis of Secondary and Key Informant Interview Data	November 10, 2016	$75,000	Pending
4	Summary of Focus Group Data and Policy Recommendations	March 17, 2017	$75,000	Pending
5	Policy Brief and Fact Sheet(s)	April 28, 2017	$31,708	Pending
Total Contract Amount			$400,000	

* Reflects the date that the deliverable is due to the MHSOAC for an internal review for compliance and approval.

MHSOAC Evaluation Dashboard September 2016

(updated 9/12/16)

Mental Health Services
Oversight & Accountability Commission

The Regents of the University of California, University of California, Los Angeles

Evaluation of Return on Investment (ROI) for Prevention and Early Intervention (PEI) Evidence-Based Practices (EBPs)

MHSOAC Staff: Angela Brand

Active Dates: June 30, 2015 – June 30, 2017

Objective: Through a previous MHSOAC contract, Trylon Associates Inc. studied the use and impact of Mental Health Service Act (MHSA) funds for PEI programs. Via this prior study, Trylon determined the total amount of MHSA PEI funds spent on PEI efforts during a designated time period; costs were broken down by program, among other things. The prior study highlighted the potential return on investment (i.e. cost savings) for PEI programs that were evidence based practices (EBPs), based on savings identified via implementation of such EBPs in other areas. The purpose of this evaluation is to investigate potential return on investment (ROI) for EBPs being implemented in California with MHSA PEI funds, and to educate MHSOAC staff on ROI and other comparable evaluation methods.

	Deliverable	Due Date*	Deliverable Cost	Status
1	Fidelity Assessment Summary	March 31, 2016	$12,500	Under Review
2	Report of Cost Savings from WSIPP-Documented EBPs: Fiscal Year (FY) 2011/2012 though FY 2014/2015	June 30, 2016	$25,000	Under Review
3	Report of Cost Savings from WSIPP-Documented EBPs: FY 2011/2012 though FY 2015/2016	March 31, 2017	$12,500	Pending
4	Training/Technical Assistance (T/TA) Plan	August 1, 2015	$12,500	Completed
5	Training Manual and Summary of Training/Technical Assistance (T/TA)	March 31, 2017	$12,500	Pending
Total Contract Amount			$75,000	

* Reflects the date that the deliverable is due to the MHSOAC for an internal review for compliance and approval.

MHSOAC Evaluation Dashboard September 2016
(updated 9/12/16)

Ongoing MHSOAC Internal Evaluation Projects

Mental Health Services
Oversight & Accountability Commission

MHSOAC Evaluation Unit

Tracking and Monitoring of Mental Health Services Act (MHSA) Programs and Activities via Plans, Updates, and Expenditure Reports

MHSOAC Staff: TBD

Active Dates: December 2013 – TBD

Objectives: Develop and implement a system for extracting and utilizing information of interest for tracking and monitoring MHSA program activities and outcomes for fiscal year (FY) 2011/12 and FY 2012/13 from County Annual Updates, Three-Year Plans, and Annual Revenue and Expenditure Reports. Consider what additional information may be useful to capture via the reporting process.

This internal evaluation project is in transition to an external evaluation project.

	Work Effort or Product	Due Date	Status
1	Determine State Needs For Information That Is Currently Provided Within Reports	March 31, 2014	Completed
2	Develop System For Extracting And Cataloging State's Data Needs	April 30, 2014	Completed
3	List Of Recommended Data Elements	June 16, 2014	Completed
4	Complete Construction Of Tables	August 15, 2014	Completed
5	Test Database Functionality	August 22, 2014	Completed
6	Complete Construction Of Queries And Forms	TBD	Pending
7	Use System To Extract And Catalog Data Needed By State For FY 2012/13	TBD	Pending
8	Data Quality Check	TBD	Pending

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MHSOAC Evaluation Dashboard September 2016

(updated 9/12/16)

MHSOAC
Mental Health Services
Oversight & Accountability Commission

MHSOAC Evaluation Unit

Mental Health Services Act (MHSA) Performance Monitoring

MHSOAC Staff: Brian Sala

Active Dates: Ongoing

Objectives: Implement a process and system for monitoring and reporting on individual- and system-level data, including the CSI and DCR, to support characterization and assessment of MHSA programs and outcomes.

This internal evaluation project is in transition to an external evaluation project.

	Work Effort or Product	Due Date	Status
1	Develop Process For Adding Additional Client, System, And Community-Level Indicators	December 31, 2014	Completed
2	Secure Health Insurance Portability And Accountability Act (HIPAA) Compliance For MHSOAC Staff And Information Systems To Allow Secure Storage And Analysis Of Client-Level Data	May 31, 2015	Completed
3	Descriptive Statistics Report of Key CSI Data Elements, by County	April 30, 2016	Pending
4	MHDA Development and Training of EPLD Templates and Protocols for Analysis of DHCS Databases	May 15, 2016	Pending
5	Develop Strategic Plan Identifying Specific Research Questions Assessing Aspects of the Mental Health System and the Impact of the MHSA	TBD	Pending
6	Web-based Dynamic Visual Analytics of Key Data Elements	TBD	Pending
7	Develop and Implement Strategic Plan for Assessing Aspects of the Mental Health System and the Impact of the MHSA	TBD	Pending

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MHSOAC
Mental Health Services
Oversight & Accountability Commission
1325 J ST STE 1700
SACRAMENTO CA 95814
(916) 445-8696
www.mhsoac.ca.gov

Public Meeting Schedule 2016 - 2017

Meeting Date and Location	Group / Topic
Wednesday, September 21, 2016 Los Angeles Area Chamber of Commerce 350 S Bixel Street, Los Angeles, CA 90017	**Exploring the Criminal Justice/Mental Health Intersection Subcommittee Meeting**
Thursday, September 22, 2016 California African American Museum 600 State Drive, Los Angeles, CA 90037	**Commission Meeting** Mental Health/Criminal Justice
Thursday, October 13, 2016 1325 J Street, Suite 1700, Sacramento, CA 95814	**Client and Family Leadership Committee and Cultural and Linguistic Competence Committee** Joint Business Meeting
Thursday, October 27, 2016 1325 J Street, Suite 1700, Sacramento, CA 95814	**Commission Meeting** Business Meeting
Thursday, November 17, 2016 1325 J Street, Suite 1700, Sacramento, CA 95814	**Commission Meeting** Mental Health/ Schools
Thursday, December 8, 2016 1325 J Street, Suite 1700, Sacramento, CA 95814	**Client and Family Leadership Committee** Business Meeting
Thursday, December 8, 2016 1325 J Street, Suite 1700, Sacramento, CA 95814	**Cultural and Linguistic Competence Committee** Business Meeting
Thursday, January 26, 2017 TBD	**Commission Meeting** Mental Health/ Criminal Justice
Thursday, February 23, 2017 1325 J Street, Suite 1700, Sacramento, CA 95814	**Commission Meeting** Business Meeting
Thursday, March 23, 2017 1325 J Street, Suite 1700, Sacramento, CA 95814	**Commission Meeting** Project Meeting
Thursday, April 27, 2017 1325 J Street, Suite 1700, Sacramento, CA 95814	**Commission Meeting** Mental Health/ Criminal Justice
rev 09/15/2016	

AGENDA ITEM 02

Information

September 22 Commission Meeting

Mental Health and Criminal Justice Commission Project Panel Presentations

Summary: Earlier this year, the Commission prioritized a research policy project looking at mental health and criminal justice involvement. A framework has been drafted to outline a series of activities that will result in the development of an action agenda for the Commission, supported by key partners and stakeholders, which will reduce the number of individuals with mental health needs who become involved with the criminal justice system, and improve outcomes for individuals with mental health need while in custody and upon release from custody into the community. Such activities include public engagement meetings, public hearings, community forums, and research and policy development strategies, including the analysis of state and local criminal justice data linked with mental health data.

Subject matter experts and stakeholders have been invited to participate in the following four presentations to support the Commissioners' understanding of local and state challenges and opportunities related to the project objectives. Commissioner Brown will report out on the most recent public engagement meeting and site visit.

Panel 1: Consumers, Family Members and Advocates

- Catherine Clay, Peer advocate
- Harold Turner, Los Angeles County parent
- Mark Gale, Criminal Justice Chair, NAMI Los Angeles County Council

Panel 2: Los Angeles County Mental Health and Public Safety Representatives

Presenter: Honorable Jackie Lacey, Los Angeles County District Attorney

- Robin Kay, Ph.D., Acting Director of Mental Health, Los Angeles County Department of Mental Health
- Mark Ghaly, M.D., Director of Community Health and Integrated Programs, Los Angeles County Department of Health Services
- Kelly Harrington, Assistant Sheriff, Los Angeles County Sheriff's Department
- Honorable James Brandlin, Supervising Judge, Criminal Division, Superior Court of Los Angeles County

Panel 3: Statewide Challenges and Opportunities

- Stephanie Welch, Executive Officer, Council on Mentally Ill Offenders (COMIO)
- David Meyer, J.D., Clinical Professor, Institute of Psychiatry, Law and the Behavioral Sciences, U.S.C. Keck School of Medicine

Panel 4: Mental Evaluation Unit

- Brian Bixler, Lieutenant II, Los Angeles Police Department (LAPD)
- Detective Charles Dempsey, Admin-Training Detail
- Detective Michael Morlan, Systemwide Mental Assessment Response Team (SMART)

Enclosures: Panelist biographies, written testimony, panel invitation letters, and presentation materials from the Council on Mentally Ill Offenders and the Mental Evaluation Unit (MEU)

Handouts: Additional panelist biographies and written testimony

MARK GALE, Criminal Justice Chair, NAMI Los Angeles County Council

Mark Gale is the Criminal Justice Chair of the NAMI Los Angeles County Council. He currently represents NAMI on the Los Angeles County District Attorney's Criminal Justice Mental Health Advisory Board, serves as a member of the Permanent Steering Committee of the new Office of Diversion and Reentry, and leads the NAMI Crisis Intervention Team (CIT) partnership with law enforcement in Los Angeles County.

Mark served two terms on the NAMI California Board of Directors as Chair of the Criminal Justice Workgroup and the NAMI California Government Affairs and Public Policy Committee. Mark represented NAMI California on the Judicial Council's Task Force for Criminal Justice Collaboration on Mental Health Issues and was recently appointed to the Collaborative Justice Courts Advisory Committee. He was the 2013 recipient of the Word to Deeds VII Conference "Community Champion" Paradigm Award and the 2014 recipient of the NAMI California Criminal Justice Advocate Award.

He is the father of a son with a serious mental illness.

HON. JACKIE LACEY, Los Angeles County District Attorney

District Attorney Jackie Lacey has spent most of her professional life as a prosecutor, manager and executive in the Los Angeles County District Attorney's Office. On Dec. 3, 2012, she was sworn in as the 42nd District Attorney. She was re-elected in 2016, running unopposed.

Her top priority is keeping the streets of Los Angeles County safe from violent and dangerous criminals. She is committed to safeguarding our children from human sex traffickers, our seniors from financial elder abuse and our communities from environmental crimes that threaten our health and our livelihood.

District Attorney Lacey has worked with business leaders on how best to protect consumers from computer network intrusions that jeopardize our bank accounts and credit ratings. She also remains committed to prosecuting government officials who violate the public's trust.

A Los Angeles native and graduate of the University of Southern California Law School, District Attorney Lacey leads a staff of roughly 1,000 lawyers, nearly 300 investigators and about 800 support staff employees.

She is the first woman and first African-American to serve as Los Angeles County District Attorney since the office was established in 1850.

ROBIN KAY, Ph.D., Acting Director of Mental Health, County of Los Angeles – Department of Mental Health

Robin C. Kay, Ph.D., is the Acting Director of Mental Health for the Los Angeles County Department of Mental Health. Dr. Kay is a psychologist who received her master's and doctoral degrees from Fordham University in New York.

Dr. Kay's career has been dedicated to community mental health where she has had experience at all levels of service delivery and administration. Beginning as a clinician working for a private nonprofit

community mental health center, Dr. Kay has directed prevention and education programs and has been a clinical supervisor and program manager. She was honored to serve as the District Chief for Service Area 5, collaborating with diverse stakeholders to enhance the system of care for children, Transition Age Youth, adults, and older adults in West Los Angeles. Committed to addressing the needs of homeless adults, Dr. Kay served as the Chair of the Westside Shelter and Hunger Coalition.

Prior to her appointment as Acting Director of Mental Health, Dr. Kay, is the Chief Deputy Director for the Los Angeles County Department of Mental Health. Earlier, she was the Deputy Director for Countywide Older Adult Programs; she is proud of the work done by her team in developing Full Service Partnerships and Field Capable Clinical Services for older adults – in addition to the excellent older adult mental health training programs they designed and implemented. Dr. Kay regularly lectures on community mental health, including presentations on crisis-oriented therapy and the funding of public mental health programs.

HON. JAMES R. BRANDLIN, Supervising Judge of the Criminal Division, Los Angeles Superior Court

Judge Jim Brandlin has been a judge for almost 24 years. Judge Brandlin has spent his entire career in the criminal justice system. He is a retired Los Angeles County Deputy District Attorney and a retired Santa Barbara County Deputy Sheriff. He is also a former Montebello Police Department Reserve Police Sergeant and a former Inglewood Police Department Senior Community Service Officer.

Judge Brandlin has spent more than half of his career in leadership roles supervising others in various capacities such as the Supervising Judge of the Criminal Division (which consists of 281 judicial officers), Assistant Supervising Judge of the Criminal Division, Assistant Supervising Judge of the Southwest District, Site Managing Judge of the Airport Courthouse, Assistant Presiding Judge of the South Bay Municipal Court, Reserve Montebello Police Sergeant, Assistant Head Deputy District Attorney of the Career Criminal Division, and Santa Barbara County Sheriff's Department Field Training Officer and Crime Scene Investigator.

Judge Brandlin is the recipient of the Los Angeles County Bar Association, Criminal Justice Section Judge of the Year Award in 2008 and the South Bay Bar Association Judge William McFaden Award for Judicial Excellence in 2012.

Judge Brandlin graduated from the Santa Barbara College of Law with a Doctor Jurisprudence, cum laude, degree in 1986 where he achieved the highest cumulative grade point average in his law school class. He also has Commission on Peace Officers Standards and Training "Basic," "Intermediate," and "Advanced" Certificates.

Judge Brandlin is a nationally recognized expert in the subjects of Judicial Privacy Protection, Judicial and Courthouse Security and he has taught these subjects across the country for various local, state and national organizations including the CA and National Sheriff's Association, The United States Marshals Service and the CA and National Judicial Colleges.

KELLY L. HARRINGTON, Assistant Sheriff, Los Angeles County Sheriff's Department

Kelly L. Harrington's law enforcement career began in 1985 with the California Department of Corrections and Rehabilitation. During his tenure with California Department of Corrections and

Rehabilitation, he literally worked his way up through the ranks of the Department working as an officer all the way up to Director of Adult Institutions. He was appointed to the position of Assistant Sheriff in March 2016 overseeing the Custody Operations of the Los Angeles County Sheriff's Department.

Assistant Sheriff Harrington is responsible for the operations of Los Angeles County's Jail system and for the care, custody, security, and rehabilitation of all sentenced and pretrial inmates housed within the county's seven jail facilities.

Assistant Sheriff Harrington attended California State University, Bakersfield and graduated with a Bachelor of Arts Degree in Criminal Justice. He has served on the Commission for Accreditation and the Standards Committee since 2014.

STEPHANIE WELCH, MSW, Executive Officer, Council on Mentally Ill Offenders (COMIO)

Stephanie Welch is the appointed Executive Officer of the Council on Mentally Ill Offenders (COMIO) based in the Office of the Secretary at the California Department of Corrections and Rehabilitation (CDCR). Prior to state service, Ms. Welch was the Senior Program Manager at the California Mental Health Services Authority (CalMHSA) were she managed the implementation of statewide programs to prevent suicide, improve student mental health, and reduce mental health stigma and discrimination.

Stephanie has over 16 years of experience in mental health policy, program administration, and advocacy, and holds an MSW from University of Southern California and a BA in Sociology from the University of California, Davis. Her career path includes serving as an Associate Director for the California Mental Health Directors Association (CMHDA), a Mental Health Services Act program consultant for Los Angeles County Department of Mental Health, and Associate Director for the California Council of Community Mental Health Agencies (CCCMHA) and the Mental Health Association in California. Stephanie also served as a campaign grassroots coordinator for the Yes on Prop 63 campaign.

DAVID MEYER, J.D., Clinical Professor, Institute of Psychiatry, Law and the Behavioral Sciences, U.S.C. Keck School of Medicine

DAVID MEYER is a Clinical Professor and Research Scholar at the Institute of Psychiatry, Law and Behavioral Sciences of the University of Southern California Keck School of Medicine where he is responsible for the criminal law and the mental health law curricula. He also consults nationwide with health care and indigent defense providers on issues related to law and mental health. Mr. Meyer previously served as Chief Deputy Director and Counsel of the Los Angeles County (LAC) Department of Mental Health, as Director of the LAC Department of Community and Senior Affairs, and as Interim Public Defender and Chief Deputy of the LAC Public Defender. Mr. Meyer is an attorney, having specialized in mental health law and criminal defense for more than 30 years. He obtained his B.A. degree at the University of Southern California and his J.D. degree from the University of California Los Angeles School of Law.

Mr. Meyer also serves on the California Council on Mentally Ill Offenders and the Executive Steering Committee of the California Mentally Ill Offenders Program. He is an internal Board member of the Elyn Saks Institute of Mental Health Law, Policy and Ethics of the University of Southern California Gould

School of Law. Mr. Meyer previously served on the California Judicial Council Task Force for Criminal Justice Collaboration on Mental Health Issues and continues to work with judges, lawyers and court administrators throughout the United States on this difficult issue. In addition, he is Chair of the Board of the national Sixth Amendment Center and is a member of the California State Bar Association; the American Bar Association and its sections on Criminal Justice and Health Care Law; the American Society for Law, Medicine and Ethics; and the American Health Lawyer's Association.

BRIAN BIXLER, Lieutenant II, Officer in Charge, Crisis Response Support Section, Detective Support and Vice Division, Los Angeles Police Department (LAPD)

Lieutenant II Brian Bixler has been a member of the Los Angeles Police Department since 1996. He was promoted to Lieutenant in 2012. He is currently the Officer in Charge of the Crisis Response Support Section which includes the Threat Management Unit and Mental Evaluation Unit. He has overseen the recent doubling in size of the nation's premiere Law Enforcement/ Mental Health program, managing a team of over 100 law enforcement officers and over 45 Los Angeles Department of Mental Health Clinicians. He has presented on issues related to policing the mentally ill at the Forensic Mental Health Association of California Annual Conference in Monterey, the Crisis Intervention Team International Conference in Chicago, the U.S. Department of Justice, as well as numerous local meetings. He has recently been appointed to the Los Angeles County Emergency Medical Services Commission.

CHARLES DEMPSEY, Detective III, Officer in Charge, Admin-Training Detail, Mental Evaluation Unit, Crisis Response Support Section, Detective Support and Vice Division, Los Angeles Police Department (LAPD)

Detective III Charles Dempsey is the Officer-in-Charge of the Administrative Training Detail, Mental Evaluation Unit (MEU), of the Los Angeles Police Department. Dempsey is responsible for the design, development, and delivery of Los Angeles Police Department's training curricula in regards to police interactions with persons suffering from a mental illness. In addition he has authored the Department's policies and procedures on police interactions with persons suffering from a mental illness. Dempsey has been in law enforcement for 26 years and is a Licensed Vocational Nurse specializing in geriatric psychiatric care.

MICHAEL MORLAN, Detective III, Officer in Charge, Mental Evaluation Unit / Systemwide Mental Assessment Response Team (SMART), Detective Support and Vice Division, Los Angeles Police Department (LAPD)

Detective III Michael Morlan is the Officer-in-Charge of the Mental Evaluation Unit of the Los Angeles Police Department. He has over twenty-one years of law enforcement experience with the Los Angeles Police Department in a variety of assignments. Currently, Detective Morlan is responsible for the day to day operations of the LAPD Mental Evaluation Unit and is a POST certified instructor. He is a retired Captain from the U. S. Air Force Reserves having served twenty years between the Air Force and the Army in a law enforcement capacity. He holds a Bachelor of Arts Degree in Psychology and a Master of Arts Degree in Organizational Management, both from Azusa Pacific University. He is an Area Chair for the University Of Phoenix, College Of Security and Criminal Justice, and an Adjunct Professor for College of the Canyons in Valencia, California.

STATE OF CALIFORNIA
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MHSOAC
Mental Health Services
Oversight & Accountability Commission

WELLNESS RECOVERY RESILIENCE

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LARRY POASTER, Ph.D.
Commissioner

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Assembly Member
Commissioner

RICHARD VAN HORN
Commissioner

TOBY EWING
Executive Director

September 7, 2016

Harold Turner
4305 Degnan Blvd., Suite #104
Los Angeles, CA 90008

Dear Mr. Turner:

Thank you for agreeing to participate in the Commission's public meeting on Thursday, September 22, 2016, at the California African American Museum (600 State Drive, Los Angeles). Your participation will assist the Commission in developing an action agenda to reduce the number of adults with mental health needs who become justice-involved, and improve outcomes for those in custody and upon release into the community.

Presentations on the challenges related to the intersection between the criminal justice and mental health systems from our diverse group of subject matter experts are scheduled to begin at 9:15 a.m. Your panel is scheduled to begin at 9:25 a.m.

Please plan on presenting for 15 minutes, specifically in the areas of:

- Your experience with the criminal justice and mental health systems.
- The strengths and challenges associated with California's current approach to preventing criminal justice involvement and improving the outcomes for justice-involved adults with mental health needs.
- The strategies you believe the State or counties should pursue to improve existing efforts to serve justice-involved Californians with mental health needs.

We ask that you please send written responses to these items by Thursday, September 15, 2016, to Ashley Mills (ashley.mills@mhsoac.ca.gov). Your written responses will allow those Commissioners attending the meeting the opportunity to prepare questions for you after your presentation, and will be available for those Commissioners unable to attend the meeting.

We also ask that you send Ms. Mills a brief biography by Thursday, September 15, 2016. Please note that your responses to the items above and your biography will be shared as public documents.

Should you have any questions, I can be reached at toby.ewing@mhsaoc.ca.gov or 916.445-8729.

Thank you again for your willingness to participate in this important meeting.

Respectfully,

Toby Ewing

Toby Ewing, Ph.D.
Executive Director

STATE OF CALIFORNIA
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MHSOAC
Mental Health Services
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LARRY POASTER, Ph.D.
Commissioner

TONY THURMOND
Assembly Member
Commissioner

RICHARD VAN HORN
Commissioner

TOBY EWING
Executive Director

September 2, 2016

Mark Gale
24116 Clarington Drive
West Hills, CA 91304

Dear Mr. Gale:

Thank you for agreeing to participate in the Commission's public meeting on Thursday, September 22, 2016, at the California African American Museum (600 State Drive, Los Angeles). Your participation will assist the Commission in developing an action agenda to reduce the number of adults with mental health needs who become justice-involved, and improve outcomes for those in custody and upon release into the community.

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Should you have any questions, I can be reached at toby.ewing@mhsaoc.ca.gov or 916.445-8729.

Thank you again for your willingness to participate in this important meeting.

Respectfully,

Toby Ewing

Toby Ewing, Ph.D.
Executive Director

Chairman Carrion, Vice Chair Wooten, Executive Director Ewing, and distinguished members of the Mental Health Services Oversight and Accountability Commission,

Thank you for the opportunity to participate as a member of your criminal justice panel on September 22, 2016 and to address the current state of the criminalization of persons with serious mental illness in California. I am a long-time member of NAMI, the National Alliance on Mental Illness, and the current Criminal Justice Chair of the NAMI Los Angeles County Council, the association of our twelve LA affiliates. This document is my personal testimony.

I am the father of a son with a serious mental illness. I never thought I would be involved in the mental health community or any of the work that now consumes so much of my attention and efforts. I did not choose to be a mental health advocate, it chose me. I started to become stronger the day I became an advocate and this work has been a critical element of my own personal recovery (yes, family members have their "lived experience" too). My son has been my greatest challenge and my greatest teacher. We have stared into the abyss together more times than I can count. In aggregate, he spent a full year of his life in the Twin Towers Correctional Facility in downtown Los Angeles and I spent another five years of my life doing everything I could to make sure he never went to prison. The perspectives I share with you today are the product of our family's personal experiences in trying to help our son and what I have learned from the literally hundreds of families I have spoken with through the years desperately coping with a loved one with a serious mental illness in the criminal justice system. I will share some of our personal journey during my oral remarks, but the importance of this meeting on Criminal Justice demands that I move directly to the work at hand; identifying problems, solutions, criticisms, and the need for true progress.

Our mental health community is often divided by ideology and belief systems. Competing belief systems can lead to discriminatory practices in funding priorities that can create wide disparities in access to different levels of treatment services and care. We must come to realize that the contributions of our mental health system in finding solutions to the increasingly horrific trends of criminalization of persons with serious mental illness must contain a **comprehensive systemwide approach that plans for full access to a complete continuum of care and services**. The **Sequential Intercept Model** provides a road map for the criminal justice system to integrate with our mental health/behavioral health care delivery systems that can which has the potential to reduce the numbers of people with mental illness in our jails and prisons. It is the core of the Stepping Up Initiative and implementation should be a statewide priority. However, there are wide disparities that exist in access to different levels of care that, unfortunately, reduce the effectiveness of this planning and implementation. It is imperative that we design systems that provide the level of care people need <u>when</u> they need it in order to produce positive outcomes for justice-involved persons with serious mental illness. Our progress with criminal justice system reform can only succeed when our mental health system also provides adequate high quality care for our communities. Let's examine a few of the ways Mental Health Services Act funding can assist in providing a meaningful contribution.

The MHSA Contribution

Can MHSA be a serious component of a comprehensive strategy to reduce the criminalization of people with serious mental illness? Absolutely! Listed below are some of the ways in which MHSA dollars can be utilized to build critically-needed programs, services, and treatment to help justice-involved individuals with mental illness and/or substance use disorders.

There are many services that are essential in providing the necessary community services and supports necessary to keep people with mental illness (and substance use disorder) out of jail in the first place (diversions programs), and other services necessary to help them successfully reintegrate back into the community through reentry programs. We are already beginning to build new resources in Los Angeles County utilizing a combination of MHSA and SB 82 dollars in addition to other sources of funding. Los Angeles has created a Blueprint for Change under the direction of the Office of the District Attorney thanks to the leadership of District Attorney Jackie Lacey. It outlines the multi-year implementation of the Sequential Intercept Model in Los Angeles County. Below are some of the recent developments where MHSA funding has made a significant difference in bringing new resources online that would otherwise not exist, or provide opportunities for partnering with other funding resources to produce a more complete program.

- Over the next five years Los Angeles County is planning to build 1,000 supportive housing beds dedicated to our diversion programs for people with mental illness and/or substance use disorders. We hope to develop 300 units in our first year and add an additional 200 units each year thereafter.
- New Urgent Care Centers (UCC) are on the drawing board. An Urgent Care Center can also double as law enforcement drop-off points for a pre-booking diversion program where people can be assessed and triaged for appropriate services. Although not developed with MHSA funding (SB 82), the UCC's can provide a direct link and conduit to available MHSA county services. Fiscal silos must be eliminated so the integration of programs supported by differing funding streams can partner to improve outcomes.
- There are also plans to utilize MHSA funding for reentry housing programs accessed through jail discharge planning.
- Full Service Partnership slots for diversion and reentry clients will be available for those who no longer need acute or sub-acute care and are now able to transition to the outpatient system.
- The new LA County Laura's Law program is receiving referrals to help some of the most challenged and severely ill clients in our communities. Many of these people have long histories of repeated incarcerations and hospitalizations. Now that SB 585 has clarified that MHSA treatment services (AOT FSP's) can be utilized to develop successful programs, AOT services are expanding across our state.
- Low security risk MIST (Misdemeanant Incompetent to Stand Trial) clients can now be engaged in a Competency Restoration program **in the community** (instead of jail) in an Enriched Residential Services (ERS) environment instead of a correctional environment. MHSA dollars support these programs and we desperately need many more community-based ERS beds.

- A new Sobering Center modeled after the nationally renowned Bexar County, TX program has opened its doors near Skid Row. MHSA is one component of funding.
- New reentry programs funded with MHSA dollars for both men and women are proving to deliver positive results as pilots and will hopefully grow into larger programs over time.
- New Crisis Residential beds and Crisis Stabilization Units (SB 82) will be developed that can help link people to the appropriate levels of care for each individual.

There is definitely a place for MHSA funding contributions to help build the necessary housing and FSP treatment resources required to achieve full build-out of the Sequential Intercept Model.

The State of Crisis Resources and the Impact on Our Criminal Justice System

It is my firm conviction that the inadequate accessibility, if any access exists at all, of crisis resources in our communities has been a major factor in the rising percentage increase of mentally ill offenders in our jails and prisons. Therefore, we must review the "state of the system" for the people who are living with the most severe symptoms of their mental illness and the impact on their families. Let's review the current status of crisis services in my own county, Los Angeles, as an example of a large, metropolitan county trying to cope with an overwhelming number of people in very serious crisis.

There are people who will seek help and are ready to progress in their own recovery. And there are others who, with careful and professional outreach and engagement, can also be convinced that engaging with the mental health system is in their best interests. But this was not the case with my son and his resistance to treatment for many years led to his deeply impaired judgment and behaviors that had consequences which seriously affected his life. Unfortunately, this is also the case for thousands of others and many are without family support. If we are to discuss justice-involved individuals with serious mental illness then it is imperative we also discuss the many who are extremely resistant to accepting treatment and are not engaged with our mental health outpatient system. This population is much more likely to only receive care when hospitalized under LPS, conserved, or through AOT, jail mental health, diversion, or reentry services. Too often, jail is the bed that never says "no." This is not a topic usually discussed at MHSA meetings, but I applaud the Commission in finally addressing the issue of criminalization.

As our state has passed through billions of MHSA dollars that have built what is now 53% of our mental health system, there are many individuals who do not, or cannot due to their illness, take advantage of what is offered and are left to deal with an overwhelmed, poorly funded, inadequate crisis treatment delivery system. In a county of ten million people, Los Angeles only has 101 public inpatient psychiatric beds and that number has remained at that level for at least the last five years. Not one extra inpatient bed has been funded since 2010 and possibly longer. (Twenty-five other counties think we are lucky in Los Angeles as they have no adult psychiatric beds at all! Where is the state strategy?) According to the California Hospital Association and the Treatment Advocacy Center, the minimum level of public psychiatric inpatient beds is

50:100,000 residents. As of 2015, Los Angeles County is 23.78:100,000; less than half of the minimum standard. If someone is found to be gravely disabled, unable to survive safely in the community, in need of a much higher level of care, and through due process a judicial determination has been made based on clinical testimony that this individual should be conserved under LPS, our current waitlist for a locked, residential IMD placement is hundreds of people long. This leaves very ill consumers found to be gravely disabled waiting in acute inpatient facilities for four to nine months for a residential IMD bed to become available. If this was your son or daughter, would you find this acceptable? The situation is horrific!

Additionally, for those who have received long-term treatment in an IMD and are now ready for community reintegration and the hand-off to the outpatient system, the lack of IMD Step-Down beds, now called Enriched Residential Services (ERS), leaves them in a similar limbo. The acute and sub-acute levels of care are bottlenecked at both the front and back doors of our delivery system. Our state did not approve of using MHSA dollars to fund acute and sub-acute care (a decision based on a belief system that it wouldn't be necessary and this was not the way we wanted to deliver care anymore), so this part of the system is dependent on Medi-Cal federal matching funds, 1991 Realignment funding and direct county support. And it is precisely this part of our system that has lacked adequate funding and is ill-prepared to assist the overwhelming numbers of people in crisis. This state of affairs is inadequate, unfair, and discriminatory. We all know that when people who are very seriously ill do not get the treatment they need the outcomes can be catastrophic. Now that this population is finally taking a disastrous toll on our criminal justice system budgets, the state and our counties are finally being forced to address this problem.

When inpatient facilities are so overwhelmed and overcrowded that people who desperately need a bed cannot gain access to one, hospital stays get shorter and patients receive less care to make room for the next individual in crisis. They are often not in treatment long enough to develop a level of wellness and stability, but are discharged because they are no longer dangerous to self or others. This also decreases the capacity of the system for people who are only gravely disabled (and not dangerous) who cannot survive safely in the community. It is not a far-fetched conclusion that this frequent revolving through multiple hospitalizations and jail (often separated by episodes of homelessness) is at the **root of the increase in the percentage of people with serious mental illness in our jails and prisons and to the explosion of incompetent to stand trial cases.** These are the most ill people in our communities and yet their access to the level of care they require is just not available. Is it any wonder somebody's family member is ending up in court and in jail, so ill they cannot understand their own court proceedings?

It is so important we not limit discussion to only Mental Health Services Act treatment resources. We must ensure that acute and sub-acute crisis care treatment is linked with the recovery services and community supports that can be accessed through MHSA. For those who are in the throes of a serious mental health crisis and unable to engage with the system voluntarily, a more acute tier of services is required and funded by the other different sources of mental healthcare financing. Medi-Cal, 1991 Realignment Funding, Affordable Care Act, AB 109, etc. form a

patchwork of funding streams that counties try to utilize despite the inadequate levels of support. These have been patched together through the years as a complicated and confusing delivery system that has been developed, at least to some degree, by peoples' belief systems, preferences, budget priorities, ideology, and the targeting of certain populations; not by the true need of consumers in our communities. Our mental health system funding scheme should be determined by the construction of a continuum of services necessary to address the very wide spectrum of acuity, severity, and treatment necessary to provide mental health care to all. However, we have not done that. We have picked winners and losers, so many of our family members living with severe symptoms of serious mental illness remain homeless on our streets or in our jails, prisons, and state hospitals, and some are living untreated in the back bedrooms of our own homes.

With the passage of Proposition 63 in 2004, I believe there were some who hoped that if we built this new treatment delivery system, based on the psycho-social recovery model, that over time the percentage of people with serious mental illness in our jails and prisons would substantially decrease. There would be more treatment available in the community, so it was natural to assume that there would be less people in jail with mental illness. But the opposite is occurring and there is great confusion as to the cause. If our outpatient treatment capacity built over twelve years with $17 billion in MHSA spending was the answer to decriminalization, wouldn't we have begun to see those results by now? The percentage of people with serious mental illness in our jails and prisons is increasing at an alarming rate and our "incompetent to stand trial" cases continue to increase. A real solution will demand a different mindset and a different range of treatment services where all levels of care inclusive of acute services have adequate funding support. You can't fix this with half a system.

A Message to Sacramento

I have not seen a comprehensive long-term plan to eliminate the acute inpatient bed crisis and sub-acute bed crisis we have in California. The current funding formula for these services is outdated, completely inadequate, and discriminates against those who are the most ill in our communities. It persists year after year. There is also no statewide comprehensive decriminalization strategy. In fact, each county addresses their challenges in their own way leading to a lack of standardization of best practices with little coordination between counties and the state. SB 29 and SB 11 are a good start, but far from a comprehensive plan. If Los Angeles County can devise a roadmap to expand treatment services and implement the Sequential Intercept Model, why can't the State of California do the same? There is a role for our state in such planning and we should all encourage Sacramento to do more.

A final point: Funding inequity becomes fiscal discrimination. We have failed to provide adequate capacity and higher levels of mental health care in our communities (in addition to supportive housing) and the people who need these services are hurting. Thousands have been pouring into our criminal justice system for years. This is catastrophic to our families and our communities. It is a problem that must be addressed or the tragedies being lived in our jails and prisons will continue. The funding formulas must be revised in order to remedy the inadequate amounts of available revenue and growth rates must keep pace with the need. Acute and sub-

acute care has gone begging for real support for far too long and the consequences have been disastrous.

It is time for our Legislature, our Governor, and this Commission to take a hard look at the non-MHSA funding streams that have created this crisis in our state and re-design our budget formulas so **all people with serious mental illness, including those in need of the most acute services, will finally get the mental health treatment they need and deserve.** Only then, will we see the numbers of people in our jails and prisons with serious mental illness finally begin to decline and real progress be made.

I hope that my testimony today can advance this dialogue a few steps forward.

Respectfully,

Mark S. Gale
Markgale510@gmail.com

September 13, 2016

STATE OF CALIFORNIA
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Commissioner

TOBY EWING
Executive Director

September 2, 2016

The Honorable Jackie Lacey
Los Angeles County District Attorney
Hall of Justice
211 West Temple Street, Suite 1200
Los Angeles, CA 90012

Dear Hon. Lacey:

Thank you for agreeing to participate in the Commission's public meeting on Thursday, September 22, 2016, at the California African American Museum (600 State Drive, Los Angeles). Your participation will assist the Commission in developing an action agenda to reduce the number of adults with mental health needs who become justice-involved, and improve outcomes for those in custody and upon release into the community.

Presentations on the challenges related to the intersection between the criminal justice and mental health systems from our diverse group of subject matter experts are scheduled to begin at 9:15 a.m. Your presentation is scheduled to begin at 10:30 a.m.

Please plan on presenting for 15 to 20 minutes, specifically in the areas of:

- The challenges that criminal justice and mental health leaders face when addressing the needs of individuals with mental health needs who are involved in the criminal justice system.
- The solutions identified by the Mental Health Advisory Board, and the progress that has been made toward implementing these recommendations.
- How the State can support local efforts to reduce the number of justice-involved adults with mental health challenges, and improve outcomes for those in custody and upon release.

We ask that you please send written responses to these items by Thursday, September 15, 2016, to Ashley Mills (ashley.mills@mhsoac.ca.gov). Your written responses will allow those Commissioners attending the meeting the opportunity to prepare questions for you after your presentation, and will be available for those Commissioners unable to attend the meeting.

We also ask that you send Ms. Mills a brief biography by Thursday, September 15, 2016.

Please note that your responses to the items above and your biography will be shared as public documents.

Should you have any questions, I can be reached at toby.ewing@mhsaoc.ca.gov or 916.445-8729.

Thank you again for your willingness to participate in this important meeting.

Respectfully,

Toby Ewing, Ph.D.
Executive Director

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TOBY EWING
Executive Director

September 2, 2016

Robin Kay, Ph.D.
Acting Director of Mental Health
County of Los Angeles – Department of Mental Health
550 S. Vermont Avenue
Los Angeles, CA 90020

Dear Dr. Kay:

Thank you for agreeing to participate in the Commission's public meeting on Thursday, September 22, 2016, at the California African American Museum (600 State Drive, Los Angeles). Your participation will assist the Commission in developing an action agenda to reduce the number of adults with mental health needs who become justice-involved, and improve outcomes for those in custody and upon release into the community.

Presentations on the challenges related to the intersection between the criminal justice and mental health systems from our diverse group of subject matter experts are scheduled to begin at 9:15 a.m. Your panel is scheduled to begin at 10:30 a.m.

Please plan on presenting for 10 minutes, specifically in the areas of:

- The efforts adopted in Los Angeles to build a mental health-law enforcement partnership to divert individuals from jail and into treatment.
- The challenges that county mental health agencies face when providing services to individuals with mental health needs who become involved in the criminal justice system.
- The strategies employed in Los Angeles to better serve those consumers who do become involved in the criminal justice system.
- The role that local mental health agencies should take to improve the quality of care for those in custody and the transition to community-based mental health services upon release.
- How the State can support local efforts to reduce the number of adults with mental health needs who become justice-involved, and improve outcomes for those in custody and upon release.

We ask that you please send written responses to these items by Thursday, September 15, 2016, to Ashley Mills (ashley.mills@mhsoac.ca.gov). Your written responses will allow those Commissioners attending the meeting the opportunity to prepare questions for you after your presentation, and will be available for those Commissioners unable to attend the meeting.

We also ask that you send Ms. Mills a brief biography by Thursday, September 15, 2016.

Please note that your responses to the items above and your biography will be shared as public documents.

Should you have any questions, I can be reached at toby.ewing@mhsaoc.ca.gov or 916.445-8729.

Thank you again for your willingness to participate in this important meeting.

Respectfully,

Toby Ewing, Ph.D.
Executive Director

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TOBY EWING
Executive Director

September 2, 2016

Mark Ghaly, M.D.
Director, Community Health and Integrated Programs
County of Los Angeles – Department of Health Services
313 N. Figueroa Street
Los Angeles, CA 90012

Dear Dr. Ghaly:

Thank you for agreeing to participate in the Commission's public meeting on Thursday, September 22, 2016, at the California African American Museum (600 State Drive, Los Angeles). Your participation will assist the Commission in developing an action agenda to reduce the number of adults with mental health needs who become justice-involved, and improve outcomes for those in custody and upon release into the community.

Presentations on the challenges related to the intersection between the criminal justice and mental health systems from our diverse group of subject matter experts are scheduled to begin at 9:15 a.m. Your panel is scheduled to begin at 10:30 a.m.

Please plan on presenting for 10 minutes, specifically in the areas of:

- The mission and role of the Office of Diversion and Reentry under the County Department of Health Services, and in relation to the Department of Mental Health.
- How factors such as housing and co-occurring disorders (e.g., substance use disorders) impact the service delivery system's ability to effectively address mental needs and prevent criminal justice involvement.
- How the state can support local efforts to reduce the number of justice-involved adults with mental health challenges, and improve outcomes for those in custody and upon release?

We ask that you please send written responses to these items by Thursday, September 15, 2016 to Ashley Mills (ashley.mills@mhsoac.ca.gov). Your written responses will allow those Commissioners attending the meeting the opportunity to prepare questions for you after your presentation, and will be available for those Commissioners unable to attend the meeting.

We also ask that you send Ms. Mills a brief biography by Thursday, September 15, 2016.

Please note that your responses to the items above and your biography will be shared as public documents.

Should you have any questions, I can be reached at toby.ewing@mhsaoc.ca.gov or 916.445-8729.

Respectfully,

Toby Ewing, PhD
Executive Director

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TOBY EWING
Executive Director

September 2, 2016

Kelly Harrington, Assistant Sheriff
Los Angeles County Sheriff's Department
Hall of Justice
211 West Temple Street
Los Angeles, CA 90012

Dear Assistant Sheriff Harrington:

Thank you for agreeing to participate in the Commission's public meeting on Thursday, September 22, 2016, at the California African American Museum (600 State Drive, Los Angeles). Your participation will assist the Commission in developing an action agenda to reduce the number of adults with mental health needs who become justice-involved, and improve outcomes for those in custody and upon release into the community.

Presentations on the challenges related to the intersection between the criminal justice and mental health systems from our diverse group of subject matter experts are scheduled to begin at 9:15 a.m. Your panel is scheduled to begin at 10:30 a.m.

Please plan on presenting for 10 minutes, specifically in the areas of:

- The types of programs and treatment options offered by Los Angeles County Jails for adults with mental health needs, including how screening is conducted and how individuals identified as in need are connected with community-based treatment upon release.
- How changes in justice and mental health policies have impacted jail capacity and treatment options for those with mental health needs.
- How the State can support local efforts to reduce the number of justice-involved adults with mental health challenges, and improve outcomes for those in custody and upon release.

We ask that you please send written responses to these items by Thursday, September 15, 2016, to Ashley Mills (ashley.mills@mhsoac.ca.gov). Your written responses will allow those Commissioners attending the meeting the opportunity to prepare questions for you after your presentation, and will be available for those Commissioners unable to attend the meeting.

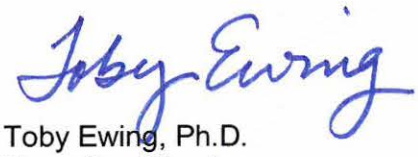
We also ask that you send Ms. Mills a brief biography by Thursday, September 15, 2016.

Please note that your responses to the items above and your biography will be shared as public documents.

Should you have any questions, I can be reached at toby.ewing@mhsaoc.ca.gov or 916.445-8729.

Thank you again for your willingness to participate in this important meeting.

Respectfully,



Toby Ewing, Ph.D.
Executive Director

OFFICE OF THE SHERIFF

COUNTY OF LOS ANGELES

HALL OF JUSTICE

JIM MCDONNELL, SHERIFF

September 12, 2016

Toby Ewing, Ph.D.
Executive Director
Mental Health Services
Oversight and Accountability Commission
1325 J Street, Suite 1700
Sacramento, California 95814

Dear Dr. Ewing:

This letter is in response to your correspondence of September 2, 2016, requesting a written response in preparation for the September 22, 2016, Commission's public meeting related to the intersection between the criminal justice and mental health systems. The following is the Los Angeles County Sheriff's Department's response to your questions.

1) *The types of programs and treatment options offered by the Los Angeles County Jails for adults with mental health needs, including how screening is conducted and how individuals identified as in need are connected with community-based treatment upon release.*

- **The types of programs and treatment options offered by Los Angeles County Jails for adults with mental health needs, including how screening is conducted and how individuals identified as in need are connected with community-based treatment upon release.**

a) All men and women entering the Los Angeles County Jail system receive a healthcare screening that assesses the need for mental health services or for the need for further evaluation by a mental health professional. This screening also serves as a triage so that acutely ill or suicidal men and women are seen quickly. Within the Inmate Reception Center those who have scored positively on the screening instrument receive full evaluations prior to placement in a mental health program. It is also during this reception center evaluation that release planning begins by including in the

assessment questions surrounding where the patient receives, social support, financial resources, and housing. It is also the first place that a referral can be made to the release planners who specialize in identifying community programs and resources to assist the patient upon release.

b) Once a patient completes this evaluation, he/she is placed in a treatment program that attempts to meet their current psychiatric needs. The following levels of care are offered at this time by the Los Angeles County Jail system: inpatient hospitalization, high observation, moderate observation, and general population mental health. Those admitted to the inpatient beds are the most acutely ill and in need of symptom stabilization. These individuals receive intensive daily treatment and monitoring by psychiatry, clinical case managers, and nursing staff. At this time Los Angeles County Jail is only able to accommodate a total of 38 men and women in inpatient beds and this has been found to be severely inadequate for the illness level of this population. At this inpatient level the patients receive care commensurate with inpatient community psychiatric practices.

c) The High Observation level of care comprises individuals who are severely impaired secondary to their mental illness and unable to program successfully in the jail setting. These individuals are often in need of medication stabilization as well as a high level of monitoring for safety. Additionally, it is the goal of the program to eventually provide 10 hours of group and individual treatment per week for those in this level of care.

d) The Moderate Observation level of care comprises the largest segment of the male mental health population. Those in the Moderate Observation program receive regular medication management from psychiatric staff as well as monthly meetings with individual clinicians. In addition, these patients receive group therapy, but not to the extent of those in High Observation. The individuals in this level of care are better able to manage their symptoms and to function within the jail setting.

e) The lowest level of care that is offered is for those needing medication and follow-up within the general population. These patients are able to function adequately within the general population setting of the

jail and manage their mental health needs largely by follow-up with psychiatric staff and maintaining their medication regimen.

f) All levels of care within the system are eligible and encouraged to participate in release planning to ensure a stable transfer to the community and attempt to reduce the likelihood of re-entering the jail system. During the initial screening referrals to release planning are offered and recommended to patients. Even if a patient declines the need for services at that time, clinicians are still able to refer the patient for follow-up at a later time by one of the release planning staff. Release planners work closely with the patient, community resources, and the patient's treatment team in determining the best individualized plan for a successful transition back to the community. Release planners avail their patients to all resources available in Los Angeles County and range from simple help with transportation or refilling medications to full service partnerships that include housing, healthcare, education, and job training to locked beds. Those patients needing acute inpatient hospitalization are sent to one of the County's contract hospitals for treatment.

g) A significant challenge presented by providing a mental health program to over 4,000 individuals in the Los Angeles County Jail system is that the physical plant was never designed to house the mentally ill nor to provide treatment for them. In order to provide treatment, day rooms and non-confidential space is utilized and clinicians find themselves providing services in areas that were never designed for such. Recruitment of clinical staff is problematic as the jail lack professional space for treatment as well as increased stress due to treating the acuity of the population. Because of this, there is difficulty in both attracting and retaining staff.

2) How changes in justice and mental health policies have impacted jail capacity and treatment options for those with mental health needs.

- Reference. Mitchell H. Katz, MD, Director, Los Angeles County Health Services, Report to the Los Angeles Board of Supervisors, May 23, 2016.

  Note the number of Involuntary to Stand Trial (IST) cases in the jail reflects the increase in the severity and types of cases Los Angeles County jail is tasked with treatment.

The number of IST cases referred to the Los Angeles Superior Court Mental Health Courthouse (D95), in 2010 was 944. This number increased to 3,528 in 2015. This represents a 350% increase in cases. This was primarily an increase in misdemeanor level cases. From 2010 to 2015, there has been a 217% increase in the total Misdemeanor Incompetent to Stand Trial population inside the jail. Correspondingly, from the year 2010 to 2015, the population of mental health inmates has increased by 50%. A significant percentage of the defendants were in custody for offenses commonly committed by persons who are homeless (trespassing, resisting arrest, vandalism, and restraining order violations.)

Potential Causes:

- AB 109 or the California Public Safety Realignment Act of 2011, which allowed non-violent, non-serious and non sex offenders to be supervised at the local county level, instead of by the State. This inadvertently cut off state supervision and medications. This resulted in an increase of 50% in IST referrals to D95 within the first year of AB109.

- Proposition 47. Many persons with co-occurring Mental Health and substance abuse problems lose the services they previously qualified for under felony diversion programs.

- A greater awareness of mental health issues and change in the culture and training among defense attorneys is perhaps present, as is the fact that the consequences for certain misdemeanor convictions are greater than before, thus incentivizing defenses accounting for a person's mental disorder.

- Lack of acute and sub-acute care psychiatric beds. The California Hospital Association reported a decline in the number of psychiatric beds available in the state from 1995, a drop of nearly 3,000 beds. Local county subacute care beds and acute inpatient care have trended up but not at the rate and capacity needed to serve the numbers of patients who are justice-involved with serious mental illness.

- Increase in homelessness in Los Angeles County from 2011 to 2015. The number of homeless increased by 51% in Los Angeles County,

from 20,517 in 2011 to 31,018 in 2015. Noted the increase IST referrals from the City Attorney's office take place in jurisdictions where there are a high number of homeless persons.

- Increase in methamphetamine use in Los Angeles County.

3) *How the State can support local efforts to reduce the number of justice-involved adults with mental health challenges, and improve outcomes for those in custody and upon release.*

- Increase in the number of State hospital beds. At any one time there are more than 200 patients awaiting placement in a State hospital bed as IST/competency restoration. Wait times can extend to more than 5 months.

- Develop more Parole outpatient resources for the severely mentally ill. Parole Outpatient Clinic (POC) resources were markedly downsized with realignment. This downsizing of POC clinical staff and POC offices, comprised care and availability of already sparse and unsatisfactory housing and treatment for parolees. This results in frequent re-incarceration of the parolees.

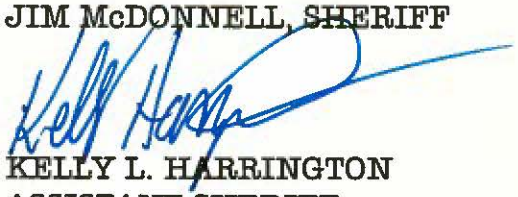
- Improve the ability of POC and Department of Mental Health to place parolees on LPS Conservatorships and co-manage the severely mentally ill. Historically the two entities do not provide any type of collaborative management.

- Assist in new construction for jails to be more treatment centered.

I look forward to participating in the Commission's public meeting on Thursday, September 22, 2016. Should you have any questions, please contact me at (213) 893-5001.

Sincerely,

JIM McDONNELL, SHERIFF



KELLY L. HARRINGTON
ASSISTANT SHERIFF

STATE OF CALIFORNIA
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TONY THURMOND
Assembly Member
Commissioner

RICHARD VAN HORN
Commissioner

TOBY EWING
Executive Director

September 2, 2016

Honorable James R. Brandlin
Clara Shortridge Foltz Criminal Justice Center
210 West Temple Street, Dept. 100, 13th Floor
Los Angeles, CA 90012

Dear Hon. Brandlin:

Thank you for agreeing to participate in the Commission's public meeting on Thursday, September 22, 2016, at the California African American Museum (600 State Drive, Los Angeles). Your participation will assist the Commission in developing an action agenda to reduce the number of adults with mental health needs who become justice-involved, and improve outcomes for those in custody and upon release into the community.

Presentations on the challenges related to the intersection between the criminal justice and mental health systems from our diverse group of subject matter experts are scheduled to begin at 9:15 a.m. Your panel is scheduled to begin at 10:30 a.m.

Please plan on presenting for 10 minutes, specifically in the areas of:

- The role of the Los Angeles County Mental Health Court, including the relationship between the Mental Health Court and the Criminal Court.
- What types of judicial reforms you believe could be implemented to prevent the cycle of arrest, incarceration and adjudication for those with mental health challenges.
- How the State can support local efforts to reduce the number of justice-involved adults with mental health challenges, and improve outcomes for those in custody and upon release.

We ask that you please send written responses to these items by Thursday, September 15, 2016, to Ashley Mills (ashley.mills@mhsoac.ca.gov). Your written responses will allow those Commissioners attending the meeting the opportunity to prepare questions for you after your presentation, and will be available for those Commissioners unable to attend the meeting.

We also ask that you send Ms. Mills a brief biography by Thursday, September 15, 2016.

Please note that your responses to the items above and your biography will be shared as public documents.

Thank you again for your willingness to participate in this important meeting.

Should you have any questions, I can be reached at toby.ewing@mhsaoc.ca.gov or 916.445-8729.

Respectfully,

Toby Ewing

Toby Ewing, Ph.D.
Executive Director

STATE OF CALIFORNIA
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Commissioner

TOBY EWING
Executive Director

September 2, 2016

Stephanie Welch, Executive Officer
Council on Mentally Ill Offenders (COMIO)
California Department of Corrections and Rehabilitation
Office of the Secretary
1515 S Street, Suite 502-South
Sacramento, CA 95811

Dear ~~Ms. Welch~~: Stephanie

Thank you for agreeing to participate in the Commission's public meeting on Thursday, September 22, 2016, at the California African American Museum (600 State Drive, Los Angeles). Your participation will assist the Commission in developing an action agenda to reduce the number of adults with mental health needs who become justice-involved, and improve outcomes for those in custody and upon release into the community.

Presentations on the challenges related to the intersection between the criminal justice and mental health systems from our diverse group of subject matter experts are scheduled to begin at 9:15 a.m. Your presentation is scheduled for 12:00 p.m.

Please plan on presenting for 10 to 15 minutes, specifically in the areas of:

- The mission and role of COMIO with regard to addressing the intersection of criminal justice and mental health, and the progress COMIO has made in pursuing its mission and role.
- The challenges and opportunities for reducing the number of justice-involved adults with mental health needs, and improving outcomes for those in custody and upon release.
- How the State can support local efforts to reduce the number of justice-involved adults with mental health challenges, and improve outcomes for those in custody and upon release.

We ask that you please send written responses to these items by Thursday, September 15, 2016, to Ashley Mills (ashley.mills@mhsoac.ca.gov). Your written responses will allow those Commissioners attending the meeting the opportunity to prepare questions for you after your presentation, and will be available for those Commissioners unable to attend the meeting.

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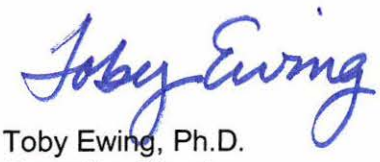
Thank you again for your willingness to participate in this important meeting.

Respectfully,



Toby Ewing, Ph.D.
Executive Director

COMIO

THE COUNCIL ON MENTALLY ILL OFFENDERS

BUILDING BRIDGES BETWEEN CRIMINAL JUSTICE AND BEHAVIORAL HEALTH TO PREVENT INCARCERATION

Stephanie Welch, MSW
Executive Officer, COMIO
Office the Secretary, Scott Kernan
California Department of Corrections and Rehabilitation
(CDCR)

1

ROADMAP

PRESENTATION OVERVIEW

- Who is COMIO
- COMIO Priority Work Areas
- Challenges and Opportunities
- How Can the State Support Local Efforts

2

WHO IS COMIO?

- With a growing recognition that youth and adults with unmet mental health needs were at high risk of becoming criminally involved without services, SB 1058 (Perata) was signed into law by former Governor Davis in 2001. The bill is codified as Penal Code Section 6044.
- Former Governor Schwarzenegger signed SB 1422 (Margett) in 2006 eliminating COMIO's sunset date.
- We are a 12-Member appointed council, chaired by the Secretary of the California Department of Corrections and Rehabilitation (CDCR). In addition to representation from the Department of Health Care Services (DHCS) and the Department of State Hospitals (DSH) members are a mix of local experts from both criminal justice and behavioral health systems.

Building bridges to prevent incarceration

3

PRIMARY GOALS

Through an annual legislative report and monthly activities, COMIO **investigates**, **identifies**, and **promotes** cost-effective strategies for youth and adults with mental health needs that:

- **Prevent** criminal involvement (initial and recidivism)
- **Improve** behavioral health services
- **Identify incentives** to encourage state and local criminal justice, juvenile justice, and mental health programs to adopt approaches that work

"Our mission at COMIO might seem daunting, but it is critically important. We aim to build bridges between partners in criminal justice and mental health so that we can tackle this challenge collaboratively."

-Secretary Scott Kernan

4

ACHIEVEMENTS

- Issued 14 Annual Legislative Reports
- 3 Special Issue Publications:
  - Mentally Ill Juveniles in Local Custody: Issues and Analysis (2011)
  - Jails and the Mentally Ill: Issues and Analysis (2009)
  - Costs of Incarcerating Youth with Mental Illness (2007)
- Issued 7 COMIO Best Practices Awards
- Involved with Word to Deeds Executive Planning Committee
- November 2014 Governor Brown appointed 1st Executive Officer, located within the executive management team of CDCR reporting directly to the Secretary
- Enhanced stakeholder engagement and communication (committee structure, website, newsletter, etc.)
- FY 2016-2017 Budget added 1 staff analyst and 1 research scientist to support enhanced COMIO activities and work product

Building bridges to prevent incarceration 5

COUNCIL MEMBER COMMENTS

Building bridges to prevent incarceration 6

ROADMAP

PRESENTATION OVERVIEW

COMIO Priority Work Areas

7

WHAT IS COMIO WORKING ON NOW?

We recognize there is a window of opportunity to advocate for what is best for individuals with mental illness at risk of incarceration:

Diversion

Training

Juvenile Justice

Building bridges to prevent incarceration

8

DIVERSION

A portion of our 2016 Legislative Report will:

- **Investigate** strategies to develop the service and housing capacity to keep individuals from incarceration
- **Identify** the unique additional needs of the justice involved - addressing needed behavioral health issues but also risk factors of recidivism
- **Identify** how existing federal, state, and local policies can be interpreted to provide the least harmful impact (unintended or intended) on the justice-involved living with mental health challenges
- **Promote** examples of exemplary and solution-oriented efforts

Building bridges to prevent incarceration 9

DIVERSION

In July 2016, COMIO honored the leadership of Jackie Lacey, the Los Angeles District Attorney's Office and the Mental Health Advisory Board with a Best Practices Award (Diversion) for the ***Blueprint for Change*** - a comprehensive system of diversion from incarceration for people with mental illness

LA Site Visit during Best Practice Award Presentation.

Building bridges to prevent incarceration 10

TRAINING

A portion of our 2016 Legislative Report will:

- **Investigate** ways to support officer mental health with tools and tailored support
- **Identify** opportunities for access to crisis intervention training, recognizing that training is only part of a needed culture/policy shift
- **Identify** emerging needs and solutions to enhance competencies for community corrections because there are more individuals with serious mental illness in these settings today
- **Promote** best practices in crisis response, de-escalation, and communications skills

Building bridges to prevent incarceration 11

JUVENILE JUSTICE

A portion of our 2016 Legislative Report will:

- **Investigate** how the local population in custody, or at risk of it, is changing and what can be done to address their mental health needs prior to custody and upon reentry
- **Identify** effective strategies for youth with mental health needs who either are, or are at risk of, being justice-involved in the wake of significant reforms taking place in the foster care system. It is imperative that we ensure that youth with serious emotional and mental health needs get specialized services to prevent incarceration
- **Promote** effective services for high risk probation youth with mental health needs

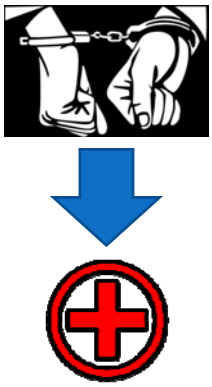
Building bridges to prevent incarceration 12

MEDI-CAL/ CDCR DATA PROJECT

FIRST REPORT DUE JUNE 2017

Project: Look at patterns of health care service utilization among former offenders now eligible for mental health and substance use services as part of implementing the Affordable Care Act (ACA)

Prediction: This data could assist counties in their planning for those who are interested in targeting services for former offenders who are Medi-Cal "super-utilizers"



Building bridges to prevent incarceration 13

ROADMAP

PRESENTATION OVERVIEW

Challenges and Opportunities

14

CHALLENGES

Tackling Stigma – Tentacles with a Far Reach

"One of the things that we have been recommending for a long time either at the officer or judicial level is having people ask themselves 'would I be making this decision if not for the mental illness?' If the answer to that question is 'no,' then that means it is time to start unpacking some alternative solutions to the problem."

"Anybody that is making critical decisions about those facing mental health and/or substance use challenges should be targeted."

- Dr. Jennifer Skeem of the University California Berkeley School of Social Welfare

Building bridges to prevent incarceration 15

CHALLENGE: STIGMA = BARRIER TO COMMUNITY-BASED ALTERNATIVES

There are effective community-based alternatives to incarceration but they are not adequately funded or well-known:

- Arraignment Diversion (pre-trial or post-disposition)
- Jail-Based Diversion
- Specialty Courts (Behavioral Health Courts)
- Specialty Probation/Compassionate Supervision

Building bridges to prevent incarceration 16

CHALLENGE: STIGMA = BARRIER TO OPPORTUNITY

Addressing stigma is essential to ensure more equitable practices in both the criminal justice and behavioral health systems.

- Stigma has become a cultural norm
- Because of stigma towards the justice-involved, former offenders reentering society face major challenges in each of the realms located to the side in this visual
- For the justice-involved person with mental illness, reintegration and a reduction in recidivism is only possible if we begin to remove the layers of stigma which collectively are debilitating

Building bridges to prevent incarceration 17

CHALLENGE: INCARCERATION = INITIAL ACCESS TO CARE

- Each year, an estimated **2 million** people with serious mental illnesses are admitted to jails nationally
- Almost **3/4** of these adults also have drug and alcohol use problems
- Once incarcerated, these individuals stay **longer** in jail and upon release are at a **higher risk** of returning to incarceration than those without these illnesses

Building bridges to prevent incarceration 18

CHALLENGE RE-ENTRY, REINTEGRATION, RECIDIVISM

Overall the trend at CDCR is that the population with mental health needs, particularly serious ones, is growing. **According to the CDCR Outcome Evaluation Report, August 2016:**

- In 2006 the Mental Health population as a percent of the total in custody population was just shy of **19%.** Currently that number is up to **30%**
- On average, the three-year return-to-prison rate for offenders released in Fiscal Year 2010-11 is **44.6%**, a **9.7** percentage point decrease from the Fiscal Year 2009-10 rate
- However, **60.3%** of Enhanced Outpatient Program (EOP) offenders, **58%** of offenders assigned to Mental Health Crisis Beds, and **50.8%** of Correctional Clinical Case Management System (CCCMS) offenders returned to prison in 3 years

Building bridges to prevent incarceration 19

OPPORTUNITY - "DECARCERATION" IS ALL THE POLITICAL BUZZ

- **President Obama** wants to make **prison reform** one of his last achievements in office. Due to the costs associated with mass incarceration, it is a rare issue that has **national bipartisan support**. (i.e. Federal Interagency Re-Entry Council)
- The **National Association of Counties, Behavioral Health, and Law Enforcement Leaders** have made it a policy priority for 2016. (i.e. *Stepping Up Initiative*) **California State Legislature** and the **Administration** have allocated state budget resources to community correctional facilities, re-entry and rehabilitation programs, law enforcement training, tackling NIMBYism, developing supportive housing and investments in addressing poverty (i.e. SSI COLAs)
- **County Boards of Supervisors** are exploring strategies locally, dedicating general fund resources to housing and diversion strategies and expanding substance use services

Building bridges to prevent incarceration 20

OPPORTUNITY – EXPANDED MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES

Design Programs and Services for Justice-Involved Offenders with Mental Health and Substance Use Needs

- Whole Person Care Pilots
- Drug Medi-Cal Organized Delivery System (DMC-ODS)
- Certified Community Behavioral Health Clinics

Implement Best Practices in Reducing Risk for Psychiatric Symptoms and Recidivism

Address "Social Needs" like Housing and Employment

Building bridges to prevent incarceration 21

OPPORTUNITY – BECOMING INFORMED BY RESEARCH AND DATA

- Public Policy Institute of California - 12 County Study
- Board of State and Community Corrections (BCSS) Fourth Annual Report on the Implementation of Community Corrections
- Emerging County/Local level efforts through programs supported by AB 109, MHSA, Mentally Ill Offender Crime Reduction Grants (MIOCR), or others
- Partner with University and Foundation Supported Research Institutes
  - Public Policy Institute of California (PPIC)
  - RAND Corporation
  - Stanford Criminal Justice Center
  - UCI Center for Evidence-Based Corrections
  - UC Berkeley School of Social Welfare

Building bridges to prevent incarceration 22

ROADMAP

PRESENTATION OVERVIEW

How Can the State Support Local Efforts

23

STATE SUPPORT FOR LOCAL EFFORTS?

Tackle Stigma and Stigma-Based Decision-Making

* *Ensure that Opportunities Do Not Exclude the Justice-Involved with Mental Health and Substance Use Needs*
* *Access to Services and Supports should be Based on Level of Need, Not Justice Status*

Areas to Review the Impact:

- Housing (Public Housing Authorities, No Place like Home Initiative)
- Employment
- Community Corrections Supervision
- Sentencing
- Bail
- Training (Behavioral Health and Criminal Justice Partners)
- Educational and Vocational Opportunities

Building bridges to prevent incarceration

24

STATE SUPPORT FOR LOCAL EFFORTS?

Maximize Federal, State, and Local Resources while there is Political Will

- Prioritize high risk, high need, and difficult to serve populations (i.e. justice involved with behavioral health needs)
- Support adoption of data driven strategies by providing clarification around barriers to data sharing and promotion of validated screening and assessment tools (i.e. Risk-Need-Responsivity Model)
- Provide incentives to design programs specific to the justice involved with behavioral health needs (programs can be supported by AB109, MHSA, Medi-Cal, Federal and State Grants, Local General Fund)
- Make Medi-Cal, SSI and other benefits as simple as possible to activate or re-instate (i.e. use suspension policies that last longer than 1 year)

Building bridges to prevent incarceration 25

STATE SUPPORT FOR LOCAL EFFORTS?

- Various State Entities (Agencies, Departments, Associations, etc.) can model the cross collaboration needed to solve system issues
- Provide leadership on Juvenile Diversion and Prevention of Juvenile Delinquency-Community Alternatives that work for adults also work for youth
- Support the development of a crisis continuum of services – which may call for state or regional strategies for smaller communities. Capture information about implementation challenges across the state from current SB 82 grantees
- Provide opportunities for local innovators to learn from each others work - "brag, borrow, and steal"
- Continue to support workforce pipeline needs – there are simply not enough trained professionals to work with this unique population

Building bridges to prevent incarceration 26

COMIO AND MHSOAC WORKING TOGETHER

- Build Bridges between Community Behavioral Health & Criminal Justice to Prevent Incarceration
- Inform Key Decision-Makers about the Unique Needs of Individuals with Behavioral Health Needs who are Justice-Involved and Strategies to Effectively Address them

Ideas? – Let's Discuss

Stephanie.welch@cdcr.ca.gov http://www.cdcr.ca.gov/COMIO/

http://www.comionews.blogspot.com

Thank You!

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RICHARD VAN HORN
Commissioner

TOBY EWING
Executive Director

September 8, 2016

David Meyer, J.D.
Institute of Psychiatry, Law and the Behavioral Sciences
USC Keck School of Medicine
1975 Zonal Avenue
Los Angeles, CA 90033

Thanks for your help. Toby

Dear ~~Mr. Meyer~~: Dave

Thank you for agreeing to participate in the Commission's public meeting on Thursday, September 22, 2016, at the California African American Museum (600 State Drive, Los Angeles). Your participation will assist the Commission in developing an action agenda to reduce the number of adults with mental health needs who become justice-involved, and improve outcomes for those in custody and upon release into the community.

Presentations on the challenges related to the intersection between the criminal justice and mental health systems from our diverse group of subject matter experts are scheduled to begin at 9:15 a.m. Your presentation is scheduled for 12:00 p.m.

Please plan on presenting for 10 to 15 minutes, specifically in the areas of:

- The challenges and opportunities for reducing the number of justice-involved adults with mental health needs, and improving outcomes for those in custody and upon release.
- How the State can support local efforts to reduce the number of justice-involved adults with mental health challenges, and improve outcomes for those in custody and upon release.

We ask that you please send written responses to these items by Thursday, September 15, 2016, to Ashley Mills (ashley.mills@mhsoac.ca.gov). Your written responses will allow those Commissioners attending the meeting the opportunity to prepare questions for you after your presentation, and will be available for those Commissioners unable to attend the meeting.

We also ask that you send Ms. Mills a brief biography by Thursday, September 15, 2016. Please note that your responses to the items above and your biography will be shared as public documents.

Should you have any questions, I can be reached at toby.ewing@mhsaoc.ca.gov or 916.445-8729. Thank you again for your willingness to participate in this important meeting.

Respectfully,

Toby Ewing

Toby Ewing, Ph.D.
Executive Director

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RICHARD VAN HORN
Commissioner

TOBY EWING
Executive Director

September 2, 2016

Lieutenant Brian Bixler
Crisis Response Support Section
100 West 1st Street
Los Angeles, CA 90012

Dear Lt. Bixler:

Thank you for agreeing to participate in the Commission's public meeting on Thursday, September 22, 2016, at the California African American Museum (600 State Drive, Los Angeles). Your participation will assist the Commission in developing an action agenda to reduce the number of adults with mental health needs who become justice-involved, and improve outcomes for those in custody and upon release into the community.

Presentations on the challenges related to the intersection between the criminal justice and mental health systems from our diverse group of subject matter experts are scheduled to begin at 9:15 a.m. Your presentation is scheduled for 2:00 p.m.

Please plan on presenting for 40 minutes, specifically in the areas of:

- An overview of the Mental Evaluation Unit and how the Los Angeles Police Department is partnering with county mental health to engage and link individuals with mental health needs with appropriate services.
- The outcomes are you seeing and how data are tracked and reported.
- The key components of the Mental Evaluation Unit that are most effective or successful, and how these components could be adopted outside of Los Angeles County.

We ask that you please send written responses to these items by Thursday, September 15, 2016, to Ashley Mills (ashley.mills@mhsoac.ca.gov). Your written responses will allow those Commissioners attending the meeting the opportunity to prepare questions for you after your presentation, and will be available for those Commissioners unable to attend the meeting.

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Should you have any questions, I can be reached at toby.ewing@mhsaoc.ca.gov or 916.445-8729.

Thank you again for your willingness to participate in this important meeting.

Respectfully,

Toby Ewing, Ph.D.
Executive Director

Written Response from LAPD's Mental Evaluation Unit

OVERVIEW: (See attached document)

OUTCOMES: Our outcomes are tracked with the use of our "MEU Database." This database tracks all crisis contacts by LAPD officers of those suffering from a mental health crisis. A report is created when an officer contacts the MEU Triage Desk (24/7). The report includes behavioral indicators, locations, times, use of force information, linkage information, and many other factors. The system can be modified to add data points as needed. The database is only accessible by those assigned to the MEU.

1. **Use of Force:** Our use of force rates are tracked for all police contacts with those suffering from a mental health crisis. We use this rate to determine the effectiveness of our de-escalation training and emergency response. The percentage of the time any type of force was used by the LAPD when responding to a person in a mental health crisis in 2015 was 2.6%.
2. **Recidivism:** Approximately 60% of our crisis calls result in a one-time contact.
3. **Decompression of County Psychiatric Emergency Departments (PED):** The Co-Deployment model allows county clinicians to query the insurance status of patients. This allows the subject to be diverted to a private facility/ hospital. YTD SMART teams have used private facilities/hospitals 1200 times vs 538 County PED. By diverting patients from the County PEDs, wait times for police, fire, and patients are significantly reduced.
4. **Pre/Post Booking Diversion:** The LAPD has written a policy allowing the Watch Commander to divert individuals to mental health services in certain cases when facing criminal charges.
    a. **LAPD Manual 4/260.**2: *When a person is taken into custody for a criminal offense and the person is suspected of having a mental illness, the MEU shall be contacted prior to the person being booked. When a subject is a suspect in a felony or high-grade misdemeanor crime, or has a felony or high-grade misdemeanor warrant, the criminal matters shall take precedence. If the subject is under arrest for a low-grade misdemeanor crime, misdemeanor warrant, or infraction, and meets the criteria for an Application for 72-hour Detention for Evaluation and Treatment, booking is at the discretion of the Area watch commander.*

Key Components: There are several components that can and have been adopted by other entities. As part of the *Specialized Policing Responses: Law Enforcement/Mental Health Learning Site* through the Council of State Governments Justice Center and the Bureau of Justice Assistance (BJA), the MEU hosts agencies from around the country and across the world in an effort to share information and duplicate effective programs.

1. **Co-Deployed Model:** This model works when police agencies partner with a local mental health authority to address mental health needs. We have two programs that utilize this model

a. **SMART:** This is our crisis response unit. This unit consists of a police officer and Los Angeles County Department of Mental Health Clinician (Psychologist, Nurse, LCSW, LMFT). These units are deployed 24/7 and respond to calls on a citywide basis. They generally arrive after the scene has been stabilized by patrol assets, take over the care of the subject and determine the best course of immediate crisis stabilization for the subject.
b. **CAMP:** This unit is a co-deployed unit with each team consisting of a LAC-DMH clinician and a police detective. The CAMP team works post-crisis to link subjects with the appropriate long-term care. They also work with the court system to assist on conservatorship cases or to advocate for court-ordered treatment. Cases are referred to CAMP upon recognition of risk factors by the Triage officer when completing the initial MEU report. The risk factors are as follows:
    i. **Increasing high risk behavior**
    ii. **Barricade/ critical incident**
    iii. **Veteran with PTSD**
    iv. **LAPD/ LAFD/ DMH high utilizer**
    v. **School violence**
    vi. **Suicide by cop**
    vii. **Guns/weapons involved**

2. **Database:** Agencies have developed their own versions to track statistics deemed most important by their agencies. The tracked statistics allow for a more precise deployment of resources, accurate information when dealing with a high risk scenario, and ability to present a more accurate picture of the subject in court.
3. **Training:** Training programs need to be tailored to first responders, focusing on reducing stigma, de-escalation, and community partnerships.

Los Angeles Police Department

Mental Evaluation Unit

September 2016

Specialized Policing Responses:
Law Enforcement/Mental Health Learning Site
October 15, 2010

March 29, 2011
June 20, 2012

The Los Angeles Police Department (LAPD) has implemented several complementary program responses to address the complex mental health needs within its jurisdiction. For over four decades, the LAPD has deployed the Mental Evaluation Unit (MEU) to assist police officers with mental health calls for service. In 1993, Los Angeles was one of the first communities to develop police/mental health co-responder teams (Systemwide Mental Assessment Response Team, or *SMART*). The program is co-supported by the Los Angeles County Department of Mental Health (LACDMH) and is the largest of its kind in the country. The program was designed to effectively engage and link persons with a mental illness to appropriate services. In 2003 the Department implemented a *Crisis Intervention Team* (CIT) training (40 hours) and strategy as a pilot. The CIT pilot program was assessed and discontinued in 2004; however, an expansion of the MEU/SMART strategy was initiated. In 2006 the Department delivered the *Introduction to Mental Health* training (24 hours) and over 800 officers were trained between the two courses.

Even after the implementation of the above strategies, a serious problem remained that involved persons with a mental illness who were the subject of a high number of emergency calls for service. Those calls for service cost the City and County millions of dollars in emergency resources without effective or measurable outcomes. In 2005, the LAPD developed the Case Assessment and Management Program (CAMP) to identify, monitor, and engage those subjects and to construct a case management approach that links them to appropriate services. The CAMP averages 15-20 new cases each week and its cases never close. The CAMP pairs police detectives with psychologists, nurses and/or social workers from the LACDMH to develop long-term solutions for the individual client's needs.

Effective in 2016, MEU SMART operates 24-hours/7-days-a-week, including the MEU-Triage Desk. The primary function of the Triage Desk is to triage all Department contacts with persons who suffer from a mental illness. Triage personnel provide advice and guidance to responding officers in the field and document all Department contacts with the mentally ill, who are in crisis, on a Mental Evaluation Incident Report. Those reports and database are separate from the Crime Analysis Databases and are protected from outside access, which protects the privacy of the individuals who are contacted. A triage mental health nurse sits alongside the officer and queries the LACDMH database to identify case managers, psychiatrists, or treatment centers. Collectively, the triage staff determines whether to dispatch a SMART unit or to direct the patrol officers to transport the person directly to a mental health facility. If the Triage personnel determine that a person has repeatedly contacted police or has demonstrated high risk behaviors, the case will be referred to the CAMP for more intensive case management.

In 2014, the Department reviewed its mental health training and a re-design was initiated. At the end of the 2014, the Department presented a POST-approved *Mental Health Intervention Training* (MHIT), which is a 40-hour course that is delivered 24 times a year to first responders (officers) who have the greatest likelihood of interaction with persons who suffer from a mental illness and who are in crisis.

In 2015, the Department, in partnership with the LACDMH, implemented an expansion plan that will double the number of SMART units that are deployed and establish Bureau liaison officers in each geographic Bureau. This expansion is expected to be completed by August 2016.

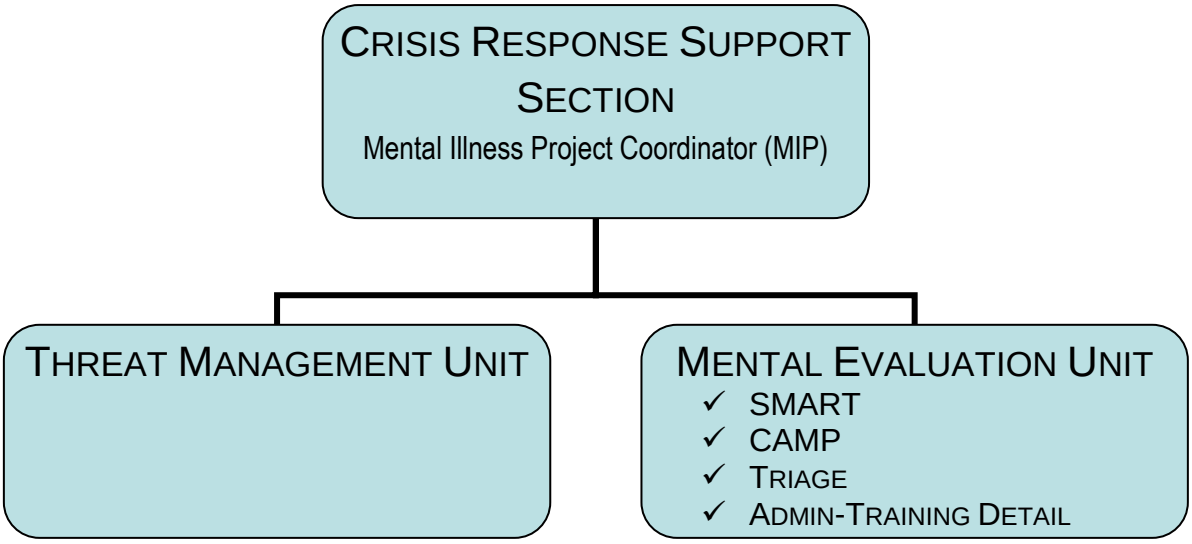
PROGRAM HIGHLIGHTS

LOS ANGELES POLICE DEPARTMENT MANUAL

***1/240.30 Contact With Persons Suffering From a Mental Illness**. In police contacts with persons suffering from a mental illness, the goal of the Department is to provide a humane, cooperative, compassionate and effective law enforcement response to persons within our community who are afflicted with mental illness. The Department seeks to reduce the potential for violence during police contacts involving people suffering from mental illness while simultaneously assessing the mental health services available to assist. This requires a commitment to problem solving, partnership, and supporting a coordinated effort from law enforcement, mental health services and the greater community of Los Angeles.*

- Multi-layered approach that includes co-deployed response, MHIT and follow-up teams.
- Comprehensive data collection and information-sharing procedures.
- Mental health professionals embedded in law enforcement agency.
- Staffed by 61 sworn officers and 30 LADMH clinicians.

OVERVIEW OF MENTAL EVALUATION–RELATED OPERATIONS



The primary mission of the MEU is to handle mental illness crisis calls-for-service in support of patrol operations. The MEU evaluates persons who pose a danger to themselves or to others per Welfare and Institutions Code (WIC) §5150. The MEU refers mental illness and homeless outreach missions to other designated non-law enforcement Los Angeles County Mental Health resources.

2015 Calls for Service	WIC §5150 Hospitalization Rate	Referred to Mental Health Services
16,641	71%	6%

MISSION STATEMENT

The mission of the Mental Evaluation Unit is to reduce the potential for violence during police contacts that involve people who suffer from mental illness and to simultaneously assess the mental health services available to assist them.

GOALS

- ✓ Prevent unnecessary incarceration and/or hospitalization of mentally ill individuals.
- ✓ Provide alternate care in the least restrictive environment through a coordinated and comprehensive system-wide approach.
- ✓ Prevent the duplication of mental health services.
- ✓ Facilitate the speedy return of police patrol units to patrol activities.

MENTAL HEALTH CRISIS RESPONSE PROGRAM (MHCRP)

The MHCRP is established as a function under Detective Bureau. The Assistant Commanding Officer, Chief of Detectives, is the MHCRP Coordinator. The Officer-in-Charge of the Crisis Response Support Section, Detective Support and Vice Division, is the **Mental Illness Project Coordinator** whose responsibilities include the following:

- Represent the Department on all matters involving police response to mental illness.
- Maintain, attend and support the MHCRP Advisory Board, which meets quarterly and consists of community stakeholders and persons in the mental health community;
- Provide information to outside agencies regarding Department procedures for handling persons with mental illness;
- Analyze state and federal legislation that affect persons with mental illness;
- Maintain liaison with DMH and hospitals on issues related to persons with mental illness;
- Design and conduct in-service mental illness training, and provide expertise and support to Training Division regarding all recruit officer mental illness-related training;
- Conduct audits of non-categorical Use of Force reports that involve persons with indicators of mental illness;
- Coordinate data collection to evaluate Department mental health crisis response; and,
- Review and revise Department strategies, policies, and procedures related to the handling of persons with mental illness.

MENTAL EVALUATION UNIT (MEU)

OVERVIEW OF MEU RESPONSIBILITIES

- Conduct preliminary investigations of persons who come to the attention of law enforcement and are suspected of having a mental illness, amnesia, senility, post-alcoholic or delirium tremors, and/or who require psychopathic examinations.
- Investigate persons suspected of being escapees from mental institutions.
- Coordinate the assignment of State Department of Mental Hygiene apprehension and transportation orders.
- Arrange, upon request, for uniformed officers to assist Lanterman-Petris-Short Act (LPS) designated Psychiatric Mobile Response Teams or court designated conservators in the apprehension of persons who suffer from mental illness and are placed on a mental health hold.
- Maintain, amend, and distribute the Department "Incidents Involving Persons Suspected of suffering from Mental Illness," Notebook Divider.
- Provide advice to officers on the confiscation and disposition of firearms or other deadly weapons confiscated from persons with mental illness.
- Provide information on attempt suicide, barricaded suspect, or hostage incidents that involve persons with mental illness.
- Assist field officers with intervention, referral, or placement of a person with mental illness to prevent the unnecessary incarceration and/or hospitalization of that person.
- Provide roll-call training relative to MEU and SMART responsibilities.
- Maintain liaison with the Missing Persons Unit to determine whether a reported missing person was placed on a 72-hour hold.
- Provide staff support for the MHCRP Coordinator and Advisory Committee.
- Maintain liaison with DMH and hospitals regarding policies and procedures that involve the detention and involuntary holds of persons with suspected mental illness.
- Provide analysis of state and federal legislation pertinent to law enforcement encounters with persons with suspected mental illness.
- Provide expertise and support to Training Division regarding all mental illness-related training.
- Conduct audits of categorical and non-categorical Use of Force reports that involve persons with indicators of mental illness.
- Review completed Use of Force reports with indicators of mental illness.
- Coordinate data collection to evaluate Department mental health crisis response.
- Review, initiate and coordinate Department mental health-related training courses.
- Maintain liaison with Psychiatric Hospitals and Mental Health Agencies.
- Maintain the Following Special Files:
  - ✓ Requests for psychopathic examination reports; and,
  - ✓ Unserved apprehension and transportation orders.

SYSTEMWIDE MENTAL ASSESSMENT RESPONSE TEAM (SMART) OVERVIEW

- Assist Department police officers whenever they contact persons with a suspected mental illness.
- Provide intervention, referral, or placement for a person with mental illness to facilitate the speedy return of field officers to other field duties.
- Prevent unnecessary incarceration and/or hospitalization of persons with mental illness.
- Provide alternate care in the least restrictive environment through a coordinated and comprehensive systemwide approach.
- Assist with intelligence functions at critical incidents.
- Assist with psychologically impaired victims at disaster scenes.

CASE ASSESSMENT AND MANAGEMENT PROGRAM (CAMP) OVERVIEW

- Manage cases that involve persons with a history of violent criminal activity caused by mental illness.
- Manage cases that involve persons with a history of mental illness who have caused numerous responses by law enforcement and the deployment of substantial police resources.
- Prevent unnecessary incarceration and/or hospitalization of persons with mental illness.
- Provide alternate care in the least restrictive environment through a coordinated and comprehensive systemwide approach.
- Maintain a file of Weapon Confiscation Receipts.

CAMP CASES INCLUDE BUT ARE NOT LIMITED TO**:**

- Subjects who attempt Suicide by Cop (SBC);
- Subjects who frequently utilize emergency services and/or abuse the 911 system;
- Subjects who are the subject of a SWAT response and/or high profile tactical operation;
- Veterans who suffer from Post-Traumatic Stress Disorder or other mental illness;
- Subjects involved in acts of targeted school violence;
- Mentally ill prohibited possessors (to ensure the seizure of all known firearms); and,
- Subjects enrolled in the State of California, Department of Mental Health, Conditional Release Program (ConRep).

TRIAGE DESK

- Receive mental illness crisis calls from patrol operations.
- Vet incoming calls and dispatch SMART to handle calls for service, as appropriate.
- Manage radio calls and SMART deployment.
- Coordinate client hospitalization for patrol personnel.
- Prepare MEU investigative reports.
- Maintain the MEU mental illness database.
- Coordinate outside agency response resources.
- Make appropriate notifications.
- Forward follow-up referrals to CAMP.

ADMINISTRATION AND TRAINING

TRAINING PROVIDED TO OUTSIDE LAW ENFORCEMENT AGENCIES

Since 1993, the MEU has trained personnel from the following agencies as a model co-response program. In 2010, the MEU was distinguished as a National Learning Site.

United States			
Maricopa County Sheriff Office	Arizona	Santa Ana Police Department	California
Alhambra Police Department	California	Santa Monica Police Department	California
Bell Gardens Police Department	California	Signal Hill Police Department	California
Beverly Hills Police Department	California	Sonoma County Sheriff Office	California
Burbank Police Department	California	Southgate Police Department	California
El Segundo Police Department	California	Torrance Police Department	California
Contra Costa County – City of Concord	California	Ventura Police Department	California
Downey Police Department	California	Vernon Police Department	California
Escondido Police Department	California	West Covina Police Department	California
Glendale Police Department	California	Denver Crime Commission	Colorado
Glenn County Sheriff Office	California	Stamford Police Department	Connecticut
Huntington Park Police Department	California	Portland Maine Police Department,	Maine
Inglewood Police Department	California	Baltimore Co. Maryland Sheriff Office	Maryland
Irvine Police Department	California	Baltimore Police Department	Maryland
La Verne Police Department	California	National Security Agency	Maryland
Long Beach Police Department	California	Boston Police Department	Massachusetts
Los Angeles Unified School District Police	California	Woodbury Police Department	Minnesota
Monterey Police Department	California	Las Vegas Police Department	Nevada
Mountain View Police Department	California	Bureau of Police, Portland	Oregon
Newport Police Department	California	Allegheny County Sheriff	Pennsylvania
Oakland Police Department	California	Austin Police Department	Texas
Oxnard Police Department	California	Houston Police Department	Texas
Pasadena Police Department	California	Plano Police Department	Texas
Petaluma Police Department	California	Tarrant County Sheriff	Texas
Redondo Beach Police Department	California	Texas Tech University	Texas
Redwood City Police Department	California	Williamson County Sheriff Office	Texas
Riverside Police Department	California	Defense Intelligence Agency	Virginia
San Diego Police Department PERT	California	National Intelligence Agency	Virginia
San Diego Sheriff Office	California	Bellevue Police Department	Washington
Los Angeles County Sheriff's Department	California	New York Police Department	New York
Los Angeles World Airports	California	Unified Police of Greater Salt Lake	Utah
San Bernardino County	California	Tucson Police Department	Arizona
San Francisco Police Department	California	Rochester Police Department	New York
INTERNATIONAL SINCE 2010			
Moorabbin Police, Melbourne	Australia	Calgary Police Department	Canada
New South Wales Police Department	Australia	Toronto Police Department	Canada
Queensland Police Department	Australia	Montreal Police Department	Canada
Victoria Police Department, Melbourne	Australia	Northern Ireland Police Department	United Kingdom
Ministere Public	Belgium	Leicestershire Constabulary	United Kingdom

CRISIS INTERVENTION TEAM (CIT) TRAINING *(40 HOURS, 2002-2004)* AND INTRODUCTION TO MENTAL HEALTH TRAINING (IMHT) *(24 HOURS, 2006-2012)*

In response to the Federal Consent Decree, MEU developed a 40-hour Crisis Intervention Training (CIT) based on the Memphis Model that was established in 1988. The course was piloted from 2002 through 2003. At the conclusion of the CIT pilot, the Department chose not to continue the course and it dropped from the California Peace Officer Standards and Training (CA-POST) list of certified courses of instruction.

In 2006, MEU developed the *Introduction to Mental Health Training*, which was a 24-hour CA-POST certified course. The IMHT course was delivered from 2006 to 2012. At the end of 2012, the Department determined that the course required substantial update, so it was decertified and dropped from the CA-POST list of certified courses of instruction. To date, 801 Department personnel have received either the 24-hour or 40-hour mental health courses of instruction.

LAPD:	801
Outside agencies:	129
Total:	**930**

OUTSIDE AGENCIES TRAINED IN CIT AND IMHT BY LAPD	
Beverly Hills Police Department	Maricopa County Sheriff Office
City Attorney Investigators	Mayors Crisis Response Team
Federal Bureau of Investigation	Pomona Police Department
Hawthorne Police Department	Redondo Beach Police Department
Los Angeles Airport Police Department	Social Security Administration Investigators
Los Angeles County Sheriff Office, CTU	United States Secret Service
Los Angeles County Sheriff Office, Mental Evaluation Team	University of Southern California Department of Public Safety
Los Angeles Unified School District Police Department	New York Police Department

MENTAL HEALTH INTERVENTION TRAINING (MHIT) 40 HOURS (ESTABLISHED SEPTEMBER 2014)

In 2013 the MEU and Police Training and Education (PTE) began development of an updated mental health training course, and in 2015, the MHIT was developed, CA-POST certified and delivered.

The course includes an overview of mental illness, crisis de-escalation and communication techniques, the Force Options Simulator (FOS) and situation simulations that were designed to test the students' understanding of, and ability to apply, their knowledge. The MHIT is a paradigm shift from the lecture-based, PowerPoint-driven, instruction of the past, as it utilizes small interactive groups that challenge the students to work as teams and participate in a facilitated learning environment. The course also includes blocks of instruction from:

- The Los Angeles Department of Mental Health
- The Autism Society of Los Angeles (ASLA); and,
- The National Alliance on Mental Illness (NAMI).

The LAPD has provided MHIT training to the following number of students, year-to-date:*

LAPD *(sworn)*:	850
Outside Agencies *(below)*:	155
Total:	**1005**

OUTSIDE AGENCIES TRAINED IN MHIT BY LAPD
Alhambra Police Department
Bell Police
Bell Gardens Police
California Highway Patrol
California State University Los Angeles Police
CSG Justice Center
Culver City Police
Glendale Police
Gardena Police
Hawthorne Police
Downey Police Department
Leicestershire Constabulary, United Kingdom
Los Angeles Airport Police Department
Los Angeles City Fire Department
Los Angeles City Park Ranger
Los Angeles County Sheriff's Department
Los Angeles Department of Mental Health
Los Angeles School Police
Montebello Police
Monterey Park Police
New York Police Department
Queensland, Australia
Redondo Beach Police
Rochester Police Department, New York
San Bernardino County Sheriffs
Signal Hill Police
Sonoma County Sheriff
South Gate Police
Torrance Police Department
Tucson Police Department
Unified Police of Greater Salt Lake City
University of Southern California

* Last updated on September 16, 2016.

ADDITIONAL MENTAL HEALTH-RELATED TRAINING

The MEU conducts or distributes the following training courses throughout the year:

Classroom

- Mental Health Intervention Training (40 hours) 24 times a year
- Field Training Officer (FTO) Update Course (SB29 – 4 hours) all FTOs every two years
- Mental Health Intervention Training Update Course (8 hours) every two years
- Mental Illness Introduction for Adult Corrections Officers (8 hours)
- Dispatcher – Persons with Mental Illness (8 hours)
- Armed Prohibited Persons/Mental Health Firearms Prohibition System (2 hours)
- Crisis Communication for First Responders (8 hours)
- Combat to Community/Police and Veteran Interaction (8 hours)
- School Threat Assessment Response Team (8 hours)

E-Learning

- Mental Illness – Use of Force and Crisis Intervention
- Mental Illness – Use of Force and Crisis Intervention – *Update*
- Legal Environment – Policing the Mentally Ill
- Mood Disorders
- Communicating with People with Disabilities

Tele-course

- Recognizing Mental Illness: A Proactive Approach

Mandated Training

In May 2014, all LAPD sworn personnel (over 9,800) were mandated to complete the two-hour CA-POST 2013 Mental Health Update course. To date, 98% have successfully completed the training and the remaining 2% were unable to complete the training due to long-term illness or injury.

As of February 2016, all LAPD sworn personnel completed a one-hour Crisis Communications for First Responders Course that was presented by the MEU staff as part of the Public Trust Training.

9-1-1 PROTOCOLS

All Police Service Representatives (PSRs) have received eight hours of training titled, *"Persons with Mental Illness."* The purpose of the training was to ensure that calls involving persons with mental illness are properly categorized, dispatched, and to ensure that sufficient information is provided to responding patrol officers. This includes information such as diagnosis, medication(s), threatening behavior, and/or weapon(s). Calls for service involving mental illness are call-typed as the following:

- 918 M Male with Mental Illness
- 918 F Female with Mental Illness
- 918 VM Violent Male with Mental Illness
- 918 J Juvenile with Mental Illness
- 918 VF Violent Female with Mental Illness
- 918 VJ Violent Juvenile with Mental Illness
- 918 AM Ambulance Male with Mental Illness
- 918 PM Possible Male with Mental Illness
- 918 AF Ambulance Female with Mental Illness
- 918 PF Possible Female with Mental Illness
- 9073 Attempt Suicide
- 907A3 Ambulance Attempt Suicide

ADDITIONAL PROTOCOLS INCLUDE THE FOLLOWING:

- In incidents that involve mental health and a crime, the crime code takes precedence; however, the PSR gathers additional information regarding the mental health issue.

- Uniformed patrol officers are dispatched to all calls that involve a person with mental illness, including Ambulance Attempt Suicide/Suicide calls.

- A notation is made by the PSR in the Incident Detail, *"*CONTACT MENTAL EVALUATION UNIT IMMEDIATELY UPON SCENE STABILIZATION 213/996-1300*"* on all calls for service that involve a person with mental illness.

- Patrol officers conduct a preliminary investigation to determine whether there is mental illness and then contact MEU for advice and possible dispatch of a SMART unit.

- If there is a medical emergency, the patrol officer must conduct an on-scene investigation, conduct a follow-up to the hospital and provide their findings to the admitting staff.

FIELD PROTOCOLS FOR CALL MANAGEMENT AND DIVERSION

After an incident is tactically stable, patrol officers must conduct an assessment of the detained individual to determine whether there is mental illness and whether the individual meets criteria for an involuntary mental health hold (WIC §5150). The incident can be managed by a SMART unit, if available, or by the patrol officers with the guidance of the MEU.

NOTIFICATIONS

When the only reason for detention is the person's suspected mental illness, the MEU **MUST** be contacted **PRIOR** to transporting an apparently mentally ill person to any health facility or hospital.

> ***Exception:*** *If the subject is injured and requires immediate medical treatment, the MEU must be contacted after the subject is transported to an appropriate medical facility.*

When a person with suspected mental illness has been taken into custody for a criminal offense, MEU **MUST** be contacted **PRIOR** to the person being booked (Department Manual §4/260.20).

Officers who receive information from a mental health professional regarding a potential threat to any person (Tarasoff Notification) must immediately notify MEU.

ARREST AND BOOKING

When a person is taken into custody for a criminal offense and the person is suspected of having a mental illness, the MEU shall be contacted prior to the person being booked. When a subject is a suspect in a felony or high-grade misdemeanor crime, or has a felony or high-grade misdemeanor warrant, the criminal matters shall take precedence. If the subject is under arrest for a low-grade misdemeanor crime, misdemeanor warrant, or infraction, and meets the criteria for an Application for 72-hour Detention .for Evaluation and Treatment, booking is at the discretion of the Area watch commander. Arrestees suffering from mental illness may be booked at any Department jail facility. Brief information concerning the mental illness should be documented in any booking reports and under the "Additional" heading in the Arrest Report.

The MEU is available for advice and assistance to facilitate the transfer of the subject to a Los Angeles County Jail Facility. Any questions concerning the arrest, booking, housing, or transfer of an individual suspected of suffering from a mental illness should be directed to the MEU Watch Commander.

JAIL MONITORING

- All Adult Corrections Officers (ACOs) have received eight hours of training titled *"Mental Illness Introduction for Adult Corrections Officers."*
- All sworn jail personnel have received four hours of mental illness training.
- All arrestees are screened during the booking process and ACOs ensure that the arresting officers have notified the MEU if the arrestee indicated that he/she suffers from mental illness, which will prompt an MEU information report.

If an arrestee is determined to be in a mental health *crisis* or is suffering from a chronic mental illness, and the arrestee can be released on their own recognizance or arrange bail, jail personnel or a patrol unit will conduct the mental illness assessment and transport to a psychiatric facility. The MEU provides telephonic advice, documents the incident, and directs transporting units to appropriate hospitals.

DIVERSION PROGRAMS

- Pre-booking diversion occurs via the patrol officers or via SMART when:
  - A crime was committed;
  - The crime is a low grade misdemeanor;
  - A report or citation and release is competed; and,
  - The person with mental illness is taken to the Psychiatric Emergency Department coordinated through the MEU.

- Post-booking diversion occurs when the subject can be released on their own recognizance or bail is posted. The subject can also be diverted to a mental health treatment provider during the arraignment process or as a condition of their plea or conviction.

MENTAL HEALTH PARTNERS

- Los Angeles County Department of Mental Health
  - ✓ System Leadership Team (SLT)
  - ✓ Court Liaison Program Community Reintegration Program (CRP)
  - ✓ Countywide Resource Management - AB109
  - ✓ Jail Services - Forensic Inpatient Program (FIP) (Twin Towers)
- National Alliance for Mental Illness of the San Fernando Valley
- National Alliance for Mental Illness (NAMI LA)
- Autism Society of America Los Angeles (ASALA)
- Los Angeles County Department of Health Services (LACDHS)
- State of California – State Mental Health Facilities (Patton State, Metropolitan State Hospital)
- State of California Mental Health Services Act – Oversight and Accountability Commission
- Hospital Association of Southern California (HASC)
- Gateways Hospitals – ConRep Administrator and Community Reintegration Program (CRP)
- Los Angeles County Superior Psychiatric Court – Department 95
- Los Angeles County District Attorney's Office – Department 95
- Los Angeles County Superior Court – Veterans Court
- California Department of Justice – Bureau of Firearms (CADOJ)
- Department of Veteran's Affairs
- Los Angeles Unified School District (Crisis Counseling)

CONFERENCES

The MEU has given presentations at the following conferences:

- 2006 National GAINS Center Conference, Boston, MA
- 2006 5th Annual Conference on Police/ Mental Health Systems Liaisons *"Psychiatrists in Blue: Emerging Partnerships,"* Ottawa, Ontario, Canada
- 2007 National Alliance on Mental Illness, Los Angeles, CA
- 2008 National GAINS Center Conference, Washington, DC
- 2008 School Threat Assessment Response Team
- 2009 School Threat Assessment Response Team
- 2010 Post Traumatic Stress Disorder- Combat to Community, Returning Veterans, in Conjunction with the National Center for PTSD, VA, Menlo Park, CA
- 2011 Justice and Mental Health Collaboration Program National Training and Technical Assistance Event: Collaborating to Achieve and Communicate Positive Public Health and Public Safety Outcomes, Baltimore, MD
- 2011 Association of Threat Assessment Professionals, School Threat Assessment Response Team (START)
- 2012 The Justice Center, The Council of State Governments: Innovative Law Enforcement Strategies for Interacting with People with Mental Illness that Frequently Require Emergency and Crisis Services, Webinar-National.
- 2014 Association of Threat Assessment Professionals, Strategic Information Sharing and Safeguarding between Risk Management Professionals and Disciplines
- 2015 JMHCP Law Enforcement Grantee Intensive Training Summit - New York
- 2015 SCA-JMHCP National Conference – Washington, DC
- 2016 Beating Mental Illness - USCGould School of Law
- 2016 Crisis Intervention Training International Conference – Chicago
- 2016 California National Alliance on Mental Illness, Annual Conference – Burlingame, Ca
- 2016 National Association for Civilian Oversight of Law Enforcement, Annual Conference- Albuquerque, NM

AWARDS, RECOGNITIONS AND ACKNOWLEDGEMENTS

UNIT AWARDS

- Certificates of Appreciation from the Los Angeles Board of Police Commissioners 2005.
- Los Angeles Police Department Police Meritorious Unit Citation, March 20, 2007.
- National Association of Counties, Achievement Award 2007.
- 21st Annual Los Angeles County Productivity and Quality, Bronze Eagle Award 2007.
- 21st Annual Los Angeles County Productivity and Quality, Million Dollar Club 2007.
- 2009 Autism Society of America, LA Hearts and Arts Award.
- 2010 *Specialized Policing Responses: Law Enforcement/Mental Health* National Learning Site as selected by the Council of State Governments Justice Center with support from the Bureau of Justice Assistance (BJA).
- 2011 LAPD Mental Illness Project selected as a "Bright Ideas" Award recipient from the Ash Center for Democratic Governance and Innovation at the John F. Kennedy School of Government, Harvard University.
- 2012 Autism Society of Los Angeles recognition for continued support and training.
- 2012 School Threat Assessment Response Team (START) selected as a "Bright Ideas" Award recipient from the Ash Center for Democratic Governance and Innovation at the John F. Kennedy School of Government, Harvard University.
- 2013 M.I.L.E. Award Program.
- 2016 Christine M. West Award, Forensic Mental Health Association of California (FMHAC)
- 2016 Los Angeles County Productivity and Quality Award, Special Merit Plaque, "Mental Health Training for First Responders."

INDIVIDUAL AWARDS

- (5) Police Stars for Bravery
- (4) Life Saving Medals
- (1) California Peace Officers Associations (CPOA) Award of Valor
- (1) California POST Excellence in Training Award (Post Incident Debriefs)
- (4) Employees of the Year, Detective Support and Vice Division (2011, 2013 and 2014)
- (1) Employee of Year 2003, Los Angeles County
- (1) Nurse of the Year 2007, Los Angeles County
- (1) Rising Star Award 2008, Los Angeles County
- (1) Extra M.I.L.E.(s) Award Individual 2013

ARTICLES, PUBLICATIONS, COMMUNITY FORUMS

- L.A. City View 35, Disability Forum, Persons Suffering from Mental Illness, October 2006.
- Los Angeles Times Newspaper Forum on Homelessness, KTLA Channel 5, 2007, working in conjunction with the Mayor's Safer Cities Initiative and the Mentally Ill.
- The BEAT Magazine, December 2007, recognition from Anthony Pacheco, President of the Los Angeles Police Commission for establishment of Autism Roll Call Training.
- Daily News Article – February 1, 2008*, "Special Cops Cope with Suicidal 7-Year Old or Britney."*
- Los Angeles Magazine, October 2009, *"The War Within"* on PTSD.
- Detective Bureau Bi-Monthly, Volume 2, Issue 1, Year 2009, recognition for the establishment of the School Threat Assessment Team strategy and the successful conferences.
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REFERENCE

TO LEARN MORE ABOUT:

The Law Enforcement/Mental Health Learning Sites, coordinated by the Council of State Governments (CSG) Justice Center and supported by the Bureau of Justice Assistance (BJA), visit www.consensusproject.org/learningsites or contact Gerard Murphy gmurphy@csg.org (646-383-5761).

Law Enforcement Responses to People with Mental Illnesses, visit www.consensusproject.org/issue_areas/law-enforcement

The Ash Center for Democratic Governance and Innovation and Bright Ideas, visit http://www.ash.harvard.edu/Home/Programs/Innovations-in-Government/Awards/Bright-Ideas. The Roy and Lila Ash Center for Democratic Governance and Innovation advances excellence and innovation in governance and public policy through research, education, and public discussion.

Three major programs support our mission:

- The Program on Democratic Governance;
- The Innovations in Government Program; and,
- The Rajawali Foundation Institute for Asia.

Social Media

Facebook: LAPDMEU ❖ Twitter: @LAPDMEU ❖ Instagram: LAPDMEU

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AGENDA ITEM 3

Action

September 22, 2016 Commission Meeting

Orange County Innovation Projects

Summary: The Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission) will consider approval of Orange County's request to fund three new Innovative (INN) projects: (1) *Community Employment Services* for a total of $2,404,815 in Innovation component funding over five years; (2) *Employment and Mental Health Services Impact* for a total of $1,645,657 in Innovation component funding over five years; and (3) *Job Training and On-site Support for TAY* for a total of $6,531,770 in Innovation component funding over five years.

The Mental Health Services Act (MHSA) requires that an INN project does one of the following: (a) introduces a new mental health practice or approach, including but not limited to prevention and early intervention; (b) makes a change to an existing mental health practice or approach, including, but not limited to, adaptation for a new setting or community; (c) introduces to the mental health system a promising community-driven practice/approach, that has been successful in non-mental health contexts or settings; or (d) participates in a housing program designed to stabilize a person's living situation while also providing supportive services on site. The law also requires that an INN project address one of the following as its primary purpose: (1) increase access to underserved groups, (2) increase the quality of services including measurable outcomes, (3) promote interagency and community collaboration, or (4) increase access to services.

(1) The Community Employment Services project proposes to increase the quality of services, including measurable outcomes in employment, by offering on-site, peer-supported employment coaching for up to 40 individuals per year living with persistent mental health challenges. The INN project complies with all MHSA requirements.

Orange County is requesting authorization from the MHSOAC to fund this five-year project in the amount of $2,404,815.

(2) Employment and Mental Health Services Impact project proposes to increase access to services by co-locating and integrating behavioral health clinicians at employment centers in Orange County. The INN project complies with all MHSA requirements.

For this project the County is requesting authorization from the MHSOAC to fund this five year project in the amount of $1,645,657.

3) Job Training and On-Site Support for TAY project proposes to increase the quality of services, including better outcomes in employment of TAY by creating a kitchen/food service business with on-site employment and behavioral health coaches. This INN project complies with all MHSA requirements.

For this project the County is requesting authorization from the MHSOAC to fund this five year project for $6,531,770.

Presenters:

- Brian Sala, Ph.D., Deputy Director, Evaluation and Program Operations
- Flor Tehrani Yousefian, Interim Administrative Manager for Innovative Projects, Orange County Behavioral Health Services
- Brett O'Brien, LMFT, Director for Children, Youth and Prevention, Orange County Behavioral Health Services

Enclosures (4): (1) Staff Innovation Summary, Community Employment Services; (2) Staff Innovation Summary, Employment and Mental Health Services Impact; (3) Staff Innovation Summary, Job Training and On-site Support for TAY; (4) County Innovation Brief.

Handout: A PowerPoint will be presented at the meeting.

Proposed Motion: The MHSOAC approves Orange County's Innovation plans, as follows:

Name: Community Employment Services
Amount: $2,404,815
Project Length: Five Years

Name: Employment and Mental Health Services Impact
Amount: $1,645,657
Project Length: Five Years

Name: Job Training and On-site Support for TAY
Amount: $ 6,531,770
Project Length: Five Years

Mental Health Services
Oversight & Accountability Commission

STAFF INNOVATION SUMMARY— ORANGE COUNTY

Name of Innovative (INN) Project: Community Employment Services

Total INN Funding Requested for Project: $2,404,815

Duration of Innovative Project: Five (5) Years

Review History

County INN plan approved by County Board of Supervisors on June 2, 2015.

Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission) consideration of INN Project: September 22, 2016.

Project Introduction:

Orange County proposes to increase the quality of services, including better outcomes by providing 100% on-site job coaching by peers to help participants living with a persistent mental health challenge manage symptoms that are interfering with workplace performance. The program aims to improve participant employment skills and abilities, behavioral health outcomes and their global health.

In the balance of this brief we address specific criteria that the Commission looks for when evaluating Innovation Plans, including: What is the unmet need that the county is trying to address? Does the proposed project address the need? Are there clear learning objectives that link to the need? And, will the proposed evaluation allow the county to make any conclusions regarding their learning objectives? In addition, the Commission checks to see that the Innovation meets regulatory requirements that the proposed project must align with the core Mental Health Services Act (MHSA) principles, promote learning, funds exploration of a new and/or locally adapted mental health approach/practice, and targets one of the four allowable primary purposes.

The Need

The County notes that employment is often identified by individuals with mental health challenges as a significant goal towards recovery, but that the very large majority of individuals with mental illnesses are unemployed. Indeed, the U.S. Bureau of Labor Statistics reported recently that only 17.5 percent of persons with a disability were employed in 2015. While the County has not demonstrated that employment for persons with mental illness is especially high within Orange County, it has explained that this proposal emerged from a series of stakeholder meetings designed to develop INN project concepts. Pilot projects that cost-effectively improve the job skills and employment success of clients could have wide appeal beyond the case of Orange County.

The Response

Orange County intends to determine if a comprehensive coaching model will ease participants' transition into currently existing supported employment programs and assist in moving participants toward employment stability and independence. The County intends to contract with a provider to supply and manage trained peer specialists to work alongside participants and provide comprehensive supportive services related to employment readiness. Peer Specialists would be placed with up to five participants at the same job site and provide on-site coaching for up to six months per client. Participants would work up to 15 hours a week earning minimum wage. The County expects that the selected contractor would staff the project with one full-time, Masters-level clinician, four peer specialists and one clerical support person. The program is intended to serve 40 participants annually.

The County notes that this proposal makes a change to an existing approach in mental health, but is somewhat unclear as to the model or approach that the County is adapting. Hence it is challenging to clearly articulate what is novel or innovative about their proposal. The County could better articulate the degree to which the proposed INN project differs both from two existing supported employment programs in the County and from such well-established supported employment strategies as Individual Placement and Support (IPS), the best-known evidence-based practice in supported employment (Rockville Institute). The County may also find useful examples to consider from the U.S. Department of Housing and Urban Development's "Bridges to Work" demonstration projects from the 1990s (see, e.g., Watson and Palubinsky), although these projects were not designed to serve persons with mental illnesses.

Orange County recently completed a prior INN project for supported employment entitled "Volunteer to Work," focused on helping clients build job skills by connecting them with volunteer opportunities. The County transitioned that program into Community Systems and Supports (CSS) funding in FY 2015-16 (Orange County, p. 3). The County is currently working on the final report which will discuss nine INN projects. They plan to submit the report in October.

The County also maintains a Supported Employment program as part of its CSS program. This program was budgeted for $1,021,417 for FY 2015-16 and included job coaching, counseling, and peer support services, among other attributes. Specifically, "each individual placed into competitive employment has the ongoing support of an Employment Specialist (ES). The ES is responsible for providing the consumer with one-on-one job support to ensure successful job retention" (Orange County MHSA Annual Update, p. 68). The County reported some successes in that program in "graduating" participants who had successfully retained paid employment for more than 90 days. The County states that the currently proposed INN project is targeted at participants who were not or likely would not be successful in this CSS program because they required greater levels of support or persons who have not had any prior work experience.

The Community Employment Services project builds on gaps in services and areas of need identified during these two projects. The County maintains that the 100% on-site

coaching and specialized trainings prior to and following the work day are what is innovative about the project.

The Community Planning Process

The County reports that it held a series of stakeholder meetings across the county to solicit and develop INN project concept proposals. This appears to have been a robust process to generate meaningful stakeholder participation in the development of the County's INN proposals. See, e.g., the "Innovation Idea Form" for this project (Orange County Community Employment Services Plan). However, the proposal presented to the Commission has evolved somewhat from the project that was approved by the County Board of Supervisors on June 2, 2015 and included in the County's 2015-16 Annual Update (Orange County MHSA Annual Update, pp. 244-5).

Learning Objectives and Evaluation

Orange County states that its primary learning goals with this program are to determine whether on-site peer support will increase the quality of their supported employment services, improve participants' employment skills and abilities, and, ultimately, improve participants' behavioral health outcomes and participants' global health.

The County proposes to measures these outcomes with intake/enrollment and project exit data, self-report outcome measures, employment retention rates following project exit and satisfaction surveys. The County could more clearly articulate how it will test the marginal impact of on-site peer support on outcomes for program participants relative to the County's standard Supported Employment approach or other models.

At the end of the fourth year, project services will be concluded. The fifth year will be used to draft the final report and document the lessons learned from the project. Given this timeline, it is not clear how long the county intends to track employment retention rates of employees if they extend beyond the project. The standard for "graduation" from supported employment programs appears to be retention of paid employment for at least 90 days, but the degree to which existing programs follow up with "graduated" participants to track job retention after exit from the supportive services is unclear.

The budget narrative states that included in the expenditures is an estimated percentage for evaluation.

The Budget

The proposed budget includes $2,404,815 in expenditures all of which are being attributed to INN funding. The budget includes an estimated $219,644 (nine percent) for evaluation. Clarification needs to be obtained from the County on the budget plan. In particular, the County attributes in documents submitted to the Commission $994,035 of its estimate to "Other expenditures," such as "the County Procurement Process, Flexible Funds, Work Plan Management, and Innovation Project Final Report." Much of this latter line-item appears to be administrative costs associated with the project. The total amount of funding for administration is not specified explicitly.

Additional Regulatory Requirements

The proposed project appears to meet or exceed minimum standards for compliance with other requirements under the MHSA. This program aligns with the core Mental Health Service Act principles. The program makes a change to an existing employment approach by providing 100% on-site job coaching by peers. The primary purpose is to increase access to mental health services.

References

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Orange County Mental Health Services Act Annual Update FY 15/16.

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Watson, Bernardine H., and Beth Z. Palubinsky. 1997. "Getting From Here to There: The Bridges to Work Demonstration First Report to the Field." Field Report Series. Public/Private Ventures (Philadelphia). https://www.huduser.gov/portal/publications/povsoc/btw/demowork.html. Accessed September 12, 2016.

STAFF INNOVATION SUMMARY— ORANGE COUNTY

Name of Innovative (INN) Project: Employment and Mental Health Services Impact

Total INN Funding Requested for Project: $1,645,657

Duration of Innovative Project: Five (5) Years

Review History

Approved by County Board of Supervisors June 2, 2015

Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission) consideration of INN Project: September 22, 2016.

Project Introduction:

Orange County proposes to increase access to services by co-locating and integrating behavioral health clinicians at employment centers in Orange County. They anticipate that by having visitors to the employment centers complete a health and quality of life assessment in conjunction with other application materials for employment services, they will provide a stigma-free point of entry (if appropriate) to the mental health care system in the County.

The County proposes to serve 150 unduplicated individuals per year who are unemployed or at risk of unemployment and who present as having mild to moderate symptoms of mental illness or co-occurring substance use disorders.

The final year of the project will consist of project evaluation as well as a decision process as to whether to support these services through another Mental Health Services Act (MHSA) component, most likely Prevention and Early Intervention.

In the balance of this brief we address specific criteria that the OAC looks for when evaluating Innovation Plans, including: What is the unmet need that the county is trying to address? Does the proposed project address the need? Are there clear learning objectives that link to the need? And, will the proposed evaluation allow the county to make any conclusions regarding their learning objectives? In addition, the OAC checks to see that the Innovation meets regulatory requirements that the proposed project must align with the core MHSA principles, promote learning, funds exploration of a new and/or locally adapted mental health approach/practice, and targets one of the four allowable primary purposes.

The Need

Orange County reports there are no employment centers in the County that provide onsite emotional/behavioral health support services. The county cites research that "unemployment negatively impacts emotional and behavioral health". Perhaps because of the economic downturn in California, in 2007 Orange County employment centers saw an increase of job seekers. The County also has experienced about a 10% population increase since 2000, which may account for some of the rise in job seekers. The County reports that while the center representatives could help most of the job seekers, they "were not prepared for the collateral emotional and behavioral health support that these individuals needed to address symptoms typically associated with unemployment."

What is not particularly clear in the proposed Innovative plan is the actual need for these services. Data from the Employment Development Department indicates that the unemployment rate for Orange County is 5.8 %, which is about 3% lower than the total unemployment for the State of California at 8.5%. Given the population data in Orange County, this does not represent a large cohort of unemployed. Further, the County indicates that some of the beneficiaries of this plan will be job seekers with substance use issues. The plan lacks detail as to the numbers of job seekers in this target population.

The Response

The County posits that traditionally, regardless of how job seekers may be feeling or how aware they are of the emotional impact of their unemployment, job seekers do not necessarily seek behavioral health support as part of a job search effort. By co-locating clinicians in employment centers, the County hopes to assist employment center staff, as well as job seekers, by identifying persons who may be having emotional problems through this early intervention.

Over the course of this five-year Innovation plan, the County intends to establish a pool of clinicians to staff various employment centers. These clinicians will provide supportive counseling (16 sessions), behavioral health workshops and support groups to the centers' clientele. During the initial stages of this plan, County administrative staff will conduct site visits to coordinate agreements, data tracking and charting along with creating a policy and procedures manual. Emotional and behavioral health screening of new and existing employment center clientele will occur throughout the course of this innovation and persons flagged by clinicians as being mildly to moderate impacted, will receive emotional support services, if they are interested.

Co-location of auxiliary and related services in employment centers is not a new concept in California. Examples include the Sacramento Employment and Training Agency (SETA) program here in Sacramento where various agencies co-located to provide bundled vocational services to the unemployed; various co-locations between the Department of Rehabilitation (DOR) and Employment Development Department facilities; and Career One Stops that have co-located individual DOR vocational counselors, veterans representatives and supported employment service agencies.

Outside of California, research to date only identifies two similarly situated programs: one in Missouri (Missouri Department of Mental Health) and another in Minnesota (Resource). The information provided for these programs, however, does not indicate whether these co-located behavioral health services are adjunctive to the employment centers in the same way that Orange County proposes.

What makes Orange County's project potentially innovative is that it provides both a methodology for identifying emotional problems (assessments) and on-site support service staff to address these problems. Other programs and co-located entities mentioned appear to have been less institutionally structured to both identify and address behavioral health concerns on-site.

It appears that the County is trying to learn and possibly to establish if there is a "causal link" between emotional problems and unemployment. In part, research that the County has relied upon appears to question whether such a connection can be made directly. Goldsmith and Diette, researchers, cited by the County articulate this:

> *Social scientists from a range of disciplines have provided cross-sectional evidence of a connection between unemployment and various indicators of mental health. However, these researchers recognize the potential for reserve causality where poor mental health can lead to joblessness and thus call their results into question. Numerous researchers attempt to address this problem by examining persons who switch over time from work to unemployment. However, their findings supporting the link between unemployment and a decline in emotional well-being, although compelling, are not definitive evidence of a causal link because something unobserved by the researcher may have changed before the onset of unemployment that damaged a person's emotional wellbeing. . . .A second shortcoming identified by Kessler, Turner and House (1988) in conventional studies using both cross-sectional and panel data is the selection into unemployment on the basis of prior mental health.*

The Community Planning Process

Orange County conducted its community planning process for this Innovation in Fiscal Year (FY) 2014/15. They state that they developed strategies to assist stakeholders throughout the process of community meetings, including providing clear definitions of the process and criteria to be used for vetting Innovation projects. They also provided stakeholders with a template for submitting ideas and provided them technical assistance via Q & A about projects that were being considered. These questions and responses are included on the County's website.

Five community stakeholder meetings were held regionally throughout the County.

> *Participation in these regional meetings included consumers, family members, providers, and individuals representing the larger health care community in Orange County that have an interest in behavioral health care.*

> *Invitations for participation were sent to consumers and consumer organizations as well as to individuals who represent safety (e.g., Probation and Sheriff), education, faith communities, physical healthcare providers (e.g., CalOptima, hospitals, community clinics), Social Services Agency), among others. Interpretive services were available for each of the meetings to remove barriers to participation for those whose primary language was not English. (Orange County New Innovative Project Description, page 2)*

This process generated thirty-one project suggestions submitted to the County. Behavioral Health staff reviewed the suggestions for fit with Innovative Project criteria and conducted a literature review to assess whether these ideas had been tried previously or if they had, if was there something about the Orange County suggestions that differentiated them sufficiently from the previous Innovation project.

Projects that passed both these preliminary levels were then presented to the MHSA Steering Committee. "The MHSA Steering Committee voted for the Employment and Mental Health Services Impact project proposal to move forward for consideration and formal submission to the MHSOAC for approval." (Orange County New Innovative Project Description, p.3)

Learning Objectives and Evaluation

Orange County states that the goals of this project will be to:

1. Increase participant access to community behavioral health and supportive services/programs.
2. Improve participant knowledge and/or awareness of behavioral health resources.
3. Improve participant behavioral health outcomes.
4. Improve participant global health. (Orange County New Innovative Project Description, p. 5)

The County intends to start the data gathering process in the second year of the project (first full service year) by collecting intake/exit data and documenting the types of services provided, types of trainings a participant may attend, referrals and linkages to other community services and participation in actual treatment with onsite clinicians. (Orange County New Innovative Project Description, p. 5).

The description of the learning objectives and evaluation methodology for this project closely mirror the statements provided in the County's Job Training and On-site Support for TAY project, also before the Commission. In both cases, the County's specification of its learning objectives and evaluation approach needs further clarification.

The Budget

The project is to be contracted out to a community-based organization and so the County is only estimating suggested line item costs. The County indicates that the actual budget will depend on the selected provider's proposal. Therefore, staffing and other expenses are contingent upon the contract provider's final budget. The County's proposed budget

should clarify what expected costs will be for contracted services versus direct County costs.

The projected budget is $1,645,657 over the five (5) year project. Evaluation costs estimated for this project are $197,814, or approximately 12% of the total plan costs. The breakout for the evaluation dollars is as follows:

5% from Personnel ($750,000) =	$37,500
5% from Operating Expenses ($303,000) =	$15,150
5% from Non-Recurring Expenditures ($15,000) =	$750
25% from Other Expenditures ($577,657) =	$144,414

As mentioned above, there do not appear to be any specific budget allocations or differentiation for administrative costs, although much of the Other Expenditures category appears to be for administrative expenses.

This project proposal has evolved considerably from the project described in the County's FY 2015/16 Annual Update (Orange County MHSA Annual Update, pp. 246-248). The County is asking the Commissioners to approve a total Project amount of $$1,645,657 for five (5) years, considerably more than the one-year funding amount included in the Annual Update discussion. The County does not clarify in its proposal how these new project amounts were determined.

Additional Regulatory Requirements

The County could provide clarifications regarding budget items (including administration expenses and proposed purchase of software) and more clarity on the actual need for this service. The proposal as presented appears to meet or exceed other minimum regulatory requirements.

References

Goldsmith, A. H. & Diette, T. M. (2012). "Exploring the link between unemployment and mental health outcomes." The SES Indicator, 5(1). Abstract

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Mental Health Services
Oversight & Accountability Commission

STAFF INNOVATION SUMMARY— ORANGE COUNTY

Name of Innovative (INN) Project: Job Training and On-Site Support for TAY

Total INN Funding Requested for Project: $6,531,770

Duration of Innovative Project: Five (5) Years

Review History

Approved by the County Board of Supervisors June 2, 2015

Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission) consideration of INN Project September 22, 2016

Project Introduction:

Orange County proposes to increase the quality of services for Transitional Aged Youth (TAY), including better outcomes by creating a working kitchen/food service business with on-site employment and behavioral health coaches. These coaches will provide job training and behavioral health support to participants/employees of the business. The County also indicates that it will provide a stipend to "a School of Business" (p. 4) in order to develop a business plan for the business.

In the balance of this brief we address specific criteria that the Commission looks for when evaluating Innovation Plans, including: What is the unmet need that the county is trying to address? Does the proposed project address the need? Are there clear learning objectives that link to the need? And, will the proposed evaluation allow the county to make any conclusions regarding their learning objectives? In addition, the Commission checks to see that the Innovation meets regulatory requirements that the proposed project must align with the core MHSA principles, promote learning, funds exploration of a new and/or locally adapted mental health approach/practice, and targets one of the four allowable primary purposes.

The Need

The County does not provide statistical evidence of a large number of unemployed TAY within Orange County. However according to the July 2014 National Alliance on Mental Illness (NAMI) report, *Road to Recovery: Employment and Mental Illness,* "the current service system is ill suited to meet their needs. Mental illness often emerges during the late teens and early adult years, hitting the gap between child and adult mental health service systems" (p.12). This is also the same time frame when youth traditionally begin their exploration of the world of work and begin to develop work habits and skills.

Persistent mental health issues create, in the TAY age group "the highest school dropout and failure rates of any disability group" (p. 12). Orange County proposes to mitigate this with a work experience that combines developing work skills building with an environment that provides emotional and behavioral support strategies for TAY.

The County states that neither its existing FSP programs nor its TAY Program for Assertive Community Treatment (PACT) address the need for TAY with a serious mental illness to develop job skills.

The Response

While the County acknowledges that there are similar work training/hardening types of programs throughout the County, they indicate that these are designed for foster youth, adults, criminal offenders and individuals with substance use disorders. This Innovative Project is only being developed for TAY. This Project will employ TAY and work on employment skills and emotional challenges while the youth is employed. It is anticipated that the TAY in this program will be better served by job coaches who are sensitive to their potential work place challenges and can better provide positive reinforcement and work place interventions for behaviors related to their persistent mental health issues, even as they are working.

The County maintains that this program will dedicate training only for those TAY who are diagnosed with persistent mental health challenges and will provide a "unique supported environment that will address a cognitive emotional component in conjunction with workplace inexperience. (Orange County INN Proposal, p. 1).

Following completion of a series of more academic and therapeutic courses, TAY recruited will work in the business and learn work behaviors, as well as meet work challenges related to their particular mental health circumstances. The County Proposes to serve 150 TAY per year who are not currently participating in or succeeding in existing supported employment programs and who are receiving behavioral health services in the County. The final year of the project will consist of project evaluation as well as a decision process as to whether to support these services through another Mental Health Services Act (MHSA) component.

Orange County acknowledges that this is not a new concept, per se. California county-based organizations and mental health agencies in the 1990s modelled this type of programming in mental health, largely through the California Association of Social Rehabilitation Agencies (CASRA). Businesses were developed for persons with mental illness. Recipients of mental health services were recruited through numerous entities such as the Department of Rehabilitation, socialization centers and group homes to be employees of these businesses.

Skill building at these businesses include "work hardening," socialization through work team efforts, learning how to manage time as well as employment preparation in the form of occupational development were the hallmarks of numerous programs. Examples,

include The Village in Long Beach, CA, Rubicon Bakery in Richmond, CA. a recycling center in Martinez, CA. and a janitorial/gardening/clerical service in Davis, CA.

What differentiates these programs from the food service program outlines in Orange County's Innovative Project is that Orange County intends to only service TAY. The vocational programs such as those identified above, initially served all adults in the mental health system. The County should further investigate the lessons learned from those examples.

For example, while the County describes some personnel expenses in its budget narrative, it does not address other issues related to running a commercial enterprise, such as workers compensation, health and safety codes, business licensing, payroll taxes, minimum wage, and insurance costs. Since it does not appear that the County intends to run this program as a sheltered workshop, these are very real issues related to doing business in California, regardless of whether it is under the auspices of a mental health program. Full development of a business plan would appear to be a necessary step prior to launching this project.

Our research indicates that supported employment programs for persons with emotional and/or behavioral issues most often are offered as part of an array of services such as housing. For example, Daniel's Place and Humanim are two housing programs for TAY in Los Angeles and Maryland, respectively, that incorporate a vocational component (supported employment). Many other programs nationwide, such as Cornerstone and the Young Adult Vocational Program and Peer Mentoring Project in Boston, offer stand-alone vocational services, not related to a business. Local to Sacramento, there are business such as Cool Beans and Crossroads Diversified Services which work with persons with mental health issues. These examples are not exclusively for TAY, however.

The Community Planning Process

Orange County conducted its community planning process for this Innovation in Fiscal Year 14/15. They state that they developed strategies to assist stakeholders throughout the process of community meetings, including providing clear definitions of the process and criteria to be used for vetting Innovation projects. They also provided stakeholders with a template for submitting ideas and provided them technical assistance via Q & A about projects that were being considered. These questions and responses are included on the County's website.

Five community stakeholder meetings were held regionally throughout the County.

> *Participation in these regional meetings included consumers, family members, providers, and individuals representing the larger health care community in Orange County that have an interest in behavioral health care. Invitations for participation were sent to consumers and consumer organizations as well as to individuals who represent safety (e.g., Probation and Sheriff), education, faith communities, physical healthcare providers (e.g., CalOptima, hospitals, community clinics), Social Services*

> *Agency), among others. Interpretive services were available for each of the meetings to remove barriers to participation for those whose primary language was not English. (Orange County New Innovative Project Description, page 2)*

This process generated thirty-one project suggestions submitted to the County. Behavioral Health staff reviewed the suggestions for fit with Innovative Project criteria and conducted a literature review to assess whether these ideas had been tried previously or if they had, if was there something about the Orange County suggestions that differentiated them sufficiently from the previous Innovation project.

Projects that passed both these preliminary levels were then presented to the MHSA Steering Committee. "The MHSA Steering Committee voted for the Job Training and On-site Support for TAY project proposal to move forward for consideration and formal submission to the MHSOAC for approval." (Orange County New Innovative Project Description, p.3).

Learning Objectives and Evaluation

Orange County states that the goals of this project will be to:

1. Increase participant access to community behavioral health and supportive services/programs.
2. Improve participant knowledge and/or awareness of behavioral health resources.
3. Improve participant behavioral health outcomes.
4. Improve participant global health. (Orange County New Innovative Project Description, p. 5)

The County intends to start the data gathering process in the second year of the project (first full service year) to establish a baseline for outcomes for Years 3 and 4 of the Project. The exact tools for this evaluative process have not yet been defined.

The description of the learning objectives and evaluation methodology for this project closely mirror the statements provided in the County's Employment and Mental Health Services Impact project, also before the Commission. In both cases, the County's specification of its learning objectives and evaluation approach needs further clarification.

The Budget

The Project is to be contracted out to a community based organization and so the County is only estimating suggested line items costs. The County indicates that the actual budget will depend on the selected provider's proposal. Therefore, staffing and other expenses are contingent upon the contract provider's final budget. The County's proposed budget should clarify what expected costs will be for contracted services versus direct County costs.

The projected budget is $6,531,770 over the five (5) year project. Evaluation costs estimated for this project are $700,642, or approximately 11% of the total plan costs. The breakout for the evaluation dollars is as follows:

5% from Personnel ($1,611,000)	$80,550
5% from Operating Expenses ($2,890,500)	$144,525
5% from Non-Recurring Expenditures ($160,000)	$8,000
25% from Other Expenditures ($1,870,270)	$467,567

As mentioned above, there do not appear to be any specific budget allocations or differentiation for administrative costs for County staff, or costs related to payroll, health and safety, payroll taxes, or other costs related to running a food service business, apart from leasing trucks and kitchen appliances. It may be that these particulars will be part of the scope of work provided to the School of Business selected to write the business prospectus for the County. Because these costs are not clearly delineated there are some costs, such as purchasing software, office furniture, etc. under non-recurring costs, which may not be appropriate to a time-limited Innovation project.

The project proposal has evolved considerably from the project described in the County's FY 15/16 Annual Update (Orange County MHSA Annual Update, pp. 255-256). The County is asking the Commissioners to approve a total Project amount of $6,531,770 for five (5) years, considerably more than the funding amount included in the Annual Update discussion. The County does not clarify in its proposal how these new project amounts were determined.

Additional Regulatory Requirements

The County could provide clarifications regarding budget items (including administration expenses and purchase of software and office equipment) and more clarity on the intended evaluation outcomes anticipated for this Innovation. The proposal as presented appears to meet or exceed other minimum regulatory requirements.

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Orange County
Mental Health Services Act (MHSA)
Proposed Innovation Projects

Background

Orange County is the third most populous county and second most densely populated county in California, with a little over 3 million people currently residing in this region. Since 2007, Orange County has consistently had the highest cost of living index compared to neighboring areas, with high housing costs significantly affecting the index and making it a very expensive place to live. According to the U.S. Bureau of the Census 2013, approximately 12.4% of Orange County's population was living under the federal poverty level, and 4.4% of residents 16 years and older were unemployed. For individuals struggling with persistent mental health challenges, these demographics highlight the significant challenges they encounter in their journey toward recovery. While employment is vital to recovery, it can be difficult to attain for individuals struggling with serious mental illness.

Orange County MHSA Community Services and Supports (CSS) currently has six programs specifically targeting transition age youth (TAY; ages 16 to 25), and 18 programs targeting adults (ages 26-59). Outcomes for these programs showed that participants enrolled in the Full Service Partnership (FSP) and Program for Assertive Community Treatment (PACT) programs achieved statistically significant gains in total days employed during FY 14/15 compared to the year prior to enrolling in these programs. However, despite these significant gains, employment continues to be a significant challenge and barrier for participants.

In FY 15/16, the Orange County MHSA Office held an extensive planning process to determine what the community stakeholders saw as the biggest needs or gaps in the system that could be addressed. Access to treatment and vocational support was among the list of areas identified. This area of need was reiterated during the Community Planning Process for the development of future Innovation projects. The proposals included in the following briefs reflect the employment and vocational support needs that were identified. These proposals were recommended and ranked as high priorities by the Orange County MHSA Steering Committee, as well as voted and approved by the Orange County Board of Supervisors as part of the Annual MHSA Plan Update.

Innovation Project Brief #1
Project: Community Employment Services

The Challenge

The Orange County Health Care Agency currently offers vocational support services to individuals struggling to enter or re-enter competitive employment. Although currently existing supported employment programs have improved the quality of services, they have also identified the need to provide additional support to participants who feel unable to independently manage the demands of employment. Without this additional support, individuals may be unable to participate in currently existing employment programs, which in turn impacts employment readiness and ultimately the participants' recovery process.

Proposal

Utilizing a peer-to-peer model, a trained peer specialist (individuals with lived experience in behavioral health and/or substance use disorders, and recovery) will work alongside participants to provide comprehensive supportive services related to employment readiness. Peer specialists will collaborate with participants to identify vocational goals, job interests, and training needed to achieve stated goals. Participants will then be placed in a host site where the peer specialists will be available on-site to assist in areas such as communication skills, symptom management and conflict resolution as they arise. Peer specialists will place up to 5 participants at the same host site and provide on-site coaching for up to 6 months. This staffing and caseload pattern will allow peer specialists to maintain support for each participant, as well as allow the participants to build social networks and interpersonal skills with each other as part of their employment readiness skills. Participants will work up to 15 hours a week (e.g., 3 hours per day, 5 days a week), earning minimum wage.

The primary role of the peer specialist is to provide on-site support to participants throughout the work shift; however, additional support provided by peer specialists may be provided before and/or after participants' work shift, as needed, in order to build skills required for successful employment.

The project has an expected start date in FY 2017/18, with a total estimated cost of $2,404,815.

Timeline

The Community Employment Services project is proposed to be a County-contracted project, with a total of five years dedicated to this project. The initial year will include the County procurement process; the following three years will include working with a selected provider for the provision of contracted services, data collection and ongoing evaluation; and the final year will be dedicated to summative analysis and evaluation.

The Innovation

This project makes a change to an existing approach by providing 100% on-site job coaching to individuals living with a persistent mental health challenge, offering behavioral health coaching at the actual site of employment to help participants manage symptoms that are interfering with workplace performance. This project is intended to bridge the gap in services for individuals who are not yet ready for the services offered in traditional supported employment programs. The comprehensive services aim to provide a safe, supportive environment where participants work with behavioral health and employment coaches to manage their behavioral health symptoms in the workplace.

Target Population

The Community Employment Services project will target adults living with a persistent mental health challenge and/or co-occurring substance use disorder. Eligible participants include individuals who have no prior work experience, have been unsuccessful in maintaining employment for a significant period of time, express a desire to work, and/or are in need of comprehensive support services to reach their vocational goals. Participants must be Orange County residents, legally eligible for employment under federal and state law, and receiving behavioral health services prior to enrollment and throughout the duration of this project.

Evaluation and Analysis

The intended outcomes of this project are to:

- Increase the quality of services, including better outcomes (primary purpose)
- Improve participant employment skills and abilities
- Improve participant behavioral health outcomes
- Improve participant global health

The intended outcomes will be measured by:

- Intake/enrollment and project exit data (e.g., number of unduplicated participants served; number of placements at host site; location of host sites; duration of job placements; types of trainings attended; number of participants attending trainings/groups, successful completions of 6-month job placements, etc.)
- Self-report outcome measures (e.g., possible measures of employment skills and abilities; pre-test/post-test or other longitudinal assessments, such as PROMIS Global Health; and one or more measures of behavioral health indicators such as motivation, self-efficacy, resilience, social support, independence/self-sufficiency, etc.)
- Employment retention rates following project exit
- Satisfaction surveys

Data analysis may include:

- *Significance testing* (i.e., paired sample t-tests, chi-square tests) to indicate statistical significance of whether changes in participants' matched pre-/post-test scores can be attributed to the benefits of receiving project services
- *Effect size* to determine practical significance and magnitude of pre-/post-test score differences
- *Minimal Clinically Important Difference (MCID)* to capture the magnitude of improvement, as well as the value participants place on the change (i.e., whether the observed changes were meaningful to participants)
- *Reliable Change Index (RCI)* to evaluate whether participants' outcomes were attributed to actual improvements or measurement error
- *Dose-effect model* to examine the relationship between length/amount of services (i.e., dosage) received and the amount of gain or improvement/change in outcomes (i.e., therapeutic effect). Analyses may examine whether there might be a dose-effect pattern and possibly an optimal level or "dose" of service provision (e.g., number of sessions or months of coached employment) to reach the desired impact/effect of the program (i.e., desired outcomes such as job readiness, etc.)
- *Comparison group* (if possible) to compare data from this innovative project to available data (e.g., national norms for scores on an outcome measure) or currently existing programs that are similar but less intensive (e.g., supported employment programs without on-site coaching)

Innovation Project Brief #2
Project: Mental Health and Employment Services Impact

The Challenge

Research suggests unemployment negatively impacts emotional and behavioral health. However, currently there are no employment centers in Orange County that provide on-site support to address the emotional and behavioral health symptoms in connection to unemployment and the job seeking experience.

Proposal

This project provides on-site behavioral health services at employment centers to support individuals struggling with emotional and behavioral health symptoms in connection to unemployment and the job-seeking experience. Behavioral health clinicians will be placed at various employment agencies throughout Orange County. A brief behavioral health and quality of life screening and assessment (e.g., Substance Abuse and Mental Health Screening Tool, PROMIS, etc.) will be included in enrollment packets for all new employment center patrons to recruit project participants. Existing patrons will receive the screening tools via their career counselor/case manager. Clinicians will review screening tools and flag patrons whose scores indicate signs of emotional and behavioral health symptoms. Clinicians will outreach to these individuals and offer supportive counseling throughout their job search. Services will include: counseling (limited to 16 sessions), behavioral health education workshops, and support groups. The weekly behavioral health education workshops and support groups will be included on general events calendars and made available to all patrons at the employment centers, regardless of their enrollment in this project. Employment center patrons will be given a choice whether or not to access the behavioral health supportive services. Any individuals deemed in need of intensive therapy not included in the scope of this project will be referred out to behavioral health clinics and/or providers who best meet their needs.

The project has an expected start date in FY 2017/18 with a total estimated cost of $1,645,657.

Timeline

The Employment and Mental Health Services Impact project is proposed to be a County-contracted project, with a total of five years dedicated to this project. The initial year will include the County procurement process; the following three years will include working with a selected provider for the provision of contracted services, data collection, and ongoing evaluation; and the final year will be dedicated to summative analysis and evaluation.

The Innovation

The Employment and Mental Health Services Impact project makes a change to an existing mental health practice that has not yet been demonstrated to be effective, such as adaptation for a new setting. This project will offer behavioral health support, education, and counseling specifically related to supporting successful transitions from unemployment to active job searching to gaining unsubsidized employment. Clinicians will have the capacity to address behavioral health issues associated with unemployment as part of the employment center environment and integrated case management team. The co-location of behavioral health and employment services will allow an innovative point of entry into the health care system for individuals who are unaware of the impact of their symptoms and/or are reluctant to seek services at a behavioral health clinic. As a result, this project will enable County Behavioral Health Services to reach an unserved/underserved population and increase their access to behavioral health and employment services.

Target Population

This project will target adults who are unemployed or at risk of unemployment and struggling with mild to moderate symptoms of mental illness or co-occurring substance use disorders. Participants must engage in services with an employment agency within Orange County and maintain their enrollment with the employment agency in order to qualify for and receive services from this project.

Evaluation

The intended outcomes of this project are to:

- Increase access to services (primary purpose)
- Improve participant knowledge and/or awareness of behavioral health resources
- Improve participant behavioral health outcomes
- Improve participant global health

The intended outcomes will be measured by:

- Intake/enrollment and project exit data (e.g., number of unduplicated participants served, types of services provided; duration of treatment; types of trainings attended; number of participants attending trainings, number of referrals and linkages to community behavioral health supports and services, etc.)
- Self-report outcome measures (e.g., pre-test/post-test or other longitudinal assessments, such as PROMIS Global Health; and one or more measures of behavioral health indicators such as motivation, confidence, resilience, social support, independence, etc.)
- Satisfaction surveys

Data analysis may include:

- *Significance testing* (i.e., paired sample t-tests, chi-square tests) to indicate statistical significance of whether changes in participants' matched pre-/post-test scores can be attributed to the benefits of receiving project services
- *Effect size* to determine practical significance and magnitude of pre-/post-test score differences
- *Minimal Clinically Important Difference (MCID)* to capture the magnitude of improvement, as well as the value participants place on the change (i.e., whether the observed changes were meaningful to participants)
- *Reliable Change Index (RCI)* to evaluate whether participants' outcomes were attributed to actual improvements or measurement error
- *Dose-effect model* to examine the relationship between length/amount of services (i.e., dosage) received and the amount of gain or improvement/change in outcomes (i.e., therapeutic effect). Analyses may examine whether there might be a dose-effect pattern and possibly an optimal level or "dose" of service provision (e.g., number of sessions) to reach the desired impact/effect of the program (i.e., desired outcomes such as job readiness, etc.)
- *Comparison group* (if possible) to compare data from this innovative project to available data (e.g., national norms for scores on an outcome measure) or currently existing programs that are similar but less intensive

Innovation Project Brief #3
Project: Job Training and Onsite Support for TAY

The Challenge

Currently vocational support is included in the Full Service Partnership (FSP) and TAY Program for Assertive Community Treatment (PACT) services for youth ages 16-25. These services have led to statistically significant gains in the number of days employed. However, many of these programs focus on youth in the foster care or juvenile justice system. Furthermore, finding sustainable employment continues to be a challenge for TAY. Among TAY in the FSP programs, many have had little or no success in the job market. In 2014, the Orange County FSPs surveyed their transition age youth (TAY; ages 16-25) to assess barriers to employment and found that the single most commonly reported obstacle was lack of confidence. They are reluctant to use skills, which they have rehearsed, for fear of failure. Supported employment programs with job coaches have been successful in some instances; however, many youth are reluctant to pursue employment or engage in self-defeating behavior once they are hired. For many of these youth, SSI becomes an attractive alternative to the struggle of establishing themselves in the workplace. It cannot be overemphasized that while the person is still young it is imperative to develop a solid work history and experience, which will in turn diminish the need to rely on public assistance.

Proposal

This project will place participants in a food service business and provide job training, on-site behavioral health and employment support and case management services. Project staff will collaborate with FSP and TAY PACT programs throughout Orange County to recruit eligible participants. Upon enrollment, behavioral health coaches will collaborate with participants to identify vocational goals, job interests, and training needed to achieve stated goals. Project staff will develop and implement a semi-structured curriculum that educates participants on “how to be an employee” (e.g., how/when to call in sick, etc.).

As participants complete their curriculum, they will be placed in one of the business’ employment positions: food/meal preparation, administrative/clerical tasks, janitorial work, meal delivery and customer service. Each participant may only work one 4-hour shift per day, up to 5 days per week, for a maximum of 20 hours per week, earning minimum wage. The work schedule may include up to 3 shifts per day for each position. During hours of operation, the employment and behavioral health coaches will be available on-site for support services. The participants, with continued assistance from staff, will be involved in all aspects of the food service business, with the prepared meals ultimately being delivered throughout the community (e.g., room and board housing, FSP participants, recovery centers, homeless shelters, etc.). Behavioral health coaches will routinely check-in with participants and identify strategies to manage behavioral health symptoms interfering with workplace behavioral and/or develop

appropriate interpersonal skills (e.g., conflict resolution, how to ask a coworker/supervisor for help, etc.). Behavioral health coaches will also collaborate with the participants' personal service coordinator from the FSP/PACT programs to ensure that treatment goals are actively being worked on in the workplace. The behavioral health coach to participant ratio will be approximately 1:12. Employment coaches will be available to address employment-related issues and concerns (i.e., tardiness, absenteeism, etc.) as they arise and assist participants with resumes, interviewing skills, and job searches as participants approach graduation from this project. The employment coach to participant ratio will be approximately 1:6. Participants may remain in the project for up to 12 months.

The project has an expected start date in FY 2017/18, with a total estimated cost of $6,531,770.

Timeline

The Job Training and On-site Support for TAY project is proposed to be a County-contracted project, with a total of five years dedicated to this project. The initial year will include the County procurement process; the following three years will include working with a selected provider for the provision of contracted services, data collection, and ongoing evaluation; and the final year will be dedicated to summative analysis and evaluation.

The Innovation

This project is intended to make a change to an existing mental health practice and is designed to increase the quality of services, including better outcomes. The innovative component of this project is two-fold in that the proposed site will be dedicated to training only those TAY who are diagnosed with persistent mental health challenges; and this project aims to provide a safe, supportive and confidence-building training environment where participants work with behavioral health and employment coaches at their actual place of employment. The full-time on-site support creates a unique supported work environment that will address a cognitive emotional component in conjunction with workplace inexperience.

Target Population

This project will target TAY (ages 18-25) enrolled in FSP or PACT programs who are not currently participating in or succeeding in existing supported employment programs in Orange County. Participants must be Orange County residents, legally eligible to work under federal and state law and receiving behavioral health services prior to enrollment and throughout the duration of the project.

Evaluation

The intended outcomes of this project are to:

- Increase the quality of services, including better outcomes (primary purpose)
- Improve participant employment skills and abilities
- Improve participant behavioral health outcomes
- Improve participant global health

The intended outcomes will be measured by:

- Intake/enrollment and project exit data (e.g., number of unduplicated participants served, length of employment, successful completions, etc.)
- Self-report outcome measures (e.g., possible measures of employment skills and abilities; pre-test/post-test or other longitudinal assessments, such as PROMIS Global Health; and one or more measures of behavioral health indicators such as motivation, self-efficacy, resilience, social support, independence/self-sufficiency, etc.)
- Successful employment following project exit
- Satisfaction surveys

Data analysis may include:

- *Significance testing* (i.e., paired sample t-tests, chi-square tests) to indicate statistical significance of whether changes in participants' matched pre-/post-test scores can be attributed to the benefits of receiving project services
- *Effect size* to determine practical significance and magnitude of pre-/post-test score differences
- *Minimal Clinically Important Difference (MCID)* to capture the magnitude of improvement, as well as the value participants place on the change (i.e., whether the observed changes were meaningful to participants)
- *Reliable Change Index (RCI)* to evaluate whether participants' outcomes were attributed to actual improvements or measurement error
- *Dose-effect model* to examine the relationship between length/amount of services (i.e., dosage) received and the amount of gain or improvement/change in outcomes (i.e., therapeutic effect). Analyses may examine whether there might be a dose-effect pattern and possibly an optimal level or "dose" of service provision (e.g., number of sessions or months of coached employment) to reach the desired impact/effect of the program (i.e., desired outcomes such as improved confidence, job readiness, etc.)
- *Comparison group* (if possible) to compare data from this innovative project to available data (e.g., national norms for scores on an outcome measure) or currently existing programs that are similar but less intensive (e.g., supported employment programs without on-site coaching)

AGENDA ITEM 4

Information

September 22, 2016 Commission Meeting

Executive Director Report

Summary: Executive Director Toby Ewing will report on projects underway, the Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission) calendar, and other matters relating to the ongoing work of the Commission.

Presenter: Toby Ewing, Executive Director

Enclosures: None

Handout: None

Recommended Action: Information item only