

Sacramento County Mental Health Board

Ad Hoc Committee

Feasibility study of alternatives for individuals with chronic untreated mental illness in Sacramento County



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Executive Summary

The main purpose of our Sacramento County Mental Health Board (SCMHB), Ad Hoc Committee was to investigate alternative treatments for seriously mentally ill individuals, especially those with continual hospitalizations and incarcerations. Our committee formed after two presentations, pro and con, about the controversial Assisted Outpatient Treatment (AOT, AB 1421, Laura's Law) in the summer of 2011. Several SCMHB members volunteered to research issues represented in both presentations. We expanded our mission to include many issues, as well as Laura's Law. We had concern about the unreached, those who have no services, especially the mentally ill, homeless population in our county. Also recidivism of some individuals brings great cost to the struggling mental health system. We hoped to shed more light on these challenging problems.

First, using a general questionnaire, we interviewed individuals, representing both sides of the AB 1421 debate. Opponents, Meghan Stanton, Delphine Brody, and Sean Rashkis, presenters to the SCMHB, gave us many substitute programs and ideas. We also interviewed John Buck and Carol Stanchfield, providers implementing AB 1421 in Nevada County. Randall Hagar, advocate of this law and a presenter to the SCMHB, suggested more reasons for his support. He shared an outline of "The History of Mental Health Treatment." One of our members researched the details of this history and its laws, found in Appendix I. The most recent legislation is summarized on page 10 of the Introduction.

Sean suggested that Laura's Law was not necessary. The Lanterman-Petris-Short (LPS) Act already covered the concerns of this law. This comment led to in-depth research into the LPS Act. We discovered its details, some not enacted, but written into the act. We interviewed Rick Pearson at the Conservatorship Office. Paul Powell and staff at Transitional Living & Community Support, Inc. (TLCS) gave us a rich recollection of vital, twenty-year history of our county's attempts to aid some of our target population. Because of funding, many outreach programs have been discontinued. Outreach is a very important need in our county at the present time. Through Susan Gallagher and Dorian Kittrell, we learned about new outreach, the Community Support Team (CST) initiated in Sacramento about eight months ago through Mental Health Services Act (MHSA), Prevention and Early Intervention (PEI) dollars. It is the beginning of filling this important gap in our community. Uma Zykofsky and Kelli Weaver told us more about this collaborative team, utilizing both professional and peer resources, helping consumers, families, and homeless individuals access more services and support.

Through this interview process, we uncovered additional issues to be addressed and found solutions already in progress. Based upon our mission to research other alternatives, answers to some questions led us to expand our original interview base. Conversations with advocates, Michael Hansen, Michael Beebe, and Larry Liseno, President of NAMI, added to our information. Interviews with Jane LeBlanc, MHSA, Marguerite Story-Baker, Alcohol and Drug Services (ADS), and Scott Seamons, Vice-President of the Hospital Council, rounded out our investigation. Our report contains details of all of our insightful interviews we conducted during a five-month period. We encouraged each interviewee to review our notes and make additional corrections and comments before we released them for this publication.

We found agreement among professionals and advocates alike that the forty-year old LPS Act should be modified, re-written or reactivated. One of the reasons that AB 1421 appeals to some people is that it empowers family, friends, and community members. They hope to get help, beyond current practice of LPS Law, for individuals at risk. We also looked at other means, like the CST, which has the beginnings of two missing components, more access for families and an outreach to the homeless.

The recent tragic events in Aurora, Colorado, underline the inability of our society to help some mentally ill individuals. Waiting until a crisis escalates is too often the norm. Early treatment and intervention helps both individuals and our communities, while a “crisis mentality” delays services and potential tragedies. How do we empower our community and not transgress the rights of individuals? We do not want to return to the archaic ways of the past nor shift the concept of “mental hospitals” to jails and the streets.

Recidivism of some clients drives up costs for the county through repeated hospital and/or jail visits. The Sacramento Mental Health Court (SMHC) is an attempt to stop recidivism and help mental health clients, caught up in the judicial system. We interviewed Steven Lewis, Chief Public Defender of this court. We learned how SMHC helps individuals stabilize and how the county saves money through its interventions. He said that there is room for expansion of these services.

Looking into the intricacies of the LPS Act, we explored the option of a court-ordered petition, Sections 5200-13, to help interested parties get an evaluation for an individual in need. An interpretation came from our County Counsel, Denis Zilaff, and another response from California Disabilities Rights (See pp. 61-63.). We suggest more inquiry into other possibilities within the LPS Act.

The issues discussed are complex and interdependent on many factors, available funding and present laws and their interpretation. Our ad hoc committee looked into many issues and a variety of potential programs. Our report established viable conclusions that address alternatives for individuals with chronic, untreated mental illness in Sacramento County. We hope our investigation will be only the beginning of continued awareness. One of our great American leaders stated, “The price of freedom is constant vigilance.”

Definition: “Feasibility studies aim to objectively and rationally uncover the strengths and weaknesses of a proposed venture, opportunities and threats as presented by the proposal, the resources required to carry through, and ultimately the prospects for success.”

Introduction

Mental health treatment has had a storied past. Horrible conditions, shackles, and inhumane systems were the norm for many years. With the closure of institutions in the 1960s and 1970s came a time that states and communities had to step up and create humane, respectful, and holistic approaches to the treatment of mental illness.

Currently mental health in California has a contentious issue over the existence and use of Assisted Outpatient Treatment (AOT). The California Welfare and Institutions Code (CW&I) reflects the Lanterman-Petris-Short Act (LPS) as well as AB 1421, or Assisted Outpatient Treatment (AOT). Sacramento County is typical of most counties where the AOT controversy overshadows the subject. It has stalemated any progress to offer assistance to mental health clients with anosognosia, inability to have insight. Sadly there has developed a schism between family members and their loved ones with mental illness. The perception of consumers is fear over the idea of forced treatment based upon the past. Family members feel at a loss about how to seek services for loved ones who suffer debilitating mental illness. There are stories of individuals who are continually incarcerated and hospitalized, rather than receiving necessary treatments. How do families, friends, neighbors, and professionals seek help for an individual and yet safeguard the individual's right to make choices for themselves without coercion?

The current approach to mental health in California is described in a publication we received from the California Network of Mental Health Clients (CNMHC). The booklet is called "Building Partnerships: Key Considerations when Engaging Underserved Communities under the MHSA," written by UC Davis Center for Reducing Health Disparities. It states: "In November, 2004 California voters passed Proposition 63, which became a state law entitled the Mental Health Services Act. This Act created the expectation of a comprehensive planning process within the public mental health system that is inclusive of underserved communities over-represented among California's most vulnerable populations, such as ethnically diverse, poor, uninsured, and geographically isolated. The Act seeks to transform the mental health system to a 'help-first' approach, such that ethnic communities, clients, family members, community-based agencies, providers, public agencies, and other stakeholders in the mental health system are key partners in the decision-making process. Given the fact that California is leading the nation in diversity, partnerships with diverse communities is essential to transforming the state's mental health system."

In our introduction we have included a visual of Mental Health Services as a baseball park, a concept given us from John Buck from Turning Point. Our report chapters are divided into two major sections. The first section describes laws and the Mental Health Court. In the second section we provide information from county and community organizations, including the Hospital Council, and we discuss peer support. The appendices list other county or state solutions. We provide acronyms but complete definitions can be found in Appendix A of the Callahan Report. There are charts and information that helped us gain awareness, such as the Level of Care Utilization System (LOCUS) and Maslow's Hierarchy of Needs. One consumer leader said Maslow's theory is "the essence of a peer-run program." Statistics, and resources available, led us to some of the recommendations. Given our short time frame, this study could not be exhaustive. The proposal and mission are provided as well as the interview questions.

The text of the Ad Hoc Committee proposal, mission, and timeline, as approved by the Sacramento County Mental Health Board in November, 2011:

This proposal is submitted for the MHB members to approve an ad hoc committee that will produce a feasibility study for Sacramento County, surrounding alternative treatments for individuals with continual chronic trauma, who have the possibility for preventable physical and mental injury.

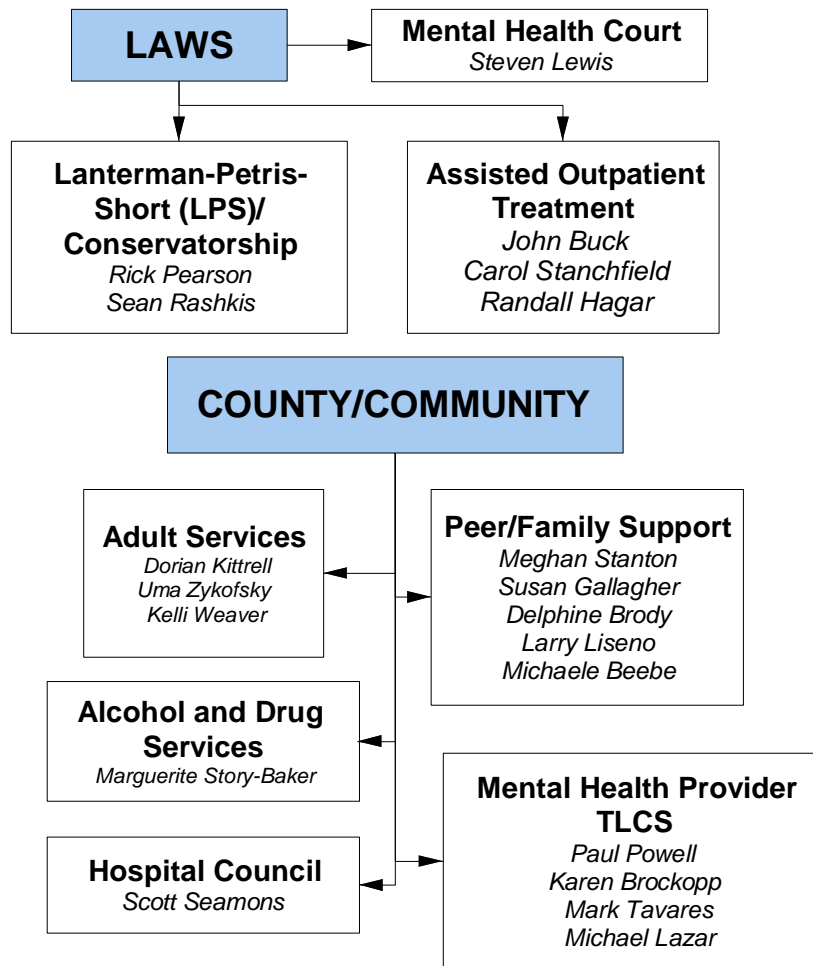
Mission: The Ad Hoc Committee will research alternative treatments for individuals with a history of continual hospitalizations and/or incarcerations that may or may not currently utilize services within the Sacramento County system of care. The goal is to identify methods to prevent further trauma. Alternatives to be considered can be new approaches within the current Sacramento County infrastructure, and possible implementation of other approaches that might require increased funding but can produce future cost savings.

Timeline: This study is to be returned back within six months to the Mental Health Board for review and possible submittal to the Sacramento County Board of Supervisors.

Final Report: The Final Report must provide recommendations to the MHB regarding the viability of any identified treatments, explaining both human and dollar costs. This report must provide verifiable facts, valid data collection, and feasibility comparisons, plus possible interviews with stakeholders. The Final Report must recommend any alternatives with implementation in Sacramento County that can be obtainable within the next three years.

Interview Questions used by the MHB Ad Hoc Committee:

- How do you feel about our mission?
- Do you think the current situation in Sacramento County covers the needs of the individuals we are targeting? If yes, how? If no, what would you suggest?
- What are your ideas for alternative treatments or solutions?
- What is your philosophy on providing services? What population do your services cover?
- How are you funded? How do you measure the success of your services? How is success quantified?
- If money was no object, what options for providing services do you think should be made available for those individuals who are at-risk and are not participating in the Sacramento County System of Care?
- If money is an issue, in your opinion, what options are possible to implement?
- Do you know the costs associated with suggested treatment services and if money can be saved in the long-term?
- Do you have any further comments that could help us in this research?
- Do you know of legislation or other documentation that would help us fulfill our mission?
- How do you feel about our mission?
- Do you think the current situation in Sacramento County covers the needs of the individuals we are targeting? If yes, then how? If no, what would you suggest?
- What are your ideas for alternative treatments or solutions?
- What is your philosophy on providing services? What population do your services cover?
- Do you know of legislation or other documentation that would help us fulfill our mission?



Steven Lewis - Chief Assistant Public Defender

Rick Pearson – Health Program Manager, LPS/Conservator Office

Sean Raskis – Attorney, Disabilities Rights California

John Buck – Turning Point, CEO

Carol Stanchfield - Turning Point, AB 1421 Program Director

Randall Hagar – Director, Government Affairs, California Psychiatric Association

Dorian Kittrell – Executive Director, Sacramento County Mental Health Treatment Center

Uma Zykofsky - Human Services Division Manager, DBHS Adult Mental Health Services

Kelli Weaver – Program Manager, DBHS Community Support Team

Marguerite Story-Baker - DBHS Health Program Manager, Alcohol and Drug Services

Meghan Stanton – Executive Director, Sacramento County Wellness and Recovery Centers

Susan Gallagher – Executive Director, Mental Health America of Northern California

Delphine Brody – MHSA and Public Policy Director, California Network of Mental Health Clients

Larry Liseno - President, Sacramento County National Alliance on Mental Illness (NAMI)

Michaele Beebe – Sacramento County Family Advocate

Paul Powell – Transitional Living and Community Support, Associate Director, Property Development & Operations

Mike Lazar - TLCS, Executive Director

Karen Brockopp - TLCS, Associate Director, Program Services

Mark Tavares - TLCS, Co-op Program Manager

Scott Seamons – Regional Vice-President, Hospital Council of Northern and Central California

LIST OF INTERVIEWS BY DATES

- I. Meghan Stanton, Wellness & Recovery Center offices, February 2, 2012
- II. John Buck and Carol Stanchfield, Turning Point offices, February 3, 2012
- III. Paul Powell and Staff, TLCS, February 14, 2012
- IV. Sean Rashkis, California Disability Rights, February 24, 2012
- V. Michaele Beebe, Family Advocate, February 24, 2012
- VI. Rick Pearson, DBHS Conservatorship Office, March 2, 2012
- VII. Susan Gallagher, Mental Health of America, Friday, March 9, 2012
- VIII. Dorian Kittrell, the Mental Health Treatment Center, March 14, 2012
- IX. Larry Liseno, President of NAMI Sacramento, March 15, 2012
- X. Delphine Brody, California Network of Mental Health Clients, March 30, 2012
- XI. Randall Hagar, California Psychiatric Association, April 13, 2012
- XII. Scott Seamons, Regional Vice-President, California Hospital Council, April 26, 2012
- XIII. Uma Zykofsky and Kelli Weaver, DBHS Adult Mental Health Services, May 2, 2012
- XIV. Jane Ann LeBlanc, DBHS Program Manager, MHSA, May 17, 2012
- XV. Marguerite Story-Baker, DBHS Alcohol and Drug Services, June 8, 2012
- XVI. Steven Lewis, Chief Assistant Public Defender, June 28, 2012

History of Mental Health Treatment and Legislation in America (Appendix I for more detail)

1842 Doctor Dorothea Dix discovered deplorable conditions and championed for better treatment of the mentally ill.

1880s Institutions were developed, expanded and improved in the US as well many parts of Europe.

1920-1940 Community based program movement started.

1952 Medication Era is born: Thorazine.

1963 Community Mental Health Centers Act

1963 Governor Reagan administration budget

1965 LPS concept born.

1965 Social Security Act of 1965, Medicare & Medicaid established, publicly funded healthcare.

1965 IMD Exclusion/Discrimination (21 & under and 65 & older)

1967 Lanterman-Petris-Short (LPS) Act signed into law.

1968 State deinstitutionalization starts.

1970 Transinstitutionalization begins. Prison system grows as state hospitals close.

1971-1974 Wyatt v. Stickney

1974-1976 Lessard v. Schmidt

1975 O'Connor v. Donaldson

1976 Tarasoff v. Regents of the Univ. of California

1978-1983 Rennie v. Klein

1979-1980 Guardianship of Richard Roe III

1979-1982 Rogers v. Okin

1980 Civil Rights for Institutionalized Persons (CRIPA) enacted.

1985 The Bronzan-Mojonnier Act

1988 The Wright-McCorquodale-Bronzan Mental Health Act

1989 Riese v. St. Mary's Hospital & Medical Center

1990 Americans with Disabilities Act enacted.

1990 "Decade of the Brain"/advent of widely available brain imaging

1990 Zinerman v. Burch

1992-1994 California's first realignment

1995-1999 MH Managed Care Consolidation—Counties assume risk of treatment.

1995 Coleman legislation decided.

1997 LPS Reform Taskforce

1998 Mentally Ill Offender Crime Reduction Grant Programs, (MIOCRG)

1999

Kendra's Law enacted in NY, Mental Hygiene Law; 1999 NY Statutes, effective since November 1999, established the first state law concerning involuntary outpatient commitment.

AB1800

Written by Assemblywoman Helen Thompson and modeled after Kendra's Law, it was the first viable attempt to update LPS in California. The goal was to expand the government's ability to provide involuntary treatment for the mentally ill who could not gain access.

Olmstead Case

The Supreme Court held that Title II prohibits the unjustified segregation of individuals with disabilities. Public entities are required to provide community-based services to persons with disabilities.

AB 88

The Mental Health Parity Law requires private health insurance plans to provide equal coverage for physical health and selected mental health conditions.

AB 34 (see AB 2034)

It sponsored three pilot programs, including Sacramento County.

2000

AB 2034

This legislation provided funding for all California counties, based on the success of the three pilot programs under AB 34. They were very successful in reducing the number of homeless, jail, and psychiatric hospital days experienced by enrollees.

AB 1421; AB1 424;

AB 1421, Laura's Law, was the first AOT law passed in California but only fully implemented in Nevada County; AB 1424 requires that any person taking an individual into custody for involuntary treatment, consider available relevant information about the historical course of the person's mental disorder.

Plata vs. Schwarzenegger

The California Supreme Court found that the California Department of Corrections and Rehabilitation (CDCR) "lacks an adequate system to manage and supervise medical care." In 2004, the Health Care Services Division of the Department was ordered to implement quality management of physicians. Failing to do so, in 2005 a receivership was appointed to oversee the department.

2003

US vs. State of California (State Hospitals)

The DOJ investigation found significant and wide-ranging deficiencies in child and adolescent patient care at Metropolitan State Hospital (MSH), a state facility housing children, adolescents, and adults who suffered from mental illness.

2004

Proposition 63/ Mental Health Services Act

The passage of MHSA provided the first opportunity in many years for the California Department of Mental Health (DMH) to increase funding, personnel and other resources to support county mental health programs.

2007

Governor Schwarzenegger, with a line-item veto, cut the \$55 million in funding, slated for AB 2034 programs, from the state budget.

2009

AB 2034 lawsuit fails

The lawsuit charged that Governor Schwarzenegger violated Proposition 63, now known as the Mental Health Services Act. He eliminated the program providing integrated services to homeless, mentally ill adults (the AB 2034 program). As a result, the AB 2034 programs in thirty-four of the state's counties were forced to shut down, leaving them scrambling to find alternative funding or provide services through other programs.

2011

AB 109/Prisoner Realignment

This legislation reassigns three groups of offenders, previously handled through the State Prison and Parole System to California counties.

AB 100/Update to MHSA/Prop 63

An existing law contains provisions governing the operation and financing of community mental health services in every county. This bill deleted the requirement for annual reviews, as well as the annual update requirement for the 3-year plans. The bill reduced the amount available for administrative costs to 3.5%, and requires the state, instead of the Department of Mental Health, to administer the Mental Health Services Fund.

2012

AB 1693

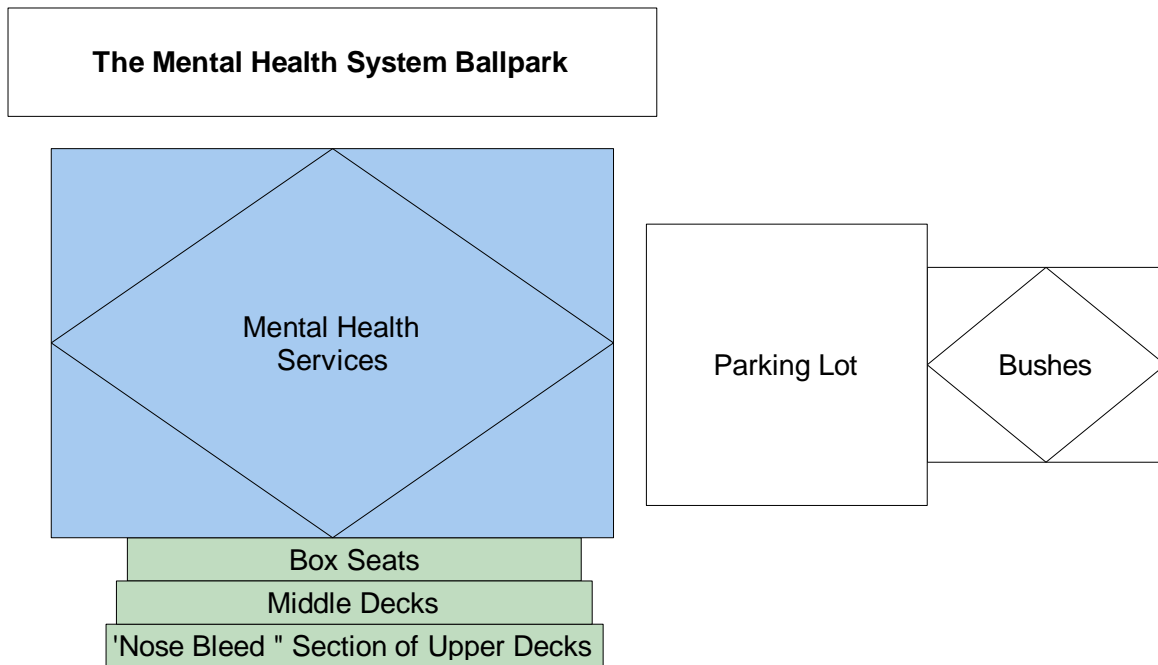
It authorizes the State Department of Mental Health to expand a specified pilot program to establish competency restoration programs in prescribed counties. It provides treatment in county jails to individuals (found to be incompetent to stand trial) who have not been committed to a state hospital. The bill passed the Assembly in May and was recommended to pass from the Senate in July.

AB 1421, Laura's Law, (now reintroduced as AB 1539 to extend its provisions as enacted) is due to sunset January 1, 2013. It is presently going through the California Legislature. It passed the Assembly and is currently in the Senate's committees.

AB 2134

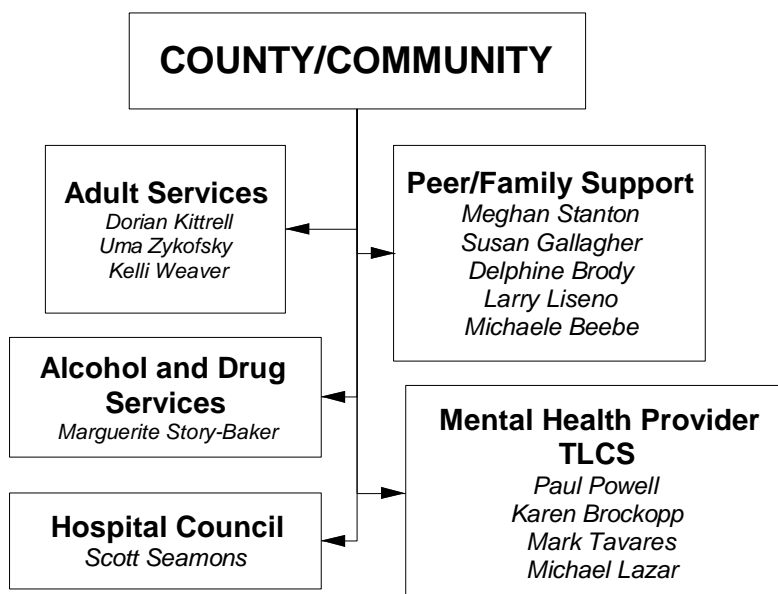
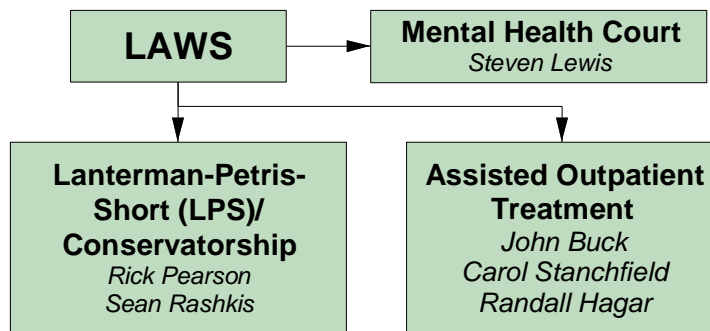
It expands county obligations if Laura's Law is implemented. This bill would require a county that adopts Laura's Law to provide additional services.

The outcome of these latter two bills should be watched carefully.



John Buck, Turning Point Executive Director, described a concept that views mental health concerns as a baseball park. The park represents all services that are available to an individual. The box seats, middle decks, and “nose bleed” sections represent the person’s understanding of what is accessible. “Box seats” mean the individual can see all resources and can utilize them with an understanding of the array that exists. This group may have private medical insurance. The “middle decks” represent those who have some idea of what exists, but may have limited viewpoints of the whole system. The “nose bleed sections” have only limited visibility to what may exist. Those inside the parking lot know there are supports, but do not know how to access them. Those individuals “in the bushes” represent those who do not know that there are services available to them. They may not want to participate in anything that can help with their mental health issues and improve their quality of life; they may have no insight into their illness.

The rules are different in each location. The further from the field, the enforced rules are fewer. Behavior that wouldn’t be acceptable in the box seats is likely overlooked and considered the norm. Additionally, it is what you can afford. The cost gets higher the closer you get to the diamond. Some cannot pay the high fee to enter the parking lot, let alone a box seat. Often times the people in the bushes have few finances, relationships, and supports. They often do not manage these effectively. They may choose to live by their own rules and have little interest in the noise coming from the stadium. There is a fence symbolic of access issues between the parking lot and the bushes. Some “people in the bushes” will come to the fence and ask the tailgaters for a spare hot dog, interfacing with society for brief occasions. Others, further out, are unable or unwilling to even come to the fence. They might be too fearful and may reject contact with others altogether.



Mental Health Conservatorship is outlined in the Lanterman-Petris-Short (LPS) Act of the Welfare and Institutions Code (W&IC). A mental health conservatorship makes an individual, called a conservator, responsible for a mentally ill, gravely disabled adult, called the conservatee. Conservatorship is a legal, not a clinical process. Conservatorship gives legal authority to the conservator to make certain decisions for the conservatee who is unable to take care of him or herself.

Assisted Outpatient Treatment (AOT) is usually court-supervised treatment in the community for those individuals with high-risk, who may hurt themselves or others. These individuals have failed to engage in treatment after repeated offers of the best and most intensive services. AOT ensures the support needed is provided to achieve stability and meaningful recovery.

Mental Health Court (MHC) is a specialized court addressing seriously mentally ill persons in the jails. The MHC targets those individuals who are frequently in and out of jail and have a mental illness. Once identified as a qualified candidate, Jail Psychiatric Services works to get participants stabilized, on medications, if appropriate, and refers them to MHC. A plan of action is put into place to ensure the offender succeeds through community supervision and regular monitoring.

The Lanterman-Petris-Short Act (LPS)

A law, signed originally in 1967, went into effect in California on July 1, 1972. It is officially noted in the California Welfare & Institutions Code, Division 5, Part 1, and Sections 5000-5034. This law set the precedent for modern mental health care in the United States. It cites in Section 5001, "The provisions of this part shall be construed to promote the legislative intent as follows:

- To end the inappropriate, indefinite, and involuntary commitment of mentally disordered persons, developmentally disabled, and persons impaired by chronic alcoholism, and to eliminate legal disabilities;
- To provide prompt evaluation and treatment of persons with serious mental disorders or impaired by chronic alcoholism;
- To guarantee and protect public safety;
- To safeguard individual rights through judicial review;
- To provide individualized treatment, supervision, and placement services by a conservatorship program for gravely disabled persons;
- To encourage the full use of all existing agencies, professional personnel and public funds to accomplish these objectives and to prevent duplication of services and unnecessary expenditures;
- To protect mentally disordered persons and developmentally disabled persons from criminal acts."

The Lanterman-Petris-Short Act, in effect, ended all hospital commitments by the judiciary system, except in the case for criminal sentencing and specific situations. It did not, however, impede voluntary commitments. It expanded the evaluative power of psychiatrists and created provisions and criteria for holds.

Anyone can ask a potentially mentally ill individual to get an evaluation voluntarily. If the individual refuses it, the person has two choices, asking for a court-ordered petition from the county to force the individual to get evaluated (Section 5201) or calling law enforcement to cause the individual to be taken into custody for evaluation (Section 5150). In either case, if a person requesting evaluation causes the individual to be detained, knowing that the potentially mentally ill individual is not a danger to him/herself or others, that person is guilty of a misdemeanor (Sections 5203 for the court-ordered petition; 5250.05 for law enforcement). Section 5150.05 allows the person requesting evaluation to offer historical information about the individual to law enforcement. This was added to the LPS Act in 2001 and can be an effective tool for families and concerned persons to be heard.

If an individual qualifies for a 5150, he or she has a three day, seventy-two hour hold for evaluation and treatment. During that time the psychiatrist or mental health director of the facility

can release them. After evaluation and treatment the patient gets released, referred for further care and treatment on a voluntary basis, or certified for intensive treatment, a 5250, fourteen day hold. There are opportunities many times during these holds for hearings to request early release against the hospital's wishes. Advocates of patient rights work to help individuals with these proceedings if they feel they are wrongly held against their wills.

At the end of fourteen days, a patient shall be released unless:

- He or she agrees to further treatment voluntarily.
- He or she is certified for an additional fourteen days as a suicide risk (5260).
- He or she is certified for an additional thirty days (5270).
- He or she is subject to temporary conservatorship. (5352 - 3)
- He or she is given a "dangerous person" status (5300).

After thirty days a patient is released unless he or she agrees to voluntarily continued treatment or is subject to Temporary Conservatorship (TCON) or given a "dangerous" status, where he or she is placed into long-term care. Conservatorship is derived from the Welfare & Institution codes, beginning with Section 5350. The courts cannot make a referral. Conservatorship can begin while a person is on a 5250 (fourteen day hold) or 5270 (thirty day hold). Once a referral has been made, the office, through the County Counsel, files a petition for TCON. It will generally last for about thirty days. Then there will be a hearing. A TCON cannot be continued for more than six months. A mental health client has potentially forty-seven days of evaluation and initial services, such as crisis counseling, medication adjustment, and respite care. The forty-seven days is calculated as a three-day 5150 hold; a fourteen-day 5250 hold; and a thirty-day 5270 hold. Conservatorship is a different legal hold though, than 5150, 5250 or 5270.

Permanent Conservatorships are granted up to the maximum of one-year. A conservatorship can be extended after the one-year hearing. At that time, a conservatee can request a jury, but this is not common. It is often hard on the clients to expose the details of their illness. A Riese Hearing, also known as Medication Capacity Hearing, is facility-based. It determines if a person on any of the LPS holds, other than Temporary Conservatorship or Permanent Conservatorship, has the capacity to refuse psychiatric medications. The chart on the next page explains the procedures used in Los Angeles County, which are common to most counties and illustrate the complex holds in the Act.

Lanterman-Petris-Short Act (LPS) addresses some of the issues that the Ad Hoc Committee investigated. The law is under-utilized and many professionals believe this forty year old act should be re-written.

LPS HOLDS CHART

LPS HOLDS	CRITERIA			COURT PROCEEDINGS
	GRAVELY DISABLED	DANGER TO SELF	DANGER TO OTHERS	
72-HOUR WIC 5150 EVALUATION & TREATMENT	ONE OR ALL MAY APPLY			<ol style="list-style-type: none"> No probable cause hearing May request Riese hearing (Decision regarding Riese carries through 14-day hold)
14 DAY WIC 5250 3-DAY EXTENSION WHEN CONSERVATORSHIP APPLIED FOR	ONE OR ALL MAY APPLY			<ol style="list-style-type: none"> Probable cause hearing must be held during first 4 days of hold unless patient request by-pass writ of habeas corpus, 24 hr. postponement, and signs voluntary or is discharged. Patient may request one writ of habeas corpus hearing at any time during 14-day hold. Riese hearing may be requested anytime during 14-day hold. Each subsequent hold requires a new Riese hearing.
ADDITIONAL 14-DAY WIC 5260	ONLY CRITERIA WHICH APPLIES			<ol style="list-style-type: none"> No probable cause or court hearing required. Original additional 14 certification form and 2 affidavits must be sent to mental health court. Patient may request writ of habeas corpus any time during 14-day period. New Riese hearing may be requested anytime during 14-day period.
30-DAY WIC 5270	ONLY CRITERIA WHICH APPLIES			<ol style="list-style-type: none"> Probable cause hearing must be held during first 4 days of hold unless patient requests by-pass writ of habeas corpus, 24 hr. postponement, and signs voluntary or is discharged. Patient may request writ of habeas corpus any time during 30-day period. New Riese hearing may be requested anytime during 30-day period.
180-DAY WIC 5300 RENEWABLE	ONLY CRITERIA WHICH APPLIES			<ol style="list-style-type: none"> Requires contact with D.A. several days prior to expiration of 14-day hold. Requires the District Attorney to file a petition with the court and an arraignment hearing in court. New Riese hearing may be requested anytime during 180-day period.
TEMPORARY CONSERVATORSHIP 30 DAYS TO 6 MONTHS	ONLY CRITERIA WHICH APPLIES			<ol style="list-style-type: none"> Requires application by the treating physician to the Public Guardian's Office Judge reviews application and determines whether to grant or deny temporary conservatorship (T-Con). Patient may request writ of habeas corpus any time during T-Con period. New Riese Petition may be filed with County Counsel. Hearing held in Dept. 95A.
PERMANENT CONSERVATORSHIP 1 YEAR RENEWABLE	ONLY CRITERIA WHICH APPLIES			<ol style="list-style-type: none"> Requires court hearing in Dept 95A. Physician may be required to testify in court. Patient may request re-hearing on conservatorship, rights denied, disabilities imposed once every six months.
RE-APPOINTMENT OF *PERMANENT* CONSERVATOR	ONLY CRITERIA WHICH APPLIES			<ol style="list-style-type: none"> Requires conservator petitioning for reappointment and a court hearing.

NOTE: Each hold requires a new Riese hearing except when going from the 72 hour to the 14-day.

Superior Court of California, Los Angeles County, Office of the Counselor in Mental Health

Assisted Outpatient Treatment (AOT)

As a possible alternative, we investigated AOT, one of the most controversial subjects encountered, in the form of AB 1421. AOT, outpatient treatment, exists in a variety of forms in forty-four states. It usually includes court-ordered treatment plans, but not always involving medication. It goes beyond the scope of current LPS Laws and can possibly give family and concerned people more of a voice than the current laws to get help for seriously, mentally ill individuals in need.

In California, 2002, Assemblywoman Helen Thomson teamed to create AB 1421 with the family of Laura Wilcox, who was killed with two others by a non-compliant, mentally ill client, Scott Thorpe. She modeled Laura's Law, as it's called, after Kendra's Law, New York, 1999. Only Nevada County fully implements this law, as part of their settlement with the Wilcox's. Surprisingly, it uses MHSA funds, as their program allows voluntary participation as well. There is also a pilot program for AB 1421 in LA County. Each county implementing this program must provide funds as there are no built-in monies for it. Every county's Board of Supervisors must approve of this law in order to have it adopted.

AB 1421, now in the form of AB 1569, is currently in the California Senate, going through a committee process, having recently passed the Assembly in an attempt to get the sunset of this bill, January 1, 2013, extended to 2019. We attended some of the committee meetings while the new bill went through Assembly sub-committees and during that time met those for and against this law.

Proponents/Opponents

Proponents claim that both hospitalization and incarceration are reduced through its use with great saving to the counties involved. Because most of these clients suffer from anosognosia, inability to discern their own mental illness, they also believe it is a humane way of getting needed early treatment for severely mentally ill individuals. Opponents site violations of civil rights from possible forced medication and other aspects of this, trauma from being in court ("Black Robe Coercion"), and potential socio-racial prejudice in the implementation of the law. There are also fears of returning to the harsh conditions existing before 1970 when consumers often had little or no rights over their court-ordered treatment. Passionate and sometimes even hostile arguments surround discussions about this law.

John Buck and Carol Stanchfield Interview

The Nevada County Laura's Law Program, which is four years old, was envisioned to help clients engage in treatments who have no insight into their illness. John Buck actually had mixed feelings about Laura's Law at the time, but in 2006 Michael Heggarty, Mental Health Director in Nevada County, asked Turning Point to provide services for Laura's Law in his county. He also knew that these services were voluntary. "Why would you want to do this?" the committee asked him. "Someone has to do this, and every person deserves the best of services. We will do the best we can."

They started in 2007 with Carol at the head. They expected to reach four to five people a year. Thirty-seven people have been referred to the program in the four years of its existence. Only nine of them have received AOT court orders, two twice and one person three times.

AACT and AOT

Carol helped us to understand the difference between AACT, Adult Assertive Community Treatment, and AOT, which are identical services, differentiated only by length, level of insight and criteria for treatment:

- AACT clients want services and have awareness of their individual need for treatment; those referred through AOT have little to no insight of their need for treatment, sometimes even afterwards.
- AACT services have no end date, versus AOT which is time limited to 180 days.
- Both AACT and AOT clients meet criteria for medical necessity (W&I Code 5600.3). Criteria for AOT are narrower, including medical necessity and requisite criteria identified in the checklist. (W&I Code 5346).
- AACT treatment includes Mental Health Court support. In the MHC process, clients may face jail through a violation of probation (VOP) if the individual fails to follow the treatment plan. AOT has no violation component and is a “no-fail” approach to treatment. This means services are not dependent on compliance with treatment expectations or timeliness of progress. Services are based on individual pace and need. Also, clients are not dis-enrolled based on expectations or their response.

One of the commonalities among clients referred is anosognosia or no awareness of their psychiatric illness, which is the primary barrier for individuals in accessing treatment.

Full Service Partnership (FSP)

Laura’s Law in Nevada County is a Full Service Partnership. One key thing Carol said, “Treatment is all about relationship; building a partnering relationship is the beginning step.” Cultivating the therapeutic relationship through a strength-based, client-centered approach is the basis for engagement and recovery and essential for AOT success. Laura’s Law in Nevada County is a Full Service Partnership. The client’s voice is respected and strongly encouraged. Choices support empowerment, independence and greater well-being. She gave an example of asking the client if he or she would see a doctor. It is a fluid process, a conversation, and a partnership. “We are all part of the team, inviting participation in the context of treatment. There is a due process in Laura’s Law. You cannot jump over it or around it.”

Carol gave us an example of a situation of a client threatening someone’s life. As a Laura’s Law client, with assessment and support, jail was averted. A 5150 would not have helped in this situation. Often clients referred for AOT present well enough at a 5150 evaluation to avoid hospitalization.

Carol gave another example of a client who for two or three years accepted engagement with no medication, but who is now actually willing to take medication. “You cannot force medication. Medication is not a cure-all.” (See Riese Hearings.)

Carol discussed the importance of not waiting for treatment. “What if we wait? Avoid more damage? Delay in treatment can create more damage.” She mentioned that there is documentation on the importance of not waiting for treatment. Carol also said there are “families

held hostage” by their loved ones with untreated, psychiatric disabilities. It is essential for there to be a quick response to both consumers and their loved ones.

John shared his position. “I don’t care what the model is. I want to keep people with psychiatric disabilities out of prison or jail. I don’t care what the law is if we can have effective programs and help people without services. How can I help my brother compassionately, from a recovery standpoint? We need effective programs to keep people from getting into worse situations. Some people in our community should have a right to treatment but they don’t have the capacity to make the choice.” There has also been a criticism of “Black Robe Coercion,” having a harsh and cold manner in court. John hasn’t experienced that with Judge Tom Anderson, in Nevada County. This also does not seem to be a reality in most mental health courts.

At the conclusion of our interview, John gave us the wonderful baseball analogy that we have included previously. Carol added the issue of hope if you provide understanding. “People want respect, which is a foundation for recovery. We know that we’ll never be able to engage everyone in treatment, but we can care enough to do more in preventing worsening symptoms associated with prolonged suffering. At the very least, AOT can be an investigative tool to assess the risk level of individuals referred and provide for proactive interventions and supports. AOT saves lives, improves the quality of life for those engaged in treatment and their families, saving money and increasing safety in the community. From a provider perspective, it is the right thing to do. It may provide an opportunity for a small number of people to get relief from the intense suffering that some of us can only imagine.”

Nevada County won a Challenge Award in 2010 from the California Association of Counties for their implementation of Laura’s Law. They also provided information about cost savings. We included this information in the statistics section of the report.

Sean Raskis Interview/the LPS Act/Conservatorship

Sean Rashkis mentioned in his presentation at the Mental Health Board and this interview the importance of using conservatorship and what already exists in the LPS Law, instead of Laura’s Law. He said that AB 1421 is unnecessary as there is already provision for what it covers in the LPS Act. He confirmed that almost all of the provisions in AB 1421 are already part of the existing Act. The main problem is the enforcement, or lack of such, of the LPS Act itself. Perhaps these things are not activated and used at this time. “Laura’s Law is not necessary.”

Sean feels that there are various reasons for not using the LPS Act, including: a) un-informed or under-informed consumers/family and law enforcement; b) a conservator or crises system that does not work due to lack of funds, space, expertise, lack of resources or other reasons; c) nobody taking the time and/or responsibility to research the issues and hold the stakeholders accountable. Therefore, Sean concludes, “Since all of the provisions of AB1421 are almost identical to the existing law, does it make sense to promote it?” AB 1421, named Laura’s Law, seemed to be a way to either innocently attempt to recharge a system that was not working or to satisfy a charged-up public, looking for solutions. It is also an admission that the current law doesn’t work, for whatever reason, and nobody is willing to take the political impact of admitting the existing system doesn’t work. A “not under my watch” mentality, plus finger pointing at other factors, instead of admitting a fault, seems to be the norm. As a result of these suggestions, we interviewed Rick Pearson at the Sacramento Conservatorship Office and investigated LPS Law.

He pointed out that Nevada County has a different concept of conservatorship and is “way behind.” For example, they talked about how Laura’s Law implementation is so much better as

contrasted with locking people up in conservatorship and having no rights. Sacramento County is much more progressive with conservatorship, using board and care and community resources more often, rather than locking people up.

Voluntary Mental Health Services

Sean believes the focus should be on increasing voluntary mental health services in the community, not involuntary services, such as Laura's Law. We talked about the importance of more voluntary services in the county, such as Crisis Residential Services. It is important to work closely with individuals who come into the county mental health system so individuals who come into the Treatment Center, don't discharge and disappear off the map of county mental health services. The Callahan Report (Appendix K) is a blueprint to improve voluntary mental health services and an individual's ability to receive timely mental health services throughout the county.

Here are some other ideas he gave us:

- Use of MHSA Prevention and Early Intervention funding can go a long way toward shoring up missing or inadequate services, such as what was available in AB 34 and subsequently AB 2034 with homeless outreach.
- Use of emergency response teams coupled with law enforcement and a mental health worker. He referred to San Diego's new crisis/outreach team. There also should be continuity of all the players and services, so that a new leader, director, or elected official in charge does not have to start over again and waste time, energy and resources.
- Conservators, either County or Private, should work closely with County Mental Health case managers, linking clients to needed services. Conservatorship is a viable option under LPS, but is severely handicapped with shortage of manpower and other resources.
- The Treatment Center should be almost exclusively used for crises services, not long-term housing for people on conservatorship. All parties need to work together with the specifics of each client in mind to place these individuals in the proper area of care. Moving persons through these various levels could also free up other areas that can be serving the clients better. Also try to develop more available sixteen bed facilities, which can increase access to Medi-Cal funds.
- Use Full Service Partnerships with intensive case management following discharge from the hospital.

Programs in Other Counties

Sean suggested other California county programs: (1) there is one program in San Diego (Appendix B), an In-Home Outreach Team, I-HOT, an alternative for AB 1421, sponsored by Telecare. It utilizes the components of three mobile outreach teams, reaching out to adults with a serious mental illness, 24/7, who are reluctant to receive mental health services. It also provides support and education to family members, an often neglected group in the process; (2) in response to an investigation of Laura's Law, Orange County has a pilot program, including teams to work with severely mentally ill individuals, removing having a judge ordering outpatient treatment. There is support to families and immediate shelter for individuals being evaluated.

We were grateful to learn of these other innovative programs, addressing important areas—the seriously mentally ill and disenfranchised families.

Meghan Stanton and Delphine Brody Interviews

The views of Meghan Stanton and Delphine Brody, who represented the opposition to AB 1421 at our MHB Meeting in August 2011, are expressed in the Peer Support section of this report. They both offered some excellent alternative ideas and constructive comments for improving our present mental health system.

Delphine told us about AB 2134, introduced by Wesley Chesbro, an assemblyman from Humboldt County, and approved by California Disability Rights and the California Psychological Association. It requires a county, which elects to implement AOT, to develop a crisis intervention team, mobile crisis teams, or psychiatric emergency response teams before implementing the law. There are other requirements attached to this law for any county, considering implementing AB 1421.

AB 2134 is a law born out of reaction to new interest in Laura's Law. If passed, it will modify AB 1569, the new number assigned to AB 1421, and make it possibly more palatable to opponents of that law. From the point of view of the proponents of AB 1569, it creates more hindrances to utilization of the law. Both AB 1569 and AB 2134 are making their way through the complex processes of committees in both the Assembly and the Senate. The outcome of both is yet to be decided as both bills are still working their way through the complex legislative process.

Rick Pearson Interview

Our conversation with Sean Rashkis led to an investigation of conservatorship. We had an opportunity to meet with Rick Pearson, Health Program Manager for the Public Guardian Conservatorship Office. Rick supervises the LPS (Lanterman-Petris-Short Act) Investigations Unit. The office has two LPS investigators and five on-going, permanent LPS conservatorship deputies.

A mental health LPS Conservatorship makes one adult, called the conservator, responsible for a mentally ill adult called the conservatee. Rick emphasized that conservatorship is a legal, not a clinical, process. LPS conservatorships are not treatments, and conservators are not making evaluations. LPS Conservatorship is only for an adult who is gravely disabled as a result of a mental illness. The conservatorship gives legal authority to the conservator to make certain decisions for conservatees who are unable to take care of themselves. The conservator can consent to mental health treatment, even if the conservatee objects to it. The conservator can agree to place the mentally ill person in a locked facility if the psychiatrist believes it is needed, and the conservator can decide where the person will live when not in a locked facility. The conservatorship starts with a referral from an inpatient director or designee from one of the six facilities within Sacramento, for example, Heritage Oaks, Sierra Vista, or the County Treatment Center.

Each county does conservatorship differently. Sacramento has three classifications: (1) Probate; (2) Public Administration Deceased; (3) LPS Conservatorship. There is differentiation in the work for each classification. For example, Probate Conservator Deputies just do probate. In Los Angeles County, the conservators have a possible caseload of about ninety individuals each. They do more than just work with individuals. They also handle estate matters, such as SSI, pension payments, and bill payments. In our county, a separate person is assigned to some of these practical functions.

Seasoned physicians and psychiatrists perform conservatorship evaluations, both initial and subsequent. The client may initially be placed in a Level IV facility or another secured facility, such as Willow Glen in Yuba County or Our House in Solano County. He or she may be able to transition to a Level III facility, such as Northgate Point or El Hogar. The consumer is assigned a Public Defender at every conservatorship hearing, and hearings are held every thirty days for a person under the conservatorship program.

There are currently about two hundred and thirty people in the LPS Conservatorship Program in Sacramento, and it receives approximately one hundred twenty referrals a year. There is some recidivism but Rick was unsure of the exact number. Of the one hundred twenty referrals last year, thirty went on Permanent Conservatorship, and thirty-seven were denied as not meeting criteria. Many may be removed from conservatorship as they either get better or are placed within the community in intensive services.

One of the issues proponents of Laura's Law contend is that conservatorships place 99% of clients in board and care facilities, while Laura's Law allows clients to live anywhere. Rick concurred that almost all of the clients go to board and care because that is the definition of conservatorship. If a person is gravely disabled, he or she cannot care for themselves or attend to basic needs, such as bathing, cooking, and dressing. There is a need for these individuals to have a place where they can get all of these living services in one location. If they are in their family home and these services are provided, there is no need for conservatorship. It is true that some board and care facilities are considered better than others, in terms of space, people and general services. It can be difficult for people to have to live with others, especially strangers. The flip side is the positive element of being around like-minded people. The county hopefully will improve advocacy and accountability covering these homes to provide greater consistency and a higher level of quality service.

Another critique of the conservatorship program is how a person presents him or herself before a judge in one of the hearings. It is sometimes easy for someone unstable earlier to quickly appear as if he or she has no problems. Rick said that he has experienced this situation before and feels it is a common attempt of persons under conservatorship. He and most other conservator offices have a good relationship with the medical professionals and trust their judgment. Conservators interface with the judge and other enforcement officials, preventing this occurrence, and get the necessary help for conservatees. When asked if conservatees have insight into their illness, Rick said that most do not (anosognosia). He emphasized that people can and do get better. He also stated that communication with psychiatrists and all involved parties is key. "More advocacy and information needs to be available to families."

We also briefly discussed "Murphy's Law" (Section 1370), where individuals "incompetent to stand trial" are conserved. These individuals are housed in Napa State Hospital for Sacramento County conservatees. They are generally given three years to be restored and Rick's office reviews those cases quarterly.

Some family members have become conservators for their loved ones in Sacramento County. They are called private conservators, different from public conservators. It is a relatively rare occurrence and has to be approved by the conservatorship office. Susan McCrea was the conservator of her daughter for a year. This was an opportunity to have more input into her daughter's treatment and care. However, at times, this put added stress on their relationship.

Randall Hagar Interview

Randall Hagar came to the MHB, July 2012, to give a presentation on AB 1421. This sparked both controversy and curiosity for some members of the Board, and created the Ad Hoc Committee. Randall defines AOT as “court-supervised treatment in the community for high-risk individuals who have failed to engage in treatment after repeated offers of the best and most intensive services available. It ensures the support needed to achieve stability and meaningful recovery.”

To meet the AOT criteria:

- The individual must be 18 years of age or older.
- The individual’s illness and stability must be deteriorating.
- The individual must be offered intensive services.
- The individual must refuse to accept the offered intensive services.
- The individual must have a mental illness and be unlikely to survive safely in the community without AOT.

An individual, who may be a relative, co-habitant, agency director, peace officer, or treatment provider, can make a referral for an individual in crisis to the county mental health director. The director investigates, and if reasonable to assume the individual meets the criteria, files a petition with the superior court for an AOT order. A hearing is held in superior court. If the judge decides the individual needs AOT, a treatment plan developed by the patient and the community service providers is presented. The judge issues a six-month treatment order that is binding for both the client and the community treatment plan.

“AOT allows for a treatment option that is less restrictive than a locked facility, involuntary inpatient care through the 5150 process. AOT does support the possibility of engaging in treatment that would not otherwise be possible for some high-risk individuals who find themselves in crisis repeatedly. Laura’s Law provides a unique community-based recovery option that not only fills a gap in a county’s treatment continuum, but can reduce mental health and criminal justice system costs.” We discussed Laura Wilcox father's comment at the Judiciary Committee, saying that his daughter’s right to live be trumped by the right to not receive treatment.

Randall prefers to use the word “leverage” instead of “coercion” when referring to AB 1421. He explained that leverage exists in all aspects of the voluntary services and is a key reason why many voluntary services are effective.

Randall mentioned the California Code of Regulations, Section 3400, explaining the allowable use of Proposition 63 funds. He said a county can use Prop 63 funds for the services provided to clients in a mental health court, or a Laura's Law ordered treatment plan, or conservatorship. He stated that this provision allowed both Nevada County and the pilot program in Los Angeles County to operate their Laura’s Law programs with funds from Proposition 63. They also used other sources of revenue.

Randall introduced us to the LPS Task Force II recommendations of which Randall was a co-author. (Appendix C) He mentioned the MIORCA Grant, 2000, which allowed coordination between jails, probation, community mental health, and hospitals to reduce recidivism in both the criminal justice and the mental health systems. Like Sean Rashkis, he suggested looking at programs in other counties. He gave us contacts that could be useful in understanding these complex problems with mental health.

Sacramento Mental Health Court

Mental health courts link offenders who would ordinarily be prison-bound to long-term community-based treatment. They rely on thorough mental health assessments, individualized treatment plans and ongoing judicial monitoring to address both the mental health needs of offenders and public safety concerns of communities.

A number of complications arise when persons with mental illness enter the criminal court system, including delays in court proceedings as a result of an incompetent-to-stand trial finding. Such delays often result in long jail stays while individuals await treatment at state hospitals. While in jail or prison the mental state of inmates often declines as the experience of being incarcerated can exacerbate psychiatric symptoms. According to the Council of State Governments, persons with mental illness spend more time in jail or prison than individuals who received similar convictions but do not have a mental illness. Without adequate community supports, this population is more likely to return to jail or prison soon after release. Recidivism rates are sometimes double that of offenders without mental illness.

Based on the success of the drug court model, a handful of jurisdictions across the country have developed specialized courts to address mental illness. Like drug courts, the central goal of mental health courts is to reduce the recidivism of defendants by providing them with court-monitored treatment. The first of these courts opened in June 1997 in Broward County, Florida. The first mental health court in California was established in San Bernardino County.

In linking defendants with mental illness to treatment alternatives, many mental health courts see themselves as practicing “therapeutic jurisprudence” - a social force producing positive life changes for defendants.

Once a defendant participates in a mental health court, one of two things happens: 1) Prosecution is frozen and, charges are dropped, after the defendant successfully completes treatment. 2) A plea is taken, which is later vacated, or charges are reduced. All of the mental health courts require a longer period of time in treatment than the defendant would have served in jail or prison if they had plead guilty to the crime charged. Most courts require participating defendants to spend a minimum of one year in treatment. The rationale behind this is two-fold: First, mandated treatment involve many fewer restrictions than being incarcerated. Many defendants are even released to their own residences. Second, mental health courts are willing to invest in treatment only if there is real promise of reducing symptom severity, thereby reducing recidivism. Experience indicates that it takes at least a year to successfully engage people with mental illness in treatment. Accordingly, many mental health courts reserve the right to extend offenders’ period of treatment in the event of non-compliance.

Sacramento County looked at mental health court in 2005, after reviewing the success in another Northern California County - Santa Clara. Judge Steven V Manley, with over thirty years of experience as a Superior Court Judge, founded Santa Clara’s Drug Court, and discovered the overwhelming need for a similar court for mentally ill offenders. In an interview with the Center for Court Innovation, Judge Manley stated “There’s a stigma with the mentally ill that they are more dangerous, which is not true. Some are; some are not. They are, however, far more difficult to work with. It makes absolutely no sense in my view to warehouse someone who is mentally ill and release them into the community with no services, when we know they will be rearrested again and go right back into jail.”

With the help of a MIOCR (Mentally Ill Offender Crime Reduction) Grant, Sacramento established a Mental Health Court in 2007.

Steven Lewis Interview

Steven Lewis, Chief Assistant Public Defender for Mental Health Court, is also a member of the AB 109 Community Corrections Partnership Committee. Mental Health Court is a collaborative court that receives no special funding. In the past there were more supporters of Mental Health Court, such as Probation and the Sheriff's Department, but with budget cuts, that support has dwindled.

Before Mental Health Court, offenders with a mental illness were often determined to be "unable to understand criminal proceedings or to assist counsel in the conduct of a defense in a rational manner (CA Penal Code Section 1368)." If they were charged with a felony, that typically meant up to three years in Napa State Hospital; if a misdemeanor, they spent six months to one year at Sacramento County Mental Health Treatment Center (SCMHTC). The sentence could include an involuntary medication order if they lacked the capacity to consent. If a mentally ill offender is restored to competence, he or she would go back to court for the resumption of criminal proceedings. For felony defendants, if they cannot be restored, they most likely would be placed in LPS or Murphy's Conservatorship.

Whether an offender is sent to the State Hospital, SCMHTC or to jail, all of these are extremely expensive. In the first year of operation (2007-08), Sacramento County Mental Health Court (SMHC) showed a savings over these other options of \$6000 per year/per client.

SMHC's goal is to identify seriously mentally ill persons in jail. Once identified, try to get them stabilized, on medications if appropriate, and get them into court quickly. A plan of action would be put into place to get the offender into community supervision with regular monitoring. The SMHC and participants try to target those individuals who are frequently in and out of jail and hospitals.

The procedure actually begins with a referral from Mark Hopkins, UC Davis contractor within the Jail Psychiatric Services. No matter who identifies the individual, Mark does an assessment and refers the inmate to the program's court coordinator. If his case is appropriate for SMHC, there will be a referral to Steven Lewis, as well as Rick Miller, District Attorney. The two of them must reach an agreement that the individual should go to SMHC. If so, the inmate is scheduled for the next Tuesday at SMHC and is met by one of six providers, serving Sacramento County—Turning Point ISA, Turning Point Pathways, TCORE, Telecare SOAR, TLCS New Direction, and El Hogar Sierra Elder Wellness Center.

The client has to agree to the program voluntarily. Generally, there are three criteria to be met in order for the offender to qualify for SMHC: 1) They need to have an AXIS I Disorder, such as schizophrenia or bi-polar; 2) the charges cannot involve serious sex or violence offenses, although some cases are accepted in specific situations; 3) they need to have one of the six Sacramento County Mental Health Providers working with them. The providers' Personal Service Coordinator (PSC) comes to court with the client to discuss treatment plans and subsequent progress. If the client agrees to the program, the PSC will usually pick up the client from jail the next day after the court hearing. There must be a specific plan in place for housing, treatment options and anything else the client may need to be successful.

One of the biggest keys to the program's success is its flexibility, especially with regard to sanctions for those who do not comply. The court works with the offender and the PSC to keep on the right track. Judge Manley stated, "Sanctions do not work with a mentally ill person unless they have significance. Often mentally ill clients feel that jail is a reward. They like it. Homeless people like it in the winter. What good does it do me to put people in jail for a sanction when they don't even understand what I'm talking about?"

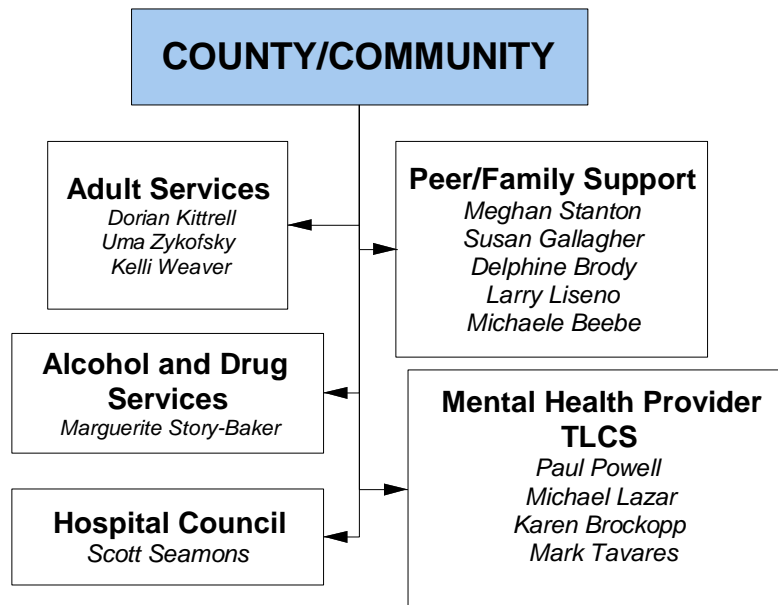
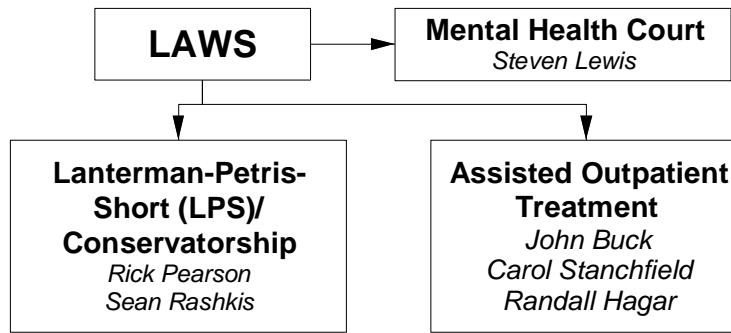
The client's incentives are fairly straightforward. In exchange for twelve to eighteen months of outpatient treatment, if successful, they will be able to withdraw their guilty plea, terminate formal probation and suspend jail time. The most imposing sanction for not complying is the reverse, with jail or inpatient status imposed as well as a criminal record. Again, any sanctions imposed are flexible. Clients start by meeting in SMHC every week to track progress. Perhaps treatments need to be adjusted. They may be ordered to attend AA/NA meetings, attend more counseling sessions, or do community service. If mistakes continue, a client may be subject to flash incarceration - an immediate trip to jail for a brief period of one or two weeks. This punishment serves hopefully as a wake-up call or time-out with the intent of getting the client back on track with his or her treatment plan. As the person's progress goes well, the court dates are gradually decreased from once a week, to every two weeks, to once a month.

In our interview, Steven Lewis said that they maintain a caseload of about thirty clients at any time, but that they have the capacity to serve closer to a hundred clients. Of course, funding is a limiting factor. Judge Jaime R. Roman, a previous SMHC judge, is returning to the team. The Public Defender and District Attorney offices are committed to the success of this program. The mental health providers in Sacramento County are supportive of an increase in potential caseloads. The only piece that is not in place at this time is the dedicated probation officers, again due to funding shortages. Unfortunately, the MIOCR Grant was only obtained in the first year of operation (2007-08). The money provided incentives for the sheriff to utilize jail staff and the county probation department could dedicate more resources to the program.

Steven hoped that either MHSA or Prisoner Realignment (Prop 109) money could be found to help SMHC. With cost savings of \$6000/year per individual compared to the alternatives, of jail or hospitalization. It would seem a logical decision to support SMHC. With the scarcity of money in these difficult economic times, coupled with the realities of politics, logic does not always prevail.

California's criminal justice system is becoming increasingly responsible for large numbers of individuals with mental illness. People with mental illness are more likely to be arrested than those in the general population for similar offenses, and many enter the criminal justice system as a direct result of their unmanaged illness. Although only 5.7 percent of the general population has a serious mental illness, approximately 18.5 percent of arraigned defendants and 23 percent of California prison inmates have a serious mental illness. The criminal justice system is ill equipped to meet the needs of this population and cannot adequately provide the treatment needed by people with serious mental illness.

Asked about the SMHC capacity for accommodating AB 1421, "It seems as though everything is in place. We have a judge, a courtroom, a Public Defender, District Attorney and a collaboration of community partners all familiar with mental illness. If we had some additional funds to keep it running, I don't see why it couldn't work."



Adult Services are the Adult Mental Health Services, Sacramento County Division of Behavioral Health Services (DBHS).

Alcohol and Drug Services are the DBHS Alcohol and Drug Services for individuals suffering from substance abuse.

Mental Health Provider is a DBHS contractor (TLCS) who provides services to meet target populations in Sacramento County.

Peer and Family Supports are community support systems for individuals who suffer from mental illness and their families.

Hospital Council is the Hospital Council of Northern and Central California that convened a workgroup to study the mental health crisis, making recommendations for redesign.

Sacramento County Adult System of Care

The first few months we focused on gaining an understanding of the laws and talking with those in opposition to "Laura's Law." That was the controversy that led to the Mental Health Board creation of the Ad Hoc Committee. We interviewed consumer group leaders who spoke at the Mental Health Board meeting in opposition to AB 1421 and other community leaders. The next step was an understanding of the current county system of care.

Dorian Kittrell Interview

Based on Dorian's understanding of Assisted Outpatient Treatment (AOT), he did not feel that Laura's Law was feasible at this time in Sacramento County. It would require a significant multi-agency collaboration to be implemented and the resources for a project such as this do not exist right now. There are too many agencies and too little money to do what it is supposed to do. He didn't see a fiscal structure that would allow for it.

"LPS conservatorship is not the same as AOT." Dorian explained. "While there are some similarities in terms of oversight, conservatorship is different as it involves 100% of a person's needs, including housing and other aspects of a person's life. It is for the gravely disabled. AOT is, on the other hand, not as restrictive and provides greater choice on the part of the clients, despite the imposed consequences of that choice under the AOT."

Alternatives Dorian mentioned are mobile units with outreach and engagement. His first work in the mental health field was with the Berkeley Mobile Crisis Team, which had on-going case management. Teams of two people were available every day from 8am-11pm. The mobile team reached many people, not willing to engage in any services. A lot of them were able to avoid hospitalization. The team had law enforcement training and badge numbers. They were able to do initial assessments, go out to homes and other sites. They had the ability to write a 5150 referral, if necessary. It engendered cooperation between law enforcement and mental health, even though they were not integrated before. As a comparison, we discussed the fact that Berkeley is a different size county and not as spread out as ours. It may have had more funds accessible at that time.

Dorian discussed the need for a Crisis Stabilization Unit (CSU) as a gateway for crisis intervention. There is currently a plan in place to provide this kind of service in a different way. A new CSU would be able to stabilize a percentage of the individuals going to the emergency rooms and avoid hospitalization. Since the crisis unit closed in 2009/10, we have seen an increase in the number of inpatient hospitalizations. The Hospital Council, now called the Community Health Partnership, has recommended going forward with the Crisis Stabilization Unit

Recently Sacramento and Contra Costa were the only two counties to apply for a federal grant, creating a pilot program to receive MediCal reimbursement for inpatient services at a private hospital. The grant provides a waiver of three years to allow those with over sixteen beds to bill MediCal. Sacramento just received the grant notice award. There is a very limited amount of money for this project spread over eleven states. It is an opportunity to look at archaic MediCal regulations that prevent payment for psychiatric treatment for individuals in hospitals greater than sixteen beds. This project came from a bill sponsored by U.S. Representative Doris Matsui that became part of the health care reform law. Dorian also brought to our attention a new pilot project called Community Support Team (CST), a mobile team funded under the MHSA Suicide Prevention component.

Uma Zykofsky and Kelli Weaver Interview

Uma Zykofsky is the Human Services Division Manager of Adult Mental Health Services (See previous chart of Sacramento County System of Care). Kelli Weaver is Program Manager of the Community Support Team (CST) project. Our research led us to the fact that there was an unfulfilled need for mobile outreach in our community. This interview was conducted to understand the activities of the CST and whether it fills this identified gap.

We discussed the various steps that led up to the Community Support Team formation and questioned whether funding for this project is sustainable. We learned the project is funded through PEI and will continue. The CST is a blended team of professional and peer staff from Crossroads Diversified Inc. It will evolve with the needs of the community. The CST team provides response to care in a variety of ways: (1) it follows up on some calls received by the Access Team. (2) It responds to individuals discharged from the hospital with phone calls or field-based visits as needed. The CST makes for a "warm hand-off" between the hospital, the family and outpatient system. (3) It makes an effort to help the homeless. Once a month, the team goes out into the homeless community in conjunction with Sacramento Steps Forward. This is also in collaboration with Volunteers of America (VOA) and Department of Human Assistance (DHA) staff - a multi-system outreach to the homeless. CST has the beginnings of both of two missing components, more access for families and an outreach to the homeless. Both of these factors are some of the reasons family members and community members have shown interest in AB 1421. With AOT, a family member is sometimes empowered to get help for a loved one, resistant to any treatment. There is also through AOT the ability to work with resistant or untreated people in a community. CST aids the family and the community to get help for those getting no assistance with their mental illnesses. Expanding and adding on to this resource or creating more outreaches like this is greatly needed in Sacramento County. There also needs to be more resources and services to provide for the "people in the bushes." Expansion of services for these individuals should also be addressed and explored. The hours of operation are Monday through Friday, 8:00 to 5:00. Hours are subject to change based on community need. The phone number is (916) 874-6015.

We briefly touched on AB109, re-entry of prisoners to the community. We also talked about hospital care and education for staff and the community. Various types of linkages for individuals in distress were discussed, including the use of faith-based and volunteer programs for formal and informal supports. Uma shared there are many factors that cause crises and stress. Frequently inpatient care and/or medication solutions are seen as the primary and only alternative. Use of medications should not be seen as the threshold for interventions. Rather we should look for blended teams where a variety of supports and staff can be involved in solution-focused treatments.

Assisted Outpatient Treatment (AOT) has specific provisions and requirements for implementation and Uma expressed the hope that our community considers those carefully so that we do not reduce outpatient resources in efforts to fund AOT. "Some of the challenges are creating programs with sustainable dollars, not relying on taking money from existing programs. People do not always take into account all the costs when programs like AOT are discussed. For example, there are expenses for courts, judges, and legal action, necessary for AOT to work. AOT depends on the same infrastructure that supports the existing systems."

"Current challenges include enormous pressure on the adult outpatient system. There is not much flexibility in the capacity of our system. Historically, the standard outpatient system has been under-funded and over-impacted by multiple referral and community needs. The RST capacity

and contracts are at a limit with no flexibility at this time. Typically, our community has seen large numbers of people needing services, and there is not enough funding to build out a large provider system. Inpatient care, high-level acute and sub-acute care needed. Expensive Realignment dollars are directed to support this level as an emergency need. Thus outpatient care is frequently at the losing end of the budget plan." Uma acknowledged that there is a great challenge in our community and "how to help the individuals not on a 5150 hold or in a hospital setting but nonetheless suffering, in distress and not hospitalized." The new Intake and Stabilization Unit (ISU) will help some of this group. They will be redirected from the emergency rooms. However, some people will get discharged from the ER to the community. There are also many people who come to the ERs with private insurance and other needs, not the county's responsibility. However, the same ERs treat everybody in the community. We have to continue to find ways to bridge the gap between ERs, hospitals and community services. Not all the residents in the community meet the criteria for mental health services within the county system.

Uma's staff implements the five major components of the Mental Health Services Act: Community Services and Support (CSS) Workforce Education, and Training (WET), Capital Facilities and Technology, Prevention and Early Intervention (PEI), and finally the current Innovation Plan. The essential purpose for the Innovation Plan is to promote interagency and community collaboration with general learning goals in mind. In 2011 a Sacramento Innovation Workgroup was formed with volunteers from various stakeholder groups. The Workgroup targeted "crisis respite" and created the Respite Partnership Collaborative (RPC). Sierra Health Foundation was chosen as the Administrative Entity that will coordinate the RPC with the Division of Behavioral Health Services. The Respite Partnership Collaborative must include the stakeholder representatives of Family Members, Transitional Age Youth (TAY), Adult Consumer, and Adult Consumer with Dependent Children, Family Member of Adult Consumer, Older Adult Consumer, and Family Member of Older Adult Consumer. Other stakeholder group representation can be gained by visiting the website of DBHS or Sierra Health Foundation. It offers promise to help fill more gaps in the county mental health services.

The question always comes up about outcomes and how to measure them. The challenge Uma Zykofsky brought to our attention is that it is very hard to measure recovery and resiliency. Our outcomes are important measures for optimal programming and changes in program design. Each county submits data to the state once or twice a year; then the state sends a comprehensive report with all county information back to each county. The difficulty is that each county's resources and programming vary and it is difficult to compare data across counties. There are also flaws in the data source points and collection process, which sometimes does not tell the full story. Historically, reports back from the state have been delayed and thus the data may be outdated compared to programming on the ground. That being said, we are trying to focus on developing better measures for our programs, Uma added.

Alcohol and Drug Services

Marguerite Story-Baker Interview

Another part of the picture is an understanding of treatment for individuals with alcohol and drug problems in Sacramento County. Marguerite Story-Baker is the DBHS Health Program Manager for Alcohol and Drug Services (ADS). Marguerite has over thirty-five years experience working in the field of co-occurring disorders. She has been active in the MHSA since the beginning, working on the first CSS proposal for young adults and co-occurring awareness for juvenile justice. Regarding our mission, Marguerite agrees that the goal is to prevent further trauma, especially to those who are often at the MHTC or the jails, sometimes called "frequent flyers." It is very important to have sensitive patient care.

Marguerite believes we should consider infusing ADS staff in non-traditional avenues of treatment. Our committee feels traditional ADS treatment may also be lacking in the training and awareness of some mental health staff. According to Marguerite, there is a "No Wrong Door" policy in ADS. Child Protective Service (CPS) cases, indigent programs, court, probation, and community teams refer clients to her organization. These are also sources of client referrals to mental health.

Marguerite mentioned The Comprehensive Continuous Integrated System of Care (CCISC) by Minkoff and Cline. The general principles of CCISC are providing a welcoming, accessible, integrated, continuous, and comprehensive system of care to patients with co-occurring disorders (COD). CCISC is a model addressing co-morbidity in an organized manner within the context of existing resources. The basic premise of this model is that all programs become dual diagnosis programs meeting minimal standards of Dual Diagnosis Capability. The job of each program is based first on what it is already designed to be doing, seeing people with COD. The goal is to organize the infrastructure of the program to routinely provide matched services.

The service matching in this model is based on a set of evidence-based principles in the context of an integrated philosophic model making sense from the perspective of mental health and addiction treatment. A way of evaluating clients is using the four quadrants Minkoff proposes: high MH needs folks with low ADS needs should be MH clients first; high ADS needs folks with low MH needs should be ADS clients first; clients with high needs in both areas must be simultaneously and team treated for both issues; and low MH and low ADS issue folks can be treated on either side of DBHS.

More training for MHTC staff on issues of alcohol and drugs could be useful since a significant number of their clients have co-occurring disorders and MH staff is not routinely well trained in substance abuse issues. Most ADS county staff is trained in MH issues. Contracted providers could probably use more training for dealing with clients with co-occurring disorders. Jail staff also needs expertise in both MH and ADS. This needs to be done routinely due to staff turnover to get updated current information. Partnering helps clients be best served.

The Mental Health Treatment Center has well trained staff that helps "frequent flyers." She has concerns, however, that jail personnel do not always understand this population. Their mandate is to protect the public and administer consequences for illegal behaviors. Mental Health and Alcohol and Drug clients are not all criminal types and yet make up the majority of those incarcerated. Sometimes "frequent flyers" are arrested due to a misunderstanding. Their diagnoses or medication may make their behavior look like they are drunk or on drugs when they are neither. A statistic is 80% of adult prisoners have a substance abuse problem. In the case of

Alcohol and Drugs Services, the usage of substance is a criminal act. In reality, many mental health clients use alcohol or other drugs to ease their pain or for self-medication. Law enforcement needs to know the whole person to know what they are dealing with and what is actually happening when they are called to intervene with a “frequent flyer.” Before incarceration, screening for alcohol and drug issues should be included so that co-occurring treatment can be offered in jail. The client can be seen as someone who is in need of MH treatment. For example, methamphetamine can produce a drug-induced psychosis. Other drugs work poorly with needed MH medication. These situations produce erratic behaviors that require medical monitoring. There is a need for drug testing for persons who are mentally ill and are incarcerated.

When asked about statistics, Marguerite mentioned the DBHS Management System could add ADS data, along with mental health, if training was made available. Whenever possible, treatment should include family members and other support personnel. ADS have no peer partners like with mental health, but would love to be able to develop that sort of component. In the past there was funding for some effective youth advocates.

Alcohol and Drug Services are funded by a subsidized federal grant called SAPT Block Grant, Drug/Medi-Cal, including minor consent Drug/Medi-Cal, Cal WORKs, and some smaller grants designated for specific populations. The system to measure ADS success, an entrance and exit measure called CALOMS. Code of Federal Regulations (CFR) 42 is stricter than mental health confidentiality rules.

"If the funds existed, there should be more outreach, co-occurring disorder groups, youth programs, peer partner programs and advocate programs in ADS. There should be an ADS counselor at Jail Psychiatric Services and the MHTC, and routine information sharing. Support groups can actually be paid for with a variety of funding sources. Regardless, ADS and MH treatment costs are always less than the costs of jails and hospitals. Also the bulk of services they offer are free to the clients."

*There is movement toward more
integration of ADS with mental health.
Some mental health clients seem
reluctant to receive substance abuse services, perhaps
due to the stigma associated with addictions.
A voice needs to be heard from Mental Health clients
who have struggled with ADS issues and found
treatment that involved both disorders was effective for them.*

Outreach to the Homeless And Faith-based

We learned from Paul Powell and staff at Transitional Living and Community Supports (TLCS) about county history regarding outreach to the homeless. It had been estimated that at least one third of this population is suffering from mental illness. They are “the people in the bushes” of John Buck’s baseball analogy.

History

One of the most successful ideas discussed was the previous Project Outreach, impacting many people who were living on the street and in places not meant for human habitation. This program, in which TLCS partnered with law enforcement and the Volunteers of America, included outreach vans. They were dispatched in an effort to locate and establish relationships with difficult to reach homeless persons with psychiatric disabilities in our community. Project Outreach positively affected many homeless individuals, who were offered food and small personal hygiene items, and were assisted to access more mainstream services, supports, and housing.

Project Outreach impacted many people living on the street and in places not meant for human habitation. This program, in which TLCS partnered with law enforcement and the Volunteers of America, included outreach vans dispatched in an effort to locate and establish relationships with difficult to reach homeless persons with psychiatric disabilities in our community. Project Outreach positively impacted many homeless individuals, who were offered food and small personal hygiene items, and were assisted to access more mainstream services, supports, and housing. One of its keys to success was establishing relationship and trust with this population through repeated and persistent contacts.

The Volunteers of America operated a similar mobile outreach team, which assisted other homeless persons in our community. Unfortunately, both of these successful programs were closed due to budget cuts. In addition, TLCS operated a program called Redirection, which was funded under a previous Mentally Ill Offenders Crime Reduction Grant (MIOCRG). This program paired mental health and law enforcement staff by utilizing an Assertive Community Treatment (ACT) model. It proved to be very effective in reducing hospitalizations, incarcerations, and episodes of homelessness for this target population. Unfortunately, this program was also defunded due to budget cuts.

“In 1999, El Hogar was able to significantly expand the services it provides to the homeless mentally ill in Sacramento County through the passage of Assembly Bill 34 (Steinberg), which authorized \$10 million for the creation of programs to provide integrated community outreach support to individuals who were homeless, at risk of homelessness or incarceration, and had a serious mental illness. El Hogar was fortunate to be one of two providers in the Sacramento region to be selected to initiate a pilot program. In 2000, the California Legislature passed Assembly Bill 2034 (Steinberg), to appropriate approximately \$55 million to expand this program to an additional 23 counties. Despite the tremendous success of this program, state funding cuts forced the closure of this program in the spring of 2008.” (from El Hogar’s website)

Project Outreach, the Mobile Outreach Team, and Project Redirection had excellent success rates in the past and should be revisited when evaluating potential ways to get the mentally ill homeless into MH services.

Present County Services to the Homeless

Presently the only access for the homeless is the Guest House, operated by El Hogar since 1987. It is an outpatient mental health clinic for homeless individuals with psychiatric disabilities. They are usually capable of servicing only two to three clients per day. It is advisable to go early to access these limited services. Its location is 1400 North A Street, Bldg. A, Sacramento, (916) 440-1500. It is open Monday through Saturday, 8:00 am to 5:00 pm.

Community and Faith-based Outreach to the Homeless

Concerned individuals in the community and faith-based organizations are aware of the tremendous problems and gaps in helping the homeless population of our county. There have been faith-based groups, ministering to the homeless for years, like Loaves and Fishes and Union Gospel Mission. Spontaneous, independent outreaches, teams going out from churches, armed with food and clothing, randomly reach out to the homeless and their immediate needs. Steps Forward, a federally operated agency in our county, is attempting to co-ordinate some of these efforts. Compassion and concern drive many to reach out to the needy in our county. Even more resources are needed to help the mentally ill, "people in the bushes," on our county's streets.

In addition, faith-based services should be re-evaluated with improved county support. Many potential volunteers have the right attitude, good hearts, and want to help. Unfortunately, many non-profit organizations lack the infrastructure necessary to support a volunteer program. Typically, Volunteer Coordinators are not "allowable expenses" under many restrictive grants and contracts. In addition, there are related administrative issues, including workers' compensation insurance coverage, which need to be addressed to effectively run a volunteer program. On a related note, the county is currently offering free, two-day training sessions on "MH First Aid" and interested parties have been invited and encouraged to attend.

Level of Care Utilization System (LOCUS)

Level of Care Utilization System:

Level 1 - Federally Qualified Health Care (FQHC)

**Level 2 - Wellness & Recovery Centers (WRC)
Regional Support Teams (RSTs)**

**Level 3 - Intensive Outpatient
Regional Support Teams (RSTs)**

**Level 4 - Full Service Partnership (FSP)
Integrated Service Agency (ISA)**

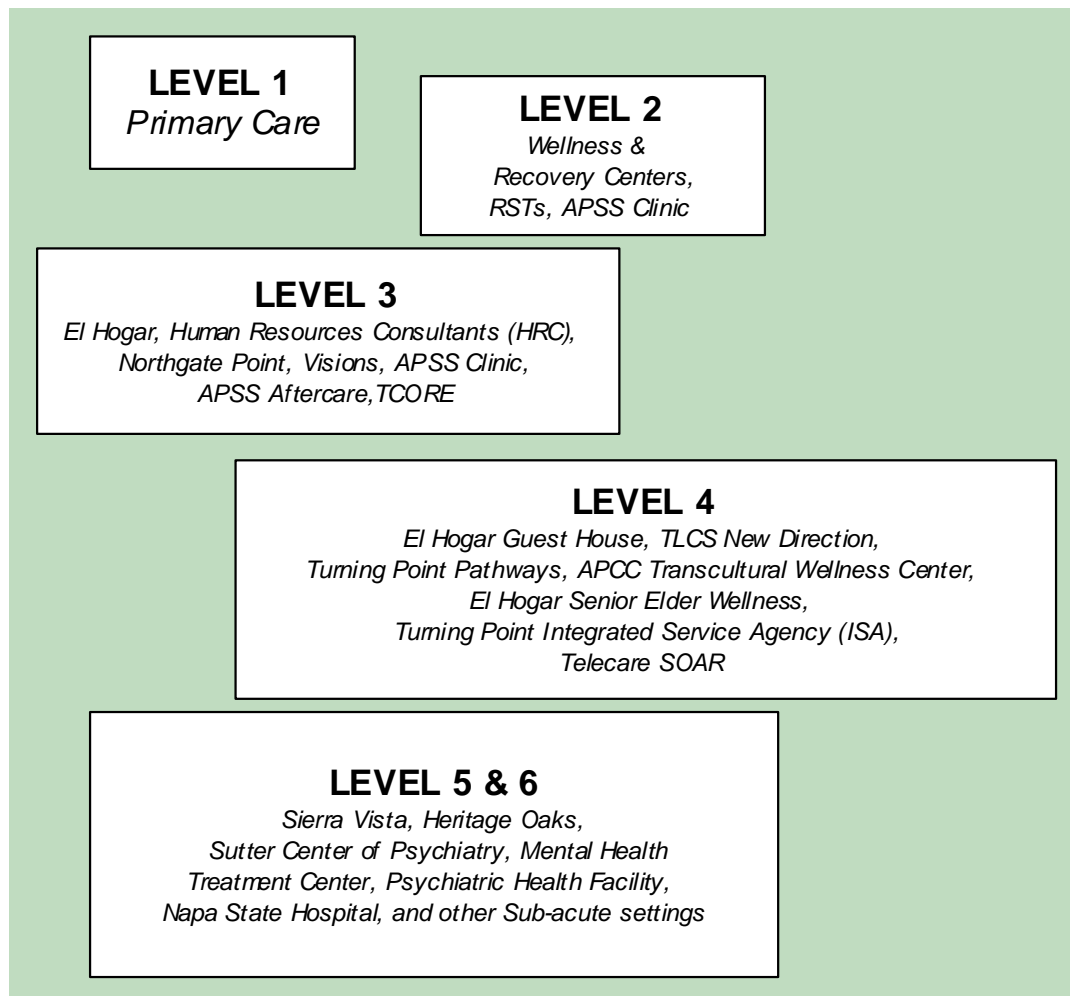
**Level 5 - Institutions for Mental Disease (IMD)
Mental Health Rehabilitation Centers (MHRC)**

Level 6 - Inpatient Hospitalization and Sub-acute settings

The mental health community uses the Level of Care Utilization System (LOCUS) to describe support services by a group of mental health service providers and agencies or to describe an individual's need for services. The three middle levels are considered moderate levels. The lowest two levels involve high need individuals. Level One can be psychiatric services at a primary care location. Most times, these levels are described with Roman numerals.

In the May 2011, an independent study of DBHS Adult Mental Health Services, called the Callahan Report (summary in Appendix K), the LOCUS levels of care were used as a methodology to categorize mental health providers in Sacramento County. This, however, does not represent the fact that a person is multi-faceted and that mental health community providers offer more than one level of care. We have provided the following chart as simply a visual reference to help understand the bigger picture of Sacramento County resources.

Adult Mental Health Services as portrayed in the May 2011 Callahan Report



Mental Health Provider

The Ad Hoc Committee contacted Paul Powell for some insight into past MH programs and services within Sacramento County. His organization, Transitional Living and Community Supports (TLCS), has been active in this area for over 20 years. It is a private, nonprofit, psychosocial rehabilitation agency. They “promote successful community living for individuals with psychiatric and other disabilities.”

TLCS currently operates through five major tiers of services:

1. Case Management Programs for individuals experiencing homelessness and meeting the criteria for the Sacramento County Mental Health Plan: The New Direction, Full Service Partnership (FSP) program, provides intensive case management services and psychiatric/medication support services to individuals referred by the Guest House. New Direction is comprised of four teams currently including: (a) the Hope Team; (b) People Achieving Change Together (PACT); (c) the Mentally Ill Chemical Abusers Case Management Program (MICA); (d) Widening Opportunities for Rehabilitation and Knowledge (WORK). All four teams provide intensive case management, and a variety of services, including vocational services for those ready to enter the workforce.
2. Case Management Program for individuals who meet the criteria for the Sacramento County Mental Health Plan: Transitional Community Opportunities for Recovery & Engagement (TCORE) is a collaboration program between Human Resources Consultants, Inc. (HRC) and TLCS to provide intensive services to those adults living in Sacramento County who have a MH diagnosis and are currently unlinked to any outpatient services.
3. Case Management for individuals who live in the Downtown Single Room Occupancy Hotels: The SRO Collaborative Service Project serves residents in the downtown Sacramento SRO Hotels, including outreach to seniors.
4. Transitional Housing Programs for individuals who are homeless: Interim housing program for eligible homeless individuals receiving services through Guest House. Forty-eight beds are provided at the TLCS Palmer Apartments.
5. Permanent Supported Housing Programs (PSH): The TLCS Downtown Coops are comprised of the following three supportive housing communities: (1) the Ninth Street Co-op (Carol’s Place), with eighteen beds; (2) the T Street Co-op, which serves nine residents with mental illness who are living with HIV/AIDS; (3) the River City Residential Club (RCRC), a fifteen bed co-op where individuals live cooperatively, share chores and activities.

TLCS also provides PSH at three apartment complexes as follows: the twenty-two bed, Bell Street Cooperative Apartments; the twenty-one units, Cardosa Village Apartments; the nineteen units, Folsom Oaks Apartments. The latter two serve families.

TLCS Interview

Paul started our discussion with an introduction to the properties described in items 4 and 5 above. In brief, TLCS houses 154 individuals in seven different residential facilities, which are funded by HUD, the Sacramento Housing and Redevelopment Agency, DBHS, and fees collected from its tenants. The TLCS Housing programs operate on budgets that average \$23 per bed for its PSH slots, at a low cost for preventative care compared to the costs of crisis management services, jails or hospitals (particularly in comparison to the County Treatment Center, which can run over \$1,000/ per day).

Karen Brockopp then described services provided to approximately two hundred and seventy-seven clients in the New Direction Program, which is an MHSAs-funded, full service partnership (FSP) Program.

Mike Lazar noted that TLCS also operates the TCORE program (short for Transitional Community Opportunities for Recovery and Engagement) in conjunction with Human Resource Consultants, Inc. (HRC), one of the county-funded, outpatient mental health service providers. TCORE is an MHSAs-funded "System Development" program.

Combined, the TLCS New Direction Program and TCORE serve approximately one thousand persons a year.

County History of RSTs

During the early-to-mid 1990's, in response to significant cuts in funding, Sacramento County reorganized its outpatient mental health services. This major reorganization followed lessons learned from some previously funded state demonstration projects. The Regional Support Teams (RSTs) were initially conceived to provide comprehensive mental health services to members in different geographic areas of the county, utilizing a one-stop model. This design could allow additional RSTs to be added to meet the needs of our citizens, as the county's population grew.

Given the available funding at the time, only three new Regional Support Teams (RST's) were established as follows: Visions, El Hogar, and Human Resources Consultants to serve the south area, the downtown area, and the eastern area of the county respectfully. Prior to establishing these three new RST's in 1993, there were seven outpatient mental health clinics. Sacramento County funded a homeless and supported housing program, operated by TLCS, and established a new Consumer Self-Help Center. Two Integrated Service Agency programs were established to serve clients who were in need of more intensive services, Turning Point and another by Sacramento County operated one model. The ISA model was later used as the basis for several major components of the current MHSAs program design. Later a fourth RST was later added in the north area (Turning Point's Northgate Point RST). Initial estimates indicated that multiple RSTs with manageable caseload sizes were needed throughout the County (possibly six or more). However, as of 2012, there are still only four RSTs, with 60:1 patient to staff ratios.

Other Changes

There has been concern that too much money has been allocated to the Sacramento County Mental Health Treatment Center (SCMHTC). The inpatient unit is not eligible for Medi-Cal reimbursement, due to its large size (over sixteen beds). Over the past decade, there have been many changes in how MH services are provided with different leadership. Budget constraints had a major effect on the mental health system of care in our community. Different ideas and program designs/approaches have been examined, with various levels of successes and failures.

Paul and his staff told us about the history of outreach to the mentally ill homeless. The group also discussed some of the more recent changes to county-funded outpatient services. This included a shift to central intake through the County Access Team and the El Hogar Guest House Clinic for homeless persons. Another change is the transfer of clients from the RSTs to qualified FQHC's, including the Effort, or primary care physicians. Medi-Cal eligible clients are now no longer considered in need of more intensive "specialty mental health services."

Another negative (and likely unintended or opposite) consequence of change is Medi-Cal/Medicare billing. There is increased pressure on staff to do the paperwork correctly or lose money. It has become so difficult for all parties that more Benefits Coordinators need to be hired to help both patients and providers to deal with the paperwork.

There are too many people in need of services and many programs are simply under-funded and overwhelmed. Currently many county-funded programs, the RSTs in particular, have staff that carries caseloads of almost seventy persons per caseworker, if not more, which is way too many. Ideally, this ratio should be closer to 20:1. Therefore, most efforts must currently go towards putting out the latest fire and moving on. People can fall through the cracks with this kind of pressure.

Other suggestions for improvement are increasing programs that can qualify for Medicare dollars with sixteen or less beds. Karen discussed the importance of the Crisis Residential Center of Turning Point and the role of crisis residential programs in general. A recent patient/peer supporter stated that the Turning Point Crisis Residential program, in Oak Park with twelve beds, is a great program. Unfortunately, there is pressure to get people in and out within two weeks. The county has also been sporadic in training sheriffs in MH issues, so as to better respond to community members in a crisis situation.

Perhaps Obama's healthcare model of the future, with "fully integrated health care" services will provide a good approach, but there needs to be more trained individuals to help in these new "Accountable Care Organizations." Where are the WET (Workforce Education & Training) dollars going? "Overall, we need to meet them clients where they are. We need a client-driven system with all the ups and downs that go with it. That's where to start," says Mark Tavares, echoed by Ms. Brockopp. "These people need to be treated as a partner," added Mr. Lazar.

Unfortunately, there are too many people in need of services and many programs are simply under-funded and overwhelmed.



Maslow's Hierarchy of Needs

Maslow's Hierarchy of Needs is a theory of psychology portrayed in the shape of a pyramid. The most fundamental human needs are the bottom level and the top of the pyramid is an individual's full potential. The most fundamental and basic four layers of the pyramid contain what Maslow called "deficiency needs". Maslow's theory suggests that the most basic level of needs must be met before the individual will seek higher level needs. Maslow did acknowledge that many different kinds of motivation could be going on in a human all at once. His focus in discussing the hierarchy was to identify the basic types of motivations, and the order that they generally progress as lower needs are reasonably well met. For the most part, physiological needs are the literal requirements for human survival. If these requirements are not met, the human body cannot continue to function properly. Clothing and shelter provide necessary protection from the elements. Personal security financial security, health and well-being and a safety net against accidents/illness have adverse impacts in the body. After physiological and safety needs are fulfilled, the third layer of human needs is interpersonal and involves feelings of belonging. The need is especially strong in childhood and can over-ride safety as witnessed in children who cling to abusive parents. Deficiencies with respect to this aspect of Maslow's hierarchy are due to hospitalization, neglect, shunning, ostracism – can impact individual's ability to form and maintain emotionally significant relationships. Many people become susceptible to loneliness, social anxiety, and clinical depression. This need for belonging can often overcome the physiological and security needs, depending on the strength of the peer pressure; an anorexic, for example, may ignore the need to eat and the security of health for a feeling of control and belonging. All humans have a need to be respected and to have self-esteem and self-respect. Esteem represents the normal human desire to be accepted and valued by others. People engage themselves to gain recognition and have an activity or activities that give the person a sense of contribution, to feel self-valued. Depression can also prevent one from obtaining self-esteem. "What a man can be, he must be." This concept forms the basis of the perceived need for reaching one's full potential or what Maslow called "self-actualization." This level pertains to what person's full potential is and realizing that potential. Theoretically, in order to reach this level of need, one must first not only achieve the previous ones, physiological, safety, love, and esteem, but also master these needs. The purpose of this study is to identify how individuals, who are not in the system and have "deficiency needs", can be reached for treatment, and especially those that continually cycle through hospitalizations or are involved in the judicial system. How can we break the cycle of repeated suffering and still respect the individual's rights?

Peer Support

The mental health community has endorsed the concept of providing treatment for mental illness by introducing the patient to another individual, a peer with similar symptoms who is successfully in recovery. The goal is to integrate these peer services within the traditional delivery system. Peer support provides hope because instead of emphasizing the question, what's wrong with the individual, the new focus is on what's wrong with the situation. Peer support programs change the concept of what it means to help an individual with mental illness. People who have lived experience can relate, empathize, understand, and validate. It offers practical advice and suggestions for strategies that professionals may not understand.

For peer support to work, the services must not take on the characteristics of traditional mental health. Instead there is an alternative view of services that identifies skills and a celebration of uniqueness, supporting the possibility of recovery. "Help" is redefined, not identifying a "recovered" or "better" person, but emphasizing both individuals sharing their vulnerabilities, strengths and finding value in helping each other. Even with paid peers, the relationship should be mutual and reciprocal. Basics to peer interaction are empowerment, self-direction, and help totally free from coercion. Services are consumer-run and directed.

Michael Hansen

An organization called Mental Health Consumer Concerns, located in Concord, conducted a MHSA survey of forty-eight youth and adults in acute settings (See Statistics.). All adults said, "having a case manager who cared about them" was the number one factor for their past and future success. Adolescents also felt that having a counselor to talk to was significant. Adults and children both emphasized a peer buddy or support group as very valuable. Adults also mentioned needs for transportation, medication support, job opportunities and housing options as important. The youths interviewed wanted something to occupy their time and having job opportunities. Michael Hansen, who provided this data, mentioned the importance of Wellness and Recovery Treatment Plans (WRAP) as they promote developing an individual's own strategies for self-reliance. In addition he explained that "health and safety checks" can be another tool for families.

Meghan Stanton Interview

In our interview with Meghan Stanton, Executive Director Wellness and Recovery Centers, we talked about family support. Meghan said she heard many families have problems accessing services. Families often stated that when they contacted law enforcement, they were unable to get help. Often law enforcement seemed unwilling to place a person who a family believed needed of mental health treatment with W&IC 5150. Meghan felt mental health providers, in general, should do a better job of educating people on how to get assistance for themselves and loved ones in need of mental health services. Additionally, she observed family members are often excluded from the treatment process. They are not informed or educated about what is happening with their loved ones. Often times it seems that confidentiality laws are used in a manner which excludes them when this may not even be the intention of their loved one.

Consumers are hesitant to go to the Treatment Center because they are fearful of being held against their will or institutionalized. When asked about the remodeling of the Mental Health Treatment Center, Meghan stated that unfortunately many consumers look at it as an institution, where they may have had negative experiences. The family too may have had unpleasant experiences. When their loved one receives inpatient services, families are often unaware of what is happening because of a lack of communication between the treatment team and families.

Compounding the issue is the number of people on long-term holds at the Sacramento County Mental Health Treatment—conservatorship and competency to stand trial. These situations impact the number of beds available for acute care. Meghan thinks that conservatorship should be used a little earlier and as more of a treatment intervention rather than as a last resort. Most of the interest of the conservators seems to be public safety rather than in rehabilitating or helping the clients.

Approximately 66% of clients held for additional involuntary treatment do not contest or disagree with the doctor. Treatment for individuals who agree with their diagnosis should be voluntary. Meghan felt that there could be a therapeutic component to the certification review hearings. Sometimes clients gain insight into their behavior as perceived by the hospital staff and understand how it is affecting their relationships.

Meghan realizes funding is a big issue, but if the community could look at a broader picture we could find the funds. It is a matter of priorities. The settlement agreement is a good start to looking at services along a continuum of care. There are still issues around resource allocation.

"The community would benefit from Crisis Intervention Teams (CIT) within law enforcement." Most CIT teams are provided with 40-80 hours of training specific to mental health issues. Sacramento does not currently have this program, mostly due to budget constraints. Who pays for the training? Who pays for the officers while in training? In 2005 Santa Clara County Law Enforcement involved mental health professionals on calls as backup, when needed. Eventually the mental health teams were called less and less as the officers became more proficient at dealing with the calls. They didn't need the support. In Sacramento, a psychiatric emergency response team (PERT) was proposed as a part of the Mental Health Services Act. Not open to this idea before, Meghan attended a 2005 CIT Conference in Columbus, Ohio where PERT was characterized as a precursor to CIT. The PERT proposal was unsuccessful because of funding issues of MHPA paying law enforcement salaries. Meghan liked CIT and felt that the officers were less stigmatizing towards mental health consumers than skilled mental health workers. This is another benefit of CIT is that it can change law enforcement attitudes and perceptions of the mentally ill. Meghan felt that mental health community could provide the CIT training for free by collaboration between existing agencies, including consumers' self-help. The only cost would be for the officers' salaries while in training and the cost of covering their regular shifts.

Another program that was successful at encouraging individuals resistant to accepting mental health treatment was Project Redirection, funded by a mentally ill offender grant. Meghan also explained that there are different levels of care. She believes that more individuals would be willing to accept treatment if the services we offered were of interest to the individual. Meghan also noted that often the focus of services is to manage symptoms rather than helping people realize their potential. There should be an emphasis on wellness and the whole person.

Susan Gallagher Interview

Susan was interviewed and stated that she and a number of clients and advocates helped to design the Wellness and Recovery Center programs in Sacramento County. Susan said she feels the "missing link" is crisis respite services and the key is a step-up system prior to the crisis. She feels we need a Crisis Stabilization Unit with a family and peer component. Her greatest concern is the lack of a crisis unit in Sacramento County. Susan does believe in a continuum of care that protects consumers, but peers can help with de-escalation. Susan said that there is the need for more PHFs and reimbursement to emergency rooms. She advocates for innovations in peer

partner support and warm-lines. We briefly touched on the MHSA Innovation program that plans to address the issue of crisis respite for individuals and families.

Family Support

Committee members saw the need for families to understand and learn how to cope with the issue of mental illness. Many families feel alienated, misunderstood, and alone in their daily struggles with a mental ill family member. The National Alliance on Mental Illness (NAMI) is the nation's largest grassroots mental health organization dedicated to building better lives for the millions of Americans affected by mental illness. NAMI has "Family-to-Family" support groups that are successful in helping families deal with the stress of loved ones who are struggling with mental illness.

Larry Liseno Interview

We interviewed Larry Liseno, President of the Sacramento County NAMI. This organization's goal is to lead the way in crafting and implementing high quality educational and support programs. He provided us with the list of the Sacramento County services offered by the local NAMI:

- Family-to-Family Training – instructs adult family members with mental illness and people who care about them with a twelve week educational curriculum.
- Family Support Groups – meet twice monthly for family support.
- Peer Support Groups – meet monthly for individuals in need of mentoring and support.
- Peer-to-Peer Training – mentors individuals with brain disorders during an eight-week training program.
- Consumer Counseling - supports consumers to share experiences and learn coping skills.
- "In Our Own Voice" newsletter—trains and manages individuals who speak about their illness for the purpose of educating the public and reducing stigma.
- Community Outreach – educate various social, professional, cultural and faith-based groups in the community about brain disorders, the services available to treat them and the need to eliminate the stigma associated with mental illness.
- Law Enforcement Training –trains new peace officers in the City and County of Sacramento about brain disorders and the symptoms of mental illness.
- Educational Materials – produce monthly newsletter, brochures, library, and website resources for individuals in need of information and support.
- Advocacy activities - participation in community forums related to mental health.

Larry mentioned some ideas for alternative treatments are 1) encourage more faith-based programs and (2) more law enforcement training of mental health issues; all with county grants or budgeting for support. He talked about CIT (Crisis Intervention Treatment), and the Expert Pool. Larry suggested mobile outreach as an option for providing services to those not currently receiving any care or services.

NAMI feels families need to be educated to understand the disorders and the challenges. Generally there should be at least one family member that can be an advocate and keep the mentally ill person continuing down the path toward treatment. Decisions should always be informed. There are several support groups for almost every discipline/illness available in Sacramento. Families and consumers alike can benefit from these groups. Currently, NAMI Sacramento does not have a firm position concerning Laura's Law.

NAMI strongly believes in the slogan "Keep Fighting Stigma!" There is no way for treatment if there is stigma and discrimination. "There are a lot of trust issues with mentally ill persons. They tend to be fearful. So many psychotic fears can get in the way of reaching them. Services need to start with outreach to gain trust then guide them to treatment. Faith-based programs can build this. Larry emphasized the importance of getting through the protective shell of psychotic fear - trust to treatment.

Michaele Beebe Interview

We interviewed Michaele Beebe who has worked for twenty years in Sacramento County as a parent and family advocate. Michaele feels we have tackled a very difficult subject and that there may be no specific answers. She believes we must emphasize the fact that the lack of appropriate and relevant treatment has a profound effect on the parents and caregivers. The issue of public safety is very important, but paramount is family safety including the seriously mentally ill individual. The direction of service comes down to two important issues: The first is trust. The mentally ill individual must have trust in the system, their therapist, the social worker, the psychiatrist, and even their peers. The second issue is the importance of continuity of treatment. Michaele's own service delivery is, first, and foremost, to developing a relationship with the family. She has often personally driven families to a service provider. She feels the family must initially confide in her and then they will feel they have a voice. Regarding funding, Michaele believes when the county receives "public safety" funds through the current prison realignment. Opportunities for new and innovative approaches may open the door for mental health funding. The current restructuring of the Department of Mental Health may also result in new approaches to service.

Delphine Brody Interview

An individual who fully understands the issues surrounding alternatives for individuals with chronic trauma is Delphine Brody, the MHSA and Public Policy Director of the California Network of Mental Health Clients (CNMHC). CNMHC is a client-run advocacy organization that grew out of the mental health consumer/survivor movement. Delphine told us the mental health consumer/survivor movement really began at the time of de-institutionalization. Former mental patients began to meet together in groups without psychiatric professionals. These former patients shared their feelings of anger at their abusive treatment and hope for independent living. They began organizing to fight for their rights and to provide support for each other. This social change movement concentrated on direct political action and organized in autonomous, grassroots groups.

Self-help and mutual support groups exist throughout the country as do client advocacy organizations in the majority of states. There are countless county and state consumer conferences and national technical assistance centers. Research has begun about clients advocating self-help and mutual support initiatives. Also there is substantive client involvement in policy-making and program development and implementation. Clients are providers in the mental health system and at management levels. There are advances in rights protections and proliferation of lawyers and others protecting our rights. The principles of CHMHC are:

- no expansion of forced treatment or involuntary outpatient commitment
- promotion of advanced directives as a safeguard against forced treatments
- need for mental health services that do no harm
- protect and respect the rights of mental health clients

- improved regulations of and rights protections in board and care homes
- the elimination of the use of involuntary restraints and seclusion
- protection of the all rights including the right to services; the needs of people with mental disabilities who are incarcerated
- the need for social and rehabilitative community mental health services that address the real life needs of persons with psychiatric disabilities - affordable housing, income supports, jobs, friends; substance abuse issue.

Delphine said she believes the Maslow Hierarchy of Needs is the essence of peer support. She endorsed our mission and feels the goal “to prevent further trauma” is key. She also believes the mental health system ignores the plight of too many. She emphasized the need for inclusion of racial, ethnic and sexual preferences. She felt we must reduce disparities and reach marginalized individuals. Delphine believes there are different solutions for each person. Pressing issues to address in Sacramento County are incarceration, hospitalization, and the number one priority of housing. Most importantly, there must be trust “to meet them where they are”. Delphine emphasized investigating current research and publications, including the Sanctuary Institute, the “Intentional Trauma Informed Peer Support and Crisis Run Alternatives, the “Bully free Workforce,” and “After the Crisis: Healing from Trauma after Disasters. The CNMHC has a publication, called “Resources for Trauma-informed Care,” which lists principles, education, training, and websites. Delphine also mentioned the Turning Point Crisis Respite Program and a European model called “democratic mental health which includes no locked facilities, and added the “open dialogue approach.”

The cornerstone of funding for peer-run programs is the Mental Health Services Act (MHSA). "Unfortunately \$861M has disappeared by Gov. Brown's covering budget shortfalls." We discussed the politics of funding. Delphine suggested letters to our congressmen is a way of showing solidarity. Various stakeholder groups are being created. Currently there is a group called “The California Stakeholder Process Coalition” that has the goal of engaging stakeholders as equal partners in the process of MHSA funding. With SB1136 taking MHSA funds she believes that should be a supplantation issue. “With the new MHSA money going directly to the counties, there are concerns about accountability. The BOS will handle the dollars, but are they educated on mental health issues and concerns? We discussed metrics for success. Delphine feels quality of service is much more important than numbers of people served. Metrics are usually third party evaluations.

Peer-Run Crisis Respite

Peer-run centers can help rebuild a sense of community for those feeling alienated. There is an emerging service philosophy of acute residential crisis services that can provide treatment for people with psychiatric disorders by offering support from others with lived experience. The goal is to encourage less dependence on the mental health system as well as assistance in avoiding the trauma of hospitalization and incarceration.

The peer-run crisis respite is usually in a safe, home-like voluntary setting. A person treated in a peer-run crisis alternative is more likely to receive assertive community treatment from aftercare and linked to the appropriate care before the next crisis. Process standards are advocacy, choice, decision-making opportunities, and a level of honesty.

Currently, the Innovation Component of the MHSA in Sacramento County is creating a crisis respite program. This Innovation Program is just getting started and has enthusiastic support from the consumer and family members as well as professional agencies.

A "peer" is the name mental health consumers give each other as a sign of respect and support. Families also need to gather support from each other and be respected. For peer support to work the services must not take on the characteristics of traditional mental health. Instead there is an alternative view of services that identifies skills and a celebration of uniqueness that supports the possibility that recovery is possible. A "peer-run respite" is a safe home-like setting where peers can learn to manage their crises and symptoms through support for each other.

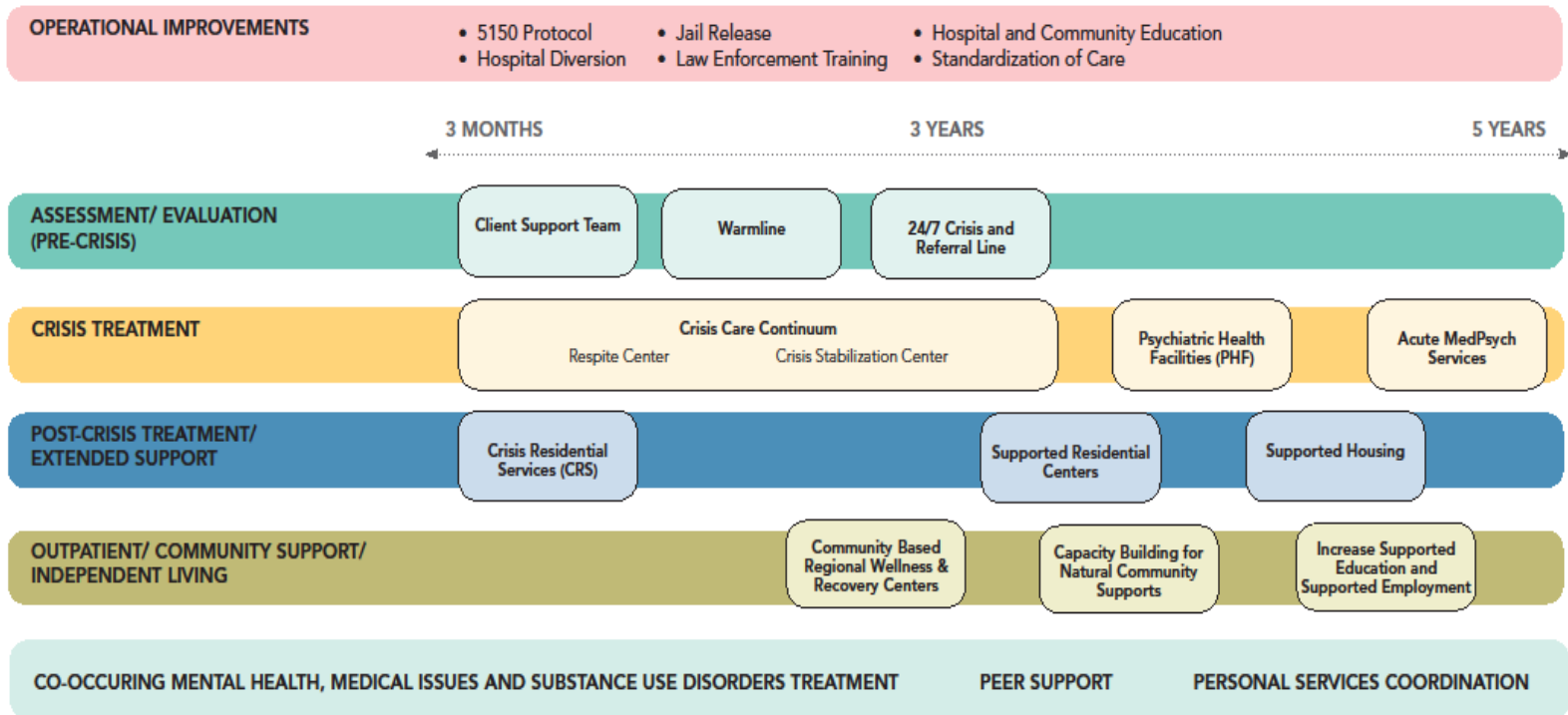
Draft Sacramento County Behavioral Health System Redesign Recommendations

CORE VALUES

- Person/ Client centered
- Recovery Driven
- Collaborative – public/private stakeholder partnerships
- Sustainable and efficient
- Evidence based and best practices
- Cultural competence

KEY ASSUMPTIONS

- Develop an integrated system of care
- Identify best-practices appropriate for our region
- Highlight key services, not agencies that will deliver the care
- Serve uninsured and underinsured consumers
- Address immediate need to help acute care providers while developing long-term strategy to prevent hospitalizations and keep people from crisis.



Operational Improvements	
<p>Review 5150 Protocol</p> <ul style="list-style-type: none"> Review and reconfirmation of existing 5150 designated facilities. Determine 5150 practices consistent with 5150 policies and procedures. Encourage voluntary psychiatric treatment during field assessment when possible. 	<p>Jail House</p> <ul style="list-style-type: none"> Agreement with Sheriff not to release inmates with mental health needs until mental health assessment has been completed. Agreement to only release inmates with mental health needs during regular business hours.
<p>Law Enforcement Training</p> <ul style="list-style-type: none"> Review field protocol and practices to determine necessary adjustments to manage and place clients with acute behavioral health needs. 	<p>Standardization of Care</p> <ul style="list-style-type: none"> Develop hospital plans of care for suicide risk, patient safety, patient's rights, safe observation, transfer to psychiatric facilities, elopements and therapeutic activities.
<p>Hospital Diversion</p> <ul style="list-style-type: none"> Agreement among hospitals not to divert patients from Emergency Departments for a 3-month period. 	<p>Emergency Department Data Collection</p> <ul style="list-style-type: none"> Emergency Departments began collecting data on clients with behavioral health needs in May to identify utilization trends.
<p>Hospital and Community Education</p> <ul style="list-style-type: none"> Provide Prevention and Management of Aggressive Behavior (PMAB) training. Train ED staff, law enforcement, Emergency Medical Services (EMS) and community members. Utilize training videos, online education. 	

Crisis Treatment	
<p>Crisis Care Continuum</p> <p>Respite Center</p> <ul style="list-style-type: none"> 24-hour homelike environment with capacity to evaluate and treat psychiatric emergencies. Provides intensive medical oversight, nursing care, medication support, peer and family support, assessment and reassessment, Wellness Recovery Action Plan (WRAP), linkage and referral to ongoing mental health services. Has general mental health services and case management with the capacity to treat patients for up to 23 hours to stabilize an acute crisis. <p>Potential Funding MHSA, Realignment, Medi-Cal, Medicare, FQHC and private funding.</p>	<p>Crisis Stabilization Center</p> <ul style="list-style-type: none"> Provides recovery-based services as well as similar services as Respite Center. <p>Potential Funding Medi-Cal, Medicare FQHC, Realignment, and private funding. MHSA only allowable for clients enrolled in MHSA Full Service Partnerships</p>
	<p>Psychiatric Health Facilities (PHF)</p> <ul style="list-style-type: none"> Provide inpatient service beds. Provide crisis stabilization, medication management, behavioral interventions, psycho-therapy, psychosocial education and a transition plan to enable a successful return to the community. Require regional planning. <p>Potential Funding Medi-Cal (16 beds or fewer), Realignment, and private funding. MHSA only allowable for clients enrolled in MHSA Full Service Partnerships.</p>
	<p>Acute MedPsych Services</p> <ul style="list-style-type: none"> Create and maintain a safe, supportive, and therapeutic environment while providing intensive, individualized care to patients. Services are designed for adults who need to be hospitalized for a period of time for stabilization due to a psychiatric illness. The patient, psychiatrist and a multi-disciplinary treatment team determine the goals of hospitalization. <p>Potential Funding Medi-Cal (16 beds or fewer), Realignment, Medicare, and private funding. MHSA only allowable for clients enrolled in MHSA Full Service Partnerships.</p>

<p>Outpatient/ Community Support/ Independent Living</p> <p>Community Based Regional Wellness & Recovery Centers</p> <ul style="list-style-type: none"> Provides extensive life skills training, peer counseling, supported education, supported employment, case management, behavior self-management, linkage to community treatment systems, WRAP, and social and recreational supports. <p>Potential Funding MHSA, Realignment, Medi-Cal for specified services (e.g. "case management"), Medicare, FQHC and private funding</p>
<p>Capacity Building for Natural Community Supports</p> <ul style="list-style-type: none"> Provides unique orientations designed to build and shape a community to support individuals with mental health issues through focused training and communication. Community organizations include faith communities, community groups, recreation centers, educational centers, school districts, employment agencies, family support centers and more. <p>Potential Funding MHSA, Realignment, Medi-Cal, and private funding.</p>
<p>Increase Supported Education and Supported Employment</p> <ul style="list-style-type: none"> Supported education is the continuous provision of education, training, supervision and support services designed to assist individuals to obtain employment. Supported employment provides integrated settings for competitive employment that provide support services to individuals to perform work. <p>Potential Funding MHSA, Realignment, Medi-Cal, and private funding.</p>

Assessment/ Evaluation (Pre-Crisis)	
<p>Client Support Team</p> <ul style="list-style-type: none"> Interdisciplinary team of mental health professionals focused on supporting Emergency Departments specifically. Provides referrals to appropriate services Includes communication function to receive information from family members about clients. <p>Potential Funding Realignment, Medi-Cal, Medicare and private funding. Mental Health Services Act (MHSA-Prop 63).</p>	<p>Warmline</p> <ul style="list-style-type: none"> Telephone service providing peer support, problem solving and service referral. Includes ability to transfer calls to emergency services when appropriate. <p>Potential Funding Realignment, Medi-Cal, Medicare and private funding. Mental Health Services Act (MHSA-Prop 63).</p>
<p>24/7 Crisis & Referral Line</p> <ul style="list-style-type: none"> 24-hour clearinghouse of services for clients seeking acute or outpatient care. <p>Potential Funding Realignment, Medi-Cal, Medicare and private funding. Mental Health Services Act (MHSA-Prop 63).</p>	

Post-Crisis Treatment/ Extended Support	
<p>Crisis Residential Services (CRS)</p> <ul style="list-style-type: none"> Expand existing programs for individuals who otherwise would require hospitalization. Provide a normalized living environment, integrated into residential communities. Follow a social rehabilitation model integrating aspects of emergency psychiatric care, psychosocial rehab, milieu therapy, case management and practical social work. <p>Potential Funding MHSA, Realignment, Medi-Cal, FQHC and private funding.</p>	<p>Supported Housing</p> <ul style="list-style-type: none"> Provides services and immediate access to independent, project-based or scatter-site apartments for chronically homeless individuals with serious mental illness. Provides support services by a team that uses a modified assertive community treatment model. <p>Potential Funding MHSA, Realignment, Medi-Cal, FQHC and private funding.</p>
<p>Supported Residential Centers</p> <ul style="list-style-type: none"> Focus on life skills training, linkage and community engagement. Serve adults in community-based residential settings. Provide extensive life skills training, peer counseling, case management, behavioral self-management, community residential treatment systems, and WRAP. <p>Potential Funding MHSA, Realignment, Medi-Cal, FQHC and private funding.</p>	

CO-OCCURRING MENTAL HEALTH, MEDICAL ISSUES AND SUBSTANCE USE DISORDERS TREATMENT: All care settings should be co-occurring competent.

PEER SUPPORT: Non-clinical staff with lived experience with mental illness to provide support, encouragement, hope, mentorship and linkage to opportunities for other peer support services.

PERSONAL SERVICES COORDINATION: A collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual's health needs, including determining eligibility and enrollment in appropriate public programs.

Hospitals, ERs, and Hospital Council

Scott Seamons Interview

Scott Seamons is the Regional Vice-President for the Hospital Council of Northern and Central California. The California Hospital Council has three regional associations, including all hospitals. In 2009-10 for various reasons, the Mental Health Treatment Center in Sacramento had drastic reductions—50 percent. The Crisis Stabilization Unit also closed at this time. According to Scott there was a sudden spike, 60 percent in emergency department admissions of patients with a mental or behavioral health issue. “We were scrambling to mitigate this. It was shutting us down. The hospitals were not licensed to deal with psychiatric needs, and did not have any mental health practitioners working in the ERs.”

Scott and others gathered about eighty people together – administrators, law enforcement, emergency workers and various stakeholders within the community to address this problem. The group started with the basic idea of assessing what were the community assets currently, impacting these issues. They didn’t know a lot of things, such as how to get mental health patients to the closest treatment facility, appropriate for the patient. Three work groups were formed – re-design, system and integration. They needed to define what needed to be done for immediate care, and where to send the patient. Everyone in the collaborative worked diligently to design a working continuum of care for the mental health patients. No other counties in California were addressing this problem. All eyes were on Sacramento to develop a plan. Darryl Steinberg pushed for solutions from the legislative side and appointed two individuals to the team, keeping him apprised of all progress.

Many individuals with mental illnesses are repeat users of the emergency room. In part, this is because follow-up after discharge is consistently low. Compounding this problem is insufficient community-based psychiatric and social service back-up for individuals with mental illnesses. Heavy reliance on emergency departments is not the answer. The ad hoc committee wanted to see where Sacramento County stood in relation to mental health patients and their impact on the local ERs.

In the US, emergency departments have to assess everyone who comes in the door. This is the most costly and ineffective method for treating a person not in immediate medical need. With the lack of a crises stabilization unit, all 5150 patients will go the ER first. The hospitals need to have access to psychiatric staff, whether as embedded employees or contractors. These trained professionals initiate a plan to redirect that patient to the most appropriate facility for further care. The participating hospitals supported this concept. The other participants needed to establish protocols for where patients should be referred.

There are five major hospitals systems in Sacramento:

- (1) Kaiser
- (2) UC Davis (Assessments team and psychiatry)
- (3) Sutter (Assessment team and psychiatry)
- (4) Mercy CHW (Dignity)
- (5) Veterans’ Hospital

There are also Heritage Oaks and Sierra Vista, both private mental health hospitals owned by Universal Health Services. They send mobile assessment teams to Kaiser and Dignity. All indigent patients are sent from ERs to the MHTC. (See next chart of Referrals and Admits by Referral Source issued by the Community Mental Health Partnership - Hospital Council)

Statistics show that ER physicians are frequently caring for people with mental illness. Their professional education and training have not kept up with trend, leaving them ill prepared. Mental health needs at the ER are in the same category as "colds and sniffles," not crisis unless they are a danger to self or others. They can walk out of ERs on a 5150 hold because hospitals do not have locked facilities. A situation occurred when the jails when they released people to the streets at 2:00 AM. Now as a result of the workgroup, they are released after 8:00 AM.

"We need to utilize 5150's in the right way. Use them better," said Scott. "There are ancient laws on the books that don't allow us to do things. Hospitals are hampered by risks they are not prepared to assume. Closure of state hospitals left many gaps. The process needs to be improved so that warm-handoffs from the hospitals to other facilities are as seamless as possible." Counties and hospitals are now talking to each other. "We're not 'flying blind' with both sides mistrusting each other. We are past this," said Scott. Patients presenting are getting medication and help. They are looking at the level of de-compensation and getting them to the appropriate places. Scott also mentioned crisis respite programs. Scott also suggested going out to the homeless and extending a hand and building trust. A good example of crises management is Dore Ally in San Francisco. (Appendix F)

In the US, the ERs have to see everyone who comes through the door. This is the most costly, and least effective, method of treatment for mental illness.

Referrals and Admits by Referral Source Fiscal Year 2011-2012

Referrals by Referral Source		FACILITY												Total	Average
		Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12		
Heritage Oaks		15	32	11	21	26	21	23	20	34	20	26		242	22
Kaiser (2/11 thru 4/11)		93	97	105	105	85	**	**	**	**	**	**	**	465	93
Kaiser Merced (12/11 thru 6/12)		**	**	**	**	**	38	47	53	36	41	42			
Kaiser South (1/11 thru 6/12)		**	**	**	**	**	53	45	38	55	66	66			
Kaiser Roseville (12/11 thru 6/12)		**	**	**	**	**	6	12	18	16	8	15			
Mercy Colson		7	11	9	9	9	9	10	10	6	10	10		100	9
Mercy General		18	18	20	16	11	14	15	18	13	21	19		183	17
Mercy San Juan		62	68	57	65	70	74	64	65	74	72	64		736	57
Methodist		30	42	38	41	34	40	38	32	37	45	42		415	38
Other		19	19	24	19	18	15	16	20	25	13	12		201	18
Sacramento County Jail		15	6	2	5	9	10	11	8	7	9	6		84	8
Sierra Vista		45	48	51	47	42	55	52	71	54	74	49		593	54
Sutter Center for Psych		13	21	12	7	14	13	13	13	6	17	11		140	13
Sutter General		85	55	47	40	48	44	50	58	49	44	39		535	49
Sutter Memorial		11	6	3	2	3	5	4	9	6	6	6		65	6
Sutter Roseville		6	7	6	5	1	2	5	7	4	6	8		61	6
UC Davis Medical Center		77	84	83	85	77	80	76	68	68	92	86		824	84
Woodland Memorial		5	5	6	4	4	10	4	4	5	4	2		48	4
Total Referrals		479	516	475	476	423	501	468	533	520	546	489	0	4802	

Admits to MHTC and Crostwood PHF by Referral Source		FACILITY												Total	Average
	Intake DGS % YTD	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12		
Heritage Oaks	1 5%	1	4	2	4	3	2	4	2	5	1	1		30	3
Kaiser	27 12%	49	34	40	58	45	**	**	**	**	**	**	**	220	44
Kaiser Merced (12/11 thru 6/12)	7	**	**	**	**	**	14	20	24	13	17	25			
Kaiser South (1/11 thru 6/12)	11	**	**	**	**	**	21	21	18	20	29	29			
Kaiser Roseville (12/11 thru 6/12)	**	**	**	**	**	**	1	5	2	0	0	2			
Mercy Colson	3 8%	5	7	6	6	5	4	7	2	2	3	5		52	5
Mercy General	5 8%	10	5	10	11	7	5	9	4	6	2	5		77	7
Mercy San Juan	5 2%	28	33	23	31	43	32	37	17	28	18	20		313	28
Methodist	21 13%	10	20	19	14	19	16	12	9	7	18	19		162	15
Other	9 7%	14	10	15	14	14	15	7	12	8	10	3		122	11
Sacramento County Jail	5 8%	7	9	8	5	9	7	6	7	6	6	5		77	7
Sierra Vista	1 5%	2	1	0	2	5	1	2	2	2	3	1		21	2
Sutter Center for Psych	0%	0	2	0	0	3	0	1	0	0	0	0		6	1
Sutter General	19 7%	28	19	13	22	21	17	22	25	14	16	10		208	19
Sutter Memorial	2 8%	4	0	2	1	3	5	2	2	2	2	2		26	2
Sutter Roseville	11 23%	5	5	3	5	4	1	4	3	2	5	5		48	4
UC Davis Medical Center	15 4%	43	40	34	39	41	38	35	34	32	29	43		406	37
Woodland Memorial	2 10%	4	1	0	5	2	2	3	3	1	0	1		20	2
Total Admits	142	204	193	181	215	224	181	191	167	154	161	182		1788	
		MHTC=150 CW=54	MHTC=145 CW=48	MHTC=138 CW=43	MHTC=171 CW=44	MHTC=178 CW=46	MHTC=141 CW=40	MHTC=141 CW=40	MHTC=137 CW=30	MHTC=135 CW=19	MHTC=114 CW=43	MHTC=111 CW=41			
		MHTC=185 CW=225	MHTC=182 CW=205	MHTC=175 CW=205	MHTC=209 CW=209	MHTC=204 CW=214	MHTC=155 CW=217	MHTC=145 CW=205	MHTC=135 CW=165	MHTC=138 CW=204	MHTC=104 CW=204	MHTC=107 CW=204			

* These numbers reflect total referrals by source but do not necessarily reflect total number of 61505 seen by each source.

STATISTICS

Numerous reports exist regarding the prevalence of mental illness. We are including a few sources along with our local statistics.

National Institute of Mental Illness (NIMH) in 2010 estimated that 7.7 million Americans suffer from schizophrenia and severe bipolar disorder - approximately 3.3% of the US population when combined. Of these, approximately 40% of the individuals with schizophrenia and 51% of those with bipolar are untreated in any given year. According to the World Health Organization, mental illnesses account for more disability in developed countries than any other group of illnesses, including cancer and heart disease. The NIMH studies report that about 25% of all U.S. adults have a mental illness and that nearly 50% of U.S. adults will develop at least one mental illness during their lifetime. Rates for both intentional (e.g., homicide, suicide) and unintentional (e.g., motor vehicle) injuries are two to six times higher among people with a mental illness than in the population overall. Mental illness is associated with increased occurrence of chronic diseases such as cardiovascular disease, diabetes, obesity, asthma, epilepsy, and cancer. People with untreated psychiatric illnesses comprise one-third, or 200,000 people, of the estimated 600,000 homeless populations. The quality of life for these individuals is abysmal. Many are victimized regularly. A recent study has found that 28 percent of homeless people with previous psychiatric hospitalizations obtained some food from garbage cans and 8 percent used garbage cans as a primary food source. People with untreated serious brain disorders comprise approximately 16 percent of the total jail and prison inmate population, or nearly 300,000 individuals. These individuals are often incarcerated with misdemeanor charges but sometimes with felony charges as a result of behaviors caused by their psychotic thinking. People with untreated psychiatric illnesses spend twice as much time in jail as non-ill individuals and are more likely to commit suicide.

Bureau of Justice Statistics Special Report, "Murder in Families"

- 4.3 percent of homicides committed in 1988 were by people with a history of untreated mental illness (study based on 20,860 murders nationwide).
- Of spouses killed by spouse – 12.3 percent of defendants had a history of untreated mental illness;
- Of children killed by parent – 15.8 percent of defendants had a history of untreated mental illness;
- Of parents killed by children – 25.1 percent of defendants had a history of untreated mental illness; and
- Of siblings killed by sibling – 17.3 percent of defendants had a history of untreated mental illness.

New York's Kendra's Law

- 77 percent fewer experienced hospitalizations compared to before AOT
- 74 percent fewer experienced homelessness compared to before AOT
- 83 percent fewer experienced arrests compared to before AOT
- 88 percent fewer experienced incarceration compared to before AOT

2012 LPS Task Force II Report “Separate but Not Equal - The Case for Updating California’s Mental Health Treatment Law” (Appendix C)

- Approximately 2% of the population suffers from serious mental illness with 40- 50% suffering from deficits in insight.
- Annualized cost of inpatient unit in jail is \$636,500 plus court and legal costs
- Annualized cost of FSP is \$24,000
- Annualized cost of Board and Care is \$26,000 - \$153,000
- Annualized cost of mental health treatment center is \$43,000 - \$78,000
- Annualized cost of Forensic skilled nursing facilities is \$150,000
- Annualized cost of Napa State Hospital is \$185,000
- Annualized cost of Psychiatric inpatient bed is \$511,000
- Annualized cost of Jail housing is \$36,000 plus treatment, court, legal costs
- Annualized cost of Prison housing is \$46,000
- Annualized treatment costs are \$2,000 - \$185,000

Emergency rooms

Individuals with psychiatric needs are a significant proportion of those using emergency departments:

- Individuals with psychiatric illness have higher rates of ER use than the general population when compared to a national sample.
- Patients with psychiatric disorders are likely to use the ER on multiple occasions and to have multiple hospitalizations, compared to patients without psychiatric disorders.
- One in eight, or nearly 12 million ER visits in the U.S. in 2007 were due to mental health and/or substance use problems in adults. Of these, 63% were related to mental health problems, 24.4% involved substance use disorders, and 11.9% involved were co-occurring psychiatric and substance use disorders.

Mental Health Consumer Concerns

Michael Hansen, a member of the Sacramento County Mental Health Board representative for Public Interest, provided this report. Mental Health Consumer Concerns, located in Concord, conducted a MHSA survey of youth and adults in acute settings. The following 48 persons completed these surveys:

Adults:

Board and Care - 10 individuals (22%)
Hospitals – 4 individuals (8%)
MHRCs – 6 individuals (12%)
Jails – 4 individuals (8%)
Homeless – 9 individuals (19%)

Youth:

Juvenile Hall – 7 youth (15%)
Hospitals – 4 youth (8%)

Residential Programs – 4 youth (8%)

When asked what past and future supports would benefit the quality of their life:

Adults:

Better access and a “good” case manager – 16 responses (14%)

Counselor to talk to – 6 responses (5%)

Peer Buddy – 12 responses (10%)

Peer support group – 8 responses (7%)

Psychiatrist – 7 responses (6%)

Individual or group counseling – 1 response (1%)

Dual Diagnosis help – 1 response (1%)

Medication – 12 responses (10%)

Pet therapy – 5 responses (3%)

WRAP – 5 responses (4%)

Transportation – 12 responses (10%)

Something to do – 6 responses (5%)

Job opportunities – 13 responses (11%)

Place to hang out – 1 response (1%)

Housing options – 10 responses (10%)

Not on survey, but needed:

Place to get some rest

Information to get help

Incentives for participation

Call before appointments and medication reminders

Clergy counseling services

Youth responses to Mental Health Consumer Concerns survey:

Good case manager – 7 responses (16%)

Counselor to talk to – 6 responses (14%)

Peer buddy – 3 responses (7%)

Peer support group – 4 responses (9%)

Psychiatrist – 2 responses (4.5%)

Individual or group counseling – 1 response (2%)

Pet therapy – 3 responses (7%)

WRAP – 4 responses (9%)

Transportation – 2 responses (4.5%)

Something to do – 3 responses (7%)

Job opportunities – 4 responses (9%)

School opportunities – 1 response (2%)

Place to hang out – 2 responses (4.5%)

Housing options – 2 responses (4.5%)

The adults and children all put “having a case manager who cared about them” as the number one factor to their past and future success. Adolescents felt “a counselor to talk to” was also significant. Adults and children emphasized a peer buddy or support group as valuable. Adults also wanted transportation, medication support, job opportunities, and housing options. The youth interviewed also wanted something to do and job opportunities.

Nevada County Statistics re: Assisted Outpatient Treatment

First individual entered into AOT on April 28, 2008.

Savings were based on the first 2.64 years of implementation

19 individuals enrolled during the 2.64 years, data collected on 17 individuals.

- \$482,443 represents the actual amount paid by Nevada County Behavioral Health to Turning Point Providence Center for services provided to the 17 individuals who received Assertive Community Treatment.
- \$1,122,264 Projected cost of hospital and jail, if not in AOT
- Total actual cost post AOT program:

\$1,122,264 Projected Cost (hospital + jail) if not in AOT
(\$136,200) Actual Post AOT Costs (hospital + jail)
<u>(\$482,443) Treatment Cost in AOT</u>
\$503,621 Total Cost Savings
- Every \$1 invested in AOT saves \$1.81

Presentation "Assisted Outpatient Treatment in California - Funding Strategies" by Michael Heggarty, MFT, Nevada County Behavioral Health February 15, 2012.

Assertive Community Treatment costs approximately \$20,000 per year and must meet WI&C 5348 (a) - (d), funded by:

- Realignment
- Medi-Cal
- Mental Health Services Act (MHSA)
- Medicare
- Private insurance
- Self pay

Behavioral Health Administration

- Cost varies and minimal; possibly few new/additional costs, because these same individuals would need administrative time related to, WIC 5350 Lanterman-Petris-Short (LPS) Court, Mental Health Court, public relations, if not being dealt with in AOT Court funded by Medi-Cal, MHSA, realignment

County Counsel

- County Counsel involvement and representation related to WIC 5350 LPS Court and Dependency Court, if not being dealt with in AOT Court
- Funded by Behavioral Health Realignment, Medi-Cal, MHSA

Judge and Court Staff

- Cost varies; but, possibly few new/additional costs, because these same individuals would need representation in Criminal Court, WIC 5350 Lanterman-Petris-Short (LPS) Court,

Mental Health Court, or Adult Drug Court, if not being dealt with in AOT Court - Funded by County General Funds

Law Enforcement

- Cost varies; possibly few new/additional costs, because these same individuals would be in Criminal Court, WIC 5350 LPS Court, Mental Health Court, Dependency Court, or Adult Drug Court, if not being dealt with in AOT Court -Funded by Superior Court State funds

Psychiatric Hospitalization

- May be funded by Medi-Cal, Medicare, Private Insurance, Behavioral Health Realignment

Potential Offsets:

- Psychiatric hospitalization; \$800/day, potential reduction of 47%
- County Jail; \$150/day, potential reduction of 65%
- Emergency Department; \$3000/visit, potential reduction of 44%

Funding LPS:

- Mostly with Realignment, for example WIC 5150, 5250, 5270, 5350, but counties also frequently use Medi-Cal and MHSA funds for mental health treatment associated with these services
- Medi-Cal is often used for WIC 5150 Assessments and 72 hour hold
- WIC 5250 14 day additional certification
- WIC 5270, 30 day additional certification
- WIC 5350, Outpatient treatment for gravely disabled individuals

MHSA used:

- WIC 5150 Assessment, Evaluation, Mobile Crisis
- WIC 5350 Individuals who are gravely disabled and needing outpatient mental health treatment
- Full Service Partnerships, such as ACT Teams, that target WIC 5350 Individuals who are gravely disabled and needing outpatient mental health treatment

How to Fund AOT?

- We tend to think of WIC 5345 as separate and distinct compared to other parts of the LPS Act, even though other parts of the Act contain much more restrictive, disruptive, and costly services.
- Consider the use of realignment, Medi-Cal, and MHSA wherever possible and allowable to pay for AOT.
- This would be consistent with how Counties fund other parts of the Act.
- AOT is a relatively low cost, front-end 'prevention' intervention that can greatly reduce the amount of money being directed into high cost, back end services

Dorian Kittrell - Sacramento County DBHS Statistics:

- MHTC Cost/Day = \$1369 with cost external intake unit that provides services to Emergency Rooms and Community
- MHTC Cost/Day = \$1100 MHTC county facility only 50 beds/day 18250 bed-days
- Private Hospital Cost/day = \$950 paid to hospitals in Sacramento County MediCal

- Crestwood PHF Cost/day = \$750 based upon negotiated value if acute MediCal eligible - \$375 is paid back.
- In 2010/11: The MHTC Inpatient Unit had 1926 admissions
- Median Length of Stay: 4 days
- The average number of admissions per day: 5.3
- The average number of dischargers per day: 5.2
- Recidivism rate (meaning a patient returned to an psych. inpatient setting within 30 days of being discharged from the MHTC): 15.2%
- Percentage of patients admitted to MHTC discharged back to the community: 97.3%

Sacramento County Mental Health Court

Steven Lewis provided the Ad Hoc Committee with information regarding Sacramento County Mental Health Court. This data involves 16 clients who were enrolled in the program from February 2007 to February 2008.

The number of people arrested decreased by 80%

The total number of arrests decreased by 74.1%

The number of days incarcerated decreased by 93.6%

The number of people using the crisis unit decreased by 33.7%

The number of people admitted to inpatient psychiatric facilities decreased by 50%

Sacramento Mental Health Court (SMHC) clients cost more than \$250,000 in the prior year. These same clients next year cost the system only \$33,000 - a decrease of 88%. The budget for the program in 2007, "Strategies for Change," was \$824,101, including \$333,981 of in-kind contributions from: UC Davis, SMHC Court Coordinator, Deputy District Attorney, Superior Court Judge, Assistant Public Defender, and Court clerk, reporter, and attendant. Mr. Lewis is currently involved with 33 MHC cases, but he said, "There is the capacity for one hundred cases." The net increase would be approximately seventy more individuals participating in this type of program.

Cost Avoidance

This following chart is a cost avoidance analysis based upon the recidivism of 70 individuals and their financial impacts in Sacramento County. The costs of jails, hospitals, and the Mental Health Treatment Center are compared to the cost of an Assisted Outpatient Treatment (AOT) contract in Sacramento County similar to the Turning Point program in Nevada County. We realize there are other costs that we are ignoring. We believe this analysis shows, however, that the costs of an AOT program is offset by the trauma an individual with a hospital stay at least four days a year, a four-day stay per year at the MHTC, and a two week jail sentence. The rates of these traumas are much higher for individuals who cycle through the system on a regular basis. We recommend using this blueprint for a three-year \$ 700,000 pilot program with referrals to the Mental Health Court.

Welfare and Institutions Code 5150 and 5200

Based on our understanding of existing statutes, entry into this program would utilize WIC 5150 and 5200, LPS Act provisions. The committee had taken into account the numerous suggestions that the LPS Act was under-utilized and Laura's Law was duplicative of these provisions. WIC 5200 could provide for those persons resistant to treatment who may present well to law enforcement under a WIC 5150 visit. Therefore, they may not be held for evaluation. Since one of the key arguments against Section 5200 was the extensive agency collaboration and existing

court delays, we were pleased to find excess capacity available in Sacramento's Mental Health Court. This court works for the benefit of every mentally ill person in a very expeditious manner.

Although the committee was aware of the usage of the 5150 statute, we inquired how the 5200 provision applies in our county. We did not get a complete response with adequate time to do further interpretation, seek additional stakeholder input, and answer the questions raised in the memo. Attached is the memorandum from Sacramento's Office of the County Counsel received July 25, 2012 in response to our inquiry. It states the procedures for WIC 5200 - 5213 have not been used in Sacramento County, most likely because of time and cost constraints. On July 30th, the committee received a response to this memo from Disability Rights California

Additionally a workgroup focus should be investigating Jail Psychiatric Services. We made numerous attempts to interview them and were not successful in obtaining information in this area. We feel this is an important piece of the treatment for persons incarcerated.

Three Year Pilot Program for Sacramento County Mental Health Court

Cost Estimate based upon Nevada County data:			
	Turning Point Contract		\$483,443
	# of years		2.64
	Total per year		\$183,122
	Individuals served		17
	Approx. cost per individual		\$10,772
	Sac.Co. individuals		70
	Total per year		\$754,033
			\$.7 M

Estimated cost avoidance for recidivism for 70 individuals:			
MHTC	\$1,100.00	ave. cost per day	
	4	ave days per stay	
	70	estimate no.of individuals	
			\$308,000
Jail System	\$150	ave. cost per day (Est.)	
	14	ave days per stay	
	70	estimate no.of individuals	
			\$147,000
Hospitals	\$950	ave. cost per day	
	4	ave days per stay	
	70	estimate no.of individuals	
			\$266,000
Estimated cost avoidance	\$721,000		\$.7 M

Funding \$700,000 for a Mental Health Court pilot program for 70 people

- 1.0 DBHS commit \$300,000/year for three years increasing each Level IV service providers' contract by \$50,000 per year OR \$300,000/yr. for one provider of a Nevada-like contract.
- 2.0 Sheriff and Probation Dept. commit \$400,000/year for three yrs. to cover MHC costs using funds that offset services averted.
- 3.0 Referrals to Mental Health Court from the MHTC Intake Stabilization Unit. No jail time for Level IV individuals. Maybe offer voucher incentives for participating in treatment plans.

Inter-Department Correspondence

Date: July 25, 2012

To: Mary Ann Carrasco
Deputy Director, Behavioral Health Services

From: Denis Zilaff
Supervising Deputy County Counsel

Subject: Welfare and Institutions Code §5200 et seq.; efficacy of providing a procedure for treating individuals with a suspected mental disorder

You have asked me to review Welfare and Institutions Code section 5200¹ et seq. as to its efficacy for providing medical treatment, evaluation, psychiatric medications and a treatment plan for reported mentally disordered individuals. Welf. & Inst. Code §§ 5200-5213 provide a means for a private individual to obtain a court-ordered evaluation for a subject alleged, as a result of a mental disorder, to be a danger to others, or to himself, or to be gravely disabled.

The potential benefit of this legislation is that someone otherwise unwilling to receive treatment voluntarily may agree to “receive crisis intervention services or an evaluation in his own home or in a designated facility” after an initial prepetition screening visit by a Mental Health professional (Welf. & Inst. Code § 5202).

This scenario avoids the need to call law enforcement to determine if there is probable cause to place the individual on a Welf. & Inst. Code § 5150 hold. This is the best-case scenario, and the only efficient means of utilizing this legislation. However, if after the “prepetition screening investigation,” the person does not agree to receive treatment voluntarily, the steps required to properly utilize this legislation involve a cumbersome process that delays treatment and is far less efficient than calling law enforcement at the outset, because the result will be essentially the same, with the only difference being a substantial delay in treatment.

Outlined below are examples of the best and probable-case scenario of a Welf. & Inst. Code § 5200 process.

Best-Case Scenario - Steps (Under Welf. & Inst. Code § 5202)

1. A concerned citizen, family member or individual contacts the Public Guardian (designated to receive application) to apply for a petition to initiate this process.
2. The Public Guardian contacts Mental Health (designated to provide pre-petition screening).
3. Mental Health conducts a “reasonable investigation of the allegations” and makes a “reasonable effort to personally interview” the person.

As part of the investigation, Mental Health must determine if the person will agree voluntarily to receive crisis intervention services or an evaluation in his own home or designated facility. If the

¹ All references are to the Welfare and Institutions Code section unless otherwise specified.

subject agrees, this is essentially the end of the process under this statute. No petition would be filed.

The time frame for this scenario depends on the availability of the Public Guardian to receive and relay the request to Mental Health. On weekends and holidays, this process would be delayed.

RESULT - The best-case scenario would be that after one or two days, the subject is interviewed and agrees to treatment or evaluation voluntarily. If holiday or weekends are involved, this process may take a week or more.

Probable (most likely)-Case Scenario Steps (Under Welf. & Inst. Code § 5202)

1. A concerned citizen, family member, individual contacts the Public Guardian (designated to receive application) to apply for a petition to initiate this process.
2. The Public Guardian contacts Mental Health (designated to provide prepetition screening).
3. Mental Health conducts a “reasonable investigation of the allegations” and makes a “reasonable effort to personally interview” the person. As part of the investigation, Mental Health must determine if the person will agree voluntarily to receive crisis intervention services or an evaluation in his own home or designated facility. Under this scenario, the person does not agree to services, and perhaps does not agree to an interview at all.
4. Mental Health completes a confidential report containing the findings and submits the report to the Public Guardian.
5. The Public Guardian reviews the report and if satisfied there is probable cause to believe that the person is, as a result of a mental disorder, a danger to others, or to himself or herself, or gravely disabled, and that the person will not voluntarily receive evaluation or crisis intervention, submits the petition request and report to County Counsel for filing.
6. County Counsel prepares the petition and submits the petition to the court for review and determination (Welf. & Inst. Code §§ 5204-5205).
7. If the Court finds probable cause for danger to others, danger to self, or grave disability as a result of a mental disorder, and that the person has refused or failed to accept evaluation voluntarily, the judge shall issue an order notifying the person to submit to an evaluation (Welf. & Inst. Code § 5206).
 - a. The court determines the time and place for the evaluation to take place.
 - b. The order and petition are served “as promptly as possible” on the subject of the petition by a peace officer, mental health counselor, or court-appointed official (Welf. & Inst. Code § 5208).
 - c. If the person refuses or fails to appear for evaluation after having been properly notified, the facility shall notify the person who served the order and that person will have the person to be evaluated taken into custody and placed in a facility for treatment and evaluation. (Presumably, the person will call law enforcement to have the person taken “into custody.”)

As outlined above, if these steps are necessary, the process takes time and is reliant upon numerous steps occurring and multiple state and local agencies cooperating before the person would be placed on a Welf. & Inst. Code § 5150 hold, a hold that does not have involuntary medication attached to it. This process would be the most typical scenario for a person in society acting out due to a mental disorder could take months to accomplish what a Welf. & Inst. Code § 5150 hold would accomplish in a matter of hours.

Under either scenario, the person may be detained for 72 hours for evaluation and treatment if, upon evaluation, the person is found to be in need of treatment because he or she is, as a result

of mental disorder, a danger to others, or to himself or herself, or is gravely disabled. The person shall be given written and oral information on any medications provided, and this shall be indicated in the patient's chart. If the information is not, or cannot be given, the justification for not giving it must also be documented in the patient's chart (Welf. & Inst. Code § 5213). Medications cannot be given to the patient involuntarily without a Riese hearing (Welf. & Inst. Code § 5332) which will also take an additional two to five days and must be renewed for each certification.

After 72 hours, the person must either be released, referred for care and treatment on a voluntary basis, certified for intensive treatment, or recommended for conservatorship.

CONCLUSION

Section 5200 et seq. provides a procedure to have a suspected mentally disordered person evaluated for an application for a 5150 hold. This section is anachronistic, time-consuming, involves multiple local and state agencies, costly, and not a timely procedure for an act that can be accomplished by law enforcement or other mental health providers in hours instead of weeks or months. To the best of my knowledge, the Welf. & Inst. Code § 5200 procedure has never been used in Sacramento County and is not used by other counties. Furthermore, since the closing of the Treatment Center as an acute mental health treatment facility for direct drop-off by law enforcement, it appears that a Welf. & Inst. Code § 5200 process would be even more time-consuming and costly with no benefits to the mentally disordered person or the initiating party.

Below: Email Response from California Disability Rights to the above Inter-Departmental Letter from County Counsel

Sent: Monday, July 30, 2012 10:10:33 AM

Subject: Re: Response to the MHB Ad Hoc Committee

...This is from one of our attorneys in San Diego. I agree with his thoughts.

Sounds like Sacramento County doesn't think much of 5200 as an alternative to Laura's Law.

It is interesting that there is no reference to offering the full scope of services available under Laura's Law, including but not limited to highly trained teams that use high staff-to-client ratios of no more than 10 clients per team member including peer support supportive housing or other housing assistance. (Section 5348(a)(1)&(2)(B)).

Further, the Section 5200 process is designed as a 5150 diversion. The pre-petition screening process requires offering at risk individuals voluntary services at home and in the community. It also includes preliminary evaluation of whether there is probable cause for evaluation. If the 5150 criteria were met, the county could go through that process rather than a 5204 petition.

Our argument has been that there are existing procedures under the LPS Act such that Laura's Law implementation is not necessary. Sounds like Sacramento County has not fully considered how the Section 5200 process could be used as an alternative to Laura's Law implementation.

Sean Rashkis
Attorney
Disability Rights California

Ad Hoc Committee Conclusions:

- *The Lanterman-Petris-Short Act (LPS) needs to be better utilized or re-written in the form of new legislation approved by members of the mental health community. It is our understanding, if Section 5200 of the LPS Act was applied as originally intended, AB 1421 might not be necessary. As per the previous memos, conflicting interpretations preclude any definitive recommendations.*
- *Assisted Outpatient Treatment (AOT) goes beyond the scope of LPS and gives families and concerned individuals more of a voice. AOT in Nevada County is a Full Service Partnership recognized as a successful foundation for recovery. This program is partially sponsored by the Mental Health Services Act (MHSA), and does not condone forced medication. AOT is an intervention allowing for a treatment option that is a less restrictive than the 5150 process or a locked facility, including jails. If all aspects of Nevada County's AOT program could be replicated here in Sacramento, we could be inclined to recommend AOT.*
- *The Sacramento Mental Health Court has room for expansion. We recommend the Sacramento County Board of Supervisors create a collaborative workgroup to increase the development and funding of Mental Health Court. This workgroup should include Probation and Sheriff's Departments, Hospitals, District Attorneys' and Public Defenders' offices, Department of Behavior Health Services (DBHS), Mental Health Court, the Mental Health Board, peer and family support groups, and other stakeholders.*
- *Mental Health Court could provide AOT or other treatment options for 70 more individuals with severe mental illness within its current structure. Our previous cost avoidance recommendations support this theory to reduce recidivism. We recommend implementing the Mental Health Court three-year pilot program.*
- *Mobile outreach teams are imperative, even expanding on the current Community Support Team (CST) model using a blended team of professional, peer, and family staff. We recommend establishing a Crisis Intervention Team (CIT), perhaps like the San Diego model. (Appendix B) Furthering the outreach concept, we recommend leveraging faith-based and other community organizations, such as Sacramento Steps Forward.*
- *Alcohol and Drug Services must be understood and incorporated at all levels of services and especially in the jail system. Clients with co-occurring disorders are not all criminal types, but must be identified and treated appropriately. There should be an ADS counselor at Jail Psychiatric Services and the Mental Health Treatment Center, and routine information sharing.*
- *ERs are not equipped to handle mental health treatment and we recommend sustainable funding for the new Intake and Stabilization Unit (ISU). We suggest continual representation by the MHB on the Community Health Partnership. Primary care physicians must also receive education to understand the complex issues of mental health.*
- *We recommend peer and family advocacy at all levels of care, even hospitals and the Mental Health Court. Updated service and legal information and education for all advocates is crucial. Continuity of treatment, the establishment of trust, and seamless transitions must be implemented and we support recommendations in the Callahan Report (Appendix K).*
- *Uma Zykofsky stated "Some of the challenges are creating programs with sustainable dollars, not relying on taking money from existing programs." We recommend leveraging funding with other organizations and investigating more grant opportunities.*

Throughout the course of this project, many approaches were discussed and presented to us. We have decided to include the following six examples of similar research and programs.

APPENDIX A.

State of Georgia

In Spring 2012 issue of the National Association for Mental Illness (NAMI) Advocate magazine, there was an article called "Georgia Program Aims to Break the Cycle of Recidivism". This article explained a pilot program called Opening Doors to Recovery (ODR). The project is being led by the National Alliance on Mental Illness (NAMI) in partnership with Emory University and the Georgia Department of Behavioral Health and Developmental Disabilities (DHBD). The following description contains excerpts from the article. Two million dollars was provided by Bristol-Myers Squibb and some of that organization's investment in mental health services are summarized on page 65.

Over the next two years, the state of Georgia is implementing an "Opening Doors to Recovery" program that will focus on people with serious and persistent mental illnesses who have an established history of recurrent homelessness, incarcerations or hospitalizations. As a pilot project, it will test a highly innovative approach to delivering tailored, recovery-oriented case management services for patients being discharged from Georgia Regional Hospital at Savannah. ODR will develop, implement and evaluate a case management service as well as a new technology system for navigating a consumer's community-based care and for tracking utilization of non-medical supports that are critical to recovery but not typically captured in medical records. "The program is initially limited to 100 participants

"This program is a result of two previously successful collaborations in the state: the Crisis Intervention Team (CIT) program and the peer specialist initiative. A strong partnership is established among individuals, family members, local providers, hospitals, law enforcement, emergency departments, clergy, and others who touch the lives of people living with mental illness. After informed consent, the names of ODR participants may be placed in Georgia's statewide criminal justice database to assist law enforcement in being aware of the ODR program in their lives. The ODR utilizes a team approach to helping its clients navigate the network of mental health, health, and social services. Unlike traditional mental health services, ODR has a comprehensive focus. Participants receive assistance in accessing treatment finding stable housing, developing and improving relationships and achieving meaning and success in their lives. There is also grant funding from the Georgia Transportation Department to provide access to that particularly important component to recovery, especially in rural areas."

"The Opening Doors to Recovery project is an example of public-private partnerships used to drive much needed innovations in the nature and quality of care and support available to patients who are managing their illness in their home and community," said Bristol-Myers Squibb Foundation Director Patricia M. Doykos. "We look forward to seeing how the project's interventions and tools help participants avoid crisis and progress toward their recovery goals." From the Bristol-Meyers Squibb website: "The Bristol-Myers Squibb Foundation has made a \$2 million grant in support of the Opening Doors to Recovery Project (ODR) in southeast Georgia. "The mission of the Bristol-Myers Squibb Foundation is to help reduce health disparities by strengthening community-based health care worker capacity, integrating medical care and community-based supportive services, and mobilizing communities in the fight against disease. In this program area for mental health in the U.S., the Foundation aims to address the disparities that exist in the southeastern states through innovative recovery-focused and community-based interventions. Improving transitions from hospitals to community living and care is one particular area of interest." (See following pages with list)

"The data collection and evaluation component of ODR is in the early stages... however...profiles show positive short term impacts, including adherence to treatment, maintaining sobriety, participating meaningful daytime activities, employment, reduction in crimes, incarceration and hospitalizations." The ODR program was endorsed by Former First Lady Roselyn Carter who said, "Mental health is defined as a state of well-being in which individuals realize their own abilities, work productively, and are able to contribute to their communities. The absence of mental health adversely affects all aspects of life."

This article states that while the initial investment of resources in serving people with a pattern of chronic recidivism may seem high, the eventual benefits in terms of saving money and people's lives cannot be overstated. People living with mental illness and substance abuse deserve a chance to achieve true recovery.

The following is another quote in the same periodical from Former First Lady Roselyn Carter: "Over the years, I have seen stigma against mental illness lifting some, but I know we have so much more work to do. It is my hope that one day mental illnesses will be seen as health conditions like any other and that our friends, coworkers and family members who have them are able to access the treatments and supports they deserve. The result will be more and more people in recovery included in our communities, and everyone will benefit from the expression of their fullest potential through use of their diverse skills and gifts."

Bristol-Myers Squibb Foundation
Serious Mental Illness Initiative Current Partnerships and Grants

- NAMI Georgia/Emory University in partnership with the Georgia Department of Behavioral Health: \$2,000,000 to support a demonstration project called *Opening Doors to Recovery in Southeast Georgia* that will develop, implement and evaluate a community-based case management service to reduce the recidivism among consumers being discharged from Savannah Regional Hospital. The State of Georgia is co-investing \$2 million in the project as well.
- Mental Health America: \$750,000 to support a program to train and mobilize peer specialists from Native American tribal communities and to educate and engage tribal leaders in de-stigmatization actions in 5 western states
- National Council for Community Behavioral Health Care: \$739,170 to develop a replicable intervention model for effective services focused on illness management, recovery and supported employment for transition-aged youth (18-26 years old) living with serious mental illness.
- American Health Initiative, Ltd.: \$350,000 to support the development and piloting of a Senior Health Corps to increase mental health services at primary care focused federally qualified health centers in Florida
- Boston Medical Center: \$497,765 to develop, implement, and evaluate a demonstration program using peer specialist navigators to assist with the coordination of primary and mental health services of consumers
- Capital Health Foundation/Henry J Austin Community Health Center: \$318,000 in grants aimed at helping expand mental health services for disadvantaged populations in Trenton, New Jersey, by co-locating a psychiatrist from a private hospital at a federally qualified health center to provide direct care and clinical mentoring and by providing didactic and Grand Rounds education to primary care providers on staff and in the Trenton area
- Dartmouth Psychiatric Research Center: \$666,323 to support the adaptation of an electronic decision support system (EDSS) for smoking cessation to meet the needs of African American and Latino smokers with serious mental illness
- Family and Youth Counseling Agency in partnership with Louisiana Office of Mental Health, Office of Addictive Disorders and NAMI Southwest Louisiana: \$749,744 to provide screening, assessment, treatment, supportive services and program evaluation for mothers experiencing depression and other mental illness in the Region V area of Louisiana by working with primary care, ob/gyn and mental health service providers
- NAMI Alabama in partnership with Cahaba Mental Health Center and West Alabama Mental Health Center: \$97,005 to support a faith leaders' summit and other training and outreach efforts targeting African American churches to strengthen their capacity to become mental health recovery and referral resources for their congregations and communities

APPENDIX B.

San Diego County's response to AB 1421

On February 3, 2011, the County of San Diego Mental Health Board approved an action item recommending the implementation of Welfare and Institutions Code 5345 – 5349.5, also known as “Laura’s Law,” in this county.

In a letter addressed to San Diego County’s Supervisors, dated February 22, 2011, the County’s Health and Human Services Agency stated that their position on this issue was to oppose the implementation of “Laura’s Law,” and instead implement a more inclusive, treatment-based alternative that targets the treatment resistant population. San Diego HHS stated, “This position is based on financial data and clinical concerns that are shared by an overwhelming majority of California counties. The cost to counties and the courts is great, and there has been no conclusive clinical evidence that this approach is beneficial.”

In late 2010, San Diego HHS proposed an alternative to the model contained in “Laura’s Law.” HHS’s proposal, the In-Home Outreach Team (IHOT) program, would combine the services of a peer specialist, a family specialist, and a mental health professional to work with those with serious mental illness who are difficult to engage and resistant to treatment.

In November 2011, San Diego County contracted with Telecare to implement the IHOT program. The details of this program are described in the following, excerpted from their official pamphlet dated January 19, 2012:

Telecare In-Home Out-Reach Team (IHOT) is a centralized program offering three mobile teams to provide In-Home Out-Reach to adults with serious mental illness who are reluctant to receive mental health services. IHOT also provides support and education to family members. Three individual teams serve the Central, North Coastal, and East County regions of San Diego. Services include outreach and engagement, crisis management, transitional case management, support and educational services and assessment as needed. Eligible individuals may have a co-occurring substance abuse diagnosis in addition to a diagnosis of a serious mental illness.

Staff on the teams will include a Peer Specialist, a Family Coach, a case manager, and a Team Lead. The Peer Specialist and Family Coaches offer personal *lived-experience* to their work with participants and family members.

All services are based in a strong recovery foundation focusing on person-centered services, strengths-based interventions and non-coercive communication.

Components used to support participants and their families towards mutually agreeable plans of action are:

Out-Reach and Engagement

Team members meet with participants in homes, hospitals, jails and the community striving to develop collaborative relationships steeped in trust and rapport.

Crisis Management

The Teams will work with participants and families to identify, recognize and talk about soft-signs of symptoms before crisis occurs. Team members will model de-escalation techniques, teach how to get the right help when needed, what to expect afterwards. Staff will also be available to help respond to crises when they occur, including:

24 hours a day, 7 days a week availability (Emergency phone consultation anytime & in person on off hours as necessary)

Help in stabilizing the situation and understanding about what occurs next.

Interventions include partnering with family members and/or others involved such as law enforcement representatives.

Transitional Case Management is typically short term in nature, approximately 90 days, or more as needed. During this period, the team provides linkages to outpatient mental health services and other supports as necessary to extend community tenure and increase participant and family member satisfaction. Other linkages may include primary healthcare, faith-based institutions, ethnic organizations, peer-run programs, eligibility assistance, housing services, social/recreational activities, employment services, educational resources, advocacy, legal services, COD services, and 12-step programs as dictated by the needs and stated wishes of the participant.

Support and Education consists of information and education about mental health services and community resources. To help decrease social isolation frequently experienced by families impacted by mental illness, recovery and wellness-

based groups will provide opportunities for participants and family members to interact with one another and with IHOT staff.

Assessment: can be offered if the individual is willing to participate in a Behavioral Health Assessment, which may include of level of care needs, strengths, mental health treatment and substance abuse histories, diagnoses, etc. The ultimate goal of the program will be to reconnect participants with their hopes and dreams, to ongoing outpatient mental health services and ultimately on to their meaningful lives. The teams will serve a combined 60-75 consumers per quarter (20-25 per team), or 240-300 per year (80-100 per team)

Referrals to Telecare IHOT will derive from collaboration with numerous referral sources such as PERT, hospitals, jails, NAMI, families, RICA, etc. to target the most acute and difficult-to-engage.

All services are provided 24 hours a day, 7 days a week. After hours calls are handled with a paging system to provide prompt response.

Telecare IHOT is under contract with San Diego County Mental Health Services. These programs are partially funded by the County of San Diego, and MHSA.

APPENDIX C.

Recommendations from the 2012 California LPS Reform Task Force II Report Entitled "Separate and Not Equal - the case for updating California's mental health treatment law"

1. Redefine the standard for "gravely disabled" to incorporate an added element that addresses the capacity of the individual to provide informed medical decisions. The standard should be amended to incorporate specific Criteria that include comprehensive details such as the probability the person would experience substantial bodily harm, serious illness, significant psychiatric deterioration or debilitation without adequate treatment.
2. Standardize the procedure for Riese Hearings. These determine a person's capacity to give informed consent to accept or refuse psychotropic medication. There is wide variation in this procedure from county to county. Some counties hold Riese Hearings simultaneously with WIC 5250 certification hearings. Adopt concurrent legal processes to determine probable cause³ for hospitalization and capacity to refuse medication in one hearing. If the patient has previously signed an Advance Directive, medication will be administered only under the terms of the directive unless the person is imminently dangerous to self or others.
3. Length of certification has some counties using the 30-day LPS hold provision while others do not. Recommendation is after 72-hour hold, certification for treatment should be 28 day regardless, renewable for an additional 28 days.
4. LPS Conservatorship should be revised to allow efficient application from a community setting to avoid unnecessary inpatient hospitalization when the community is the least restrictive environment for the person's needs. A judicial order appointing a conservatorship should be recognized in other California officials in other California counties and apply throughout the state, rather than only in its county of origin.
5. "Demonstrated danger" should be based on the assessment of the present mental condition, with no time limitation regarding the consideration of past behavior. A standardized AB1424 form should be developed and approved by the appropriate mental health agency and other necessary government agencies in every county of California. This form will be accepted and used by every police force, sheriff's department, psychiatric mobile response team, clinical and medical facilities, and superior court and hearing officer in California.
6. Historical course of an individual's illness should be considered at each step of the evaluation process.
7. The State should develop a system of interagency collaboration among mental health departments, law enforcement, designated and non-designated hospitals and transport entities.
8. The State must develop medical necessary definitions appropriate to acute psychiatric illness episodes and ensure Medi-Cal definitions for both voluntary and involuntary hospitalization are consistently defined, monitored and applied with appeals to be conducted by a neutral third party.
9. Crisis stabilization services should be available in each county with a full array of step-down levels of care available for recovery.
10. More fully implement Laura's Law statewide.
11. Seek expansion of mental health courts and mental health calendars in all jurisdictions and increase the capacity and utilization of current mental health courts.
12. Each county should develop a comprehensive and coordinated emergency response capacity under a legislative framework that requires emergency responder and mental health interagency collaboration and standardized training for response teams.
13. A workgroup should be established consisting of representatives for hospital, county counsel, law enforcement, and transportation entities to produce a uniform standard for custodial requirements for personnel who generate, continue, enforce or release a hold resulting from a 5150 or greater LPS Act status.
14. Ensure statewide uniform application of the Lanterman-Petris-Short Act. It is critical that the LPS Act be updated.

For more information on the LPS Reform Task Force II
Contact Carla Jacobs, 714-771-2321 or Randall Hagar, 916-442-5196

APPENDIX D.

Orange County Report from October 2011

Orange County Options Examined:

Implement AB 1421.

The Board could elect to implement AB 1421. Adoption of AB 1421 would obligate the County to provide the required services and staffing. HCA would need 6 to 12 months to complete the design and implementation of an AOT program.

Do not implement.

The high cost, lack of funding, complex requirements and limited ability to enforce a court order are seen as major disadvantages to implementing AB 1421. Also, at the time AB 1421 was enacted in 2002, County Mental Health Programs had very few intensive outpatient programs/services. With the passage of Proposition 63 in November 2004, a broad range of voluntary services has been funded and implemented in Orange County. These programs, as described in the Attachment, have demonstrated decreases in hospitalization, incarceration and homelessness as well as increases in vocational and employment activities. Many of these new treatment services are geared specifically to persons resistant to seeking help or who have historically been underserved.

Develop a pilot program with some AB 1421 features.

AB 1421 does not provide authorization for implementation of a pilot program or anything less than total implementation. However, HCA could design a voluntary pilot program that incorporates some features of AB 1421 and implement the program on a provisional or short-term basis, without the Board adopting an AB 1421 resolution. It could be a new program or modification of an existing program. Such a program would not include any court enforcement provisions or oversight; however, it would provide a dedicated resource to work with individuals to engage their loved ones in needed treatment. A period of at least 6 months would be needed to design such a program and obtain the necessary review and approval. The pilot could potentially be funded by MHSA, provide access for families and treatment providers to request an evaluation, and provide outreach and engagement services, assessment/evaluation and a comprehensive array of treatment services. Such a program would require approval of the MHSA Steering Committee, Mental Health Board and the Board of Supervisors.

A pilot program may not be considered adequate by AB 1421 proponents because they are seeking court oversight and court intervention in the care of their loved ones. However, in lieu of court oversight, the HCA Patient's Rights Program could potentially fill a mediation role, providing oversight and intervention as necessary.

Orange County Mental Health Services Similar to Those Described in AB 1421

Following is a list of current funded mental health services, totaling more than \$45 million, similar those described in AB 1421, that are designed to reach and assist persons historically resistant to treatment:

Full Service Partnerships

The Mental Health Services Act (MHSA) funds several Full Service Partnerships that are intensive programs emphasizing recovery and resilience. They include individualized mental health services and offer integrated services for clients and families. These programs link to extensive services, including mental health, medical, education, employment, and housing. They have a pool of flexible funding that may be used to provide "whatever it takes" for a client to attain recovery. There are 24/7 accesses to a team member. Caseload ratio is 1:15. The target population for these programs is the chronic mentally ill who are homeless or at risk of homelessness and may also be diagnosed with substance abuse or dependence disorders. One of the newer Full Service Partnership programs serves persons admitted to the Assisted Intervention Treatment Court. This court program is for low-level offenders who are chronically mentally ill and have historically been difficult to serve. This program is similar to AB 1421, except that the client must have been involved in minor criminal offenses before a Court referral can be made. In contrast, Laura's Law is a non-criminal proceeding. The Assisted Intervention Treatment Court offers full service partnership services for up to twenty-five clients. Those services are funded by MHSA and the client voluntarily agrees to the treatment plan and court supervision. Referrals for the program generally come from the Public Defender's Office representing clients in their criminal proceedings. HCA's current budget includes approximately \$31 million for Full Service Partnership programs. Program for Assertive Community Treatment Orange County has programs for Assertive Community Treatment teams for Transitional Age Youth, Adults, and Older Adults. These teams provide (1) medication services; (2) individual, group,

substance abuse, and family therapy; and (3) supportive services such as money management training, physical health care, and linkage to benefits. The target population is persons with severe and persistent mental illness that typically has high needs that include substance use, but do not meet all the criteria to enroll in a Full Service Partnership program. Clients served in the program have frequently cycled through the inpatient system and but have not been effectively linked to outpatient services. These programs provide an intensive level of services similar to Full Service Partnership programs. The main difference between the two programs is that there is not pool of flexible funding and housing resources for Program for Assertive Community Treatment programs.

HCA's current budget includes about \$5 million for Program for Assertive Community Treatment Programs

Outreach and Engagement programs focus on identifying and engaging people with Severe Mental Illness who are not receiving treatment. This program employs local outreach workers trained in recovery and resiliency; they are highly visible and knowledgeable about resources. Major points of contact for the outreach staff are parks, homeless shelters, bridges, and other places where the County's homeless population may be found. In August 2011, additional Outreach and Engagement programs were added aimed at intervening with individuals and families prior to onset of serious mental illness. These programs serve people of all ages who are at risk of developing a mental illness or who are displaying early signs of emotional, behavioral or mental instability or related disorders. Services include outreach and education, screening/assessment, wellness plan development, case management including crisis management, linkage to appropriate services, short-term interventions, educational and life skills classes, support groups, and transportation support. HCA's current budget includes approximately \$5 million for Outreach and Engagement services.

Orange County Center for Resiliency Education and Wellness

HCA recently implemented a new Orange County Center for Resiliency Education and Wellness. It serves persons age 14-25 experiencing the first onset of psychotic illness with duration of untreated psychosis of less than one year. Services include assessment, individual/family counseling, psychiatric services, educational family groups, health and wellness activities and educational and vocational support. Educational opportunities are also available to the greater community to learn more about psychosis, and how to improve the outcomes of young people who are affected by it. HCA's current budget includes about \$3 million for the Orange County Center for Resiliency Education and Wellness.

APPENDIX E.

Santa Barbara County

Through Randal Hagar, the committee was introduced to a report from a group in Santa Barbara County that looked at the issues regarding drug and alcohol usage and mental illness among those incarcerated in their county. The following are excerpts from that report and the entire report is available on the web.

(<http://www.scribd.com/doc/89881761/Families-ACT-Report-In-Search-of-Solutions-to-Santa-Barbara-s-Revolving-Door-Final-Edit>)

"Families ACT!" is a grassroots organization formed in 2007 by Santa Barbara families impacted by the injustice, lack of compassion and inefficient treatment of people with mental health and substance use disorders. In May of 2008, Families ACT! convened a "Santa Barbara Task Force on Co-Occurring Disorders" to address the need for alternatives to the costly "revolving door" for residents suffering with co-occurring mental health and substance use disorders. The task force published their recommendations in January 2012.

"California's recidivism rate of 67.5% is among the highest in the nation...the population cycles in and out of jail, prison, emergency rooms, shelters, sober living houses and our streets and is at great risk of dying of suicide, overdose or neglect. The goal of the Task Force was to foster much needed communication and collaboration between criminal justice and treatment providers, document the extent of the crisis and identify obstacles to and opportunities for, effective low-cost, high-impact solutions. De-institutionalization was well intentioned, but the failure to provide for the treatment needs of the patients has turned this policy into one of the greatest disasters of the twenty century."

The Santa Barbara Report identified several critical gaps in services to this subpopulation, including:

- adequate integrated mental health and substance abuse treatment
- case management and mentoring
- acute, transitional and long term residential treatment beds
- supportive housing
- meaningful volunteer or work opportunities.

Families ACT! proposed various policy reforms, including but not limited to:

- a radical reform of alcohol, drug and mental health treatment service delivery to "bring the department to the people it purports to serve",
- reallocate resources from middle management to direct services to ensure adequate mobile crisis response, acute hospitalization and street outreach to the homeless population affected by mental health disorders
- refocusing of Probation and AB-109 funds on rehabilitation programs in contrast to punitive supervision and incarceration
- redirection of funding from the District Attorney's office to holistic programs within the public defender's office

Effective solutions proposed include:

- A System-Integration/Ombudsman Office charged with streamlining a fragmented delivery system, improving intra- and inter-system communications, coordination and collaboration between service providers (including law enforcement and judicial systems)
- Expand Restorative Justice & Restorative Policing Programs
- A Cadre of Trained Volunteer Mentors, System Navigators, Paraprofessionals
- Engage the local business community

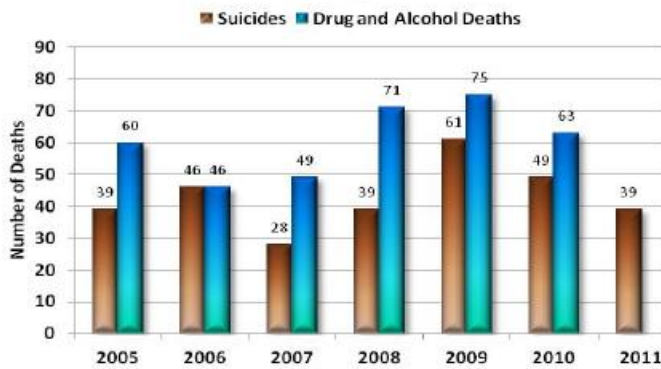
In the report these are words from the National Alliance on Mental Illness (NAMI): "Those who struggle both with serious mental illness and substance abuse face problems of enormous proportions. Mental health services tend not to be well prepared to deal with patients having both afflictions. Often only one of the two problems is identified. If both are recognized, the individual may bounce back and forth between services for mental illness and those for substance abuse, or they may be refused treatment by each of them. Fragmented and uncoordinated services create a service gap for persons with co-occurring disorders."

“The “No Wrong Door” philosophy in dual diagnosis treatment requires that each provider accept the responsibility to provide clients with, or link them to, appropriate services, regardless of where the client enters the system. It requires that relationships be built between providers and agencies to prevent clients from falling through the cracks between the jails, county mental health, detox centers, shelters, hospitals, etc. Mental Health Policy advocates warned a decade ago, that: states cannot be allowed to shirk their historic responsibilities to provide a safety net for indigent patients regardless of diagnosis. Their support is particularly needed for residential and rehabilitation services. Turning public care over to the managed care industry is not a solution; indeed, it simply exacerbates the problem.”

Ideally, according to Kenneth Minkoff, “The expectation that persons with mental health disorders are struggling with drug and alcohol use must be included in every aspect of system planning, program design, clinical policy and procedure, and clinical competency, as well as incorporated in a welcoming manner in every clinical contact, to promote access to care and accurate screening and identification of individuals and families with multiple co-occurring issues.” “Effective integrated treatment consists of the same health professionals, working in one setting, providing appropriate treatment for both mental health and substance abuse in a coordinated fashion. The caregivers see to it that interventions are bundled together, with no division between mental health and substance abuse assistance. The approach, philosophy and recommendations are seamless.””

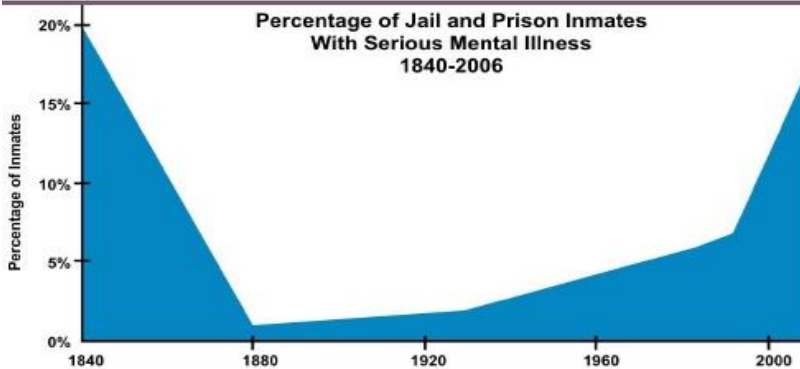
FAMILIES ACT!

Santa Barbara County Suicides and Drug and Alcohol Deaths Annual Data, 2005-2011



Source: Santa Barbara County Coroner's Office

FAMILIES ACT!



Source: *More Mentally Ill Persons Are in Jails and Prisons Than Hospitals: A Survey of the States*, Treatment Advocacy Center, May 2010



APPENDIX F.

San Francisco

Over the course of fiscal year 2007-08, DPH Community Behavioral Health Services worked with Progress Foundation to establish the Dore Urgent Care Center (DUCC), which opened its doors in July 2008. The program is designed to assist SFGH Psychiatric Emergency Services (PES) and other hospital emergency services by accepting clients in psychiatric crisis who do not require hospitalization but who are overcrowding into PES for evaluation and assessment. The Dore Urgent Care Center provides a social rehabilitation model approach to crisis intervention as a helpful diversion from PES for individuals who do not require involuntary treatment, seclusion or restraint. Its goal is to improve patient care outcomes by providing services designed to meet the distinct needs of this population. The Dore Clinic is a medically staffed psychiatric crisis stabilization clinic that will be open 16 hours per day (7am – 11pm) seven days a week. DUCC also has a 14-bed short-term crisis residential treatment program capability, the Dore House, located on the same site, for clients who need continued support beyond the limited operating hours of the Dore Clinic.

After years of debate over how to deal with the city's large population of severely mentally ill people who refuse treatment, San Francisco officials have quietly implemented a version of the controversial Laura's Law. The Department of Public Health treats 23,000 mental health patients each year. Reaching a few dozen of the worst cases could help reduce the cost for care and emergency services and improve the quality of life on the streets where residents and tourists alike often complain about mentally ill homeless people creating havoc, city leaders said. City leaders have never adopted Laura's Law, but the Department of Public Health initiated a voluntary version of the law last year to treat a handful of people who were patients in the psychiatric ward of San Francisco General Hospital. The first set of results being evaluated now show promise, city officials said. Laura's Law allows counties to compel outpatient treatment in extreme cases, but it does not require patients to take medication.

Under San Francisco's Community Independence Pilot Project, patients must voluntarily agree to participate once they're already hospitalized. If they do, they are assigned a public conservator who makes treatment decisions, including administering medication for the patient. Edwin Batongbacal, Director of the Health Department's Adult Behavioral Health Services Division, said San Francisco's version is cheaper and less bureaucratic, raises fewer legal questions, and could be just as successful as Laura's Law.

"It's more streamlined and friendlier to the clients," he said. "It's really about our ability to engage positively with clients rather than negatively through a court process where their rights are taken away." Under Laura's Law, a concerned citizen like a family member or neighbor reports a mentally ill person to the county in hopes of compelling treatment. The mental health department then conducts an investigation, and patients qualify if they're severely mentally ill and have been repeatedly arrested or hospitalized because they refuse treatment.

A judge ultimately decides whether the people qualify, and the patients can argue against the decision in court. If the patients qualify, law enforcement officers have the authority to pick up the participants for hospitalization. "There was concern that people with mental illness get help before anything bad happens, but there are a lot of complications with Laura's Law," Batongbacal said of San Francisco's decision to try an alternative approach. So far, he said, doctors at S.F. General have referred eight patients to the program, but he had statistics only for the first six. Of those, one referral was withdrawn, one patient refused treatment, and four were admitted. Those four were found to have a serious mental disorder, multiple hospitalizations and a failure to comply with treatment. While in the program - which hooks them up with a host of social services that already exist in city government - there were no more hospitalizations. One person was incarcerated, but wants to participate when released. None is homeless; it's unclear whether they were homeless when they entered the program. No further details about the patients were provided. Asked how severely mentally ill patients can make informed decisions about participating in the program, Batongbacal said, "We make sure they know what they're participating in. They're free to decide other things later down the road." Laura's Law was enacted in California in 2002 and named for Laura Wilcox, a 19-year-old college student in Grass Valley who had been shot and killed by a man with untreated schizophrenia the year before. His family had known of his violent tendencies and tried to get him into treatment, but he had refused.

Under the law, each county's Board of Supervisors must pass a resolution authorizing participation. So far, only Nevada County, the site of Wilcox's killing, has fully opted in - doing so in 2008. The county has reported hospital days were reduced 61 percent among Laura's Law patients, and jail days were reduced 97 percent. The county estimates it has saved \$1.81 for every \$1 it has spent on the program. Whether to authorize the use of Laura's Law in San Francisco has long been a point of contention among city officials. Former Mayor Gavin Newsom supported adopting Laura's Law but wasn't able to get it by the Board of Supervisors. In 2010, then-Supervisor Michela Alioto-Pier wrote legislation to authorize Laura's Law, but didn't put it up for a vote after then-Public Health Chief Mitch Katz voiced his objections.

Chief Katz argued that the law was not very effective because it doesn't allow the county to compel medication. Proponents of the law say patients usually agree to prescribed medication once they are in the program. San Francisco's voluntary pilot program doesn't need any particular authorization from the Board of Supervisors, and few City Hall insiders even know the program has been started. Barbara Garcia, the current public health chief, is supportive of the program. The program does have participation from several social service and criminal justice agencies within the city and is being overseen by San Francisco Superior Court Judge Mary Wiss.

Mayor Ed Lee said it's important for the city to give "sustained attention" to those individuals who are causing the most harm to themselves and others because of their mental illness. He said he wants to see the outcomes of the experiment before deciding whether to support the full-fledged adoption of Laura's Law. "It could be we don't adopt the whole thing," he said. "We just have to take a look at what's working."

APPENDIX G.

Acronyms

AACT Adult Assertive Community Treatment

AB 100 2011 Mental Health Services Act

AB 1421 WI&C Code for AOT or "Laura's Law"

AB 1569 Extension of Laura's Law

AB 2030 Integrated Services for Homeless Adults with a Mental Illness

ACCESS to Community Care & Effective Services and Support

ACT Assertive Community Treatment

ADA Americans with Disabilities Act

AOT Assisted Outpatient Treatment

ADS Alcohol and Drug Services

BHS Behavior Health Services

BOS Board of Supervisors

CalWORKS California Work Opportunity and Responsibilities to Kids

CALOMS California Outcomes Measurement Services

CASRA California Association of Social Rehabilitation Agencies

CDMH California Department of Mental Health

CiMH California Institute of Mental Health

CIT Crisis Intervention Team

CMHC Community Mental Health Centers

CNMHC California Network of Mental Health Clients

CPS Child Protective Services

CSS Community Services and Support MHS Component

DHA Sacramento County Department of Human Assistance

DHHS Sacramento County Department of Health & Human Services

DBHS Sacramento County Department of Behavioral Health Services

DMH State Department of Mental Health

DSM-IV Diagnosis & Statistical Manual of Mental Disorders

EBT Evidence Based Practices

FQHC Federally Qualified Health Care

FSP Full Service Partnership
HIPAA Health Insurance Portability and Accountability Act
HRC Human Resource Consultants
HUD Housing and Redevelopment Agency
IDEA Individuals with Disabilities Education Act
IMD Institute of Mental Disease
INN Innovation Component of MHSA
ISA Integrated Service Agency
LOCUS Level of Care Utilization System
LPS Lanterman-Petris-Short Act
LRE Least Restrictive Environment
LCSW Licensed Clinical Social Worker
MDT Multi-Disciplinary Team
MERT Minor Emergency Response Team
MHANC Mental Health America of Northern California
MH Mental Health
MHB Mental Health Board
MHC Mental Health Court
MHRC Mental Health Rehabilitation Centers
MHSA Mental Health Services Act
MHTC Mental Health Treatment Center
MICA Mental Ill Chemical Abusers
MIOCR Mentally Ill Offender Crime Reduction
NAMI National Alliance on Mental Illness
NIMH National Institute of Mental Health
OAC Oversight and Accountability Commission
ODR "Opening Doors to Recover"
PACT People Achieving Change Together
PEI Prevention and Intervention component of MHSA
PHF Psychiatric Health Facility
PSH Permanent Supported Housing

RCRC River City Residential Club
RH Riese Hearings
RST Regional Support Team
SAMSHA Substance Abuse and Mental Health Services
SAPT Substance Abuse Prevention and Treatment
SMHC Sacramento Mental Health Court
SSI Social Security Income
SRO Single Room Occupancy
Technology Component of MHSA
T-Con Temporary Conservatorship
TLCS Transitional Living and Community Supports
TCORE Transitional Community Opportunities for Recovery and Engagement
VOA Volunteers of America
W & R C Wellness & Recovery Centers
WET Workforce Education & Training MHSA Component
WI&C Welfare & Institution Code
WORK Widening Opportunities for Rehabilitative and Knowledge

APPENDIX H.

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APPENDIX I.

History of Mental Health Treatment and Legislation in America

1842 Doctor Dorothea Dix discovered deplorable conditions and abuses suffered by people with mental disorders housed in Massachusetts' prisons and "apartments for idiots, and lunatic or insane persons not furiously mad." Dr. Dix spent the next forty years championing for better treatment of the mentally ill.

The Community Mental Health Centers Act

By the mid-1950s, over 500,000 Americans were housed in state run institutions. The average length of stay was measured in years. For the previous 100 years the focus was custody versus treatment. In the late 1950's President Eisenhower commissioned a study of these institutions, which found evidence of social and functional deterioration following long-term care and reinforced the notion that institutions actually caused chronic disorder.

After the "deadliest nightclub fire" in US history killed 492 people and injured many more (Coconut Grove), Dr. Erich Lindemann, a Boston Psychiatrist, studied survivors and relatives. He published "Symptomatology and Management of Acute Grief" and created the first Community Mental Health Center (CMHC) in 1948.

The first CMHCs were principally devoted to consultation and education for community agencies, but offered treatment to new groups of previously untreated, acutely ill, and emotionally troubled patients. Few persons with severe and chronic diseases were treated however.

In 1955 Congress passed the Mental Health Study Act to study the problems of mental illness. The final report (1961 Action for Mental Health issued by the Joint Commission on Mental Health and Illness) main tenets: Immediate care be made available to mentally ill patients in community settings. Fully staffed, full-time mental health clinics be accessible to all people living in the US. Community based aftercare and rehabilitation services for mentally ill individuals be greatly expanded.

In 1961 John F Kennedy became president. He had personal family experience with mental illness. His sister, Rosemary had a lobotomy at age 23 and was confined to an institution until her death at age 86. President Kennedy addressed congress in 1963 outlining a bold new approach, which recommended: (1) A national mental health program to assist in the inauguration of a wholly new emphases and approach to the care of the mentally ill; (2) Focus on comprehensive community care; (3) A new type of health care facility, one which would return mental health care to the mainstream of American medicine and upgrade mental health services; (4) Authorize grants to states for the construction of comprehensive community mental health centers; (5) Authorize short term project grants for the initial staffing costs.

On October 31, 1963, The Mental Health Retardation Facilities and CMHC Construction Act was signed. This ended 109 years of federal noninvolvement in state services for the mentally ill. The CMHCs provided 5 essential services: (1) inpatient services, (2) outpatient services, (3) day treatment, (4) emergency services, and (5) consultation and education services. The premise was to ensure continuity of care between the services, be accessible to the general population and serve people regardless of their ability to pay.

Presidents Ford, Carter and Reagan Shift Responsibility for Social Services to the States

In 1975 President Gerald Ford vetoed the extension of the Community Mental Health Act. Congress overrode the veto, but passed amendments that added more requirements for the mental health centers. It did not appropriate the funds necessary to pay for the newly required services. After 1975 no new construction was attempted due to prohibitive costs, mostly because of inflation.

Most CMHCs were focused on primary and secondary prevention programs. Severely mentally ill persons, leaving state hospitals, did not receive follow-up services necessary to live in the community. Between 1955 and 1980 the population of state mental hospitals dropped from 558,000 to 140,000. Funds from the states that were supposed to follow patients from the hospital to the community did not provide sheltered housing and treatment. As a result poverty, homelessness and criminalization increased.

Community Support Systems were the NIMH's response to the unmet needs of the community mental institutions. By 1982 most states had received some sort of community support planning help for the CMHCs such as: case management, psychosocial rehabilitation, supported living, supported working and crisis care. There were also new evidence-based practices such as Assertive Community Treatment.

In 1977 a Presidential Commission, chaired by First Lady Rosalyn Carter, was created to reassess the CMHC program. The commission found persons with chronic mental illness who had been de-institutionalized, lacked the basic necessities of life, including adequate housing, clothing and food. Also half of the people released from large mental hospitals were being readmitted within a year of discharge. An effort to reinvigorate the CMHC program resulted in President Carter signing into law the National Mental Health Systems Act of 1980, one month before losing the election to Ronald Reagan.

During Reagan's "New Federalism" most of the responsibility for social programs returned to the states. The Omnibus Reconciliation Act of 1981 repealed the Mental Health Systems Act, eliminated all of the federal initiatives of the previous eighteen years, and all of the ten federal regional offices of NIMH. The Act withdrew direct federal grant support from CMHCs and replaced it with block grants from the states. It returned primary authority to states to decide how and to whom mental health services should be provided. CMHCs increased fees and reduced staffing and services. Waiting lists developed and the service quality was drastically decreased.

Medicaid and SSI

Medicaid was created in 1965 to provide health insurance for low-income parents, children, seniors, and people with disabilities. Supplemental Security Income was established in 1972 to provide welfare to those disabled due to mental illness. By the 1980s all CMHCs switched to Medicaid and away from block grant money.

In 1965 state and local psychiatric hospitals housed large numbers of persons with severe mental illness at (non-federal) public expense. The Congress made sure that the new Medicaid dollars were not supplanting this public effort with resources from state and local governments. Later, exemptions for children and the elderly were added by amendment. The exclusion for adults was upheld in a Supreme Court case. In the early 1980s, the 16-bed exemption was legislated as a response to the Court's decision. It made a moderate concession to the realities of deinstitutionalization, and restated opposition to financing warehousing in state hospitals.

Institutions for Mental Disease (IMDs) are inpatient facilities of more than 16 beds whose patient roster is more than 51% people with severe mental illness. Federal Medicaid matching payments are prohibited for IMDs with a population between the ages of 22 and 64. IMDs for persons under age 22 or over age 64 are permitted, at state option, to draw federal Medicaid matching funds.

Out of the Asylum into the Cell

CMHCs could not handle the huge number of patients who had been released after spending months or years in the large institutions. A Treatment Advocacy Briefing Paper, written in 2007, stated, "Nowhere in our society is the debacle of deinstitutionalization felt more than in our criminal justice system. America's jails and prisons are now surrogate psychiatric hospitals for thousands of individuals with the severest brain diseases. In 2008 10-16% of US inmates have serious psychiatric illnesses like schizophrenia, bipolar disorder and disabling depression."

Wyatt v. Stickney (M.D. ALA. 1971; 5TH CIR. 1974)

The precipitating factor in the Wyatt case was a cut in Alabama's cigarette tax. As a result of the budget shortfall, over 100 employees at Bryce Hospital in Tuscaloosa, Alabama lost their jobs. The Department of Psychology at Bryce spearheaded the suit for reinstatement brought by those laid off. For tactical reasons it added a patient, Ricky Wyatt, the nephew of one of the laid-off employees. Adding the patient enabled the suit to allege that patients' treatment suffered as a result of the layoffs. Federal District Judge Frank M. Johnson dismissed the part of the suit brought by the professionals, holding that the Alabama Department of Mental Health had the right to lay off employees, but consented to hear the part of the suit dealing with the patients' grievances.

Judge Johnson ruled that a patient "unquestionably has a constitutional right to receive such individual treatment as will give each of them a realistic opportunity to be cured or to improve his or her mental condition", and that the programs at the hospital "failed to conform to any known minimums established for providing treatment for the mentally ill." He ruled that the due process of the Constitution was violated: "To deprive any citizen of his or her liberty upon the altruistic theory that the confinement is for humane therapeutic reasons and then fail to deprive adequate treatment violates the very fundamentals of due process."

Wyatt was the seminal case in achieving drastic deinstitutionalization of previously committed patients. Following Judge Johnson's decision, there was similar litigation in a number of states. Rather than face costly court-imposed standards, some of them impossible to meet, states rapidly emptied their hospitals. Although in 1975, in the Donaldson Case, the Supreme Court would refuse to endorse the existence of a constitutional "right to treatment." States were not prepared to run the risk of expensive court-ordered overhauls of state mental hospitals.

Lessard v. Schmidt (E.D.WIS. 972; Vacated & Remanded 1974-421 U.S. 957, 1975; Reinstated 1976).

This legislation transformed mental health law. A federal district court in Milwaukee struck down Wisconsin's commitment law as unconstitutional. Setting aside traditional *parens-patriae* grounds for commitment, the three-judge court set a narrow dangerousness standard. Involuntary commitment was only permissible when "there is an extreme likelihood that if the person is not confined he will do immediate harm to himself or others." Moreover, the court for the first time required that commitment proceedings provide the mentally ill with all the protections accorded the criminal suspect—among them a right to counsel, a right to remain silent, exclusion of hearsay evidence and a standard of proof beyond a reasonable doubt.

In their decision, the judges acknowledge, but dismiss, the traditional argument that due process safeguards in commitment hearings can be less stringent than in criminal cases. The state is acting in a role of *parens-patriae*, with the aim of treating rather than punishing the individual. On the contrary, the judges maintain, "the interests in avoiding civil commitment are at least as high as those of persons accused of criminal offenses." They declare that the civil deprivations, faced by the mental patient, are more serious than those confronting the felon. The stigma is worse, and the mortality rates in mental hospitals are higher.

The decision was appealed, and was twice vacated and remanded by the U.S. Supreme Court. In each case the District Court substantially reinstated its earlier decision.

Lessard turned out to be the high water mark for involuntary commitment law. Most states stopped short of implementing all the restrictions demanded by the Lessard court. Few states would follow Wisconsin in according patients the "right to remain silent," or in imposing a "beyond a reasonable doubt" standard for commitment.

The psychiatric interview was regarded as too important a piece of evidence. The decision veered between assuming mental illness was untreatable to arguing that commitment for treatment seriously damaged the individual, and in most cases he was better off foregoing treatment than being hospitalized for it.

O'Connor v. Donaldson, 422 U.S. 563 (1975)

This decision has been used by opponents of involuntary commitment to argue that it is unconstitutional to commit an individual involuntarily who is not imminently dangerous to himself or others.

A key paragraph in the decision reads: "A finding of mental illness alone cannot justify a State's locking a person up against his will and keeping him indefinitely in simple custodial confinement. In short a state cannot constitutionally confine without more a non-dangerous individual who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends."

The mental health bar, spearheaded by the ACLU, has interpreted this decision to mean that it is unconstitutional to commit for treatment an individual who is not imminently dangerous. It has maintained the individual must be considered "capable of surviving safely in freedom" if his life is not in immediate danger. This interpretation has been important in hampering efforts to implement changes in civil commitment law.

The Supreme Court ruled that an individual, who is "capable of surviving safely in freedom" by himself or with the help of others, could not be confined. Donaldson was fully capable of living independently, had people who were willing to support him, if necessary, and posed no danger to himself or others.

According to the Treatment Advocacy Center: "When it ruled by 'surviving safely in freedom', the Supreme Court did not have in mind rummaging in garbage cans for food or lying in the street in one's own waste. Nowhere in this decision did it say that the individual must be permitted to deteriorate to the point he is dangerous."

Tarasoff v Regents of the Univ. of California

The Supreme Court of California held that mental health professionals have a duty to protect individuals who are being threatened with bodily harm by a patient. The original 1974 decision mandated warning the threatened individual, but a 1976 rehearing of the case by the California Supreme Court called for a "duty to protect" the intended victim. The professional may discharge the duty in several ways, including notifying police, warning the intended victim, and/or taking other reasonable steps to protect the threatened individual.

Rennie v. Klein (DNJ 1978; On Remand, 720 F 2d 266-3D Cir. 1983)

This case, the first to establish an involuntary committed patient's right to refuse medication, was brought in December 1977 by 38-year-old John Rennie, a patient at Ancora State Hospital in New Jersey. His first hospitalization occurred in 1973; in the following years he became a revolving-door patient, with one of the reasons, trial judge Stanley Brotman noted, "his failure to continue taking medications after he has left the hospital's custody."

Federal District Judge Brotman dismissed the argument of Rennie's counsel that forced medication violated the first amendment by interfering with his mental process, and the Eighth Amendment constituting cruel and unusual punishment. However, he ruled that the right to refuse treatment can be based on "an emerging right of privacy" broad enough to include the "right to protect one's mental processes from government interference." Judge Brotman asserted that the uncertainty of a psychiatric diagnoses gave weight toward "leaving the final decision with the patient rather than deferring to doctors." "Whether the potential benefits are worth the risks is a uniquely personal decision which, in the absence of a strong state interest, should be free from state coercion."

Nevertheless, said Judge Brotman, the right to refuse was not absolute. Other patients in the hospital had a right to protection from harm from an assaultive patient like Rennie. The states' *parens patriae* powers also come into play, but only to the extent a fact finder determined that the patient's refusal was based on the underlying interest. The more the patient lacked insight the greater the impetus to override his right to autonomy.

In his decision, Judge Brotman stipulated that a refusing patient was entitled to a due process hearing, conducted by an independent psychiatrist. Judge Brotman also asserted the principle of the least restrictive alternative should be extended to medication; and that hearing officers should insist that the least restrictive medications should be tried prior to more intrusive medications.

Prior to be given medication, patients would have to sign consent forms that explained their side effects. Hospitals had to employ patient advocates who would act as 'informal counsel' to patients wishing to refuse treatment in hearings before independent psychiatrists. Judge Brotman established a category of "functionally incompetent" patients—patients who were not legally incompetent but could be certified by their physician as "unable to provide knowledgeable consent to treatment."

Rennie v. Klein established that an involuntarily committed, legally competent patient who refused medication had a right to professional medical review of the treating psychiatrist's decision. In contrast to the Roger's case, which provided for judicial review, Rennie left the decision-making process to medical professionals. According to the Treatment Advocacy Center, "Unfortunately, despite the Supreme Court's backing for the professional judgment standard, it is not the Rennie, but the Roger's model, which shifts psychiatric decision-making from the medical to the legal profession, that has become prevalent."

Judge Brotman's decision did establish a category of "functionally incompetent" patients. These were patients not found to be incompetent by the courts but whom the psychiatrist determined were unable to make their own treatment decisions because of lack of insight into their illness. This is precisely the situation of a great many psychiatric patients today.

Guardianship of Richard Roe III (421 N.E. Rep. 2D 40)

Massachusetts' highest court, the Supreme Judicial Court, ruled that what happens when a mentally ill individual, who is incompetent to make his own treatment decisions, refuses treatment, only a court can decide if he is to be treated. Further, it must do so on the basis of substituted judgment, i.e. what the individual would choose, given what is known of his values and preferences, if he were competent.

The Court found the evidence that Richard Roe was incompetent "more than adequate" and said Richard's judgment was so severely impaired there was a strong likelihood he would inflict serious injury on himself or others. The judges concluded he needed a guardian and his father was the appropriate choice. However his father could not make treatment decisions. The Court ruled that only a judge could conduct the "detached but passionate investigation" necessary to decide if Richard should take medication.

The Court's opinion was highly critical of anti-psychotic drugs, describing them as extraordinary medical treatment, "powerful enough to immobilize mind and body." It said "the impact of the chemicals upon the brain is sufficient to undermine the foundations of personality." The opinion also dwelt at length upon side effects: "Although the intended effects of antipsychotic drugs are extreme, their unintended effects are frequently devastating and often irreversible."

The case assumed broader significance. This was because, after the Massachusetts Supreme Judicial Court issued its opinion, the U.S. Supreme Court remanded the long running, multi-million dollar, federal Rogers case, which involved the right to refuse treatment of civilly committed hospitalized patients. What started out as a minor case – could Richard Roe’s guardian decide on his treatment – became the basis for requiring that, except in emergency situations, judicial hearings must be held before a non-consenting hospitalized mental patient can be treated, with the decision to be made on the basis of “substituted judgment.”

Rogers v. Okin (478 f.Supp.1342-D.Mass.1979, 634 F.2D 650-1st Cir. 1980);(Mills v. Rogers 457 U.S. 291-1982).

At the trial level Judge Touro ruled under Massachusetts law, committed mental patients were presumed to be competent to manage their own affairs. The judge stated, “Such rights pale in comparison to the intimate decision as to whether to accept or refuse psychotropic medication.” He asserted that in a non-emergency “it is an unreasonable invasion of privacy, and an affront to basic concepts of human dignity to permit the forced injection of mind altering drugs...” Although the state had a duty to make treatment available to mental patients, it had no duty to impose it on “the competent involuntary patient who prefers to refuse medication, regardless of its potential benefit.”

In his opinion Judge Touro took note of the defendant psychiatrist’s argument. It was the state’s *parens patriae* obligation to provide treatment for patients who had been committed for the purpose of treatment, even in the face of their opposition to it. He dismissed the argument on the grounds that “the State’s interest in protecting the safety of the general public is the justification for commitment of mental patients.” Involuntary treatment, Judge Touro ruled, “is not necessary to protect the general public, since the patient has already been quarantined by commitment.” The committed mental patient, said Judge Touro, had the right to make treatment decisions until he was adjudicated incompetent by a judge. At this point, he noted, the *parens patriae* right of the state could be exercised and a guardian appointed by the court to make decisions, including treatment decisions, for the patient.

The Supreme Court granted certiorari but then remanded the case back to the court of appeals in the light of Roe. That decision required that a court, not a guardian, as in judge Touro’s decision, should decide whether an incompetent patient should be treated, based on “substituted judgment. Moreover, the substituted judgment decision required a full evidentiary hearing, with counsel for both sides, independent examiners and expert witnesses, if requested.

Civil Rights of Institutionalized Persons Act (CRIPA)

CRIPA was passed in 1980 to protect the rights of people in state and locally run nursing homes, mental health facilities, institutions for people with intellectual and developmental disabilities, and correctional facilities for youth and adults.

The Special Litigation Section in the U.S. Department of Justice’s Civil Rights Division is responsible for investigating and enforcing CRIPA.

In August of 1996, pursuant to the Civil Rights of Institutionalized Persons Act, 42 U.S.C. § 1997 et seq., the United States Department of Justice (DOJ) toured the Los Angeles County Jail with experts in the field of correctional mental health services. On September 5, 1997, DOJ issued a letter reporting its findings based on the tour of its experts, the County’s response to the tour, and the additional information received. DOJ concluded that mental health care at the Jail violated the inmates’ constitutional rights.

In its findings letter, DOJ detailed numerous alleged constitutional deficiencies with regard to mental health care, including inadequate (1) intake screening and evaluation, (2) diagnosis, (3) referral to mental health professionals, (4) treatment plans, (5) administration of medications, (6) suicide prevention, (7) tracking and medical record keeping, (8) staffing, (9) communication, and (10) quality assurance. The report also noted that the County had allegedly mistreated and abused mentally ill inmates, including using excessive force and improper restraint practices.

In 1990, Congress enacted the Americans with Disabilities Act “to provide a clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities.” In passing this groundbreaking law, Congress recognized that “historically, society has tended to isolate and segregate individuals with disabilities, and, despite some improvements, such forms of discrimination against individuals with disabilities continue to be a serious and pervasive social problem.” For those reasons, Congress prohibited discrimination against individuals with disabilities by public entities: “No qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity.”

As directed by Congress, the Attorney General issued regulations implementing Title II, which are based on regulations issued under section 504 of the Rehabilitation Act. The Title II regulations require public entities to “administer services,

programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities.” The preamble discussion of the integration regulation explains that “the most integrated setting” is one that “enables individuals with disabilities to interact with nondisabled persons to the fullest extent possible.” (See Olmstead v. LC.)
1985 The Bronzan-Mojonnier Act

This enacted significant provisions relating to: (1) identifying the shortage of services, which resulted in the criminalization of the mentally disordered, (2) community support for homeless mentally disordered persons, (3) vocational services, and (4) seriously emotionally disturbed children.

The Wright-McCorquodale-Bronzan Mental Health Act

The act funded pilot projects that combine treatment and rehabilitation and provides integrated, flexible and 24/7 services.

Riese v. St. Mary’s Hospital & Medical Center (259 Cal Rptr. 669, 774 P.2D 698, 1969)

In 1987 the California State Court of Appeals overruled the traditional interpretation of California’s Lanterman-Petris-Short Act of 1968. It had been assumed that the Act permitted involuntary treatment for those detained under an initial three-day hold, for evaluation and treatment, and subsequent 14-day hospitalization. The Court of Appeals found that these patients had the right to exercise informed consent to the use of antipsychotic drugs. Should they reject medication, “a judicial determination of their incapacity to make treatment decisions” was necessary before they could be involuntarily treated.

The trial court upheld the traditional interpretation of LPS and ruled that there was no right to refuse medication. But the Court of Appeals reversed its decision. It was appealed to the California Supreme Court, which refused to hear it, allowing the Court of Appeals decision to stand.

The Court of Appeals dismissed the argument of the defendant hospital – that just because LPS did not explicitly grant a right to refuse antipsychotic medication, such a right did not exist. The judges zeroed in on the issue of presumed competence of mental patients. Mental patients were presumed competent unless found incompetent by a court. In their decision they quoted a section of the LPS Act: “No person may be presumed to be incompetent because he or she has been evaluated or treated for mental disorder...regardless of whether such evaluation or treatment was voluntarily or involuntarily received.” Moreover, said the court, since treatment with antipsychotic drugs “has profound effects on mind and body,” the right to refuse treatment with these drugs “clearly falls within the recognized right to refuse medical treatment.” That right had been established in California in 1972, four years after the passage of the LPS Act. In *Cobbs v. Grant*, the California Supreme Court declared the right to informed consent to medical treatment was a constitutional right, which could only be denied if the patient was incompetent. In that case the patient’s “authority to consent is transferred to a guardian or the closest available relative.”

In passing the then revolutionary LPS Act in 1968, the legislature had attempted to strike a balance. The commitment period would be brief, no more than seventeen days except in highly circumscribed special circumstances. Psychiatrists would be allowed to treat the patient in that time span. Indeed, LPS specified that a person detained for evaluation and treatment “shall receive whatever treatment and care as his or her condition requires for the full period that he or she is held.” (See the LPS Act elsewhere in this report).

According to the Treatment Advocacy Center, “In practice, grafting the right to refuse on the LPS time limit has meant that it becomes very difficult to treat refusing patients at all. It generally takes five days to get a Riese hearing so that almost a third of the time is wasted right there. California psychiatrist Barbara Silver describes a series of results of the Riese decision similar to what has occurred in other states where there is a right to refuse treatment. There is increased use of seclusion and restraints, warehousing of patients, inappropriate release of patients to avoid the cumbersome and time-consuming hearings, injury to other patients and staff plus patient deterioration.”

1995 Coleman v. Wilson

Thousands of people with mental illness are currently serving terms in California state prisons. These individuals receive inadequate medical and psychiatric care, serve longer terms than the average inmate, and are released without adequate preparation and support for their return to society. As a result, mentally ill offenders are more likely than general-population offenders to violate parole and return to prison. The poor treatment of California’s mentally ill prisoners burdens the judicial system, drains the state’s budget, and causes needless inmate suffering.

California treats more of the mentally ill inside prison than out. Prisons and jails treat more people with mental illness than hospitals and residential treatment centers combined. Ten-and-a-half percent of California state prisoners—

approximately 17,000—are treated with psychotropic medications, while 12.5% receive in-custody therapy from a trained professional on a regular basis. Mentally ill prisoners find themselves in a vicious circle. Mental illness leads to discipline/victimization problems, solitary confinement, and to decompensation. This worsens mental illness, resulting in further discipline/victimization and further segregation. Mentally ill prisoners get sicker, stay longer, suffer more, and wind up back in prison soon after their release.

These failures have long been apparent. In 1995, the federal district court in *Coleman v. Wilson* held the treatment of the mentally ill in the California corrections' system so inadequate that it violated the Eighth Amendment's prohibition on cruel and unusual punishment. The *Coleman* court found that the following deficiencies violated the Eighth Amendment of the U.S. Constitution: (1) the lack of any screening mechanism for mental illness; (2) inadequate mental health staffing levels; (3) the lack of quality assurance mechanisms for evaluating mental health staff; (4) delays and denials of medical attention; (5) inappropriate use of punitive measures; and (6) an "extremely deficient" records system. Judge Thelton Henderson of the Northern District of California placed the entire prison health care system into receivership in October 2005. He described the system as "broken beyond repair" and stated that the California Department of Corrections and Rehabilitation (CDCR) was "incapable of successfully implementing systemic change."

California's mental health screening process, developed in response to the *Coleman* lawsuit, is inadequate, notwithstanding court orders to improve it. The current screen is designed to give mentally ill prisoners a "red flag" during intake interviews; a more detailed psychiatric screening no more than seventy-two hours later; and a full psychiatric evaluation within eighteen days. In 2005, however, the Plata court found that "the reception center intake process fails to adequately identify and treat the health care problems of new prisoners." An adequate screen should take at least fifteen minutes to administer. However, prisoners' exams in CDCR reception centers typically last no more than seven minutes. Inmates are often screened in groups without regard to confidentiality so that the examinations are therefore unlikely to be accurate. Screens should also incorporate objective factors as well as self-reporting, since inmates with acute mental illness are often unable to communicate their symptoms and/or diagnoses. Screens must also account for co-occurring disorders—that is, mental illness as well as substance abuse. Co-occurring disorders present particular problems in penal mental health screening because symptoms of mental illness can be masked by or misdiagnosed as the result of drug or alcohol abuse. Screening for drug abuse alongside mental illness is crucial in the penal context; however, a state study estimated that chemical reactions in the brain cause seventy percent of California prisoners' major mental disorders, the primary cause of which is use of mind-altering drugs.

Zinermon v. Burch (494 U.S. 113 (1990))

In 1981 Darrell Burch was admitted to a Florida State Mental hospital and stayed for five months. Shortly after his release, Burch filed a complaint, stating that he had been inappropriately committed, and did not remember signing any admission or treatment forms. In February, 1985, Burch filed a Section 1983 lawsuit in federal district court arguing that his constitutional rights had been violated when he was treated as a voluntary patient. Because of evidence that his mental condition made him incapable of giving voluntary consent, he was entitled to the procedural safeguards of the involuntary placement procedure.

A divided Supreme Court (5-4) ruled that Burch was entitled to bring the suit. Writing for the majority, Judge Blackmun noted that Florida's law explicitly requires the patient to give "express and informed consent, and that the very nature of mental illness makes it foreseeable that a person needing mental health care will be unable to understand any proffered explanation and disclosure of the subject matter of the forms that person is asked to sign. He will be unable to make a knowing and willful decision whether to consent to admission." Yet, wrote Judge Blackmun, Florida statutes "do not direct any member of the facility staff to determine whether a patient is competent to give consent..."

The Court suggested that regardless of whether or not a state had a law with language similar to that in Florida, the admitting facility might need to examine the patient's competence to consent.

According to the Treatment Advocacy Center, the Court's opinion for the majority undercuts the voluntary treatment system, which has increasingly characterized care for the mentally ill. "In the early 1960s the vast majority of patients were hospitalized involuntarily. Today, as a result of what have generally been viewed as desirable reforms, 73% of the 1.6 million annual admissions are voluntary, yet little research has been done on the capacities of these patients to make their own treatment decisions. That would mean 800,000 patients who would have to go through, in the words of the Supreme Court decision, the 'established procedure for involuntary placement,' overwhelming that system. Moreover, many current voluntary patients might not be eligible for involuntary commitment, failing to meet the dangerousness standard."

Concerned about the potential impact of the decision, the American Psychiatric Association established a task force to come up with a policy for complying with the *Zinermon* decision, without disrupting the present largely voluntary system of care. Its conclusions were approved by the APA's Board of Trustees in 1992. The task force recommended a brief in-

hospital clinical assessment of capacity, based on easy-to-meet substantive standards. The patient need only understand that he was being admitted to a psychiatric hospital.

Again the Treatment Advocacy Center notes: "What the Zinermon decision demonstrates is the need to end the dichotomy between the standard for voluntary and involuntary treatment. Currently, in many states, voluntary patients can be treated because they need treatment, involuntary patients only because they are dangerous. The suit really points up the absurdity of the law in failing to provide a common need for treatment standard applicable to the mentally ill regardless of their mode of hospital admission."

1991 California Realignment

In 1991, the state faced a multibillion-dollar budget problem. Initially, responding to Governor Wilson's proposal to transfer authority over some mental health and health programs to counties, the Legislature considered a number of options to simultaneously reduce the state's budget shortfall and improve the workings of state-county programs. Ultimately, the Legislature developed a package of realignment legislation that: (1) Transferred several programs from the state to the counties, most significantly certain health and mental health programs; (2) Changed the way state and county costs are shared for social services and health programs; (3) Increased the sales tax and vehicle license fee (VLF) and dedicated these increased revenues for the increased financial obligations of counties.

In order to fund the more than \$2 billion in program transfers and shifts in cost-sharing ratios, the Legislature enacted two tax increases in 1991, with the increased revenues deposited into a state Local Revenue Fund and dedicated to funding the realigned programs. Each county created three program accounts, one each for mental health, social services, and health. Through a complicated series of accounts and subaccounts at the state level, counties receive deposits into their three accounts for spending on programs in the respective policy areas.

Before the enactment of realignment, state funding for local mental health services was subject to annual legislative appropriation, which could vary significantly from year to year depending upon the state's financial condition. 90 percent of so-called Short-Doyle grant funding for mental health programs generally came from the state, with the remaining 10 percent funded by the counties. Local mental health services were particularly vulnerable to reductions when the state was faced with financial shortfalls. In 1990-91, for example, state expenditures for community mental health programs declined by about \$54 million or 8.6 percent below the prior year's spending level. At the time that realignment legislation was considered, mental health program experts had voiced concern that the uncertainty created by the annual state appropriations process was harmful to the development of sound community programs. The significant year-to-year swings in funding levels and uncertainty in the state budget process were also said to have discouraged county government officials from making the multiyear commitments needed to develop innovative programs. Before a pioneering new program could be staffed, made operational, and fully developed over several years, a county mental health department was at risk of having to scale back the commitment of funding and personnel for such efforts. The intent of realignment was to provide mental health programs stable and reliable funding through a dedicated revenue source in order to foster better planning and innovation.

Mentally Ill Offender Crime Reduction Grant Programs.

In 1998, the California Legislature authorized the Mentally Ill Offender Crime Reduction Grant (MIOCRG) program to fund innovative local programs targeting mentally ill offenders. MIOCRG currently provides 80 million dollars to thirty projects in twenty-six of California's fifty-eight counties. To set the program's priorities, county service providers and law enforcement officials were asked what their needs were in dealing with mentally ill offenders; their responses included (1) better prison discharge planning, (2) more housing options, (3) increased treatment capacity, and (4) interagency coordination. The MIOCRG programs are funded with these priorities in mind. Though the funding is disbursed at the state level, all MIOCRG programs are administered at the county level. This allows counties to tailor programs to their needs without engendering resource differentials between counties. Because mental health services are provided through counties, local administration allows community stakeholders a greater opportunity to coordinate care. Two-thirds of county programs draw on the Assertive Community Treatment model, employing a multidisciplinary group of providers that service clients as a team, with availability around the clock. A study aggregating data from the programs showed positive results. Participants scored higher on the improved Global Assessment of Functioning (GAF) and lowered rates of criminal bookings, convictions, drug and alcohol usage, and homelessness. The strategies common to the most successful programs were interagency collaboration, intensive case management, assistance in securing housing and government benefits, use of a center or clinic, assistance with transportation, and peer support for participants.

AB 1800

Written by Assemblywoman Helen Thompson & modeled after Kendra's Law, this was the first viable attempt to update LPS in California. The bill's major points were:

(1) Broadened the definition of "gravely disabled" for the purpose of involuntary detention and conservatorship to include a person who "presents, as a result of mental disorder, an acute risk of physical or psychiatric harm to the person in the absence of treatment." It also applied this expanded definition to the procedures for the involuntary administration of psychotropic medication to prisoners; (2) It placed new conditions on family members or other third parties whose assistance might prevent an individual from being determined "gravely disabled," by requiring such third parties to show they are "willing and able to assist the person in meeting his or her medical and psychiatric needs," in addition to helping provide for the person's needs for food, clothing or shelter; (3) It doubled the length of involuntary certifications (detentions), following an initial 72-hour hold, from 14 to 28 days; (4) It replaced the existing probable cause standard required for involuntary detentions, which currently requires a finding that a person is a danger to himself or herself, or to others, or is "gravely disabled," with a less restrictive "there is probable cause to believe the person certified should be involuntarily detained" standard; (5) It provided that, if a person certified for treatment refuses treatment with psychotropic medication, the certification review hearing officer shall, in addition to making the decision regarding the underlying detention, determine in the same hearing whether the person lacks the capacity to make an informed refusal of the treatment; (6) It eliminated the requirement that capacity hearings be conducted solely by a judge or court-appointed commissioners, referees, or hearing officers. Instead, the bill allowed such hearings, including the new combined detention and capacity hearings described above, to be conducted by lawyers and law students, as well as a variety of lay hearing officers, including medical doctors, licensed psychologists, registered nurses, licensed clinical social workers, and licensed marriage, family and child counselors; (7) It provided that a person subject to the expanded 28-day certification who is also determined to lack the capacity to make an informed refusal of psychotropic medication at the combined hearing may obtain a *de-novo* review of both decisions in court via a writ of habeas corpus. Current law provides for separate *de-novo* review of the detention and capacity determinations; (8) It required that a facility providing treatment to an individual subject to the expanded 28-day certification must obtain his or her medication history. Current law does not contain this requirement; (9) It doubled the length of post-certification commitments for persons who are dangerous to others from 180 days to one year; (10) It sought to assist at-risk persons by providing that individuals subject to 72-hour holds, 28-day certifications, and additional involuntary certifications, must be placed in "community assisted outpatient treatment programs" for 180 days if several conditions exist; (11) It provided that, in the event the patient does not or cannot abide by the terms of the agreed upon community treatment plan, and the person poses an acute risk of physical or psychiatric deterioration, the person may, by court order, be returned to inpatient treatment for the remaining days of the underlying involuntary treatment certification, (12) It permitted, but did not require, a county to offer a community-assisted outpatient treatment program to persons in the community who are diagnosed with a severe and persistent mental illness; (13) It required the Department of Mental Health (DMH) to provide training and technical assistance to counties and their mental health contract providers, and others involved in making involuntary commitment and treatment decisions. It also requires the department to collect certain data and report to the Legislature, on or before April 1, 2002, on the effectiveness of this legislation.

Olmstead v. L.C., 527 U.S. 581 (1999)

In the Olmstead decision the Supreme Court held that Title II prohibits the unjustified segregation of individuals with disabilities. The Supreme Court held that public entities are required to provide community-based services to persons with disabilities when (a) such services are appropriate; (b) the affected persons do not oppose community-based treatment; and (c) community-based services can be reasonably accommodated, taking into account the resources available to the entity and the needs of others who are receiving disability services from the entity. The Supreme Court explained that this holding "reflects two evident judgments." First, "institutional placement of persons who can handle and benefit from community settings perpetuates unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life." Second, "confinement in an institution severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment."

To comply with the ADA's integration mandate, public entities must reasonably modify their policies, procedures or practices when necessary to avoid discrimination. The obligation to make reasonable modifications may be excused only where the public entity demonstrates that the requested modifications would "fundamentally alter" its service system.

An Olmstead Plan is a public entity's plan for implementing its obligation to provide individuals with disabilities opportunities to live, work, and be served in integrated settings. A comprehensive, effectively working plan must do more than provide vague assurances of future integrated options or describe the entity's general history of increased funding for community services and decreased institutional populations. Instead, it must reflect an analysis of the extent to which the public entity is providing services in the most integrated setting and must contain concrete and

reliable commitments to expand integrated opportunities. The plan must have specific and reasonable time frames and measurable goals for which the public entity may be held accountable, and there must be funding to support the plan, which may come from reallocating existing service dollars. The plan should include commitments for each group of persons who are unnecessarily segregated, such as individuals residing in facilities for individuals with developmental disabilities, psychiatric hospitals, nursing homes and board and care homes, or individuals spending their days in sheltered workshops or segregated day programs. To be effective, the plan must have demonstrated success in actually moving individuals to integrated settings in accordance with the plan. A public entity cannot rely on its Olmstead Plan as part of its defense unless it can prove that its plan comprehensively and effectively addresses the needless segregation of the group at issue in the case. Any plan should be evaluated in light of the length of time that has passed since the Supreme Court's decision in Olmstead, including a fact-specific inquiry into what the public entity could have accomplished in the past and what it could accomplish in the future.

Mental Health Parity Law

In 1999, California passed a mental health parity law (AB 88) requiring private health insurance plans to provide equal coverage for physical health and selected mental health conditions, including serious mental illnesses (SMI) in adults and serious emotional disturbances (SED) in children. The law requires health plans to eliminate the benefit limits and reduce the cost-sharing requirements that have traditionally made mental health benefits less comprehensive than physical health benefits.

AB 2034

In 1999 the State Legislature passed Assembly Bill, AB 34, which provided \$10 million for pilot programs to provide services for homeless individuals in Stanislaus, Los Angeles, and Sacramento counties. Future funding for similar programs was dependent on the success of the three pilot programs as measured by positive client and system outcomes including cost effectiveness within that first year. The pilot programs were very successful in reducing the number of homeless days, jail days, and psychiatric hospital days experienced by enrollees. As a result of this success the legislature passed AB 2034, which expanded the pilot programs and created additional programs statewide directed at serving homeless persons, parolees, and probationers with serious mental illness. At the height of the program, AB 2034 funds were serving over 4,500 mentally ill homeless or incarcerated individuals (AB34.org) through 53 programs operating in 34 counties throughout California.

AB 2034 funds allowed localities to provide comprehensive services "to adults who have serious mental illness and who are homeless, at risk of becoming homeless, recently released from a county jail or state prison, or others who are untreated, unstable, and at significant risk of incarceration or homelessness unless treatment is provided to them." (Leg. Report 2). Due to the flexibility of funding provided under AB 2034, counties were able "to provide a comprehensive array of services including outreach, supportive housing and other housing assistance, employment, substance abuse, and mental and physical healthcare" to enrollees.

The AB 2034 programs were very effective at serving a variety of consumer needs. The success of these programs can be seen by comparing pre-enrollment information to post-enrollment information (data current as of January 31, 2003). There was marked improvement in several categories including hospitalizations, incarcerations, levels of homelessness, income, and employment. For example:

- Number of consumers hospitalized decreased 42.3%
- Number of hospital admissions decreased 28.4%
- Number of hospital days decreased 55.8%
- Number of consumers incarcerated decreased 58.3%
- Number of incarcerations decreased 45.9%
- Number of incarceration days decreased 72.1%
- The number of SSI recipients increased by 93.1%
- The number of people receiving wages from employment increased by 279.8%
- There was a 73.5% reduction in the number of consumers who were homeless
- The number of consumers who became homeless since enrollment compared to the number of consumers who were homeless prior to enrollment decreased 71.3%
- The overall number of homeless days experienced by consumers decreased by 67.3%
- There was a 19.6% increase in the number of consumers who were employed full time with a 65.4% increase in the number of days of employment
- There was a 14.4% increase in the number of consumers who were employed part-time, with a 53.1% increase in the number of days of employment
- As of January 31, 2003, 13.3% of all consumers enrolled in the program were employed

2000 Plata vs Schwarzenegger

The Court found that the California Department of Corrections and Rehabilitation (CDCR) "lacks an adequate system to manage and supervise medical care." There is "a culture of non-accountability and non-professionalism" in the Health Care Services Division (HCSD); in September 2004, the HCSD was ordered to implement quality management of physicians but "failed to come close" to doing so. Also, corrections officers currently play too large a role in determining treatment for mentally ill prisoners, making medical decisions based primarily on security considerations. According to Dr. Michael Friedman, director of medical care at Soledad Prison, "the system, in my view, is totally corrupted" because "nonmedical staff are making medical decisions, because everything is about security, not how we look after the inmates." Because corrections officers have daily contact with inmates, they could provide timely referrals for mental health treatment; however, COs fear that prisoners are just faking their symptoms ("malingering") means that referrals often are not made until prisoners are grossly psychotic.

US v. State of California (State Hospitals)

On May 13, 2003, the U.S. Department of Justice's Civil Rights Division (DOJ) sent its findings letter to California's governor, advising him of the results of one component of the June and July 2002, DOJ investigation of conditions and practices at the Metropolitan State Hospital (MSH), a state facility housing children, adolescents, and adults who suffered from mental illness. The letter set out the DOJ's findings concerning MSH's child and adolescent residents. Findings regarding the adult patient component of MSH had not been completed. The investigation occurred under the authority of the Civil Rights of Institutionalized Persons Act (CRIPA), 42 U.S.C. § 1997. According to the letter, DOJ and expert consultants visited the facility, reviewed a wide array of documents there, and conducted interviews with personnel and residents. The letter commended MSH staff for providing a high level of cooperation during the investigation, as well as the dedication many showed for patient well-being. Nevertheless, the investigation found "significant and wide-ranging" deficiencies in child and adolescent patient care at MSH.

DOJ concluded that these deficiencies at MSH existed in a dozen topic areas, including (1) psychiatry; (2) nursing services; (3) psychology; (4) pharmaceutical services; (4) general medical care, including deficiencies in vision services, x-ray reviews, and incontinence and headache evaluation; (5) infection control; (6) dental care; (7) dietary services; (8) placement in the most integrated setting; (9) special education; (10) protection from harm; and (11) First Amendment and due process rights to confidentially communicate with investigators. The letter provided details of deficiencies for all twelve of these categories.

Another findings letter from the DOJ addressed deficiencies found at the Napa State Hospital (NSH), another California mental health facility. The DOJ letters eventually resulted in cooperative resolution of these hospitals' many problems, at least on paper. California's officials and the DOJ reached agreement that became the basis of a consent judgment filed contemporaneously with a CRIPA complaint against the state. Via DOJ Civil Rights Division lawyers, the United States, on May 2, 2006, filed in the U.S. District Court for the Central District of California a CRIPA lawsuit against California and state officials responsible for operation of MSH and NSH. The case sought declaratory and injunctive relief to end the substantial departures from generally accepted professional standards of care at each hospital in the multiple aspects mentioned in the findings letters.

Proposition 63, Mental Health Services Act (MHSA)

A 2004 new law, was written by then Assemblyman Darrell Steinberg, who later became a State Senator, and mental health lobbyist Sherman "Rusty" Selix. The new tax is to affect the wealthiest 0.1 percent of California's taxpayers, which amounts to approximately 30,000 taxpayers. The result is approximately a 31 percent increase to the previous to Proposition 63's annual mental health budget of \$2.6 billion. These funds are to be used to transform the State's public mental health system, expand it, and revolutionize the existing system with a focus on promoting recovery-oriented programs.

The Mental Health Services Act (MHSA) was projected to generate approximately \$254 million in the 2004-2005 fiscal year, \$683 million in 2005-06 fiscal year, and then increasing amounts subsequently. Much of the funding provides county mental health programs funds for programs consistent with their local plans. The purpose and intent of the Proposition was to address serious mental illness among children, adults, and seniors involving prevention and early intervention services and supportive medical care; to reduce the adverse impact from untreated serious mental illness from individuals, families, and state and local budgets; to expand innovative and successful service delivery programs for children, adults, and seniors, including culturally and linguistically competent approaches for underserved populations; to provide the state and local governments with funds adequate to meet to meet the needs of all children and adults; and to ensure that all funds are spent in the most cost effective manner and services are provided following best recommended practices, with local and state oversight to ensure accountability.

The 5 Components of the MHSA are:

(1) Community Services and Supports (CSS)—provides funds for direct services to individuals with severe mental illness. (2) Capital Facilities and Technological Needs (CFTN)—provides funding for building projects and increasing technological capacity to improve mental illness service delivery. (3) Workforce, Education and Training (WET)—provides funding to improve the capacity of the mental health workforce. (4) Prevention and Early Intervention (PEI)—provides investment of 20% of the MHSA funding for outreach programs for families, providers, and others to recognize early signs of mental illness. The overall goal is to improve early access to services and programs, to reduce stigma, and discrimination experienced by individuals with mental illness. MHSA Prevention and Early Intervention Programs serve Californians of all ages. (5) Innovation (INN)—funds and evaluates new approaches increasing access to the underserved and unserved communities, promote interagency collaboration, and increase the overall quality of mental health services.

2011 AB 109 Prisoner Realignment

The AB 109 legislation reassigns three groups of offenders, previously handled through the State Prison and Parole System, to the counties. The first group includes convicted offenders receiving sentences for new non-violent, non-serious, non-sex offender (N3) crimes that will be served locally, one year or more. Offenders in this category will have no prior violent or serious convictions. The second group involves post-release offenders, up to three years, coming under Probation Department supervision for “N3” crimes released from State Prison. Offenders in this category may have had prior convictions for violent or serious crimes. The third group includes state parole violators who are revoked to custody. With the exception of offenders sentenced to life with parole, this group will be revoked to local County Jail instead of State Prison.

In the initial 2011 Public Safety Realignment Plan, developed and approved by the Sacramento County Community Corrections Partnership (CCP), limited funding was provided for mental health or alcohol / other drug service needs of this new jail inmate and offender populations. There was an analysis of the number of inmates and type of mental health services currently being provided to AB 109 custody inmates detained in the Sacramento County jail system, Main Jail and RCCC, between October 1, 2011 and March 31, 2012. It indicated that during the first six months of the Realignment implementation period, the Sheriff’s Department had processed 989 AB 109 inmates. A total of 407 (41.2%) received mental health services, crisis counseling, clinical and case management services, and medication support. Nearly 294 or 72.2% of the inmates received outpatient mental health services while 66 (16.2%) were housed in the Main Jail’s Psychiatric In-patient Unit. Another 47 inmates were assessed by psychiatric clinical staff, but refused or did not need services. Among the 407 inmates receiving jail mental health services, a total of 251 or 61.7% were prescribed psychotropic medications that are monitored and overseen by Jail Psychiatric Services clinicians.

The budget for the development and implementation of programming to address the substance abuse and mental health needs of the County Jail Prison (N3), Parole, and Flash Incarceration offenders incarcerated in the Main Jail and RCCC, for FY 2012 – 13, is \$1,475,361. The cost for AOD service needs and mental health needs, including psychotropic medications for the PRCS populations, is estimated at \$1,039,088. The CCP allocation request recommended by the Work Group totals \$2,514,449. Unfortunately, this is approximately double what the State originally anticipated for Sacramento County’s realignment program. Hopefully the CCP will recognize the actual need and act accordingly.

AB 100 Update to MHSA/Prop 63

Existing law contains provisions governing the operation and financing of community mental health services for the mentally ill in every county through locally administered and locally controlled community mental health programs. The act funds a system of county mental health plans for the provision of mental health services, as specified. It provides that it may be amended by the Legislature by a 2/3 vote of each house as long as the amendment is consistent with and furthers the intent of the act, and that the Legislature may also clarify procedures and terms of the act by majority vote.

Existing law establishes the Mental Health Services Oversight and Accountability Commission (MHSOAC). Under existing law, the commission is required to annually review and approve county mental health programs for expenditures relating to innovative programs and prevention and early intervention programs. Existing law authorizes the State Department of Mental Health to provide technical assistance to county mental health plans, as specified. This bill would delete the requirement for these annual reviews and would authorize the commission, instead of the department, to provide technical assistance to the county mental health plans.

Existing law requires each county mental health program to prepare and submit a 3-year plan to be updated at least annually and approved by the department after review and comment by the commission. This bill would delete the

annual update requirement for the 3-year plans and the requirement that the plans be approved by the department after review and comment by the commission.

The act establishes the Mental Health Services Fund, continuously appropriated to and administered by the department, to fund specified county mental health programs. The act prohibits funds from the Mental Health Services Fund from being used to supplant existing state or county funds utilized to provide mental health services, and requires state financial support for mental health programs with not less than the same entitlements, amounts of allocations from the General Fund, and formula distributions as the 2003-04 fiscal year. Existing law also requires, subject to availability of funding, the department to distribute a single lump sum of the total amount of approved funding to each county.

This bill would require the State of California, Controller's office, instead of the department, to administer the fund. The bill would authorize continued financial support for mental health programs to come from the Local Revenue Fund 2011, in the State Treasury, and would, commencing July 1, 2012, require the Controller to distribute to the counties all unexpended and unreserved funds on deposit in the Mental Health Services Fund monthly.

Under existing law, moneys in the Mental Health Services Fund may be used only for specified purposes, including 5% for innovative programs, as specified, and 5% for administrative costs of the department, the California Mental Health Planning Council, and the commission. The bill would reduce the amount available for administrative costs to 3.5% and would make that distribution subject to appropriation each fiscal year in the annual Budget Act. The bill, for the 2011-12 fiscal year, would allocate specified funds in the Mental Health Services Fund for Medi-Cal specialty mental health services, mental health services for special education pupils, and the Early and Periodic Screening, Diagnosis, and Treatment Program. By allocating moneys in the Mental Health Services Fund for new purposes, this bill would make an appropriation.

Existing law requires the department to develop regulations, which may be enacted as emergency regulations, for the department or designated local agencies to implement the act. This bill, instead, would require the state to develop regulations for the department, the commission, or designated state and local agencies to implement the act.

AB 1693 Incompetent-to-Stand Trial

This bill authorizes the Department of Mental Health (DMH) to expand a pilot program by establishing competency restoration programs in Los Angeles County, San Diego County, Kern County, and any other county that opts to participate, jails to inmates who have been found incompetent to stand trial (IST) but not committed to a state hospital. It requires that admissions' criteria for competency restoration programs be coordinated through DMH, prioritizing ISTs most likely to be restored to competency. It specifies that competency-restoration programs shall include at least: (a) objective competency assessment upon admission; (b) individualized treatment programs; (c) multimodal, experiential competency education experiences; (d) education addressing the criminal justice system; (e) education for individuals with lacking specific knowledge; (f) periodic reassessment of competency; (g) medication treatment; and, (h) capacity and involuntary treatment assessment. It also declares that a special law is needed because of the historically long waiting lists of ISTs in the three specified counties, which expose the State to potential future court involvement from delays in the treatment of ISTs held in county jail longer than recommended by the courts.

AB 2134, proposed bill by Assemblyman Wesley Chesbro (currently in Assembly committees, as of July 2012)

For purposes of subdivision (e) of Section 5346, a county that elects to provide assisted outpatient treatment services pursuant to this article shall offer assisted outpatient treatment services including, but not limited to, all of the following:

(1) Community-based, mobile, multidisciplinary, highly trained mental health teams that use high staff-to-client ratios of no more than ten clients per team member for persons subject to court-ordered services pursuant to Section 5346.

(2) A service planning and delivery process that includes the following:

(A) Determination of the numbers of persons to be served and the programs and services that will be provided to meet their needs. The local director of mental health shall consult with the sheriff, the police chief, the probation officer, the mental health board, contract agencies, and family, client, ethnic, and citizen constituency groups as determined by the director; (B) Plans for services, including outreach to families whose severely mentally ill adult is living with them, design of mental health services, coordination and access to medications, psychiatric and psychological services, substance abuse services, supportive housing or other housing assistance, vocational rehabilitation, and veterans' services. Plans shall also contain evaluation strategies, which shall consider cultural, linguistic, gender, age, and special needs of minorities and those in the target populations. Provision shall be made for staff with the cultural backgrounds and linguistic skills necessary to remove barriers to mental health services as a result of having limited-English-speaking ability and cultural differences. Recipients of outreach services may include families, the public,

primary care physicians, and others who are likely to come into contact with individuals who may be suffering from an untreated severe mental illness who would be likely to become homeless if the illness continued to be untreated for a substantial period of time. Outreach to adults may include adults voluntarily or involuntarily hospitalized as a result of a severe mental illness; (C) Provision for services to meet the needs of persons who are physically disabled;

(D) Provision for services to meet the special needs of older adults.(E) Provision for family support and consultation services, parenting support and consultation services, and peer support or self-help group support, where appropriate; (F) Provision for services to be client-directed and that employ psychosocial rehabilitation and recovery principles;

(G) Provision for psychiatric and psychological services that are integrated with other services and for psychiatric and psychological collaboration in overall service planning; (H) Provision for services specifically directed to seriously mentally ill young adults 25 years of age or younger who are homeless or at significant risk of becoming homeless. These provisions may include continuation of services that still would be received through other funds had eligibility not been terminated as a result of age; (I) Services reflecting special needs of women from diverse cultural backgrounds, including supportive housing that accepts children, personal services coordinator therapeutic treatment, and substance treatment programs that address gender-specific trauma and abuse in the lives of persons with mental illness, and vocational rehabilitation programs that offer job training programs free of gender bias and sensitive to the needs of women; (J) Provision for housing for clients that is immediate, transitional, permanent, or all of these; (K) Provision for clients who have been suffering from an untreated severe mental illness for less than one year, and who do not require the full range of services, but are at risk of becoming homeless unless a comprehensive individual and family support services plan is implemented. These clients shall be served in a manner that is designed to meet their needs; (L) (i) Provision for services related to responding to a mental health crisis, in accordance with the best practices developed pursuant to subdivision (e). (ii) This subparagraph shall not apply to a county that, as of January 1, 2012, is providing services pursuant to this article.

(3) Each client shall have a clearly designated mental health personal services coordinator who may be part of a multidisciplinary treatment team responsible for providing or assuring needed services. Responsibilities include complete assessment of the client's needs, development of the client's personal services plan, linkage with all appropriate community services, monitoring of the quality and follow-through of services, and necessary advocacy to ensure each client receives those services that are agreed to in the personal services plan. Each client shall participate in the development of his or her personal services plan, and responsible staff shall consult with the designated conservator, if one has been appointed, and, with the consent of the client, shall consult with the family and other significant persons as appropriate.

(4) The individual personal services plan shall ensure that persons subject to assisted outpatient treatment programs receive age-appropriate, gender-appropriate, and culturally appropriate services, to the extent feasible, that are designed to enable recipients to:

(A) Live in the most independent, least restrictive housing feasible in the local community, and, for clients with children, to live in a supportive housing environment that strives for reunification with their children or assists clients in maintaining custody of their children as is appropriate; (B) Engage in the highest level of work or productive activity appropriate to their abilities and experience; (C) Create and maintain a support system consisting of friends, family, and participation in community activities; (D) Access an appropriate level of academic education or vocational training; (E) Obtain an adequate income; (F) Self-manage their illnesses and exert as much control as possible over both the day-to-day and long-term decisions that affect their lives; (G) Access necessary physical health care and maintain the best possible physical health; (H) Reduce or eliminate serious antisocial or criminal behavior, and thereby reduce or eliminate their contact with the criminal justice system.; (I) Reduce or eliminate the distress caused by the symptoms of mental illness; (J) Have freedom from dangerous addictive substances.

(5) The individual personal services plan shall describe the service array that meets the requirements of paragraph (4), and to the extent applicable to the individual, the requirements of paragraph (2): (a) A county that provides assisted outpatient treatment services pursuant to this article also shall offer the same services on a voluntary basis; (b) Involuntary medication shall not be allowed absent a separate order by the court pursuant to Sections 5332 to 5336, inclusive; (c) A county that operates an assisted outpatient treatment program pursuant to this article shall provide data to the State Department of Mental Health and, based on the data, the department shall report to the Legislature on or before May 1 of each year in which the county provides services pursuant to this article. The report shall include, at a minimum, an evaluation of the effectiveness of the strategies employed by each program operated pursuant to this article in reducing homelessness and hospitalization of persons in the program and in reducing involvement with local law enforcement by persons in the program. The evaluation and report shall also include any other measures identified by the department regarding persons in the program and all of the following, based on information that is available:

(1) The number of persons served by the program and, of those, the number who are able to maintain housing and the number who maintain contact with the treatment system; (2) The number of persons in the program with contacts with local law enforcement, and the extent to which local and state incarceration of persons in the program has been reduced or avoided; (3) The number of persons in the program participating in employment services programs,

including competitive employment; (4) The days of hospitalization of persons in the program that have been reduced or avoided; (5) Adherence to prescribed treatment by persons in the program; (6) Other indicators of successful engagement, if any, by persons in the program; (7) Victimization of persons in the program; (8) Violent behavior of persons in the program; (9) Substance abuse by persons in the program; (10) Type, intensity, and frequency of treatment of persons in the program; (11) Extent to which enforcement mechanisms are used by the program, when applicable; (12) Social functioning of persons in the program; (13) Skills in independent living of persons in the program; (14) Satisfaction with program services both by those receiving them and by their families, when relevant.

(d) (1) A county that elects to provide assisted outpatient treatment services pursuant to this article shall develop best practices for the purposes of responding to a mental health crisis. These best practices include, but are not limited to, the utilization of crisis intervention teams, mobile crisis teams, or psychiatric emergency response teams, with an emphasis on peer support; (2) This subdivision shall not apply to a county that, as of January 1, 2012, is providing services pursuant to this article.

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APPENDIX K.

The Callahan Report dated May 10, 2011 **Summary of Transformation Recommendations for** **Sacramento County Adult Mental Health Services**

- Develop a Response Team to strengthen the access system.
- Providers conduct intake assessments for easy access to services.
- Redesign Crisis Response and Crisis Intervention Services at the county and provider level.
- Develop a Welcoming Line to offer consumer support 24/7.
- Redesign the regional outpatient system to offer a continuum of services at each provider.
- Improve notification of inpatient and MHTC admissions and coordinate discharge planning.
- Develop Intensive Outpatient Services (IOS) programs to help persons discharged from sub-acute residential placements successfully return to the community.
- Consolidate the two county outpatient clinics and plan how the remaining staff can best support the system transformation.
- Create wellness and recovery-focused services in a welcoming environment at each provider.
- Hire Peer Support Specialists for volunteer and paid service delivery positions.
- Provide Wellness and Recovery Training.
- Identify innovative evidence-based practices and provide training, supervision, and ongoing feedback to integrate these new skills throughout services.
- Implement a training program that facilitates communication between consumers and psychiatrists.
- Identify evidence-based practices and provide training for staff on the treatment of co-occurring disorders.
- Develop a training program to train UC Davis Residents to integrate client's voice in treatment.
- Integrate persons with lived experiences as part of the MHTC service delivery team to ensure communication.
- Develop an expedited process for helping individuals qualify for Medi-Cal benefits.
- Maximize billing for services that are eligible for Medi-Cal reimbursement.
- Expand Crisis Residential programs.
- Expand PHF Services
- Develop a Crisis Stabilization Unit
- Develop Crisis Respite Services
- Reduce the use of MHTC beds
- Reduce the use of private Psychiatric Hospitals
- Reduce the use of Mental Health Rehabilitation Centers and State Hospital.
- County leadership adopts a continuous quality improvement process to use data to inform system-level decisions.
- Develop the capacity to systematically produce accurate data reports.
- Develop an Outcomes Leadership Group composed of managers from the county and providers, as well as clients, to work together to use data to measure client and performance outcomes, identify gaps, and develop strategies to improve outcomes.

Biographies

Susan McCrea has served on the Sacramento County Mental Health Board (SCMHB) since 2007. Susan is alternate on the Sacramento County Mental Health Services Act (MHSA) Steering Committee, and the Chairperson of the Sacramento Mental Health Board Ad Hoc Committee. She is a member of the new Respite Partnership Collaborative. In November 2010, Susan and her family suffered the death of a loved one, a daughter with mental illness. Currently she is writing her memoirs and working with her husband, an assistant pastor at a local church. She has a BA in History from U.C. Berkeley, an elementary teaching credential from USF, and a license in pastoral counseling.

Lois Cunningham has been a member of the SCMHB since 2010 and is Chair of the SCMHB Budget Committee. Lois is past member of the Sacramento County Mental Health Services Act (MHSA) Steering Committee and served as a member of its Executive Committee. Lois has participated in many MHSA sub-committees, including the Innovation Workgroup and the Workforce Education and Training Workgroup. Lois' family has struggled with mental illness over the years and her frustrations with the system led her to involvement in mental health advocacy. Lois has a B.A. in Social Science from San Jose University and an MBA from the University of Santa Clara.

Brian Brereton has served on the SCMHB since June 2011. Brian has over thirty years of experience in the financial services industry and recently changed careers to work in healthcare. Brian is currently a certified EMT and Medical Assistant and has worked for the past two years in various local volunteer capacities including the Sacramento Medical Reserve Corps, and Rock Med-Haight Ashbury Clinics. Brian has a B.A. in Business Finance from Sacramento State University and an MBA from CSU, East Bay/Hayward. Brian is hoping to complete his nursing degree within the next 2 years with an emphasis on mental health.