



WELLNESS • RECOVERY • RESILIENCE

State of California

**MENTAL HEALTH SERVICES OVERSIGHT AND ACCOUNTABILITY COMMISSION**

Minutes of Meeting  
March 28, 2013

**Members Participating**

Richard Van Horn, Chairperson  
David Pating, M.D., Vice Chairperson  
Sheriff William Brown  
Victor Carrion, M.D.  
David Gordon  
LeeAnne Mallel  
Ralph Nelson, Jr., M.D.  
Larry Poaster, Ph.D.  
Tina Wooton

**Members Absent**

Senator Lou Correa  
Assemblymember Bonnie Lowenthal  
Andrew Poat

**Staff Present**

Sherri Gauger, Executive Director  
Filomena Yeroshek, Chief Counsel  
Kevin Hoffman, Deputy Executive Director  
Renay Bradley, Director of Research and Evaluation  
Norma Pate, Administrative Chief  
Jose Oseguera, Plan Review Chief

**1. CALL TO ORDER/ROLL CALL**

Chairperson Richard Van Horn called the meeting of the Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission) to order at 9:04 a.m. and welcomed everyone. Administrative Chief Norma Pate called the roll and confirmed the presence of a quorum.

Chairperson's Remarks

Chairperson Van Horn introduced new governor appointees LeeAnne Mallel and David Gordon. Commissioner Mallel holds a master's degree in speech and language. She is a licensed psychological technician in the office of Dr. Jonine Biesman, and a developmental Floortime specialist in private practice. Commissioner Mallel holds the seat of a parent of a child with mental health issues. Commissioner Gordon earned a Master of Education degree from Harvard University, and is the county superintendent at the Sacramento County Office of Education. He was the Elk Grove district superintendent, deputy superintendent at the Department of Education, and was on the board of Mental Health America of California. He is an advocate for mental health in schools. Commissioner Gordon holds the seat of superintendent of a school district.

Chairperson Van Horn pulled item five from the day's agenda.

**2. APPROVAL OF JANUARY 10 AND 24, 2013, MHSOAC MINUTES (ACTION)  
MARCH – MAY 2013 MHSOAC CALENDAR  
MARCH 2013 MHSOAC DASHBOARD**

**Action:** Vice Chairperson David Pating made a motion, seconded by Commissioner Carrion that:

*The Commission approves the January 10 and 24, 2013, minutes as presented.*

- Motion carried, 9-0

### **3. ADOPTION OF THE EVALUATION MASTER PLAN AND IMPLEMENTATION PLAN (ACTION)**

#### **a. Second Read - Evaluation Master Plan**

Vice Chairperson Pating stated that this is the second read of the Evaluation Master Plan developed by Dr. Joan Meisel. The first read was two months ago, and staff was directed to create an implementation plan using the Evaluation Master Plan. He turned the presentation over to Dr. Renay Bradley, MHSOAC Director of Research and Evaluation.

Dr. Bradley stated that the issue is that MHSOAC has been trying to develop a prioritization process to identify evaluation activities to focus on over the next three to five years. There is a statutory role for MHSOAC to evaluate not only the Mental Health Services Act (MHSA), but also California's public community-based mental health system. The Commission can use evaluation as a method to provide continual monitoring and assessment of the services, systems, and outcomes. To date, there has been no framework to guide these efforts, so in 2011 MHSOAC hired Dr. Joan Meisel to create an Evaluation Master Plan. Commissioners provided feedback after the first read, and other state entities have also provided feedback. Those changes have been incorporated in the Master Plan.

Dr. Bradley described the "Paradigm for Evaluation Master Plan" (Paradigm) on page 7 and "Evaluation Master Plan Activities" (Activities) on pages 12-13 of the Evaluation Master Plan, and stated that the Commissioners will prioritize this list of activities to be implemented over the next three to five years. A list of priority-setting criteria is on page 38 for the Commissioners' reference.

The two changes that were requested by Commissioners were the addition of "and family members" and "family connectedness" to the outcomes boxes in Paradigm, page 7, and the addition of "peer-led" to Study 6 in Activities, page 13.

Department of Health Care Services (DHCS) requested to change their role in performance monitoring after completion of the University of California, Los Angeles (UCLA) contract. Dr. Meisel had suggested that DHCS take over the role of calculating the requested indicators. MHSOAC staff will meet with DHCS to discuss the best method for sharing this responsibility.

The Master Plan indicated the need to strengthen the current data collection and reporting system, and suggested DHCS assume that responsibility. DHCS requested that language be softened to say that MHSOAC will partner with them to ensure support and maintenance of those systems. Staff has met with DHCS; their IT department is working to catalog the areas that require strengthening. MHSOAC has given financial assistance to DHCS to ensure this data is not lost.

The California Mental Health Planning Council (CMHPC) will be involved in developing future performance outcomes of MHSA, and requested that MHSOAC ensure that all forthcoming documents are understandable by Mental Health Services Act (MHSA or Act) stakeholders.

The California Mental Health Directors Association (CMHDA) provided positive feedback and requested no specific changes. They did request more collaboration with counties on evaluation designs.

#### **Commissioner Questions and Discussion:**

Commissioner Poaster stated that the language that is currently in the Master Plan with regard to DHCS should not be changed, as they are responsible for both owning and fixing the data systems as the regulatory entity. Executive Director Gauger asked if Commissioner Poaster

was concerned with the word “partnering,” . Part of the problem with the prior language was that it implies that DHCS was doing nothing, when in fact they are working to improve the collection systems.

Commissioner Poaster stated that, until it is determined who owns and is responsible for these systems, they will never be improved. Dr. Bradley stated that MHSOAC is reliant on that data and needs it to be strengthened and maintained, but DHCS claims they do not have adequate resources to do that. MHSOAC has assisted them by providing resources to them, but she was not sure that is appropriate on an ongoing basis.

Chairperson Van Horn stated that the motion is to approve the Evaluation Master Plan as it has been presented.

Commissioner Nelson referred to page 9 of the Evaluation Master Plan, under the one basic evaluation question: Are persons served doing better? Commissioner Nelson asked if “persons” includes both consumers and their family members. Dr. Bradley stated that these were meant to be very open questions that Dr. Meisel has proposed to guide the Commission’s evaluation efforts. She stated that the words “consumers and family members” could be added to ensure that the option is open.

Commissioner Nelson suggested adding “and are satisfied” to ensure input from those being served. Dr. Bradley stated that those changes would be made.

Commissioner Nelson referred to the Activities chart on page 13, and stated that he felt Study 8 should be a high priority, rather than medium as it is currently listed, because consumers are dying twenty-five years earlier than the normal population. The mental health field routinely ignores physical health. Dr. Bradley stated that inclusion of that item as a high priority will come into play within the scope of the implementation plan.

Commissioner Wooton asked about the Office of Statewide Health Planning and Development (OSHPD) and their five-year plan. The recommendation is that MHSOAC evaluate their efforts; she asked Dr. Bradley to talk about that process. Dr. Bradley stated that, because OSHPD’s five-year plan is still in the process of being developed, Dr. Meisel suggested waiting until it is fully developed to identify indicators with the performance monitoring system for the Workforce Education & Training (WET) component specifically.

In addition, the Master Plan suggests that the Commission monitor OSHPD as they carry out evaluations of WET component. The Master Plan also suggests that OSHPD focus more on counties; OSHPD indicated they would be open to considering this, but resources would be an issue. This fall, during MHSOAC’s reprioritization for the next fiscal year (FY), the Commission will reach out to OSHPD to determine whether they are ready to partner with MHSOAC in that way.

**Action:** Commissioner Poaster made a motion, seconded by Commissioner Wooton that the Commission:

*Adopt MHSOAC Evaluation Master Plan*

- Motion carried, 9-0

b. Implementation Plan for the Master Plan

Dr. Bradley stated that the Evaluation Implementation Plan provides two evaluation priority alternatives for the next five-year period: what additional staff and resources would be required to carry out all activities outlined in the Master Plan, or what evaluation efforts can be completed with the current staff and resources over the next five-year period.

Alternative 1:

Dr. Bradley referenced the chart on page 9 of the Evaluation Implementation Plan, which outlines the number of evaluation activities proposed in each of the five years, the total funds needed to complete the activities, and the additional number of staff required to complete the activities. Currently, MHSOAC has three positions fully committed to evaluation: Dr. Bradley as the director of research and evaluation; Ashley Mills, a recently hired research program specialist; and an associate governmental program analyst whom Dr. Bradley is currently recruiting. To complete all the activities outlined in the chart, Dr. Bradley stated that she will require two additional research scientists and three research program specialists, as well as an IT person to help set up the data systems and resolve security issues.

Dr. Bradley summarized the chart. MHSOAC receives \$1 million each year. In addition, Alternative 1 will require an additional \$5.85 million over the next five years to carry out all activities outlined in the Master Plan. She stated that additional staff would allow MHSOAC to build an internal evaluation unit that will complement work done by contractors and provide ongoing performance monitoring. Additional funds will provide support of the statewide data collection and reporting systems, and evaluation activities and priorities will be dictated by needs, rather than available resources.

Alternative 2:

Dr. Bradley referenced the chart on page 12 of the Evaluation Implementation Plan, which outlines the number of evaluation activities proposed in each of the five years using the current resources of \$1 million each year and three full-time staff members committed to evaluation activities.

Dr. Bradley stated that this answers Commissioner Nelson's question about being able to complete the high- versus medium-priority activities outlined in the plan. Using the process that Dr. Meisel has put forward, MHSOAC will be able to carry out all of the high-priority activities over the next five years, but only four of the fourteen medium-priority activities, which would not include Commissioner Nelson's suggestion.

Vice Chairperson Pating referenced the Study 8 criteria on page 101 of the Evaluation Master Plan. The different priorities are ranked high, medium, and low, based on approximately ten criteria. These ratings will be reevaluated annually, and Commissioner Nelson's concern may be able to be ranked higher at that time.

Dr. Bradley stated that Alternative 2, using current resources, will not allow MHSOAC to contribute funds to strengthening the statewide data collections systems. There will be no internal research capacity; all activities will be contracted out. Projects will be dictated by available funds rather than the work that needs to be done. Dr. Bradley lowered the estimated costs in order to complete some activities, which would lower the quality of the outcomes. Ongoing work and monitoring or carrying out proposed activities may not be feasible given the current amount of resources, and most medium-priority studies would not be completed.

**Commissioner Questions and Discussion:**

Commissioner Carrion asked if Dr. Bradley thought all activities could be completed with Alternative 1. Dr. Bradley stated that all activities can be completed, and she plans to include the assistance of students and interns to provide any additional support for these activities.

Commissioner Carrion asked why year one requires \$300,000 in additional funds with an increase in activities, but year two requires \$1.15 million without increasing the number of activities. Dr. Bradley stated that the first year's funds have already been encumbered in

previous FYs for contracts currently underway, so no additional funds would be required for that year. The \$300,000 would be used for starting larger-scale projects in that year.

Commissioner Nelson asked who would monitor MHSOAC if the work is done in-house. Dr. Bradley answered that there are still a number of outside contracts to provide a less subjective view, although those contractors bring their own agendas to the plate.

Commissioner Brown asked if the IT person is included in the budget figures. Dr. Bradley stated that the numbers on those tables do not include IT. Additional personnel, including the IT person, would be an additional \$3.235 million, for a total of \$9.085 million. That number reflects a savings of \$2.045 million over the course of five years if all work is done in-house. Commissioner Brown requested those numbers be analyzed and added to Chart.

Commissioner Brown stated that Alternative 1 has up to seventeen activities and Alternative 2 has up to seven. He asked if there could be an Alternative 3, contracting for those seventeen activities, but not hiring internal staff. Dr. Bradley stated that it takes an estimated \$500,000 for each large-scale project, but it also takes staff to monitor those contracts, and the Commission is currently understaffed.

Commissioner Brown suggested determining available resources to implement these plans by doing a cost benefit analysis that shows the pros and cons of internal staff versus contracting. He suggested developing an Alternative 3 to show what is available if activities are increased by fifty percent.

Executive Director Gauger stated that unions have been critical of departments that rely solely on contract staff. Staff designed a blend of in-house staff and contract staff to maintain objectivity, and to find a balance that will not create opposition from the unions.

Commissioner Carrion asked what percentage of MHSOAC budget the \$10 million for Alternative 1 is. Chairperson Van Horn stated that it is a large percentage of MHSOAC budget, but a small percentage of the total MHSA funding. The total for administrative funds is 3.5%, or \$35 million. MHSOAC, DHCS, and OSHPD have pieces of that. He likened the Evaluation Implementation Plan to a Global Positioning System (GPS), which lays out alternative maps if there is an obstruction on the current route. The Evaluation Implementation Plan lays out a strategic course for a five-year period. The Master Plan will be reviewed in the spring of every year, with adjustments made as necessary.

Executive Director Gauger stated that MHSOAC's current budget is \$6.2 million. The addition of the six proposed staff members would be an additional \$645,000.

Commissioner Gordon asked when staff would know which level of funding the Commission will have. Dr. Bradley stated that it is dependent upon the result of Executive Director Gauger's inquiries. Commissioner Gordon stated that, if there is a higher level of funding, the studies done initially are likely to be compelling enough to make a case for an additional level of funding. Dr. Bradley added that staff has been getting the word out about MHSOAC evaluation work. They shared a series of fact sheets for MHSOAC evaluations completed in the past with Senator Steinberg's office. Senator Steinberg's office plans to write a cover letter to share with members of the legislature.

Vice Chairperson Pating encouraged Commissioners to adopt the Evaluation Implementation Plan, as it addresses the core function of oversight and accountability and outlines a transformation strategy through evaluation. Without evaluation, it is difficult to perform the Commission's core oversight and accountability function. Evaluation needs to be done within a reasonable timeframe; the less money available, the longer it will take to get that done. He stated that what Commissioners are approving today is a direction for implementing the Master

Plan. He encouraged Commissioners to approve the plan so staff can begin to work with the Department of Finance to create a reasonable funding strategy.

Commissioner Poaster stated his concern that this Commission might become just another bureaucracy, and cautioned Commissioners to carefully consider this in the future and to ensure that MHSOAC does exactly what it says it is going to do.

Commissioner Brown stated that he wanted to ensure that everything is done in the most cost-effective manner, and that Commissioners recognize that it amounts to an increase in the activities budget. In the current budget environment, it is likely to attract criticism and scrutiny, and MHSOAC needs to be able to ensure that this is truly what is needed and to defend against the argument that whatever monies are going into this are less monies going into actual delivery, service, and treatment. He stressed the importance of achieving a proper balance.

**Public Comment:**

Sandra Marley, consumer and advocate, asked where she can go to learn more about the specific activities outlined in the Master Plan. Ms. Marley referred to the heading on page 24 of the Master Plan, which states, "The continuing devolution of control ... increases the importance of local advocates..." She questioned how the counties will find those local advocates and what kind of training they would receive. Chairperson Van Horn stated that it is up to each county's local mental health advisory board, which is selected by the boards of supervisors in each county. The training is up to the county; however, there is a contract held by MHSOAC to bring the leadership of those boards together four times a year for additional intercommunication and training.

Steve Leoni, consumer and advocate, stated that generally 5% to 10% is used for evaluation. Evaluation funds should include county efforts and the efforts of other state entities. He has not seen a list of what the counties are doing or what they should be doing and a sense of where MHSOAC is in that. He stated that he would like to see MHSOAC be the linchpin in a statewide evaluation effort with many partners.

**Action:** Commissioner Poaster made a motion, seconded by Commissioner Carrion that the Commission:

*Adopt the MHSOAC Evaluation Implementation Plan for Fiscal Years 2013/14 – 2017/18.*

Motion carried, 9-0

**4. PRESENTATION ON PROPOSED CHANGES TO CIVIL COMMITMENT STATUTES**

Sheree Kruckenberg, the Vice President of the California Hospital Association (CHA), stated that she works with the hospitals' evaluations departments. She stated that there has been a significant shifting where individuals are being taken by law enforcement and others to deal with evaluation assessment needs for involuntary care. She is working with Senate Pro Temp Steinberg who authored Senate Bill (SB) 364 to amend the Lanterman-Petris-Short Act (LPS Act).

CHA's objective to modernize the LPS Act is to improve the timely assessment and treatment of individuals, to improve access to the least restrictive environment, to reduce wait time in emergency departments, to improve safety of treatment and coordination of services, to standardize who can generate, release, or continue holds, and to improve uniformity across county lines. Ms. Kruckenberg stated that CHA is not seeking to change hold criteria, expand civil commitments, address child or adolescent holds, or change court process.

Ms. Kruckenberg stated that the (LPS) involuntary commitment statute, commonly known at the

5150 law, passed in 1967. The state closed 25,000 state hospital beds in the 1970s. Currently there are 5 state hospitals and about 6,500 beds, of which about 2,000 are for providing acute psychiatric services for individuals found not guilty by reason of insanity, sexually violent predators, and court-ordered admissions.

In the early 1970s, when a robust state hospital system was still in effect, the federal government committed to send state funding for one thousand community clinics, known as state clinics. The government only provided for four hundred clinics, withdrew all funding, and then passed a law which stated that adults between the ages of 21 and 64 would not have federal funding for any part of inpatient psychiatric care in dedicated psychiatric settings with more than sixteen beds. By 1972, increased numbers of individuals with mental illness were incarcerated, homeless, untreated, or inadequately treated.

Ms. Kruckenberg stated that hospitals began contacting CHA to ask what was causing the significant increase in emergency departments being the only treatment provider available 24/7 for individuals with suspected serious mental illnesses. Emergency departments in hospitals that do not provide inpatient psychiatric services do not typically have the capacity or capability to serve this population and, increasingly, they are unable to locate appropriate resources to assist those with mental illness and substance use disorders.

There are a little over 1,000 residential centers for individuals to transition to. The increasing numbers being brought to hospital emergency departments that do not have an emergency condition include individuals brought in on a proposed 5150 pass and put on an involuntary hold. There is no data tracking for this information.

Ms. Kruckenberg stated that the original intent of LPS must be preserved. LPS ends inappropriate, indefinite, involuntary commitments; provides prompt evaluation and treatment; guarantees and protects public safety; safeguards individual rights through judicial review; protects persons with a mental illness from criminal acts; provides individualized treatment, supervision, and placement for gravely disabled persons; encourages the full use of existing agencies, professional personnel, and public funds; and prevents duplication of services and unnecessary expenditures.

She stated that those who qualify for involuntary care are individuals who are a danger to self or others, or are gravely disabled due to mental illness. Patients who have been put on a 5150 get to an emergency department by law enforcement, ambulance, family, friends, or themselves, but there is no data on this information.

CHA is working on this issue because most California hospitals do not have the capacity or capability to cover these individuals. Just five years ago, a mental hospital might have two or three individuals in their emergency department that needed an evaluation for 5150. That number is now ten to fifteen every day, resulting in patients languishing in hospitals for weeks. In 2006, CHA began collecting data about capacity from the acute care hospital side. In 2009, CHA sponsored Senate Bill (SB) 743 to amend some Health and Safety Code sections that dealt with individuals being brought to emergency departments, extending the hold on patients from eight hours to twenty-three hours.

Ms. Kruckenberg stated that CHA is interested in seeing Welfare and Institutions Code Sections 5150 (detail and transport), 5151 (assessment), and 5152 (treatment) modernized. They are focusing on the adult population in these three sections. CHA would like to see the statutorily mandated 5150 form revised, as it does not have a place to write the time the mandated hold begins. CHA would also like to see the state oversight of the 5150 process be removed from the Department of Social Services (DSS) and transferred to DHCS, along with clarification of definitions in the existing LPS Act, the development of additional community-based crisis

services, clarification on LPS designation process, establishment of uniform standards for who can detain and transport for an assessment under a 5150 hold, clarification on who can conduct a 5151 assessment and who can release an individual from a 5150 detainment, establishment of a uniform standard on when the 5152 72-hour involuntary treatment clock starts and stops, and consistent application of LPS Act to achieve equity and equal protection for all citizens in California.

**Commissioner Questions and Discussion:**

Commissioner Brown stated that Ms. Kruckenberg was doing well with him until she made the comment that law enforcement is just bringing inebriated people to the emergency room “to get them out of their hair.” The realities are that the cuts referenced in this presentation and the decreased number of accessible and available beds for people with mental illness who are in crises decrees that the only alternative for taking people to the hospital is to take them to jail. He stated that the fifty-eight sheriffs of the counties of California already run what are, in essence, the largest de facto mental institutions in the state. The individuals who are suffering from crises are the ones that typically get intervention in the field, and the sheriffs have had numerous problems, as have the hospitals, as a result of the cut-backs.

Commissioner Brown referenced Ms. Kruckenberg’s comment about people languishing in hospitals and stated that the alternative is people languishing in jail. Most correctional and law enforcement administrators believe that hospitals are more appropriate for people suffering from mental illness than jails are.

Regarding a uniform method of who can place holds on people, Los Angeles County police officers themselves make the 5150 holds and bring people to the hospital. In Santa Barbara County, there are mental health professionals who are called out by law enforcement to the field to make the 5150 holds and bring people to the hospital. Commissioner Brown stated that Ms. Kruckenberg pointed out that there are twenty-five counties that do not have inpatient facilities in their counties; therefore, he submitted it would be almost impossible to try to get a uniform methodology. Commissioner Brown stated that people who are sometimes brought into the hospitals are inebriated, but have an underlying mental illness that is co-occurring with that inebriation. All too often, that person sobers up and, when the so-called problem is no longer there, is pushed out the door when, in reality, the underlying problems that caused them to be suicidal or disorderly in public or to assault someone and to come to the attention of law enforcement remain untreated. He suggested to Ms. Kruckenberg, as she looks to make these recommendations, that CHA partner with law enforcement and recognize that the problem is not with law enforcement. The problem is that the federal government did not provide the community treatment centers as promised, so there are a significant number of mentally ill people in the communities who come to the attention of law enforcement who really should be treated by the medical community instead.

Commissioner Poaster commented on the irony that MHSOAC, which is devoted to the development and enhancement of voluntary placement, should be talking about methods that potentially expand involuntary commitments. Ms. Kruckenberg argued that CHA does not want to do any expansion, but wants it to be used appropriately and to reduce involuntary care. Commissioner Poaster stated that he has a different viewpoint from that.

Commissioner Poaster asked what Ms. Kruckenberg meant by “move to deemed status for hospitals” in Slide 18. Ms. Kruckenberg stated that a hospital that provides inpatient psychiatric services would be deemed designated unless they opt out of being designated. Commissioner Poaster asked if private hospitals automatically are deemed 5150 facilities unless they opt out. Ms. Kruckenberg stated that they are, if they provide inpatient psychiatric services. She added that it is more of an administrative simplification concept than it is anything else. Commissioner

Poaster stated that, with all due respect, that he did not see that as the case. He asked Ms. Kruckenberg if she had spoken with the mental health directors. Ms. Kruckenberg stated that she has met with the staff of CMHDA and with the mental health directors of several counties. Commissioner Poaster suggested it may be important for Ms. Kruckenberg to sit down and talk to the people who have the responsibility of administering LPS Act.

Vice Chairperson Pating stated that he agreed with Commission Brown, that this is just the tip of the iceberg of a set of issues that are evolving with social and behavioral consequences of mental health patients either ending up in the hospitals or in the jails. In addition, under MHSA, peer services and crises services are evolving. He stated that he does not know whether DHCS or MHSOAC should convene a broader discussion, but there are problems that need to be discussed. There is a lack of resources, and patients are being forced to travel great distances to receive care. Urban county emergency rooms are overflowing. The costs to the hospital and county systems that run them are enormous, and, with Health Care Reform, a newly insured population will be coming online. With Assembly Bill (AB) 109 and Health Care Reform, there is not enough capacity to manage the severe consequences of mental health and substance abuse.

Vice Chairperson Pating gave an example of what can be done. When the Martin Luther King Hospital closed in Los Angeles, they adopted community-based, peer-run crisis clinics. The hospital reopened, but these programs were a marvelous invention of necessity, and they were funded by MHSA.

The real issue is that the full continuum of necessary services has not been reached, and the involuntary status has been such a time bomb that the reasonable solutions to this have not been approached. Vice Chairperson Pating suggested that the Client and Family Committee convene a gathering of police, sheriffs, judicial courts, hospitals, and peers to discuss this issue, or have a peer-chaired Committee on how to find a solution to the safest way to provide the right care, in the right place, at the right time. This set of problems needs to be discussed because, with Health Care Reform and the newly insured, it will put a burden on the system in a much more severe way.

Commissioner Nelson stated that most mental health hospitals require a medical clearance from the Emergency Room (ER) before the hospital will accept a patient. Ms. Kruckenberg stated that she sees some growth in this area, with more and more counties looking at it as part of the problem and trying to develop one set of standards that everyone will accept.

Commissioner Nelson asked if CHA is addressing the quality of treatment and staff respect for consumers who are hospitalized, and if CHA is doing any studies to find out why consumers detest mental health hospitalization, but do not feel that way toward medical/surgical hospitals. Ms. Kruckenberg agreed that stigma is alive and well in emergency departments. Commissioner Nelson stated that he is not as concerned about the ER, but is concerned about the mental health hospitals that are there to help and treat consumers. Ms. Kruckenberg answered that CHA has not done those studies, nor are there any plans to in the future.

Commissioner Nelson asked if CHA is addressing the many mental health hospitals that will not accept people who are on Medi-Cal unless they are 5150. Ms. Kruckenberg stated that she has heard that ambulance transportation cannot accept them unless they are 5150. Commissioner Nelson asked if CHA has surveyed the hospitals to see that they actually do require a 5150 before they will accept the Medi-Cal patient. Ms. Kruckenberg stated that that such a survey is not a requirement. Commissioner Nelson suggested that CHA survey them.

Commissioner Wooton stated that she agreed with Commissioners Poaster and Pating about the values of MHSA to service consumers in the least restrictive care and to look at recovery-oriented systems. This includes stigma and the involvement of consumers and family members.

In addition, there are programs around the state that consider peer respite and crisis residential centers, either run by consumers and family members or led by them. Commissioner Wooton stated that it is very important and she hoped CHA will look at some of those places, even if they are not run by peers.

Commissioner Wooton encouraged Ms. Kruckenberg to bring information from the peers to Senator Steinberg's office when she meets with him about developing the bill.

**Public Comment:**

Linda Dickerson, Ph.D., Research Analyst of CMHPC, stated that she became acquainted with these issues in the course of her work, although today she is speaking as a private citizen. As a matter of civil rights, if there is no data on what is going on with the 5150 process in a timely fashion, then it cannot be monitored or changed. If it is not measured or counted, it cannot be assessed or fixed. She stated that she has been asked by the Chair of the CMHPC Continuous System Improvement Committee to try to find data on how often this process has been used. She stated that she contacted a variety of organizations and looked at various state sites, but it is not clear where the data is. CHA proposed that the oversight be moved from the California Department of Social Services (CDSS). She stated that she has not been able to locate data information on that website. Moving it into DHCS means moving it into a complex organization with complex data systems, which have difficulty responding in a timely fashion to the new demands placed on them. It might be better to move that oversight to the Office of the Patient Advocate or another organization that may have hospital discharge data. In addition, a fundamental issue of concern is that there is no access to hospital-based or community-based emergency care in large portions of this state.

Patricia Ryan, Executive Director of CMHDA, stated that one of the key issues that has not been addressed is that county mental health is not responsible for paying for all hospital emergency care. California does not have mental health parity or the kind of insurance plans responsible for providing the services that people need when they need them so they do not end up in the emergency room. The vast majority of people who come to emergency rooms and end up in crisis are people who have private insurance. Counties are responsible for managing LPS designation and the 5150 evaluation process, but they are not responsible for the entire system. That is something that needs to be recognized and evaluated.

Ms. Ryan stated that CMHDA has met with Senator Steinberg and CHA several times to create language that will help alleviate some of the issues that Ms. Kruckenberg brought up today, such as people coming to the emergency room who do not have a true emergency. If there is a way to evaluate people through crisis stabilization or to bring people who are placed on a 5150 who do not need to go to an emergency room or do not need to be transported four hours to the next available inpatient facility because they do not have a medical problem, then that should be explored, along with the ability to do 5150 assessments in the most appropriate and the least restrictive setting so that the demand on the emergency rooms can be reduced. There are many things that can be done and CMHDA has provided instructive language to Senator Steinberg.

This is a good opportunity to examine these issues more systematically during the move toward Health Care Reform, because people who do not have insurance now and are ending up in the emergency room will soon have insurance. It is necessary to ensure that not only do the counties have the appropriate crisis response system, but that the private system does their part to address serving the clients that they insure.

Vice Chairperson Pating asked if this is a series of continued conversations or if there is a separate conversation because of the crisis of Health Care Reform. Ms. Ryan stated that, short-term, there is Senator Steinberg's bill, SB 364, which will have language in it that the

public will be able to comment on and be involved in discussion about the policies that are associated with it. Long-term, it is a larger systemic issue, and she was not sure what the proper format is.

Vice Chairperson Pating asked if CMHDA would be interested in participating in that kind of conversation. Ms. Ryan answered in the affirmative.

Mr. Leoni stated that he was alarmed to see the definition of the 5150 criteria on the PowerPoint that "danger to others" is equated with "homicidal." He stated that he would hope that people making PowerPoints would not draw that correlation. Thinking that everyone that is 5150 is homicidal is stigmatizing. Mr. Leoni explained that one of his concerns is defining the 72-hour hold as beginning with the assessment rather than the detention.

## **5 INNOVATION PLAN APPROVAL (ACTION)**

Jose Oseguera, MHSOAC Chief of Plan Review, stated that Ventura County has requested \$6,537,220 for a four-year Innovative Program (INN) entitled Health Care Access and Outcomes. The INN integrates physical health with mental health by combining two programs for older adults with serious and persisting mental illness and chronic medical issues. The two programs are Empowering Partners through Interactive Community Services Intensive Program, or EPICS, and Older Adults Full Service Partnership (FSP) programs. The adaptation of the FSP with physical health, which is at the forefront of this INN, is considered a holistic approach that exemplifies the integrated care model and uses a multidisciplinary team to assist with the navigation of these health services.

**Action:** Commissioner Nelson made a motion, seconded by Commissioner Gordon that:

*Approve Ventura County's Innovation Plan upon the condition of Ventura County submitting to MHSOAC a mutually acceptable executed Fiscal Accountability Certificate as required by Welfare and Institutions Code Section 5847 (b) (9).*

- Motion carried, 9-0

## **6. AWARD CONTRACT FOR INNOVATION PROGRAM EVALUATION BASED ON COMPETITIVE BID (ACTION)**

Chairperson Van Horn announced that the item was pulled from the agenda.. One hundred thirteen entities viewed the Request for Proposal (RFP), fifty entities that downloaded it, and five letters of intent to bid were received. Of the two bids received, neither met the minimum required points for a successful bidder. Staff will explore other administrative options for this task.

## **7. AUTHORIZE MHSOAC EXECUTIVE DIRECTOR TO ENTER INTO TWO STAKEHOLDER CONTRACTS (ACTION)**

Contract with National Alliance on Mental Illness, California (NAMI)

Commissioner Nelson recused himself from this portion of the meeting.

Kevin Hoffman, MHSOAC Deputy Executive Director, stated that he will provide a presentation regarding two of MHSOAC stakeholder contracts, with the goal of the Commission providing the Executive Director the authorization to review and enter into the contracts.

Chairperson Van Horn stated that Commissioner Poaster had indicated a willingness to move these contracts without further presentation. MHSOAC was specifically given the funds for

these contracts by the legislature. The Commission is authorizing the Executive Director to sign the contracts.

Commissioner Wooton asked if Mr. Hoffman could give a brief summary.

Mr. Hoffman stated that the NAMI contract supports the inclusion of people living with mental illness and their families in mental health community planning and policy considerations. It supports and provides information and opportunities for constituents, to ensure that their voices are heard by policy makers on issues relevant to Proposition 63 mental health treatment provisions.

Mr. Hoffman reviewed the nine deliverables as outlined on the PowerPoint.

**Public Comment:**

Stacie Hiramoto, the Director of the Racial and Ethnic Mental Health Disparities Coalition (REMHDCO), stated that she is in support of the contract for National Alliance of Mental Illness (NAMI) and the United Advocates for Children and Families (UACF). Ever since the REMHDCO was formed, they have hoped to become like NAMI and the UACF in order to represent underserved communities in California who often have difficulty having their voices heard. She asked MHSOAC to put out a statewide RFP that can represent underserved racial, ethnic, and cultural communities.

**Action:** Commissioner Poaster made a motion, seconded by Commissioner Wooton that:

*MHSOAC authorizes the Executive Director to execute the contract with NAMI California for three years for a total amount of \$2,008,197 and an annual amount of \$669,399 for the deliverables outlined by staff.*

- Motion carried, 8-0

Contract with United Advocates for Children and Families (UACF)

Mr. Hoffman stated that the UACF contract supports the inclusion of children, youth, and their families living with mental illness in mental health community planning and policy considerations. It supports and provides information and opportunities for constituents, to ensure that their voices are heard by policy makers on issues relevant to Prop 63 mental health treatment provisions.

Mr. Hoffman reviewed the five deliverables as outlined on the PowerPoint.

**Action:** Vice Chairperson Pating made a motion, seconded by Commissioner Brown that:

*MHSOAC authorizes the Executive Director to execute the contract with United Advocates for Children and Families (UACF) for three years for a total amount of \$1,310,485 and an annual amount of \$436,828 for the deliverables outlined by staff.*

- Motion carried, 9-0

**8. GENERAL PUBLIC COMMENT**

James Lockett, of the Academy of Integrated Recovery, stated that he attended today by the request of the Alameda County mental health consumers. He stated that there are over 1,500 people waiting to hear from him in hopes that he will bring positive results and connections from this Commission. He has reached out to DHCS, the Board of Supervisors, and various other entities in Alameda County. He asked for assistance in making the necessary connections to

help resolve some of the mental health issues in Alameda County, such as the misappropriation of funds, stigma in the behavioral health care services, and the administration contracting outside the county. He suggested providing multiservice centers and realistic support services for returning veterans and individuals being released from prison with mental health issues.

Chairperson Van Horn assured Mr. Lockett that Executive Director Gauger will assign staff to meet with him to talk about specific issues and to make a follow-up meeting in Alameda County. Chairperson Van Horn cautioned that MHSOAC does not have authority over individual counties or how they behave internally, but the Commission will make an effort to ensure that Mr. Lockett's issues are taken seriously in Alameda County.

## **9. CALIFORNIA MENTAL HEALTH SERVICES AUTHORITY (CaMHSA) UPDATE**

Stephanie Welch, the Senior Program Manager of the California Mental Health Services Authority (CaMHSA), distributed a Prevention and Early Intervention (PEI) booklet developed by CaMHSA in collaboration with CMHDA, which contains real stories of people who have been impacted by PEI services, why PEI services are cost effective, an impact statement, and a resource guide of CaMHSA's twenty-five projects.

CaMHSA has an approved work plan budget of approximately \$1.47 million, of which 80% goes directly into programs and 7.5% goes to RAND Corporation for conducting an independent statewide evaluation.

There are four program areas in the suicide prevention program: a suicide prevention network, a capacity building program, a social marketing campaign, and a training and education campaign. The prevention network goals are to identify best practices and to exchange knowledge. Over one thousand stakeholders from forty-six counties participated in the planning process. The capacity building program has seven contracts within the program. The social marketing campaign, "Know the Signs," is one of the largest projects in the suicide prevention campaign. Ms. Welch stated that the website [www.YourVoiceCounts.org](http://www.YourVoiceCounts.org) is the internal engine of the campaign. It contains a wealth of information, including a county-by-county resource directory. The last part of the suicide prevention program is training and workforce. CaMHSA is training trainers as well as delivering training. The Applied Suicide Intervention Skills Training (ASIST) has over 180 certified trainers and has resulted in 1,500 community members receiving two-day trainings. E-suicide is a one- to two-hour online suicide awareness training that aims to reach 16,000 people.

The stigma and discrimination reduction program has four programs and ten contracts, and is based on the state's strategic plan. CaMHSA's goal is to have targeted local continuous credible contact strategy, called TLC3. The four program areas include creating supportive environments; changing policies, practices, and values to promote inclusion and acceptance; promising practices for underserved groups; and upholding and advancing the law to eliminate discrimination and stigmatizing practices. Creating supportive environments includes regional training forums and websites with members across the state that create a feedback loop where members can access materials of the campaign, gather information, and bring that information back to the communities. The social marketing campaign is one of the larger projects and includes websites geared toward the TLC3 across the lifespan. May 30, 2013, will be the premiere of CaMHSA documentary airing statewide on thirteen PBS stations, entitled, "A New State of Mind: End the Stigma of Mental Illness." This documentary will be a tool for community dialogues. The documentary will be available in DVD and CaMHSA will hold trainings on how to use it in a variety of educational settings.

In changing policies program area, CaMHSA has a contract with the Entertainment Industries Council, and has developed an Associated Press Style Guide on how to report accurately on mental illness. This signifies the first time guidance will be provided to journalists about how to

report on mental health issues. The promoting integrated behavioral health program supports small communities on how to promote integrated behavioral health care in their communities upon implementation of Health Care Reform. Other programs in changing policies area are wellness works, which promotes mental health in the workplace; the ending the silence program, which promotes reducing stigma and discrimination in mental health and system partners; the resource development and promising practices program, which is a website that lists effective programs that are actively reducing stigma in communities; and the disability rights program, which advances policies to eliminate discrimination by using a stigma and discrimination reduction filter.

The student mental health program is about identifying students at risk, ensuring students in the school community have heightened awareness and acceptance of people with mental health challenges, and about reducing bullying and other stigmatizing actions. The statewide K-12 program includes the student mental health policy workgroup, which recently made a recommendation to the state superintendent that all future teachers' credentialing include a mental health and wellness curriculum component. The community colleges program includes twenty-three campuses that have received student mental health grants and have peer group training activities and faculty trainings about increased mental health awareness and suicide prevention. The California State University project includes a magazine developed to educate students about issues related to mental wellness; Applied Suicide Intervention Skills Training (ASIST ) trainings; question, persuade, and refer (QPR) trainings; the mental health first aid trainings; and the Red Folder, which is a campus-by-campus resource for assisting students in distress.

CalMHSA considers how to maximize and leverage the efforts of all twenty-five projects, such as the Directing Change Public Service Announcement (PSA) Contest. There will be a red carpet award ceremony at the Crest Theatre on May 23<sup>rd</sup>. CalMHSA also has projects reaching underserved populations and, with MHSOAC's approval of an amendment to the work plan, \$14 million more has gone specifically to work to reach underserved communities.

#### **Commissioner Questions and Discussion:**

Commissioner Carrion stated that disasters can increase the need for all of these programs and the accessibility for them. He asked if CalMHSA is doing any work in terms of disaster preparedness. Maureen Bauman, the Vice President of CalMHSA, stated that there is disaster preparedness happening with the mental health directors. The State Department of Mental Health has historically had that responsibility, but she stated that CalMHSA would be happy to do an update to ensure that is done county by county.

Commissioner Nelson asked what will happen to these programs when MHSA funding stops in four to five years. Ms. Bauman stated that there are multiple options. Ms. Welch stated that several programs contain legacy pieces, such as changing the teacher credentialing requirements, ensuring that reporters are trained on how to accurately report mental illness, and the social marketing component, which do not require continued funding. However, the labor-intensive evaluation takes an honest look at how well these programs performed and how effective they were. Ms. Bauman added that ongoing funding is the responsibility of the counties that benefit from these programs. Since this is a long-term effort, there are structural changes that may not require continued funding.

Vice Chairperson Pating congratulated CalMHSA on their efforts and stated that working with new markets and young people requires a fresh, energetic approach. Ms. Bauman stated that CalMHSA looks forward to sharing more in the future.

Vice Chairperson Pating stated that his concern is with the programs' sustainability. He

requested that Ms. Bauman and Ms. Welch ask Ann Collentine, the program director of CalMHSa, to connect with Commissioners who would be very interested in these projects.

Commissioner Brown congratulated CalMHSa and stated that it is nicely packaged and marketed. He added that he would like to see a resource similarly packaged that specifically addresses anger management, violent thoughts, and homicidal thoughts to enable people suffering from those feelings to be brought into the health care system.

#### **10. PRESENTATION OF THE MENTAL HEALTH SERVICES ACT STATEWIDE PARTICIPATORY EVALUATION REPORT**

Dr. Bradley stated that this is the final report out of the contract with University of California, Los Angeles (UCLA). Jane Yoo, Ph.D., of Clarus Research, stated that Clarus is part of the larger UCLA evaluation team. Kristin Ward, Ph.D., of Clarus Research, introduced two participatory evaluation partners (PEPs) who will be joining them to speak about the process and the outcomes of the evaluation, John and Hurley Merical, as well as Steve Leoni, Delphine Brody, and Kathleen Derby, who are in the audience.

Hurley Merical, the Executive Director of Oak Park Outreach Services, thanked UCLA and Clarus for allowing the Merical brothers to participate in this research. He first became involved in November 2011 as part of the Consensus Focus Group. He has a background in epidemiology, infectious disease, and at-risk behavior. To begin with, research was done by Webinar with a large audience and a survey that researched three services: peer support, crisis intervention, and employment. Mr. Merical stated that he tried to capture the at-risk audience for this research to understand the reasons they were not accessing available services. He passed out surveys, but many of these consumers do not utilize a computer or have enough time to complete a lengthy survey. He thanked Clarus for putting this together and stated that he felt that the clients were protected, which was one of his main concerns, along with dignity and respect for the participants of the evaluation.

John Merical, the Deputy Director of Oak Park Outreach Services, stated that he was impressed with this study. He spent twenty-five years in law enforcement and retired a captain with the Sacramento Police Department. His brother asked him to work with him four years ago. He stated that, with the limited time period and the number of people to contact, and starting from the ground up, he was impressed with the group and what they accomplished. Oak Park Outreach deals with the underserved community, many of whom minimally access services or access none at all. He stressed that mental health for veterans, parolees, and the homeless is a critical problem, and he was impressed with how this study utilized approaching them. He stated that his fellow law enforcement officers did not like to respond to family crises; they just wanted to get in and get out, but it never fixed the problem. Now, he feels he is a member of a team that is trying to solve those problems, addressing issues that families have.

Dr. Yoo described how, by using participatory research, Clarus contracted to study the impact of at least one service on one MHSa outcome, with one service that was evaluated funded by the General Systems Development funding. At least one service had to involve individuals living with mental illness, their families, and personal caregivers. Clarus studied three service areas: peer support services, employment support services, and crisis intervention services.

The study began with a statewide planning process with ninety-one participants, who helped identify the services that Clarus was to evaluate. Ten PEPs worked closely with the evaluation team in every aspect of the evaluation. Dr. Yoo asked John and Hurley Merical to talk about their role as PEPs.

John Merical stated that one concern he had initially was the amount of time available for the

task at hand. There was a great deal of work to be done with a large number of people to contact by phone and conference call, but the staff provided good training and was very supportive. Mr. Merial stated that he thinks that is why they worked as hard as they did and accomplished what they did – because of the great support.

Hurley Merial stated that UCLA facilitated each Webinar. He pointed out that the group of stakeholders and people from the mental health field brought lived experiences from the community. He stated that he was excited to take this survey out to the few that he could reach to have them bring back information about lived experience. He felt he was reaching people whose voices may never have been heard before. He stated that there are mental health clients out there who do not know that there are services that can raise their quality of life. He stated that this is only a start; they brought information to draw from and the evaluation team just had to put it together.

Dr. Yoo stated that they received 949 surveys and completed forty in-depth qualitative interviews. She expressed her gratitude to PEPs for their assistance with the surveys and for making it possible to connect with people who were willing to give insightful interviews. She stated that the survey and interview samples were represented by all regions of the state, rural and urban communities, all age categories, and traditionally unserved and underserved populations. The questions guiding the study included characteristics of those who received MHSA services, the types of services they received, and their perceptions about access to services. For those who received crisis intervention services, questions included whether there was continuity of care and what the implications were, to what extent services exemplified a recovery and resilience orientation, and whether there were any changes in employment, housing, and recovery/resilience and wellness after receiving services.

Dr. Yoo stated that there were 328 survey respondents who received peer support services. Ten percent had difficulty accessing those services; approximately 77% reported that the services were appropriate. Clarus used the Recovery Oriented Services Indicators scale. There was a statistically significant difference in perceptions between those who received peer support services and those who did not. Those who received peer services felt that the overall services they received in the mental health system were more recovery-oriented.

For employment services, Clarus looked at employment changes in a twelve-month period for those who received peer support services and those who did not. There was not a significant difference; however, when asked for more information, close to 50% said that the services they received improved their employment situation. There also was not a significant difference in the housing category; however, 72% of the people receiving peer support services said the services they received improved their housing situation. In the recovery/resilience and wellness category, in comparing the two groups, Clarus found a significant difference between the two. Those who received peer support services believed that their recovery improved a lot more than those who did not receive those services. 81.3% reported that they believed the services they received helped them to feel better, and 76.9% said services helped with their recovery.

Dr. Ward summarized that there is an importance of overlapping services, high levels of access with room for improvement, greater continuity of care, positive perception of services as recovery-oriented, mixed findings on employment and housing, and improvement in recovery/resilience and wellness. For practical implications, there was value added for those who received peer support services, which should be emphasized in the larger systemic care. For evaluation implications, Dr. Ward emphasized the benefits and importance of the mixed methodology of measurement strategies that Clarus used. There were also implications for the strengths of participatory evaluation and its use.

**Commissioner Questions and Discussion:**

Vice Chairperson Pating stated that there is a process the Evaluation Committee will be doing with each of these studies, establishing work groups to follow up on these studies and then going into the Client and Family Committee for additional comments. He asked how many participated in the crisis intervention services. Dr. Yoo stated that there were 231 survey respondents who received services, and 92 who did not but wanted them.

Vice Chairperson Pating asked for additional information about the 21% who had difficulty accessing crisis intervention services. He asked, since Clarus was not able to demonstrate a reduction in hospitalizations, if that indicated that the end was too low. Dr. Yoo stated that Vice Chairperson Pating was correct and that Clarus asked how many times people were hospitalized, and compared those numbers to those who received services and those who did not. There was a 13% difference, meaning that those who received services had a lower rate than those who did not. Those who did not receive services probably were more likely to be hospitalized, but in terms of a statistical perspective at the 0.05 level, it did not show. She theorized it was largely because the sample size is so small in terms of those who actually reported they were hospitalized.

**Public Comment:**

Mr. Leoni stated that he is proud to have been a part of this endeavor and applauded the quality of the professional research staff, who treated everyone with genuine respect. He stated that it was a far better research facility to have that collaboration. He stated that he is pleased that the Commission will be following up, because there is a lot of good information in these studies. It was a great process, but it does take more time and he felt it was rushed toward the end; he recommended allowing more time for this type of endeavor in the future.

**11. PRESENTATION ON STATUS OF CRIMINAL JUSTICE REALIGNMENT: ASSEMBLY BILL 109 IMPLEMENTATION**

Brenda Grealish, CDCR

Brenda Grealish, the Deputy Director of the Office of Research of the California Department of Corrections and Rehabilitation (CDCR), stated that CDCR has thirty-three prisons with approximately 133,000 inmates and 63,000 parolees, which is significantly less than in the past because of Realignment. County sheriffs supervise approximately 77,000 inmates, and the county supervises approximately 275,000.

Overcrowded prisons have been a challenge historically. The 2011 Realignment was undertaken, in part, to comply with a federal court order to reduce overcrowding in the state's thirty-three prisons to no more than 137.5 percent of the design capacity by June 2013. Other historical challenges have been high recidivism rates with almost two-thirds of CDCR parolees returning to prison within three years. CDCR has been under federal court oversight for the health care system since the early 2000s, and there is a large growth of the state's corrections budget. In FY 2005-2006, the budget was \$7.9 billion, and in FY 2008-2009, it was almost \$11 billion.

The initial efforts to reduce overcrowding included an emergency proclamation in 2006 to immediately transfer inmates to out-of-state facilities, implementation of program reforms in 2007-2008 including risk-and-needs assessments and other evidence-based practices, and a parole violation decision-making instrument in 2009. Early legislative efforts to reduce overcrowding include SB 678, which created financial incentives for counties; adjusted property crime thresholds; and established non-revocable parole, parole reentry courts, milestone completion credits, an alternative custody program, and medical parole. These early reforms

did cause a slight trend downward, but Ms. Grealish stated that it was not enough. More reforms were required, so the United States Supreme Court affirmed the order to reduce the prison population. The fiscal crisis also required major reductions.

Ms. Grealish stated that this led to the 2011 Public Safety Realignment Act, which was enacted on October 1, 2011. It allowed lower-level offenders to serve their sentences locally in counties; certain offenders released from state prison to be supervised by local county probation instead of state parole agents; and parole violators to no longer be returned to state prison, but go to the county jail. An offender will be subject to state parole supervision as determined by the offender's commitment offense, such as a current serious or violent felony, a lifer, a mentally disordered offender, or a high-risk sex offender. The Realignment Act has resulted in a monthly institution population drop of approximately 40,000 offenders. Ms. Grealish stated that much of this is due to parole violators not returning, along with the fact that the parolee population has decreased.

Ms. Grealish stated that the Office of the Inspector General (OIG) conducts medical inspections of the institutions and provides medical exceptions for CDCR. The process was designed to assess whether or not the state is adhering to medical community standards. OIG developed a tool for this purpose based on these medical community standards. Each institution receives a score after each report. The inspection team is made up of physicians, registered nurses, deputy inspectors general, and analysts. Adherence score post-Realignment for all thirty-three institutions is increasing from a moderate adherence to a high adherence level.

The post-Realignment release demographics show a higher number of males to females with slightly more male offenders under state supervision than under post-release community (county-level) supervision (PRCS). In contrast, there are more female PRCS offenders than there are female state parolees. For age of release, the eighteen to twenty-nine and over sixty age groups are more likely to be on state parole, and the thirty to fifty-nine age group tends to have a greater percentage of PRCS offenders than state parolees do. The race/ethnicity distribution shows most post-Realignment releases were Hispanic/Latino, White, or Black/African American. There are slightly more Hispanic/Latino or Black/African American state parolees than PRCS offenders and there are slightly more White PRCS offenders than state parolees. For the commitment offense category, state parolees are much more likely than PRCS offenders to have been committed to CDCR for crimes against persons. By comparison, PRCS offenders are much more likely to have been committed for property crimes or drug crimes. For the California static risk assessment (CSRA) scores, state parolees are more likely to have a low CSRA score, whereas PRCS offenders are more likely to have a high score. Under Realignment, the greatest percentage of offenders classified as serious and/or violent remain under the supervision of CDCR.

Changes enabled by the 2011 Realignment are a reduction in CDCR's budget; a Constitutional level of health care to end costly lawsuits and court oversight; improved prison operations, including new staffing standards; an improved classification system which eliminates the need for twelve thousand celled beds and improved gang management; and expanded rehabilitative programs to help reduce recidivism and save long-term costs.

#### **Commissioner Questions and Discussion:**

Chairperson Van Horn asked for a response to an article in today's Sacramento Bee, entitled "Fury at Hearing on California Prison Mental Health Case" by Denny Walsh and Sam Stanton. Ms. Grealish stated that she had not seen the article yet, but will look at it.

#### Robert Ochs, County Probation

Robert Ochs, the Chief Probation Officer of Sonoma County, stated that he was filling in for

Mack Jenkins, the President of the Chief Probation Officers of California (CPOC), and would speak about the probation perspective on Realignment.

Realignment is the biggest change in criminal justice in decades, realigning over 130,000 offenders, more than the prison population of thirty-eight states. However, it is easy to be blinded by the light of Realignment.

Prior to Realignment, county criminal justice systems faced many struggles. The systems require the right combination of probation supervision and programs in order to work well. California was one of only two states with no state support or county general fund support for adult probation. During the recession, most probation departments in the state took cuts in probation officers and programming budgets, leading to higher caseloads. SB 678 acted as a precursor to Realignment.

PRCS, the realigned population, are those that have been selected by the county courts, prosecutors, and probation to go to state prison. Individuals in a state prison tend to come out with more mental health and substance abuse needs. The population in state prisons is currently much lower. Now it is up to the counties. In addition, how counties are doing varies depending on collaboration, programs, and treatment.

For Realignment to work statewide or at the local level, it is going to take an approach at the county level of thinking broadly. There is not enough money in the funding formula for any county to just lock up offenders. Detention alternatives, programming, and appropriate supervision are viable options.

Mr. Ochs stated that his department employs almost 300 employees and has a \$50 million budget. The highest-risk people who will be realigned are only about 10-15% of the adult offender population. In order for Realignment to reach its full potential, underlying felony and the high-risk probation system must be repaired as well, or that population will feed the realigned population.

Some counties will not be able to take care of the realigned population, and some counties will be able to function at a very high level, which means they can use some of their resources to help the broader criminal justice system. As an example, in Sonoma County, Mr. Ochs stated that he can use the funding for the Data Reporting Center for the CRPS population, but he can place felony high-risk probationers there. They have a LCSW and an alcohol and drug specialist embedded in the adult probation office to deal with the newly realigned population and to help with the adult probation population.

Mr. Ochs stated that his concern is about the medical problems and Americans with Disabilities Act (ADA) lawsuits that may come up in jail, because money paid to medical lawsuits is taken from supervision and planning.

#### Aaron Maguire, CSSA

Aaron Maguire, the Legislative Representative of the California State Sheriffs' Association (CSSA), stated that he would speak about the great change to the state of California and the system of justice. With the founding of California in 1872, there were only three designations of crime: infractions, misdemeanors, and felonies. Misdemeanors were served in the county jails, and felonies were either served in state prison or were punishable by death. So county corrections facilities were constructed with the idea that people would be sentenced there for misdemeanors, and then there was a statutory cap of one year's imprisonment in place. Realignment increases the term of imprisonment.

CSSA recently put out a survey of jail populations. The current statewide population is approximately 1,200 people sentenced for over five years in the county jail; in some counties, there are approximately 50 people sentenced to over ten years in the county jail. Los Angeles has a person who has a county jail sentence of 43 years. These statistics are alarming because these facilities were not designed to house these individuals. The purpose of Realignment was to deal with a host of issues including the budget and the state prison population cap, but CSSA is concerned about this long-term population in the county jails.

Mr. Maguire highlighted some challenges in the mental health area. First, mentally disordered offenders (MDO) would normally go to state parole, which allowed them to receive some inpatient treatment services through the state hospital system. One of the quirks of Realignment is that, if someone is determined to be a MDO, they are required to remain on state parole so they can receive all those services; however, that statute is complicated. An individual must have committed a private crime with certain findings by mental health professionals and been certified as a MDO. Instead, decertified MDOs are realigned to PRCS, which interrupts treatment.

Another challenge is the increase in violence at the state hospitals themselves. They are not necessarily hardened facilities, and so there has been a tension between corrections and the Department of State Hospitals. In counties such as Napa and San Luis Obispo where there is a state hospital, the person who has acted violently is arrested and booked into the county jail, which is not equipped to handle someone with mental illness.

A similar challenge is the number of people determined to be incompetent to stand trial. They are arrested and spend time in the county jail pretrial. However, if they are found incompetent to stand trial, they are sent to the state hospital, where they are often discharged once they are restored to competency to stand trial. The county jail may not be equipped to handle severe mental illness, and this creates a cycle.

These concerns are part of Realignment, but not necessarily caused by Realignment. Prior to Realignment, over twenty county jails had either self-imposed caps, court caps, or federal caps that were exacerbated by Realignment and the new populations that the county jails have responsibility for.

Mr. Maguire stated that counties have to do things differently now. They cannot build their way out and they cannot lock people out continually because of insufficient funding. But the state has also provided some extra funding, \$500 million, as part of SB 1022 from last year, not to build increased jail capacity, but to build different kinds of beds or to replace rundown and decrepit facilities. CSSA is hoping to see some alternative proposals to provide programming – not to create hardened jail facilities, but alternatives such as Sonoma County's Data Reporting Center to provide programming.

#### Anne Robin, CMHDA

Anne Robin, the Forensics Committee Chairperson of CMHDA, stated that CMHDA completed its first survey to analyze the effects of AB 109 on the alcohol and drug programs and mental health programs. She stated that fifty-four counties are behavioral health counties, with an inclusionary substance use service as well as ongoing needs for additional mental health services. Statewide, over 40% of substance use funding has been lost in the last five years, so the substance use and disorder systems in the counties are highly in need of reform and additional supports. CMHDA is doing more forensic work in substance use and disorders services.

From the county treatment perspective, AB 109 varies county to county. A person who has been released from CDCR must find a place to live, manage a bank account, regain eligibility,

find a job, and acquire medication. These are the people who require more intensive mental health services.

Many of the enhanced offender population (EOP) are staying within the parole population; however, the most current offense is what makes someone eligible for AB 109 when they are released. It does not take into consideration that there may be previous violent offenses.

Many counties provide jail services themselves. Butte County contracts with the California Forensic Medical Group for mental health and medical services. CMHDA is working with the sheriff's office to provide some pretrial services and work with the people in the alternative custody services, even if they are not eligible for Medi-Cal.

### **Commissioner Questions and Discussion:**

Commissioner Brown agreed that prisons and jails were in rough shape to begin with. Thirty-seven out of the fifty-eight counties were already under some kind of court-ordered population capacity limit in their jails prior to Realignment. He stated that, in his case, he has added 15% prisoners in jail that he did not have before. This has caused tremendous issues that are directly connected to mental health. It is important for the Commission to understand the importance of this and to recognize that there is a need. He stated that Sonoma County's example of using Proposition 63 money for their probation officer and the mental health coordinator is exactly the type of supplement needed for the current system to be able to provide some of the necessary services. The services will be paid one way or another, either proactively or reactively.

Vice Chairperson Pating stated that Senator Correa asked for this panel and he assured that staff will get this information to him. He encouraged members of the panel to give comments to Executive Director Gauger that they would like to get to Senator Correa.

Vice Chairperson Pating asked a series of questions for the panel. He asked if there are demographics and statistics on what percentage of the releases involved mental health and what percentage involved substance abuse. Statewide, it is generally about 13-17% of the state prisons that have been mental health, and he asked if it has been a higher or lower population for substance abuse.

In terms of the consequences from a systemic perspective, Vice Chairperson Pating asked if there was an increase in homelessness or hospitalizations, and the impact of other services.

Vice Chairperson Pating also asked if there are model programs that MHSOAC can share with others, and if MHSA monies can be used to rebuild programs targeting populations that are at risk of recidivating because of mental health problems. He suggested involving the courts in discussions.

Vice Chairperson Pating summarized his questions stating he was trying to characterize some of the mental health issues, the consequences, and the role of MHSA, and whether there is a role the Commission could play in convening conversations between jails and hospitals, jails and peer services, , mental health directors, and substance abuse directors.

Ms. Robin stated that there are statistics available on CDCR's website. She used the statistics from February as a sample: 1,405 offenders were released from CDCR to PRCS, 80% of which were general population level; 16% were triple CMS, which is regular, standard, outpatient-level care; and 2% were EOP level of care. She stated that CMHDA has been working very closely with CDCR to collaborate and coordinate. There have been a number of difficulties in gathering statistics, because each county deals with individuals who are being enrolled in various levels of service. The sheriffs and probation officers may have some details, but data on who is

receiving treatment varies by county. CMHDA survey indicated most counties have the current capacity to treat the released individuals out of AB 109, but AB 109 is a time-limited population. After the individuals are released, they will no longer receive the treatment they need. Ms. Robin added that capacity does not mean prevalence, which does not mean quality of care.

Vice Chairperson Pating asked whether the shift of patients is simply financial, moving them from CDCR budget to the Medi-Cal budget. Ms. Robin stated that, if they are Medi-Cal eligible or low income plan eligible, the benefits are still yet to be determined. One of the details CMHDA is watching is the expansion population for Medi-Cal. The Medi-Cal patients in California are a carved-out population with a medical necessity top for a severely or chronically ill population. A number of people who need mental health treatment do not receive it if they have Medi-Cal, because they do not meet that medical necessity. In addition, the drug Medi-Cal system is underfunded and antiquated.

Chairperson Van Horn stated that the ongoing responsibility concerns the rehabilitation side of CDCR, which will happen at the county level. Ms. Robin stated that the community corrections partnerships (CCP) are helpful here. For instance, the Data Reporting Center and probation department had GED training programs. The Office of Education and sheriffs' departments are also involved in GED training. CMHDA is looking into a welding program and other activity training programs through the sheriffs' departments in conjunction with local education.

Regarding MHSA, Ms. Robin stated that there is a stakeholder process, and most of MHSA funding has been committed already. When there is additional funding available for MHSA, it is possible that local stakeholders will request further forensic services for this population. Not all counties have had mental health courts or are able to support them.

Vice Chairperson Pating agreed that it is important, when making newly integrated three-year plans, to involve and collaborate with the sheriffs.

Ms. Robin added that Butte County may have been so successful because its MHSA funding went to crisis intervention training for local law enforcement, EMTs, and paramedics. CMHDA helped provide the funding out of MHSA, which has led to a better partnership with law enforcement over the past several years.

Chairperson Van Horn cautioned Commissioners to remember that 49% of all community services and support (CSS) funding is discretionary to counties, so counties could possibly spend it on people affected by AB 109. MHSA does not have state money available to dedicate to this. It is up to the counties. It is very important to gather the right stakeholders to make decisions. At the local county level, the focus must be on the leadership group, including people who understand the level of need, particularly law enforcement representatives.

Ms. Robin stated that a number of MHSA advisory committees in counties have included some part of law enforcement, and, with the new awareness of the partnership, better treatment and care for folks who have criminal records will be the new standard. She added that parolee outpatient clinics that used to serve EOP patients have gone from forty-four psychiatrists to ten, and the population reduction has been less than 40%. CMHDA and CDCR will develop a work group to address this, but counties are not prepared to take on new parolees.

Chairperson Van Horn stated that there was also the possibility, fifteen years ago, of eliminating the parolee outpatient clinics and folding them into mental health. In addition, if the people in parolee outpatient clinics were in the county mental health system, they may be candidates for full service partnerships.

Ms. Grealish stated that CDCR Office of Research is working with data and recidivism, trying to measure the performance of Realignment by examining the one-year group of releases prior to

realignment and comparing the arrest and conviction rates. The data analysis and subsequent report are in progress, and will include demographics. Their data will be compared to the previous year, since PRCS population is beginning to stabilize.

Commissioner Nelson asked if probation officers can be paid with MHSA funds. Mr. Ochs stated that their mental health court program has a probation officer funded by MHSA. He believed MHSA could not fund services in custody. After state funding ceased, the county decided to fund the program, and the PO for the probation officer came from MHSA funding. Ms. Robin added that the probation needs to be part of a treatment team, not on the correctional side of probation.

Commissioner Nelson asked if parolees are searched for drugs. Mr. Ochs stated that this is part of a probation officer's role.

Commissioner Nelson asked if the suicide rates have gone down in prisons compared to three years ago. Ms. Grealish was unable to answer this question.

Mr. Ochs stated that, in response to an earlier question, funding co-eligibility workers through AB 109 to work with mental health and Medi-Cal is a wonderful program that connects individuals, even inmates, to services early. For PRCS population, they are connected to the system before they time out. There is also a misdemeanor/incompetent to stand trial program in the jail; it is not directly related to the realigned population, but it is very difficult population, which causes a lot of trouble for the jail. The program helps to relieve the pressure in a correctional system that will be under additional pressure soon.

Vice Chairperson Pating suggested connecting the individuals with the Health Insurance Exchange, because some of them may be eligible for private insurance. In addition, in a separate work MHSOAC did with the judicial council, the Commission found a solid recommendation for continued screening. With the risk assessment screen, this creates an active screening process.

## **12. COMMISSIONER COMMENTS**

Chairperson Van Horn stated that there will be a conference, in the September timeframe, for different components of evaluative and research studies across the behavioral health field to collaborate and vote on a common approach. By this time next year, the Commission will have a data set that applies across the board. At that time, there will be people coming into the system resulting from the increase in coverage through the Health Insurance Exchange. The Insurance Exchange will have a crossover of insured, uninsured, and Medi-Cal clients, and will alter the availability of employment for those people. It is important to find common ground in order to move toward a competent and comprehensive evaluative system.

Vice Chairperson Pating suggested that the Commission possibly facilitate a conversation between hospitals, jails, and peers.

The Department of Alcohol and Drug Programs merges with DHCS on July 1<sup>st</sup> and, with the retirement of Vanessa Baird in July, there will be no deputy director for behavioral care, nor is there an assistant deputy for mental health or drug and alcohol. There are three positions open at this time; the director's hope is to have at least one deputy position filled before July 1<sup>st</sup> for that person to be able to interact with Ms. Baird before she retires. There was no progress on the other two positions that Chairperson Van Horn was aware of.

Vice Chairperson Pating stated that everything else will fall under behavioral health services, leaving MHSA under mental health. He acknowledged the Commission's growing need to address behavioral health services in addition to the main mission of mental health services.

Chairperson Van Horn agreed that this is evolving naturally. There will be further discussions throughout the year on the Commission's role in these changes.

Commissioner Nelson stated that he did not believe the sheriff's department was participating in the stakeholder process at the county level. Chairperson Van Horn answered that this shifts from county to county. Law enforcement is deeply involved in some counties, particularly those with joint teams.

### **13. GENERAL PUBLIC COMMENT**

No public comment.

### **14. ADJOURNMENT**

There being no further business, the meeting was adjourned at 4:15 p.m.