WELLNESS • RECOVERY • RESILIENCE

Mental Health Services
Oversight & Accountability Commission

May 26, 2016
PowerPoint Presentations and Handouts

Tab 3:	•	**Handout:**	**OAC Financial Oversight Committee Financial Report, May 26, 2016**
	•	**PowerPoint:**	**Revised 2016 MHSA Financial report, May 26, 2016**
Tab 4:	•	**PowerPoint:**	**Orange County Innovation Plan - OAC Staff, May 26, 2016**
Tab 5:	•	**PowerPoint:**	**Sacramento County Innovation Plan – OAC & County Staff, May 26, 2016**
Tab 6:	•	**PowerPoint:**	**City of Berkeley Innovation Plan – OAC Staff, May 26, 2016**
Tab 7:	•	**Handout:**	**Exploring the Criminal Justice/Mental Health Intersection Project Framework**

Mental Health Services
Oversight & Accountability Commission

Financial Oversight Committee

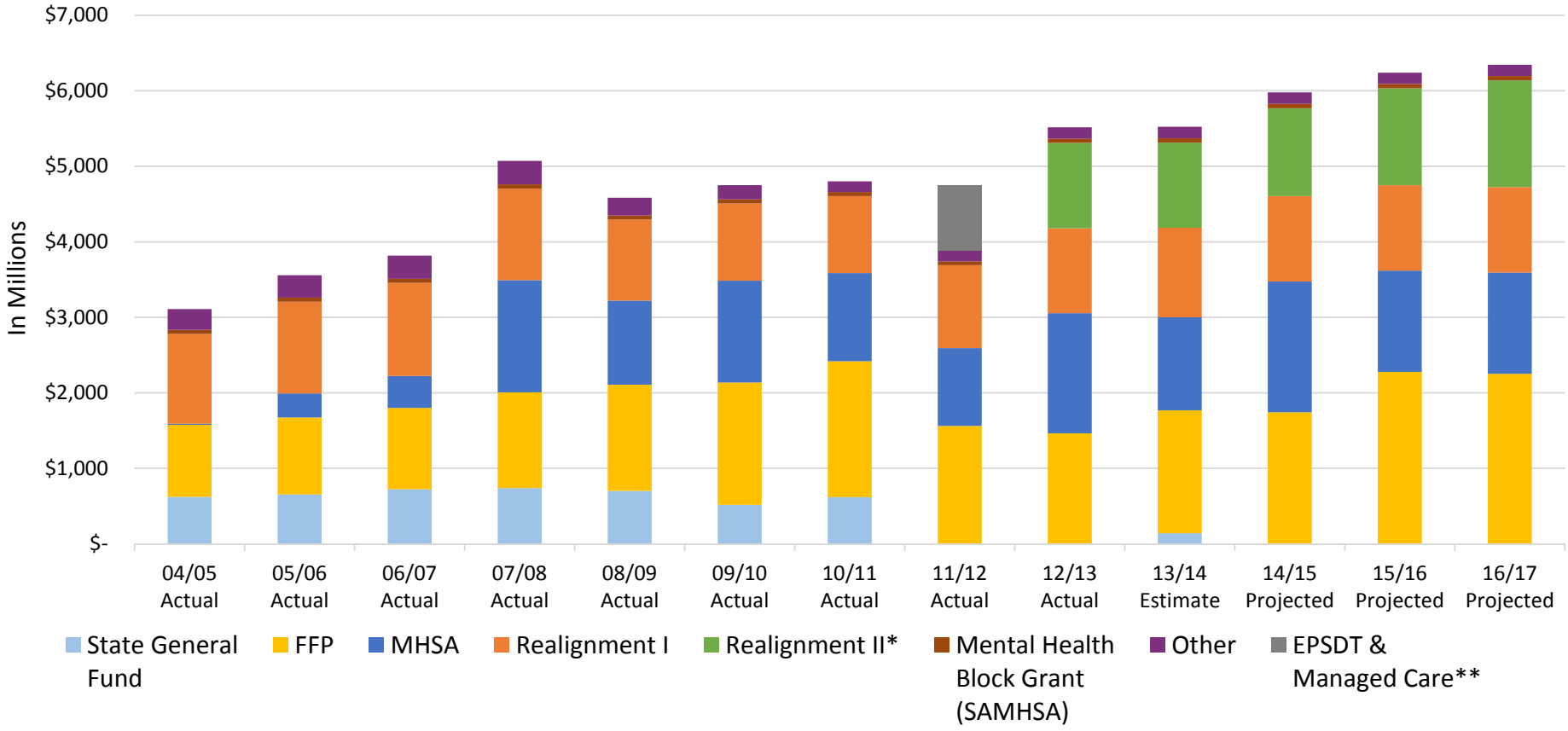
Financial Report

May 26, 2016

Mental Health Funding at the Local Level

FY 03/04 - 16/17

The graph below displays local mental health funding levels from 2004 to 2016 from different funding sources. The graph also indicates that even with fluctuations of individual accounts, funding for the overall system has grown since the enactment of the MHSA in 2005.



MHSA funding for counties shown above is from the governor's budget and the actual amount distributed will be based on actual revenues deposited into the fund less the amount reserved and spent on administration.

Realignment I 1991: Transferred control of several health and mental health programs from the state to the counties, reduced State General Funds to the counties, and provided the counties with "new" tax revenues from increased sales tax and vehicle license fees dedicated to counties for their increased financial obligations for health and mental health programs.

Realignment II 2011: shifts "existing" state revenues from sales tax, vehicle license fee for various programs including EPSDT and mental health managed care. The total funds for the 2011 Realignment includes funds for Substance Use Disorders.

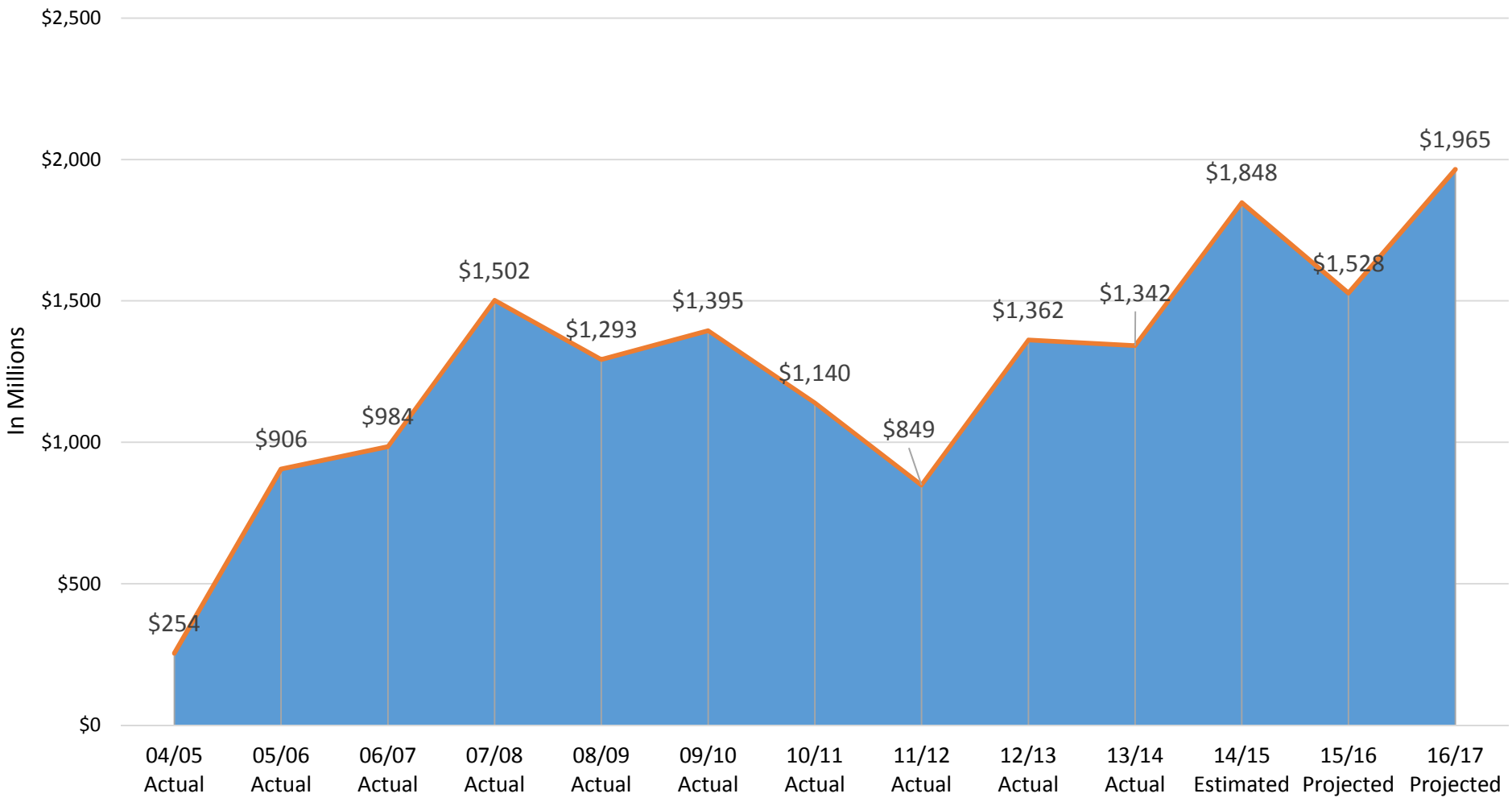
** One time redirected MHSA funding for EPSDT and Mental Health Managed Care. State general funding for mental Health was replaced by Realignment I and *Realignment II.

Source: Sources identified in Appendix 1
May 2016
Updated Semi-Annually

Total MHSA Revenue

FY 04/05 - 16/17

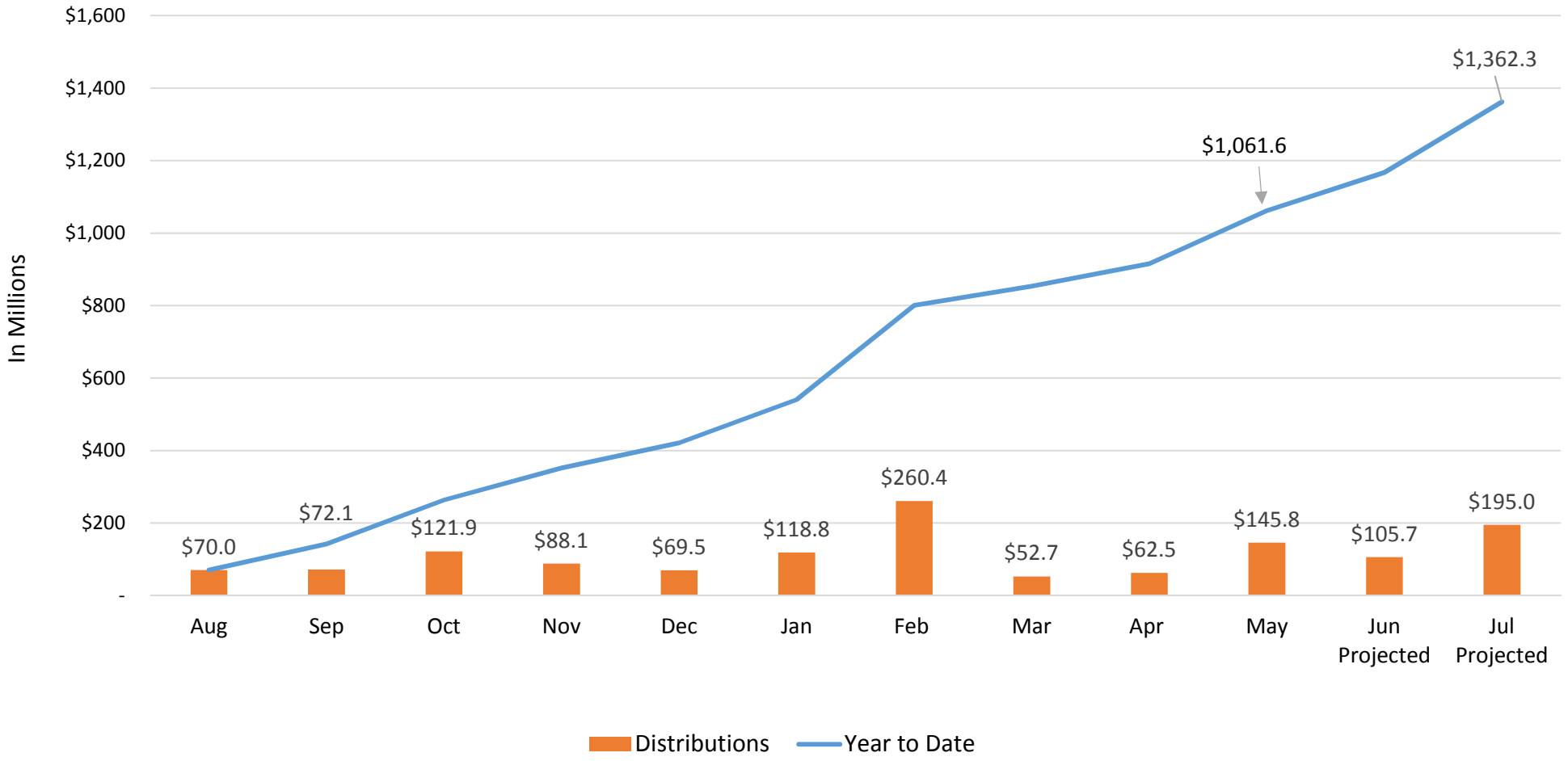
The graph below indicates the actual and estimated total MHSA Revenue received from 2004 to 2016. MHSA funding is susceptible to economic fluctuations as noted in the graph below. Each county is required to establish a prudent reserve that would mitigate, but not prevent, the need for program reductions in years with such extreme decreases in revenue. Each county's prudent reserve will be treated as a county-specific encumbrance by the Department and the target for each county's initial reserve amount was 50 percent of its CSS planning estimate.



Source: Sources identified in Appendix 2
May 2016
Updated Semi-Annually

Mental Health Services Funds Distributed to Counties FY 2015/16

This chart reflects changes to distributions of MHSA Funds from July 2015 to June 2016. Currently, these funds are no longer distributed by MHSA Component, (Community Services and Supports, Prevention and Early Intervention, Innovation, etc.).
Distribution in FY 2015/2016 represents actual Mental Health Services funds distributed for the first 10 months of 2015/16 and projected distributions for June and July.



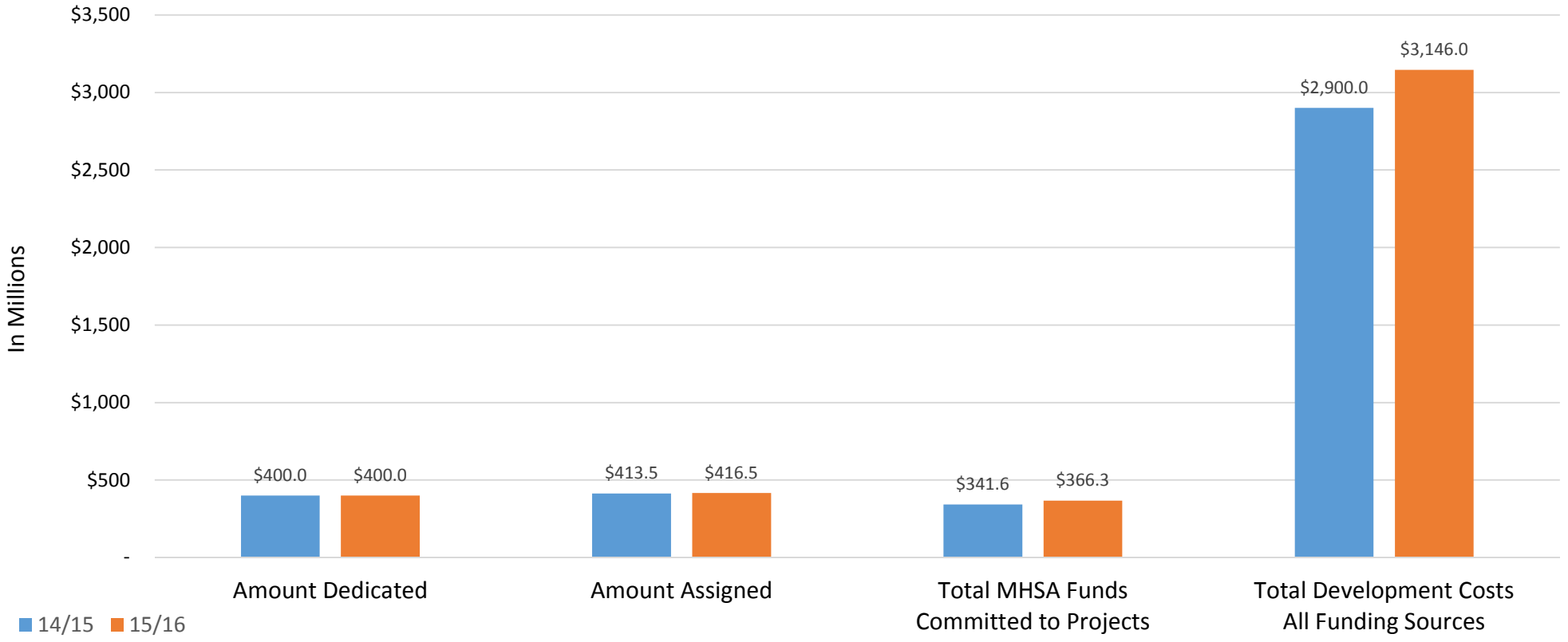
For a year to date, county by county summary of distributions, refer to the following link:
http://www.sco.ca.gov/Files-ARD-Payments/mentalhealthservices ytd 15/16.pdf

Source: State Controller's Office
May 2016
Updated Semi-Annually

MHSA Housing Program

FY 15/16

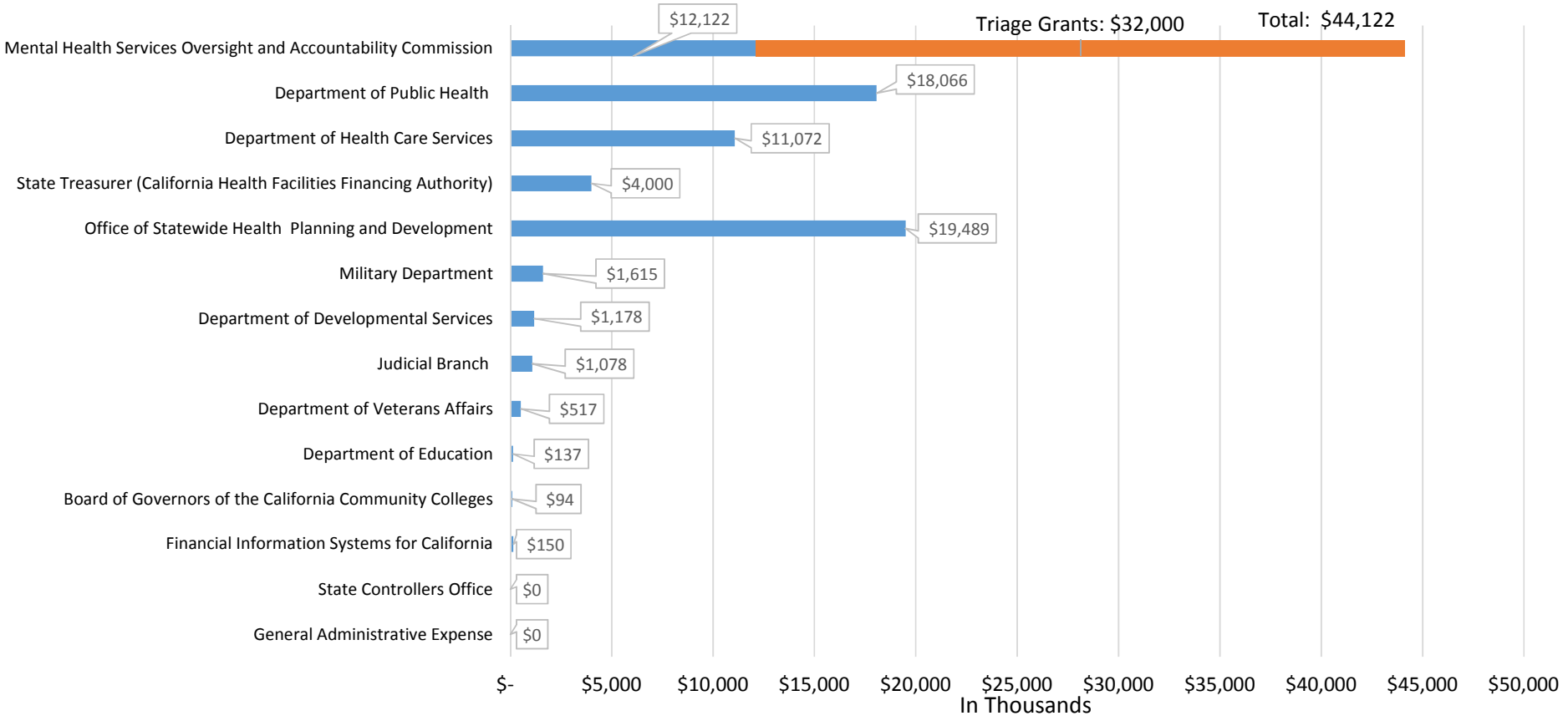
Executive Order S-07-06, signed by Governor Schwarzenegger on May 12, 2006, mandated the establishment of the MHSA Housing Program, with the stated goal of creating 10,000 additional units of permanent supportive housing for persons with serious mental illness who are homeless or at risk of homelessness. In May 2007, $400M of MHSA funds was made available under the MHSA Housing Program. This program makes permanent financing and capitalized operating subsidies available for the purpose of developing permanent supportive housing, including both rental housing and shared housing, to serve persons with serious mental illness who are homeless or at risk of homelessness. This was a one-time allocation of MHSA funds. Continued funding of the program will be a local decision as a county determines whether to assign additional MHSA funding beyond the original $400 million.



Source: Department of Health Care Services
January 2016
Updated Semi-Annually

MHSA Administration Funds by Department (In Thousands) FY 2016/17

This graph identifies the the state entities that receive MHSA Administrative Funds. These funds are utilized for administration, services, research, etc. A portion of these funds were reappropriated from prior year administrative funds and are attributed to the 5% administrative cap for a different fiscal year in which they are expended. The figure omits $233,000 proposed for the Department of Corrections and Rehabilitation.



Amount Budgeted for Fiscal Year 2016/17 $ 101,518 Projected

Source: Governor's Budget Summery for FY 2016/17 (4260 Department of Health Care Services)

Appendix 1: Mental Health Funding Levels at the Local Level (In Millions) FY 04/05 - 16/17

	04/05 Actual	05/06 Actual	06/07 Actual	07/08 Actual	08/09 Actual	09/10 Actual	10/11 Actual	11/12 Actual	12/13 Actual	13/14 Estimate	14/15 Projected	15/16 Projected	16/17 Projected
State General Fund	$ 621.6	$ 653.5	$ 721.8	$ 738.5	$ 701.0	$ 518.0	$ 619.4	$ 0.1	$ -	$ 142.5	$ -		
Realignment I	$ 1,189.9	$ 1,217.1	$ 1,230.9	$ 1,211.5	$ 1,072.4	$ 1,023.0	$ 1,023.0	$ 1,097.6	$ 1,124.0	$ 1,185.0	$ 1,134.0	$ 1,132.6	$ 1,133.4
Realignment II*	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 1,131.0	$ 1,129.0	$ 1,163.3	$ 1,283.1	$ 1,411.1
Mental Health Block Grant (SAMHSA)	$ 53.5	$ 54.4	$ 54.7	$ 55.1	$ 53.7	$ 54.0	$ 53.7	$ 53.1	$ 57.4	$ 57.4	$ 57.4	$ 57.4	$ 57.4
FFP	$ 955.5	$ 1,019.9	$ 1,076.8	$ 1,266.4	$ 1,404.6	$ 1,619.2	$ 1,799.9	$ 1,562.5	$ 1,465.0	$ 1,624.0	$ 1,743.0	$ 2,277.6	$ 2,252.9
MHSA	$ 12.7	$ 316.9	$ 426.3	$ 1,488.2	$ 1,117.0	$ 1,347.0	$ 1,165.1	$ 1,029.9	$ 1,589.0	$ 1,235.0	$ 1,730.0	$ 1,340.0	$ 1,340.0
EPSDT & Managed Care**	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 861.2	$ -	$ -	$ -		
Other	$ 276.2	$ 295.4	$ 306.8	$ 313.3	$ 233.9	$ 187.6	$ 139.4	$ 139.4	$ 150.0	$ 150.0	$ 150.0	$ 150.0	$ 150.0
TOTAL	**$ 3,109.4**	**$ 3,557.2**	**$ 3,817.3**	**$ 5,073.0**	**$ 4,582.6**	**$ 4,748.8**	**$ 4,800.5**	**$ 4,743.8**	**$ 5,516.4**	**$ 5,522.9**	**$ 5,977.7**	**$6,240.7**	**$6,344.8**

State General Fund (SGF): The SGF is funded through personal income tax, sales and use tax, corporation tax, and other revenue and transfers. Prior to the Governor's FY 2011/12 Budget Proposal, the primary obligations of the SGF provided counties with mental health dollars to fund specialty mental health benefits of entitlement programs including Medi-Cal Managed Care, Early and Periodic Screening Diagnosis Treatment (EPSDT) and Mental Health Services to Special Education Pupils (AB 3632). State General Fund for mental Health was replaced by Realignment I and Realignment II.
State General Fund in 2013/14 was for the California Health Facilities Financing Authority Senate Bill (SB) 82 Grants.

Realignment 1991: In the 1991/92 fiscal year, State-Local Program Realignment restructured the state-county partnership by giving counties increased responsibilities and funding for a number of health, mental health, and social services programs. This realignment provides counties with dedicated tax revenues from the state sales tax and vehicle license fee to pay for these programs.

Realignment 2011: Realignment is the shift of funding and responsibility from the State to the counties to provide mental health services, social services and public health. There are two sources of revenue that fund realignment: 1.0625 cents of State sales taxes and a portion of State vehicle license fees. The primary mental health obligation of realignment is to provide services to individuals who are a danger to self/others or unable to provide for immediate needs. It is also a primary funding source for community-based mental health services, substance abuse services, State hospital services for civil commitments and Institutions for Mental Disease (IMDs) which provide long-term care services. Realignment II is for behavioral health services more broadly. The numbers displayed exclude the fixed set-aside for Women and Children's Residential Treatment.

Mental Health Block Grant (SAMHSA): Mandated by Congress, SAMHSA's block grants are noncompetitive grants that provide funding for substance abuse and mental health services.

Federal Financial Participation (FFP): FFP is the federal reimbursement counties receive for providing specialty mental health treatment to Medi-Cal and Healthy Families Program beneficiaries. The amount of federal reimbursement received by counties is based on a percentage established for California and which is called the Federal Medical Assistance Percentage (FMAP) and gives counties the funding responsibility for EPSDT and Mental Health Managed Care.

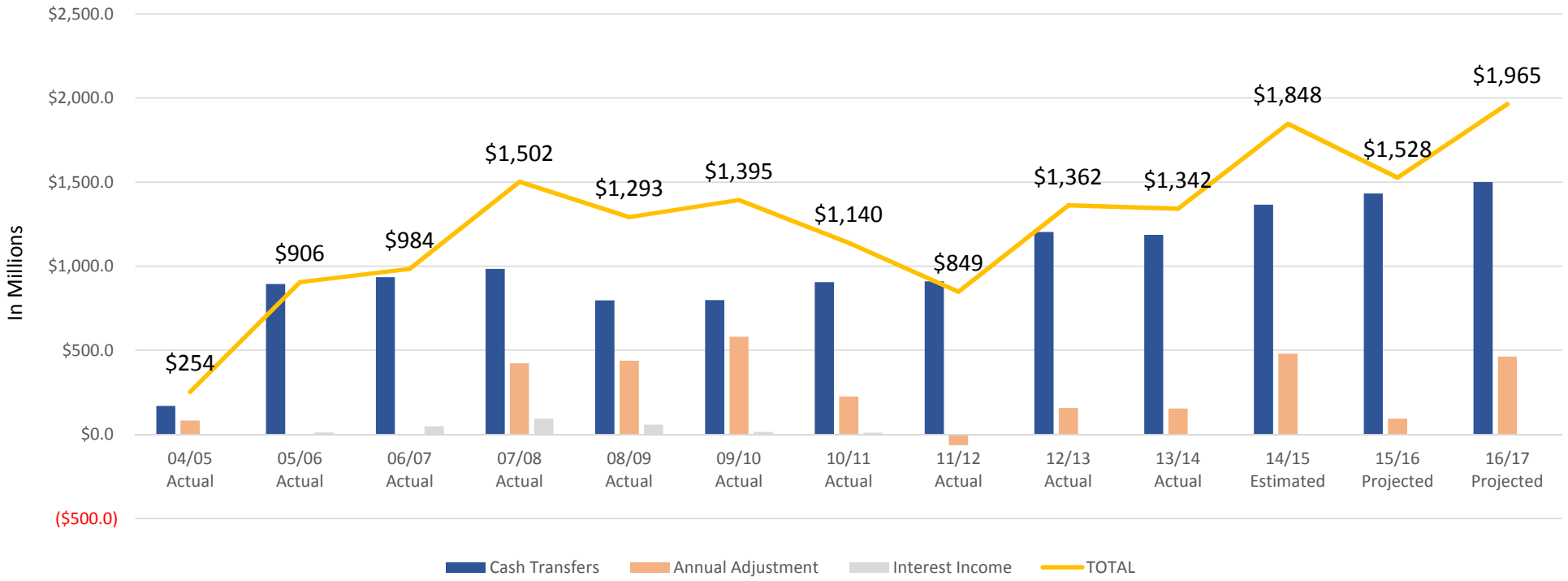
Proposition 63 Funds (MHSA): The MHSA is funded by a 1% tax on personal income in excess of $1 million. The primary obligations of the MHSA is for counties to expand recovery based mental health services, to provide prevention and early intervention services, innovative programs, to educate, train and retain mental health professionals, etc.

** One time redirected MHSA funding for EPSDT and Mental Health Managed Care.

Other: Other revenue comes from a variety of sources--county funds are from local property taxes, patient fees and insurance, grants, etc. The primary obligation of the county funds is the maintenance of effort (the amount of services required to be provided by counties in order to receive Realignment funds).

Appendix 2: Total MHSA Revenue FY 04/05 - 15/16

This graph and chart displays in more detail the information found on the graph on page two, Total MHSA Revenue . The dollars identified below may not tie to Annual Adjustment figures published by DOF because DOF uses an accrual method to determine dollars and DMH (DHCS after June 30, 2012) and the MHSOAC base their figures on cash received.



	04/05 Actual	05/06 Actual	06/07 Actual	07/08 Actual	08/09 Actual	09/10 Actual	10/11 Actual	11/12 Actual	12/13 Actual	13/14 Actual	14/15 Estimated	15/16 Projected	16/17 Projected
Cash Transfers	$169.5	$894.6	$935.1	$983.9	$797.0	$799.0	$905.0	$910.0	$1,204.0	$1,187.0	$1,367.0	$1,432.7	$1,500.6
Annual Adjustment	$83.6	$0.0	$0.0	$423.7	$438.0	$581.0	$225.0	($64.0)	$157.0	$154.0	$480.0	$94.0	$464.0
Interest Income	$0.7	$11.2	$49.2	$94.4	$57.6	$14.9	$9.7	$2.7	$0.7	$0.5	$0.8	$0.8	$0.8
TOTAL	$253.8	$905.8	$984.3	$1,502.0	$1,292.6	$1,394.9	$1,139.7	$848.7	$1,361.7	$1,341.5	$1,847.8	$1,527.5	$1,965.4

Mental Health Services
Oversight & Accountability Commission

Motion:

The MHSOAC accepts the May 2016 Financial Report.

Mental Health Services
Oversight & Accountability Commission

Revised 2016 MHSA Financial Report

May 26, 2016

WELLNESS • RECOVERY • RESILIENCE

Outline

- Revisions from the January report
- Motion

Revisions from the January Report

- The May 2016 Financial Report contains minor changes to projected MHSA revenues for FY 2015-16 and FY 2016-17.
- Projected MHSA revenue is down 2 percent for FY 2015-16 and 1.75 percent for FY 2016-17 from January.
- Projected distributions to the Counties from MHSF for FY 2015-16 are down 0.56 percent from January.* Monthly distributions have been higher year-over-year every month except August and May (both down sharply from last year).
- Through May, distributions to Counties are down $388 million from this point last year, but up $61.3 million from this point in 2013-14

Proposed Motion

- The MHSOAC accepts the May 2016 Financial Report as presented by the MHSOAC Financial Oversight Committee.

MHSOAC

Mental Health Services
Oversight & Accountability Commission

ORANGE COUNTY INNOVATION PLAN

May 26, 2016

WELLNESS • RECOVERY • RESILIENCE

Outline

- Summary
- Background
- Motion

Summary

- On April 24, 2014, the MHSOAC approved five multi-year Innovative Project plans for Orange County. In presenting the plans, Commission staff indicated that the amount sought for approval was $2,354,414. This amount was in error.
  - The correct total request should have been $6,932,589, as specified in County documents submitted on April 9, 2014.
- Orange County seeks approval for the balance of the requested funds: $4,578,175.

Orange County INN Projects

- Proactive On-Site Engagement in the Collaborative Courts. Four years of services.
  - Amount included in 2014 presentation: $370,261.
  - Project total requested: $1,437,348.
  - **Balance requested: $1,067,087.**
- Religious Leaders Behavior Health Training. Three years of services.
  - Amount included in 2014 presentation: $429,032.
  - Project total requested: $1,087,115.
  - **Balance requested: $658,083.**
- Access to Mobile/Cellular/Internet Devices in Improving Quality of Life. Three years of services.
  - Amount included in 2014 presentation: $327,583.
  - Project total requested: $938,215.
  - **Balance requested: $610,632.**
- Veteran Services for Military Families. Three years of services.
  - Amount included in 2014 presentation: $737,184.
  - Project total requested: $2,126,045.
  - **Balance requested: $1,388,861.**
- Developing Skill Sets for Independent Living. Three years of services.
  - Amount included in 2014 presentation: $490,354.
  - Project total requested: $1,343,866.
  - **Balance requested: $853,512.**

Background

- Staff are presenting these projects to the Commission for consideration of amendment in recognition of the full, county-requested funding amounts.
- The proposed motion would approve the difference between the originally requested amounts for total projected costs and the amounts presented to the Commission in Staff-prepared materials on April 24, 2014.
- Staff provided five background documents
  - STAFF INNOVATION SUMMARY—ORANGE COUNTY. Background brief.
  - Agenda Insert, Approval of the Orange County Innovation Plan (April 24, 2014)
  - Innovation Plan Approval Summary, Orange County Innovation (April 24, 2014)
  - Orange County Innovation (MHSOAC Staff PowerPoint, April 24, 2014)
  - MHSOAC Minutes of Teleconference (April 24, 2014)

Background, continued

- Start-up delays have affected all five projects
  - None has yet exceeded the dollar amounts considered and approved by the Commission in 2014.
  - Two projects have not yet started:
    - Access to Mobile Devices
    - Developing Skill Sets for Independent Living
- County staff are on this call and available to answer questions Commissioners may have about these projects.

Materials

- The following materials were included in the meeting packets and are posted on our website:
  - Staff Innovation Summary—Orange County
  - Agenda Insert, Approval of the Orange County Innovation Plan (April 24, 2014)
  - Innovation Plan Approval Summary, Orange County (April 24, 2014)
  - Orange County Innovation (MHSOAC Staff PowerPoint, April 24, 2014)
  - MHSOAC Minutes of Teleconference (April 24, 2014)

Proposed Motion

- The MHSOAC approves the balance of requested funding for Orange County's multi-year Innovative Projects originally approved on April 24, 2014, as follows:

- **Name**: Proactive On-site Engagement in the Collaborative Courts.
  - **Additional Amount**: $1,067,087.
- **Name**: Religious Leaders Behavioral Health Training.
  - **Additional Amount**: $658,083.
- **Name**: Access to Mobile/Cellular/Internet Devices in Improving Quality of Life.
  - **Additional Amount**: $610,632.
- **Name**: Veteran Services for Military Families.
  - **Additional Amount**: $1,388,861.
- **Name**: Developing Skill Sets for Independent Living.
  - **Additional Amount**: $853,512.

MHSOAC

Mental Health Services
Oversight & Accountability Commission

SACRAMENTO COUNTY INNOVATION PLAN

May 26, 2016

WELLNESS • RECOVERY • RESILIENCE

Outline

- Summary
- OAC Process
- Sacramento County Presentation
- Proposed Motion

Summary

- Sacramento County proposes to make a change to an existing mental health practice or approach by adapting existing urgent care clinic models to local circumstances in order to increase the quality of services for individuals experiencing a mental health crisis.
  - Mental Health Crisis/Urgent Care Clinic. Five years, $12,500,000 in MHSA funding
- Staff recommends that Sacramento County's proposal has met program requirements

Regulatory Criteria

- **Funds exploration of new and/or locally adapted mental health approach/practices**
  - Adaptation of an existing mental health program
  - Promising approach from another system adapted to mental health
- **One of four allowable primary purposes:**
  - Increase access to services
  - Increase access to services to underserved groups
  - Increase the quality of services, including measurable outcomes
  - Promote interagency and community collaboration
- **Addresses a barrier other than not enough money**
- **Cannot merely replicate programs in other similar jurisdictions**
- **Must align with core MHSA principles (e.g. client-driven, culturally competent, recovery-oriented)**
- **Promotes *learning***
  - Learning ≠ program success
  - Emphasis on extracting information that can contribute to systems change

What OAC Staff Look For

- **Specific requirements regarding:**
  - Community planning process
  - Stakeholder involvement
  - Clear connection to mental health system or mental illness
  - Learning goals and evaluation plan
- **What is the unmet need the county is trying to address?**
  - Cannot be purely lack of funding!
- **Does the proposed project address the need(s)?**
- **Clear learning objectives that link to the need(s)?**
- **Evaluation plan that allows the county to meet its learning objective(s)?**
  - May include process as well as outcomes components

Materials

- The following materials were included in the meeting packets and are posted on our website:
  - Staff Innovation Summary—Sacramento County
  - County Innovation Brief—Sacramento County

Sacramento County Presentation

- Uma K. Zykofsky, LCSW, Director, Division of Behavioral Health Services, Sacramento County Department of Health and Human Services.

SACRAMENTO COUNTY

Division of Behavioral Health Services

Proposed INN Project Mental Health Crisis/ Urgent Care Clinic

Uma K. Zykofsky, LCSW
Behavioral Health Director

Project Overview

- Urgent Care clinics are recognized as a successful intermediate step between routine and emergency physical health care
- Proposed project seeks to adapt mental health urgent care models operating in other counties
  - Adaptation will integrate wellness and recovery principles
  - Adaptation will focus on four key areas:
    1. Crisis program designation, including hours of service;
    2. Direct access;
    3. Ages served; and
    4. Medical clearance screening pilot
- Proposed project approach is supported by literature
  - *A Community-Based Comprehensive Psychiatric Crisis Response Service* (2005)
  - Publication describes a psychiatric crisis response system that includes core components, including Walk-In Crisis Service (i.e. proposed Mental Health Crisis/Urgent Care Clinic)

SACRAMENTO COUNTY

How is this project Innovative?

Sacramento County's proposed Mental Health Crisis/Urgent Care Clinic is innovative and differs from the other county models in the following key areas:

1. **Crisis Program Designation** – Operate as an after-hours outpatient treatment program versus a Crisis Stabilization Unit thus has a more flexible staffing pattern, allowing for tailored services to better meet community needs;
2. **Direct Access** – Provide direct linkage as an access point for both mental health plan and alcohol and drug treatment services;
3. **Ages Served** – Designed to serve all ages (children, youth, adults and older adults); and
4. **Medical Clearance Process Pilot** – Pilot a medical clearance process utilizing a screening tool developed with expertise from Sierra Valley Medical Society, UC Davis staff and broad-based local community subject matter experts. This tool will, as part of this process, allow clinical staff to initially screen to identify medical issues on site as needed. This will expedite mental health and substance use disorder interventions, either directly at the clinic or through other levels of care, including real-time coordination with system providers.

What are the key adaptations?

Proposed Sacramento County Model	Other County Models
Crisis Program Designation **Outpatient treatment program** • More flexible staffing pattern including peers and cultural brokers • Open after hours with immediate connectivity to 24/7 crisis stabilization unit	**Crisis stabilization unit (majority)** • More prescribed staffing based on regulations • Open 24/7 **Outpatient treatment program (one county)** • Open M-F, 9:00 am – 6:00pm
Direct Access • Provide direct linkage and authorization as an access point for mental health plan/alcohol and drug treatment services	• Provide linkage and referral to services
Ages Served • Designed to serve all ages	• Only adults served in Outpatient treatment program
Medical Clearance Screening Process Pilot • Multi-tiered screening process that includes service delivery and medical staff as needed, to better identify medical issues	• Nursing assessment

SACRAMENTO COUNTY

Proposed Clinic Design

- Proposed clinic operations will be contracted out through a competitive bidding process
  - Design of clinic will be determined through the competitive process and subsequent contract negotiations
- Clinic will serve all ages and will be open after-hours, weekends and holidays, 7 days per week
- Clinic will fully incorporate culturally and linguistically competent wellness and recovery principles
- Staffing will include: Peers and Family Members; Cultural Brokers; Nurse or Nurse Practitioner; Psychiatrist (including dually boarded); Licensed Clinicians; Alcohol and Other Drug Specialist; Case Manager; Administrative Staff; Psychiatric Residents; and Volunteers/Trainees

Background and System Considerations

- Sacramento County operates a significantly contracted behavioral health service delivery system – Approximately 90% of services are contracted
- Sacramento County is one of the most diverse communities in California with five threshold languages (Spanish, Russian, Vietnamese, Hmong, Cantonese) and a high number of newly arriving refugees
- Sacramento County has been working to build an improved crisis response service capacity

Sacramento County Crisis Services

SACRAMENTO COUNTY

Community Planning Process

- Process began with MHSA Steering Committee support for development of proposed project
- Community Input Sessions (125 participants)
  - Consumer/Family Member Focus Group
  - Pharmacy and Therapeutics Committee Focus Group
  - Cultural Competence Committee Focus Group
  - Provider Focus Group
- Workgroup developed project recommendation, incorporating Focus Group input
- MHSA Steering Committee refined recommendation and supported project inclusion in MHSA Annual Update
- MHSA Annual Update (including project) approved by Board of Supervisors on March 22, 2016

SACRAMENTO COUNTY

Significant Learning Objectives

- Sacramento County seeks to learn *whether* these adaptations will result in improved quality of services, including better outcomes for individuals experiencing a mental health crisis, as well as increased access to services
- Project will test *how* these adaptations can improve client and system outcomes, including:
  - Creating an effective alternative for individuals needing urgent mental health care
  - Improving the client experience in achieving and maintaining wellness
  - Reducing unnecessary or inappropriate psychiatric hospitalizations and incarcerations
  - Reducing emergency department visits for urgent mental health needs
  - Improving care coordination across the system, including linkages to other needed resources and timely access to mental health services

SACRAMENTO COUNTY

Project Evaluation

- Division will collaborate with University of California (UC) Davis, Department of Psychiatry to evaluate the effectiveness of the adaptation
- Evaluation team will develop an evaluation framework to address the effectiveness of four (4) key adaptive innovations, including consideration of the identified learning objectives and refinement of study question, and evaluation of system and client level outcome measures
- Longstanding partnership with UC Davis Department of Psychiatry, including provision of psychiatric services at our clinics
- UC Davis Department of Psychiatry will provide their evaluation activities in-kind, at no cost to the project
- Project evaluation will have many levels and stakeholders will have input along the way
- Progress and outcomes will be communicated to the community through email blasts and presentations and updates at community and system partner meetings, provider meetings, Cultural Competence Committee, MHSA Steering Committee and Mental Health Board meetings

Project Evaluation (cont'd)

Adaptations and learning considerations/questions:

1. **Crisis Program Design, including hours of operation**
   - Does the proposed program design, with flexible staffing patterns (including peers and cultural brokers) provide improved services leading to better client outcomes and improved client satisfaction?
   - Are the proposed alternate hours of operation optimal to meet system and community need?
2. **Direct Access**
   - Does direct access lead to shorter waiting times for new services and expedited reconnection to existing providers to improve client outcomes?
3. **Ages Served**
   - Is the proposed mental health urgent care model responsive to the needs of each of the following: children, youth, adults and older adults?
   - Which age groups most benefit from these services?
4. **Medical Clearance Screening Pilot**
   - Does a multi-tiered screening process better identify medical issues and expedite linkage to the most appropriate service provider?

Conclusion

- Other counties have implemented mental health urgent care centers; however, this proposed project includes adaptations in four key areas:
  1. Crisis program designation, including hours of service;
  2. Direct access;
  3. Ages served; and
  4. Medical clearance screening pilot
- Sacramento County's mental health system is unique and complex and warrants the opportunity to test this approach as an Innovation project
  - Sacramento County has been working to build an improved crisis response service capacity
  - The ability to test the Mental Health Crisis/Urgent Care Clinic in this evolving crisis services continuum is key to ensuring services are responsive to current community needs

SACRAMENTO COUNTY

Questions/Comments

Contact Information:

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Behavioral Health Director
Sacramento County
Division of Behavioral Health Services
email ZykofskyU@SacCounty.net
Phone (916) 875-9904

Proposed Motion

- **The MHSOAC approves Sacramento County's INN Project.**
  - Name: Mental Health Crisis/Urgent Care Clinic
  - Amount: $12,500,00
  - Project Duration: 5 Years

MHSOAC

Mental Health Services
Oversight & Accountability Commission

CITY OF BERKELEY INNOVATION PLAN

May 26, 2016

CITY OF BERKELEY

WELLNESS • RECOVERY • RESILIENCE

Outline

- Summary
- OAC Process
- Motion
- City of Berkeley Presentation

Summary

- The City of Berkeley proposes to adapt an existing mental health approach, Trauma Informed Care (TIC) training for educators, in partnership with Berkeley Unifed School District and interested parents, to create an institutional culture of trauma informed educators and increase access to mental health services.
  - Trauma Informed Care for Educators
  - 3 years, $180,000 in MHSA funding
- Staff recommends that the City of Berkeley proposal has met program requirements

Regulatory Criteria

- **Funds exploration of new and/or locally adapted mental health approach/practices**
  - Adaptation of an existing mental health program
  - Promising approach from another system adapted to mental health
- **One of four allowable primary purposes:**
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- **Cannot merely replicate programs in other similar jurisdictions**
- **Must align with core MHSA principles (e.g. client-driven, culturally competent, recovery-oriented)**
- **Promotes *learning***
  - Learning ≠ program success
  - Emphasis on extracting information that can contribute to systems change

What OAC Staff Look For

- **Specific requirements regarding:**
  - Community planning process
  - Stakeholder involvement
  - Clear connection to mental health system or mental illness
  - Learning goals and evaluation plan
- **What is the unmet need the county is trying to address?**
  - Cannot be purely lack of funding!
- **Does the proposed project address the need(s)?**
- **Clear learning objectives that link to the need(s)?**
- **Evaluation plan that allows the county to meet its learning objective(s)?**
  - May include process as well as outcomes components

Materials

- The following materials were included in the meeting packets and are posted on our website:
  - Staff Innovation Summary—City of Berkeley
  - County Innovation Brief—City of Berkeley

Proposed Motion

- **The MHSOAC approves Berkeley City's INN Project.**
  - Name: Trauma Informed Care for Educators
  - Amount: $180,000
  - Project Duration: 3 Years

Mental Health Services
Oversight & Accountability Commission

EXPLORING THE CRIMINAL JUSTICE/MENTAL HEALTH INTERSECTION

Project Framework

Goal

Develop an action agenda for the Commission, supported by key partners and stakeholders, which will reduce the number of individuals with mental illness involved with the criminal justice system, and improve outcomes for mentally ill individuals in custody and upon release from custody into the community.

Objectives

1. Document the intersections between the mental health and criminal justice systems.
2. Explore best practices and strategies for alternatives to criminal justice involvement and incarceration (i.e., diversion), treatment and programming for those in law enforcement custody, and transitioning out of custody into the community.
3. Identify challenges to reducing the number of individuals with mental illness in the criminal justice system, and improving treatment for those who must remain in custody and those released into the community, including "warm hand-off" to community-based services.
4. Explore models or strategies for improving outcomes for individuals with mental illness involved in the criminal justice system, including prevention, intervention, treatment addressing both psychiatric need and factors that contribute to criminal offending (i.e., criminogenic factors), discharge planning, and other service approaches.
5. Identify incentives, and other opportunities, such as training and technical assistance, to improve the use of best practices, innovations, and model approaches to reducing the number of individuals with mental illness involved with the criminal justice system, and improve outcomes for mentally ill individuals in custody and upon release from custody into the community.

These objectives will be integrated to advance the overall goal via the project's four elements: Project structure, public engagement, research and policy development, and communications and drafting.

Project Structure

The project's structure is designed to facilitate public involvement and provide transparency, incorporate information and develop a common understanding of issues and opportunities, and to inform and build integrity into the Commission's conclusions and final work product.

MHSOAC. The project is designed for the Commission and key partners to develop a shared common understanding of the options and opportunities to improve outcomes for mental health consumers involved with the criminal justice system.

MHSOAC Subcommittee. To ensure this project is consistent with the direction of the MHSOAC, a subcommittee of the Commission, chaired by Sheriff Bill Brown, will guide the project. The Subcommittee will formulate action-oriented recommendations for consideration by the Commission.

Public Engagement

Public Hearings. Public hearings before the full Commission will support the Commission's understanding of challenges and identification of opportunities for addressing those challenges. Hearings including individuals with lived experience, subject matter experts, policy leaders, advisory workgroup members and members of the public will provide additional foundational knowledge and first-person experiences supported by a discussion of existing challenges and potential opportunities for improvement. Sufficient time will be scheduled during public hearings to allow for an in-depth discussion between presenters and the Commission.

Public hearings will be designed to explore the following questions and others related to the criminal justice and mental health systems intersection:

1. What is the current structure of the criminal justice system, and at what points does this system intersect with the community-based mental health system and its consumers? Where is this intersection working well? Where is it not? How could it be improved?
2. How could community-based services be expanded to support better coordination between law enforcement or first responders and the mental health delivery system? How can mental health needs be met before criminal activity/history occurs or prior to involvement with the criminal justice system?
3. How do social determinants of crime (e.g., housing, employment, and education) and co-occurring disorders (e.g., substance use disorders, developmental disability, traumatic brain injury) impact the service delivery system's ability to effectively treat mental illness and prevent criminal justice contact?
4. What mechanisms are currently in place in the criminal justice or mental health system to identify individuals with mental health needs and divert them into appropriate services instead of the criminal justice system, or to services within the criminal justice system and in the community upon release? How do these mechanisms support reductions in recidivism and increases in wellness and recovery?
5. How are programs and services addressing both the psychiatric and criminogenic needs of this population to achieve better outcomes? What are the current alternative placement options for individuals with mental illness who commit low-level offenses? What is working and what is not working with regard to how crisis intervention/stabilization services and crisis residential programs are being deployed with this population?
6. What are the barriers or potential obstacles to expanding or replicating successful models across the state, and what are the opportunities or recommendations for overcoming those obstacles?

Subcommittee Public Engagement Meetings. The MHSOAC Subcommittee will conduct a series of meetings to engage stakeholders and subject matter experts to explore topics in-depth. These meetings will include subject matter experts from behavioral health, public safety, social services, and those with lived experience, representing state and county leaders, service providers, community members and others impacted by this issue. All meetings will be open to the public and will strive to incorporate a broad range of perspectives and experiences to support the development of shared knowledge, ensuring that any proposed recommendations address the needs and interests of diverse communities throughout California.

Community Forum. A community forum may be organized to engage clients, family members, professionals and other stakeholders in a dialogue about the criminal justice and mental health systems intersection. Presentations will be organized around local challenges and barriers, as well as solutions and innovative strategies.

Research and Policy Development

Data Linkage. The Commission will explore opportunities to conduct data analysis, such as matching criminal history data from the Department of Justice to mental health data to describe criminal justice involvement among those receiving mental health services, validate the arrest data within the Data Collection Reporting (DCR) database, and other analyses.

Literature Review. A thorough review of available written materials including academic articles, white papers, and public sector reports will shape and focus the project scope, support the development of problem definitions, and identify potential service delivery, models, or system improvement efforts. Information gleaned from the literature review will be summarized and provided to the Subcommittee, and stakeholders to support a shared understanding and develop recommendations.

Model Program Exploration. The Commission may explore opportunities to learn from national models in Florida, Texas and elsewhere. This exploration will highlight innovative strategies to reduce the number of people with mental illness in the criminal justice system, and develop alternative approaches to treatment in custody and upon release.

Site Visits. The Commission will organize site visits to support the development of foundational knowledge regarding the criminal justice/mental health intersection. Site visits may include county jails/correctional facilities, community-based service providers, mental health courts or other locations.

Communications and Drafting

To support the public engagement and policy development activities, the project will communicate all aspects of the project, including the status of public engagement activities, emerging descriptions of challenges and possible solutions, and ultimately the Commission's conclusions.

The final work product will be available on the Commission's website, with summaries of the activities and information gathering and as ongoing resource for implementation efforts. The final product, adopted by the Commission, should include the following three elements:

1. What can be done (policies, best practices; delivery systems).
2. How to get there (lowering barriers, building capacity, developing incentives).
3. The mechanisms for adoption and implementation (county plan proposals; legislation, learning collaboratives).

Project Schedule

This project is expected to last 15 months with projected completion by July 2017. Please see the calendar below for a proposed schedule of events and meetings. All dates and activities are tentative at this time and subject to change.

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Tentative Project Schedule

TENTATIVE PROJECT SCHEDULE		
Date*	**Task/Activity**	**Goals**
June 30, 2016	· MHSOAC Subcommittee Public Engagement Meeting	· Formalize project scope and goals · Refine schedule and activities · Discuss criminal justice system and mental health intersection
July 2016	· Model Program Exploration	· Visit programs and attend meetings on strategies being deployed in Miami-Dade County, Florida (Judge Steven Leifman) and Bexar County, Texas (Leon Evans)
August 2016	· MHSOAC Subcommittee Public Engagement Meeting	· Share findings from the Model Program Exploration and discuss potential application to California
September 21, 2016	· Site Visit - TBD	· Explore custody challenges for persons with mental health needs and challenges to preparing these individuals for release back into the community · Improve understanding of opportunities and challenges to diverting individuals with mental illness from the criminal justice system
September 22, 2016	· Public Hearing	· Hear from subject matter experts about the opportunities and challenges to reducing the number of individuals with mental illness in the criminal justice system, and improving treatment for those who must remain in custody and those released into the community
October 2016	· Community Forum - TBD	· Host community forum to engage with stakeholders (specifically clients and families) on local issues and solutions
November 2016	· MHSOAC Subcommittee Public Engagement Meeting	· Review alternate models and system improvement efforts · Guide selection of potential site visits and public hearing participants
January 25, 2017	· Site Visit - TBD	· Explore best practices, models and strategies for alternatives to criminal justice involvement and incarceration (i.e., diversion), treatment and programming for those in law enforcement custody, and transitioning out of custody into the community
January 26, 2017	· Public Hearing	· Hear testimony and discuss with subject matter experts best practices in mental health and criminal justice, and incentives to use such best practices · Explore models or strategies for improving outcomes for individuals with mental illness involved in the criminal justice system, including prevention, intervention, treatment addressing both psychiatric need and factors that contribute to criminal offending (i.e., criminogenic factors), discharge planning, and other service approaches
February 2017	· MHSOAC Subcommittee Public Engagement Meeting	· Summarize project findings and identify potential action-oriented recommendations

March-May 2017	· Draft Summary Action Agenda and Recommendations	· Organize, summarize and document activities and recommendations
June 2017	· MHSOAC Subcommittee Public Engagement Meeting	· Secure input and approval of action agenda and recommendation prior to presentation to full Commission
July 27, 2017	· Commission Review & Approval	· Commission to review, discuss and approve action agenda and recommendations

*All dates are tentative at this time and subject to change.

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Additional Engagement Opportunities

The Commission has been in consultation with federal, state and local organizations on this issue. Below additional opportunities for engagement with other organizations have been identified (subject to change):

June 2016: **White House Office of Science and Technology Policy, Data Driven Justice Initiative Convening, Washington, D.C.**

Workshop hosted by the White House Office of Science and Technology Policy to convene jurisdictions across the country that are involved in the "Data Justice Initiative" which will focus on local data exchanges, diversion, and data-driven risk assessment tools.

July 2016: **Council on Mentally Ill Offenders (COMIO), Site Visit to the Los Angeles Office of Diversion and Reentry, Los Angeles, California**

COMIO's primary purpose is to "investigate and promote cost-effective approaches to meeting the long term needs of adults and juveniles with mental disorders who are likely to become offenders or who have a history of offending." The Office of Diversion and Reentry was created within the Department of Health Services to oversee diversion of inmates who are mentally ill, have substance abuse issues and who are at risk of becoming homeless once they are released from jail.

September 2016: **White House Office of Science and Technology Policy, Data Driven Justice Initiative Convening, California**

Potential workshop in California to convene local jurisdictions that are involved in the "Data Justice Initiative" which will focus on local data exchanges, diversion, and data-driven risk assessment tools.

November 2016: **Words to Deeds Conference, Sacramento, California**

Since 2003, Words to Deeds has provided a unique forum that has evolved into a standard best practice for creating a true shift in the paradigm between criminal justice and mental health by fostering successful and ongoing collaboration among courts, criminal justice agencies, mental health professions, and governmental and nongovernmental organizations.

Early 2017: **Council of State Governments Justice Center/CPOC/CSSA/CBHDA/CSAC, Stepping Up California Summit**

Convening of California county leadership teams as part of the national Stepping Up Initiative to help counties reduce the number of adults with mental illnesses and co-occurring substance use disorders in jails.

March 2017: **Forensic Mental Health Association of California (FMHAC) Conference, Monterey, California**

The FMHAC provides an essential voice in California by training forensic mental health professionals, educating the public and giving support to legislation that improves the system in which we provide treatment to mentally ill individuals. FMHAC's annual conference has provided intensive training in current forensic mental health issues.