WELLNESS • RECOVERY • RESILIENCE

Mental Health Services
Oversight & Accountability Commission

November 17, 2016
PowerPoint Presentations and Handouts

Tab 2:	•	**PowerPoint:**	**Research and Evaluation Update and New Contracts**
	•	**Handout:**	**Exploring the Criminal Justice/Mental Health Intersection Project Commission Update**
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Mental Health Services
Oversight & Accountability Commission

Research and Evaluation Update and New Contracts

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Agenda Item 2
November 17, 2016

WELLNESS • RECOVERY • RESILIENCE

Update on Research and Evaluation Priority Areas

- Policy Projects
- County Supports
- Data Projects

Policy Projects

- Schools and Mental Health
  - Project goals
  - Subcommittee members
  - Dec. 6 Subcommittee workgroup meeting at Greater Sacramento Urban League from 12:30 to 4:30
  - Site visit to elementary school from 10:00 to 11:00
  - Collaboration with California Department of Education

Policy Projects

- Criminal Justice and Mental Health
  - Project goals
  - Goal of the Summaries
    - Subcommittee Meetings (June 30; Sept. 21)
    - Twin Towers Site Visit (Sept. 21)
    - Public Hearing (Sept. 22)
    - Texas/Florida Site Visits (Sept. 26-30)
    - Words to Deeds Conference (Nov. 2-4)
      Summary is forthcoming

Policy Projects

- Criminal Justice and Mental Health
  - Scheduled activities
    - December 9: Community Forum
    - January 18 & 19: Stepping Up in California Summit
    - February 22: Subcommittee Meeting and Site Visit(s)
    - February 23: Public Hearing
  - Upcoming activities
    - Community Forums and Focus Groups
    - Data Linkage and Analysis

County Supports

- Duration of Untreated Mental Illness study
- Toolkit for the CSS Tracking, Monitoring, and Evaluation System
- Evaluation of Triage Projects

Proposed for 2017

- Fourth Priority Area: Surveillance
  - Annual Mental Health in California Report Card
    - Data from existing sources/surveys
    - Support for existing surveys (e.g., MCAH and new questions based on gap analysis)
  - Survey to Assess Levels of Unmet Needs Among Selected Populations (e.g., TAY)

Next Steps

- The December Evaluation Committee meeting will include a discussion of these potential projects in light of available resources

Update on the MHSOAC Transparency Website

- Last month we demo'd the fiscal reporting tool.
  - User testing and final revisions will extend through early January.
- We are in the specification stages for the next applications (FSP classification; classification for all programs, providers, services)
- The ask today: up to $225,000 for recurring support of the web portal

Contracted Resources

Alexan RPM

- IT Strategy
- Quality Assurance
- Vendor Management
- Project Management
- Compliance

MHDATA

- Requirements Specification
- Database Architecture
- User Acceptance Testing
- Data Quality Management

iFish Group

- SAS Hosting and Support
- Data Portal Design, Development, Implementation and Maintenance
- Software Development

Informatix, Inc.

- Public Facing Website Design, Development and Maintenance
- Content Management Process Development
- Technical Support

Planned Budget

Deliverable	Estimated Not to Exceed	Status		
		Approved	New Request	Future Request
Proposition 63 and MHSOAC Website consolidation	$50,000	$50,000 Informatix (FY15/16)		
MHSOAC Website ongoing maintenance	$50,000	$50k Informatix (FY16/17)		
MHSOAC Data Portal infrastructure	$139,500	$139,500 iFish (FY15/16)		
Fiscal Transparency	$250,000	$250,000 iFish (FY16/17)		
Full Service Partnership	$390,000	$140,000 MHDATA (FY15/16) $250,000 iFish (FY16/17)		
Programs, Providers and Services	$475,000	$250,000 iFish (FY16/17)		$225k (specifications, detailed design, user acceptance, FY16/17)
Fiscal Transparency v2.0	$475,000	$250,000 iFish (FY16/17)		$225k (specifications, detailed design, user acceptance, FY16/17)
MHSOAC Data Portal Hosting and Maintenance (recurring)			$130,000 (12 months)	
MHSOAC Data Portal Data Maintenance and Application Maintenance (recurring)			$95,000 (12 months)	
Totals	$2,054,500	$1,379,500	$225,000	$450,000

Hosting Cost Breakdown

IFG Managed Services Costs	Annual Cost - Year 1	Annual Costs - Subsequent Years	Explanation of Costs	Explanation (Internal)
VM Instances/Infrastructure	$45,871.08	$45,871.08	VM/System Req: Prod: 1 web server: 2 core, 8 GB vRAM, storage: 100GB for OS/100GB for data/files, OS = Windows server; 1 SQL Server Standard: 4 core, 24 G vRAM, storage: 100GB SSD for OS/500GB for data files; Test/Dev: 1 consolidated server instance: 4 core, 24G vRAM, 150GB for OS & Dev tools/500GB for	This pricing includes all vmware, server infrastructure, networking, security/AV. Licensing will be separate. This category will also include Facility/NOC/Monitoring.
Licensing	$2,362.90	$2,362.92	All Servers: windows server 2012 std, DB for Prod: MS SQL (Dev DB: MSDN version)	OS/Windows: $52.92 (3 copies); SQL: $143.99 (1 copy), Test/Dev SQL
LiveStories Subscription	$11,995.00	$11,995.00	Annual subscription for up to 10 named users	Includes premium support
Daily Threat Protection and Monitoring	$17,280.00	$17,280.00	AlertLogic Threat Protection Subscription	
Storage	$7,157.16	$7,157.16	Total storage requirements	set for 1350GB (mix- SSD and SAS)
Backup	$5,367.84	$5,367.84		Compression/dedup included - resulting 75% of original footprint (less dedup because DB)
Bandwidth	$5,700.00	$5,700.00	forecasted 50Mbps	Does not include any special networking, such as vpn.
Support Services	$33,279.96	$33,279.96	Includes 16 hrs/mo of support	all support included
Total:	**$129,013.94**	**$129,013.96**		

Application Maintenance

- Estimated ongoing costs include:
  - Uploading and validating new data (e.g., ARERs): $28,000-$33,000
  - Application revisions (e.g., new functionality, requested modifications, etc.): up to $62,000

Proposed Motion

- The MHSOAC authorizes the Executive Director to enter into contracts for an amount not to exceed $225,000 for ongoing support of a platform-as-a-service for display and visualization of data regarding MHSA-related programs, providers, and services.

Mental Health Services
Oversight & Accountability Commission

Exploring the Criminal Justice/Mental Health Intersection Project

Commission Update – November 17, 2016

Meeting and Site Visit Summaries Attached:

- June 30, 2016 - Subcommittee Public Engagement Meeting
- September 21, 2016 - Subcommittee Public Engagement Meeting
- September 21, 2016 - Twin Towers Site Visit
- September 22, 2016 - Public Hearing during Commission Meeting
- September 26-30, 2016 - Texas/Florida Site Visits

Exploring the Criminal Justice/Mental Health Intersection Project

June 30, 2016 Subcommittee Meeting Summary

Project Background: The Mental Health Services Oversight and Accountability Commission (MHSOAC) is exploring how California serves justice-involved adults with mental health needs. The goal of this project is to reduce the number of individuals with mental health needs who become involved with the criminal justice system, and improve outcomes for those in custody and released from custody.

To support this project, the MHSOAC is facilitating a series of public hearings, public engagement meetings and community forums, and conducting sites visits to understand challenges and solutions, identify needs and gaps, and explore opportunities to build on past and present initiatives with similar objectives.

Meeting Summary: The first Subcommittee meeting was held on June 30, 2016 to introduce the project and its purpose to stakeholders, to review and discuss the project framework and scope, and to have an open discussion about how the criminal justice system intersects with the community-based mental health system. Attendees of the meeting were identified through a variety of outreach strategies, including engagement with professional mental health and criminal justice-related associations, MHSOAC Committees, and advocacy organizations.

"Our system of care is broken. We cannot help our clients if we cannot fix the system."
-Comment made by Behavioral Health Director during June 30 meeting

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The meeting began with speakers discussing their experiences as mental health consumers and family members, and was followed by a group discussion. A number of concerns emerged:

- Systemic barriers to reaching or serving those in custody and connecting them with available services in the community must be identified and addressed.
- Community services need to address more than mental health conditions; people need housing, employment, substance use services, and tools to build healthy social relationships to prevent incarceration and re-incarceration.
- We need to better understand funding and how existing funds can be leveraged: including Mental Health Services Act (MHSA), Triage (SB 82), Realignment (AB109), etc.
- SB 82 was designed to build a crisis system; we need to expand this system to develop alternatives to jails and hospitals as pre-booking diversion strategies.
- Gaps in the continuum of care that are contributing to the increases in mentally ill individuals in contact with our justice system need to be explored and funded as appropriate; models in San Antonio and Miami should be investigated and possibly adapted here in California.
- Forensically oriented Full Service Partnerships (FSPs) should be explored and possibly expanded.
- Public safety, not just law enforcement officers, should receive training such as crisis intervention training (CIT) to better understand mental illness and de-escalation.
- Individuals from diverse communities are overrepresented in the justice system; we need to explore and promote effective community-defined practices as they relate to diversion.
- There is a need to intensify case management, build more community connections, and focus on prevention and intervention.
- Counties are unique; solutions should avoid "cookie cutter" or "one-size-fits-all" approaches.
- Possible solutions: Sequential Intercept Model, collaborative courts, integrated interdisciplinary teams, supportive permanent housing, coordinated systemic approach, peer support workers, community-based competency restoration, and better risk assessments and screening.

Related past and present initiatives referenced during the meeting included the Consensus Project[1], Mental Health Issues Implementation Task Force[2], and The Stepping Up Initiative[3].

The meeting ended with a summary of next steps, which include identifying successful local and national models; working to develop a systematic approach to reducing incarceration; and improving treatment and lowering recidivism rates for the mentally ill. Attendees received a post-meeting survey to assess the value of the meeting and project.

"This is such a timely issue, and I'm hoping that the outcome of this project will result in a more comprehensive statewide approach to solving the overincarceration of individuals with serious mental illness in California."
-Anonymous meeting attendee response to post-meeting survey

For more information, including upcoming events, please visit www.mhsoac.ca.gov.

Organizational Attendee List

Federal Agencies and Organizations
- US Department of Veterans Affairs
- Council of State Governments

Legislature
- Assembly Budget Committee

State Agencies and Organizations
- Board of State and Community Corrections (BSCC)
- CA Department of Finance (DOF)
- CA Mental Health Planning Council (CMHPC)
- Council on Mentally III Offenders (COMIO)
- Legislative Analyst's Office (LAO)

State Associations
- CA Association of Social Rehabilitation Agencies (CASRA)
- CA State Sheriffs' Association (CSSA)
- Chief Probation Officers of CA (CPOC)
- County Behavioral Health Directors Association of CA (CBHDA)
- Peace Officers Research Association of CA (PORAC)

Local Agencies and Organizations
- Alameda County Behavioral Health Care Services
- CA Mental Health Authority (CalMHSA)
- Fresno County Department of Behavioral Health
- Fresno County Sheriff's Department
- Los Angeles County Department of Mental Health
- Napa County Department of Mental Health
- Napa County Department of Probation
- Orange County Health Care Agency
- Sacramento County Public Defender's Office
- San Bernardino County Department of Behavioral Health
- SF/Citywide Case Management Forensic Program
- Stanislaus County Sheriff's Department
- Yolo County Administrator's Office

Advocacy and Other Partners
- Disability Rights CA (DRC)
- Words to Deeds
- Mental Health America of Northern CA
- CA Telehealth Network (CTN)
- Turning Point Community Programs (TPCP)
- CA Association of Mental Health Peer-Run Organizations (CAMHPRO)
- Mental Health America (MHA)
- United Advocates for Children and Families (UACF)
- Racial and Ethnic Mental Health Disparities Coalition (REMHDCO)
- Steinberg Institute

[1] For more information: https://csgjusticecenter.org/wp-content/uploads/2013/03/consensus-project-full-report.pdf
[2] For more information: http://www.courts.ca.gov/documents/MHIITF-Final-Report.pdf
[3] For more information: https://stepuptogether.org/

Exploring the Criminal Justice/Mental Health Intersection Project

September 21, 2016 Subcommittee Meeting Summary

Project Background: The Mental Health Services Oversight and Accountability Commission (MHSOAC) is exploring how California serves justice-involved adults with mental health needs. The goal of this project is to reduce the number of individuals with mental health needs who become involved with the criminal justice system, and improve outcomes for those in custody and released from custody.

To support this project, the MHSOAC is facilitating a series of public hearings, public engagement meetings and community forums, and conducting sites visits to understand challenges and solutions, identify needs and gaps, and explore opportunities to build on past and present initiatives with similar objectives.

Meeting Summary: The Subcommittee held its meeting on September 21, 2016 to explore current and former efforts to address the criminal justice and mental health intersection, and discuss how these efforts should inform or be incorporated in the project, and identify any topics for exploration. Attendees of the meeting were identified through a variety of outreach strategies, including engagement with professional mental health and criminal justice-related associations, MHSOAC Committees, and advocacy organizations.

MEETING RESOURCE LIST

Words to Deeds
An annual conference to create a true shift in the paradigm between criminal justice and mental health by fostering collaboration.
http://www.fmhac.net/trainingw2d.html

Judicial Council
Mental Health Issues Implementation Task Force: Final Report
http://www.courts.ca.gov/documents/MHIITF-Final-Report.pdf
Task Force for Criminal Justice Collaboration on Mental Health Issues: Final Report
http://www.courts.ca.gov/documents/Mental_Health_Task_Force_Report_042011.pdf

Council of State Governments (CSG)
Criminal Justice / Mental Health Consensus Project
https://csgjusticecenter.org/wp-content/uploads/2013/03/consensus-project-full-report.pdf

The Stepping Up Initiative
https://stepuptogether.org/

The meeting began with speakers sharing their lived experience of participating in a community-based competency restoration program, followed by presentations from representatives of the Judicial Council and the Council of State Governments Justice Center. After the presentations, meeting attendees were invited in a public-forum setting to address the Subcommittee and provide comment. The feedback and insights offered during this public comment period included:

- A major shift in thinking and perceived importance on the topic has occurred. There are now more champions for persons with criminal justice experiences and mental health needs.
- Having historically more mentally ill people in jail is a community issue, not just a crime or mental health issue.
- Most crimes committed by this population are not due to mental illness, but to poor decision-making skills, which could be improved with integrated treatment.
- The population often receive their first diagnosis in the criminal justice system. However, the criminal justice system is only treating a fraction of those with mental health needs.
- Increases in the number of persons with mental health needs who become involved in the criminal justice system may be due to the defunding of school centers, school psychologists, community centers, and decreases in affordable and subsidized housing.
- Individuals classified as MIST (Misdemeanor, Incompetent to Stand Trial) can be “stuck in jails for months” until they are willing or have access to effective treatments.
- Conditions that mentally ill individuals face when released from prison (e.g. homelessness, lack of transportation, nutrition deficiencies) make complying with probation requirements difficult, and are in part responsible for re-incarceration.

"I've seen a paradigm shift in the last 10 years [regarding mental health and criminal justice]; many counties now have people who are in tune with the need for change. We know the 'what,' so now we need to focus on the 'how.'" – Kit Wall, Program Director for Words to Deeds

- Race/ethnicity must remain a factor in the discussion, both in how individuals from certain racial/ethnic groups are treated by criminal justice personnel and the disproportionate rates of incarceration and mental health disorders among certain racial/ethnic groups.
- The importance of data to summarize the seriousness of the problem and potentially calculate a risk to re-offend were discussed; counties cannot make improvements without having data to reveal current problems and gauge progress.
- A shortage of psychologists to treat those with mental health needs is a problem; there is a lack of county funding to attract and keep physicians who are "mental health/criminal justice capable."
- There is a lack of statewide collaboration on problems; since many counties have their own, narrow focus, there is a need for regional approaches, especially for small counties, as well as state guidance.

The meeting ended with a summary of next steps, which include more active engagement with communities already involved with Commission efforts; acting strategically to make sure that limited resources are allocated to solutions to the right problems; learning and applying what successful counties are doing to address the problems; coordinating efforts to deal with multifaceted issues (mental illness, incarceration, housing, education, drug treatment, unemployment); making change happen by implementing the Commission's final recommendations and not allowing the final report "to simply sit on a shelf." Attendees received a post-meeting survey for the purpose of assessing the value of the meeting and project.

For more information, including upcoming events, please visit www.mhsoac.ca.gov.

Organizational Attendee List

Federal Agencies and Organizations
- Council of State Governments

State Agencies and Organizations
- Judicial Council
- CA Mental Health Planning Council (CMHPC)
- Council on Mentally Ill Offenders (COMIO)

Local Agencies and Organizations
- Kern County Department of Mental Health
- Los Angeles County Board of Supervisors
- Riverside County Department of Probation
- Los Angele County Mental Health Commission
- Los Angeles County Department of Mental Health
- Los Angeles County Public Defender's Office
- San Bernardino County Department of Behavioral Health

Advocacy and Other Partners
- Disability Rights CA (DRC)
- Words to Deeds
- Anti-Recidivism Coalition
- Los Angeles Reintegration Council
- Mental Health Hookup
- NAMI Urban Los Angeles
- Little Tokyo Service Center
- United Advocates for Children and Families (UACF)
- Racial and Ethnic Mental Health Disparities Coalition (REMHDCO)
- Exodus Recovery
- California Forward

Exploring the Criminal Justice/Mental Health Intersection Project

Twin Towers Correctional Facility Site Visit Summary

Project Background: The Mental Health Services Oversight and Accountability Commission (MHSOAC) is exploring how California serves justice-involved adults with mental health needs. The goal of this project is to reduce the number of individuals with mental health needs who become involved with the criminal justice system, and improve outcomes for those in custody and released from custody.

To support this project, the MHSOAC is facilitating a series of public hearings, public engagement meetings and community forums, and conducting sites visits to understand challenges and solutions, identify needs and gaps, and explore opportunities to build on past and present initiatives with similar objectives.

Site Visit Summary: On September 21, 2016, Commissioners and MHSOAC staff visited the Los Angeles Twin Towers Correctional Facility, also known as the Twin Towers Jail.

The facility was selected for a site visit because it has the reputation of being the largest mental health facility in the United States. The jail has four levels of care reflecting a "step down" approach: inpatient hospitalization, high observation, moderate observation, and general population. Inmates in the high observation unit have a goal of 10 hours per week in group and individual therapy, along with medication. Those in the moderate observation unit receive medication and monthly meetings with clinicians. Care for the general population consists of medication management and follow-ups with clinicians.

LA County Jail Daily Inmate Population Statistics

L.A. County Jails 2016 Average Daily Inmate Population (Jan –Jun): 16,653

Mental Health 2016 Average Daily Inmate Population (Jan –Jun): 4,130 or 24.8% of total

Average Daily Male Mental Health Inmate Population (2009-2015)
2009: 2,052
2015: 3,084
+33% Increase

Average Daily Female Mental Health Inmate Population (2009-2015)
2009: 524
2015: 626
+16% Increase

SOURCE: Los Angeles County Department of Mental Health Population Trends Report

During the site visit, Commissioners and staff were escorted to and observed inmates in the moderate observation, high observation, and inpatient hospitalization areas of the jail.

The site visit also involved meetings with staff including the Assistant Sheriff and Chief of Custody Services Division. These administrators noted that over the years, the jail population has decreased but the proportion of inmates with mental health needs has increased. They discussed how addressing the complex needs of individuals with mental illness is challenging given staff vacancies, turnover, and available space within the facility. The difficulty in hiring and retaining clinicians was attributed to the lack of space for treatment and the stress of treating the acuity of illness in the jail environment. A lack of space to provide both individual and group therapy was identified.

"A significant challenge presented by providing a mental health program to over 4,000 individuals in the Los Angeles County Jail system is that the physical plant was never designed to house the mentally ill nor to provide treatment for them." – Assistant Sheriff Kelly Harrington, Los Angeles County Sheriff's Department, in a letter to the Commission

Another challenge identified by jail administrators was the lack of time to stabilize and treat inmates prior to release. While some inmates serve lengthy sentences, the period of time from intake to release for others can be quite short, often only a few hours. This "churning" of individuals with complex, behavioral health needs was said to make it difficult (in some cases impossible) to complete thorough assessments of mental health history or current needs, provide effective treatment and develop appropriate discharge plans before release. It was expressed that clinicians do what they can to stabilize what imminent psychiatric conditions are present, but they often have to terminate treatment early because the inmate is ordered to be released. Jail administrators reported that a large percentage of those in need of care had not received mental health services prior to incarceration. If these inmates are not connected to services in the community to maintain treatment, it was reported that they often return to incarceration.

In an attempt to break the cycle of incarceration, inmates with mental health needs, as identified through screening processes during booking, are encouraged by jail staff to create a release plan. Jail staff involved in release planning work with the inmate and his or her treatment team to identify appropriate and available community-based resources that can include full service partnerships, housing, education and job training. However, it was noted that two major challenges with this planning is not knowing when an inmate will be released from custody and where the inmate will reside following his or her release to ensure direct linkage to an accessible local mental health provider.

Commissioners and Twin Tower Jail administrators alike acknowledged that jails are an inappropriate place for those with mental health needs to receive treatment, and yet recognized that the only treatment received for some in need occurs in a custody setting. Community-based alternatives to jails for those detained by law enforcement are an alternative option to incarceration and are being investigated as part of this project. The Commission's project on mental health and criminal justice will continue to explore alternatives and the ways in which the concerns outlined by Twin Tower Jail staff and observations by Commissioners and staff represent information for identifying methods to improve in custody and release outcomes for those with mental health needs.

Exploring the Criminal Justice/Mental Health Intersection Project

September 22, 2016 Public Hearing Summary

Project Background: The Mental Health Services Oversight and Accountability Commission (MHSOAC) is exploring how California serves justice-involved adults with mental health needs. The goal of this project is to reduce the number of individuals with mental health needs who become involved with the criminal justice system, and improve outcomes for those in custody and released from custody.

To support this project, the MHSOAC is facilitating a series of public hearings, public engagement meetings and community forums, and conducting sites visits to understand challenges and solutions, identify needs and gaps, and explore opportunities to build on past and present initiatives with similar objectives.

Meeting Summary: The first public hearing before the full Commission was held in Los Angeles on September 22, 2016. The Los Angeles County public hearing highlighted both the challenges and successes to addressing the criminal justice and mental health intersection. Stakeholders and subject matter experts provided testimony and presented to Commissioners on: (1) needs and service gaps; (2) how the Commission could support improved outcomes for the mentally ill in custody and upon their release back into the community; (3) state and county roles; and (4) how the Commission can help California achieve the goals of the Mental Health Services Act (MHSA). Testimony and information from the public hearing is summarized in these four areas below.

Identification of needs and gaps.

Panelists stated that the number of people in jail with acute mental illness is increasing. Testimony was provided indicating that jail was often the first instance where individuals with mental health needs are assessed and treated. Collaboration between criminal justice and county behavioral health programs was said to be needed; the practice of using incarceration to obtain mental health services must end. Furthermore, panelists stated that jails were not built for the mentally ill or to provide treatment; space to hold individual or group mental health services are almost non-existent. Stakeholders noted that jails are violent and overcrowded; going to jail is generally a traumatic experience, but often worse for people with mental health issues.

"We are in crisis right now because of the delays involved in getting incompetent individuals from our jails to the state hospital to get them restored to competency. The length of time that they're being delayed is unconscionable." – Judge James Brandlin, Supervising Judge, Superior Court of Los Angeles County

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Finding appropriate housing for those with mental health needs who become involved with the justice system was identified as a problem. It was stated that these individuals are often chronically in crisis. A large percent of mentally ill people who enter the criminal justice system have a history of homelessness; the difficulty of finding housing for individuals re-entering the community was noted as a problem for cities and counties, which need to build more affordable housing. It was stated that of the 300 people released from county jails in California every day, one-third are mentally ill and 20 percent return homeless.

Panelists reiterated that diversion from jail is necessary, but not enough; better management of health care services in jail and innovative tools for improving housing accessibility are also essential. Incarcerated mentally ill individuals must get appropriate treatment as soon as possible; they also were said to need a continuum of care and a discharge plan to outpatient care.

Testimony was heard that there is a lack of acute and sub-acute psychiatric beds that limit treatment options for those needing a higher level of care while incarcerated. Twenty-five counties were reported to have no psychiatric beds. Stakeholders stated that there needs to be more funding for higher levels of care, and that acute care services must be connected to recovery services.

Presenters and panelist asserted that the status quo needs to be challenged. Involuntary psychiatric hold laws and regulations need to be reevaluated; they were criticized as discriminatory and vague, and often times court personnel are not even aware or clear on the laws. Rules currently in place are the biggest obstacle to getting help for those with mental health issues (e.g., Welfare and Institutions Code (WIC) 5150, which requires an "incident" to prove an individual is a danger to self or others). Major concerns were expressed over variations in county policies. Meeting participants emphasized the detrimental impact of stigma for those with mental illness and justice involvement, especially for the disproportionate number of African Americans involved in the criminal justice system. One panelist representing the county mental health department stated that we need to more effectively share confidential information (i.e., data sharing HIPAA information across service providers) to ensure a continuum of care.

"If we build all these housing options, support diversion, and we don't do something about attacking some of the bureaucratic impediments, then we won't see a sizable reduction in the number of people in jail."
– District Attorney Jackie Lacey, Los Angeles County

Improvement of outcomes.

Methods identified by presenters and panelists at the public hearing to improve outcomes for those returning back to the community from custody include "peer navigators" inside the jail to link individuals with community-based treatment and a "warm hand-off" to treatment and housing when individuals are released.

Testimony indicated that peer support, recovery outreach coaches and networking with county mental health departments, law enforcement and the courts have improved outcomes, but statewide evidence-based data are needed to support these findings and secure funding. Meeting participants also stated that performance measurements should be instituted, because outcomes cannot be changed without data that shows what is and is not working.

LOS ANGELES COUNTY PROGRAMS

Using the Sequential Intercept Model, LA County has diversion strategies at every "intercept":

Intercept One
- Pre-booking Diversion
- Urgent Care Centers
- Crisis Residential Treatment Programs

Intercept Two
- Mental Health Court Linkage/court Liaison Program
- Misdemeanor Incompetent to Stand Trial (MIST)
- Court Diversion and Alternative Sentencing Pilot

Intercept Three
- Community Reintegration
- Alternative to Custody IMD Step-Down
- Co-occurring Disorders Court

Intercept Four
- Forensic Outreach Teams (FOT)
- Just In Reach
- Comprehensive Adult Re-Entry (CARE)
- Mentally Ill Offender Crime Reduction Grant
- Reintegration Centers

Intercept Five
- Assisted Outpatient Treatment (AOT)
- Forensic Full Service Partnerships (FFSP)

For more on the programs offered by LA County, please visit: www.dmh.lacounty.gov.

For more information on the Sequential Intercept Model, please visit: http://www.prainc.com/wp-content/uploads/2016/04/SIMBrochure.pdf.

Panelists agreed that improvements must be made in continuity of care: from jail to community, especially related to medications, to increase chances of successful transition. Supportive education, employment and housing are key once released into the community to end the cycle of incarceration.

Panelists representing public safety asserted that some jails now have hospitals; what is needed is jails within hospital-like settings. Competency restoration should be done in mental health programs, not in jail. Testimony reiterated that programs and services for this population must address long-term homelessness and housing.

State and county roles.

The Commission heard testimony that a comprehensive system is needed and must be based on best practices – not ideology, personal preferences or discrimination. At the local level, this was said to mean county leadership must collaborate across agencies and with stakeholders to identify ways in which programs can be developed, funding can be blended and data can be shared. While planning is being conducted at the local level, the state must do its own strategic planning. Panelists and presenters stated that a statewide strategy is crucial to close the "revolving door" for the mentally ill (i.e., jail, mental hospital, homelessness, re-incarceration) and to provide diversion and re-entry programs (especially housing). Testimony was heard that the state should support counties by promoting best practices, identifying incentives, and reexamining the laws governing the treatment of those with mental illness during a crisis which often results in law enforcement intervention.

"We believe that the state can help support our local governments by taking the lead in developing a shared vision and understanding among all partners roles, restraints and opportunities for promoting recovery for our shared clients, supporting mechanisms for information sharing across systems, promoting the use of validated assessment tools that can assess risk and needs together with mental health and underlining substance use disorder issues, and identifying and disseminating best practices for working with the justice involved population."
— Robin Kay, Ph.D., Acting Director of Mental Health, Los Angeles County Department of Mental Health

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As a state entity, the Council on Mentally Ill Offenders (COMIO) was created in 2001 to bring together criminal justice and mental health representatives; devise ways to keep the mentally ill out of criminal justice; help with their re-entry into the community; and reduce recidivism. COMIO works to improve the behavioral health system; investigate, identify and foster cost-effective strategies to help the mentally ill; and use the early window of opportunity to advocate for people with mental illness at risk for incarceration. A representative of COMIO stated at the public hearing that the MHSOAC and other state entities (including associations) should model the cross collaboration needed at the local level to create lasting systems change.

Achieving the goals of the MHSA.

More funding was identified as being needed to increase the number of pre- and post-booking diversion strategies; shorten the long wait for a state hospital bed; and linkage to appropriate treatment programs when a person is identified as needing mental health services. One pilot project in Los Angeles County identifies candidates for Full Service Partnership (FSP) or Integrated Case Management Services, and then links them to services upon release. The biggest challenge is having enough

resources and linkages to services. Testimony was heard that the Commission should advocate for more forensically-oriented FSP slots, support wraparound services funded by MHSA at the front and back end of the justice system, promote MHSA values within acute settings, and support counties that want to blend MHSA with other funding, including examining barriers that may prevent them from doing so.

Mental Evaluation Unit.

The Commission heard testimony from the Mental Evaluation Unit (MEU) within the Los Angeles Police Department (LAPD). LAPD policy gives watch commanders some discretion on misdemeanor warrants involving the mentally ill. In 80 percent of 911 calls, the person is let go. In 9 percent to 10 percent of cases, the individual is diverted (i.e., referred) to health services; the remaining offenders are incarcerated. For felony crimes, the individual is booked, and the Case Assessment Management Program (CAMP) team follows up with the court system and probation to mandate mental health treatment. Lack of health care continuity and a shortage of facilities pose the main roadblocks to helping the mentally ill.

The Systemwide Mental Assessment Response Team (SMART) work 24 hours a day, seven days a week. The program has day- and night-watch units with eight cars each, plus an additional car and triage staff around the clock. Mental health clinicians team up with specially trained officers to assess the situation and get mentally ill individuals the help they need. Senior lead officers do outreach and training, meet with stakeholders and hospitals to discuss how to improve the program, and serve as liaisons to hospitals.

The MEU also provides a 40-hour police training program on responding to crisis calls (similar to Crisis Intervention Training or CIT). SMART cases are referred to detectives who do workups and additional follow-up with the individuals involved to ensure they receive services. Collaboration and teamwork are key. Data about interventions and crises in the field is captured on the front end; this information enables outcome assessment on the back end. Cases are never closed because mental illness cannot be turned on or off. Law enforcement continues to monitor these cases and also tracks outcomes. Helping the mentally ill is a social and community problem, not just a criminal justice problem.

Next steps.

During the first public hearing, Commissioners heard testimony from subject matter experts and stakeholders to support the Commissioners' understanding of local and state challenges and opportunities related to reducing the number of individuals with mental health needs who become involved with the criminal justice system, and improving outcomes for those in custody and released from custody. The next public hearing will 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.

For more information, including upcoming events, please visit www.mhsoac.ca.gov.

Exploring the Criminal Justice/Mental Health Intersection Project

Texas and Florida Site Visits Summary

Project Background: The Mental Health Services Oversight and Accountability Commission (MHSOAC) is exploring how California serves justice-involved adults with mental health needs. The goal of this project is to reduce the number of individuals with mental health needs who become involved with the criminal justice system, and improve outcomes for those in custody and released from custody.

To support this project, the MHSOAC is facilitating a series of public hearings, public engagement meetings and community forums, and conducting sites visits to understand challenges and solutions, identify needs and gaps, and explore opportunities to build on past and present initiatives with similar objectives.

Site Visit Summary: During the week of September 26-30, 2016, a delegation of criminal justice and behavioral health representatives from California visited Bexar County, Texas and Miami-Dade County, Florida to observe and gather information on nationally-recognized models that reduce the justice involvement of those with mental health needs. The National Institute of Corrections (NIC), within the U.S. Department of Justice, supported the travel and provided technical assistance for these site visits.

California Delegation

Virginia Bass, Humboldt County Supervisor, and Vice Chair, Administrative Justice Committee, California State Association of Counties (CSAC)

Bill Brown, MHSOAC Commissioner and Sheriff, Santa Barbara County

Victor Carrion, Chair, MHSOAC

Toby Ewing, Executive Director, MHSOAC

Sandra Gallardo, Assistant Secretary, California Health and Human Services Agency (CHHS)

Linda Penner, Chair, Board of State and Community Corrections (BSCC)

Ashley Mills, Senior Researcher, MHSOAC

Stephanie Welch, Executive Officer, Council on Mentally Ill Offenders (COMIO)

This document summarizes the Texas and Florida models the delegation visited and outlines strategies California could adopt, adapt or expand to reduce the number of adults in jail with mental health needs and improve outcomes for those in custody.

Bexar County, Texas Model: Developers of the Bexar County model recognized the need to stretch existing dollars by blending funding streams, and that required trust and the willingness to collaborate across systems. Specifically, county partners acknowledged that individuals with behavioral health and housing needs contributed to unnecessary overcrowding in jails and excessive law enforcement overtime, and could better be served by community-based services. In response, county partners established guidelines for giving officers discretion to divert eligible non-violent detainees into community-based crisis care.

"This is the future of policing." – San Antonio Police Department Officer when describing how officers are now being trained to better recognize and respond to signs of serious mental illness

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The California delegation first met with representatives from The Center for Health Care Services, the mental health authority for Bexar County, to learn how their programs and services are saving more than $50 million by providing an alternative to jail for those in a mental health or substance use crisis who come into contact with law enforcement. The delegation toured The Restoration Center, which is open 24 hours and accepts walk-ins and individuals detained by law enforcement. The Center provides a full range of services to address physical and behavioral health needs, including psychiatric stabilization and detoxification. Substantial cost savings are due to decreased officer involvement time. After being brought to The Restoration Center, officers are able to leave within 5-10 minutes and individuals in crisis

are assessed and observed, and if appropriate, are able to stay up to 48 hours in the inpatient psychiatric unit. All San Antonio Police Department officers also are required to take 40 hours of Crisis Intervention Training (CIT) to learn de-escalation techniques and handle behavioral health crises.

The site visit to Texas included a tour and meeting with representatives from Haven for Hope, a campus-style resource for addressing homelessness. Since Haven for Hope opened in 2010, the homeless population in downtown San Antonio has dropped approximately 80%, and 90% of those receiving a housing placement have not return to homelessness after one year. In addition to offering on-site housing, available services on campus include job training and employment readiness, education, behavioral health services, spiritual services, and other services such as legal, animal kennel, and physical rehabilitation. Those unwilling or waiting to participate in services are able to stay in The Courtyard, an outdoor but enclosed safe place to sleep.

Bexar County, Texas Model Highlights:

- An accessible resource for law enforcement to divert individuals in a behavioral health crisis to co-located services (a "one-stop-shop") that address a full range of behavioral health and physical health needs as an alternative to incarceration or hospitalization.
- Behavioral health crisis training for all law enforcement officers and established guidelines providing officer discretion to divert non-violent, misdemeanor-level offense detainees with apparent behavioral health needs.
- Utilization of technology that allows for data sharing to access medical records across agencies and systems, and to search for and identify available resources in the community, such as open bed space.
- Formal and informal (see "Four Questions" box) screening and assessment of mental health needs at numerous diversion points, including in the field by law enforcement and in custody settings by jail personnel.
- Emphasis and respect for the role of Certified Peer Support Specialists as partners in the treatment of those recovering from behavioral health conditions.
- Resources and services provided through public/private partnerships. Significant funding for Haven for Hope came from local philanthropy. The Center for Health Care Services receives over $99 million in revenue from 135 different sources, including federal, county, state, grants and private donations.

Four Questions

Individuals coming into contact with the justice system are asked four questions by law enforcement and jail staff:

1. Have you ever been seen by a doctor for mental illness?

2. Have you ever been prescribed medication for mental illness?

3. Have you, in the past, considered or tried to kill yourself?

4. Are you considering killing yourself today?

Miami-Dade County, Florida Model: Under the leadership of Judge Steven Liefman and following a lawsuit filed by the US Department of Justice against the county jail, Miami-Dade County developed model pre- and post-booking diversion strategies intended to reduce the justice involvement of those with serious mental illness (i.e., schizophrenia, bipolar disorder, major depression) or co-occurring serious mental illness and substance use disorders, and to connect those individuals with community-based treatment. The delegation met with representatives from the Eleventh Judicial Criminal Mental Health Project (CMHP) and witnessed Felony Jail Diversion Program proceedings. Eligible individuals with misdemeanor or some felony

"Whoever you have in your life, bring them along. They need to learn how to support you." – Jail Diversion Program Team Leader on the role of family in diversion programs

charges are diverted voluntarily to an alternative docket (similar to a mental health court, however, it does not include those incompetent to stand trial) where they are offered services through community-based service providers while under court supervision. The program serves approximately 600 individuals annually.

The delegation then heard about CMHP's investments in Crisis Intervention Training (CIT). Similar to Bexar County, 40-hour CIT for law enforcement is now delivered in all police departments in the county, and they are seeing meaningful reductions in use of force and injuries to officers. Training also is made available for emergency dispatchers, hospital staff, court staff, and the business community. In 2015, CIT officers responded to over 10,000 calls, diverting almost 1,900 individuals but having to make only 24 arrests.

What is Crisis Intervention Training?

Developed in Memphis, TN, Crisis Intervention Training (CIT), is a 40-hour training program for first responders, particularly law enforcement, who come into contact with individuals experiencing a behavioral health crisis, and better prepares them for such contact. Recognition of mental illness and verbal de-escalation techniques are emphasized.

Overall goals:

- Promote safety for individuals in a mental health crisis and those responding
- Appropriately divert those in crisis to services

More information on CIT can be can be found at: http://cit.memphis.edu/.

The delegation ended its visit to Miami-Dade County by touring Camillus House, a campus-style facility providing food, clothing, shelter, and a full range of physical and behavioral health services. CMHP recently partnered with Camillus House to develop a residential reentry program for criminal offenders and an innovative diversion strategy that utilizes special identification cards for those receiving mental health services. If an officer detains a holder of these special cards for minor incidents, those officers know they can take those individuals to a mental health facility for services instead of jail.

Within two years, the county hopes to open the Mental Health Diversion Facility which is being converted from a forensic jail that closed in 2007 as an alternative to jail. The facility will be a one-stop-shop similar to that in Bexar County, equipped with a central receiving area, triage, behavioral and physical health services, a court room and crisis unit.

Miami-Dade County, Florida Model:

- Postbooking diversion program and crisis stabilization unit as an alternative to jail for those with a serious mental illness that are arrested for misdemeanor and some felony charges.
- Employs certified peer support specialists to partner in treatment and community reentry, but also encourages the involvement of the family to support individuals as they progress through diversion programs.
- Development of the Mental Health Diversion Facility, designed to provide a full range of services, such as crisis stabilization, transitional housing, day treatment, and intensive case management for those with serious mental illness involved in the justice system.
- Assistance for those applying for social security benefits using SSI/SSDI Outreach Access Recovery (SOAR), an approach that yields 91% approval rate within 40 days of applying for first time benefits.
- Robust Crisis Intervention Training (CIT) for law enforcement and others for those that may come into contact with someone experiencing a behavioral health crisis.
- Screening for mental health, substance use and criminogenic risks and needs using The Mental Health Screen Form III (MHSF-III); The Texas Christian University Drug Screen V (TCUDS V); and the Ohio Risk Assessments: Community Supervision Tool (ORAS-CST), and individualized treatment plans based on needs.

- Access to a full range of housing, mental health and social services.

Considerations for California: Several key concepts emerged from the site visits that could be explored to strengthen California's approach to addressing the needs of justice involved adults with mental health needs. It should be noted that some counties are already implementing or are planning to implement similar concepts.

1. Enhance local agency collaboration and strategic planning. The Texas and Florida models recognize the need for programmatic changes and local systems transformation across agencies that have not traditionally collaborated despite having shared "clients." In addition to forming county collaboratives made up of representatives from relevant agencies, these counties used best practices such as sequential intercept mapping[1] to operationalize such transformation. Counties in California may benefit from guidance on how agencies could collaborate, blend funding, and develop their own strategic plan with and supported by stakeholders. One of the goals of the upcoming *Stepping Up in California Summit*[2] is to equip counties with the tools to begin to develop such plans.
   - Santa Clara County's Jail Diversion and Behavioral Health Subcommittee of the Re-Entry Network is an example of how one county is working across agencies to collaborate and develop a strategic plan. Other California counties have pursued similar strategies.

2. Develop jail alternatives for those experiencing a behavioral health crisis detained by law enforcement especially for minor offenses. Both Texas and Florida sites have either created or are creating a public health option as an alternative to jail for law enforcement officers who come into contact with individuals with behavioral health needs. In California, many counties have similar programs, utilizing Mentally Ill Offender Crime Reduction (MIOCR), Mental Health Services Act (MHSA), Triage (SB82) or other funds. The options vary across counties and include crisis stabilization units, mobile crisis units, crisis residential, urgent cares centers, and sobering units. However, not all counties have this array of services and it is not clear how or how well investments in additional diversion strategies can reduce impact on jails, improve outcomes, and reduce costs.
   - Los Angeles County is currently developing a diversion program that will allow law enforcement to take individuals detained on certain offenses to urgent care centers rather than jail.

3. Expand CIT or similar trainings. Both sites highlighted their countywide crisis training programs to better prepare law enforcement and others with tools for de-escalation and management of behavioral health crisis situations. Those trained were able to informally screen individuals in the field to better place them with appropriate mental health or substance use services. According to the developer's website, CIT training is offered in 24 counties in California. It is unclear, however, to what extent officers and first responders are being trained and to what degree of intensity. Modifying the "Memphis Model" of CIT appears to be common practice. California counties and law enforcement agencies may benefit from coordinated and consistent training standards to ensure all first responders are equally and adequately prepared to handle a behavioral crisis situation, for the safety of all involved.
   - Under current law, law enforcement academy trainees are required to receive at least 15 hours of training on "Persons with Disabilities," which includes mental illness among many

[1] For more information on "The Sequential Intercept Model" see: http://www.prainc.com/wp-content/uploads/2016/04/SIMBrochure.pdf

[2] For more information on the Stepping Up Initiative see: https://stepuptogether.org/

others. In 2015, legislation was enacted to enhance peace officer training specifically on behavioral health and de-escalation techniques. SB 11 (Beall, 2015) requires the Commission on Peace Officer Standards and Training to update continuing education classroom training to include sections on behavioral health and law enforcement interaction with individuals with behavioral health challenges. These sections must be at least 15 hours. SB 29 (Beall, 2015) requires field training officers to receive at least 8 hours of training on behavioral health and crisis intervention.

4. Use peers and family to support treatment and recovery. Both sites highlighted the role of peer and family involvement in diversion programs. Peers were characterized in Miami-Dade County as "the secret sauce" that enables reductions in criminal justice involvement and improve outcomes. Having someone with shared behavioral health experiences and justice involvement, coupled with family support, appear to increase the likelihood that consumers would engage in treatment and successfully complete programs. It is unclear to what extent peers and family members are being utilized in diversion programs in California, and how outcomes are being measured and reported.
   - Sacramento County's Triage/SB 82 grant funded peer navigator program is an example of how one county is deploying peers to identify individuals in jail with mental health needs and connecting those individuals with services in the community upon release.

5. Utilization of data and technology. Florida and Texas leaders stated that one feature of a truly collaborative system must be the sharing of data across agencies. Sharing information on the people served by county behavioral health and justice services has two main purposes; data can be used to describe a shared population (those individuals being served by more than one local agency) and data can be used to support treatment decisions and a continuum of care. In addition, technology can be used to support the awareness of resources. For example, Bexar County has an electronic system to search for open psychiatric beds. Mobile applications could be used to identify local resources for law enforcement and the community alike.
   - San Diego County's ConnectWellSD effort is an example of how one county has created an "information sharing hub" that draws from nine different county data systems so that information can be shared across service providers.

6. Develop and Use Public/Private Partnerships. Both sites have successfully integrated private philanthropy and public resources to fund co-located, comprehensive, and integrated services. In San Antonio, these services included assessment, medical services, sobering center, detox facility, coordinated housing referrals, etc. in a "one-stop-shop." It is unclear to what extent counties in California are leveraging public dollars with private funding, or to what extent different public funding streams are being blended or braided. California could benefit from learning collaboratives to share information about how California can fund comprehensive and integrated diversion programs and services, especially in times of recession.
   - For example, San Francisco's Citywide Case Management Forensic Program received grant funding to support housing incentives for clients from The Battery, a philanthropy organization in San Francisco.

NEXT STEPS: Challenges and solutions will continue to be explored. Project activities are scheduled through Spring 2017, with a final report to the Commission scheduled for Summer 2017.

Mental Health Services
Oversight & Accountability Commission

MADERA COUNTY INNOVATION PLAN

November 17, 2016

WELLNESS • RECOVERY • RESILIENCE

Outline

- Summary
- Materials
- Regulatory Criteria
- What OAC staff Look for
- Madera County Presentation
- Motion

Summary

- Madera County seeks approval for one innovation project.
- Tele-Social Support Services Project.
  - Total INN funding Requested for Project: $685,592.
  - Duration of Innovative Project: Five (5) Years.
  - Project primary purpose is to improve access to services for County residents who have been placed in out-of-county intensive psychiatric treatment facilities by adapting current Tele-Psychiatry Services to allow consumers to continue to receive peer support services remotely.
- Staff recommends that Madera County's proposal has met or exceeded minimum regulatory requirements.

Materials

- The following materials were included in the meeting packets and are posted on our website:
  - Staff Innovation Summary, **Tele-Social Support Services**
  - County's Innovation Proposal
- The following material is provided as a handout:
  - County Innovation Brief, **Tele-Social Support Services**

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

Mental Health Services
Oversight & Accountability Commission

MHSA Innovation Project
11-17-16

Madera County Behavioral Health Services
(MCBHS)

WELLNESS • RECOVERY • RESILIENCE

Madera County Profile

- Population: 154,548 (2014)
  - 54% Hispanic population
    - Have indigenous population from Oaxaca Mexico which don't speak Spanish nor English
      - Speak Triqui, Mixteco and Zapoteco languages
- Madera is located exactly in the middle of California ("Heart of California")
- Madera is the Gateway to the Sierra Mountains and Yosemite National Parks
- Madera ranks 14th in California counties in overall production of agricultural crops.

Madera County Profile

- Total Population 153,409 (32 County Ranking)
- Uninsured
  - Madera 20.6% California 17.8%
- Public Health Insurance
  - Madera 43.5% California 29.5%
- Total Concentrated Poverty
  - Madera 53.8% California 29.9%
- Youth in Poverty
  - Madera 60.5% California 34.6%
- Adolescent Birth Rate (aged 15-19)
  - Madera 41.8 California 23.2 County ranking—5th

State Dept of Finance Statistics Census 2010	Population Ages 18—64	Population Ages 65+	Population Total
Mental (Psychiatric) hospitals and psychiatric units in other hospitals	0	0	0
Hospitals with patients who have no usual home elsewhere	0	0	0
In-patient hospice facilities	0	0	0
Military treatment facilities with assigned patients	0	0	0
Residential schools for people with disabilities	0	0	0
Residential treatment centers—Adults	0	0	0
Residential treatment centers (non correctional)—Juveniles	0	0	0

State Dept of Finance Statistics Census 2010	Population Ages 18—64	Population Ages 65+	Population Total
Correctional Facilities for Adults	7642	402	8135
Correctional Facilities Intended for Juveniles	1	0	18

Scenario

- 13 year old Hispanic female
  - Tells the teacher at school she hurts and feels terrible inside
  - She wants to kill herself to end the pain
  - She ends up on a W and I Code 5150 and is going to be placed at the nearest open psychiatric bed which is over three hours away.
  - Her family is poor. They don't own a car (can't afford one). They don't have a cell phone (can't afford one)
  - They don't speak English. She is the interpreter for them.
  - She is taken by ambulance to the hospital. She doesn't understand what a 5150 is.
  - She has seen "mental" hospitals in those scary movies her brother watches. She is terrified and swears she will never tell anyone how she feels ever again.
  - She knows no one at the facility. They give her medications that gave her a headache and sick to her stomach.
  - She is worried about her family and has no way to contact them.

Scenario

- Mother of the 13 year old child who is being hospitalized
  - She does not speak nor understand English. She speaks Zapoteco del Sud.
    - The hospital has no interpreters who speak that dialect.
  - Her daughter is being hospitalized. She has no way to communicate with her.
  - She cannot afford a car.
    - She has no transportation to get to the hospital which is over a three hour car ride away.
  - She cannot accompany her daughter to the hospital as she has to take care of her other children in the home and she just found work pruning the grape vineyards.
    - She needs the money to take care of her children.
  - She is terrified as she does not understand what is happening to her daughter and to her family.

Madera's INN proposal

- We will place secure video conferencing equipment at hospitals, IMD facilities, board and care facilities where our clients are placed
  - Clients/family members will be able to communicate with one another through this equipment
  - Peer support staff will be available to facilitate the communication and assist with on-going peer support services once someone is discharged and returns to Madera
  - The equipment will also be used to facilitate discharge planning between the clinical staff and the facility staff
  - The equipment can also be used for MD to MD conferencing
- Madera has no facilities located within its County's borders.
  - Clients are often placed several hours away
  - Peer staff may or may not be able to drive
  - Traveling between the bay area and southern California is difficult even under the best of circumstances

Madera's INN proposal

- Existing video conferencing used to provide tele-psychiatry is used for the great majority of the psychiatric services in Madera.
  - The Innovation project service will need its own dedicated and secure line so that it does not disrupt psychiatric services.
- The 1.0 FTE dedicated to the INN project may be made up of more than one person providing the peer and family support services.
- Peer staff will be trained in curriculums such as WISE, Mental Health First Aid, Motivational Interviewing, safeTALK, technical training on how to use the video conferencing equipment, etc.
  - As the project progresses Madera expects that training needs will arise and Madera will provide these training needs as well.
- Madera contacted 10 of the 22 facilities that Madera contracts with, which have the most frequent placement of Madera's clients need psychiatric hospitalizations
  - 6 of these 10 psychiatric hospital indicated that they were interested in participating in this Innovation project.

Madera's INN proposal Learning Goals

1. Can the use of video conferencing equipment for video conferencing promote wellness?
2. Will the use of this technology increase client contact and increase recovery time?
3. Will this approach reduce recidivism?
4. Will this approach reduce the length of stay at various facilities?
5. Will recovery improve with peer support provided in 24 hour facilities via virtual face-to-face peer and family contacts?
6. Will this method of communication improve discharge planning and communication between MD's?

Measurement instruments to be used

- **PROMIS® (Patient-Reported Outcomes Measurement Information System)**
- **Measures that evaluates and monitors**
  - Physical, mental, and social health in adults and children.
  - Can be used with the general population and with individuals living with chronic conditions.

- **Why Use PROMIS?**
  - Developed and validated with state-of-the-science methods
  - Psychometrically sound
  - Relevant across all conditions for the assessment of symptoms and functions
  - Translations available in Spanish and many other languages

- HealthMeasures is the official information and distribution center for PROMIS, which was developed and evaluated with National Institutes of Health (NIH) funding.
- *PROMIS and the PROMIS logo are marks owned by the U. S. Department of Health and Human Services.*

Measuring and Evaluation

- The **PROMIS** system will be used for measuring self reported status of:
  - Physical health
  - Mental health
  - Social health

- **Other Measures Include**
  - Client length of Stay on Involuntary Facility
  - Client Recidivism Rate
  - Projected Cost Savings Had The Client Not Been Assigned to This Project

- **Evaluator**
  - A professional evaluator will be hired to complete the evaluation for this MHSA Innovation project

Request to Approve Madera's Proposal

- We very much want to provide supportive services to the most vulnerable of our population;
  - Those in inpatient facilities and other 24 hour facilities

If this project is successful;

- We are hoping to expand to foster youth placed outside of Madera County so they may return to a home environment more quickly

Proposed Motion

- **The MHSOAC approves Madera County's INN Project as follows:**
  - Name: **Tele-Social Support Services**
  - Amount: $685,592
  - Project Length: Five (5) Years

Summary/Briefing

Madera County's Proposed Innovation Project FY 2016-17

The FY 2016-17 MHSA annual plan update was developed with the participation of community stakeholders in accordance with Title 9, California Code of Regulations (CCR) Sections 3300, 3310(d) and 3315(a). The draft plan update was circulated for 30 days to stakeholders for review and comment. The new INN project was presented during this process. A public hearing by the Madera County Behavioral Health Board (BHB) was held on May 18, 2016, and the BHB unanimously recommended that BHS move forward to submit the plan for Board approval on June 15, 2016. On November 2, 2016, the INN project was approved by the Madera County Board of Supervisors.

The INN Project Tele-Social Support Services proposes, using information communication technology (specifically secure video conferences and electronic communications), to reduce the negative impact of social isolation due to placement (e.g. acute psychiatric hospitals, IMD's, board and care and group homes) outside of Madera County, especially multiple placement episodes. The goal is to facilitate ongoing social supports from friends, family, and peers who have a positive influence on the client's wellbeing. This project in-reaches to the *most vulnerable* of our population; those in inpatient and locked facilities, away from family and other social supports.

The majority of Madera County stakeholders (52.5% of people completing surveys) involved in the FY 16/17 MHSA Community Program Planning process chose this project option for the next MHSA Innovation project. These stakeholders agreed that this project was important because it would help individuals remain connected to people who are familiar and have positive relationships.

Madera is a small, poor, rural county. There are no inpatient, IMD, or board and care facilities for the mentally ill, etc., located within the boundaries of the County. Many individuals are placed in the bay area or in southern California. Our client's family members may not have a car for their personal use. They cannot afford them. Public transportation is limited. This project will allow for family members and peer support staff to stay in touch with the client while residing in the facility.

Peers will assist in facilitating the virtual face-to-face contacts and encourage use of peer support services after discharge from the facility. Case managers, clinicians and physicians will assist with discharge planning with the staff from the institutions through the video conferencing equipment. It is estimated that this program will serve 20 children, and up to a total of 80 TAY, adults, older adults.

In this plan, Madera County is requesting INN funding for a five year project for the Fiscal Year (FY) 2016-2017 through 2020-2021 for one new project and administration: The amount of funding is $150,902 for this MHSA INN 2016-17 Plan update.

Approved Staffing: A 0.05 FTE Clinical Supervisor, a 0.05 FTE Mental Health Clinicians, a 0.05 MHSA Coordinator, 0.05 FTE Case Worker, a 0.05 FTE, a 1.00 FTE Peer Support Worker, and a 0.05 FTE MHSA MHP Clerical Support. Salaries are based on current Madera County salaries approved by the Board of Supervisors **Total FTE: 1.30.**

Employee Benefits: Benefits for the 1.30 FTE are based on the current Madera County benefits package that includes the following: FICA 0.0608, Medicare 0.0142, PERS 0.2467, and health insurance coverage of $995 per month based on full time equivalency.

The total personnel expenditures will be $79,976.

Operating Expenditures: The actual estimated expenditures are $51,243. This includes professional services of translation and interpreter services, site connectivity including Application Service Provider (ASP), site security, and evaluator ($8,000). For travel and transportation, staff will use a County van to transport family members or other social supports or will be reimbursed at 54 cents per mile if they use their own vehicle to travel to County sites where the equipment will be located. Operating expenditures also include building maintenance lease and utilities. General Office expenses include the estimated costs for office supplies, phone and cell phones, educational materials, program flyers and computer software. One time Purchase of tele-social equipment including laptop, webcam, and speaker.

The **Total Revenues** of $0 is estimated for this work plan.

The net program cost estimated for county operation is $131,219.

Administration:

Madera County is requesting $19,683 in INN funding to sustain the costs associated with the concerted amount of administration support required for ensuring ongoing community planning, implementation and monitoring of our MHSA programs and activities.

Five Year Innovation Project Program Budget

Description	FY 2016-17	FY 2017-18	FY 2018-19	FY 2019-20	FY 2020-21	Total
Project Year	Year 1	Year 2	Year 3	Year 4	Year 5	
Total Wages	79,976	82,623	85,369	87,843	90,165	425,976
Operating Expense	43,243	21,391	21,619	21,851	22,087	130,191
Evaluator	8,000	8,000	8,000	8,000	8,000	40,000
Admin	19,683	16,802	17,248	17,654	18,038	89,425
Total INN Proposed Budget	150,902	128,816	132,236	135,348	138,290	685,592
Total Revenue	0	0	0	0	0	0
Net MHSA INN	150,902	128,816	132,236	135,348	138,290	685,592