Advocacy Committee
Thursday, April 20, 2017

Holiday Inn San Jose
1350 North 1st Street
San Jose, California 95112

Salons F/G
8:30 a.m. to 12:00 noon

Time	Topic	Presenter or Facilitator	Tab
8:30 am	Welcome and Introductions	Barbara Mitchell, Chairperson Elect	
8:35	Agenda Review	Barbara Mitchell	
8:40	Approval of Minutes from November 2016, January and March 2017	Barbara Mitchell and All	A
8:50	Legislative and Regulatory Updates related to Mental Health may be discussed, including but not limited to: AB 89, AB 470, SB 562, SB 223, etc.	Barbara Mitchell and All	B
9:30	Vic Ojakian presentation/requesting support of AB 89.	Vic Ojakian and All	C
9:50	Break		
10:00	Work Plan: Status on RCF Paper and Trinity County Presentation	Barbara Mitchell, Noel O'Neill and All	D
10:20	Residential Care Facility (RCF) Panel: Discussion on what works, what does not, are there solutions.	All	E
11:20	Break		
11:25	Panel: Wrap-up, Questions, Comments, and/or Recommendations	Barbara Mitchell and All	
11:55	Public Comment	Barbara Mitchell and All	
12:00 pm	Adjourn	Barbara Mitchell	

The scheduled times on the agenda are estimates and subject to change.

Committee Officers:

Chairperson: Maya Petties
Chair Elect: Barbara Mitchell

Members: Amy Eargle, Arden Tucker, Carmen Lee, Daphne Shaw, Darlene Prettyman, Deborah Starkey, Melen Vue, Monica Wilson, Simon Vue, Steve Leoni

Staff: Dorinda Wiseman

If reasonable accommodations are required, please contact Chamenique Williams at (916) 552-9560 <u>not less</u> than 5 working days prior to the meeting date.

___A__ TAB SECTION **DATE OF MEETING 04/20/2017**

MATERIAL PREPARED BY: Wiseman **DATE MATERIAL PREPARED** 03/14/2017

AGENDA ITEM:	Approval of Minutes
ENCLOSURES:	Minutes for: • November 2016 • January 2017 • March 2017

How this agenda item/presentation relates to the Council's mission.
The minutes are a means to document and archive the activities and/or discussions of the Advocacy Committee in its efforts to move the mission and vision of the Council forward.

The context for this agenda item/presentation is as follows:
Documentation.

BACKGROUND/DESCRIPTION:

The Committee members are to vote on and accept the draft minutes presented for the January and March 2017 meetings.

ADVOCACY COMMITTEE
Wednesday, November 9, 2016
11:00 am – 12:15 pm

1000 "G" Street, Fourth Floor, Suite 450
Sacramento, California 95814

Conference Call
Dial 1-866-742-8921 participant code 5900167

Members Present
Darlene Prettyman, Chairperson
Maya Petties, Chair Elect
Barbara Mitchell
Daphne Shaw
Arden Tucker
Steve Leoni
Amy Eargle

Staff Present
Dorinda Wiseman

Public:

Members Absent
Monica Wilson
Adam Nelson
Carmen Lee

The meeting commenced at 11:04 a.m. Darlene Prettyman welcomed all present. A quorum was present.

Item #	Topic	Issue/Options	Action/Resolution	By Whom?	By When?	Completed
1.	Welcome and Introductions		Darlene Prettyman welcomed all present.	Darlene Prettyman	N/A	
2.	Agenda Review	Work Plan 2: There will not be a vote on the Draft RCF paper. There are		Darlene Prettyman	N/A	

Item #	Topic	Issue/Options	Action/Resolution	By Whom?	By When?	Completed
		significant changes to be made to the document.				
3.	Work Plan Goal 2: Draft RCF Paper to Finalize	The RCF Paper has significant changes and edits. Barbara Mitchell provided suggested changes to staff. The committee members discussed the need for more "concrete" data and use of the County Questionnaire.	Dorinda Wiseman advised there has been interest from CCL about the lack of placements and how the Council can possibly provide insight. The committee members unanimously pushed the release of the paper to January 2017.	Staff	January 2017	No
4.	Work Plan Goal 3: Draft AB 109 Paper to Finalize	The committee members opted to vote on the paper during the December 2016 meeting, to give the members that did not read the draft a chance to read.	There was no vote to move the paper forward for presentation to the full Council in January 2017.	All	December 2017	No
5.	Draft: Policy Platform to Finalize	There was discussion of several concepts and terms, not limited to the following: Financial eligibility Use of cultural humility Cultural competency The committee members accepted the edits provided, prior to and during the meeting.	**Motion**: To accept the policy platform with changes, as final for 2017 to present to the full Council. Daphne Shaw (1st) and Arden Tucker (2nd) carried the motion. The vote – Yes: Darlene Prettyman, Maya Petties, Daphne Shaw, Arden Tucker, Amy Eargle; No: Steve Leoni; No abstentions. **The motion carried.**	All		Yes
6.	Legislative and Regulatory Updates	The Committee Members discussed the Department of Health Care Services' (DHCS) decision to not include mental	The members decided to continue to watch the situation and take			

Item #	Topic	Issue/Options	Action/Resolution	By Whom?	By When?	Completed
	related to Mental Health may be discussed, including but not limited to: election results	health board trainings in the contract with California Institute for Behavioral Health Solutions (CIBHS). The Committee Members discussed the possibility of the Trump Administration possibly repealing the Affordable Care Act (ACA), commonly referred to as Obamacare.	steps to advocate if necessary in the future. The members decided to watch and determine the new Administration's direction, before making any firm decision(s) on actions to take.			
7.	Public Comment	None.		Darlene Prettyman and All		
9.	Adjourn	The meeting adjourned at 12:10 pm. The next meeting is scheduled for December 14, 2016 11:00 am – 12:00 pm.		Darlene Prettyman, Chairperson		
	PARKING LOT ISSUE(S) BELOW					
A.		Meeting with Housing and Community Development: discussion of policy and procedures and issues related to NPLH Advisory Board.	Pending			
B.		Collaborate with Each Mind Matters on the Mental Health license plate efforts.	Future legislative cycles			

Meeting adjourned at 12:10 p.m.

Advocacy Committee
Thursday, January 19, 2017
Courtyard Marriott San Diego
595 Hotel Circle South
San Diego, California 95630
Convene 6 – 6th Floor
8:30 a.m. to 12:00 noon

Members Present
Barbara Mitchell, Chairperson-Elect
Steve Leoni
Daphne Shaw
Simon Vue
Arden Tucker
Deborah Starkey
Monica Wilson

Members Absent
Maya Petties
Amy Eargle
Carmen Lee
Melen Vue
Darlene Prettyman

Staff Present
Dorinda Wiseman

Public:
Samuel Jain, California Association of Mental Health Patients' Rights Advocates (CAMHPRA)
Heidi Shrunk, California Association of Mental Health Peer-Run Organizations (CAMHPRO)
Dante Dauz, J.D. Alliance for Community Empowerment (ACE)
Celeste Hunter, ACE
Hussein Auli, ACE
Jhaga Mahat, ACE

The meeting commenced at 8:30 a.m. Barbara Mitchell welcomed all present. A quorum was present.

Item #	Topic	Issue/Options	Action/Resolution	By Whom?	By When?	Completed
1.	Welcome and Introductions	Darlene Prettyman and Maya Petties were unable to attend the meeting.	Darlene Prettyman and Maya Petties were unable to attend the meeting.	Barbara Mitchell,	N/A	Yes

Item #	Topic	Issue/Options	Action/Resolution	By Whom?	By When?	Completed
				Chairperson-Elect		
2.	Change of Officers	Darlene Prettyman and Maya Petties were unable to attend the meeting.	Barbara Mitchell presided over the meeting. The members thanked Darlene Prettyman for her services as Chair.	Barbara Mitchell	N/A	Yes
3.	Agenda Review	Barbara Mitchell, (Steve Leoni second the suggestion) requested to add The *No Place Like Home (NPLH)* regulatory process to the agenda. Steve Leoni requested to add the Housing Department's Affordable Housing work and the Workforce Education and Training (WET) Plan/Summit to the agenda.	Discussion of NPLH will occur during the legislative and regulatory issues. Discussion of the WET Plan/Summit will occur during Public Comment.	Barbara Mitchell		Yes
4.	Approval of Minutes from October, November and December 2016	October 2016 – Motion to accept the minutes as written. 1st: Daphne; 2nd: Arden. Vote: Yes – Daphne, Monica, Steve, Arden; No – none; Abstain: Barbara, Deborah, Simon. November 2016 – The committee members advised the November 2016 minutes needed significant edits. The vote will occur at the next committee meeting.	The staff will make appropriate edits to the November 2016 minutes and present them at the next Advocacy Committee meeting.	Dorinda Wiseman	March 2017	Yes No

Item #	Topic	Issue/Options	Action/Resolution	By Whom?	By When?	Completed
		December 2016 – Motion to accept the minutes as written. 1st: Steve; 2nd: Monica W. Vote: Yes – Barbara, Daphne, Arden, Monica W.; No – none; Abstain – Steve, Simon, Deborah.				
5.	Work Plan: Status on RCF Paper, Summary of the County Survey results – Next Step(s)	Goal 1: <u>Alternatives to Locked Facilities/IMD</u> – the Committee pended this issue. Further advised to obtain a partner to work with on this issue. CAMHPRO maybe interested in working with the Committee on this matter. Goal 2: <u>Residential Care Facility closures</u> - Barbara Mitchell led the discussion about Residential Care Facilities (also known as Board and Cares). 22 Counties responded to the RCF survey inquiry. What will be done with the information obtained? Theresa Comstock was recognized for assisting with getting the survey out to the counties and writing a paper on the subject matter, approximately two years prior. Controversy - Current RCF-model is a dying model. What should be done now?	Retain Goal 1 on the Work Plan. Pend any active work, at this time. 1) models out there; 2) given the MHSA funding, what is out there? 3) What are the license and board and care issues → there is no place for these individuals to go. Trinity County owns its six-bed board and care home. Staff to contact Noel O'Neill to obtain their budget. The Committee Members want to hear from person/entities (at the April 2017 meeting) directly impacted and working in and with RCFs to develop potential recommendations for the RCF paper.	Staff	April 2017	

Item #	Topic	Issue/Options	Action/Resolution	By Whom?	By When?	Completed
		• Lobby the State to increase the SSI rate – hit to State's General Fund/Mental health Budget • Query clients, most do not want to live in RCFs, and typically do not view as permanent housing. • Do you want to shore up an industry for individuals that need care and supervision? If so, what? If not, what are the alternatives? • What are other communities doing/saying about this issue (e.g. senior with incontinence issues, diabetes, etc., individuals with developmental delays, etc.)? What is the public policy aspect of the issue? What is our recommendation? Any conclusion out of this paper will not be popular. <u>Additional Data</u>: What happens to the people displaced by facility closures? What alternative models are available; include those that incorporate medical	Potentially invite Community Care Licensing, County Behavioral Health Director (problems with beds), Patients' Rights, Public Guardian's Office, Consumer Advocacy Group and Wrap Around Service Case Managers – if any have issues, what are they and what are their alternatives/suggestions for improvement. Turning Point – Deborah – intensive services model option. Finish the paper by June 2017. The finished product will be used for lobbying, advocacy, highlight the lack of tangible and accessible data.			

Item #	Topic	Issue/Options	Action/Resolution	By Whom?	By When?	Completed
		issues? **Highlight the difficulty of obtaining the DATA for the paper**. <u>Recommendation options</u>: Alternatives to living in RCFs; Increase the PATCH rates; Increase the SSI rate; Intensive Support Services or Combination of the above items. Goal 3: <u>AB 109 Follow-up Report on the Criminal Justice Realignment of 2011</u> – the report is complete. It will be presented to the full Council during General Session. Goal 4: <u>Children and Youth</u> – Wellness and prevention strategies of at-risk and/or criminal justice involved youth.	Completed Continue to conduct research on the various programs and prevention strategies throughout the state.			

Item #	Topic	Issue/Options	Action/Resolution	By Whom?	By When?	Completed
	Legislative and regulatory Updates related to mental Health may be discussed, including but not limited to: Legislative support status, 21st Century Cures Act; Adult Marijuana Use Act, etc.	Council name change update: Senator Beall advised he was unable to sponsor the Council's legislation to change the name. Assembly Member Chad Mayes has advised his support to potentially support the Council's efforts. Robert Blackford is in the process of securing Assembly Member Mayes' staff to confirm their support. Daphne Shaw advised Assembly Member Todd Gloria may also be a potential supporter of mental health issues. Several Committee members are concerned about the "language" surrounding "substance use disorder." Several members expressed caution/anxiety in placing the Mental Health Planning Council in tackling a significantly larger disciple within substance use disorders. Other members fear that the current activity of changing the name may place the Council in peril, if the state/legislature decides there is no need for this entity to exist. The Committee Members expressed concern over the possible replacement of the Affordable Care Act (ACT).	**Motion**: The Council will sent a letter to Congress/Senators indicating the concern of possible loss of Medi-Cal Expansion and its impact to the number of individuals served within the behavioral health system. 1st: Daphne Shaw; 2nd Arden Tucker.			

Item #	Topic	Issue/Options	Action/Resolution	By Whom?	By When?	Completed
		The Committee Members discussed potential benefits and outcomes of the 21st Century Cures Act. The members decided to not take any action at this time. No Place Like Home Advisory	**Vote:** Yes – Barbara, Arden, Daphne, Deborah, Monica, Simon, Steve; No – none; Abstain – none. The staff is to monitor the legislation and advise the member of any pertinent activities.			
7.	Presentation: Dante Dauz, J.D., Program Supervisor for Alliance for Community Empowerment (ACE)	Dante R. Dauz, J.D. – ACE program Supervisor Celeste Hunter, Certified Grief and Recovery Specialist Hussein Auli – Program Graduate Jhaga Mahat – Program Graduate The panelist from the Alliance for Community Empowerment (ACE) provided an overview of the umbrella organization from which they are associated. The Committee Members were provided insight into what works, what improvements can be made and success stories.	The Presenters extended an invitation to the Committee Members to tour their 'soon-to-be-open' business development center (tentative opening mid-2017).			
8.	Public Comment	None.				
9.	Adjourn	The meeting was adjourned at 12:03 pm.				

Item #	Topic	Issue/Options	Action/Resolution	By Whom?	By When?	Completed
	PARKING LOT ISSUE(S) BELOW					
A.		Meeting with Housing and Community Development: discussion of policy and procedures and issues related to NPLH Advisory Board.	Pending			
B.		Collaborate with Each Mind Matters on the Mental Health license plate efforts.	Future legislative cycles			

Meeting adjourned at 11:57 am

ADVOCACY COMMITTEE
Wednesday, March 8, 2017
10:00 am – 11:00 am

1000 "G" Street, Fourth Floor, Suite 450
Sacramento, California 95814

Conference Call
Dial 1-866-742-8921 participant code 5900167

Members Present
Barbara Mitchell, Chair-Elect
Deborah Starkey
Daphne Shaw

Staff Present
Jane Adcock
Dorinda Wiseman

Public:
Theresa Comstock

Members Absent
Maya Petties
Steve Leoni
Darlene Prettyman
Carmen Lee
Melen Vue
Monica Wilson
Amy Eargle
Arden Tucker
Simon Vue

The meeting commenced at 10:06 a.m. Barbara Mitchell welcomed all present. A quorum was not present.

Item #	Topic	Issue/Options	Action/Resolution	By Whom?	By When?	Completed
1.	Welcome and Introductions		Barbara Mitchell welcomed all present.	Barbara Mitchell	N/A	

Item #	Topic	Issue/Options	Action/Resolution	By Whom?	By When?	Completed
2.	Agenda Review	N/A		Barbara Mitchell	N/A	
3.	Approval of Minutes – November 2016	N/A	Pend until April 2017	Staff		
4.	Work Plan Goal 2: Status on RCF Paper, April Meeting Panel	N/A	The participants on the call discussed the RCF paper and potential questions to be asked of the panel presenters at the April 2017 Advocacy meeting.	All		
5.	Legislative and Regulatory Updates related to Mental Health may be discussed, including but not limited to: election results	N/A	N/A			
6.	Public Comment	N/A	N/A	Barbara Mitchell and All		
7.	Adjourn	The meeting adjourned at 10:57 am. The next meeting is April 20, 2017, 8:30 am – 12:00 pm in San Jose, California.		Barbara Mitchell Chairperson -Elect		

Item #	Topic	Issue/Options	Action/Resolution	By Whom?	By When?	Completed
	PARKING LOT ISSUE(S) BELOW					
A.		Meeting with Housing and Community Development: discussion of policy and procedures and issues related to NPLH Advisory Board.	Pending			
B.		Collaborate with Each Mind Matters on the Mental Health license plate efforts.	Future legislative cycles			

___B__ TAB SECTION **DATE OF MEETING 04/20/2017**

MATERIAL PREPARED BY: Wiseman **DATE MATERIAL PREPARED** 03/14/2017

AGENDA ITEM:	Legislative and Regulatory Updates
ENCLOSURES:	• Legislative Potential Position Chart • Legislative Year-End Chart • CMHPC Policy Platform 2017

How this agenda item/presentation relates to the Council's mission.
The Legislative and Regulatory updates provide the Council with the opportunity to advocate for the people of California impacted by mental illness. Further, through the legislative process, the Council also provides education to the Governor, Legislature and the Department on the issues faced by the people of California within the public mental health system.

The context for this agenda item/presentation is as follows:
The Council provides support for legislation and policy that is an extension of the Council's vision. The CMHPC envisions a mental health system that makes it possible for individuals to lead full and productive lives. The system incorporates public and private resources to offer community-based services that embrace recovery and wellness. The services are client and family-driven, responsive, timely, culturally competent, and accessible to ALL of California's populations.

BACKGROUND/DESCRIPTION:

The Committee members will review and discuss legislative and/or regulatory issues/items.

The *Legislative Potential Position Chart* was initially created utilizing the CMHPC's Policy Platform as a framework. The Committee Members will **briefly review** to provide **feedback on its functionality** (e.g. quick reference tool).

In January 2017, the Health Care Integration (HCI) Committee was approached to support Senator Holly Mitchell's legislation, *Senate Bill 323*, regarding Federally Qualified Health Centers (FQHC) and Rural Health Centers: Drug Medi-Cal and Specialty Mental Health Services. HCI has taken lead on the bill. HCI inform the Advocacy Committee of its activities related to SB 323.

The link to the 21st Century Cures Act bill text.
Assembly and Senate bills can be found at http://www.leginfo.ca.gov/.

Title	Author	Overview	Position/Comment(s)
	Assembly	**Concurrent**	**Resolution**
ACR 8	Jones-Sawyer	PT "street" disorder	**Oppose** - perpetuates stigma/discrimination; concept is not from a clinical diagnosis
blank	**Assembly**	**Bills**	blank
AB 42	Bonta	Bail Reform	**Support** - decreases stigma/discrimination; reduction seclusion/restraint; reduce disparities/increase access to services
AB 64	Bonta	Cannabis: Regs& Ads	**Support** - decrease impact/use of persons under the age of 21
AB 74	Chiu	Housing	**Watch**
AB 76	Chau	Marijuana - marketing	**Support** - decrease impact/use of persons under the age of 21
AB 89	Levine	Psychologists: suicide prevention training	
AB 152	Gallagher	BSCC: Recidivism	
AB 154	Levine	Prisoners-MH Tx	**Support**-reduce seclusion/restraint; reduce disparities/increase access; least restrictive setting
AB 171	Lackey	Medical Cannabis	
AB 175	Chau	Marijuana: marketing	**Cautious support** - decrease impact/use of persons under the age of 21
AB 186	Eggman	Safer drug consumption	**Watch**-similar to needle-exchange program
AB 191	Wood	Involuntary Tx	**Oppose** - seclusion/restraint use
AB 193		Healing Arts MFTLCSW	
AB 208	Eggman	Pre-Trial Diversion	
AB 210	Santiago	Homeless MDT	**Cautious Support**-reduce disparities
AB 244	Cervantes	Maternal MH	**Watch** -telepsychiatry referral pilot
AB 266	Thurmond	Inmate Housing Assgn Mental Health	
AB 275	Wood	LongTermCare facilities	
AB 285	Melendez	Drug/Alcohol residences	
AB 340	Arambula	EPSDT Trauma Screening	**Support -** appropriate tx
AB 346			

AB 395	Bocanegra	SUD Tx providers	
AB 451	Arambula	Health facilities	**Watch** - access to tx
AB 456		Healing Arts SW	
AB 462	Thurmond	Wage info access	**Support** - use of data and evaluation
AB 470	Arambula	Specialty MH Services	**Watch** - (outcome measurement) MH parity; quality
AB 473	Waldron	MH and Crim Just	
AB 477	Ridley-Thomas	Comm MH Services	
AB 488	Kiley	MHSA	**Oppose** - OAC to Agency
AB 501	Ridley-Thomas	CommCare Facilities	**Neutral** - concept to increase access to tx for children, necessary and commendable
AB 575	Jones-Sawyer	ElderAbuse Reporting: SUD counselor	
AB 596	Choi	Diversion/victim comp	
AB 620	Holden	Prisoners:TraumaInfoTx	
AB 700	Jones-Sawyer	SUD Counselors - Career Ladder	**Support**
AB 715	Wood	Opioid Wrkgrp Review	
AB 720	Eggman	Psychiatric Medication	**Neutral**
AB 727	Nazarian	MHSA housing asst.	**Schedule mtg**
AB 729	Gray	Non-medical Marijuana	
AB 763	Sala	Independent Living Center - Funding	
AB 823	Chau	EdibleMarijuana ads	
AB 834	O'Donnell	SchoolBasedHealthTx	**Support**
AB 844	Burke	Marijuana: Performance Standards	
AB 850	Chau	MHSOAC member	**Neutral -** although increasing membership by one to include person with 'experience reducing MH disparities, seems redundant
AB 860	Cooley	FactFinding Tour	**Watch**-Amendment to Bagley-Keene for specific factfinding tours
AB 903	Cunningham	Mariuana/CHP	
AB 916	Quirk-Silva	Workforce Devlop.	**Potential MHSA WET option????**
AB 917	Arambula	Pupil: Suicide Prevention Policies	**Support**
AB 935	Stone, Mark	Juv:Competency	
AB 974	Quirk-Silva	MH Advocacy	

AB 1074	Maienschein	Health coverage PDD/Autism	**Watch** - licensing and/or supervision of paraprofessional
AB 1095	Harper	Alc/SUD Tx Facilities	
AB 1119	Limon	Dept. State Hospitals	
AB 1134	Gloria	MHSA Fellowship Program	**Support?** - access; decrease barriers to potential employment barrier
AB 1136	Eggman	Resid. MH/SUD Tx	**Neutral** - Directs DHCS to apply for fed grant
AB 1188	Nazarian	Health Professionals: Loan Repaymt	
AB 1203	Gloria	HousingDisc:Transitional	
AB 1215	Ridley-Thomas	SU Tx Funding	
AB 1240	Fong	Essential Health Benefits	**Support**
AB 1261	Berman	Suicide Prevention	
AB 1300	Burke	SubAbuseCoordination Cmte	
AB 1314	Irwin	County MH veterans	
AB 1315	Mullin	Mental Health	
AB 1340	Maienschein	ContMedEdu-Integration	
AB 1372	Levine	Crisis Stabilization Units	
AB 1456	Low	Professional Licensure	
AB 1473	Quirk-Silva	Crisis Stabil.-Pilot	
AB 1474	Eggman	Pre-Trial Diversion	
AB 1513	Kalra	RCFElderly: Review	
AB 1514	Gloria	WomenChild - ResTx	
AB 1539	Chen	MH: Patients' Rights	
AB 1554	Fong	State Hospitals:Commitments	
AB 1685	Maienschein	Children's Mental Health	
blank	**Senate**	**Bills**	blank
SB 2	Atkins	Building Homes and Jobs Act	
SB 3	Beall	Housing Bond Act	**Neutral/oppose** - increase debt obligation to the state/future generations; no provisions, other than for 'affordable housing'

SB 8	Beall	Diversion	**Support** - Pretrial diversion program; least restrictive setting; access to treatment
SB 10	Hertzberg	Bail: Pre-Trail Release	
SB 12	Beall	Education; Financial Aid former foster youth	**Neutral** - access to education; increase employment of consumers/family mbrs
SB 34	Bates	Substance Abuse: residential environments for recovery	
SB 142	Beall	Defendants: MI Hx	**Support** - least restrictive setting; access to treatment; decreasing stigma/discrimination
SB 143	Beall	Prop36/47 eligibility for State Hosp commitments	**Support -** least restrictive setting; access to treatment; decreasing stigma/discrimination
SB 162	Allen	Alzheimer's guidelines	**Neutral**
SB 167	Skinner	Benefit preenrollment	**Support** - access to services, treatment; employment; self-sufficiency; decrease stigma/discrimination
SB 177	Nguyen	Respite services	**Support?** - comprehensive care/treatment
SB 191	Beall	Pupil MH/SUD	**Support** - access to services, decreased stigma/discrimination; least restrictive setting
SB 192	Beall	MHSA Reversion Funds	**Oppose** - futility of activity; misappropriation of MHSA administration
SB 219	Wiener	LGBT LongTerm Care Facility resident Bill of Rights	
SB 220	Pan	Medi-Cal Children's Health Advisory Panel	
SB 222	Hernandez	Inmates: health care enrollment	
SB 223	Atkins	Health care language assistance services	**Neutral** - support culturally appropriate services
SB 237	Hertzberg	Criminal procedure: arrest	**Support** - least restrictive setting; stigman reduction
SB 253	Nielsen	Veterans: homelessness	

SB 323	Mitchell	MediCal FQHC reimbursement	**Support** - access to treatment; parity
SB 350	Galgiani	Incarcerated persons: Health records	
SB 374	Newman	Health insurance: discriminatory practices: MH	**Support** - parity and equity
SB 399	Portantino	Health care coverage: PDD or Autism	**Neutral/support** - access; non-discrimination; stigma reduction; least restrictive setting; decrease duplication/redundancy of policy/regulation; clarification of role/regulations
SB 409	Nguyen	Veterans homes: residents with complex mental and behavioral health needs	
SB 449	Monning	Skilled nursing and intermediate care facilities: training programs	
SB 565	Portantino	Mental health: Involuntary commitment	
SB 562	Lara/Atkins	CA for a Healthy CA Act	**????** -"... single-payer health care coverage program and health care cost control system of the benefit of all residents of the state."
SB 565	Portantino	MH: Involuntary Commitment (reasonable attempts to notify family mbrs/patient designee-36 hrs prior to certification review hearing)	**Support** - stakeholder process; appropriate service delivery
SB 608	Hernandez	Narcotic treatment programs	
SB 648	Mendoza	Health and care facilities: referral agencies	
SB 684	Bates	Incompetence to stand trial: conservatorship: treatment	
SB 688	Moorlach	MHSF research/eval	

blank	**Senate**	**Resolution**	blank
SR 26	Hernandez	Patient Protection and Affordable Care Act	

Date:
To: All Council Members

From: Advocacy Committee

Re: Year-End Legislation 2017-2018

This document is submitted to the California Mental Health Planning Council to inform its members about the Legislative efforts and activity of the 2017-2018 legislative cycle.

CMHPC/ADVOCACY COMMITTEE – 2017-2018 ACTIVE LEGISLATIVE BILLS
Each bill has a hyperlink to legislation information. This tool will hopefully help with discussions to formulate the Council's position.

Bill	Description	Support	Support w/Amendments	Oppose	Oppose unless Amended	Neutral	Action Taken	Comment(s)
ACR 8 Jones-Sawyer	Post-Traumatic "Street" Disorder			X				
AB 42 Bonta (D)	Bail Reform	X						3.21.17 CCMH support
AB 64 Bonta, Cooley, Jones-Sawyer, Lackey and Wood	Cannabis: medical and nonmedical: regulation and advertising	X						
AB 74 Chiu (D)	Housing							
AB 76 Chau (D)	Adult-use marijuana: marketing	X						
AB 89 Levine (D)	Psychologists: suicide prevention training							Vic Ojakian to present and request support at April 2017 meeting
AB 96 Ting (D)	2017 Budget Act						WATCH	
AB 154 Levine (D)	Prisoners	X						
AB 175 Chau (D)	Adult-use marijuana:	X						Support with caution

Bill	Description	Support	Support w/Amendments	Oppose	Oppose unless Amended	Neutral	Action Taken	Comment(s)
	marketing; packaging and labeling							
AB 186 Eggman (D)	Controlled substance: safer drug consumption program						WATCH	Hearing 3.21.17
AB 191 Wood (D)	Involuntary Tx Personnel (secondary signatures)			X				
AB 210 Santiago (D)	Homeless MDT Personnel	X						Support with caution
AB 244 Cervantes (D)	Maternal MH						WATCH	
AB 451 Arambula (D)	Health facilities: emergency services and care.						WATCH	
AB 462 Thurmond (D)	MHSOAC: wage information data access	X						3.16.17 support letter

CMHPC/ADVOCACY COMMITTEE – 2017-2018 ACTIVE LEGISLATIVE BILLS
Each bill has a hyperlink to legislation information. This tool will hopefully help with discussions to formulate the Council's position.

Bill	Description	Support	Support w/Amendments	Oppose	Oppose unless Amended	Neutral	Action Taken	Comment(s)
AB 470 Arambula (D)	Medi-Cal: Specialty Mental Health Services: Performance Outcome System							2.24.17 CPEHN requesting letter of support
AB 488 Kiley (R)	Mental Health Services Act			X				3.16.17 met with Joshua Hoover to discuss (will provide written solutions to assist with legislative development)
AB 501 Ridley-Thomas (D)	Mental health: community care facilities					X?		Increasing treatment space for children needed; potential licensing issue mixing with adults. 3.21.17 CCMH support
AB 720 Eggman (D)	Inmates: psychiatric medication: informed consent					X		
AB 727 Nazarian (D)	MHSA: housing assistance			X				Schedule meeting
AB 850 Chau (D)	MHSOAC					X		Increase commission by one person with "experience reducing MH disparities"

CMHPC/ADVOCACY COMMITTEE – 2017-2018 ACTIVE LEGISLATIVE BILLS
Each bill has a hyperlink to legislation information. This tool will hopefully help with discussions to formulate the Council's position.

Bill	Description	Support	Support w/Amendments	Oppose	Oppose unless Amended	Neutral	Action Taken	Comment(s)
AB 860 Cooley (D)	MHSOAC: factfinding tour						WATCH	
AB 1074 Maienschein (R)	Health care coverage: PDD or Autism					X		
AB 1134 Gloria (D)	MHSOAC: fellowship program	X						3.16.17 Support letter written
AB 1136 Eggman (D)	Health facilities: residential mental or substance use disorder treatment					X		Directs DHCS to apply for Federal grant
AB 1863 Chapter 610								CMFT Jill Epstein – delayed implementation – 2017 budget fiscal restrictions
SB 3 Beall (D)	Affordable Housing Bond					X		Increase debt obligation to state/future generations
SB 8 Beall (D)	Diversion: Mental Disorders	X						NASW researching; COMIO support; 3.21.17 CCMH support

CMHPC/ADVOCACY COMMITTEE – 2017-2018 ACTIVE LEGISLATIVE BILLS
Each bill has a hyperlink to legislation information. This tool will hopefully help with discussions to formulate the Council's position.

Bill	Description	Support	Support w/Amendments	Oppose	Oppose unless Amended	Neutral	Action Taken	Comment(s)
SB 12 Beall (D)	Foster youth: postsecondary education: financial aid assistance					X		Access to education; increase employment of consumers/family mbrs
SB 72 Mitchell (D)	2017 Budget Act						WATCH	
SB 142 Beall (D)	Defendants: Mental Illness	X						
SB 143 Beall (D)	Sentencing: State Hospital	X						
SB 162 Allen (D)	Alzheimer's Disease: updated guidelines					X		Financially exhaustive for the Public MH System
SB 167 Skinner (D)	Supplemental Security Income and CalFresh: pre-enrollment	X						COMIO support
SB 177 Nguyen (R)	Cognitively Impaired adults: caregiver resource centers	X						

CMHPC/ADVOCACY COMMITTEE – 2017-2018 ACTIVE LEGISLATIVE BILLS
Each bill has a hyperlink to legislation information. This tool will hopefully help with discussions to formulate the Council's position.

Bill	Description	Support	Support w/Amendments	Oppose	Oppose unless Amended	Neutral	Action Taken	Comment(s)
SB 191 Beall (D)	Pupil: MH and SUD	X						
SB 192 Beall (D)	MHSA: Reversion Fund			X				Futility of activity; Staff to meet with Sen Beall's staff 3.17.17
SB 223 Atkins (D)	Health Care language assistance services					X		Support culturally appropriate services
SB 237 Hertzberg (D)	Criminal procedure: arrest (bail reform)	X						
SB 323 Mitchell (D)	Federally qualified health centers and rural health centers: Drug Medi-Cal and Specialty mental health services	X						2.24.17-HCI Committee is lead on this bill. California Primary Care Association (CPCA) is requesting support
SB 374 Newman (D)	Health insurance: discriminatory practices:	X						3.21.17 CCMH support

Bill	Description	Support	Support w/Amendments	Oppose	Oppose unless Amended	Neutral	Action Taken	Comment(s)
	mental health							
SB 399 Portantino (D)	Health care coverage: PDD or Autism					X		Access; non-discrimination; stigma reduction; decrease duplication/redundancy of policy/regulation
SB 562 Lara (D)	Californians for a Healthy California Act						WATCH	
SB 565 Portantino (D)	Mental health: involuntary commitment	X						Inclusion of family mbrs; stakeholder process; appropriate service delivery
SB 688 Moorlach (R)	Mental Health Services Fund: research and evaluation						WATCH	

Notes:

02/13/2017 – Asm Mayes was unable to sponsor legislation
02/14/2017 – Asm Gloria contacted via email with supporting documents
02/15/2017 – Asm Holden contacted via email with supporting documents
02/17/2017 – Obtained some information that the Assembly Health Committee may be considering carrying the legislation
03/08-15/2017 – communication between DHCS and CMHPC to tease out appropriate language to get name change agreement.

Here is a link to a Glossary of Legislative Terms.

Chapter

After a bill has been signed by the Governor, the Secretary of State assigns the bill a "Chapter Number" such as "Chapter 123, Statutes of 1992," which is subsequently used to refer to the measure rather than the bill number.

Chapter Out

When two or more bills, during one year of the session, amend the same section of law and more than one bill becomes law, amendments made by the bill enacted last (and therefore given a later or higher chapter number) becomes law and prevail over the amendments made by the bill or bills previously enacted.

Enrolled Bill

Whenever a bill passes both houses of the Legislature, it is ordered enrolled. In enrollment, the bill is again proofread for accuracy and then delivered to the Governor. The "enrolled bill" contains the complete text of the bill with the dates of passage certified by the Secretary of the Senate and the Chief Clerk of the Assembly.

Veto

The act of the Governor disapproving a measure. The Governor's veto may be overridden by 2/3's vote. The Governor can also exercise an Item veto, whereby the amount of appropriation is reduced or eliminated, while the rest of the bill approved. An Item veto may be overridden by 2/3's vote in each house.

For additional information, please click on Legislative Terms.

CALIFORNIA MENTAL HEALTH PLANNING COUNCIL
POLICY PLATFORM
January 2017

The California Mental Health Planning Council has federal and state mandates/duties to review State Plans, advocate for individuals with serious mental illness, children with severe emotional disturbance and other individuals with mental illnesses or emotional problems and to monitor the mental health services within the State.

The statements below are the Council's guiding principles.

1. Support proposals that embody the principles of the Mental Health Master Plan.

2. Support policies that reduce and eliminate stigma and discrimination.

3. Support proposals that address the human resources problem in the public mental health system with specific emphasis on increasing cultural diversity in efforts to reduce disparities and promoting the employment of consumers and family members.

4. Support proposals that augment mental health funding, consistent with the principles of least restrictive care and adequate access, and oppose any cuts.

5. Support legislation that safeguards mental health insurance parity and ensures quality mental health services in health care reform.

6. Support expanding affordable housing and affordable supportive housing.

7. Actively advocate for the development of housing subsidies and resources so that housing is affordable to people living on Social Security Income (SSI)/Social Security Disability (SSD)/Social Security Disability Insurance (SSDI) and people with similar limited incomes.

8. Support expanding employment options for people with psychiatric disabilities, particularly processes that lead to certification and more professional status and establish stable career paths.

9. Support proposals to lower costs by eliminating duplicative, unnecessary, or ineffective regulatory or licensing mechanisms of programs or facilities.

10. Support initiatives that reduce the use of seclusion and restraint to the least extent possible.

11. Support adequate funding for evaluation of mental health services.

12. Support initiatives that can reduce disparities and improve access to mental health services, particularly to unserved, underserved populations, and maintain or improve quality of services.

13. Oppose bills related to "Not In My Back Yard" (NIMBY) and restrictions on housing and siting facilities for providing mental health services.

14. Support initiatives that provide comprehensive health care and improved quality of life for people living with mental illness, and oppose any elimination of health benefits for low income beneficiaries, and advocate for reinstatement of benefits that have been eliminated.

15. Oppose legislation that adversely affects the principles and practices of the Mental Health Services Act.

16. Support policy that enhances the quality of the stakeholder process, improves the participation of consumers and family members, and fully represents the racial/cultural and age demography of the targeted population.

17. Support policies that require the increased use and coordination of data and evaluation processes at all levels of mental health services.

18. Support policies that promote appropriate services to be delivered in the least restrictive setting possible.

19. Support policies or legislation that promote the mission, training and resources for local behavioral health boards and commissions.

20. Support policies/initiatives that promote the integration of mental health, substance use disorders and physical health care services.

<u>The policies below are issues of interest to the Council.</u>

1. Support proposals that advocate for blended funding for programs serving clients with co-occurring disorders that include mental illness.

2. Support proposals that advocate for providing more effective and culturally appropriate services in the criminal and juvenile justice systems for persons with serious mental illnesses and/or children, adolescents, and transition-aged youth with serious emotional disturbances, including clients with co-occurring disorders.

3. Support proposals that specify or ensure that the mental health services provided to Assembly Bill 109 (AB109) populations are paid for with AB 109 funding.

4. Support the modification or expansion of curricula for non-mental health professionals to acquire competency in understanding basic mental health issues and perspectives of direct consumers across the age spectrum and family members and those from ethnic/racial/cultural populations.

5. Promote the definition of outreach to mean “patient, persistent, understanding, respectful and non-threatening contact” when used in context of engaging hard to reach populations.

6. Support policies, legislation or statewide initiatives that ensure the integrity of processes at the local behavioral health boards and commissions.

7. Support the modification or expansion of curricula for Mental Health professionals to fully encompass the concepts of wellness, recovery, resiliency, cultural and linguistic competence, cultural humility, and perspectives of consumers, family members and members of cultural communities.

___C__ TAB SECTION **DATE OF MEETING 04/20/2017**

MATERIAL **DATE MATERIAL**
PREPARED BY: Wiseman **PREPARED** 03/14/2017

AGENDA ITEM:	Assembly Bill 89 (AB 89) – Suicide Prevention
ENCLOSURES:	• AB 89 Fact Sheet • AB 89 Sample Support Letter • AB 89 Support Letter Template

How this agenda item/presentation relates to the Council's mission.
The Legislative and Regulatory updates provide the Council with the opportunity to advocate for the people of California impacted by mental illness. Further, through the legislative process, the Council also provides education to the Governor, Legislature and the Department on the issues faced by the people of California within the public mental health system.

The context for this agenda item/presentation is as follows:
The Council provides support for legislation and policy that is an extension of the Council's vision. The CMHPC envisions a mental health system that makes it possible for individuals to lead full and productive lives. The system incorporates public and private resources to offer community-based services that embrace recovery and wellness. The services are client and family-driven, responsive, timely, culturally competent, and accessible to ALL of California's populations.

BACKGROUND/DESCRIPTION:

The Committee members will review and discuss legislative and/or regulatory issues/items.

Vic Ojakian has requested to address the California Mental Health Planning Council in an effort to obtain support for AB 89. The California Board of Psychology sponsors AB 89. The Honorable Marc Levine authored the bill.

After the death of his son to suicide, Victor Ojakian has devoted his life to suicide prevention and improving mental health care. He has served on several federal, California statewide or regional boards or committee, including SAMHSA Suicide Prevention Resource Center (SPRC) Steering Committee, the California Department of Education's Student Mental Health Policy Workgroup, and the California statewide Stigma and Discrimination Reduction Committee.

Victor has participated in numerous non-profit board of directors, including the National Alliance on Mental Illness – Santa Clara Chapter (NAMI – SCC), and Asia Americans for Community Involvement (AACI). He currently chairs Santa Clara County Suicide Prevention Oversight Committee (SPOC) and is a member of the Santa Clara County Behavioral Health Board

He has been the co-recipient along with his wife Mary of several awards including NAMI -- SCC 2008 Community Merit Award, the Palo Alto Tall Tree Award's Outstanding Volunteer/Citizens, and the Jefferson Award. Victor is also a former City of Palo Alto City Council Member and Mayor.

For this presentation, Vic Ojakian is representing himself.

To date, supporters of Assembly Bill 89 include the American Foundation for Suicide Prevention, County Behavioral Health Directors Association of California, the Steinberg Institute, several NAMI California chapters, the Trevor Project, and others.

OFFICE OF ASSEMBLYMEMBER

Marc Levine

TENTH ASSEMBLY DISTRICT

AB 89: Suicide Prevention

SUMMARY

AB 89 requires all applicants for licensure as a psychologist with the Board of Psychology to complete a minimum of six hours of coursework and/or applied experience in suicide risk assessment and intervention.

EXISTING LAW/BACKGROUND

Over the last decade suicide rates in California have increased. Suicide is the 11th leading cause of death overall. On average, one person dies of suicide every two hours. In California, twice as many people die of suicide than by homicide.

National research has shown that 77% of those that die by suicide had contact with their primary care provider in the year before their death. Studies have found that approximately one-third of individuals who commit suicide had contact with a mental health professional (psychiatrist, psychologist, marriage and family therapist, social worker, clinical counselor or psychiatric nurse) within a year of death. National studies have also found that some mental health professionals are not adequately trained to provide proper assessment, treatment, and management of suicidal patients and clients, or know how to appropriately refer them for specialized treatment.

Two surveys of graduate programs, internship programs, and post-doctoral training programs for psychologists done by the California Board of Psychology found that the majority of respondents provided some education and training on suicide risk assessment and intervention. However the amount of education and training varied widely. The amount of training ranged from integrating pieces of the education and training across multiple courses (not quantifiable in hours) to dedicating time in courses or training programs ranging from as little as 6 hours to up to as many as 50 hours.

The states of Kentucky, Nevada, New Hampshire, Utah, and Washington passed legislation requiring mental health professionals to receive training in suicide assessment, treatment, and management.

Currently there are numerous requirements in California Business and Professions Code governing graduate and continuing education requirements. There is no specific law in California that requires graduate training or continuing education in suicide risk assessment and intervention.

THIS BILL

AB 89 establishes a baseline requirement for all licensed psychologists in suicide risk assessment and intervention. This requirement could be met through coursework in their qualifying degree program, continuing education courses, or as a part of their applied experience. The bill would also require a licensee prior to the time of his or her renewal, or an applicant for reactivation or reinstatement, to meet a one-time requirement of six hours of coursework and/or applied experience in suicide risk assessment and intervention.

This will ensure that all licensed psychologists receive training in this critical area, highlight the importance of this training in the field of psychology, and hopefully encourage graduate programs, internships and post-doctoral training programs to evaluate the amount of training provided in their programs.

SUPPORT

California Board of Psychology (Sponsor)
American Foundation for Suicide Prevention

Staff Contact: Jenny Berg jenny.berg@asm.ca.gov (916) 319-2010

Last updated: 2/14/17

Assemblymember Marc Levine
California State Capitol
P.O. Box 942849
Sacramento, CA 94249-0010

RE: Support AB 89 Suicide Prevention

Dear Assemblymember Levine:

I am writing on behalf of (fill in blank) to express our strong support for Assembly Bill 89, which would require all applicants for licensure as a psychologist with the Board of Psychology to complete a minimum of six hours of coursework and/or applied experience in suicide risk assessment and intervention.

National research has shown that 77 percent of those that die by suicide had contact with their primary care provider in the year before their death. Nearly Third had contact with mental health services within a year of their death. Mental health professionals need suicide assessment, treatment, and management training. Suicide is the 11th leading cause of death statewide. On average, one person dies of suicide every two hours. In California, twice as many people die of suicide than by homicide.

By creating standards for suicide prevention training for specified mental health professionals, we can ensure that psychologists are equipped to identify potential signs that a patient is at risk of suicide.

(Describe your organization and its membership, including numbers)

AB 89 improves the education of mental health professionals and help save the lives of at risk individuals. If you have any questions, please feel free to contact me at (give number and email).

Sincerely,

March __, 2017

The Honorable Rudy Salas, Jr.
Chair, Assembly Committee on Business and Professions
State Capitol, Room 4016
Sacramento, CA 95814

RE: AB 89 (Levine): Psychologists: Suicide Prevention Training – **SUPPORT**

Dear Assembly Member Salas:

On behalf of the [YOUR ORGANIZATION NAME HERE], we are writing to urge you to **Support** AB 89 (Levine), which would require all licensed psychologists to have obtained a minimum of six (6) hours of education or training in suicide risk assessment and intervention.

Suicide is a critical issue in the state of California. The Centers for Disease Control and Prevention's (CDC's) data shows that suicide is the third leading cause of death for Californians ages 15 to 34, and the tenth leading cause of death for Californians of all ages between the years of 2000-2015. Furthermore, CDC data also shows that the overall suicide rate in California has increased by 21.4 percent between the years 2000 through 2015. In 2008, California adopted the "California Strategic Plan on Suicide Prevention: Every Californian is a Part of the Solution," which proposed developing and implementing guidelines to promote effective and consistent suicide prevention by incorporating suicide prevention training in existing licensing, credentialing, and graduate school programs. AB 89 (Levine) is a step in the right direction to meeting the strategic plan's goals by ensuring that all psychologists have a minimum level of training in this critical area.

Currently, six other states require psychologists and health care professionals to obtain a minimum number of hours of education or training in suicide risk assessment and intervention, and it is time for California to take a leading role in helping prevent suicide.

For these reasons, we urge you to **Support** AB 89 when it is heard in the Assembly Committee on Business and Professions.

Thank you.

Sincerely,

[YOUR NAME]
[TITLE, ORGANIZATION NAME]

cc: Members of the Assembly Committee on Business and Professions
Assembly Member Marc Levine
Le Ondra Clark Harvey, PhD, Chief Consultant, Assembly Committee on Business and Professions
Bill Lewis, Consultant, Assembly Republican Caucus

___D__ TAB SECTION **DATE OF MEETING 04/20/2017**

MATERIAL **DATE MATERIAL**
PREPARED BY: Wiseman **PREPARED** 03/15/2017

AGENDA ITEM:	Work Plan Goal 2
ENCLOSURES:	• Work Plan • Residential Care Facility draft paper

How this agenda presentation relates to the Council's mission.
The Panel Presentation is one method to hear from the "voice" of the public mental health system in California. Although, Residential Care Facilities are one aspect of care and/or treatment in the continuum of care, it is a vital step in assuring mental health stability. The Council is an advisory body to the Governor, the Legislature, local and state government entities and California's residents. As advocates, we encourage communication and knowledge sharing at the local, county and state level. This panel is one mechanism of obtaining and providing information.

The context for this agenda item/presentation is as follows:
Noel O'Neill, LMFT, Trinity County Behavioral Health Director will present his county's innovative way to provide Board and Care services.

Noel has been the Director of Trinity County Behavioral Health for the past eight (8) years and is licensed as a Marriage Family Therapist. Noel is a council member on the California Mental Health Planning Council and serves on the Mendocino County Juvenile Justice Commission. Noel is a strong supporter of the use of Peer Specialists within the County System of Care.

BACKGROUND/DESCRIPTION:
The Advocacy Committee members are attempting to learn from models or innovative programs throughout the State that take a different approach to the Board and care industry. Trinity County owns its Board and Care Facility. Trinity County requested to share their lessons learned from their Mental Health Service Act (MHSA)-funded Innovation Program.

1. Goal Statement:	Relation to PC Mandate:	Description of Work/Action Steps (Timeframes):
Report on logistical, fiscal and/or programmatic efforts being made to transition people out of IMDs. If none, what challenges are experienced in doing so.	Support Council focus on Alternatives to Locked Facilities. Federal Public Law (PL) 102-321- Monitor, review and evaluate annually, the allocation and adequacy of mental health services within the State. Welfare and Institutions Code Section 5772(a) & (c).	~IMD data will be provided by DHCS, possibly April 2016; ~Staff will attempt to obtain data on the impact of board and care closures. **~The Committee will revisit this goal. Timeframe to be determined at a future meeting.**
Target Audience: DHCS, Legislators, Stakeholders, Local Mental Health Boards **Expected Outcomes:** Acquisition of data (qualitative and quantitative) to illustrate the difficulty in placing individuals in an appropriate level of care following care in an IMD. **End Product:** A report to be distributed to the PC and released to the public. Date: TBD	Intentionally Blank	Intentionally Blank

2. Goal Statement:	Relation to PC Mandate:	Description of Work/Action Steps (Timeframes):
Look into closures of Residential Care Facilities in California, qualitative and quantitative data.	Federal Public Law (PL) 102-321- Monitor, review and evaluate annually, the allocation and adequacy of mental health services within the State. Welfare and Institutions Code Section 5772(2) To review, assess, and make recommendations regarding all components of California's mental health system, and to report as necessary to the Legislature, the State Department of Health Care Services, local boards, and local programs, and (5) To advise the Legislature, the State Department of Health Care Services, and county boards on mental health issues and the policies and priorities that this state should be pursuing in developing its mental health system.	~Obtain data on the Levels of Care Statistics on closures, length of stay, flow of transition for individuals utilizing RCFs; ~Provide recommendations for statewide changes (e.g. Prohibition of centralized medication storage, etc.) ~Identify why people are in the various levels of care and the flow through them. ~Research the financial viability of the models. ~Research any alternative or innovative housing options.

Target Audience: Legislators, DHCS, Stakeholders and Local Mental Health Boards. **Expected Outcomes:** To illustrate the severe lack of available placement options for individuals needing out-of-home. **End Product:** A draft report will be submitted to the PC in *June-Aug 2017*.	Intentionally Blank	Intentionally Blank
3. Goal Statement:	**Relation to PC Mandate:**	**Description of Work/Action Steps (Timeframes):**
Follow-up Report on the implementation of AB 109, Criminal Justice Realignment, amongst Los Angeles, Santa Clara, San Mateo, and Stanislaus Counties.	Support Council focus on Alternatives to Locked Facilities. Federal Public Law (PL) 102-321- Monitor, review and evaluate annually, the allocation and adequacy of mental health services within the State. Welfare and Institutions Code Section 5772 Effect of Realignment.	~Obtain information from the original four counties' progress made, since the 2012 report was released. ~Work collaboratively with DHCS, COMIO, BSCC and other policy/research entities vested in the AB 109 community.

Target Audience: Stakeholders, Legislators, DHCS and Local Mental Health Boards. **Expected Outcomes:** To illustrate the improvement(s) in collaboration between county systems since the implementation of AB 109. **End Product:** A comparison report will be released to the Planning Council January 2017; released to the public February 2017.	Intentionally Blank	Intentionally Blank

4. Goal Statement:	**Relation to PC Mandate:**	**Description of Work/Action Steps (Timeframes):**
What is/are the wellness and prevention strategies utilized for at-risk and/or criminal justice-involved youth?	Support Council focus on Children/Youth. Federal Public Law (PL) 102-321- Monitor, review and evaluate annually, the allocation and adequacy of mental health services within the State. Welfare and Institutions Code Section 5772 Focus on Children and Youth with the Juvenile Justice System.	~Research programs, interventions and strategies used to deter involvement in the Juvenile Justice System.
Target Audience: Legislators, CDSS, CDCR, BSCC, Stakeholders and Local Mental Health Boards. **Expected Outcomes:** To encourage progressive and/or successful programs, interventions and strategies across the state. **End Product:** A report released to the Planning Council and shared with the Public. Date: TBD	Intentionally Blank	Intentionally Blank

California Mental Health Planning Council

- **Advocacy**
- **Evaluation**
- **Inclusion**

Residential Care Facilities

How the lack of residential care facilities has affected housing options for individuals with serious mental illness in California.

Written by:

The Advocacy Committee in collaboration with Barbara Mitchell, MSW; Lynda Kaufmann; and Theresa Comstock

The California Mental Health Planning Council (Council) is under federal and state mandate to advocate on behalf of adults with severe mental illness and children with severe emotional disturbance and their families. Our majority consumer and family member Council is also statutorily required to advise the Legislature on mental health issues, policies and priorities in California. The Council has long recognized disparity in mental health access, culturally-relevant treatment and the need to include physical health. The Council has advocated for mental health services that will address the issues of access and effective treatment with the attention and intensity they deserve if true recovery and overall wellness are to be attained and retained.

This report is one of the Council's many functions as a federal and state mandated entity. This report is the beginning of an effort to highlight a significant public health issue: the lack of residential care facilities as housing options for individuals with serious mental illness in California.

Welfare and Institutions Code 5772. The California Mental Health Planning Council shall have the powers and authority necessary to carry out the duties imposed upon it by this chapter, including, but not limited to, the following:

(a) To advocate for effective, quality mental health programs;
(b) To review, assess, and make recommendations regarding all components of California's mental health system, and to report as necessary to the Legislature, the State Department of health Care Services, local boards, and local programs.
(e) To advise the Legislature, the State Department of Health Care Services, and county boards on mental health issues and the policies and priorities that this state should be pursuing in developing its mental health system.
(k) To assess periodically the effect of realignment of mental health services and any other important changes in the state's mental health system, and to report its findings to the Legislature, the State Department of Health Care Services, local programs, and local boards, as appropriate.

Acknowledgements: This paper was written with the assistance of Theresa Comstock, board member of the Napa County Mental Health Board, Lynda Kaufmann, Director of Government and Public Affairs with Psynergy Programs, Inc., Barbara Mitchell, M.S.W., Executive Director of Interim, Inc., and the Advocacy Committee Members.

Residential Care Facilities: How the lack of residential care facilities has affected housing options for individuals with serious mental illness in California.

The California Mental Health Planning Council (Council) is under federal and state mandate to advocate on behalf of adults with severe mental illness and children with severe emotional disturbance and their families. Our majority consumer and family member Council is statutorily required to advise the Legislature on mental health issues, policies and priorities in California. The Council has long recognized disparity in mental health access, culturally-relevant treatment and the need to include physical health. The Council advocates for mental health services that will address the issues of access and effective treatment with the attention and intensity they deserve for recovery and overall wellness to be attained and retained.

Individuals utilizing the services of Residential Care Facilities (RCF) can and are diverse in their treatment needs, income status and level of family and/or community support and involvement. With the diversity in the individuals needing mental health treatment, should there not be variety/selection in the type of treatment and housing services available to them when discharged from institutional settings?

This paper will discuss the need for residential care facilities and explore the growing shortage of community placements for individuals diagnosed with mental illness. This complex issue involves agencies at the local, state and federal levels. While this paper will not be able to provide all the keys to a solution, we hope to generate an open and honest dialogue on the issue among those in a position to effect change.

Description of bottleneck – to be inserted

In June 2016, the Advocacy Committee began to obtain information directly from the counties about their RCF availability. The Committee developed a survey (Attachment A), which was disseminated to the Counties between September and November 2016. The survey was hand-delivered to several County Mental Health Board Directors by Advocacy Committee Members. Theresa Comstock, a board member of the Napa County Mental Health Board, electronically sent the survey to all 58 Mental/Behavioral Health Boards and/or Directors. Twenty-two of the fifty-eight counties responded by November 2016. The responses were collected, sorted and analyzed. This paper is a direct result of the information obtained from the survey responses and will address the need for RCFs, reasons for closures, challenges and recommendations.

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The twenty-two counties responding varied in size and complexity. The chart below provides an illustration of the responding counties and their populations.

County Name	Population
Sierra	**3,166**
Colusa	**22,312**
Glenn	**29,000**
Amador	**37,302**
Siskiyou	**44,563**
Tuolumne	**54,511**
Nevada	**97,946**
Napa	**141,625**
Shasta	**178,795**
Imperial	**184,760**
El Dorado	**182,917**
Yolo	**212,747**
Santa Cruz	**274,594**
San Luis Obispo	**276,142**
Monterey	**435,658**
Tulare	**465,013**
San Joaquin	**728,509**
San Mateo	**762,327**
Kern	**884,436**
San Bernardino	**2,127,735**
Riverside	**2,331,040**
Orange	**3,165,203**

Note: The population estimates provided in the table above were obtained from the California State Association of Counties website on December 30, 2016. The information can be accessed at: http://www.counties.org/county-websites-profile-information

As noted in the above chart, Sierra was the smallest responding county. There were several mid-range counties responding to the survey. Three large counties, with Orange County being the largest, responded to the survey.

Question 1: How many adult residential care beds are available in your county for persons with serious psychiatric disabilities, who can pay the Social Security Income (SSI) rate?

Several counties indicated they had "zero" beds available to accommodate individuals. San Joaquin County reported, "287 Adult beds and 187 older adult beds, totaling 474 beds out of a total of 627 existing (many require additional monies)." The remaining 153

beds are the "RCFE beds for private pay residents only, with a number of the facilities only taking the private pay clientele."

Only few homes take the SSI/SSA rate. This affects the resources available to clients with limited income and severe and persistent mental illness with no ability to pay private pay rates.) The availability of beds typically ranged under 200, within the reported counties.

Question 2: Do you have a Supplemental Payment, or PATCH, for residential care beds? If so, how many beds are provided and what is the PATCH range?

Of the 22 counties responding, nine (9) reported they do not pay any Supplemental Payments for residential care beds. One county responded, "No, we do not have enough beds. We only patch for one Board and Care for those transitioning out of acute or long term locked psychiatric placements. We do not patch for other facilities." Another county responded, "We have attempted to contract with providers for up to $24-day patch since 2005 and have been unable to attract any provider at this rate." Fourteen counties responded they do provide Supplemental Payments for residential beds. Interestingly, of the 14 counties, the supplemental payment range was as low as $12.50 per day to a high of $350.00 per day. Two (2) counties advised their patches were specifically for 'out-of-county' placements.

Question 3: How many additional residential care beds are needed in your county to sufficiently meet your county's needs?

County	Number of Beds Needed
Sierra	N/A
Colusa	Left Blank
Glenn	Zero
Amador	Ten (10)
Siskiyou	N/A
Tuolumne	Four (4)
Nevada	Ten (10)
Napa	18
Shasta	25
Imperial	Ten (10)
El Dorado	25
Yolo	40
Santa Cruz	100
San Luis Obispo	At least 50
Monterey	20
Tulare	40 – 30 additional to meet need
San Joaquin	50 for Adults and 90 for Older Adults
San Mateo	Approximately 50

County	Number of Beds Needed
Kern	100 to meet the need
San Bernardino	Number not provided
Riverside	200-300
Orange	35-50

San Joaquin County responded, "50 for Adults at minimum and 90 beds for Older Adult." Shasta County stated, "We currently have 25 clients placed in Board and Care homes outside our county." Tuolumne County's response to the number of beds needed in their county, "There are no B&Cs in the County. We do not have supplemental housing. For those in board and care the reasons are specifically matched to their needs – thus no one home would be able to accept all 4 persons currently at B&C as one is elderly, two are dual diagnosed with intellectual disability and mental illness, one has dual substance abuse and mental illness." The responses provided illustrate the lack of resources allowed for individualized care to meet the needs of individuals with substance use disorders, medical conditions and/or other conditions beyond mental health.

Question 4: If your County places individuals out-of-county, how many are placed out-of-county per month?

County	Out-of-County Placements
Sierra	Two (2)
Colusa	Seven (7)
Glenn	22
Amador	Average ten (10)
Siskiyou	Unsure, no RCF beds available within the county
Tuolumne	Four (4)
Nevada	One (1)
Napa	22
Shasta	25
Imperial	Eight (8)
El Dorado	25
Yolo	Average 13
Santa Cruz	20
San Luis Obispo	44
Monterey	45
Tulare	Number not provided
San Joaquin	16
San Mateo	Two (2) or Three (3)
Kern	One (1)

County	Out-of-County Placements
San Bernardino	Number not provided
Riverside	Unknown, not tracked
Orange	25

Of the responses from the 22 counties, the lowest out-of-county placement was one (1) per month, to a high of forty-five (45). The range of explanations for the out-of-county placements included the following in no particular order:

- Not enough of beds, of any kind, are available;
- Not enough placements that will accept clients with serious mental health needs;
- Not enough placements that meet the needs of individuals over the age of 60;
- Not enough placements for individuals with criminal history;
- Not enough placements for individuals that are sex offenders; and
- Not enough placement for individuals with medical needs, such as diabetes, chronic medical needs, incontinence, etc.

Many of the counties responded the needs of individuals who also have medical needs, chronic health conditions, such as diabetes, those with criminal justice involvement and/or substance use disorders are quite difficult to place.

Question 5: Has your county lost any residential care beds within the last two (2) years? If so, please provide the number of lost beds.

County	Number of Lost Beds
Sierra	None
Colusa	None
Glenn	None
Amador	None
Siskiyou	"Have had none to start with."
Tuolumne	None
Nevada	None
Napa	8
Shasta	At least 12
Imperial	None
El Dorado	Number not provided
Yolo	None
Santa Cruz	None
San Luis Obispo	None
Monterey	6
Tulare	40; last 3-10 years over 150

County	Number of Lost Beds
San Joaquin	187
San Mateo	34
Kern	100
San Bernardino	249 within last 6 months; one year ago 105; two years ago 126
Riverside	50
Orange	Number not provided

The top three responses from the Counties, as to why beds have been lost, in order of responses are:

1. Aging out of providers;
2. Poor property conditions; and
3. Not financially viable.

Siskiyou simply responded, "No. Have had none to start with." Kern County reported losing "100 beds." Whereas San Joaquin County reported losing "187 both adult and older adult" beds.

Question 6: The counties were asked to provide any anecdotal perspectives. Some of the anecdotal responses are as follows:

- "Referring strictly to locked psychiatric facilities, our county is in need of several more beds (perhaps up to 40 additional beds). Due to recent legislative changes (since 2014), there has been a voluminous increase in referrals for LPS evaluations and more persons placed on LPS conservatorship. We often need our clients to have treatment in State Hospitals or IMDs for a protracted period as we are seeing a more severely mentally ill profile in addition to a much more violent population. We also are seeing a trend of younger persons in need of this high level of care and some of the IMDs are disinclined to accept said group. Therefore, we need not only more beds, but facilities willing to accept this younger, more violent type of patient."

- "Land in our county is too expensive to develop. Labor costs are too high. Cannot hire or retain trained and experienced staff. A "Not In My Backyard" mentality of prospective neighbors" hinders increasing the number of board and care facilities in our county.

- One County stated it does not have B&C beds/facilities other than the six bed ARF. Over the last two years, three separate providers have become Room and Boards in a neighboring county, which is one of its larger neighbors. The County

further stated it has been difficult to find licensed facilities that are operated by trusted providers in the larger county that can meet the needs of the individuals being served.

- "Lack of in-county board and care availability (specifically, enhanced board and care beds) results in the county having to place large numbers of clients out-of-county. This can cause many challenges related to providing effective case management/treatment and occasionally poses challenges to family members of clients who are placed out of county. There is most definitely a need for more in-county board and care facilities (specifically enhanced board and care beds) to serve the needs of County clients who are often older and facing significant physical health concerns in addition to their intensive mental health related needs."

- "As older operators age out, the establishment of new facilities is cost prohibitive given the current SSI/SSP rates to provide "basic" care and supervision. Therefore, existing resources are diminishing each year and we are seeing faster turnover (open, then close) of new small facilities. Supplemental Rates are established to reimburse for "augmented" services in order to cover the additional cost for the operator. It is not designed to cover basic operating cost. The cost of property, related taxes, increased oversight by CCL and enforcement of labor laws (OT, Workman's Comp., Insurance, etc.) either requires the owner/operator of a 6 bed to work 24/7 or not operate (not enough funds to hire help). Reimbursement does not cover facility maintenance costs so a number of existing facilities are in major disrepair. This has resulted in very poor quality housing and increased CCL citations and fines that the owners do not have funds to address. As a result, the only viable fiscal option is to work to establish large homes (40 beds+) to achieve economies of scale and even then, it may not be fiscally viable without some type of augmentation. Larger facilities are generally more institutional in environment and, if new, face the challenge of NIMBY opposition."

The above depicts numerous reasons for the lack of Residential Care Facilities (RCF) throughout California. One of the prominent barriers to successfully running an RCF is its financial viability. The chart below is an example of a typical **sample** budget. This budget presumes owner-operated property for 13-bed facility. Owner has $500,000 loan on property purchased for $600,000 and interest/principal payments of $2533/month on 30-year loan at 4.5%. *Note that this would not be realistic for property costs in the Bay Area or Los Angeles*.

Residential Care Facility Sample Annual Budget

Title	Amount	Comment
Revenue		
Resident Fees	$150,274	$1014/month for 13 residents at 95% occupancy
Donations		
Total Revenue	**$150,274**	
Personnel Expenses		
Line Staff	$182,000	4.5 Staff at $15/hour covers single coverage 7 days/week. Plus 1 FTE at 40 hours/week for administration/transport of clients to doctors, admissions, grocery shopping, etc.
Landscaping	$2400	$200/month
Relief Staff	$15,600	Fill-in for sick/vacation employees at 20 hours/week
Total Wages	$200,000	Presumes 9 sick days, 14 vacation days, 8 holidays/employee/year
Salary Related Expenses		
Health/Dental/Life/Vision Insurance (HSA)	$39,600	$600 month/employee, prorated for part-time
Unemployment Insurance	$1,482	
Worker's Compensation Insurance	$13,836	
FICA/Medicare	$15,116	
Total Salary Related Expenses	$70,034	
Other Personnel Expenses		
Training	$2000	
Total Other Personnel Expenses	$2000	
Total Personnel Expenses	**$272,034**	
Operating Expenses		
Legal and Other Consultation	$1000	
Household Supplies	$10,000	Cleaning, paper supplies, non-food, any recreational supplies
Office Supplies	$2,250	
Computer/Office Furnishings	$1000	
Utilities	$20,238	
Maintenance – Building and Equipment	$12,000	Presumes that this includes furniture replacement
Vehicle Maintenance	$6,000	Presume one vehicle for use at $550/month
Food	$40,880	$8 person/day plus one staff eating
Insurance	$8,215	
Telephone/Internet/Cable	$3000	
Printing and Postage	500	
Licensing and Permits	$1,711	
Property Taxes	$6,000	Presumes property purchased for $600,000 with $100,000 down payment
Advertising	500	

Total Operating Expenses	$113,294	
Rent or Loan Payments	$30,396	
Total Expenses	$415,724	
Total Net Income (Loss)	**(265,450)**	(Revenue $150,274 minus Cost $415,724 = Loss $265,450)

The budget listed above does not depict all of the costs associated with running a viable Residential Care Facility. The above-listed budget does not account for…

- *Appropriate staffing ratio* for 24 hours/day, seven (7) days/week. The sample budget illustrates one staff person at 24 hours/day seven (7) days/week, which is the equivalent of 4.5 staff. The salary was budgeted at $15 hour, plus benefits. Many facilities are unable to hire staff at the $15-hour rate, as that is typically the salary for 'relief' staff.
- *Additional staff* other than one (1) administrator that performs numerous duties, such as resident admissions, transportation, etc. The labor laws are quite complex when staffing a 24-hour facility (e.g. number of staff on premises, night staff 'awake' requirements while on the premises, etc.).
- *Owner profit*. Owner profit would add approximately $20,000 year at 5%. Adding a 5% profit margin would increase costs by approximately $125 person/month.

In order for a facility to break even, the resident fee would need to be increased to $2953 month at 95% occupancy. Thus, currently, many individuals, organizations, counties and corporations do not open this type of housing/business due to the enormous complexities and excessive costs associated with running a financially viable residential care facility.

Potential inclusion of a 45-bed Residential care Facility budget - to be inserted

With the number of RCF closures and no new facilities, many individuals are not able to obtain appropriate housing within the next level of care following any type of in-patient treatment program (hospitalization or correctional setting). Therein lies the heart of the problem. No shelter, no treatment. This equals a recipe for another mental health crisis.

California is making great efforts to shift away from institutional care towards care and support in an individuals' community. However, in order for individuals to remain in the least restrictive environments, within their communities, there needs to be available housing and support options. The RCFs are at the crux of this dilemma. RCF are an

essential component needed to assist individuals in remaining as independent and unrestricted as possible, along with appropriate levels of services and supports, when living with severe mental illness.

The Council is interested in shining a light on this lack of available beds for individuals requiring care in a Residential Care Facility and highlight a few programs currently providing innovative solutions. The Council is acutely aware of the need for expanded mental health treatment services including crisis response and crisis stabilization, however, an even greater need is for an increase in appropriate RCFs to accommodate individuals released from acute psychiatric care.

There are numerous anecdotal stories across the state regarding the lack of *placements* for individuals needing psychiatric treatment and support post-institutionalization. What can be done to remedy the shortage of facilities?

One argument for change to the residential care industry comes from the California Advocates for Nursing Home Reform special report, "A New Model of Care is Necessary – One Size Does Not Fit All (Reform, 2013)[1]."The special report cites the failure of the RCFE Act of 1985. The report indicated the Act was to "establish three levels of care within the RCFE regulatory structure to address the fluctuating health and care needs of older residents." However, the funding connected to the legislation "is subject to Budget Act appropriations and has never been implemented. Thus, for the past 28 years, CCL has been forced to maintain or had no choice but to maintain a "one size fits all" approach to residential care for elders, stretching the regulations to accommodate an ever-growing acuity level…" (Page 4).

Psynergy Programs, Inc. has been successful in running RCFs in a number of counties. They incorporate a rigor of daily activities with educational and recreational choices. Psynergy's housing alternative include comfortable, non-institutional shared rooms, small or large private rooms, and semi-independent private apartments. The clinical program encompasses on-site psychiatric and inter-disciplinary teams. Psynergy has locations in (Nueva Vista) Morgan Hill, (Cielo Vista) Greenfield, and Psynergy of Sacramento, California. Psynergy "continuously provides clients, and their families, a support team that assist in the process of recovery and community re-integration…Focusing on client care that is individually planned, and coordinated, our treatment team provides coping skills for the multiple symptoms and behaviors that client's experience. We are committed to creating innovative options for individuals to move out of locked settings and into successful community living." (Psynergy Programs, Inc., 2016)

The International Journal of Psychosocial Rehabilitation (Myra Piat, 2002) published a journal article titled, *Developing Housing for Persons With Severe Mental Illness: An*

[1] Website link to Residential Care in California: Unsafe, Unregulated & Unaccountable

Innovative Community Foster Home[2]. The premise of the article was to report on a study that "evaluate[d] an innovative housing project that integrated a nursing assistant into a foster home for persons with a severe mental illness. The residents who were evaluated had tried to live in the community on numerous occasions, but their attempts had failed." The study found that individuals that were unsuccessful in prior community housing attempts had increased success of remaining in the community while residing in the Community Foster Home, and therefore did not return to an institutional setting. "The overall time spent in the hospital by the residents one year pre- and post-evaluation differed greatly (in total 650 days before versus 124 days after placement). Supportive relationships were formed between the residents, nursing assistant and caregiver."

A Place of My Own: How the ADA is Creating Integrated Housing Opportunities for People With Mental Illnesses is a report published by the Judge David L. Bazelon Center for Mental Health Law. This report discusses the effects of deinstitutionalization, key community integration principles and how the American with Disabilities Act and the *Olmstead* decision are making strides for a more robust supportive housing system in America. Website link to A Place of My Own report

When Opportunity Knocks…How the Affordable Care Act Can Help States Develop Supported Housing for People with Mental Illnesses is another report completed by the Bazelon Center for Mental Health Law. This report provides further rationale and examples of how the ADA can provide promising supports and financial assistance to individuals with mental illness. Website ink to When Opportunity Knocks report

Workforce Implications of Models of Care for Older Adults with Mental Health and Substance Use Conditions (J. Eden, 2012) provides reviews of "nine models of care delivery for older adults who have depression, substance use conditions, serious mental illness, or psychiatric and behavioral symptoms related to dementia." The models for geriatric mental health and substance use disorder are as follows:

- Models for Managing Depression
    1. Improving Mood-Promoting Access to Collaborative Treatment (IMPACT)
    2. Kaiser Nurse Telehealth Model
    3. Program to Encourage Active and Rewarding Lives for Seniors (PEARLS)
- Models for Substance Use
    1. Screening, Brief Intervention, and Referral for Treatment (SBIRT)
    2. Primary Care Research in Substance Abuse and Mental Health for the Elderly (PRISM-E)
- Older Adults with Serious Mental Illness Models
    1. Helping Older People Experience Success (HOPES)

[2] Website link to Developing Housing For Persons With Severe Mental Illness: An Innovative Community Foster Home

2. Psychogeriatric Assessment and Treatment in City Housing (PATCH)
3. Wellness Recovery Action Planning (WRAP)

- Psychiatric and Behavioral Symptoms Related to Dementia models
  1. Providing Resources Early to Vulnerable Elders Needing Treatment (PREVENT)
- MH/SU Care for Older Nursing Home Residents Models
  1. Consultation Model

The article goes on to provide the implications for the impact on workforce deficits and additional training needs to work effectively with the older public.

Immediate improvements to this issue need to be made. As a society, we cannot wait for another life to be lost, by wasting away in an institution. Investment in supportive housing is **one** possible solution. Not all individuals living with severe mental illness may benefit from supportive housing alone. [begin highlight]As stated previously, RCFs are not financially viable. The individuals needing the option often do not have the personal income to obtain housing on their own. The owners of such facilities often are tasked with running a facility with deficits, due to the gap between meeting the needs of the individuals and running a safe facility.[end highlight] [begin strikeout]~~Supportive housing in additional to resources such as vocational, education, transportation and socialization are essential. Local, state and federal initiatives, policies, regulatory and legislative changes can and should be demanded that would enable different types of residential care facilities to operate in a way that is fiscally viable. This would allow for the flow of individuals through each level of care and relieve the current bottleneck for individuals ready to step-down from locked or hospital settings.~~ [end strikeout]

In conclusion, individuals with severe mental illness are suffering from a medical condition. Attention must be paid to provide housing and treatment options for these individuals that addresses their diverse needs. It is essential for this growing population to have access to appropriate and affordable housing options. No one deserves to be homeless or incarcerated due to [begin highlight] an untreated[end highlight] medical condition.

Recommendations: [These are to be inserted following the April Meeting.] Additionally, is there means to assist struggling RCFs? Is there a way for RCFs to share best practices, in a cost efficient manner?

The policies and regulations governing RCFs need to be revised to include more robust training for staff and owners to know how to work with this vulnerable population and how to maintain fiscal stability.

Potential Questions to be answered during the panel discussion:

Macro Level issues

•Has your county quantified the number of consumers wanting to leave board and care homes?
•Has your County studied the impact of alternatives to board and care? What were the costs?
•What type of data is needed to a) expand board and care facilities; b) increase monetary support to board and care facilities;
•How are unlicensed facilities utilized in your county?
•Please itemize how your Patch is utilized.
•If this is a dying industry, what should replace it?
•What licensing issue(s) prevent optimal functioning?
•How has Conservatorship affected advocacy efforts, if at all?

Micro Level issues

•What has been your experience with board and care facilities as a consumer, as a case manager?
•Please provide insight on what works.
•Please provide insight on what does not work.
•What do you believe is/are the major barrier(s) for individuals placed in board and care facilities?

Recommendations from the April 2017 panel discussion(s):

1) Complex Medical issues
2) Room and Board policy and regulation changes, specifically to the central storage of medication (medicine delivery method).

___E__ TAB SECTION **DATE OF MEETING 04/20/2017**

MATERIAL PREPARED BY: Wiseman **DATE MATERIAL PREPARED** 03/14/2017

AGENDA ITEM:	Residential Care Facility Panel Presentation
ENCLOSURES:	• Community Living Coalition PowerPoint Presentation • http://www.scscourt.org/self_help/probate/conservatorship/conservatorship_lps.shtml#what

How this agenda presentation relates to the Council's mission.
The Panel Presentation is one method to hear from the "voice" of the public mental health system in California. Although, Residential Care Facilities are one aspect of care and/or treatment in the continuum of care, it is a vital step in assuring mental health stability. The Council is an advisory body to the Governor, the Legislature, local and state government entities and California's residents. As advocates, we encourage communication and knowledge sharing at the local, county and state level. This panel is one mechanism of obtaining and providing information.

The context for this agenda item/presentation is as follows:
The Panel Presenters will illustrate the "on-the-ground" experiences of consumers and professionals intimately involved with Residential Care facilities. The panelist will share their perspective on 'what works', 'what does not work' and 'possible solutions'. The questions below are potential discussion questions:

Macro Level issues

- Has your county quantified the number of consumers wanting to leave board and care homes?
- Has your County studied the impact of alternatives to board and care? What were the costs?
- What type of data is needed to a) expand board and care facilities; b) increase monetary support to board and care facilities;
- How are unlicensed facilities utilized in your county?
- Please itemize how your Patch is utilized.
- If this is a dying industry, what should replace it?
- What licensing issue(s) prevent optimal functioning?
- How has Conservatorship impacted advocacy efforts, if at all?

Micro Level issues

- What has been your experience with board and care facilities as a consumer, as a case manager?
- Please provide insight on what works.
- Please provide insight on what does not work.
- What do you believe is/are the major barrier(s) for individuals placed in board and care facilities?

BACKGROUND/DESCRIPTION:

The panel participants will explore the issue(s) they have experienced with Residential Care Facilities (RCFs). The panelists will define what those issues have been. The panelists will provide their alternatives and/or suggestions for improvement.

Residential Care Facility Panel Discussion Participants

Mr. Jung Pham has been a staff attorney with Disability Rights California since 2008. DRC is a federally funded private non-profit organization created by Congress to provide advocacy, education, and legal services for all Californians with disabilities.

Jung works in the Investigations Unit where he focuses on the abuse and neglect of persons with disabilities in facility and community settings.

Jung's special interest is investigating the abuse and exploitation of clients living in community congregate settings. He is currently working on raising awareness and developing an innovative multi-county coalition-based approach to mitigate the risk of exploitation in those settings.

In addition to his advocacy work he is also involved in several legislative and public policy issues, one of particular interest being police training in interacting with persons in mental health crisis.

In his "spare time" Jung is working hard to raise disability awareness and reduce its stigma in the Asian community. He also coordinates the intern and volunteer attorney recruiting efforts in DRC's Oakland office.

Disability Rights California: Who We Are

Disability Rights California is a nonprofit public interest law firm, established in 1978 under federal mandates to protect the legal, civil and service rights of persons with disabilities.

Our offices in Oakland, Sacramento, Fresno, Los Angeles, and San Diego serve Californians with developmental disabilities (such as mental retardation, autism and other severe disabilities) as well as persons with psychiatric disabilities, regarding their rights within the mental health system, and persons with mobility and communication disabilities.

Over the years, we have been involved in important class actions and individual litigation regarding access to community-based healthcare, deinstitutionalization, voluntary mental health treatment, fair housing and discrimination issues under the Rehabilitation Act, Americans with Disabilities Act (ADA), and Individuals with Disabilities Education Act (IDEA) as well as California law. In addition, we have also achieved positive systemic reform through our public policy and legislative work in the area of abuse and neglect against persons with disabilities.

Ms. Lorraine Zeller, Certified Psychiatric Rehabilitation Specialist (CPRP), was employed with the County of Santa Clara in 2009 as a Peer Mentor and became a Lead Mental Health Peer Support Worker in 2012. In addition to her service as a lead and clinic peer support worker, her position allows her to publish "*Our Voice*", the quarterly Consumer Affairs newsletter. She also works as the Community Living Coalition Coordinator, which serves to ensure high quality and safe living in unlicensed room and board facilities, and participates in Residents' Rights workshops for consumers living in board and care facilities. She also served as Peer PALS Program Coordinator for the National Alliance on Mental Illness (NAMI), Santa Clara County, playing a key role in launching the program that matches mental health consumers with each other to support their continuing recovery.

Both her work with NAMI and her current position with the County allows her the opportunity to show her gratitude for the peer support she received following her hospitalization in 2006 for clinical depression. Lorraine brings her perspective to this panel as a consumer who lived for a few months in the unlicensed wing of a board and care and as an advocate for her peers who live in licensed board and care and room and board facilities.

Ms. Mary Clarke – Santa Clara County Public Guardian's Office/LPS Ongoing, Supervisor. In 1982, Mary Clarke graduated from the University of Oregon with a Bachelor in Psychology and a certificate in Gerontology. In the 1980's, Mary worked as an activity director/social service director in a nursing home in Vermont. Beginning in 1990, Mary worked for the Long Term Care Ombudsman based at Catholic Charities of San Jose as an advocate for clients living in residential care facilities and those in nursing homes. This included investigating elder and dependent adult abuse.
In 2006, she began work as a Deputy Public Guardian Conservator for Santa Clara County working with both LPS (mental health) and Probate conservatees. Mary Clarke became the Supervising Deputy Public Guardian Conservator for the LPS Ongoing team in 2007. Mary has held the position since. The team is responsible for overseeing the needs of approximately 500 conserved mental health consumers.

<u>Office of the Public Guardian</u> – **Who We Are**
The Office of the Public Guardian insures the physical and financial safety of persons unable to do so on their own, and when there are no viable alternatives to a public conservatorship. The Superior Court determines whether a conservatorship should be established. The court process includes petitioning the court and notifying the proposed

conservatee and his or her family of the proceedings. A conservatorship is only established as a last resort through a formal hearing. The Superior Court can appoint the Public Guardian as a conservator of the person only, estate only (for probate) or both person and estate.

Probate Conservatorships are primarily established for frail adults who are unable to provide for their own personal needs for physical health, food, clothing and/or shelter, cannot manage their own finances, or cannot resist undue influence. Probate conservatorships are often used for older adults with severe limitations and for younger adults who have serious cognitive impairments, and will remain in effect until the conservatee can show that he/she is again capable of handling his/her own affairs appropriately. A probate conservator does not have the authority to place a conservatee in a psychiatric treatment facility. Click here for more information on Probate conservatorships.

Referrals are usually made to the Public Guardian through Adult Protective Services or may be made directly to the Public Guardian by a relative, friend, neighbor, doctor, police officer, the court or other concerned individual.

LPS Conservatorships are established to arrange mental health treatment and placement for people who are gravely disabled and unable to provide for their food, clothing, shelter and treatment needs as a result of a mental disorder. It is named for the three legislators who wrote the law that passed in 1969. An LPS conservator does have the authority to place a conservatee in a psychiatric treatment facility, and these conservatorships must be renewed on an annual basis. An LPS conservatorship can only be initiated by a psychiatrist while a patient is in an acute psychiatric hospital. A referral packet must be completed.

Deputy Public Guardians provide each conservatee with the best and most independent living environment possible, within the conservatees' abilities and resources. The Deputy Public Guardian may arrange for health care, housing, meals, transportation, personal care and recreation. In addition, the Deputy Public Guardian may be authorized to gather all assets, apply for income, collect all bills and make decisions on which bills can be paid. The Deputy Public Guardian is accountable to the Superior Court for all actions taken on behalf of the conservatee.
For additional information contact: **408-755-7610**

Ms. Michelle Ho – Santa Clara County Behavioral Health Department, Supervisor of the 24-Care Branch. Michelle Ho is a licensed marriage and family therapist and a program manager of the intensive services unit for the behavioral health services department with Santa Clara County. She is responsible for assessing and finding placements for patients discharging from the acute psychiatric emergency hospitals to the community. She has been with the Behavioral Health Department since 2013. She has extensive knowledge about board cares and other residential options for psychiatric patients. The name of her unit is 24 Hour Care Unit, which is responsible for authorization of placements to and from the psychiatric institutions to the community.

COMMUNITY LIVING COALITION

Presented by John Hardy and Lorraine Zeller, Consumer Affairs

Hilary Armstrong and Kim Pederson, Mental Health Advocacy Project

Jung Pham, Disability Rights California

STEERING COMMITTEE MEMBERSHIP

Consumers & Families
Housing Operators
Behavioral Health Services Department Consumer Affairs
NAMI Santa Clara County
Mental Health Advocacy Project
Disability Rights California
Peninsula Health Care Connections

MISSION STATEMENT

The Community Living Coalition exists to empower, educate, promote self-advocacy, and to ensure safe and supportive community housing for behavioral health consumers. The coalition builds connections and collaboration equally partnered by consumers, families, behavioral health providers, community housing operators, and advocates.

Why Do We Need a Community Living Coalition?

SB WOMAN ARRESTED

People held in coops

THE CRISIS: A LITTLE BACKGROUND

- This is a crisis in our County – Silicon Valley is facing an overall housing crisis, and behavioral health consumers are left in the cold, enduring horrific conditions and severe shortage of safe and habitable housing
- Summer 2011: Board and Care Improvement Project (BCIP) was initiated by consumers with assistance from the Mental Health Advocacy Project (MHAP) as a grass roots collaborative.
- The need for this project was clearly established by reports about sub-standard living conditions from clinicians, consumers, case managers, and family members collected by Lorraine Zeller and MHAP.

WORK, ACCOMPLISHMENTS & OUTCOMES - BCIP

- Residents' Rights Workshops
- Recruitment/Involvement of Stakeholders
- Adoption by the Mental Health Department (Nancy Peña)
- Outreach visits to County contracted homes
- Mental Health Peer Support Workers included as team members in site reviews
- Consumer Affairs staff participating in quarterly meetings with 24 Hour Care operators

PROJECT EVOLUTION . . . fast forward to SUMMER 2014

- Chair of Behavioral Health Board Systems Planning & Fiscal Committee involvement
- Established as a priority by the Systems Planning & Fiscal Committee
- Gathering of stakeholders, foundational planning/discussions
- Survey and results/priority issues
- New member, Kathy McDow - first hand testimony
- Jung Pham’s outreach to seven operators who own multiple homes well-received
- Disability Rights California has opened 2 cases investigating complaints at SCC facilities
- Linkage with Office of Supportive Housing

FUTURE ACTIONS

- Develop charter, establish SMART goals & outcomes, determine resources needed to achieve goals
- Distribute survey to contract agency case managers to gather additional data
- Nuts and Bolts – building the coalition (including defining standards and membership requirements, list, coalition meetings)
- Training and outreach to operators, consumers, clinicians, case managers, family members
- Systems advocacy on state and local levels
- Implementation of additional peer support (Project REACH) once funded via budget proposal or INN project

QUESTIONS?

COMMENTS?

SUGGESTIONS?