

**MENTAL HEALTH/DEVELOPMENTAL SERVICES COLLABORATIVE
MINUTES OF MEETING OF JANUARY 18, 2012**

Attendees:

Alta RC	Olivia Balcao
CVRC	Tom Keenen
GGRC	Hal Kirklin
HRC	Michael Tredinnick
NBRC	Alfonso Carmona, Pamela Madden-Krall, Michi Gates
SGPRC	Steve Mouton, Keith Penman
VMRC	Nicole Weiss
SDRC	Carlos Flores

Priorities	Jeff Payne, Melanie Tugend
Telecare	Ann Christen
Liberty Health Care	Ken Carabello
Omelegah, Inc.	Matt Omelegah, Ebony Omelegah

SELPA – Napa County	Shelton Yip
MH – Sonoma County	Mike Kennedy
ARC-CA	Tony Anderson
DDS	Julia Mullen, Jeanie Thurston, JoEllen Fletcher, Renee Carnes
ARCA	Bob Baldo, Joan Hoss, David Riester

By Telephone:

Area Board IX	Anastasia Bacigalupo
MH – Los Angeles County	Irma Castaneda
WRC	Erica Schuster, Aga Spatzier
IRC	Genii Greco, Jennifer Cummings
GGRC	Lisa Rosene
NBRC	Patrick Maher
RCRC	J Holden

The meeting was chaired by Carlos Flores and Mike Kennedy. Following introductions and approval of the minutes of the September 1, 2011 meeting, the following matters were discussed.

1. Consultant Reports:

Joan Hoss reported that she attends meetings of the California Mental Health Directors' Association including their policy forums. She follows developments in others states' policies and practices related to people with a dual diagnosis and seeks viable treatment models for individuals with mental illness in the criminal justice system.

David Riester reported on the Consumer and Community Protection meeting held on December 1, 2011. This meeting was a small conference devoted to a discussion of the protection of the community from regional center clients who pose a public safety risk while preserving their right to due process. The discussion was facilitated by David Meyer, USC law professor and former LA County Mental Health Deputy Director. The Judicial Council, Disability Rights California and the Assembly Health and Human Services Committee and the Senate Health Committee were represented along with representatives from regional centers and county Mental Health agencies. There is little likelihood of sufficient support for expansion of WIC6500 (civil commitment of people with mental retardation, who are dangerous to self others) to other categories of developmental disabilities. There was consensus, however, that we need to determine who is at risk of requiring secure treatment and to identify the resource gaps in community services to meet their needs. Julia Mullen of DDS and David Riester, Collaborative staff, are working on this project.

The MH/DS Collaborative is a co-sponsor of the 5th Annual Solutions Building Conference scheduled for March 15 in San Diego. The Collaborative is also co-sponsoring two conferences with Alta Regional Center in April and June on collaboration in services to children and adults with dual diagnosis in the criminal justice system.

2. Developmental Services Report:

Bob Baldo announced that, after sixteen years, he has retired from the ARCA Directorship. Bob will continue to serve as a consultant to the organization. The new ARCA Director is Eileen Richey, former deputy director of the Department of Developmental Services.

The current year state budget contained a trigger feature in the event that revenues did not meet projections. The trigger was pulled in December and \$100M was taken from the DDS budget. While this may not pose serious problems this year, there is a \$200M loss for the 12-13 developmental services budget. DDS will conduct six stakeholder meetings across the state. Stakeholders will be asked to consider:

- a) strategies to decrease the need for admissions from the community into developmental centers;
- b) strategies to achieve efficiencies through emerging technologies;
- c) opportunities for expenditure reduction offered by recent legislation, e.g., insurance coverage for autism services;
- d) the extension of all or part of the 4.25% rate reduction which has been restored in the budget proposal.

3. Mental Health System Report:

As Patricia Ryan, Director of CMHDA, is in Washington, D.C., Joan Hoss gave this report. The mental health system is breathing a tentative sigh of relief as there were no major reductions proposed in the Governor's budget to local public mental health. The Department of Mental Health and the Drug and Alcohol Agency will be dissolved effective June 30, 2012. The financial functions of these departments have been transferred to the Department of Health Care Services (DHCS). Cliff Allenby has left the DMH Director's post as he has worked the maximum number of hours available to a retired annuitant. The DMH licensing function will transfer to the Department of Social Services (DSS). A new Department of State Hospitals (DSH) will be established. County mental health directors will be dealing with multiple state agencies in the future.

This is a transition year for transfer of responsibility for providing mental health services to K-12 students from county mental health agencies to the schools. In many counties, the schools are continuing their contracts with county mental health while they prepare to assume full responsibility with their own staff resources in July. There is considerable uncertainty for the schools as they do not know what level of State funding will be available to them for the fulfillment of their mental health service mandates. Furthermore, the Governor's budget for education relies on the assumption that voters will pass a tax increase proposal in November.

Joan also raised the issue of "IMD ancillaries." An Institute for Mental Disease (IMD) is a skilled nursing facility (SNF) with a distinct program for people with mental illness. As an example, the Sunbridge Sierra Vista facility in Highland offers a specialized mental health program for regional center clients and is classified as an IMD. Federal regulations prohibit Medicaid payment for IMD services. If a county mental health agency places a client in an IMD, fees are paid solely with county funds. If a regional center uses an IMF facility, absent an agreement with mental health to share the cost, the regional center pays the daily rate. Counties and/or regional centers must also cover the cost of psychotropic medications used by IMD residents as Medi-Cal does not cover these costs. However, Medi-Cal coverage is still available for medical care unrelated to the resident's mental illness. As an example, if a resident breaks a bone, Medi-Cal will pay for care and treatment for the broken bone. Joan reports that DHCS is currently considering billing counties for all medical care costs for IMD residents, choosing to re-interpret Federal regulations and reduce state Medi-Cal expenditures. Counties are prepared to sue the state over this issue. The implications for regional centers are that their IMD residents' medical care would no longer be covered by Medi-Cal and the regional center would incur new costs. The Medi-Cal IMD exclusion also applies to Mental Health Rehabilitation Centers (MHRC)

4. MHSA Grants Administered by DDS:

Jo Ellen Fletcher and several representatives of regional centers reported progress on the grants they have received. The grants awarded for the period FY11-12 through 13-14 are as follows:

a) Alta:

- Substance Abuse Reduction Project – Conference scheduled for February 7
- MHSA Forums – Conferences scheduled for April and June

b) CVRC:

- Foundations of Infant Mental Health Training – Will train up to 300 professionals in infant mental health techniques

c) NBRC:

- Building Bridges – Conferences scheduled for March 7 and March 8
- Project Connect – Will train professionals in infant mental health assessment and treatment

d) SGPRC:

- Anchor Project Replication of 30 High-Risk Clients – Will feature anger management training. Partner is ALMA Family Services.

e) Westside RC:

- Transition Age Youth Services Integration Projects – See the website ReachAcrossLA.org
- Tools for Accessing Quality Services

5. Providing Services to Offenders with Dual Diagnosis:

This presentation was made by Matt and Ebony Omelegah who currently provide adaptive skills training and supported living services (SLS) to regional center clients involved with the criminal justice system. Ebony worked as the GGRC forensic social worker prior to becoming a community service provider. In that capacity, as GGRC's liaison with the courts, she served more than 500 clients. She worked on court ordered evaluations, conservatorship reports, 4418 assessments, diversion reports, and assisted counselors in responding to court orders. Her experience enabled her to identify gaps in resources for offenders that included:

- Specialized residential resources offering close supervision individualized to the risk to public safety posed by the resident. Traditional providers are typically reluctant to accept residents with a criminal history.
- Transition planning upon release from jail or a psychiatric hospital. Immediate help is needed to navigate the regional center, mental health and criminal justice systems. Relapse or recidivism often results when timely case management services are not available.
- Drug and alcohol treatment program – often 1:1 services are needed because clients are not successful in traditional AA and NA groups. Substance abuse is rampant among the offender population.
- Close monitoring of Medi-Cal eligibility - As clients move from county to county and in and out of jail, Medi-Cal eligibility might be re-established.

- Specialized caseloads in regional centers and probation agencies – would permit case managers and parole agents to focus on resources and treatment options available for offenders.

Matt Omelegah has a resource development background and currently serves as Chief Operating Officer of West Bay Housing Corporation. Omelegah, Inc. currently serves 25 offenders of which 20 have a dual diagnosis. They also have two four-bed adult residential facilities in development to serve GGRC and RCEB clients. Matt reports that they provide their consumers with positive role models and reward-based programs. Their services, including recreational activities, are highly structured. The intensity of supervision is dictated by their “levels” system adapted from the systems used at Porterville Developmental Center and California Psychiatric Transitions. Residents earn their reduction of restriction through responsible behavior. Substance abuse treatment is provided by in-home counselors in monthly groups which offer a modified AA curriculum. Incentives for positive behavior change include gift cards and tickets to concerts and sporting events. They have a “Books for Bucks” program that offers bookstore gift cards for reading books. They currently serve two females. Their SLS counselors reside in shared housing as Bay area housing is otherwise unaffordable. Twenty-four hour supervision is required by 50% of their caseload, and the remainder generally receive 40 hours per week of service in their Adaptive Skills Training program. Family involvement is encouraged and facilitated. Several of their consumers have a history of sex offenses and locating a home more than 2,000 feet from schools and parks is challenging. A powerpoint presentation on Omelegah, Inc. was sent to Collaborative members.

6. Identifying Unmet Resource Needs:

Carlos Flores led the discussion on this topic which included the following highlights:

a) IST Experiment in San Bernardino County – Ken Carabello of Liberty Health Care has a state-funded demonstration project providing training and treatment to jail residents with mental illness who are found incompetent to stand trial. Instead of sending these residents to state hospitals with long waiting lists, San Bernardino established a 20-bed unit in the jail and contracted with Liberty Health Care to treat and train the residents for restoration of competency. In most cases, Liberty has been able to restore competency within six months and thus save money for the county and the state. Liberty accepted 66% of the referrals. Prisoners are given incentives (cookies, shampoo, etc.) for voluntary compliance with their psychotropic medication regimen. IST jail days were reduced and Liberty reimbursed the county for health care costs. The State Legislative Analysts’ report on this project has been sent to Collaborative members via e-mail.

b) Competency Training at RCRC – J Holden reported that CPP funds were used for the provision of training in competency restoration to J, a clinical psychologist, and others in the Redwood Coast catchment area. Competency training is provided as a 1:1 service in a variety of environments including jails and IMDs. Two out of every three ISTs are restored to competency and psychologists generally know within two months if the person can be “restored to competence.” County mental health agencies in the RCRC area are adapting the RCRC curriculum for training with individuals with chronic mental illness.

c) Risk Assessment – The services provided depend, in part, on the risk that a person will pose to the health and safety of others. The client requires a safe place to live and that place may be in a locked facility (developmental center or private), a delayed egress setting, a supervised and licensed living arrangement, a supported living situation, with family and even individually with supports. What level of security is required for community protection varies with each person. Whether in a locked or unlocked setting, the elements of a treatment plan for the regional center client with mental illness would generally include:

- 1) Supervision and guidance;
- 2) Medication management;
- 3) Training, education, socialization (behavior management);
- 4) Therapy (for example, anger management, sex offender treatment, substance abuse treatment, dialectical behavior treatment, traditional counseling).

d) Incompetence to Stand Trial and Developmentally Disabled – If the regional center client is charged with a misdemeanor or a felony that can be reduced to a misdemeanor, a diversion (from the criminal justice system) plan can be considered by the court. A competency assessment is not necessary in this instance. If charged with a felony and found IST, the court will order competency training in the least restrictive program as recommended by the Regional Center. But, if the felony charge is a sex offense (PC290) or a violent crime (PC667.5c), then the Judge must order competency training in a locked and controlled treatment environment or in a facility with a locked perimeter. This facility can be a developmental center or a private locked facility.

County mental health directors are seeing a reduction in the number of IST referrals with the October implementation of the Public Safety Realignment Act (AB109). Under this new law, individuals convicted of non-violent, non-serious, non-sex crimes will be incarcerated and supervised by the counties and will not be sent to state prison. The law responded to a federal court order to reduce the prison population by 30,000. Defendants and their attorneys often consider jail less onerous than prison or a state hospital.

Studies of public safety risk among mentally ill defendants find that clinical status does not predict danger. Probation uses risk assessment tools which look at criminogenic factors, such as family stability. Telecare operates some AB109 programs (county plans are required to have some mental health components) and uses a risk assessment tool to determine the potential for antisocial behavior.

e) Full Person Assessment – Dr. Ruth Ryan, a pioneer in the development of treatment techniques with individuals with MI/DD diagnoses, encouraged full-person assessment that includes medical, social, psychological, dental, vision, hearing tests preparatory to treatment planning. All too often, we seek only a psychiatric assessment to explain dangerous behavior and accept the prescription of medication as the primary behavior change agent. Could a state-operated program (for example, Canyon Springs, mobile or telemedicine teams) be used for full-person assessment, perhaps replacing or supplementing the WIC4418 assessment now practiced? This full-person assessment might better inform individualized service planning, resource development, resource sharing, and interagency collaboration.

f) Locked Community Resources – There was a discussion of the locked resources, IMDs and MHRCs, used by regional centers today. These include College Hospital’s DDMI program, California Psychiatric Transitions, Sierra Vista, Sanger Place and several IMDs with only a few regional center clients. One committee member mentioned that the services of a vendorized day program are available at the Bungalows, a long-term care locked facility serving 30 regional center clients. This facility has been useful in transitioning out residents as the residents can continue in less restrictive residential care but with the same day program.

g) State Developmental Center – Regional centers refer people with unmanageable, dangerous behavior to all of the state operated programs. These people are not criminals, but they, very often over several years, have exhausted all community options. The state operated program is the placement of last resort as there is no community service provider willing to serve them. They have burned all their bridges and have placed others in jeopardy. Absent the development of state operated last resort community options, regional centers will continue to make general treatment area referrals. It was reported that there have been 500 admissions in the last five years (in both GTA and STA).

The Secure Treatment Area at Porterville Developmental Center is viewed as “the old prison” by judges. There are 220 STA residents today, more than the legislature cap of 200 beds. No federal funds can be used for treatment in the STA.

h) Delayed Egress – Delayed egress indicates that there is a bar on all exit doors that delays opening for fifteen seconds and sets off alarms, giving staff the time to redirect and counsel the resident. The 15-bed Priorities program is eligible for federal funds, but the 36-bed Redwood Place, due to capacity, is not. After several years of experience, Redwood Place is considering converting a portion of their MHRC facility to locked care.

i) Specialized Homes – There is a wide array of specialized homes for regional center clients, licensed by the State Department of Social Services. Sex offender treatment, substance abuse treatment, mental health treatment, behavior management, crisis homes, homes for juvenile offenders all exist in California, but in insufficient numbers. There are also highly specialized supported living, adaptive skills training, employment and outpatient treatment programs designed exclusively for clients with mental illness and/or a criminal history.

j) Evidence Based Practices and Promising Practices – These are important concepts in the fields of mental health and substance abuse treatment. Anger Management, Relapse Prevention, and Motivational Interviewing are examples of programs that research has proven to be effective. Fidelity to the model is key to successful use of these interventions. Promising practices are models used successfully, but on too few people nationally to be eligible for evidence based status. The use of even the identification of evidence based practices is not yet part of the developmental services culture.

7. Next Meeting – The next meeting of the MH/DS Collaborative will be held in Sacramento on Wednesday, May 16.

Submitted by: David Riester