Recovery Focused Hospital Diversion and Aftercare – Transformation in Services Will Equal Transformation in Lives

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Executive Summary

There are well-established crisis alternatives that support individuals in their efforts to seek help and take an active role in their own recovery. These alternatives are more likely to produce better outcomes than crisis interventions that take place after a person is already in acute crisis. By providing services on an ongoing basis and before acute crisis occurs, these alternatives can help end the revolving door of hospitalization and even incarceration. At this time, even with limited funding, counties are doing a variety of things to improve the delivery of mental health services including development of the types of alternatives discussed in this report. Investing in the development, implementation and support of these types of proven and cost-effective services should be an important part of any county’s efforts to improve and develop services.

The crisis alternatives discussed in this report are treatment interventions that have been proven in practice and have undergone scientific evaluation and include the following:

1. Illness Management and Recovery
2. Supported Employment
3. Supported Education
4. Permanent Supportive Housing
5. Assertive Community Treatment (ACT)
6. Integrated Mental Health and Substance Abuse Services
7. Consumer-Operated Services
8. Family Psycho-education

There are nationally recognized core elements of a Community-Based Crisis Response System, which include the following1:

1. 24/7 Warm Lines and 24/7 Crisis Lines
2. Walk-In Clinic/Center;
3. Mobile Crisis Services;
4. Full Service Partnership (FSP) Programs;
5. Crisis Residential; and
6. Crisis Respite
In addition to the core elements, there are recovery-focused activities that provide continuity of care and help avoid the revolving door of rehospitalization, institutionalization, or incarceration. These include:
1. Aftercare Planning
2. Peer Support
3. Supportive Housing
4. User-Friendly Menu of Services
5. Psychiatric Advance Directives
6. Coordination between Public Mental Health Programs and Private Insurance

Section 1 of this report presents information on core elements of a community-based crisis response system. These are recovery-based services that increase service satisfaction and reduce cost. Recovery has been defined as, “A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.….2 By definition, the recovery process must be self-directed by the individual, who defines his or her own life goals and designs a unique path towards those goals.”3

Section 2 presents information on effective crisis services, many of which are already part of public mental health programs. These include strategies to help people access needed community support, such as peers, benefit counselors including vocational rehabilitation4, religious or spiritual leaders, and housing providers. Section 2 also presents information on coordination between private health care service plans and public mental health programs. Various possible funding options are also discussed.

Section 3 of this report presents information on recovery-focused aftercare planning and services, including supportive housing.
Section 4 of this report outlines recommendations to promote access to crisis alternatives that can produce better outcomes. These focus on:

1. Building the capacity of California’s community crisis response system based on the Recovery Vision for providing mental health services and supports;
2. Improving aftercare or discharge planning from facilities to promote an individual’s access to support services that support Recovery Vision goals;
3. Increasing access to Supportive Housing;
4. Improving performance outcome measures;
5. Providing a user-friendly menu of crisis services;
6. Promoting psychiatric advance directives;
7. Hiring people with lived experience in the mental health system; and
8. Improving coordination with private insurance.

This report was prepared by Disability Rights California as part of the Stigma and Discrimination Reduction (SDR) Initiative. The SDR Initiative is funded by county mental health departments with Mental Health Services Act (MHSA) Prevention and Early Intervention funds provided through the California Mental Health Services Authority (CalMHSA). The SDR Initiative uses a full range of Prevention and Early Intervention Strategies across the lifespan and across diverse backgrounds to confront the fundamental causes of stigmatizing attitudes and discriminatory and prejudicial actions.5
Introduction

There are well-established crisis alternatives that support individuals in their efforts to seek help and take an active role in their own recovery. These alternatives can produce better outcomes than crisis interventions that take place after a person is already in acute crisis. By providing services on an ongoing basis and before acute crisis occurs, these alternatives can help end the revolving door of hospitalization and even incarceration. This improves people’s lives and also saves money. This report will describe a number of strategies for developing proven and cost-effective crisis alternatives and make recommendations for their implementation.

A crisis system that relies exclusively on police as the first responders can do more harm than good. To begin with, police are not mental health treatment professionals and may not have adequate training in how to work with people with mental health challenges. From the standpoint of the person in crisis, being handcuffed and taken in the back of a police car to an unfamiliar facility without knowing what to expect can be terrifying and can lead to feelings of helplessness. In addition, if what people in crisis want for themselves, and how they would like to go about getting their needs met, is not considered, additional fear and hopelessness can result. All of this can cause additional trauma and discourage people from seeking further help.

Fortunately, there are alternative crisis responses and treatment options that provide better outcomes. Counties now have an opportunity to develop many of these alternatives. These alternatives will help move the community mental health system away from a law-enforcement and emergency-response system that many people with mental health challenges would like to avoid and toward a system that will encourage people to seek help when they need it. These alternatives will save lives and money by reducing emergencies and assisting people in getting the help they need on an ongoing basis. These alternatives provide the opportunity for people to fully engage in the process of their recovery and support them in their efforts over time. This is respectful of people receiving mental health services and helps reduce the stigma and
discrimination that people often experience from numerous sources when they are in crisis.

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6. Integrated Mental Health and Substance Abuse Services
7. Consumer-Operated Services
8. Family Psycho-education

These programs and practices help divert people from hospitals and support them in their recovery plans. For example, Assertive Community Treatment (ACT) is an evidence-based practice funded as part of the MHSA full-service partnership (FSP) program. These recovery-focused programs have demonstrated success in reducing costs related to psychiatric hospitalization, physical health care, and the criminal justice system.

Section 1 of this report presents information on core elements of a community-based crisis response system. These are recovery-based services that increase service satisfaction and reduce cost. Recovery has been defined as, “A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential…. By definition, the recovery process must be self-directed by the individual, who defines his or her own life goals and designs a unique path towards those goals.”

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public mental health programs. Various possible funding options are also discussed.

Section 3 of this report presents information on recovery-focused aftercare planning and services including supportive housing.

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1. Building the capacity of California’s community crisis response system based on the Recovery Vision for providing mental health services and supports;
2. Improving aftercare or discharge planning from facilities to promote an individual’s access to support services that support Recovery Vision goals;
3. Increasing access to Supportive Housing;
4. Improving performance outcome measures;
5. Providing a user-friendly menu of crisis services;
6. Promoting psychiatric advance directives;
7. Hiring people with lived experience in the mental health system; and
8. Improving coordination with private insurance.

Section 1: Core Elements of Community-Based Crisis Response Systems Increase Satisfaction and Decrease Costs Consistent with Evidence-Based Programs and Practices.

The California Legislature has found that “70% of people taken to emergency rooms for psychiatric evaluation can be stabilized and transferred to a less intensive level of crisis care.” Absent an adequate array of crisis services, people have little choice but the emergency room for evaluation and potentially “unnecessary inpatient hospitalization.”

The Recovery Vision

Alternative crisis services discussed below provide options to avoid emergency room visits, hospitalizations, and incarcerations. They significantly reduce the stigma and discrimination experienced by people who enter the mental health system by helping them obtain and maintain independence and community services and supports consistent with the
Recovery Vision. Under this approach, “recovery” is viewed as a journey of healing and transformation that empowers a person with a mental health challenge to realize his or her full potential. Under the Recovery Vision, empowering the person with a mental health challenge is a central concept. This holistic approach does a better job than the traditional medical model of taking into account the full spectrum of concerns of people with lived experience in the mental health system.

Recovery has been defined as “A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.” The federal Substance Abuse and Mental Health Services Administration (SAMHSA) has issued a consensus statement on mental health recovery. Through the Recovery Support Strategic Initiative, SAMHSA has delineated four major dimensions that support a life in recovery:

1. **Health** - Overcoming or managing one’s disease(s) or symptoms and making informed, healthy choices that support physical and emotional wellbeing for everyone in recovery
2. **Home** - A stable and safe place to live
3. **Purpose** - Meaningful daily activities such as a job, school, volunteerism, family caretaking, or creative endeavors, and the independence, income and resources to participate in society
4. **Community** - Relationships and social networks that provide support, friendship, love, and hope

The consensus definition identifies the following ten guiding principles of recovery:

1. Recovery emerges from hope
2. Recovery is person-driven
3. Recovery occurs via many pathways
4. Recovery is holistic
5. Recovery is supported by peers and allies
6. Recovery is supported through relationship and social networks
7. Recovery is culturally-based and influenced
8. Recovery is supported by addressing trauma
9. Recovery involves individual, family, and community strengths and responsibility

10. Recovery is based on respect

Recovery has been identified as a primary goal for behavioral health care.\textsuperscript{21} The recovery model of care addresses many limitations of the medical model of care, which focuses on symptom reduction and the role of the health care provider in determining which interventions are best suited to providing relief. The medical model tends to break down for chronic medical conditions.\textsuperscript{22} Its focus on curing disease tends to reinforce negative perceptions of people who are not “cured” of their chronic conditions.\textsuperscript{23} People are often described as “treatment resistant,” “noncompliant,” or “lacking insight,” implying that they are incapable of getting better or don’t want to get better. Too often, the health care system gives up on them, which leads them to give up on themselves, too.

In contrast, the recovery model focuses on the whole person and aims to improve the long-term quality of their lives rather than apply short-term fixes that temporarily manage their symptoms. It is based on the recognition that recovery is highly individualized and not a “one size fits all” approach. “By definition, the recovery process must be self-directed by the individual, who defines his or her own life goals and designs a unique path towards those goals.”\textsuperscript{24} The individual, rather than the treatment provider, decides what is in his or her “own best interest.” The recovery model instills hope that people can and do get better – they learn to thrive rather than merely survive with their disability. The individual recovery services should optimally be provided in flexible, unbundled packages that evolve over time to meet the changing needs of recovering persons.\textsuperscript{25} Individuals should also be able to access a comprehensive and coordinated array of services that support them throughout their unique journeys to sustained recovery.\textsuperscript{26} Recovery-oriented systems of care must be designed to support individuals across their lifespan.\textsuperscript{27}

Using a recovery-oriented approach to develop crisis alternatives is essential to overcome the limitations of the medical model in its provision of these services. The medical model, with its emphasis on the role of medical providers and treatment of illness, tends to focus on episodic medical care for people in crisis rather than ongoing interventions that may include a wide range of medical and non-medical services identified by the person who seeks services. The crisis alternatives described in this report
are based on the concept of ongoing, flexible, individually tailored services that are person-centered and support people in their journey towards recovery.

**Core Elements of a Community-Based Crisis Response System**

Confining and isolating people in an unfamiliar, controlling, and often frightening environment without their usual support system and any privacy can add to trauma and discourage people from seeking assistance in the future. Crisis alternatives can provide a greater feeling of safety and connection by providing a smaller and more familiar setting, access to more peer providers with shared experience, and more focused and intensive recovery-model services. They may provide “trauma-informed care” for people who were victims of child abuse or other trauma.

There are nationally recognized core elements of a Community-Based Crisis Response System, which include the following:

1. 24/7 Warm Lines and 24/7 Crisis Lines
2. Walk-In Clinic/Center;
3. Mobile Crisis Services;
4. Full Service Partnership (FSP) Programs;
5. Crisis Residential; and
6. Crisis Respite

An effective community-based crisis response system is necessary for meaningful informed consent and provision of services in the least restrictive, most integrated setting.

In addition to increasing the satisfaction of service recipients, these programs reduce costs and implement evidence-based practices. There are a number of funding sources for programs that improve and expand positive and life-affirming opportunities for mental health recovery. These include funding for Recovery-Focused Aftercare Programs and Supportive Housing, which are key elements of an effective community crisis response system. Additionally, the federal Affordable Care Act as well as state and federal mental health parity laws require that private health services plans provide medically necessary mental health services, including core elements of a community crisis response system.
Counties are using a number of funding sources, including Mental Health Services Act (MHSA) funding, to develop these essential programs consistent with evidence-based programs and practices. Recently, the California Legislature enacted Senate Bill 82 (Steinberg), Investment in Mental Health Wellness Act of 2013, Welfare and Institutions Code section 5848.5 (SB 82). SB 82 provides grants to counties to develop recovery-based crisis services that offer alternatives to hospitalization.

The objectives of the Investment in Mental Health Wellness Act of 2013 (SB 82) are to:

1. Expand access to early intervention and treatment services to improve the client experience, achieve recovery and wellness, and reduce costs.
2. Expand the continuum of services to address crisis intervention, crisis stabilization, and crisis residential treatment needs that are wellness, resiliency, and recovery-oriented.
3. Add at least 25 mobile crisis support teams and at least 2,000 crisis stabilization and crisis residential treatment beds.
4. Add at least 600 triage personnel to provide intensive case management and linkage to services for individuals at various points of access, such as at designated community-based service points, homeless shelters, and clinics.
5. Reduce unnecessary hospitalizations.
6. Reduce recidivism and mitigate unnecessary expenditures of local law enforcement.
7. Provide local communities with increased financial resources to leverage additional public and private funding sources.

The SB 82 grants can be used to leverage other sources of funding. For example, SB 82 services that are covered under Medi-Cal can be matched with federal funds. Because the federal government provides at least 50% of the funding for Medi-Cal-covered services, counties can provide at least twice the services that they would otherwise be able to provide with SB 82 grant funding alone. As discussed in this report, this type of focused funding has already helped counties to identify and implement cost-
effective alternatives to hospitalization that produce better outcomes in accordance with recovery model principles.

**Increased Service Satisfaction**

Crisis alternatives are shown to increase satisfaction. For example, people with lived experience in the mental health system prefer crisis residential programs to hospital-based crisis care. Crisis residential programs are generally in small, unlocked, home-like settings rather than in locked, institutional facilities. They may “encourage an ethic of peer mutual support” or be operated by people with lived experience in the mental health system.

According to the California Mental Health Planning Council, “…CRPs are more effective than PHFs [psychiatric health facilities] because the smaller scale created by reduced staffing ratios and fewer beds allow for focused, individualized recovery-oriented treatment plans. The homelike environment of a residential setting creates a safe base from which clients can assess their needs and assist in framing their own recovery plan.”

This type of supportive environment increases treatment satisfaction and a sense of hope, which is crucial to a person’s recovery. Over 90% of people receiving assistance from Progress Foundation prefer the crisis residential programs to the hospital. One study reported that “[f]emale patients in particular prefer non-hospital alternatives (such as crisis houses) to acute inpatient treatment, and this may reflect the lack of perceived safety in (a) hospital.”

Service satisfaction is important in its own right, but it has other benefits as well. If people are satisfied with the services they receive, they are more likely to seek out services in the future on a voluntary basis. Service satisfaction may lead to better mental health and consequently a reduced need for services. This reduces costs.

**Decreased Costs**

Crisis alternatives are also cost-effective. For example, crisis residential treatment outcomes may be clinically comparable or superior to hospital treatment, and the daily rate for Crisis Residential Programs may be one-third to one-half the cost of inpatient hospitalization. Further, “[d]ue to
their lower overhead costs for medical staff and general facility expenses, CRPs can operate far less expensively than hospitals or PHFs [psychiatric health facilities].”

In 2010, the California Mental Health Planning Council reported as follows: “Crisis residential programs [CRPs] reduce unnecessary stays in psychiatric hospitals, reduce the number and expense of emergency room visits, and divert inappropriate incarcerations while producing the same, or superior outcomes to those of institutionalized care. As the costs for inpatient treatment continue to rise, the need to expand an appropriate array of acute treatment settings becomes more urgent. State and county mental health systems should encourage and support alternatives to costly institutionalization, and improve the continuum of care to better serve individuals experiencing an acute psychiatric episode.”

Costs do not only affect county mental health programs. The health care system in general and the criminal justice system also incur costs as a result of inadequate crisis alternatives.

Currently, not all counties have an array of crisis services specifically intended to divert persons to less restrictive, recovery-focused levels of care. This leaves individuals with little choice but to access an emergency room for assistance, which may result in unnecessary hospitalization. Additionally, this often requires law enforcement personnel to stay with persons in an emergency room waiting area until a less intensive and less restrictive level of care can be found. One finding identified in SB 82 is that 70 percent of people taken to emergency rooms for psychiatric evaluation can be stabilized and transferred to a less intensive level of care.

Developing better crisis alternatives can help to reduce all of these costs.
Section 2: Effective Crisis Response Programs

24/7 Warm Lines and 24/7 Crisis Lines

California Law recognizes the need for Pre-crisis and Crisis Services in an effective array of service options for adults and children that are available 24 hours a day, seven days a week.\textsuperscript{47}

The California Strategic Plan on Suicide Prevention includes recommendations to expand the number and capacity of accredited suicide prevention Crisis Hotlines.\textsuperscript{48} This would ensure that each county “has at least one accredited suicide prevention hotline call center or that the county has a formal partnership with an accredited call center.”\textsuperscript{49} A number of counties are currently promoting these efforts through the Suicide Prevention project, which is one of the statewide MHSA Prevention and Early Intervention (PEI) projects.\textsuperscript{50}

Some counties have Warm Lines and Crisis Hotlines that operate 24 hours a day, seven days a week.\textsuperscript{51}

San Joaquin County has a Warm Line that offers people the chance to share concerns, obtain referrals, and talk with a peer who generally understands their perspective and is willing to listen and talk with them.\textsuperscript{52} Tulare County has planned for a Spanish Community Warm Line as well as for a Warm Line serving people in the lesbian, gay, bisexual, transgender and questioning community.\textsuperscript{53} The MHSA PEI Suicide Prevention project, funded by counties through the California Mental Health Services Authority (CalMHSA), is helping to establish programs such as these.\textsuperscript{54}

A Warm Line may be integrated with a Crisis Hotline. This enhances early identification and intervention in crisis situations. As a result, it promotes community education and prevention so that people get services before a crisis worsens.

Walk-In Clinic/Center and Other Crisis Stabilization Programs

California Law recognizes the need for comprehensive evaluation and assessment that includes “but is not limited to, evaluation of and assessment of physical and mental health, income support, housing,
vocational training and employment, and social support service needs.”\textsuperscript{55} Assessment can be provided offsite through mobile services,\textsuperscript{56} or at a walk-in clinic or center. The latter refers to an “outpatient” program that provides one-time and short-term (less than 24-hours) urgent and crisis mental health services, which include assessment, linkage to ongoing mental health services and community resources and medication evaluations. This could be a clinic where people can go at designated hours for crisis and other counseling, as well as referral to other crisis alternatives.\textsuperscript{57}

Walk-in programs are convenient and readily accessible. People may not have calendars or smart phones to keep track of scheduled appointments, so they have ready access to assistance when needed rather than being required to wait for the next available appointment.

Exodus Recovery has 23-hour Urgent Care Centers in Los Angeles. These are described as “a welcoming environment where individuals in crisis can be assessed for stabilization services, medication evaluation and management, or hospitalization if necessary.” The centers are “open and available 24 hours per day, 365 days per year, on a walk-in basis.”\textsuperscript{58}

Fresno County has opened an Urgent Care Wellness Center. The program is described as follows: “Delivers urgent care services for up to 90 days. Services include crisis evaluation and intervention, medications, individual/group therapy, and linkage to other appropriate services. The program expanded to include evening hours and Saturday. Center's goal is to reduce visits to emergency rooms and crisis services, incarcerations, and acute psychiatric hospitalizations.”\textsuperscript{59}

Counties have developed other community programs as an alternative to hospital-based crisis assessment.

Progress Foundation has the Dore Urgent Care Clinic in San Francisco. It provides acute crisis assessment and stabilization in a community-based setting. Aftercare planning begins at intake. The goal “is to establish linkages to community outpatient services, intensive case management, medication support services, substance abuse treatment and support services, public or private benefit advocacy, and housing.”\textsuperscript{60} Unlike a walk-in center, people may be
referred to the program by designated behavioral health providers or pursuant to 5150 detention by the police department. However, all people are admitted on a voluntary basis for up to 23 hours.  

**Mobile Crisis Services**

California law has long provided for mobile crisis services. In 1967, the LPS Act mandated access to voluntary crisis intervention services provided in a person’s home. Nearly 25 years later, the Legislature recognized mobile crisis services as necessary for a “minimum array of services. This includes “[a]ssertive outreach…to homeless and hard-to-reach individuals with mental disabilities.”

Mobile crisis services include mobile crisis teams that can assist when a person is in crisis and is being considered for detention for mental health evaluation and treatment. Mobile crisis services can also include intensive case management, linkage to services, monitoring of service delivery, monitoring the individual’s progress, and providing placement services and assistance with plan development. Grants to support these types of mobile crisis services are specifically provided for in SB 82, which refers to these services as “triage.” These can be matched with federal Medicaid funds to the extent these services are funded under the Medi-Cal program. (See below for Medi-Cal reimbursement possibilities.)

Some mobile crisis programs team with law enforcement officers (e.g., Humboldt County, San Diego County). Some focus on the needs of people whose primary language is Spanish (e.g., Tulare County). Others have focused on peer-led support services (e.g., Sonoma County). Some are expanding their programs or increasing their capacity to serve increased numbers of people. (e.g., San Joaquin County). Los Angeles County is establishing youth stabilization teams using SB 82 funds.

San Diego County has a mobile team that includes Peer Support Specialists and Family Coaches for outreach to adults “who are reluctant or ‘resistant’ to receiving mental health services.” Services include: Crisis management, transitional case management and linkages to community resources, such as healthcare, food banks, and clubhouses. The program also provides support and education to family members.
Accessible and affordable transportation is essential. Referrals to community mental health providers and other resources are sometimes ineffective due to inadequate access to transportation. Outreach workers may assist people in getting to appointments. This support is a two-pronged service: transportation and support. While accompanying the person to his or her appointment, outreach workers with lived experience in the mental health system have time to connect with the person and potentially provide guidance and share personal experiences about the path toward wellness and recovery.

**Full Service Partnership (FSP) Programs**

California’s systems of care have evolved over the past quarter century. In 1984, the California Legislature established an interagency system of care for children labeled as seriously emotionally disturbed in Ventura County. In 1991, it recognized the critical importance of systems of care for people of all ages. In 1996, it enacted the Adult and Older Adult Mental Health System of Care Act. Standards governing these integrated systems of care programs include, but are not limited to, the following:

1. Meeting the cultural, linguistic, gender, age, and special needs of each individual;
2. Recognizing the special needs of women from diverse cultural backgrounds, including housing that accepts children; and
3. Providing housing that is immediate, transitional, and permanent.

The MHSA builds on these standards through programs that are called Full Service Partnership (FSP) programs. FSP programs can include “Assertive Community Treatment (ACT), an evidence-based practice - consistent with MHSA principles - where services can be delivered in the person’s home and are available 24 hours a day, 7 days a week,” which can be funded under Medi-Cal as a mental health rehabilitation service. They have a team “do whatever it takes” approach that serves people 24/7. “The service provider may need to be medical consultant, coach, mentor, friend, peer, advisor, sponsor, student, customer, fellow patient, political activist, or even confessor to best help a person recover.” In addition, they provide peer support and housing. For example, housing funds are
available for a security deposit or first and last month’s rent. FSP services also include crisis intervention and/or stabilization services. The target population for FSP programs is people with serious mental health conditions who are homeless or at risk of homelessness and may also be diagnosed with a substance use disorder.

Counties across California have developed FSP programs. Services are provided at clinic sites, in people’s homes or at other sites, such as at primary care providers. The programs may coordinate treatment with primary care providers and includes peer support and education. Some programs focus on adults and transition age youth and provide services primarily in English, Spanish and Hmong (e.g., Merced County). They may focus on older adults (e.g., Napa County) and/or individuals who are high users of hospitalization or are in or at risk of long-term institutional placement (e.g., San Diego County).

The main difficulty with expanding FSP programs is that the programs are expensive and MHSA funds are limited. For this reason, they have been made available to only a limited number of people. That is why it is important to develop additional strategies to assist people in crisis while continuing to find ways to secure additional funding for FSP programs.

**Crisis Residential Programs**

California law has long provided for “a short-term crisis residential alternative to hospitalization for individuals experiencing an acute episode or crisis requiring temporary removal from their home environment.” The primary focus is on crisis reduction, stabilization and assessment of the person’s existing support system, including recommendations for referrals upon discharge. It was designed for people “who would otherwise be referred to an inpatient unit, either locally or in the state hospital.”

As referenced above, people prefer the open environment of crisis residential programs to the traditional acute care setting. Also, unlike the hospital environment, the residential treatment setting has many of the aspects of community living that people will experience when they move to a more independent living arrangement in the community. This makes it easier to assess people’s community living skills and therefore provides a
better assessment of how well people will do outside the program. This provides for better outcomes, which increases satisfaction.

Counties are using or considering use of MHSA capital facilities funds to develop crisis residential programs (e.g., Orange County, Amador County). SB 82 also provides grants for crisis residential services. Some counties seem to have difficulty in maintaining funding for this type of program. Further investigation is needed to identify what the funding issues are and how to address them.

**Crisis Respite**

California law has provided for emergency housing or respite care services for decades. Such assistance is “for persons…in need of temporary housing, but who do not require hospitalization or the more intensive support…of the crisis residential treatment program.” Services include advocacy, counseling and linkages to community mental health and other human services, including vocational and housing options.

Counties have proposed or developed overnight stay respite programs. Trinity County, for example, has provided funding for a Respite Support Project in partnership with Native American Tribes.

The Sacramento County Respite Partnership Collaborative is planning to roll out three types of respite projects: (1) Planned Respite, (2) Crisis Respite, and (3) Peer-Run Respite. Planned Respite “refers to a preventative respite that serves to reduce the risk for mental health crisis….” Crisis Respite “refers to a safe and holistic environment where individuals [who are] undergoing a mental health crisis can stabilize with professional support and may also include peer support.” Peer-Run Respite “refers to a safe respite environment facilitated and coordinated by mental health consumers as peers. In this setting, individuals learn to manage crisis in a warm, welcoming, home-like environment that is facilitated by one’s peers.”

SB 82 grant funds are an option for developing crisis respite programs. If the respite provider offers intensive case management while providing respite, SB 82 triage funds could be used. If the intensive case
management is also eligible for Medi-Cal reimbursement, the SB 82 funds could be matched with federal Medicaid funds.

**Section 3: Recovery-Focused Aftercare Planning and Services Including Supportive Housing**

In addition to the services listed above, an effective, recovery-focused crisis response system also includes the following:

**Aftercare Planning**

Aftercare planning must begin the moment a person receives crisis assessment and services and must include the person’s direct participation in the planning process. Encouraging full participation in aftercare planning and the recovery process is a necessary part of mental health treatment. It is both respectful and empowering, and is likely to encourage people to seek help voluntarily in the future.¹⁰⁰

“Providers have two significant challenges. The first is to move away from the power-over-people approach of using control and coercion, a strategy that can diminish a person’s ability to learn choice-making personally. This means providers must allow and support individuals in taking risk through having life experiences, even if this means individuals may fail, or have their choices turn out badly. There is dignity in the right to failure because it is through experience that we learn to make choices. The second is that providers have a responsibility to work with individuals to learn the skill of making choices. This includes not only the process of learning approaches to future choice-making, but also the effort of learning from failures and ineffective choices.”—Telecare Corporation.¹⁰¹

Many times people who are involuntarily hospitalized are not given information that they need to make informed decisions. This includes information such as the reason for and duration of their detention, treatment alternatives, discharge criteria, and aftercare options. One reason may be a misperception by some hospital staff that people who have been involuntarily hospitalized are incapable of making any decisions for themselves. In an effort to address this particular issue, the California Hospital Association has proposed, as part of its legislative proposal to
revise 72-hour detention procedures, to add presumption of capacity language to the legislative intent section of the Lanterman-Petris-Short Act.\textsuperscript{102}

The aftercare plan should include more than a list of referrals.\textsuperscript{103} A person who is feeling overwhelmed may need help in accessing services. A person may not have the tools they need to navigate the complexities of the mental health system and reintegrate into society. Continuity of care requires that a full spectrum of resources, including access to peers, benefit and vocational counselors, religious or spiritual leaders, or housing providers be offered.\textsuperscript{104}

The lack of adequate access to needed home and community support services may lead to re-hospitalization and long-term institutionalization, incarceration or homelessness. This can perpetuate trauma. Providing sufficient aftercare planning, including access to supportive housing, financial assistance, follow-up mental health services and other community support services can provide hope and increase the ability to recover and return to life in the community. People face immense obstacles on their road to recovery. People need the tools and supports necessary to avoid or better cope with future crisis situations such as supportive housing, financial assistance and available mental health services. Providing these support services will help to achieve the goal.

There are challenges in getting out of a facility and trying to reintegrate into society. People have to get used to not having hospital or institutional staff making decisions for them, such as what and when to eat, what to wear and when to engage in various activities. A person may forget or lose the ability to make their own decisions. When the person moves into the community, he or she must be supported in involving family and other loved ones in treatment and recovery, if desired. Family and other loved ones may need assistance in developing strategies for providing the support that the person needs. Assistance with all of this should begin as soon as possible after admission to the facility so that the support can begin immediately after the person is discharged. This will increase the likelihood of success.
Peer Support

There is also a need to provide peer support and promote self-advocacy skills to give people tools to move forward, not only on a short-term basis, but for a sustained period in the future. Counties are developing programs to address these concerns.

Alameda County has a Peer Mentor Program that assists people with adjustment following discharge from an involuntary psychiatric hospitalization. Peers meet with people while at the facility and make calls and visits after discharge. There has been a 68% to 72% reduction in re-hospitalization rates for people who receive these services. The grant totaled $238,000. The program reportedly resulted in a savings in hospitalization costs of $1,062,500, and a total return on investment of $824,500.

Stakeholders in other counties have identified the need to increase access to these services following a crisis situation through peer support, including peer “bridgers,” peer counselors, peer case managers and peer self-help facilitators who help people enter and continue to receive treatment as needed through the mental health system. Counties are beginning to do this and are beginning to see better outcomes at lower cost.

Del Norte County has used MHSA funds to form a bridge team to better address the needs of clients in need of crisis stabilization. The county reports that this has resulted in a dramatic decrease in the need for late-night on-call service.

Madera County has used MHSA innovation funds to establish collaboration between emergency room staff, mental health staff and peer/family members who will engage clients (and families) in crisis. The focus of the mental health and emergency room staff is assessment of health problems, medication management, and crisis services. Once the need for health and/or crisis services has been resolved, the mental health staff will link the individual to peer providers/family members for follow-up services to assist and engage the clients in recovery activities such as outpatient treatment or community support groups.
Santa Clara County has used MHSA innovation funds to establish the Mental Health and Law Enforcement Post-Crisis Intervention Project. The Santa Clara County project provides immediate (within 24 hours), voluntary, compassionate, post-crisis contact with a culturally competent team comprised of a peer/family advocate and a clinician for individuals and families who experience a mental health or suicide-related event that involves law enforcement. The program assesses the impact of post-crisis responses in engaging consumers and family members to prevent them from “falling through the cracks” in the system. It evaluates outcomes, including a reduction in repeat law enforcement interventions, use of force, multiple hospitalizations, and avoidable suffering. It provides the opportunity for individuals and families in crisis to provide input about what is most helpful to them during and/or after a mental health crisis. These measures increased collaboration and active participation in effective crisis response situations. This program is similar to programs in Butte and Sonoma Counties.

MHSA-funded programs include Recovery Vision aftercare programs. These have staff to assist the person in transitioning from a facility (e.g., inpatient hospital, psychiatric health facility, jail) into the community. They could include Health Navigators, Promotores, and/or other program staff with lived experience in the mental health system and/or family members designed to assist people in accessing follow-up physical and/or mental health care and other community support services. Some of these activities can be funded under the Medi-Cal program.

The [federal] Center for Integrated Health Solutions has developed training for people interested in becoming “whole health and wellness coaches,” called Whole Health Action Management. Georgia’s Medicaid program includes coverage for whole health and wellness peer support provided by certified peer specialists. At least 29 additional states and the District of Columbia have added certified peer specialists to their Medicaid programs.

Peer support specialists can assist in reducing disparities in services experienced by underserved groups, including people of color and members of LGBTQ communities, based on the idea that lived experiences
will strengthen relationships between providers and consumers within targeted communities. The President’s New Freedom Commission on Mental Health found that “[i]ndividuals from ethnic and racial communities may encounter stigma and discrimination as they attempt to get help for their mental health conditions, often receiving differential treatment and poorer quality of care.” It also found “significant underrepresentation of minority populations in the mental health workforce as another barrier to access.”

A substantial proportion of the Latino participants believe that limited access and underutilization of mental health services in the Latino community are primarily due to gaps in culturally and linguistically appropriate services, in conjunction with a shortage of bilingual and bicultural mental health workers, nonexistent educational programs for Latino youth, and a system of care that is too rigid.

SB 82 provides grants for peer support as part of the triage personnel program. This provides an opportunity to develop more peer support, particularly if it is provided under the Medi-Cal program. There is currently a bill before the Legislature that would provide for a statewide peer and family support specialist certification program and would require peer and family support specialist to be added as a provider type under the Medi-Cal program.

Supportive Housing

People with mental health challenges repeatedly say housing is their most pressing concern. The lack of adequate and stable housing impedes recovery. Too often, following their discharge from an inpatient facility or crisis services, people do not have a place to live or return to, either because they lacked housing prior to the crisis, which may have precipitated the crisis, or they lose their housing while in a facility. Nearly one in three individuals who are homeless has a serious mental health condition. The “Housing First” approach seeks to break this cycle of homelessness and acute care and has been effective in reducing homelessness of people with a diagnosis of serious mental illness.
According to the Corporation for Supportive Housing: “Homeless people have much higher incidence of emergency department visits and inpatient hospital admission than people who are stably housed. County hospitals often face the financial burden of both homeless uninsured and Medi-Cal beneficiaries. Those with costs for medical or mental health services while in jail incur a 56% increase in county costs.”123 “For people who are chronically homeless or have other significant barriers to housing stability, creating more permanent supportive housing is the only means of ending homelessness.”124

Supportive housing is designed to assist people in obtaining housing and providing services and supports to help people retain housing. The concept is based on the recognition that without stable housing, people will not have the opportunity to do what they need to do to live stable and productive lives.

“Housing First” is a recognized evidenced-based best practice. According to the National Governors Association, “supportive housing is a successful, cost-effective model that combines affordable housing with services to help people live more stable, productive lives.”125 The Housing First approach recognizes that having a place to live is an essential first step in the recovery process.126 Supportive services help tenants to maintain housing. Supportive housing is cost-effective in reducing shelter use, hospitalizations, length of hospitalizations, and incarcerations.127

Supportive housing leads to better outcomes and is cost-effective. Research also shows that the cost of providing someone with supportive housing is essentially the same as having that person remain homeless and trapped in the revolving door of high-cost crisis care and emergency shelter.128

There are three components to financing supportive housing. The first two relate to the physical housing itself--capital funding to build, rehabilitate or acquire housing; and operational funding to manage and maintain the building over and above the rents from low-income tenants.129 The third component relates to the services that people need to remain in that housing.130
The MHSA has been an important source of capital and operational funding for the housing itself. In 2006, the MHSA Housing Program received $400 million to construct or rehabilitate 10,000 new units of permanent supportive housing for people with mental health challenges. As of March 2013, there were 1,095 MHSA supportive housing units ready for occupancy, and it appears that the goal of 10,000 units has been scaled back to 2,500 units of permanent supportive housing. There are other potential sources of bond funds as well.

Finding funds to pay for supportive services to help people maintain their housing is a challenge. The Corporation for Supportive Housing reports that supportive housing sponsors often report an inability to obtain commitments for services funding as the largest obstacle to creating supportive housing. Strategies for financing services will be the focus of the rest of this section.

An important source for funding supportive services has been the MHSA. MHSA Housing Programs provide supportive services designed to help people live more independently in the community. Assistance could include crisis intervention services, peer support or public benefits counseling. A person cannot lose his or her housing because he or she does not accept services. This helps prevent the cycle of homelessness.

There are other programs that may also be a source of funds for supportive services. Supportive Housing program grants from the federal Department of Housing and Urban Development (HUD) are one potential source of funding. The Medi-Cal program is another. SAMHSA has a useful kit with ideas for developing permanent supportive housing.

Federal Department of Housing and Urban Development (HUD) Supportive Housing Programs.

The federal Department of Housing and Urban Development (HUD) has several programs that are being used for supportive housing, including the Continuum of Care housing program.

Continuum of Care (CoC) Supportive Housing Program (SHP)

The CoC program consolidates the HUD Supportive Housing Program, Shelter Plus Care, and Section 8 Moderate Rehabilitation.
Riverside County, and other counties, receive funds from HUD for the Continuum of Care (CoC) Program. The programs provide outreach, transitional and permanent housing for people who are homeless. These programs can provide support for people with mental health challenges who are homeless.

**Section 811 Program**

HUD periodically makes available Section 811 funds to fund a limited number of housing opportunities for very low income people with disabilities. A previous grant to California targeted people with serious mental illness who are homeless or at risk of being homeless:

Jointly administered by the California Department of Mental Health [now the California Department of Health Care Services] and the California Housing Finance Agency on behalf of counties, the Section 811 Housing Program offers permanent financing and capitalized operating subsidies for the development of permanent supportive housing, including both rental and shared housing, to serve persons with serious mental illness and their families who are homeless or at risk of homelessness. Section 811 Housing Program funds were allocated for the development, acquisition, construction and/or rehabilitation of permanent supportive housing.

This can be a useful source of ongoing funding when the grants become available.

**Medi-Cal Programs**

There are a number of options under the Medi-Cal program for financing supportive housing services. The various options are discussed below:

**Rehabilitation Option and Targeted Case Management**

Rehabilitation Option services and Targeted Case Management (linkage) are specialty mental health services offered by county mental health plans (MHPs). Anyone who receives specialty mental health services from the MHP may be eligible to receive rehabilitation services and targeted case management, if needed. If necessary, these services can be one-to-one
services provided at any time, in person or by telephone, and can be provided anywhere, including a person’s home.\textsuperscript{141}

Intensive case management for supportive housing can be provided under the Therapy and Rehabilitation components of Mental Health Services under the Medi-Cal program. Rehabilitation includes “activities that are designed to enable the client to overcome the limitations due to the mental disorder and teach the client to perform these activities for themselves.”\textsuperscript{142} “There is no cap or limit on the number of hours per day or the number of days per week that this service activity may be provided, nor is there an annual or lifetime cap or limit.”\textsuperscript{143}

Some examples of Rehabilitation services include:

1. Explaining and ensuring the person understands the importance of consistently following their current treatment plan, such as taking prescribed medications or attending follow-up appointments, and working with the person to develop a system that would help him or her adhere to the treatment plan.\textsuperscript{144}
2. Teaching a person to shop, prepare and eat meals and reviewing the effectiveness of the instruction at periodic intervals.\textsuperscript{145}
3. Planning social activities with the person consistent with the person’s socialization goals and encouraging participation in these activities.\textsuperscript{146}

Linkage to services can be provided under Targeted Case Management. Targeted Case Management services assist a beneficiary to access needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services.\textsuperscript{147} The service activities may include, but are not limited to, communication, coordination, and referral; monitoring service delivery to ensure beneficiary access to service and the service delivery system; monitoring the beneficiary’s progress; placement services; and plan development.\textsuperscript{148} Other states are also using Targeted Case Management to provide supportive housing services.\textsuperscript{149}

Case management under the Medi-Cal program can consist of a combination of Mental Health Therapy, Mental Health Rehabilitation, or Targeted Case Management. These three categories are robust enough to
fund supportive housing services and supports, including Assertive Community Treatment (ACT).

Increased Access to Housing and Supportive Services Program

California is requesting approval to establish an “Increased Access to Housing and Supportive Services Program” as part of its application to the federal government for renewal of its Section 1115 demonstration waiver. The target population includes people who are homeless (or who will become homeless upon discharge from a facility) and who have a mental health or substance use disorder.¹⁵⁰

The program envisions a partnership between Medi-Cal managed care plans and county mental health plans to provide services to reduce homelessness and institutionalization and reduce costs. Managed care plans and county partners could contribute funding to a shared savings pool to provide respite care to ensure timely discharge from inpatient hospitalization or long-term care, housing subsidies, support for long-term housing, and additional housing-based case management.

There are two components: Managed Care Plan expanded and non-traditional services, and regional housing partnerships.

Medi-Cal managed care plans would receive funding for intensive housing-based care management services and intensive care management, including discharge planning.¹⁵¹ Managed care plans will have the option of paying for non-traditional services, such as nutritional services, continuous nursing, personal care, habilitation services, and tenancy supports. Tenancy supports may include outreach and engagement, housing search assistance, stabilization assistance, paying rent and bills on time, assistance with collaborating with and respecting neighbors, maintaining SSI and other benefits.

There is incentive funding to develop regional housing partnerships between counties, managed care plans, housing authorities, and other service providers. A regional housing partnership is a regional integrated care partnership specifically focused on housing. A region could incorporate a single county, a portion of a large county, or counties working together to form a partnership. Counties, managed
care plans, local non-profit coordinating organizations, or foundations could lead in creating partnerships.\textsuperscript{152}

**Home and Community-Based Services (HCBS)**

Supportive housing services can be provided as a component of Medi-Cal Home and Community-Based Services (HCBS). California has long had HCBS waivers under the Medi-Cal program. These waivers allow the state to offer an expanded menu of Medi-Cal services to individuals who meet institutional level-of-care requirements and who would not otherwise be eligible for Medi-Cal. Now there is a state plan option under Section 1915(i) that allows states to offer HCBS services to targeted groups who are not eligible for HCBS waivers, including people who do not meet institutional level-of-care requirements.\textsuperscript{153} This could be a potential source of funding if the Legislature adopts this option.

In the wake of Hurricanes Katrina and Rita, Louisiana received a federal grant to provide rent subsidies and supportive services to people with mental health challenges who were homeless or displaced by the hurricanes. The state has continued the program under Section 1915(i). Services are delivered through ACT teams. One component of the program provides “restoration, rehabilitation, and support to develop skills to locate, rent, and keep a home, landlord/tenant negotiations, selecting a roommate, and renter’s rights and responsibilities.” Included in these services are “assisting the individual to develop daily living skills specific to managing their own home, including managing their money, medications, and using community resources and other self-care requirements.” Habilitation is included in “developing and implementing social, interpersonal, self-care, daily living, and independent living skills to restore stability, to support functional gains, and to adapt to community living.”

**Health Home**

A health home provides a comprehensive system of care coordination designed to integrate and coordinate all primary, acute, behavioral health, and long-term services and supports (LTSS) to treat the “whole person” across the lifespan. Required services include the following:

1. Comprehensive care management;
2. Care coordination and health promotion;
3. Comprehensive transitional care from inpatient to other settings, including follow-up;
4. Individual and family support; and
5. The use of health information technology to link services, as feasible and appropriate.\textsuperscript{154}

A state that amends its Medicaid state plan to add optional health home services will receive a 90 percent enhanced federal match for the specific health home services that are defined in this benefit for the first eight quarters in which the program is effective. A state may establish more than one health home program, and therefore may receive more than one period of enhanced federal match.\textsuperscript{155}

“Many State Medicaid programs have developed medical home models….States have implemented delivery systems beyond traditional primary care case management programs, many focusing on high-cost, high-user beneficiaries (not limited to specific diagnoses). While many of these models are physician-based, there is a growing movement toward interdisciplinary team-based approaches. Services such as care coordination and follow-up, linkages to social services, and medication compliance are reimbursed through a “per member per month” structure….Some States are using full-risk managed care plans and demonstrations approved under section 1115 of the Act to implement their medical homes.”\textsuperscript{156}

Federally-Qualified Health Centers (FQHC) and Rural Health Clinics (RHC)

Federally qualified health centers (FQHCs) and Rural Health Clinics (RHCs) provide comprehensive primary care services, which can include mental health services.\textsuperscript{157} FQHCs include all organizations receiving grants under Section 330 of the Public Health Service Act (PHS). FQHCs are commonly referred to as Community Health Centers, Migrant Health Centers, and Health Care for the Homeless Programs.\textsuperscript{158} FQHCs must serve a medically underserved area or population and provide comprehensive services. RHCs provide services in medically underserved rural areas.\textsuperscript{159} FQHCs and RHCs qualify for enhanced reimbursement from
Medicare and Medicaid. FQHCs must offer a sliding fee scale to people who do not receive Medi-Cal or other health benefits with zero share of cost.

Health Centers and Health Care for the Homeless programs can provide services linked to housing through one or more of the following models:

1. Delivering on-site services through home visits or satellite clinics located in or near Permanent Supportive Housing (PSH) buildings.
2. Operating a clinic that is easily accessible by PSH residents and designed to meet their needs.
3. Partnering with a mental/behavioral health service provider to conduct outreach and deliver integrated care to people experiencing homelessness and residents of scattered-site PSH, creating a multi-disciplinary team of primary and behavioral health care providers.
4. Engaging “frequent users” of emergency room care and people experiencing homelessness who are being discharged from hospitals and linking them to permanent housing.160

Not all FQHCs and RFCs provide mental health services. However, partnering with these providers holds promise for providing both one-stop primary care and off-site supportive housing services.

Certified Community Behavioral Health Clinics.

Section 223 of the Protecting Access to Medicare Act of 2014 (P.L. 113-93, H.R. 4302, 42 USC 1396a, note) provides for “Demonstration Programs to Improve Community Mental Health Services.”161 States can apply for demonstration program grants. States have until August 5, 2015, to apply for planning grants.162

The overall goal is to evaluate demonstration programs in up to eight states that will establish CCBHCs according to specified criteria that will make them eligible for enhanced Medicaid funding through the Prospective Payment System (PPS). The program requires: (1) the establishment and publication of criteria for clinics to be certified by a state as a certified community behavioral health clinic (CCBHC) to participate in a
demonstration program; (2) the issuance of guidance on the development of a Prospective Payment System (PPS) for testing during the demonstration program; and (3) the awarding of planning grants for the purpose of developing proposals to participate in a time-limited demonstration program.\textsuperscript{163}

**User-Friendly Menu of Services**

For many people with lived experience in the mental health system and their loved ones, access to services can be haphazard. Rob Chittenden, Peer/Self-Advocacy Unit Manager at Disability Rights California, reports as follows:

*I hear this from people working at our Wellness Center. A lot of people are homeless. Some people get FSP, which includes housing, and some don't. People don't understand why they are left out in the cold, and others are not. Why can't I get these services? What are the criteria for getting the services? Why can't I become a part of this housing program? I need the services as much as the other guy. Those answers aren't given to people.*

*Getting people aware is part of changing the atmosphere for people. It's about transforming the system. What recovery means to people and what services are available that people can use that are different than traditional services, such as medication management, case management, anger management. Those traditional services keep people in the system. [We] need to support people in moving on with their own lives.*

If people do not get the services they need when they need them, they have to be able to find out why not. If people can't find out why they did not get services while someone else did, a perception that the system is arbitrary is largely unavoidable. This problem is made much worse if people have no expectation that they will ever be able to get the services. If people feel that being in the right place at the right time (or, more cynically, knowing the right people) is what it takes to get services, they are more likely to either spin their wheels trying to get services that are not available or to give up. Therefore, counties need a transparent process for
letting people know how they can get the services they need, now or in the future.

If people have access to specific information describing each of the services the county offers, the eligibility criteria for obtaining the services, the availability of each service, and the steps they need to take to get the services, people would know what options they have and the information they need to make choices. This type of information should be widely disseminated in multiple formats and languages and made available to all people served in the county. Counties should keep the service menu up-to-date.

Many county websites have information about the services offered by the county. NAMI California has developed an online search tool for determining what services are available in each county. The search tool enables a search by county and by type of service provider in the county. This is a good first step towards developing organized tools to provide better access to information about available services.

If there are a limited number of slots for services, counties should have transparent procedures for letting people know how they can access the services in the future, how to get on waiting lists for the services, how long the wait can be expected to last and how the waiting lists work. This way, people can at least have the assurance that they will get needed services when their name comes up to the top of the list.

Housing programs provide an example of how this process works. Subsidized housing is always in very short supply. The MHSA supported housing program provides an example of how the program criteria and waiting lists can be structured so that the process is transparent. First, the program recognizes that not all people can be served. It therefore provides a definition of the target population for supportive housing:

“The State of California recognizes that there is currently, and will continue to be for the foreseeable future, inadequate funding to provide permanent supportive housing for all those with serious mental illness who need it…. [The department] has defined the MHSA Housing Program target population as low-income adults, or older adults with serious mental illness,
and children with severe emotional disorders and their families who, at the time of assessment for housing services, meet the criteria for MHSA services in their county of residence and are homeless or at risk for homelessness.”

Second, the county application for MHSA supported housing funds must describe the tenant selection process in accordance with the following requirements:

“Provide a tenant selection plan specific to the proposed development that describes the following:

1. How prospective tenants will be referred to and selected for MHSA units in the development;
2. The tenant application process;
3. The procedure for maintaining the wait list;
4. The process for screening and evaluating the eligibility of the prospective MHSA tenants;
5. The criteria that will be used to determine a prospective MHSA tenant's eligibility for occupancy in the development;
6. The appeals process for individuals who are denied tenancy in an MHSA unit; and,
7. The reasonable accommodations policies and protocols.”

Central to this is a properly-functioning grievance and appeal procedure. Counties have developed policies and procedures for disseminating information about grievance and appeal processes for denial, termination or reduction of Medi-Cal-funded programs and services. Counties should do the same for non-Medi-Cal funded programs and services, including MHSA services. In this way, people will know their rights and be able to appeal if they believe their rights have been violated or they have not gotten what they need.

**Psychiatric Advance Directives**

A person with a mental health disability can benefit from having an Advance Directive in a number of ways. For example, an Advance
Directive can empower the person to make her treatment choices known in the event that she needs mental health treatment and is found to be incapable of making healthcare decisions. The person can specify preferences on crisis services, including programs or facilities. Further, an Advance Directive can improve communication between the person and her doctor. It is a good way to open up discussion with providers about treatment plans and the full spectrum of choices in treatment. This can include plans for avoiding a crisis, as well as plans in the event that one develops.

Marin County has developed a Client Choice and Hospital Prevention Program that includes a Crisis Residential Program and assistance for people to develop crisis plans.

In previous years over 90% of the admissions to acute psychiatric hospitals from the county’s Psychiatric Emergency Services were involuntary. That means that most clients did not want the treatment they received. By creating a community- based alternative to the locked hospitals, clients will find assistance in resolving crisis situations on a voluntary basis and will be assisted to return to their pre-crisis level of functioning. Prior to a crisis, MHSUS clients will be encouraged to create their own Crisis Plan, similar to an advance directive for health care.

In Marin County, a person with lived experience in the mental health system facilitates the development of Advance Directives as a component of this program. Other counties should consider this model. Psychiatric advance directives are being used as a tool across the country to help people express their preferences and choices for future mental health treatment.

Coordination between Public Mental Health Programs and Private Insurance

Nearly one in five American adults had a diagnosable mental illness in 2011. Among these 45.6 million adults, about 4 in 10 adults received mental health services during that year. Among those who had serious mental illness, only about 60% had received mental health services.
Stigma accounts for some of this lack of access and utilization of services. People may fear seeking help due to the shame associated with having a mental health disability. Another barrier is the lack of access to necessary treatment services because of unlawful discrimination in insurance coverage. Often, people with mental health disabilities do not receive services that are on par with services provided to people with physical illnesses.

Mental health parity laws address this stigma and discrimination by requiring that health plans and insurers apply the same standards that are applied to medical/surgical benefits to mental health benefits as well. Because of mental health parity laws, people will have greater access to private insurance benefits, which will mean less use of public resources.

In 1999, the California Legislature passed the California Mental Health Parity Act. It required health care service plans or health insurance plans regulated by the State of California to cover medically necessary treatment for persons with “severe mental illnesses” as statutorily specified under the same terms and conditions applied to other medical conditions. In 2008, Congress passed the Mental Health Parity and Addiction Equity Act to require health insurance carriers and employers to provide equal treatment coverage for people with mental health challenges.

The state and federal parity laws are enforced by the Department of Managed Health Care (for health plans) and the California Department of Insurance (for health insurance). These agencies have begun to take an active role. The California Department of Managed Health Care (DMHC) has found deficiencies concerning state parity implementation. For example, DMHC found deficiencies in the provision of accurate and understandable information regarding the availability and optimal use of mental health care services provided by the plan or affiliated health care organizations.176 In 2013, the California Department of Managed Health Care (DMHC) fined Kaiser for deficiencies that limited access to mental health services, including lack of access and availability of providers and lack of accurate and understandable mental health education materials.177

The Affordable Care Act (ACA) has further improved parity by adding mental health and substance use disorder benefits to the essential health benefits (EHB) package that must be included in all Covered California
plans, non-grandfathered small employer (less than 50 employees) plans, Medi-Cal managed care plans and Medi-Cal alternative benefit plans.

The expansion of private health care coverage to include mental health and substance use benefits, together with the requirement that those benefits be offered at parity with medical-surgical benefits, provides an opportunity for obtaining those benefits from private health plans and insurers. This includes residential treatment and other rehabilitative mental health services, if medically necessary.\textsuperscript{178}

**Section 4: Recommendations for State and Local Government Actions**

The role of people with lived experience in the mental health system generates change and helps reduce stigma.\textsuperscript{179} As well, recovery-focused crisis response services have demonstrated success. Further, public education on mental health is increasing.\textsuperscript{180} Finally, private health care plans have more stringent responsibilities than ever before to provide mental health services under state and federal parity and health reform laws.

**RECOMMENDATION #1 – CRISIS SYSTEM CAPACITY & DEVELOPMENT**

**Need for Community-Based Crisis Response System Development**

Even though need is high and resources are limited, California has the opportunity to expand its community crisis response system. California should do this. In 2013, the California Legislature found as follows:

*Recent reports have called attention to a continuing problem of inappropriate and unnecessary utilization of hospital emergency rooms in California due to limited community-based services for individuals in psychological distress and acute psychiatric crisis.*\textsuperscript{181}

Absent an adequate array of crisis services, people have little choice but to go to the emergency room for evaluation and potentially “unnecessary inpatient hospitalization.”\textsuperscript{182} Many people who do not need hospitalization go to the high-cost emergency room for basic needs, such as:
1. Prescription refills;
2. Resolution of homelessness;
3. Resolution of crisis;
4. Assistance with substance-abuse crises;
5. Hunger; and
6. Seeking information regarding mental health services.\textsuperscript{183}

Alternative crisis services provide options to avoid costly and less-effective emergency room visits, hospitalizations, or incarceration. They help people maintain their level of independence and support in the community. Additionally, studies indicate that peer support combined with traditional and non-traditional mental health services is more effective than either type of service alone.\textsuperscript{184}

There are gaps that can be filled in the community-based crisis response system across California. As of December 15, 2009, there were 35 crisis residential programs in 18 counties, with room to serve only 417 people. Even in counties that have core elements, there are limitations with respect to capacity to serve everyone in need.

**Recommendation:** Counties, in collaboration with the California Department of Health Care Services, the California Mental Health Planning Council, local planning processes and other stakeholders should educate and inform private health care service plans of the opportunities to create an effective crisis response system. These stakeholders should also collaborate in developing protocols and memorandums of understanding for service coordination between the private and public systems of care\textsuperscript{185} and integration of peer support services. These should include provisions for access to, and financing of, the following core service elements:\textsuperscript{186}

\begin{itemize}
\item a. 24/7 Warm Lines and 24/7 Crisis Lines
\item b. Walk-In Clinic/Center;\textsuperscript{187}
\item c. Mobile Crisis Teams;
\item d. Full Service Partnership (FSP) Programs;
\item e. Crisis Residential programs; and
\item f. Crisis Respite programs.\textsuperscript{188}
\end{itemize}
Need to Overcome Barriers to Establishing a Cost-Effective, Community-Based Crisis Response System

There are significant barriers to expansion of the core elements of a comprehensive crisis response system in both public mental health programs and private health care services plans. These barriers exist even though this crisis response system would be cost-effective.

For example, the Planning Council found that despite 30 years of research and data on cost effectiveness, crisis residential programs face barriers including:

1. Public resistance, such as NIMBYism (Not-In-My-Backyard);\(^ {189} \)
2. Professional resistance;\(^ {190} \)
3. Federal and regulatory biases;
4. Lack of facilities; and
5. Lack of political will to support programs.\(^ {191} \)

**Recommendation:** Appropriate state entities, public mental health programs, the County Behavioral Health Directors of California (CBHDA), the California Mental Health Planning Council and local planning processes should engage stakeholders, including private health plans, to develop an action plan to address these and other barriers to public and private systems of care in each region of the State.\(^ {192} \) This could include a needs assessment process to identify gaps in the public and private crisis response systems of care and plans for the development and implementation of short-term and long-term deliverables to fulfill unmet needs, including integration of peer support services.

**Recommendation:** Responsible state entities should assess the effectiveness and opportunities for contracting with a California professional organization with experience in crisis respite and crisis residential programs to provide technical assistance to counties and private health care service plans in establishing those programs.\(^ {193} \)

**Recommendation:** Responsible state and local entities should identify responsible state, local and private entities to test and adapt evidence-based practices on effective crisis responses to support data-driven policies and evidence-based programs in a variety of community settings.
and among diverse population groups, as well as to incorporate and build capacity for peer support and peer-operated service models.\textsuperscript{194}

**Need for Timeliness Standards for Service Access**

Timely access to services can help prevent worsening of crisis situations and the need for a more intensive level of treatment if services are provided promptly. The California External Quality Review Organization (CAEQRO) states that “[t]he ability to provide timely services ensures successful engagement with consumers and family members and can improve overall outcomes while moving beneficiaries through the system of care to full recovery.”\textsuperscript{195}

County mental health plans must meet state standards for timely access to care and services.\textsuperscript{196} Currently, there are no state regulations requiring timeliness of care standards for county mental health plans.\textsuperscript{197} The state requires the county mental health plans to determine timeliness standards.\textsuperscript{198} The standard used to measure post-hospitalization follow-up care is not specific enough or well-defined. Under current California External Quality Review Organization (CAEQRO) standards, when the “minimum performance standard is greater than 7 days but not more than 30 days after psychiatric hospitalization,” this standard is considered “partially present.”\textsuperscript{199}

In 2012, CAEQRO found that “Critical data that is often unavailable includes service-level data required to measure timeliness, such as time to a first visit. Currently, few MHPs measure time to first psychiatric visit, yet this wait is frequently noted as a problem by consumers and family members.”\textsuperscript{200} Further, many MHPs do not have mechanisms in place to assure prompt outpatient care after an inpatient episode.”\textsuperscript{201} Seventeen percent of inpatient admissions resulted in another admission within 30 days of discharge.\textsuperscript{202} Few Mental Health Plans closely monitored “no shows.”\textsuperscript{203} Nearly one out of five Mental Health Plans did not have a process to monitor outcomes of individuals served.\textsuperscript{204}

Some counties do not track access data for the length of time from Crisis Response Program (CRP) referral to initiation of services with a Level I or Level II service team.\textsuperscript{205} It would be helpful to have this information so that
counties could determine what standards are appropriate as well as how to reduce current wait times.

There is also an unmet need for community education so that enrollees in both the public and private mental health systems will be better able to distinguish the differences among emergency, urgent and routine mental health services. For example, an appointment following outpatient or inpatient crisis care may qualify as urgent care requiring more immediate access than 10-15 business days.

**Recommendation:** The DHCS, in coordination with the CBHDA and other stakeholders, should develop statewide standards on timely access to mental health services provided by county mental health plans and their contracting providers. California already has statewide timeliness standards for private health care plans. These standards are designed to help people obtain mental health services when needed. These standards apply to private plans only. However, these standards can serve as a baseline for the development of county mental health plan timeliness standards. The statewide timeliness standards are:

a. Within 48 hours of a request for an urgent care appointment for services that do not require prior authorization;
b. Within 96 hours of a request for an urgent appointment for services that do require prior authorization;
c. Within ten (10) business days of a request for non-urgent primary care appointments;
d. Within fifteen (15) business days of a request for an appointment with a specialist; and
e. Within ten (10) business days of a request for an appointment with non-physician mental health care providers.

**Recommendation:** There should be mechanisms in place to assure prompt outpatient care following inpatient hospitalization, including adequate timeliness standards.

**Recommendation:** There should be adequate data collection so that timeliness of care can be measured and evaluated.

**Recommendation:** There should be additional public education so that individuals understand the difference between emergency care, primary
care and urgent care. This will help to save money by reducing utilization of costly and unnecessary emergency care.

**RECOMMENDATION #2 – IMPROVE DISCHARGE / AFTERCARE REQUIREMENTS**

**Monitoring and Evaluation of Discharge and Aftercare Planning**

In addition to providing an extensive array of crisis services, there is an urgent need to improve discharge or aftercare planning from facilities through additional enforcement of existing laws or adoption of additional measures to fill systemic gaps and avoid unnecessary trauma and re-hospitalization.

California law requires that mental health facilities provide for continuity and coordination of care.\(^{208}\) It specifies that “[a]ll persons shall be advised of available pre-care services which prevent initial recourse to hospital treatment\(^{209}\) or aftercare services which support adjustment to community living following hospital treatment.”\(^{210}\) It also mandates discharge or aftercare plans from certain inpatient programs, namely “[a] licensed inpatient mental health facility, as described in subdivision (c) of Section 1262 of the Health and Safety Code.”\(^{211}\)

The State Strategic Plan on Suicide Prevention found that “discharge planning procedures for emergency departments vary in their provision of referrals for professional mental health assessments and follow-up services.”\(^{212}\) The report focused on the need for “consistency across hospital, emergency department, and other inpatient settings to implement protocols for follow-up care and effective referral to ensure the continuity of care that can save lives.”\(^{213}\)

**Recommendation:** The state and counties, in conjunction with stakeholders, should develop a process for monitoring and evaluating and making necessary improvements to what happens when people leave a facility. As referenced above, state law requires inpatient programs to “appraise the outcome of referral.”\(^{214}\) This requires follow-up to ensure that the person is linked with services or to identify and overcome any barriers. Developing this process would be cost-effective because it would reduce re-hospitalization, institutionalization, and incarceration.
Legislative Improvement of Discharge and Aftercare Planning

State law only specifies aftercare requirements for certain inpatient programs. These standards do not apply uniformly across other inpatient programs (e.g., crisis residential), nor to “outpatient” programs that are designated for 5150 evaluation (e.g., crisis stabilization units). There is a lack of consistency across inpatient and outpatient programs in referral and access to services that support adjustment to community living following facility-based treatment. There is also a need for standards regarding referral, coordination of care among service providers, and linkage to community support services, including peer support.

The aftercare plan required under Section 1262 of the Health and Safety Code must include “[r]eferrals to providers of medical and mental health services.” State law defines “referral” to include, but not limited to, all of the following based on individual need:

1. Informing the person of available services;
2. Making appointments on the person’s behalf;
3. Discussing the person’s mental health issues with the agency or individual to which the person has been referred;
4. Appraising the outcome of referrals; and
5. Arranging for personal escort and transportation when necessary.

The term “when necessary” is vague and requires a definition for purposes of offering and providing transportation. “Transportation is an essential ingredient of the crisis system that ties all the service components together.”

In addition, the above-referenced provisions need additional enforcement to promote service coordination for individuals when returning to the community after facility-based care. Inadequate care coordination is especially problematic for individuals who receive services outside of their home communities for a variety of reasons, including:

a. The person may lose contact with family, friends and social support;
b. Transportation to one’s home community is difficult to arrange;
c. Out-of-county facility staff may not be familiar with resources in the person’s home community; and

d. Mental health providers in the home community may lose contact with the person.

**Recommendation:** The Legislature should extend statutory discharge and aftercare planning provisions that now apply only to certain inpatient facilities to other inpatient facilities, such as crisis residential, and to outpatient facilities, such as crisis stabilization. This is necessary to ensure consistency in referral and access to services across all inpatient facilities and also outpatient programs that are 5150-designated, including but not limited to when individuals receive care in out-of-county facilities. One possible way to implement this is through Medi-Cal coordinated care requirements.

**Recommendation:** The Legislature should require that the responsible state entities develop regulations that provide an operational definition of “referral,” and establish requirements and standards for coordinated care between counties and private health care service plans, assistance with linkage to community support services (e.g., via peers or navigators) and identifying individuals who would likely benefit from someone assisting them find housing and other community supports and making this assistance available. One way to implement this is through the Medi-Cal program. Medi-Cal continues to add care coordination requirements as the program implements and extends managed care.

**Regulatory Improvement of Discharge and Aftercare Planning**

There is a lack of emergency standards to ensure that service providers (e.g., mental health rehabilitation centers, skilled nursing facilities with special treatment programs, acute inpatient hospitals, psychiatric health facilities, crisis residential treatment facilities, adult residential treatment facilities and crisis stabilization units) follow appropriate and effective procedures for the discharge of people who are homeless or otherwise at risk. Too often, people leaving facilities do not have stable living situations to return to, creating a revolving door to frequent and subsequent re-hospitalizations.
Existing laws require that all agencies or facilities provide evaluation services that appraise referral outcomes. This should be used to determine whether persons referred have successfully linked with or encountered roadblocks to obtaining community supports and to reduce re-hospitalization rates.

**Recommendation:** Standards should be developed to ensure that service providers perform appropriate and effective follow-up to help prevent rehospitalizations and assist people in obtaining stable living situations that enable them to live independently and reintegrate into the community. Potential sources of funding are Medi-Cal funds for medical homes, care coordination, and case management. As discussed elsewhere in this report, avoiding rehospitalizations and homelessness will save money.

**Recommendation:** Emphasis should be on outreach, engagement and linkage to ensure community support access, including:

1. Assessment of whether or not the person meets medical necessity criteria for Medi-Cal covered Targeted Case Management/Linkage Services.
2. Contact with a service provider (e.g., peer) prior to discharge from the inpatient or outpatient crisis facility to facilitate transition back into the community;
3. Availability of a service provider (e.g., peer), if desired, to accompany the person to his or her appointment(s) as needed in the community;
4. Instruction on crisis contingency and response plans and strategies for “getting through the day” developed by the individual with staff assistance;
5. Provision of a list of self-help, self-advocacy, and peer support groups and meetings in their area, and linkage with someone to accompany the individual to a meeting, if desired;
6. Provision of sufficient medication, at least until the date of the person’s follow-up appointment and provision for timely refill if needed;
7. Initiation of Supplemental Security Income (SSI), CalFresh (Food Stamps), and other public benefit applications before discharge and transportation to the Social Security and other offices if needed, and
identification of the responsible agencies for follow-up and completion of needed applications;
8. Provision of contact information for suicide hot lines and warm lines (e.g., on a card that can be carried at all times);
9. Daily check-in with a peer provider, if desired;
10. Provision for at least three (3) months of a disability bus pass or other transportation assistance, if needed;
11. Provision of some financial assistance, if needed (i.e., grocery store gift card);
12. Provision for housing, including but not limited to emergency, transitional and supportive housing, consistent with state and federal standards for receipt of services in the least restrictive, most integrated setting appropriate to individual needs;
13. Mechanism or support to help the person keep track of appointments and contact information for community providers, e.g., pocket-sized calendar;
14. Three (3) months of personal services coordination or case management if the person desires and qualifies for such assistance, which can be provided by peers;
15. Data collection on the place to which the person was discharged, such as: own home or apartment, home or apartment of family/friend, psychiatric emergency services (PES), residential facility, housing provider, homeless, or other;
16. Data collection on incidents of re-hospitalization within 30 days, 60 days, 90 days, six months and one year;
17. Follow-up on referrals to find out whether the individual successfully linked and is satisfied with community support services, including proper procedures for following up with people who are homeless.

RECOMMENDATION #3 – INCREASE ACCESS TO SUPPORTIVE HOUSING

There is a great need for increased access to supportive housing in line with the Housing First approach. Lack of housing can contribute to or exacerbate mental health challenges and make recovery even more difficult. There have been many obstacles to providing emergency and transitional housing as well as supportive housing, including “Not-In-My-Backyard” or “NIMBY” barriers and significant reductions in the construction
of new units. Without a secure and permanent place to live, people have fewer opportunities to live independently and avoid the cycle of homelessness.

**Recommendation:** There should be a statewide assessment of the need for supportive housing in California, including emergency and transitional housing, and the barriers to providing it. Participants in the assessment should include all local, state and federal housing agencies, departments responsible for certifying IMDs and large congregate care facilities, and local stakeholders. There should be an opportunity for people who need supportive housing to give oral and written testimony. As part of the process of determining the need for supportive housing, the assessment should consider the number of people who are homeless or at risk of homelessness including those who are subject to 5150 or 5250 holds, living on the streets, in jails, in “Institutions for Mental Diseases (IMDs)” or large congregate care facilities. Local barriers to providing supportive housing should be identified, such as lack of financing, NIMBYism, stigma, discrimination, restrictive zoning practices, or lack of political will.

**Recommendation:** The state and counties, in conjunction with stakeholders, should conduct an assessment of existing supportive housing units and identify and implement strategies to overcome the barriers that prevent the development of additional supportive housing.

**Recommendation:** Eligibility criteria should be developed for the housing program in each county to ensure equitable allocation of supportive housing and to let people know where they stand in the process. In addition, a clear process for being placed on a waiting list for supportive housing should be developed, and clear written instructions on grievance procedures should be provided if access to a program or waiting list is denied.

**Recommendation:** The state and counties, in conjunction with stakeholders, should develop a Strategic Plan for Supportive Housing for Individuals in Need with short- and long-term goals and measurable outcomes. This would include reviewing best practices by facility-based service providers in discharge or aftercare planning to ensure that a person is able to access housing upon discharge. This is necessary to ensure that people do not get lost or overlooked. See Recommendation #2 above. It would also include identifying and exploring funding sources to pay for the
physical housing as well as funding sources to pay for the supported services needed by people so that they can maintain their housing. Some potential sources of funding have been identified in this report.

RECOMMENDATION #4 – IMPROVE PERFORMANCE MEASURES

It is difficult to plan and develop mental health services or systems without adequate information on outcomes. There is a critical need for performance outcome measures for all public mental health services.\(^\text{228}\) The California Mental Health Planning Council has proposed performance indicators for evaluating the public mental health system, including outcome measures for adults such as: Living Situation; Justice Placement; Number of moves; Hospitalization; Employment; Number of arrests; Self-rating of improvement in functioning; Access to Services and Appropriateness of Care; Participation in Treatment; and Penetration Rate.\(^\text{229}\) Outcome measures should also include access to peer support or peer-operated services.

Stakeholders at the local and state level cannot exercise their oversight and accountability functions without additional timely data that measures systemic strengths and weaknesses. County mental health plans also need additional data for planning and quality improvement projects. For example, sufficient data on individualized services by race or ethnicity is essential. A recent report by the California Reducing Disparities Project (CRDP) on disparities affecting Californians indicates as much as a three-fold over-representation of African-Americans in the receipt of 24-hour inpatient services.\(^\text{230}\) However, it is unclear what specific service was provided. This 24-hour category includes: hospital inpatient, administrative days, psychiatric health facility, skilled nursing facility intensive, IMD basic, IMD with a patch,\(^\text{231}\) adult crisis residential, jail inpatient, residential other, adult residential, semi-supervised living, independent living, and mental health rehabilitation centers.\(^\text{232}\) The report asked, "What is the actual service received?" The report further states, "As reported by DMH, service outcome data was not available as of 04/12/2012."\(^\text{233}\) In addition, CAEQRO has found that "[a] significant number of MHPs do not use penetration rates\(^\text{234}\) to measure access by sub-groups, particularly by underserved populations."\(^\text{235}\)
Research literature indicates that involuntary commitment rates of people with serious mental health challenges may gauge how well the public mental health system functions.\textsuperscript{236} Involuntary commitment data is an indicator of progress towards Recovery Vision implementation.\textsuperscript{237} Counties report data on involuntary detentions under Section 5402 of the Welfare and Institutions Code. Available state reports on this data show massive discrepancies in county involuntary detention rates.\textsuperscript{238} Timely and accurate data on involuntary detention rates is important to a broad array of stakeholders that interface with the public mental health system. For example, the San Francisco Police Department has found that data on California Involuntary Detention Rates is of “high usefulness for estimating police workload.”\textsuperscript{239}

**Recommendation:** The California Department of Health Care Services, California Mental Health Planning Council, California Mental Health Services Oversight and Accountability Commission, and CBHDA, in conjunction with stakeholders, need to adopt performance outcome measures for services provided to individuals under all state and county mental health programs, including the Medi-Cal Specialty Mental Health Services, the Bronzan-McCorquodale Act and the Mental Health Services Act. Counties support improvement of the mental health system, including quality of service, through effective data collection processes.

**Recommendation:** The California Legislature should amend subsection (a) of Section 5402 of the Welfare and Institutions Code to require the California Department of Health Care Services (DHCS) to publish information on the number of persons subject to 72-hour and 14-day involuntary detention on a quarterly basis rather than annually. Reports mandated under Section 5402 must be made available in a timely and complete manner for effective oversight and program development. This will cut down on the delay in publishing the information, thereby increasing its usefulness.

**Recommendation:** The DHCS should produce and post data annually showing expenditures for 24-hour modes of service by county. This should include jail-based services as a distinct mode of 24-hour service. Pursuant to the Planning Council recommendation, such data should also document the race, ethnicity and language of individuals receiving each of the
specified 24-hour modes of service. This will help county mental health plans determine more accurately the cost-effectiveness of alternatives to 24-hour modes of service. Hard data document the actual costs of 24-hour modes of service will help to demonstrate the increased cost of cutting back on community alternatives when budgets are tight.

RECOMMENDATION #5: PROVIDE A USER-FRIENDLY MENU OF CRISIS SERVICES

Many people do not know what crisis services are available to them or have information that is easy to understand. The Recovery Vision also recognizes the need for information and services that are linguistically and culturally competent.

Individualized communication ensures that people fully comprehend their situation and can base their decisions on accurate and easy-to-understand information that is in plain language. A menu of services should be both described to a person orally and provided to him or her in a written format.

Recommendation: Each County, in coordination with its Local Mental Health Board or Commission, should work with stakeholders to develop and disseminate a user-friendly menu of available prevention, crisis intervention and aftercare services that includes easy-to-understand information on how and where to access services and how to overcome common roadblocks. This would facilitate the requisite statutory advisement of appropriate services as an alternative to hospitalization. It should include information about emergency, transitional and supportive housing as well as crisis services. This includes other needed community supports, such as peer providers, benefit counselors, vocational rehabilitation and religious or spiritual leaders.

RECOMMENDATION #6 – PROMOTE PSYCHIATRIC ADVANCE DIRECTIVES

Frequently, people do not know that they can prepare for and make decisions about any future treatment or services by developing an Advance Directive. As a result, they are unable to exercise their right to make life decisions.
**Recommendation:** The Legislature should modify state law to require counties and private health care service plans to provide individuals with information and an opportunity to develop an advance directive upon enrollment/admission, including a crisis and hospital diversion plan, and to modify it while in a facility and/or following inpatient care. The user-friendly menu of services discussed above in Recommendation #5 should be available to ensure that individuals can exercise informed consent to crisis alternatives.

**RECOMMENDATION #7: DEVELOP PEER SUPPORT & PEER-OPERATED SERVICES**

Peer supports are a necessary component of the Recovery Vision and are an evidence-based practice. The federal Centers for Medicare & Medicaid Services (CMS) recognizes that “[q]ualified peer support providers assist individuals with their recovery from mental health and substance use disorders.” Initiatives for developing peer supports include:

1. Developing work opportunities for people with lived experience in the mental health system, including family members. Hiring peers will help address the shortage of service providers;
2. Integrating peer support in the range of crisis services;
3. Contracting with a peer professional organization to provide technical assistance on Recovery Vision implementation and program development (e.g., crisis respite and crisis residential programs);
4. Building capacity for peer support and peer-operated service models to implement data-driven policies and evidence-based programs in a variety of community settings and among diverse population groups;
5. Connecting individuals with peer support prior to facility discharge and during aftercare to promote both self-advocacy skills and community integration;
6. Providing for culturally competent post-crisis contact with a team comprised of a peer/family advocate and a clinician for individuals and families who experience a mental health crisis;
7. Incorporating peer support services as integral to services offered through Supportive Housing and other residential options;

8. Including peer support or peer-operated services in performance outcome measures;

9. Developing educational materials, including a user-friendly menu of available prevention, crisis intervention and aftercare services that includes easy-to-understand information on how and where to access services and how to overcome common roadblocks; and

10. Assisting people to develop Advance Directives.

Funding has not been identified for peer providers in all regions of the State who can assist a person in transitioning from a facility (e.g., inpatient hospital, psychiatric health facility, etc.) into the community consistent with the Recovery Vision. Such assistance can facilitate informed consent to crisis alternatives and other available services. MHSA Workforce Education and Training (WET) funds are a potential source of startup funds.248

Recommendation: Each County, in coordination with its Local Mental Health Board or Commission, should work with stakeholders to develop, implement and monitor a plan to build capacity for and disseminate information on these and other peer support and peer-operated services, such as peer warm lines and peer-run crisis respite centers, as part of crisis prevention and intervention and follow-up services. This plan should also include requirements that people be paid for provision of such assistance.249

Recommendation: Funding should be identified and provided for peer providers throughout the State. This could include Health Navigators or Promotores250 and/or other programs including staff with lived experience in the mental health system and/or family members designed to assist people in accessing follow-up physical and/or mental health care and other community support services. For example, such services may be funded under the Targeted Case Management amendment to the State Medicaid Plan, which provides reimbursement for peer providers251.
Recommendation: “[P]romotores can and should be included in Prevention and Early Intervention (PEI) programming in California to the extent that county and state PEI planning processes determine that promotores best meet desired outcomes.”

RECOMMENDATION #8 – IMPROVE COORDINATION WITH PRIVATE INSURANCE

The California Department of Managed Health Care (DMHC) has found deficiencies concerning state parity implementation. For example, DMHC found deficiencies in the provision of accurate and understandable information regarding the availability and optimal use of mental health care services provided by the plan or affiliated health care organizations.253 There is a need to ensure that current and future enrollees know about the effective behavioral health services for which they are eligible and the complaint procedures and other recourse available to ensure receipt of this necessary assistance. Outreach, education and advocacy are needed to ensure that people have information and assistance to exercise their rights and reduce discrimination under state and federal parity laws.

Furthermore, there is a critical need for accurate, understandable and effective behavioral health education services, including information regarding the availability and optimal use of mental health care services provided by the plan or affiliated health care organizations.254 Incomplete information may dissuade people from pursuing needed assistance.255 In addition, there is a vital need for accurate and easy-to-understand information for stakeholders on the availability and optimal use of services between the private and public mental health service systems to ensure continuity and coordination of care.256

Recommendation: The following state entities with oversight responsibility for mental health programs and services should work together towards delineating roles and responsibilities for coordination of services and continuity of care across private and public mental health delivery systems:

1. Department of Health Care Services (DHCS)
2. Department of Managed Health Care (DMHC)
3. Department of Insurance
4. Mental Health Services Oversight and Accountability Commission (MHSOAC)\textsuperscript{260}

5. Department of Social Services (DSS)\textsuperscript{261}

6. California Department of Corrections and Rehabilitation (CDCR)\textsuperscript{262}

7. California Mental Health Planning Council.\textsuperscript{263}
We want to hear from you! After reading this report please take this short survey and give us your feedback.

English version:

Disability Rights California is funded by a variety of sources, for a complete list of funders, go to http://www.disabilityrightsca.org/Documents/ListofGrantsAndContracts.html.

The California Mental Health Services Authority (CalMHSA) is an organization of county governments working to improve mental health outcomes for individuals, families and communities. Prevention and Early Intervention programs implemented by CalMHSA are funded by counties through the voter-approved Mental Health Services Act (Prop 63). Prop. 63 provides the funding and framework needed to expand mental health services to previously underserved populations and all of California’s diverse communities.


4 State Department of Rehabilitation (DOR) services are available throughout the State of California for people with disabilities, including people with mental health disabilities. Some county behavioral or mental health programs provide vocational rehabilitation services such as through clubhouses and/or through Full Service Partnerships. [See Welf. & Inst. Code § 5600.4(h); 9 C.C.R. § 3620(a)(1)(A)(iii)].

5 More information on the Stigma and Reduction (SDR) Initiative can be found on the CalMHSA website at: http://calmhsa.org/programs/stigma-discrimination-reduction-sdr/.

6 Discussed further below at subsection D, Full Service Partnerships.


8 See UCLA Center for Healthier Children, Youth and Families, “Full Service Partnerships: California’s Investment to Support Children and Transition-Age Youth with Serious Emotional Disturbances and Adults and Older Adults with Severe Mental Illness (October 31, 2012) available at: http://mhsoac.ca.gov/Meetings/docs/Meetings/2012/Nov/OAC_111512_Tab4_MHSA_CostOffset_Report_FSP.pdf


11 State Department of Rehabilitation (DOR) services are available throughout the State of California for people with disabilities, including people with mental health disabilities. Some county behavioral or mental health programs provide vocational rehabilitation
services such as through clubhouses and/or through Full Service Partnerships. [See Welf. & Inst. Code § 5600.4(h); 9 C.C.R. § 3620(a)(1)(A)(iii)].

12 See Senate Bill No. 82, approved by the Governor and filed with the Secretary of State on June 27, 2013; Welf. & Inst. Code § 5848.5(a)(4).


15 See Welf. & Inst. Code §§ 5600.1, 5806(c)(1)-(10) & (d); see also, American Psychiatric Association, “Recovery-Oriented Care,” available at: http://www.psychiatry.org/practice/professional-interests/recovery-oriented-care

16 See Mark Ragins, M.D., “Recovery: Changing From a Medical Model to a Psychosocial Rehabilitation Model,” available at: http://www.empowermentzone.com/recovery.txt


21 Id., p. 2.


23 Id.


26 Id.
27 Id.

29 California law also provides for outreach and education to prevent crises. (Welf. & Inst. Code § 5600.2(m)). The MHSA supports these efforts through prevention and early intervention (PEI) programs. (Welf. & Inst. Code § 5840). Placer County has used MHSA funds to develop Community House at King’s Beach. Located in a former motel the program was designed to include a drop in center, food pantry, counseling, and other services to people in crisis and for crisis prevention. San Diego County provides culturally and linguistically competent outreach and prevention services to people in the Chaldean and Middle Eastern communities.


31 Welf. & Inst. Code §§ 5806(a)(6), 5813.5(d)(1).

33 Increased access to crisis alternatives may reduce the amount of time and staffing that law enforcement agencies spend in response to calls involving people with mental health disabilities. Further, this may also reduce the public’s tendency to equate mental illness and danger. See California Legislative Assembly, Subcommittee on Mental Health Services, “The Dilemma of Mental Commitments in California” (1967) at Report at pp. 14-15. One former mental health director pointed out that an expenditure by a mental health department now might result in a cost savings by a jail or other law enforcement program, and yet it may not be considered a cost savings to the mental health department.

34 Also, the Investment in Mental Health Wellness Act of 2013 (SB 82) established a new grant program to disburse funds to “increase capacity for client assistance and
services in crisis intervention, crisis stabilization, crisis residential treatment, rehabilitative mental health services, and mobile crisis teams." See http://www.treasurer.ca.gov/chffa/imhwa/ Senate Bill 82 provided funding for alternatives to hospitalizations including through the services referenced above and through peer provider opportunities.

35 This refers to a program that provides staff to assist the person in transitioning from a facility (e.g., inpatient hospital, psychiatric health facility, jail) into the community consistent with the Recovery Vision. See Recommendation #2 below.

36 Permanent Supportive Housing is an evidence-based practice. See Recommendation #3 below. This program or practice is also referred to as "supported" housing.

37 Welf. & Inst. Code § 5848.5(b).

38 Id. Other core elements of an effective community-based crisis response system are also cost-effective, e.g., Full Service Partnerships or Assertive Community Treatment, discussed further below at subsection D.


40 Id.


42 Id.; see also Excerpts from Crisis Residential Treatment Manual, Steven Fields, 2004 Funded by the Center for Mental Health Services (CMHS) available at: http://www.dhcs.ca.gov/services/MH/Documents/04b%20Tab%20W%20-%20Crisis%20Residential%20Treament%20Manual%20Chapter%201%20and%20Bibliography%20May%202013.pdf

43 In FY 2009-10, the Short-Doyle/Medi-Cal Maximum Reimbursement 24-hour rates Hospital Inpatient, Psychiatric Health Facility (PHF) and Adult Crisis Residential were $1,129, $585, and $330, respectively. See Planning Council Report, “Crisis Residential Programs,” (2010), at p. 4.

44 Id. at p. 5.

45 Id. at p.1.


47 Welf. & Inst. Code §§ 5600.4(a), 5600.5(a), 5600.6(a), 5600.7(a).

48 California Strategic Plan on Suicide Prevention: Every Californian Is Part of the Solution ["Strategic Plan on Suicide Prevention"], p. 54, available at: http://www.mhsoac.ca.gov/docs/Suicide-Prevention-Policy-Plan.pdf.

49 Id. at p. 56.

50 Mental Health Services Oversight and Accountability Commission (MHSOAC), Guidelines for Prevention and Early Intervention (PEI) Statewide Programs, p. 3
(January 28, 2010), available at: http://www.dhcs.ca.gov/formsandpubs/MHArchives/InfoNotice10-06_PEIGuidelines.pdf. Statewide PEI projects are projects that “would result in a statewide impact and provide a statewide foundation for counties to build upon in the future.” The current statewide PEI projects are: (1) Suicide Prevention, (2) Stigma and Discrimination Reduction, and (3) the Student Mental Health Initiative.  Id. p. 2.

51 See http://www.suicide.org/hotlines/california-suicide-hotlines.html It is unclear the extent to which these are accredited.

52 See http://www.co.san-joaquin.ca.us/mhs/programs/Consumer%20Support%20Warm%20Line.htm


55 Welf. & Inst. Code § 5600.4(b); see also §§ 5600.5(b), 5600.6(b), 5600.7(b).

56 Id.; see also discussion of mobile crisis teams at subsection C below.

57 In 1967, the California Legislature proposed emergency service units (ESUs) across the state. ESUs would provide crisis evaluation and treatment in community settings, including at home. They would also be responsible for linking people to needed mental health and social support services in the community to minimize the risk of institutional placement. See California Legislative Assembly, Subcommittee on Mental Health Services, “The Dilemma of Mental Commitments in California” (1967) at Report at pp. 85-96.

58 See http://exodusrecoveryinc.com/Los_Angeles_Programs.html


60 “Progress Foundation Dore Urgent Care Center Dore Clinic and Dore Residence.”

61 Unlike a walk-in center, people are referred to the program by designated behavioral health providers or pursuant to 5150 detention by the police department. However, all people are admitted on a voluntary basis for up to 23 hours. Some Medi-Cal certified Crisis Stabilization Units accept people on an involuntary basis and have capacity for involuntary treatment, seclusion or restraints. As such, these programs may be similar to traditional psychiatric settings. In addition, there may be less focus on aftercare planning, for which there are no current state statutory standards for these “outpatient” programs.


63 Welf. & Inst. Code §§ 5600.2(d), 5600.4(a), 5600.7(a).

64 Welf & Inst. Code § 5600.2(d).

65 Senate Bill 82 (Steinberg), Investment in Mental Health Wellness Act of 2013, Welf. & Inst. Code § 5848.5(e).

66 See http://co.humboldt.ca.us/hhs/mhb/mhsa/crisisinterventionservices.asp

67 See http://sandiego.networkofcare.org/mh/services/agency.aspx?pid=PsychiatricEmergencyResponseTeamPERT_61_2_0

68 See http://www.tpocc.org/mhsa/
See http://www.mhsoac.ca.gov/Counties/Innovation/docs/InnovationPlans/Sonoma_INN_ApprovalSummary.pdf


Telecare, IHOT Program Description 2012.

Welf. & Inst. Code § 5851(b).

Welf. & Inst. Code § 5600.2(c).

Welf. & Inst. Code § 5800 et seq.


State regulations specify FSP eligibility criteria for children and youth, adults and older adults, and transition age youth. (9 C.C.R. § 3620.05).


See http://www.countyofnapa.org/Pages/DepartmentContent.aspx?id=4294967837

See http://www.sdcounty.ca.gov/hhsa/programs/bhs/documents/MHSA_CSS.pdf

Welf. & Inst. Code § 5671(a).

Id.

Id.

See http://ochealthinfo.com/bhs/about/pi/mhsa/what/factsheet

See http://www.mhsoac.ca.gov/Innovation/docs/InnovationPlans/Amador_FY13-14_AnnualUpdate_FINAL.pdf


Welf. & Inst. Code § 5671(e).

Id.

Additionally, FSP programs, discussed above, include provision for respite care. (9 C.C.R. § 3620(a)(1)(B)(vi)).
See http://www.mhsoac.ca.gov/Counties/Innovation/docs/InnovationPlans/INN_Trinity_Approval_12_09.pdf


Id.

Id.

Id.

Welf. & Inst. Code § 5848.5(e).


Id., p. 3.


See Recommendation #2 above for further discussion.


Supported Work/Employment and Supported Education are evidence-based practices, referenced below at Section 4. These are services to support people in obtaining and retaining work and school opportunities, respectively. Having a job can be important in providing hope and countering learned helplessness. See Patricia Deegan, “Recovery as a Journey of the Heart,” Psychiatric Rehabilitation Journal (Winter 1996) Vol. 19, No. 3, pp. 91-97. Having a job or something meaningful to do during the day can support the recovery journey.


See http://www.mhsoac.ca.gov/Counties/Innovation/docs/InnovationPlans/Madera_INN_ApprovalSum.pdf

See http://www.mhsoac.ca.gov/Counties/Innovation/docs/InnovationPlans/INN_SantaClara_ApprovalSummary.pdf

Id. at p. 5.
There are also federal discharge requirements for people coming out of psychiatric hospitals and long-term care facilities, such as psychiatric nursing homes. See https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Discharge-Planning-Booklet-ICN908184.pdf; see also http://canhr.org/factsheets/nh_fs/html/fs_transfer.htm

Such programs increase peer and family member employment in the mental health system, including peers and family members from underserved racial and ethnic communities. See California Institute for Mental Health, “Promotores in Mental Health in California and the Prevention and Early Intervention Component of the MHSA,” available at: http://www.cimh.org/sites/main/files/file-attachments/promotores_policy_paper.pdf


Id.


Senate Bill No. 614 (Leno)(2015-2016 Reg. Sess.).


Corporation for Supportive Housing, Approaches for Ending Chronic Homelessness in California through a Coordinated Supportive Housing Program, p. 12 (January 2011),
Voluntary services also include Supported Employment, which is an evidenced-based practice, referenced above. This can help individuals obtain and retain employment. Work provides purpose and can lead to recovery. People often introduce themselves by their name and work or job title. Having a job is important for integration into the community. See Bond, G. R., Becker, D. R., Drake, R. E., Rapp, C. A., Meisler, N., Lehman, A. F., et al., “Implementing supported employment as an evidence-based practice,” *Psychiatric Services*, 52, 313-322 (2001). Supported education, another evidenced-based practice referenced above, can also provide purpose and meaning, and lead to recovery.

See National Governors Association: Center for Best Practices, “Supportive Housing for People with Mental Illness: Regaining a Life in the Community” at p. 3.

Kate Durham, Corporation for Supportive Housing, *Using Medi-Cal to Fund Services in Supportive Housing* p. 1 (January 2005).


9 C.C.R. § 3615(a)(4). Additionally, Full Service Partnership (FSP) programs, discussed further below, include provision for housing, “including, but not limited to, rent subsidies, housing vouchers, house payments, residence in a drug/alcohol rehabilitation program, and transitional and temporary housing.” 9 C.C.R. § 3620(a)(1)(B)(iii).

For example, Social Impact Bonds (SIB) are a promising approach. Social impact bonds (SIBs) are pay-for-success arrangements. SIBs are used as financing mechanisms to raise upfront funding from private investors for social and public health preventative interventions. They function by leveraging the anticipated savings of prevention as a source for potential financial rewards for the intervention’s investors. In a SIB arrangement, rewards are due if and only if the intervention succeeds in reaching predetermined benchmarks, thereby shifting the financial burden of success to the investors. For more information, See, e.g., [http://www.cdc.gov/phlp/docs/sib-brief.pdf](http://www.cdc.gov/phlp/docs/sib-brief.pdf).

135 For information on additional housing programs not covered in this report, see: Disability Rights California, Everyone’s Neighborhood: Addressing “Not in My Backyard” Opposition to Supportive Housing for People with Mental Health Disabilities p. 10-12 (September 2014) available at: http://www.disabilityrightsca.org/pubs/CM5301.pdf.


137 See https://www.hudexchange.info/shp/.

138 See http://dpss.co.riverside.ca.us/homeless-programs/housing-and-urban-development.


147 9 C.C.R. § 1810.249.

148 Id.


Social Security Act § 1915(i), 42 U.S.C. 1396n(i).


CMS, State Medicaid Manual § 4231.


Available at: https://www.congress.gov/113/plaws/publ93/PLAW-113publ93.pdf.


It is important that people have this information before a crisis to more effectively deal with a crisis if and when it happens. New information may be more difficult to understand during a crisis situation.


See MHSA Housing Program Background, and Information about the Application, Commitment and Funding Processes, page 4 (February 1, 2011) available at: http://www.dhcs.ca.gov/services/MH/Documents/MHSAHPBackgroundInformation.pdf (Background and Information Document).

See Rental Housing Development Application, Section D, Item D.6, page 7 (2/20/13) at http://www.dhcs.ca.gov/services/MH/Pages/MHSAHousing.aspx
For example, see Del Norte County statement at: http://www.co.del-norte.ca.us/departments/health-human-services/mental-health-branch

Federal law requires hospitals participating in Medicaid (Medi-Cal) and Medicare to provide information to all adult patients regarding their right to make advance directives concerning health care decisions. This law is called the Patient Self-Determination Act (PSDA) and is found at 42 U.S.C. §§ 1395cc(f) and 1396a(w). Regulations written pursuant to the PSDA are found at 42 C.F.R. §§ 489.100 and 489.102. California law sets out the requirements for making an Advance Health Care Directive, including who can make an Advance Directive, who can be an Agent and what health care providers must do to comply with Advance Directives. This law is called the Health Care Decisions Law and is found at California Probate Code § 4600 et seq.


See http://www.nrc-pad.org/


Id.

See Nicholas Kristof, “First Up, Mental Illness. Next Topic Is Up to You,” New York Times (1-4-14) at: http://www.nytimes.com/2014/01/05/opinion/sunday/kristof-first-up-mental-illness-next-topic-is-up-to-you.html?_r=0

Senate Bill No. 82, approved by the Governor and filed with the Secretary of State on June 27, 2013; Welf. & Inst. Code § 5848.5(a)(4).

Welf. & Inst. Code § 5848.5(a)(4). See Recommendation #4 below for discussion in how trends in involuntary treatment rates can be used as a systemic performance outcome measure.


See Fact Sheet on “Peer Support Services are Integral to Mental Health Recovery” available at: http://www.disabilityrightsca.org/pubs/CM1501.pdf
187 These could include Urgent Care Centers or Crisis Stabilization Units.
188 See Section 4-E below for a description of the program.
190 For example, “[s]tudies have shown that sigma is even prevalent among the mental health provider community.” California Strategic Plan on Reducing Mental Health Stigma and Discrimination, at pp. 24-25, available at: http://calmhsa.org/downloads/aboutus/Strategic-Plan-for-Reducing-Stigma-and-Discrimination.pdf.
192 The Legislature has adopted the Kaiser Foundation Health Plan Small Group 30 Plan as the benchmark for Affordable Care Act (ACA) implementation. [Health & Safety Code § 1367.005(a)(2)(A)]. This includes crisis residential treatment. [See Kaiser Evidence of Coverage for Sample Group Agreement, p. 34, available at: https://www.statereforum.org/sites/default/files/ca_kaisersmallgroupmho.pdf. As a result, private health care services plans have a duty to provide crisis residential treatment as a condition of participation under ACA implementation.
196 42 CFR §438.206(c)(1)(i).
197 See, e.g., 9 C.C.R. § 1810.200; CAEQRO Key Component Review Protocol FY 13-14 at pp.15-17, available at: http://www.caleqro.com/#/archived_materials/Previous_California_EQRO_APS_Healthcare/Previous_California_EQRO_APS_Healthcare|California_EQRO_Resources/Previous_California_EQRO_APS_Healthcare|California_EQRO_Resources|CAEQRO_Archive

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199 Id. p. 18.


201 Id. p. 66.


204 Id. p. 68; performance outcomes measures are discussed further below at Recommendation #4.

205 Id. pp. 65-66.

206 Some counties offer urgent care or walk-in clinic services that offer access to services without an appointment, and such assistance should be available in each county.

207 See 28 C.C.R. § 1300.67.2.2(c)(5); see also Department of Managed Care, Timely Access to Care website, available at: https://www.dmhc.ca.gov/HealthCareinCalifornia/YourHealthCareRights/TimelyAccessToCare.aspx#.VXHiCdJVhHw.

208 See Fact Sheet on "Mental Health Facility Diversion & Aftercare that Focuses on Recovery" available at: http://www.disabilityrightsca.org/pubs/CM0501.pdf

209 See Recommendation #5 below, User Friendly Menu of Crisis Services.

210 Welf. & Inst. Code § 5008(d).

211 Welf. & Inst. Code § 5622(a). Health and Safety Code § 1262(c) does not cover crisis residential programs or "outpatient" facilities that can be designated for 5150 detentions such as crisis stabilization units.

212 Strategic Plan on Suicide Prevention, p. 28, http://www.mhsoac.ca.gov/docs/Suicide-Prevention-Policy-Plan.pdf.

213 Id.

214 Welf. & Inst. Code § 5008(d).


216 Welf. & Inst. Code § 5008(d). The statutory term “when necessary” is vague. “Necessary” needs a definition.


See, e.g.: http://www.dhcs.ca.gov/services/ltc/Documents/CareManagementCurriculumforCE.pdf.

See, e.g.: http://www.dhcs.ca.gov/services/ltc/Documents/CareManagementCurriculumforCE.pdf.


Welfare and Institutions Code § 5008(d) mandates that each designated agency or facility must have current agreements with agencies or individuals accepting referrals and to appraise of the results of past referrals. This requires a designated agency or facility to follow up and determine whether a person actually linked with the referred service provider.

Again, county quality improvement processes should integrate this information, e.g., CAEQRO.

These may be available for $.99 at discount stores.

This should be done in coordination with data collection requirements under the Affordable Care Act to prevent re-hospitalization. There is a need to address the issue that due to difficulty in finding bed space, individuals may be re-hospitalized in a different facility. In addition, county quality improvement processes should integrate this information, e.g., CAEQRO. Counties support wanting to improve the process and quality of service through effective data collection processes.


See “We Ain’t Crazy! Just Coping with a Crazy System – Pathways into the Black Population for Eliminating Mental Health Disparities” (May 2012) at p. 52-3 (Table 9) available at: http://www.cdph.ca.gov/programs/Documents/African_Am_CRDP.Pop_Rept_FINAL20
This refers to a supplemental rate that a county may pay for an individual placed at a facility, such as those designated as an “Institution for Mental Disease” of “IMD” under federal Medicaid law. See Disability Rights California, “A Tale of Two Settings – Institutional and Community-Based Mental Health Services In California Since Realignment In 1991” (January 2003), pp. 11-12, available at: http://www.disabilityrightsca.org/pubs/540301.pdf.

234 This refers to the number or percentage of individuals in a target population that is actually served versus the estimated number of individuals within the population group. See Technical Assistance Collaborative and Human Services Research Institute, “California Mental Health and Substance Use Needs Assessment” (Draft 1/30/12), at p. 4, available at: http://www.dhcs.ca.gov/Documents/All%20chapters%20final%201-31-12.pdf.


237 The California mental health system has adopted the Recovery Vision standard; an indicator to measure progress includes reduction in 3 and 14 day involuntary commitments under Sections 5150 and 5250 of the Welfare and Institutions Code, respectively. See Mental Health Services Oversight & Accountability Commission, Mental Health Services Act (MHSA) Community Services and Supports (CSS)/System of Care Initial Priority Outcomes and Indicators available at: http://www.mhsoac.ca.gov/Evaluations/docs/FactSheet_Narrative_2B_Chart_Indicators.pdf.

238 This information is based on data from the California Department of Health Care Services website at: http://www.dhcs.ca.gov/services/MH/Pages/InvoluntaryDetention-MH.aspx. Psychiatric hospitals and facilities providing 72-hour evaluation and treatment and certifications for 14-day treatment and additional 14-day intensive treatment complete the report, among other forms of treatment. While the data is listed by county, not all counties have psychiatric hospitals or psychiatric health facilities (PHFs). Therefore, this data does not indicate from which county the person was referred. See note 197, below. Small counties without hospitals or PHFs may transport people to psychiatric facilities in other counties. It would be helpful for data collection to include county of residence for the person involuntarily detained and treated at out of county facilities. Such information could also be used to ensure aftercare coordination of care.


241 Welf. & Inst. Code § 5600.2(g).


245 The Lanterman-Petris-Short (LPS) Act provides that a person subject to detention under Section 5150 of the Welfare and Institutions Code must be evaluated to determine if he or she “can be properly served without being detained . . . ” (§ 5150(b)). If so, “he or she shall be provided evaluation, crisis intervention, or other inpatient or outpatient services on a voluntary basis.” Id. The LPS Act further provides that a 14-day detention under Section 5250 of the Welfare and Institutions Code requires that the individual has been “advised of the need for, but has not been willing or able to accept, treatment on a voluntary basis.” (§ 5252). Also, under Section 5008, “[a]ll persons shall be advised of available pre-care services which prevent initial recourse to hospital treatment or aftercare services which support adjustment to community living following hospital treatment.”


249 Boards and commissions have duties that include advising the governing body and local mental health director on any aspect of the local mental health program. (Welf. & Inst. Code § 5604.2(a)(3)).

250 “Promotores de salud (health promoters) play a key role in advancing the well-being of the communities they serve...Because of the relationship they have with their
community, they are particularly effective at reaching Latinos and other unserved and underserved families and individuals. They can address multiple barriers to accessing services, such as those related to transportation, availability, culture, language, stigma, and mistrust. Although more widely engaged in the field of physical health, promotores increasingly address mental health concerns as well." California Institute for Mental Health, “Promotores in Mental Health in California and the Prevention and Early Intervention Component of the MHSA,” (November 2008), at p. 1, available at: http://www.cimh.org/sites/main/files/file-attachments/promotores_policy_paper.pdf


252 Id. at p. 18.


255 Id. at 19.


257 DHCS and the counties administer the Medi-Cal program. Eligible Medi-Cal beneficiaries may receive benefits through Medi-Cal Managed Care Plans and Fee-For-Service (FFS) delivery systems, which cover the following: individual and group mental health evaluation and treatment (psychotherapy); Psychological testing; Outpatient medication monitoring; Outpatient laboratory, medications, supplies and supplements; and Psychiatric consultation. Medi-Cal Specialty Mental Health Services are provided through County Mental Health Plans (MHPs), which provide outpatient services (Mental Health Services, Medication Support, Day Treatment Intensive, Day Rehabilitation, Crisis Intervention, Crisis Stabilization, Crisis and Adult Residential Treatment, Targeted Case Management) and Inpatient Services. As of January 1, 2014, Medi-Cal Substance Use Disorder (SUD) Benefits expanded to include: Intensive Outpatient Treatment; Residually Based SUD Services; Medically Necessary Inpatient Detoxification; and Screening and Brief Intervention. See http://www.dhcs.ca.gov/services/medi-cal/Pages/Medi-Cal_EHB_Benefits.aspx

258 DMHC regulates individual and group managed health care service plans, including Blue Cross or Blue Shield PPO; see http://www.dmhc.ca.gov/

259 The Department of Insurance regulates health insurance plans; see http://www.insurance.ca.gov/
The OAC oversees implementation of the MHSA; see http://www.mhsoac.ca.gov/About_MHSOAC/About_MHSOAC.aspx
DSS licenses certain mental health facilities (e.g., Crisis Residential Treatment programs).
CDRC is responsible, *inter alia*, for aftercare planning from jails and prisons.
“The California Mental Health Planning Council is mandated by federal and state statutes to advocate for children with serious emotional disturbances and adults and older adults with serious mental illness, to provide oversight and accountability for the public mental health system, and to advise the Administration and the Legislature on priority issues and participate in statewide planning”; see http://www.dhcs.ca.gov/services/MH/Pages/CMHPCCouncilOverview.aspx.