COUNTY OF YOLO

Health and Human Services Agency

Joan Planell
Director

137 N. Cottonwood Street • Woodland, CA 95695
(530) 661-2750 • www.yolocounty.org

Local Mental Health Board

Regular Meeting: Monday, July 27, 2015, 7:00 PM – 9:00 PM*

~~600 A Street, Davis, CA, 95616 – Conference Room~~

NEW LOCATION: St. James Catholic Church Parish Center, 1275 B Street, Davis, CA 95616

All items on this agenda may be considered for action.

**This meeting will include a Public Forum beginning at 6:00 PM, followed by a regular meeting from 7:00 PM – 9:00 PM. This agenda reflects the regular meeting agenda items.*

7:00 PM CALL TO ORDER

1. Welcome and Introductions
2. Public Comment
3. Approval of Agenda
4. Approval of Minutes from June 22, 2015
5. Announcements
6. Correspondence
   - June 24, 2015 Email to the Mental Health Executive Committee
   - July 6, 2015: LMHB Budget and Finance Committee Letter Response to the BOS
   - July 8, 2015: Yolo County MHSA Housing Project Letter
   - July 9, 2015: LMHB and Brown Act Compliance

7:15 PM CONSENT AGENDA

7. Mental Health Director's Report – Karen Larsen
   - SAMHSA'S Certified Community Behavioral Health Clinic Planning grant
   - HHSA Integration
   - Homeless Services
   - Jail/JDF Medical/Mental Health
   - Crisis Intervention Training
   - Community Intervention Program
   - Consumer Satisfaction Surveys

7:20 PM TIME SET AGENDA

8. **7:20 PM:** County 2016-2019 Strategic Plan Goals, "Thriving Residents" and "Safe Communities" – Tracey Dickinson, Associate Management Analyst and Becky Eby, Management Analyst from the Yolo County Administrator's Office
9. **7:35 PM:** MHSA Plan Update – Resource Development Associates
10. **8:10 PM:** Yolo County Housing Update – Lisa Baker, CEO of Yolo County Housing

8:40 ~~7:20~~ PM REGULAR AGENDA

11. Board of Supervisors Report – Supervisor Jim Provenza
12. Department Report – Karen Larsen

If requested, this agenda can be made available in appropriate alternative formats to persons with a disability, as required by Section 202 of the American with Disabilities Act of 1990 and the Federal Rules and regulations adopted implementation thereof. Persons seeking an alternative format should contact the Local Mental Health Board Staff Support Liaison at the Yolo County Department of Health Services – Alcohol, Drug and Mental Health Administration, 137 N. Cottonwood Street, Suite 2500, Woodland CA 95695 or 530-666-8516. In addition, a person with a disability who requires a modification or accommodation, including auxiliary aids of services, in order to participate in a public meeting should contact the Staff Support Liaison as soon as possible and preferably at least twenty-four hours prior to the meeting.

13. Chair Report – Bob Schelen
    a. Consider proposed amendment to LMHB Bylaws
    b. Designate LMHB representative for the quarterly CFMG jail Quality Assurance Committee Meeting
    c. Legislative Ad Hoc Committee Report
    d. Board Committee Reports
        - Communication and Education Committee
        - Program Committee
        - Budget and Finance Committee: June 22, 2015 Report

9:00 ~~8:00~~ PM ADJOURNMENT

14. Future Meeting Planning and Adjournment – Bob Schelen
    - Consider request to move the August 2015 LMHB meeting date from August 24th to August 31st
    - Next Meeting Date and Location – Monday, August *TBD*, 2015, 7:00 – 9:00 PM in the Arthur F. Turner Community Library Meeting Room, 1212 Merkley Avenue, West Sacramento, CA 95691.**The next meeting will include a Public Forum from 6:00 – 7:00 PM, followed by a regular meeting from 7:00 – 9:00 PM*

I certify that the foregoing was posted on the bulletin board at 625 Court Street, Woodland CA 95695 on or before Friday, July 24, 2015.

Local Mental Health Board Staff Support Liaison
Makayle Neuvert, Secretary
Yolo County Health and Human Services Agency

Makayle Neuvert

From: LMHB
Sent: Thursday, June 25, 2015 4:07 PM
To: Bob Schelen ; Robert Canning; 'James Glica-Hernandez'
Subject: FW: Mental Health Executive Committee - Response Requested

Categories: LMHB

Hello ~ Please see below. Please copy me on your response or if you want me to forward your comments, just let me know. Thanks!

Makayle Neuvert, Secretary
Yolo County Department of Health Services
Main: (530) 666-8516 • Direct: (530) 666-8946
From: Elodia Burlingame [mailto:EBurlingame@tularehhsa.org]
Sent: Wednesday, June 24, 2015 4:00 PM
To: Karen.Shuler@hsd.cccounty.us; MentalHealthBoard@SacCounty.net; behavioralhealth@tuolumnecounty.ca.gov; jlawless@mariposahsc.org; lmarsh@sierracounty.ca.gov; LMHB; mentalhealth@co.modoc.ca.us; ngorham@kingsview.org; shopper@co.sutter.ca.us
Subject: Mental Health Executive Committee - Response Requested

Good afternoon,

I serve as the Mental Health Board liaison for Tulare County. I am looking to contact representatives from other counties in search of Executive Committees that work alongside county Mental Health Boards. I would like to learn how their Executive Committee operates in relation to the Brown Act.

Any contact information or guidance would be greatly appreciated!

Thank you.

Elodia Burlingame
Administrative Aide
Tulare County Mental Health Department - Managed Care
5957 S. Mooney Blvd
Visalia, CA 93277
Direct Line: (559) 624-7462
Fax: (559) 733-6428
Office Hours: Monday-Thursday 7:00A - 5:30P
EBurlingame@tularehhsa.org

COUNTY OF YOLO

Health and Human Services Agency

Joan Planell
Director

137 N. Cottonwood Street • Woodland, CA 95695
(530) 661-2750 • www.yolocounty.org

Date: July 6, 2015

To: Board of Supervisors

From: Karen Larsen

CC: Patrick Blacklock; Jill Cook; Joan Planell

RE: Response to LMHB Budget and Finance Committee Report to BOS

In response to the LMHB letter to the Board of Supervisors regarding 2015-2016 budget I have been asked to highlight our efforts toward addressing the LMHB key recommendations. First, it should be noted that as the mental health plan for the County of Yolo, it is our responsibility to care for the uninsured and underinsured residents of our communities struggling with severe emotional disturbance and serious mental illness. Our agency is the primary provider of these services for the Medi-Cal population of Yolo County, approximately 25% of our County population, via our own services and those we contract out.

There has been a significant increase in the number of individuals covered by Medi-Cal bringing with it many benefits and some unintended consequences. We saw a dramatic increase in our hospitalization and placement costs over the past year as a result of newly covered population. This is because several of our hospital partners cannot bill Medi-Cal for services, yet we are responsible for paying these costs for Medi-Cal beneficiaries. *We continue to do everything in our power to avoid hospitalization. However, these costs are not reimbursable and were an unanticipated consequence for mental health plans statewide.*

We agree that we could use more resources toward improving these numbers and we also agree that we should do everything within our existing resources to ensure that we are providing appropriate access to care, level of service, and improving outcomes for the vulnerable populations we serve.

Toward that end, please note that the following several strategic initiatives already underway and planned for the coming fiscal year to improve consumer satisfaction, access to care and outcomes.

- Implement Level of Care Utilization System (LOCUS**)** to determine appropriate level of care for our consumers and most efficient use of resources. *Implementation has begun and will be complete by October 1, 2015*. *No additional cost to the county or additional resources required.*
- Create interdisciplinary care teams for population of focus as means for providing integrated services for whole person care.
- Implement Adult Needs and Strengths Assessment and Child, Adolescent Needs and Strengths (ANSA/CANS) to track outcomes and quality of life measures over time.

- Increase focus and resources for the homeless**.** This cannot be fully achieved without increasing the supply of affordable housing available throughout Yolo County. *We have already hired a mental health specialist, social worker for the neighborhood court and began recruiting for the county homeless coordinator position. More resources for permanent supportive housing options are necessary to fully address the homelessness issues our county faces.*
- Increase outreach to the Latino Community**.** Our penetration rate for the Hispanic/Latino community is 2.95%, well below the state average of 3.92% and notably below medium size county average of 3.22%. *We are funding an innovative program through MHSA with CommuniCare Health Centers to provide targeted outreach and services to this population. No additional funding needed.*
- Implement a Full Service Partnership team and Wraparound slots for children, youth and adults to provide intensive community based services in an effort to avoid out of home placements. This will help to mitigate the uncertainty tied to increased responsibility for hospitalizations and other more intensive placements. *This RFP will be released before the end of July*. *These costs will be covered by MHSA and Medi-Cal and shouldn't require more resources from the County.*
- Continue to expand hours/days for the Community Intervention Program. We have already begun exploring how to provide weekend/evening coverage with cost savings from past year. No additional cost to the County.
- Increase coordination of Substance Use Disorder Services. Over the past two years we have seen a 39% decrease in treatment admissions for substance use disorder treatment locally, despite the fact that more than 75% of those in custody and on probation are facing substance related offenses. This is in no way a reflection of decreased need, but rather decreased coordination. *We have invested additional resources at probation, the jail and juvenile detention facility in hopes of improving this trend. Additionally we have released an RFI for detoxification services locally and will be opting into the 1115 Waiver within the next 18 months. The 1115 waiver will result in additional financial responsibilities for the County which should be offset by the state.*
- Continue to maximize utilization of Assisted Outpatient Treatment as a means for reducing conservatorship and costly out of home placements and incarcerations. *We have successfully increased our AOT slots by flexing our ACT slots leading to an average AOT census of 7 rather than 5. This contract did run more than $100,000 over budget in the current fiscal year and could use more financial support in the coming fiscal year.*

As true of other localities, we continue to have difficulties in recruiting psychiatrists**.** We have begun to recruit part time psychiatrists as consulting specialists over the past year. This allows us to pay a higher hourly rate and allows the providers to work part time which is preferable to most. This is a supply issue that more resources will not remedy.

We are working diligently to ensure that we are maximizing revenue and minimizing costs, while continuing to provide high quality and accessible services for some of our most vulnerable residents. Many of the Healthy Yolo priorities focus on prevention, early intervention and those facing mild to moderate mental health issues within our community. We will continue to evaluate whether or not MHSA prevention and early intervention funds can support these priorities.

We will continue to hold the needs of the seriously mentally ill as a top priority. We look forward to continuing this work. Please contact me if you have additional questions.

Makayle Neuvert

From: slobadbobs@aol.com
Sent: Monday, June 15, 2015 4:26 PM
To: Don Saylor; Jim Provenza; Matt Rexroad; Oscar Villegas; Duane Chamberlain; Karen Larsen; Makayle Neuvert
Subject: Fwd: LMHB Budget & Finance Committee - Review of 2015-16 Budget
Attachments: LMHB B&F Meeting 05-12-15.docx

The attached report of our Budget and Finance Committee was approved on an unanimous vote of the Yolo County Local Mental Health at our May meeting held on May 26, 2015.

While the Committee Report will be included in our Local Mental Health Board Annual Report as required by the California Statutes to the Board of Supervisors later this year, we felt it important that you see this document and our concerns before the 2015-2016 Budget Workshop and Vote.

A short summary would be that while the LMHB is releived Yolo County Board of Supervisors have established programs, such as the implementation of "Laura's Law, Mental Health Court, Day Reporting and others....that a way to develop a larger capacity for people to enter these programs is important.

That, while a "A Bridge to Housing" is, again, a good start on transitioning to a "Housing First" approach with homelessness and mental illness, that more can be done to meet unmet needs.

We are happy that efforts to replenish the severe cuts of the 2008 recession are taking place, that more can be done.

Thank you for your consideration

Bob Schelen
Chair -- Yolo County Local Mental Helath Board

LMHB Budget & Finance (B&F) Committee Report,
Meeting to Discuss Proposed 2015-16 Budget, May 12, 2015

Attendees: Karen Larsen, Mental Health Director, John Buzolich, Deputy Director Health-Finance, Richard Bellows, Chair, Janlee Wong, Nicki King, Robert Schelen, LMHB Chair

Recommendation Summary:

The B&F committee recommends approving the budget with strong concerns that a number of pre-emptive programs need additional funding.

The Budget & Finance Committee met to review the proposed 2015-16 ADMH Budget. Key Recommendation are highlighted below in red.

The present budget is largely a maintenance-of-effort budget. Funding comes from many federal, state and local sources that can be unpredictable and difficult to increase. As a result many desirable pre-emptive programs, programs that could both improve human outcomes and at the same time reduce local costs (law enforcement, jail, courts, probation, emergency room visits, hospitalizations, long term care) remain underfunded. This is penny foolish rather than pound-wise!

Finally, Bridge to Housing and Substance Abuse services need greater coordination between county departments to be fully effective.

Key Recommendations:

Major Uncertainty - Rising Medi-Cal Costs – **This could be a surprise to the downside.** To the positive, the Affordable Care Act (ACA) has increased healthcare coverage for many more Yolo residents. Unfortunately, many mental health services must be co-funded with county funds by as much as 50%. These expenses are difficult to predict in an expanding program. The LMHB recommends the Board of Supervisors plan for this additional funding and with other counties seek assistance from the Legislature.

LOCUS (Level-of-Care-Utilization System) – **LOCUS should lead to a reduction of unnecessary expenses.** LOCUS is designed to match appropriate service levels to an individual's service needs. This should lead to a reduction of unnecessary expenses. All consumers do not have equal needs for service. For example, lower acuity patients could potentially receive fewer visits with medical staff. A caution; re-imbursement for services in this LOCUS initiative could encounter unintended consequences.

Housing of the Homeless – **Bridge to Housing (BTH) needs coordinated funding amongst several departments and agencies to continue.** ADMH's role is only tangential to the overall housing issue. BTH is a ground-breaking initiative and provides a model for the whole country. Yolo is proud of this BTH initiative, and would like to see

these efforts continued, especially with the homeless in need of mental health services. The LMHB recommends the Board of Supervisors seek to establish a permanent Bridge to Housing program with coordinated multi-agency and multi-jurisdictional funding.

Serving the Latino Community – **More needs to be done to increase mental health services in the Latino Community.** This large group remains underserved. However, "front door" entry through the Health Department has the potential to improve access because primary care services do not carry the stigma of Mental Health. Over time, it should be possible to familiarize these Yolo County residents with the range of programs and services offered by ADMH.

Adding a New Full Service Partnership (FSP) Team – The department is issuing an RFP for FSP services for children as well as creating an FSP team internal to the department in the coming year.

Increasing Community Intervention Program (CIP) – **Expansion of CIP into the weekend and nighttime should be a high priority.** CIP, funded from SB-82, has been a promising intervention program in reducing unnecessary hospitalizations and avoiding criminalization of mental health episodes. Sending someone to jail and through the court system is expensive. In many cases, it is unnecessary and inappropriate. Present CIP coverage is limited to mid-week in the late afternoon to early evening. The LMHB recommends to the Board of Supervisors additional funding for this program.

Substance Abuse Services – **Other Yolo departments need to coordinate more effectively with ADMH substance abuse treatment services.** Referrals, especially those from Probation, dropped significantly in the last 3 years, leaving unspent resources. Substance Use Disorder treatment is proven to reduce recidivism. Possible referrals need to come directly from law enforcement, the District Attorney (pre-trial) and the courts.

Expansion of Assisted Outpatient Treatment (AOT) – AOT is the preferred name for Laura's Law as practiced in Yolo. Originally, Laura's Law allowed for forced medication. However, each county has implemented their own version. **Forced medication is not a part of Yolo's AOT.** The AOT program has been expanded from 4 to 8 slots by using ACT slots. Currently, there is no wait list.

Psychiatrists – **Funding for psychiatrist positions remains a high priority.** Psychiatric positions have been very difficult to fill because of scarcity of applicants, the low pay scale and the difficult caseload. Part-time positions have been easier to fill. With supervision, primary care physicians, psychiatric Physician's Assistants (PAs) and Nurse Practitioners (NPs) are an acceptable option, and might be easier to identify and recruit. The LMHB recommends to the Board of Supervisors adding these personnel classifications to the behavioral health program that could help prescribe psychotropic medication.

Healthy Yolo – Many recommendations identified in the Healthy Yolo campaign remain under-funded. Three top priorities included mental health, chronic disease prevention, and health issues associated with aging.

Serious Mental Illness (SMI) Remains Top Priority – Healthy Yolo (see above) identified three broad community health needs, mental health, chronic disease prevention, and health issues associated with aging that will require funding. When these new initiative are funded, SMI will still remain Priority #1 for the department.

Richard Bellows, Chair of B&F Committee

Makayle Neuvert

From: slobadbobs@aol.com
Sent: Wednesday, July 08, 2015 10:09 AM
To: LMHB
Subject: Fwd: Yolo County Housing Project/5th Street Housing Project/Housing First/Davis and Yolo County Letter for YCLMHB and Yolo NAMI
Attachments: LMHB_Housing_Letter_2015-06-26_Final.pdf

Categories: LMHB, Health Council

This is the letter with a comment that was attached send to the City of Davis Councilmembers (I will also send to city clerk) and the others listed.
I am glad you reminded me.....now I will also send to the media outlets.

Bob S.

Please find a letter attached from the Chair of the Yolo County Local Mental Health Board and the President of the Yolo County Chapter of the National Alliance for the Mentally Ill regarding housing and mental health issues in Davis and Yolo County.

Yolo County Department of Health Services

Local Mental Health Board

June 26, 2015

Yolo County Board of Supervisors
625 Court Street
Woodland, CA 95695

RE: YOLO COUNTY MHSA HOUSING PROJECT

Mr. Chair and Board Members:

There is an existing contract which will use Mental Health Services Act (MHSA) housing funds for a housing project on the site of the old Yolo General Hospital. On May 26, 2015, the Local Mental Health Board approved a motion for a joint LMHB and NAMI recommendation that asks you to review the contract for a potential opt-out. On June 13, 2015 the NAMI-Yolo Board approved the same motion.

Recent updates provided by the Alcohol Drug and Mental Health Department and Yolo Housing Authority have identified changes to the project's timeline where the completion date is extended indefinitely. Many individuals that are in need of such services cannot wait for housing support, and we urge that you review this project to determine whether the County is able to opt-out of this contract for a few reasons: 1) Individuals with mental illness urgently need this housing with supportive services immediately; 2) Housing costs are increasing and value of the MHSA funds will not be able to meet the cost of housing in the future; and 3) An opt-out provision in the contract may help put pressure on the contractors to expedite the project timeline if they perceive the Board is willing to withdraw their support for the project and use the opt-out provisions to terminate the contract.

It has also come to our attention that a proposal for apartments on the EMQ/Families First site has been proposed to the City of Davis. It seems study should be given to this site for possible use in a "Housing First" model for the mentally ill, homeless and others that need housing in our city and county.

Therefore we would recommend that you request your County's Administration, that may include staff from your County Counsel, the Alcohol Drug and Mental Health Department, Yolo Housing Authority, and Contract Division, to review the contract provisions and submit a report to the Board to consider whether you have the authority to opt-out of the contract and inform stakeholders of these findings, so that they may support you in your efforts for alternative recommendations for a more timely completion of developing supportive housing services using MHSA Funds. Further, that the Yolo Housing Authority, County of Yolo and City of Davis look into such an effort before approving any private use of the EMQ/Families First site.

Please contact Bob Schelen at (916) 849-2110 or Cass Sylvia, Interim President of NAMI-Yolo (530) 756-8181, if you have any questions.

Sincerely,

Bob Schelen, Chair
on behalf of a unanimous
Yolo County Local Mental Health Board

Cass Sylvia, President
NAMI-Yolo

BS:CS:mf:kl:jf:mn

Cc: Yolo County Housing
City of Davis (with requested distribution the City Council and Planning Commission)

COUNTY OF YOLO

Memorandum

Date:	07/09/15
To:	Makayle Neuvert, Administrative Liaison to the Local Mental Health Board
From:	Philip Pogledich, County Counsel
RE:	LMHB and Brown Act Compliance

Makayle,

Under the Brown Act, a standing committee is any committee created by a legislative body—here, the LMHB—that has either: (1) ongoing jurisdiction over a particular issue or set of issues; or (2) a meeting schedule fixed by formal action of the legislative body that created it (Gov. Code Section 54952(b)). Standing committees frequently include less than a quorum of the legislative body, and may include public members as well.

Standing committees are treated as "legislative bodies" for all purposes under the Brown Act. That means:

- Their regular meetings must be noticed 72 hours in advance;
- Their special meetings must be noticed 24 hours in advance;
- If they want to meet by teleconference, they must comply with the requirements in Gov. Code Section 54953 (see the attached document).

There may be more issues here, but I'm not seeing any that aren't generally covered by the points set forth above. Please let me know if you need something different or additional.

Phil

54952.6. Action taken

As used in this chapter, "action taken" means a collective decision made by a majority of the members of a legislative body, a collective commitment or promise by a majority of the members of a legislative body to make a positive or a negative decision, or an actual vote by a majority of the members of a legislative body when sitting as a body or entity, upon a motion, proposal, resolution, order or ordinance.

54952.7. Copy of chapter

A legislative body of a local agency may require that a copy of this chapter be given to each member of the legislative body and any person elected to serve as a member of the legislative body who has not assumed the duties of office. An elected legislative body of a local agency may require that a copy of this chapter be given to each member of each legislative body all or a majority of whose members are appointed by or under the authority of the elected legislative body.

54953. Requirement that meetings be open and public: Teleconferencing

(a) All meetings of the legislative body of a local agency shall be open and public, and all persons shall be permitted to attend any meeting of the legislative body of a local agency, except as otherwise provided in this chapter.

(b) (1) Notwithstanding any other provision of law, the legislative body of a local agency may use teleconferencing for the benefit of the public and the legislative body of a local agency in connection with any meeting or proceeding authorized by law. The teleconferenced meeting or proceeding shall comply with all requirements of this chapter and all otherwise applicable provisions of law relating to a specific type of meeting or proceeding.

(2) Teleconferencing, as authorized by this section, may be used for all purposes in connection with any meeting within the subject matter jurisdiction of the legislative body. All votes taken during a teleconferenced meeting shall be by rollcall.

(3) If the legislative body of a local agency elects to use teleconferencing, it shall post agendas at all teleconference locations and conduct teleconference meetings in a manner that protects the statutory and constitutional rights of the parties or the public appearing before the legislative body of a local agency. Each teleconference location shall be identified in the notice and agenda of the meeting or proceeding, and each teleconference location shall be accessible to the public. During the teleconference, at least a quorum of the members of the legislative body shall participate from locations within the boundaries of the territory over which the local agency exercises jurisdiction. The agenda shall provide an opportunity for members of the public to address the legislative body directly pursuant to Section 54954.3 at each teleconference location.

(4) For the purposes of this section, "teleconference" means a meeting of a legislative body, the members of which are in different locations, connected by electronic means, through either audio or video, or both. Nothing in this section shall prohibit a local agency from providing the public with additional teleconference locations.

(c) No legislative body shall take action by secret ballot, whether preliminary or final.

Yolo County Health and Human Services

BEHAVIORAL HEALTH SERVICES

Local Mental Health Board
Mental Health Director's Report
July27, 2015

SAMHSA'S Certified Community Behavioral Health Clinic Planning Grant

On June 29, 2015, Karen was asked to participate in a conversation with Congresswoman Matsui's office and several regional and statewide behavioral health representatives regarding DHCS's application for this grant. This grant opportunity was born out of Congresswoman Matsui's Excellence in Mental Health Act and would transform behavioral health care if granted.

HHSA Integration

HHSA integration continues to move forward. The executive team continues to meet weekly and discuss items related to job classifications, communication, space, and training. Each Branch Director has developed 6 month program plans and one year strategic plans toward the integration and enhancement of services.

Homeless Services

We have completed the first round of interviews for the Homeless Coordinator position. Additionally, we have finalized an MOU with the City of West Sacramento surrounding their Homeless Coordinator. We are also in discussions with Davis and Woodland regarding next steps in addressing homelessness in these communities.

Jail/JDF Medical/Mental Health

We are in the final stages of developing the RFP for Jail and Juvenile Detention Facility Medical and Mental Health services. While this RFP will be issued shortly, the contract won't officially be awarded until the Spring with services to commence July 1, 2016.

Crisis Intervention Training

The department has issued an RFP for our Crisis Intervention Training. This is part of our regular process to put services out for bid every 3-5 years.

Community Intervention Program

RDA completed our first Annual Evaluation of CIP (please see attached). Additionally, we are actively working toward finding weekend coverage and expanding access to other first responders and the community at large. Additionally, on July 28th, the Board of Supervisors will be recognizing Mark Sawyer, our West Sacramento CIP clinician as a Difference Maker in Yolo County in light of his actions last month. See letter from West Sacramento Police Department attached.

Consumer Satisfaction Surveys

This year we dramatically increased our participation in the Consumer Perception Surveys. In Spring 2014, we collected 179 surveys. This number increased to 279 in Fall of 2014. I am happy to report that in Spring 2015 we collected 501 surveys. See attached summary and overview of results.

Program Evaluation of County of Yolo Community Intervention Program

Annual Evaluation Report 2015

Prepared by:

Resource Development Associates

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Executive Summary

Program Summary

Mental health crises in Yolo County have been a continual source of difficulty for individuals who experience them as well as public mental health and law enforcement system first responders. The passing of SB 82 in California in 2013 led to the provision of funds to support programs responding to mental health crises. Yolo County Department of Drug, Alcohol, and Mental Health (ADMH) used these funds to develop the Community Intervention Program, which allowed for collaboration between mental health and law enforcement for crisis response. The program allows for a clinician who is trained to address mental health crises to pair with law enforcement officers when a crisis is reported in the community. The goal of the intervention is to deescalate the crisis and avoid hospitalization or arrest when possible. Additionally, the program uses a peer follow-up model to facilitate linkages to ongoing outpatient services for consumers once they have exited the crisis phase. It is expected that these activities will lead to a decrease in inpatient psychiatric hospitalizations over time, and an increase in utilization of outpatient mental health services, as consumers are linked to ongoing treatment post-crisis. It is also expected that costs associated with hospitalizations and law enforcement response will eventually decrease.

Evaluation Approach

This evaluation explores patterns of inpatient and outpatient service utilization among consumers who utilized the CIP intervention since its inception in November 2014. It describes demographics of individuals using CIP, information about the encounters, and the outcomes of encounters. It also details characteristics of individuals with both high rates of utilization of the CIP program and also outpatient and inpatient treatment. Further, it explores whether the program has yet realized a decrease in inpatient utilization, and an increase in outpatient utilization. It also explores consumer satisfaction with the program. This first annual evaluation serves as a baseline for the beginning of CIP implementation and the findings produced several recommendations that CIP can consider as it moves forward.

Key Findings

- CIP consumers were largely White, non-Hispanic adults with low levels of education, inadequate housing, previous criminal justice system involvement, and a history of psychiatric hospitalizations.
- The majority of crisis responses during the reporting period were due to 911 calls or at the request of law enforcement agencies.
- CIP staff responded to a crisis in 11 minutes on average; response time varied from one minute to two hours. The average length of encounter was 48 minutes.
- Twenty four percent of CIP encounters resulted in hospitalization, 6% resulted in arrest, and 2% resulted in admittance to crisis residential treatment.

- Referral packets were given to clients after 38% of encounters. Safety plans were developed in 4% of encounters.
- Ten consumers, considered "high utilizers," had more than one CIP encounter during the reporting period. These individuals also had higher rates of mental health treatment utilization.
- Eight consumers completed satisfaction surveys and reported satisfaction with the services received, that they felt they were helped by the services, and that CIP staff treated them respectfully.

Recommendations

Continue to increase the level of follow-up support and linkages to ongoing services for CIP consumers. Data showed that the level of follow-up provided to consumers after crises was not as high as it could be. In order to improve the well-being of CIP consumers and reduce recurring mental health crises, CIP should strengthen its outreach to consumers after the initial crisis event.

Expand the sharing of referral packets and develop safety/wellness plans during all crisis interventions when possible. Referral packets were provided to some consumers, but fewer participated in the development of a safety plan. An important component of the intervention is ensuring that consumers have knowledge about and linkages to ongoing resources, and referral packets and safety plans are useful opportunities to do so.

Implement a data tracking process related to follow-up attempts to better understand barriers to post-crisis engagement. Follow-up support is a crucial step in linking consumers to services post-crisis. Data demonstrated that fewer follow-ups were conducted than hoped; and it would be helpful to understand what issues might be getting in the way of following up with consumers.

Expand use of alternatives to hospitalizations for post-crisis response services when appropriate. Though the majority of CIP encounters did not result in hospitalization, consumers were hospitalized more often than they were admitted to crisis residential treatment.

Conclusion

Yolo County's implementation of the Community Intervention Program presents an exciting opportunity to meet the needs of consumers with mental health crises, while simultaneously reducing overall costs for the county. So far, 90 unique consumers have been recipients of CIP services, who provided a total of 107 encounters between November 2014 and March 2015. Overall, the data gleaned from the current evaluation suggest that CIP can potentially have significant and meaningful impact on clients. Stakeholders can use the information provided in this report to understand the patterns of consumers who use their services and enhance programming to comprehensively meets consumers' needs, particularly the utilizers of multiple systems (i.e. inpatient, outpatient, crisis, criminal justice, etc.).

Introduction

In 2013, the California Legislature approved the Investment in Mental Health Services Act (MHSA; SB 82), which aims to increase the capacity of counties to improve access to and provision of crisis services for residents affected by mental health disorders. As part of SB 82, the State established the Mental Health Services Oversight and Accountability Commission (MHSOAC) to oversee administration of the MHSA. In addition, the California Health Facilities Financing Authority Act established and authorized the California Health Facilities Financing Authority (CHFFA) to adopt rules and regulations regarding provision of SB 82 funds to counties to increase and expand upon mental health crisis response capacities.

Prior to the establishment of this funding mechanism, the County of Yolo had limited ability to provide adequate mental health crisis intervention and support. The typical intervention consisted of a police officer responding to a mental health crisis call, and then either taking the individual to the public hospital, arresting the individual, or leaving them where they were. County service providers and law enforcement agreed that this level of response was inadequate, burdensome to the public system, and ultimately unsupportive of consumers' needs. In recognition of this gap, the County of Yolo Department of Alcohol, Drug, and Mental Health (ADMH) applied for and was awarded CHFFA and MHSOAC grant funds to develop a crisis intervention program and increase the County's capacity to provide services to those affected by mental health crises.

The resulting mobile Community Intervention Program (CIP) is a collaboration between Yolo County's law enforcement agencies, ADMH, and community-based behavioral health service providers. CIP was designed to have trained clinical staff available when law enforcement responds to a mental health crisis with the goal of minimizing the costly placement of individuals in hospitals and jails when a less restrictive treatment option is available. When a law enforcement agency is called to respond to a mental health crisis call, CIP staff are sent into the field along with police officers to offer brief assessment and intervention. At the onset of the crisis response, police officers determine whether the situation is stable, and if deemed so, the CIP clinician takes over the remainder of the response and works to address the consumer's needs. CIP staff begin with an assessment of the person experiencing a mental health crisis using a standardized risk appraisal protocol to inform the type of crisis intervention and support that may be useful. As part of the response, CIP staff de-escalate the crisis, work with consumers and their support network to develop appropriate safety and wellness plans, and then link individuals to services provided by AMDH or other community-based providers, only recommending hospitalization if absolutely necessary. As part of the program, peer counseling follow-up support is offered to consumers after a crisis event has passed to facilitate access to and engagement in services that will prevent future crisis events and promote recovery and wellness.

CIP began providing services in November 2014 and will continue to do so for the next three years. The program rolled out in four cities throughout the County gradually, starting in West Sacramento in November 2014, followed by Woodland in December 2014, Davis in March 2015, and finally in Winters and the Sheriff's department in June 2015.

ADMH contracted Resource Development Associates (RDA) to conduct a three-year evaluation of program utilization. As part of the evaluation, RDA worked with ADMH to gather information about the program resources and components, expected results, and desired outcomes. RDA and ADMH then collaboratively developed a program diagram in order to guide the evaluation activities (Figure 1).

Figure 1. Community Intervention Program Diagram

Program Resources	Program Components	Expected Results	Desired Outcomes
• **Funding**: Investment in mental wellness, Federal financial participation, Insurance payments • **Staffing**: Crisis intervention clinicians, Peer counselors, and Supervisors • **Service Locations**: Homes, Community settings, Shelters, etc. • **Data Collection**: Electronic health record, CIP services • **Collaboration**: Law enforcement, ADMH, Service provider, and Evaluator	• Mobile crisis intervention services in conjunction with law enforcement • Follow-up peer counseling after crisis event • Individualized safety and follow-up plan, referrals, and linkages	• Number of persons served by CIP, by service type, demographics, and service history • Number and length of services provided by service type • Service locations • Referrals and linkages to post-crisis services • Disposition of mobile crisis events • Service provision costs	• ↑participation in post-crisis therapeutic services • ↓hospital utilization • ↓ unnecessary emergency room (ER) use • ↓jail utilization • ↓ overall system and per person costs • Consumer satisfaction

As can be seen above in Figure 1, CIP has a number of resources contributing to the formation of the program including financing, staffing, and data collection. These contributions ensure that the various program components can be carried out to produce the desired outcomes of the program. The main goals of the intervention are to reduce unnecessary emergency room (ER), hospital, and jail utilization; increase participation in post-crisis therapeutic services; reduce the overall system and per person costs associated with behavioral healthcare; and ultimately decrease the occurrence of mental health crises. Although there will be up-front expenditures associated with implementation, it is expected that costs associated with hospital, jail, and ER utilization will ultimately be reduced, resulting in net savings. In order to assess whether CIP is meeting its stated goals, the current evaluation measures utilization and satisfaction; future evaluations will also include subsequent cost-related outcomes. The overarching evaluation questions are:

- To what extent is CIP being utilized?

- To what extent does utilization of various types of clinical services change after CIP implementation, as compared with the previous 12 months?
- To what extent are consumers satisfied with CIP services?

This first evaluation report presents data from the first five months of CIP's operation, November 2014 to March 2015, describes CIP's level of service provision, examines the characteristics of consumers being served by CIP, assesses the types of follow-up and linkage services being utilized by consumers, and explores the change in service utilization of consumers before and after their engagement with CIP. Future annual evaluation reports will provide information about ongoing operations, continue to aggregate service utilization data on CIP consumers, and describe changes to the behavioral healthcare system, including impact on costs. Additionally, longer term outcomes will be included as they begin to materialize. Quarterly briefs are also produced to offer updates on program utilization. An executive summary is included with this report, condensing the findings and recommendations reported here.

Methods

Data Sources

For this evaluation report, data were provided to RDA by Turning Point, the ADMH contracted community-based service provider for CIP; ADMH; and the Sheriff's Office, under established data sharing agreements. CIP consumers signed consent forms that allow for provision of services and sharing of information for evaluation purposes; however, service provision was not contingent on consent for evaluation. RDA obtained IRB approval for the evaluation.

- Turning Point provided information on demographics of consumers served including behavioral health history and criminal justice involvement, reasons for crisis, location of crisis, length of CIP encounter, type of services provided, and disposition of the response. They also provided data regarding post-crisis services and linkages offered to consumers.
- ADMH provided data on follow-up services offered to people who received CIP services. In addition, ADMH provided information on CIP consumers' past and current outpatient (e.g. group therapy) and inpatient (i.e. hospitalizations) service utilization.
- The Sheriff's Office, which covers unincorporated areas of Yolo County, provided information regarding mental health calls to which they responded, including time of call, reason for call, and disposition of encounter.

At the time of this report, law enforcement information was only provided by the Sheriff's Office, but additional law enforcement data from the Davis, West Sacramento, Winters, and Woodland police departments will be incorporated into future reports.

Consumer and Caregiver/Family Member Satisfaction

This report also includes data from consumer satisfaction surveys. The satisfaction survey instrument is comprised of eight questions designed to understand the consumer's experience of the CIP encounter. Versions were developed for consumers as well as family members/caregivers in the event that consumers did not have the capacity to complete the survey themselves. Each question has five answer options: Strongly Agree, Agree, Neutral, Disagree, and Strongly Disagree. The survey is administered via phone during a follow-up call after the crisis has passed. For the current report, satisfaction data are limited as implementation of the surveys only began in the first quarter of 2015.

Analyses

This evaluation report provides basic frequencies and descriptive statistics for CIP service data in order to examine the characteristics of consumers being served, types of services being provided, and follow-up support that consumers received. In addition, paired t-tests were conducted to examine changes in service utilization before and after consumers participated in CIP relating to the number and units of service of outpatient services utilized, hospitalizations, and hospital days.

Results

This section of the report presents findings regarding characteristics of the individuals utilizing CIP, information about the response to crisis from both CIP and law enforcement, and post-CIP outcomes. Additionally, this section describes high utilizers of CIP services. We also include findings related to changes in the types and frequency of ADMH services accessed by CIP consumers before and after their CIP encounters, including both inpatient and outpatient service utilization.

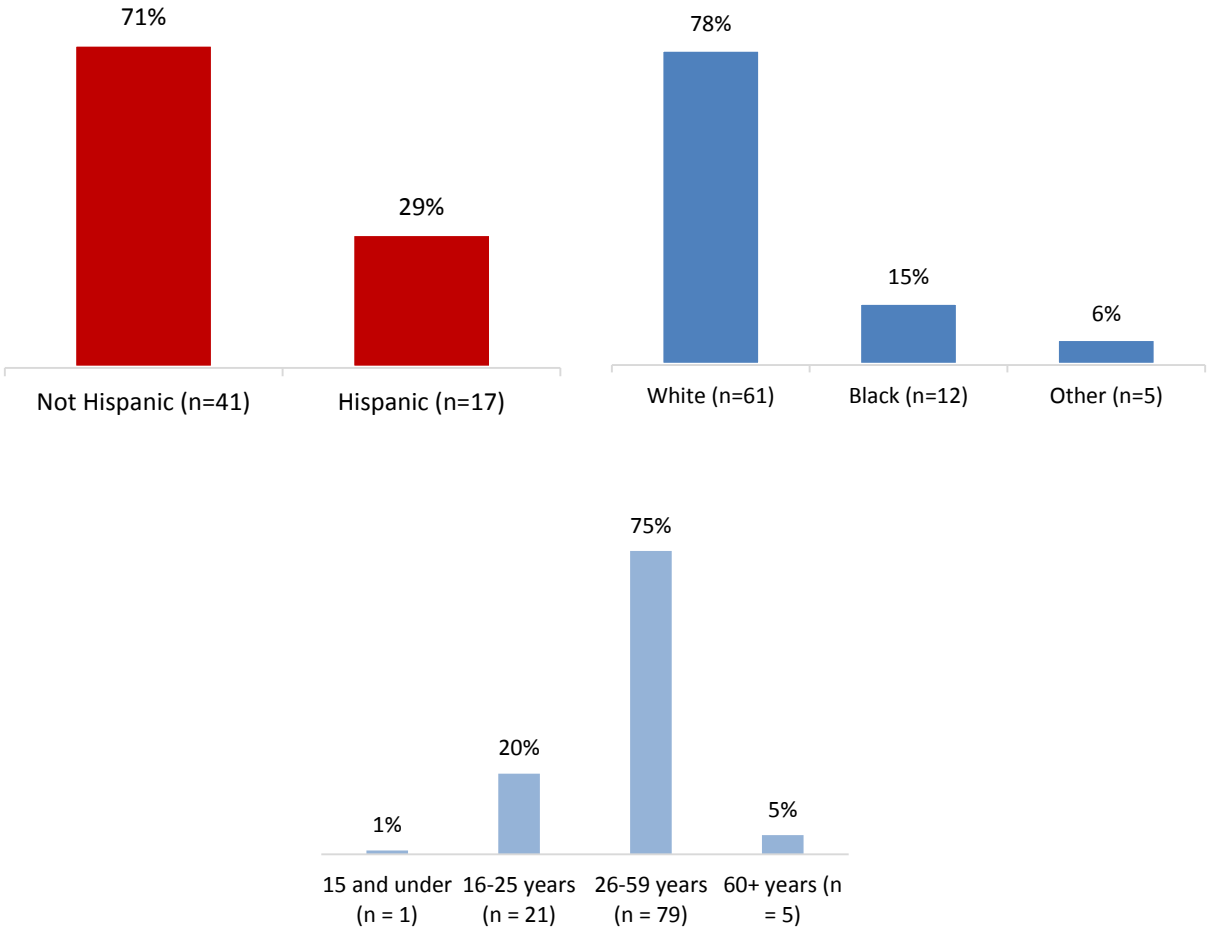
CIP Consumer Profile

CIP served a total of 90 unique consumers between November 2014 and March 2015. In total, CIP had 107 separate encounters among the 90 unique consumers. This section of the report outlines the demographic breakdown of the consumers CIP is serving. It should be noted that many of these data were self-reported by clients and thus should be interpreted with appropriate caution.

Gender, Race, Ethnicity, and Age

For consumers who reported their ethnicity, 29% (n = 17) identified as Hispanic. Seventy-eight percent (n = 61) of consumers identified their race as White, while 15% identified as Black. An additional 6% reported being of another race. Gender was evenly split between male (n = 44) and female (n = 44) identification. In terms of age, 75% of consumers were between the ages of 26-59 (n = 79), followed by participants between ages 16-25 (20%; n = 21). Five percent were 60 years or older (n = 5), and 1% was under 16 (n = 1). Figure 2 displays demographic information for CIP consumers.

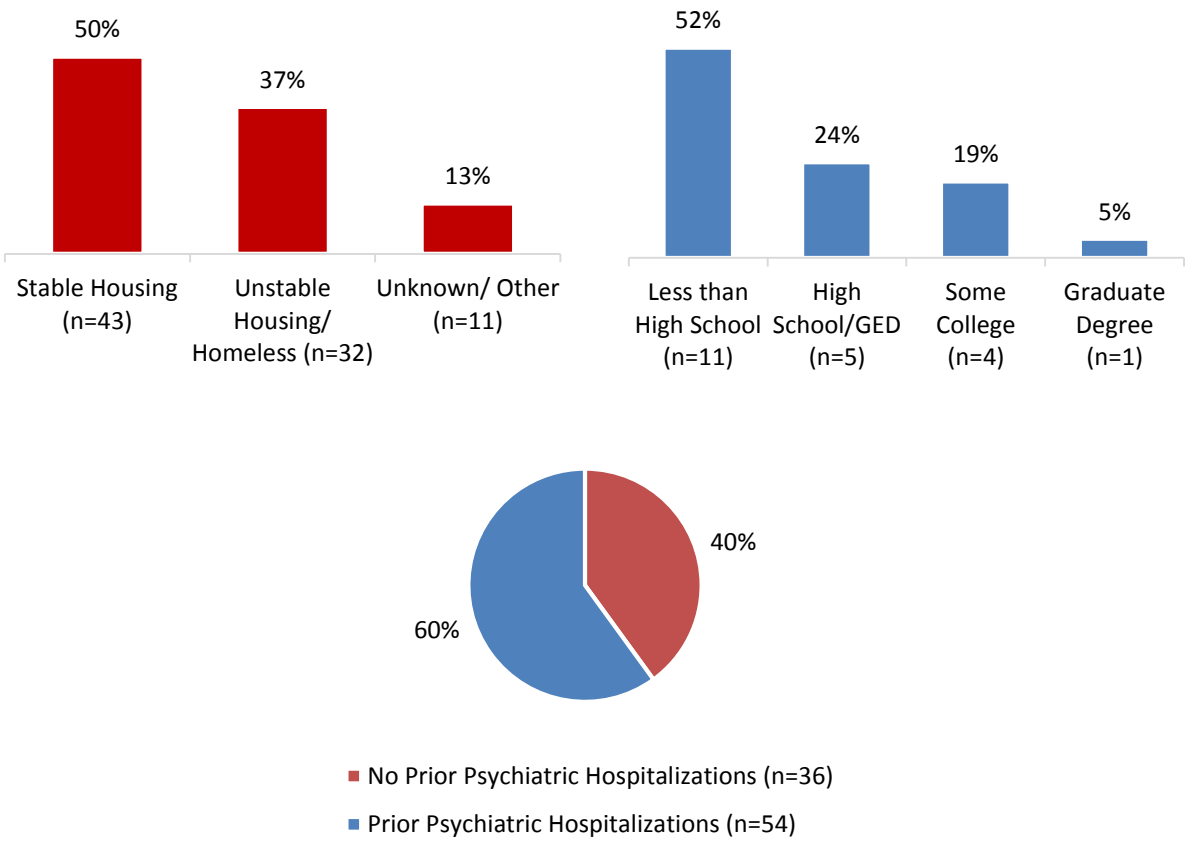
Figure 2. Ethnicity, Race, and Age Breakdown of CIP Consumers



Psychosocial Background of CIP Consumers

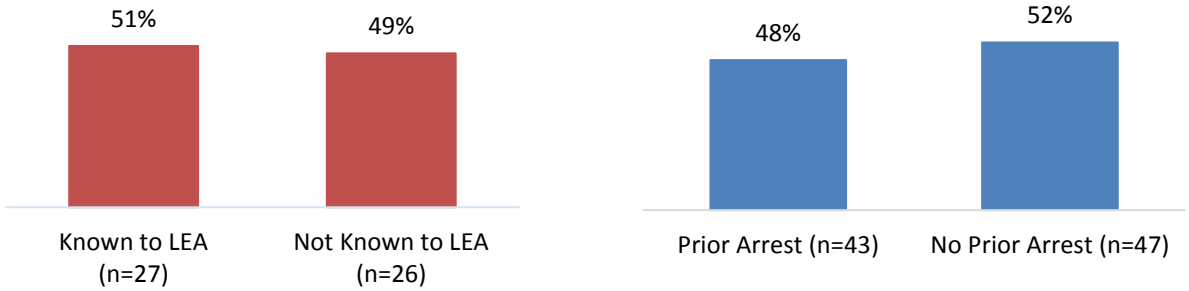
For consumers for whom information was available, 50% reported having a stable housing situation. An additional 37% reported unstable housing or homelessness. In terms of employment, 99% of consumers were unemployed at the time of the CIP encounter. Limited information was available regarding consumers' educational attainment; of the 21 consumers who shared this information, 52% had less than a high school education, 24% completed high school or GED equivalent, and 19% reported some college experience. One individual reported having a graduate degree. Sixty percent of CIP consumers reported a history of at least one psychiatric hospitalization prior to the CIP encounter. Figure 3 displays information regarding CIP consumers' housing, educational history, and past psychiatric hospitalizations.

Figure 3. Psychosocial Background of CIP Consumers



Among consumers who had a CIP encounter during the reporting period, 51% reported having some type of interaction with law enforcement in the past, although these interactions did not necessarily involve arrest or incarceration. Slightly less than half, 48%, did report previous arrests. Figure 4 displays information about CIP consumers' law enforcement and arrest history.

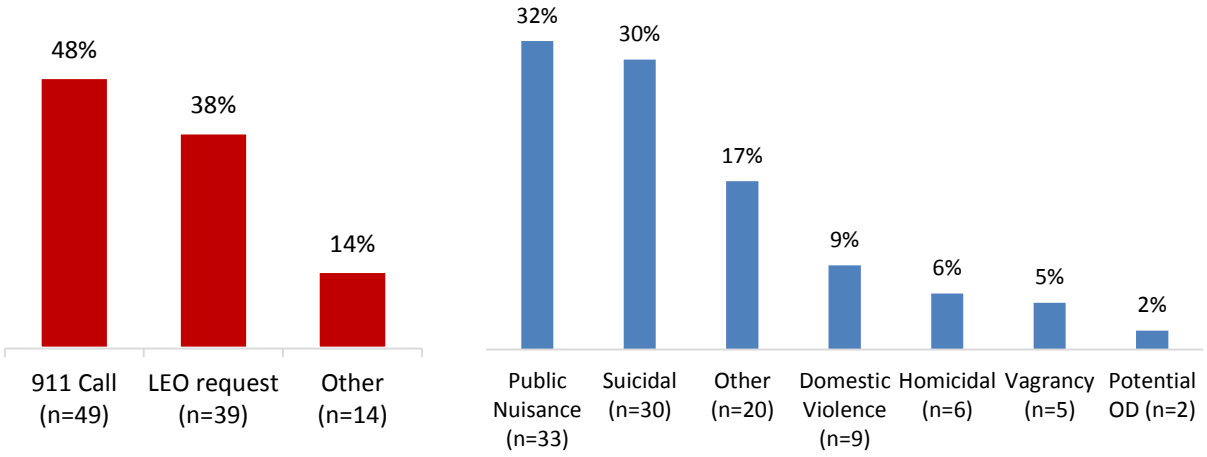
Figure 4. Previous Law Enforcement Involvement of CIP Consumers



Response Information

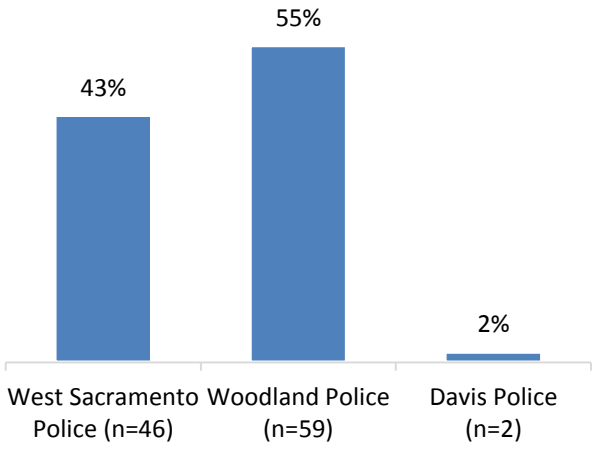
Of the 102 CIP encounters for which data were available, 48% were due to 911 calls, 38% were from law enforcement officer (LEO) requests, and 14% were categorized as "Other," which included welfare checks and follow-ups from previous encounters (Figure 5). The majority of calls were regarding public nuisance (32%) or suicide (30%); other issues included domestic violence (9%), homicidal persons (6%), potential overdose (2%), and vagrancy (5%). Seventeen percent of the calls fell into the "Other" category, which included such issues as grave disability, welfare checks, and bizarre behavior.

Figure 5. Type of Calls Responded to by CIP Staff



Woodland Police Department handled 55% of CIP encounters, followed by West Sacramento, with 43% (n = 46), and Davis Police at 2% of calls (n = 2). Winters is not yet represented in these data as their program implementation continues to ramp up. This breakdown is consistent with the implementation timeline as West Sacramento and Woodland implemented CIP several months before Davis. Figure 6 displays the breakdown of encounters by law enforcement agency.

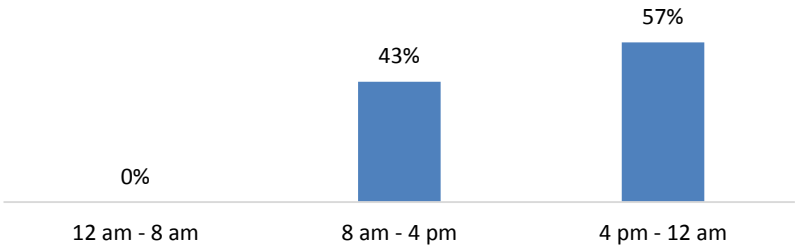
Figure 6. Police Department Jurisdiction of Crisis Calls



Timing of CIP Encounters and Mental Health Crises

CIP hours vary by location, but to date, CIP does not currently operate overnight; however discussions are taking place to examine changes in days and timing of CIP operations. Currently, in all police jurisdictions, CIP operates only from Monday to Friday, but at various times depending on the region. The majority of CIP encounters were between 4pm and 12 am (57%), and the remaining 43% took place between 8 am and 4 pm. Figure 7 displays time of day information for CIP encounters.

Figure 7. Time of Day of CIP Encounters



Response Time

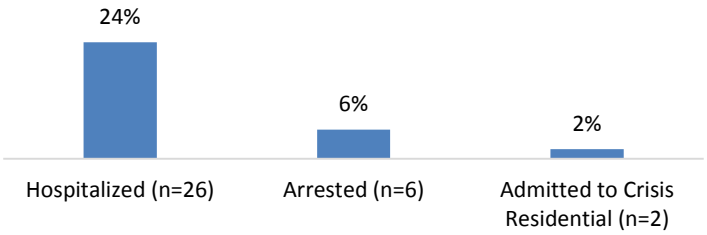
On average, it took CIP staff 11 minutes to respond to a crisis; however, response time varied from one minute to two hours. The average length of encounter was 48 minutes (length of encounter ranged from three minutes to five hours, 20 minutes).

Post-CIP Outcomes

Same Day Support

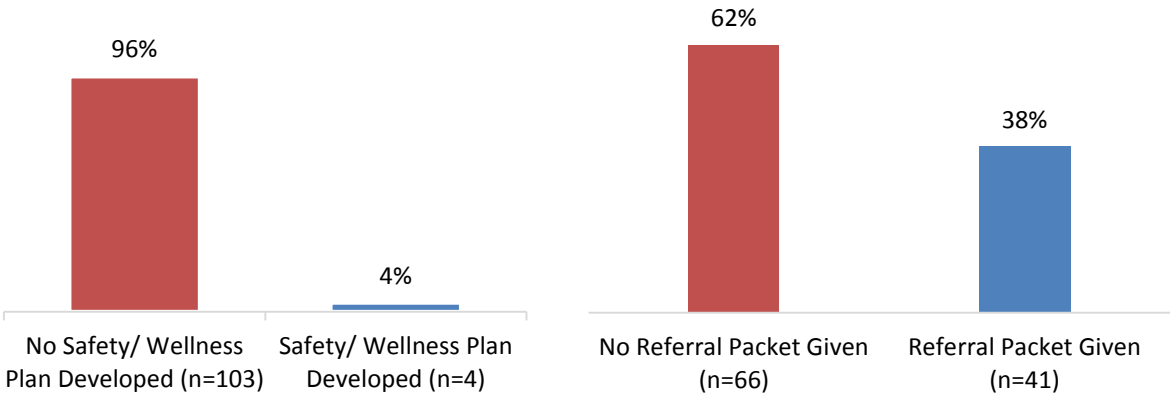
Only 6% of encounters concluded with the consumer entering police custody. Twenty-four percent of encounters resulted in treatment at a hospital, and 2% resulted in admittance to a crisis residential facility. Figure 8**Error! Reference source not found.** displays consumer disposition information following CIP encounter.

Figure 8. Consumer Disposition after CIP Encounter



During encounters, CIP staff can develop a safety/wellness plan with consumers to help guide them in the future when new crises arise. CIP staff can also work with consumers and their caregivers to inform them about additional available services, and provide referral packets that can help clients link to ongoing services after the crisis concludes. To date, safety plans were developed for 4% of clients, and referral packets outlining services and programs that the consumer could access were given after 38% of CIP encounters (Figure 9).

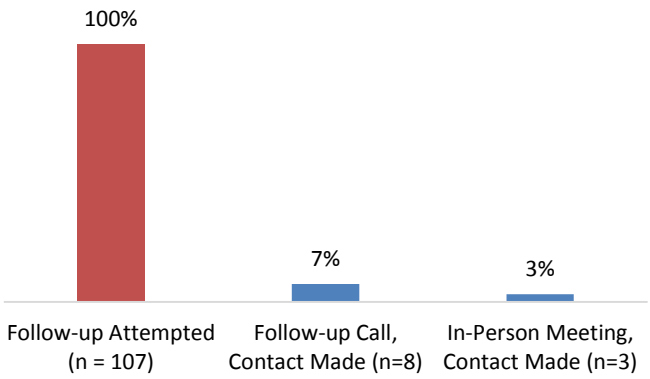
Figure 9. Wellness Plan and Referral Packet Services Provided



Follow-up Support

Despite the fact that CIP staff made multiple attempts to reach all CIP consumers after the initial crisis encounter ended, both in person and via phone, only 7% of consumers were successfully contacted for follow-up via phone, and 3% were reached in person (Figure 10).

Figure 10. Follow Up Information



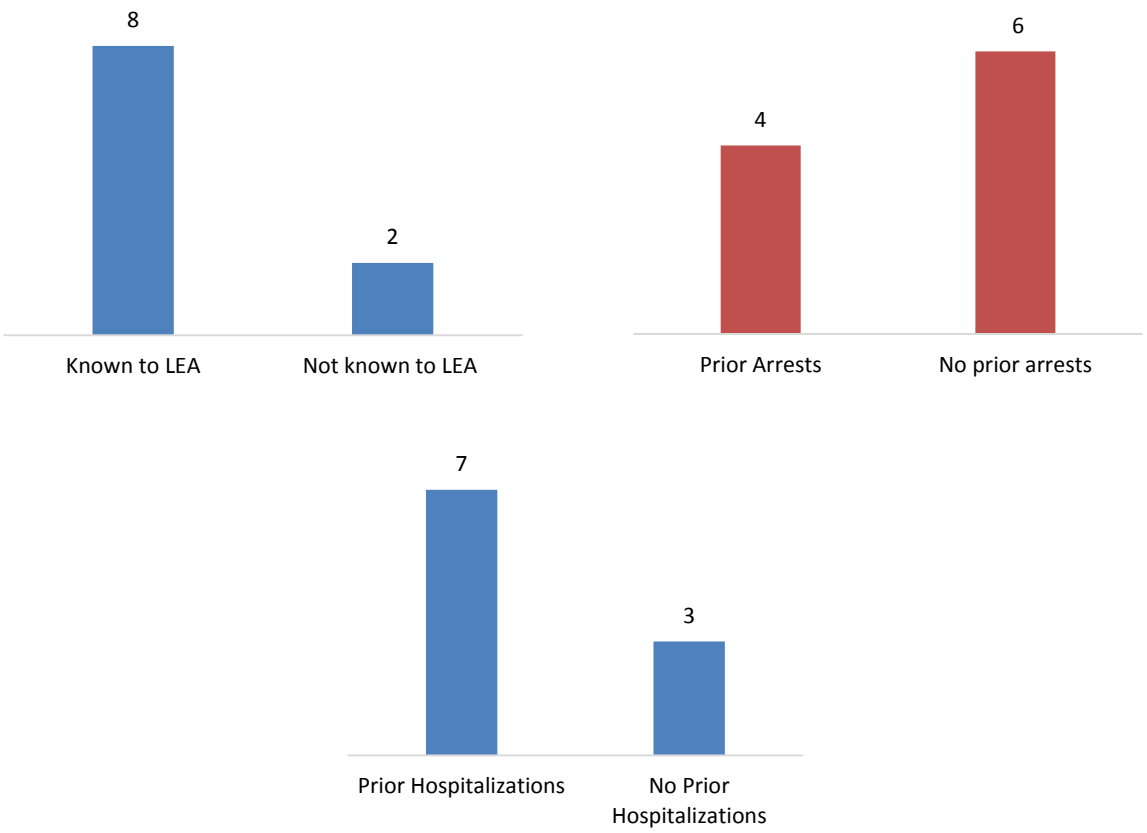
High Utilizers of CIP

High Utilizers' Psychosocial Profile

A subset of 10 individuals had more than one CIP encounter during the reporting period; this group had a total of 25 encounters between them, accounting for 23% of total CIP encounters. The number of CIP encounters for this group ranged from two to four. The following analyses look at service utilization patterns among these "high utilizer" consumers.

Demographically, nine out of ten high utilizers reported White race/ethnicity. All were unemployed. Most fell between the ages of 26-59 (seven out of ten), while three were in the range of 16-25 years. None were aged 60 or older. Seven out of ten high utilizers were female and 6 out of 10 were homeless. Eight out of ten high utilizers were known to law enforcement before their first CIP encounter, meaning that they had experienced previous interactions with police that did not necessarily result in arrest or incarceration. Seven clients reported a history of past psychiatric hospitalization. Figure 11 displays prior psychiatric and law enforcement information for high utilizers.

Figure 11. Prior Psychiatric and Law Enforcement Involvement, High Utilizers



High Utilizers' Outpatient and Inpatient Mental Health Utilization

High utilizers were compared to consumers with only one CIP encounter to investigate if there were different patterns of hospital and outpatient treatment utilization between the two groups. In terms of outpatient utilization, high utilizers received significantly more outpatient units of service during the reporting period than non-high utilizers.[1] This finding indicates that in addition to high CIP utilization, high utilizers also receive more outpatient treatment than non-high utilizers, both before and after their first CIP intervention. The same analysis could not be conducted for number of hospitalizations and average days per hospitalization because of the relative infrequency of hospitalizations among both high and non-high utilizers. Future analyses will include this inquiry as more data become available.

Outpatient and Inpatient Service Utilization

In total, ADMH provided 2,552 units of outpatient service to CIP consumers. Of the 90 unique consumers who had CIP encounters, 29 received ADMH outpatient services, and 33 had psychiatric hospitalizations

[1] High utilizers: M = 45.43, SD = 1.181; non-high utilizers: M = 37.47, SD = 1.186 (t(2717) = 5.46, p < 0.01). The units of service distributions were logarithmically transformed so as not to violate statistical assumptions to conduct the analysis. The means and standard deviations reported here are the anti-log of the transformed means.

during the reporting period. Of the total 2,552 outpatient units of service provided by ADMH, the top six types of services are displayed in Table 1.

Table 1. Top Services Provided to CIP Consumers by ADMH

Type of Service	Units of Service (UOS)	Percent of Total UOS
Rehab/ADL*	733	29%
Medication Support	515	20%
Targeted Case Management	482	19%
Collateral Services**	176	7%
E & M Est. Patient***	174	7%
Group Rehabilitation	113	4%

* Rehab/ADL refers to rehabilitation treatment and activities of daily living assessment
**Collateral Services refers to working with consumer's family or caregiver
*** E&M Est. Patient refers to evaluation and monitoring of established patients

To determine the extent to which CIP impacted mental health treatment utilization, we examined differences between the number of consumers enrolled in mental health treatment (outpatient and inpatient) before and after CIP encounters. We also assessed differences between the total number of units of service that were provided per person, as well as length of hospital stays, before and after CIP encounters. Likely due to the short amount of time that the program has been in operation, no significant differences were found in any of these analyses.

CIP Consumer and Caregiver/Family Member Satisfaction

Consumer satisfaction surveys were only administered to eight individuals following CIP encounter given the low level of follow-up. Table 2 shows the highest-rated statements on a 1 to 5 scale, with 5 indicating the highest level of satisfaction. Overall, respondents reported that CIP assisted them during their mental health crisis and that staff were respectful. However, as Table 3 indicates, consumers were less satisfied with follow-up services provided by CIP. They also felt that CIP taught them skills to prevent future crises to a lesser degree. These results are consistent with other findings that suggest opportunities to improve the follow-up process.

Table 2. Highest Rated Questions on Consumer Satisfaction Survey

Question	Score (out of 5)
I am satisfied with the CIP services I received.	4.29
CIP helped me during a mental health crisis.	4

CIP staff treated me with respect.	4

Table 3. Lowest Rated Questions on Consumer Satisfaction Survey

Question	Score (out of 5)
The CIP counselor reached out to me within one business day of the crisis.	3.14
CIP services taught me skills and tools to help prevent a future crisis.	3.43

Consumer satisfaction data should be interpreted with caution, given the small number of respondents to date. It is expected that future reports will provide a more robust understanding of consumers' satisfaction with CIP as more consumers and family members will have an opportunity to provide input.

Discussion

Yolo County's implementation of the Community Intervention Program presents an exciting opportunity to meet the needs of consumers with mental health crises, while simultaneously reducing overall costs for the county. So far, 90 unique consumers have been recipients of CIP services, who provided a total of 107 encounters between November 2014 and March 2015. Overall, the data gleaned from the current evaluation suggest that CIP can potentially have significant and meaningful impact on clients. Stakeholders can use the information provided in this report to understand the patterns of consumers who use their services and enhance programming to comprehensively meets consumers' needs, particularly the utilizers of multiple systems (i.e. inpatient, outpatient, crisis, criminal justice, etc.).

In terms of client profile, this evaluation report shows that CIP consumers are a disenfranchised population that is predominately White, non-Hispanic adults. Many consumers have low levels of education, inadequate housing, previous criminal justice system involvement, and a history of psychiatric hospitalizations. The majority of the crisis responses during the reporting period were due to 911 calls, or at the request of law enforcement agencies, which reflects the collaborative effort between Turning Point and law enforcement. However, due to the brief reporting period and slower than expected roll-out of field operations, CIP is still working toward the desired outcomes of reduced hospitalization and increased outpatient service utilization. As CIP continues to be implemented, it is anticipated that these changes in service utilization patterns will emerge. Another finding suggested that post-crisis follow-up is a not-yet-optimized opportunity to connect consumers to ongoing services. Going forward, it will be important to decrease barriers to successful follow-up, increase outreach and continuity of care, and ultimately, support better outcomes for consumers.

Additionally, in examining extensive usage of both CIP and ADMH services, we found that certain consumers had high levels of utilization in both service systems. Additionally, 80% of high utilizers were previously known to law enforcement, representing an important subset of consumers to continue to monitor to ascertain how CIP can best meet their needs. This is the first annual CIP evaluation report and future reports will continue to examine the consumer profile and types of services provided by CIP. In addition, future reports will explore changes in CIP consumers' level of service utilization over time, and whether the program is able to reduce utilization of costly services and future mental health crises.

Recommendations

The following recommendations are intended to guide adjustments to program delivery and better ensure that various program components (i.e. safety plans, follow-up, etc.) seamlessly function together.

Expand the sharing of referral packets and develop safety/wellness plans during all crisis interventions when possible. Referral packets contain important pieces of information for those suffering from mental health crisis, as well as their support systems. In light of earlier findings, which indicate that staff often are unable to reach CIP consumers after the crisis event, such referral packets may provide the only opportunity to encourage consumers to enroll in ongoing treatment. In addition, it may be useful to provide such packets to family members or caregivers involved in the care of consumers or others that may be at the scene of the crisis event. Also, in order to continue keeping consumers involved in their care, CIP should develop safety and wellness plans with all consumers and their caregivers when available. This practice may in turn support increasing the level of follow-up and linkage to services.

Continue to increase the level of follow-up support and linkage to ongoing services for CIP consumers. In order to improve the well-being of CIP consumers and reduce recurring mental health crises, CIP should strengthen its outreach to consumers after the initial crisis event. Wherever possible, the program may benefit from gathering more in-depth information during the crisis response about how to reach the person in the future. For example, if a consumer does not have a reliable phone number, the clinician could obtain a release to follow-up with family or friends or ask if he or she regularly visits a drop-in center. The CIP may also explore additional collaboration with law enforcement to help locate individuals, particularly when they are already known to law enforcement. Another suggestion is to set up a follow-up appointment with the consumer at the end of the crisis response, rather than leaving successful contact to chance.

Implement a data tracking process related to follow-up attempts, to better understand barriers to post-crisis engagement. Data should be gathered related to the number of attempts that CIP makes to contact the consumer, the method of attempt (e.g. phone, in-person), the result of the follow-up attempt (e.g. contact, no contact), and the ultimate outcome of follow-up (e.g. whether the person was ultimately enrolled in ongoing services, and how many and what types of follow-up encounters led to that linkage).

Continue to explore ways to increase administration of the consumer satisfaction survey. Consumer satisfaction surveys were administered to the eight individuals who had either a phone or in-person

follow-up contact. This finding suggests that though surveys are administered consistently when the opportunity to follow-up exists, the vast majority of CIP consumers have not yet had the opportunity to provide feedback on their satisfaction with the program. CIP should explore other opportunities to administer the survey and consider asking caregivers to complete it during the crisis response if feasible.

Expand use of alternatives to hospitalization for post-crisis response services when appropriate. In order for CIP consumers to receive care in the least restrictive setting available, CIP should expand linkages to residential services for consumers whose crises can be resolved without admittance to an inpatient setting. Currently, 24% of encounters ended with consumers being admitted to the hospital, and only 2% resulted in admittance to crisis residential services. By increasing the use of alternatives to hospitalization, consumers will be able to receive appropriate treatment without the upheaval often associated with hospitalization, which should also help the consumer maintain stability to mitigate future mental health crises.

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June 23, 2015

TO: MARK SAWYER, MENTAL HEALTH CLINICIAN

FROM: ROGER KINNEY, POLICE SERGEANT

SUBJECT: OUTSTANDING PERFORMANCE / 15088070

On Tuesday, June 16, 2015, approximately 1545 hours, I requested your assistance for a suicidal female at 3rd and "B" Street. The female was on top of a 150 foot tall metal tower, she would not communicate and was constantly moving around which led officers to believe she may jump.

You quickly arrived and began trying to build a dialogue with the female. She stood up and staggered around the top of the tower several times and we thought she would fall, this continued for over an hour. A friend of the female arrived and through your communication with this friend and then working with her, you were able to build a rapport with the suicidal female. You convinced the female to come down twenty feet to a cross beam, she nearly fell several times but you continued communication with her. You were able to keep her calm and then convinced her to allow the fire department to raise a ladder, she crawled down to the ground and you placed her on a 5150 W& I hold.

As she was placed in the police car, I saw she was in tears, I overhead her tell you, "I'm glad you kept talking to me, thank you."

It is my strong belief your communication with this suicidal female helped bring this incident to a safe and peaceful conclusion. I have been very impressed with your skill and dedication in the past, but your efforts during this call were exemplary and serve as an important reminder of how fortunate we are to have you working with our department.

Thank you for your dedication and commitment.

Sincerely,

ROGER KINNEY
Sergeant

Consumer Perception Survey Analysis

Both ADULT samples (2014 & 2015) were made up of ethnically white individuals (57% and 58%, respectively) and Hispanic individuals (21% and 24%, respectively). These groups make up 78% (in 2014) and 82% (in 2015) of our sample. Both samples contained comparable gender representations (2014: 40% Female, 41% Male, 19% unknown) and (2015: 42% Female, 49% Male, 9% unknown). Both ADULT samples overwhelmingly preferred to complete their surveys in English (97% and 98%, respectively). Thus, their needs and perceptions (i.e., coping, skills, and satisfaction with services) appear to have been influenced similarly by their composition in the following areas: sample size, ethnic make-up, gender make-up, and language comprehension.

From this analysis, it appears that there has **not been** a significant shift in ADULT consumer satisfaction scores from May 2014 to May 2015. Scores remain in the "Agree" (range: 4.00-4.99). Thus, ADULT consumers Agree that:

REGARDING SATISFACTION

1. They like the services they get
2. They would still get services from the MHP if they had other choices
3. They would recommend this agency to a friend or family member
4. They perceive that the location of services is convenient
5. They perceive that staff are willing to see them as often as they feel it is necessary
6. They perceive that staff return their calls within 24 hours
7. They perceive service times are good for them
8. They are able to get all the services they think they need
9. They are able to see a psychiatrist when they want to
10. They feel comfortable asking questions about their treatment and medication

REGARDING MHP COMPLIANCE

1. They feel free to complain
2. They are given info about their rights
3. They have been told about side effects to watch out for
4. They feel staff have respected their wishes about who should be given info about their treatment
5. They got to decide their treatment goals

REGARDING WELLNESS & RECOVERY

1. Staff believe that they can grow, change & recover
2. Staff encourage them to take responsibility for how they live their life
3. Staff give them info to help them manage their illness
4. They are encouraged to use consumer-run programs (groups, drop-in centers)

REGARDING CLIENT COPING SKILLS

1. They deal more effectively with daily problems
2. They are more in control of their lives
3. They are better able to deal with crisis
4. They are better able to take care of their needs
5. They are better able to handle things when they go wrong

REGARDING CLIENT SUPPORTS

1. They get support from family & friends when they are in crisis
2. Staff & psychiatry staff are available to them when consumers need them

Areas to Explore

Adult consumer satisfaction scores from May 2014 to May 2015 also indicate that there has not been a significant shift in consumer perception in the following areas pertaining to well-being:

Academic/ Work Skills

It appears that even though 79% (2014) and 76% (2015) of our samples are involved in some type work or academic-related activity, they do not perceive that they are doing better in those arenas. More supportive programming (e.g., academic tutoring, work-related socialization classes, work-related stress management courses, etc.) could be piloted at the Wellness Center or contracted out to workforce development programs.

Sense of Community (Belonging to a Community)

It appears that both point-in-time samples do not perceive that they "belong" to their community. There are many opportunities for the county to partner with groups, agencies, churches, volunteer programs (already existing, or in-development) that would provide this population with meaningful social interactions or a sense of contribution to society. There are many studies that can direct the MHP in structuring sound methods or interventions that would vastly improve the lives of consumers. Empirical evidence also points to health-related benefits obtained by recipients who engage in peer-to-peer programs and/ or community groups. Many outcome measures are also available to capture the gains or losses made by individuals who participate in these activities.

Life Satisfaction

It appears that both point-in-time samples do not perceive improvements on the life satisfaction indicator from 2014 to 2015. Both samples indicated that they had "Mixed" feelings about life satisfaction. As stated previously (about Sense of Community), there are many areas of life satisfaction that can be explored in our consumer population. Empirical studies have narrowed down different areas of life satisfaction (according to life span development) that correspond with improved health outcomes. Similar to previous remarks, life satisfaction can also be enhanced by linking consumers to peer-to-peer programs and/ or community groups. Many simplified outcome measures are also available to track overall life satisfaction in diverse populations.

Overall Health

It seems that one survey question related to overall consumer health might be too broad and/ or subjective to obtain a "true value" of overall consumer health. Taken as merely a perception of overall health, it seemed that the majority of consumers endorsed the response "Mixed" (in 2014 & 2015) when asked, "How do you feel about your health in general?" It might be better to capture this indicator with other concise, mixed-method (objective and subjective) questions in order to track overall client health.

Samantha Fusselman, LCSW, CPHQ
Clinical Program Manager, Quality Management
Yolo County Department of Health and Human Services
Adult and Aging Branch

SCORED ON A LIKERT SCALE (1-5):

1- **Strongly Disagree**
2- **Disagree**
3- **Undecided**
4- **Agree**
5- **Strongly Agree**

2015 ADULT RESULTS FOR YOLO COUNTY

DEMOGRAPHICS
(N = 240)

*Surveys Completed in English: 97%
* Surveys Completed in Spanish: 2.5%
* Surveys Completed in Russian: 0.5%

Genders Represented: 42% Female, 49% Male, 1% Other Gender, and 8% Unknown

Ethnicities Represented: 57% White, 24% Hispanic, 9% Black, 7% American Indian, 3% Asian, 1% Pacific Islander, 14% Other Race, 3% Unknown Race

Geographical Locations Represented: Woodland, West Sacramento, Davis

SATISFACTION W/ SERVICES — Mean Score: 4.29

Overall Satisfaction (#1-3):	4.37
Customer Satisfaction (#4-9; 11):	4.22

DIVERSITY FACTORS

18. Sensitive to Cultural Background/ Race/ Religion (*Group Factors*):	4.12

COMPLIANCE — Mean Score: 4.01

12. I felt free to complain	3.71
13. I was given information about my rights:	4.23
15. Staff told me side effects to watch for:	3.93
16. Staff respected wishes about who is to be given info about my treatment:	4.28
17. I decided my treatment goals:	3.90

WELLNESS & RECOVERY — Mean Score: 4.30

10. Staff believe that I can grow, change and recover:	4.47
14. Staff encourage me to take responsibility for how I live my life:	4.38
19. Staff gave me info so I could manage my illness:	4.22
20. I was encouraged to use consumer-run programs (groups, drop-in centers):	4.12

AS A RESULT OF SERVICES, ADULTS PERCEIVED THE FOLLOWING:

CLIENT'S PERCEPTION OF THEIR COPING SKILLS — Mean Score: 4.14

21. I deal more effectively with daily problems:	4.21
22. I am better able to control my life:	4.19
23. I am better able to deal with crisis:	4.05
30. I am better able to take care of my needs:	4.19
31. I am better able to handle things when they go wrong:	4.05

CLIENT'S PERCEPTION OF ACADEMIC/ WORK SKILLS	
26. Doing Better School/ Work:	3.93 *Did not pertain to 24% of sample
CLIENT'S SENSE OF BELONGING (COMMUNITY)	
35. I feel I belong in my community:	3.92
LEVEL OF SUPPORT	**Mean Score: 4.06**
36. Support from Family/ Friends in Crisis:	4.09
6. MHP Returned Calls within 24- hours:	4.15
9. I had access to a psychiatrist when I wanted to:	3.95

GENERAL HEALTH 12A. How do feel about your health:	**SCORED ON A LIKERT SCALE (1-7):** **1- Terrible** **2- Unhappy** **3- Mostly Dissatisfied** **4- Mixed** **5- Mostly Satisfied** **6- Pleased** **7- Delighted**	**MIXED** 4.73
GENERAL LIFE SATISFACTION: 1. How do feel about life in general:		**MIXED** 4.85

SCORED ON A LIKERT SCALE (1-5):

1- **Strongly Disagree**
2- **Disagree**
3- **Undecided**
4- **Agree**
5- **Strongly Agree**

ADULT RESULTS FOR YOLO COUNTY- 2014

DEMOGRAPHICS N = 243

*Surveys Completed in English: 98%
* Surveys Completed in Russian: 1%
* Surveys Completed in Spanish: 1%

Genders Represented: 40% Female, 41% Male, 19% Unknown

Ethnicities Represented: 58% White, 21% Hispanic, 7% American Indian, 6% Black, 3% Asian, 2% Pacific Islander, 12% Other Race, 2% Unknown Race

Geographical Locations Represented: Woodland, West Sacramento, Davis

SATISFACTION W/ SERVICES — Mean Score: 4.23

Overall Satisfaction (#1-3): 4.40, 4.18, 4.27	4.28
Customer Satisfaction (#4-9; 11):	4.17

DIVERSITY FACTORS

18. Sensitive to Cultural Background/ Race/ Religion (*Group Factors*):	4.26

COMPLIANCE — Mean Score: 4.07

12. I felt free to complain	3.98
13. I was given information about my rights:	4.19
15. Staff told me side effects to watch for:	3.93
16. Staff respected wishes about who to give treatment info to:	4.27
17. I decided my treatment goals:	3.98

WELLNESS & RECOVERY — Mean Score: 4.27

10. Staff believe that I can grow, change and recover:	4.46
14. Staff encourage me to take responsibility for how I live my life:	4.25
19. Staff gave me info so I could manage my illness:	4.21
20. I was encouraged to use consumer-run programs (groups, drop-in):	4.14

AS A RESULT OF SERVICES, ADULTS PERCEIVED THE FOLLOWING:

CLIENT'S PERCEPTION OF THEIR COPING SKILLS — Mean Score: 4.09

21. I deal more effectively with daily problems:	4.14
22. I am better able to control my life:	4.08
23. I am better able to deal with crisis:	4.10
30. I am better able to take care of my needs:	4.12
31. I am better able to handle things when they go wrong:	4.02

CLIENT'S PERCEPTION OF ACADEMIC/ WORK SKILLS

26. Doing Better School/ Work:	3.90
	*Did not pertain to 21% of sample

CLIENT'S SENSE OF BELONGING (COMMUNITY)

35. I feel I belong in my community:	3.92

LEVEL OF SUPPORT	**Mean Score: 4.06**
36. Support from Family/ Friends in Crisis:	4.04
6. MHP Returned Calls within 24- hours:	4.11
9. I had access to a psychiatrist when I wanted to:	4.03

SCORED ON A LIKERT SCALE (1-7):

1- **Terrible**
2- **Unhappy**
3- **Mostly Dissatisfied**
4- **Mixed**
5- **Mostly Satisfied**
6- **Pleased**
7- **Delighted**

GENERAL HEALTH	**MIXED**
12A. How do feel about your health:	4.72
GENERAL LIFE SATISFACTION:	**MIXED**
1. How do feel about life in general:	4.74

2016-2019 Strategic Plan Goals

- Goals adopted February 2015
- Key Initiatives in development, to be adopted October 2015

These goals are supported by the following guiding principles:

- Advance innovation
- Collaborate to maximize success
- Provide fiscally sound, dynamic and responsive services
- Strategically align our organization
- Engage and empower our residents

Meaning: expanded definition of the Strategic Plan Goal

Key Concepts: actionable items reflected in the meaning

Goal: **Robust Economy**

Meaning: *A balanced, thriving economy that offers job opportunities for every resident who wants to work, ample services and up-to-date infrastructure and technology for long term sustainability.*

Key Concepts

Create an environment to support quality jobs that are right for Yolo County and our residents	**Support job growth, housing and community balance throughout the county**	**Understand our economy to adapt to opportunities and threats**	**Provide a climate that makes it easier for business to succeed**	**Promote the benefits of doing business in Yolo County**
Attract industries and jobs that support our strengths of agriculture, research and services	Seek a healthy regional workforce distribution between employers concentrated in cities and those located in the unincorporated county	Understand our economy and improve our services and infrastructure to adapt quickly to opportunities and threats	Support business growth and job creation by encouraging investment locally and with streamlined regulations and processes	Foster a fair and equitable marketplace with businesses of all types and sizes to support job creation and growth

Goal: **Thriving Residents**

Meaning: *Social, economic and physical environments are created and supported which promote good health and protect vulnerable populations so that community members and future generations have the opportunity to learn and grow to their full potential.*

Key Concepts

Promote healthy communities	**Protect and support vulnerable populations**	**Protect consumers**	**Achieve and maintain self-sufficiency**
Create and improve physical and social environments and expand community resources that enable residents to make healthy lifestyle choices, decrease their risk of chronic disease and develop to their maximum potential	Protect and support those at risk for physical, emotional or economic harm (including the poor, mentally ill, elderly, homeless, physically disabled, families with children and children at risk for abuse, delinquency or already under jurisdiction of the Court)	Consumers are protected from fraud, public health threats, safety hazards, substandard housing and blighted conditions.	Provide services (including safety net) and opportunities that support the economic security and wellness of residents so they can contribute to the stability of themselves, their families, the community and future generations

Goal: **Safe Communities**

Meaning: *Safe communities and homes are maintained through informed offender case management, an appropriate blend of criminal justice supervision and evidence-based treatment strategies, and code enforcement of unsafe conditions*	**Key Concepts**			
	Ensure safe communities Hold offenders accountable, restore victims and enforce code requirements to protect residents and visitors from unfair practices and unsafe conditions	**Emphasize behavior change** Case manage and treat offenders with an emphasis on behavior change, recidivism reduction and regulatory compliance without compromising public safety or contributing to further victimization	**Employ evidence-based criminal justice practices** Exercise collaboration among criminal justice partners are to ensure practices, policies and operating standards that have been proven to effectively reduce crime and an offender's likelihood to reoffend	**Provide legal representation** Provide quality representation through zealous advocacy that protects the liberty, constitutional rights and livelihood of vulnerable and indigent clients

Goal: **Flourishing Agriculture**

Meaning: *Support a vibrant and resilient agricultural economy that concurrently preserves sufficient farmland to maintain regional food security in perpetuity.*	**Key Concepts**		
	Support economic viability Prevent foreign pest infestations, provide equity in the marketplace, assist in regulatory processes and set policy to support long-term economic sustainability	**Maintain and enhance infrastructure** Maintain a transportation and distribution network; provide training and technical support; facilitate access to water, raw and renewable materials, energy; and provide storage facilities and waste and recycling resources for ag	**Ensure land availability** Preserve and protect agricultural lands for food, fiber and livestock production through mitigation, easements and land use planning

Goal: **Sustainable Environment**

Meaning: *Efficient utilization of natural resources to provide recreational opportunities and ensure availability for generations to come, protect and improve water quality and quantity, lower greenhouse gas emissions, maximize the use of renewable energy*	**Key Concepts**			
	Efficiently manage natural and renewable resources Protect natural areas to maintain open space and habitat for public access with sustainable revenue and maximize material reuse, recycling and resource reclamation	**Protect open space and provide recreational opportunities** Maintain and enhance existing recreational facilities for residents and facilitate regional tourism	**Protect and improve water and air quality** Eliminate sources of contamination water, soil and air to ensure protection of public health and the environment , including the Delta, surface and ground water resources.	**Lower green house gas emissions** Restructure and/or incentivize reduction of activities that may contribute to climate change and related impacts

COUNTY OF YOLO

Health and Human Services Agency

Joan Planell
Director

137 N. Cottonwood Street • Woodland, CA 95695
(530) 661-2750 • www.yolocounty.org

TO: **LMHB Members**

FROM: **Bob Schelen, Chair and James Glica-Hernandez, Secretary**

SUBJECT: **Proposed amendment to the LMHB Bylaws:**

We are seeking a proposed change in the by-laws. After reading the Yolo County Counsel interpretation of the Brown Act and how they apply to our Board, we are requesting the elimination of Section 15 of the by-laws and replacing it with a new Section 15 as follows:

"The Chair shall appoint, with Executive Committee advice, Ad-Hoc Committees of this Board that shall deal with the specific and general needs of the population of Yolo County in terms of the mission of the Local Mental Health Board, oversight of the administration, and programs of the County Departments, such as the Yolo County within the Health and Human Services Agency. Ad-Hoc Committees shall serve at the Chair's leisure, with permission of the Board."

Attachment: LMHB By-laws, dated December 11, 2013

YOLO COUNTY DEPARTMENT OF ALCOHOL, DRUG AND MENTAL HEALTH

LOCAL MENTAL HEALTH BOARD

137 N. Cottonwood Street, Suite 2500
Woodland CA 95695
Office – 530-666-8516
Fax – 530-666-8294

BYLAWS

ARTICLE I

SECTION I: MISSION, VALUES AND RESPONSIBILITIES

Mission:

Yolo County Local Mental Health Board supports the wellness, recovery, and resilience of all Yolo County residents through the identification of local mental health assets and needs, informed advocacy and education and collaboration with policymakers, service providers, consumers, and family members.

Values:

- Every person deserves well-being and quality of life
- Every person has value, importance and is unique
- Meaningful consumer and family participation
- Cultural sensitivity, appropriateness, and appreciation for the diversity of the region
- Highest quality, integrated services and supports
- Strong social safety net
- Political and personal accountability
- Advocacy beyond the minimum mandated care
- Evaluation and evidence based decision making

Duties and Responsibilities: *(Welfare and Institutions Code, Section 5604; Yolo County Ordinance 2-2.1302)*

The Yolo County Mental Health Board shall:

1. Review and evaluate the Yolo County mental health needs, facilities, services and special problems.
2. Review any county agreements or contracts entered into pursuant to Section 5650 of the Welfare and Institutions Code.
3. Advise the governing body and the local mental health director as to any aspect of the local mental health program.
4. Review and approve the procedures used to insure citizen and professional involvement in all stages of the planning process.
5. Submit an annual report to the County Board of Supervisors on the needs of performance of the county's mental health system.
6. Review and make recommendations on applicants for the appointment of a local director of mental health services. The Mental Health Board shall be included in the selection process prior to the vote of the Governing Body.

7. Review and comment on the county's performance outcome data and communicate its findings to the California Mental Health Department, the Board of Supervisors and the State Mental Health Commission.
8. Assess the impact of the realignment of services from the state to the county on services delivered to clients and the local community as required by Section 5604.2 (b) Welfare and Institutions Code.

SECTION II: RELATIONSHIP WITH THE COUNTY BOARD OF SUPERVISORS

It is the intent of the Board to maintain excellent relations with the Yolo County Board of Supervisors. The primary role of the Board is to advise the County Board of Supervisors on all mental health issues in Yolo County as defined by the California Welfare and Institutions Code.

SECTION III: RELATIONSHIP WITH THE COUNTY DIRECTOR OF MENTAL HEALTH

It is the intent of the Board to maintain a collaborative and supportive relationship with the County Director of Mental Health and staff.

SECTION IV: MEMBERSHIP

The Mental Health Board shall consist of sixteen (16) members appointed by the Board of Supervisors as follows:

(a) Permanent members: There shall one permanent member of the board, who shall be a member of the Board of Supervisors.

(b) Rotating members: There shall be fifteen (15) rotating members appointed as follows:

  (1) At least fifty (50%) percent of the members shall be consumers or the parents, spouse sibling, or adult children of consumers, who are receiving or received mental health services;

  (2) At least (20%) of the total membership shall be consumers and at least twenty (20%) percent of the total membership shall be families of consumers.

(c) The Board of Supervisors shall, through its appointments to the Mental Health Board, strive to reflect the ethnic diversity of the client population of the County.

(d) The Board of Supervisors is encouraged to appoint individuals who have experience and knowledge of the mental health system.

SECTION V: MEMBERSHIP TERMS

The initial terms of the fifteen (15) rotating members of the Mental Health Board shall be as follows:

(a) Five (5) members shall be appointed for a three (3) year term.

(b) Five (5) members shall be appointed for a two (2) year term.

(c) Five (5) members shall be appointed for a one-year term.

(d) Thereafter, as vacancies occur, subsequent appointments shall be made for three (3) year terms.

(e) Membership shall be effective upon appointment by the Board of Supervisors. However, all terms shall be deemed to have commenced on February 1 following the initial appointment, and thereafter all terms shall be aligned to begin on February 1 and end on January 31.

(f) There shall be an equal number of appointees by each member of the Board of Supervisors.

(g) No member of the Mental Health Board or his or her spouse shall be a full-time or part-time county employee of a County mental health service, an employee of the State Department of Mental Health, or an employee of, or a paid member of the governing body of, a Bronzan-McCorquodale contract agency.

(h) A member of the Mental Health Board shall abstain from voting on any issue in which the member has a financial interest as defined in Section 87103 of the California Government Code.

(i) If, prior to the expiration of a term, a member ceases to retain the status which qualified the member for appointment to the Mental Health Board, the membership of the member shall be terminated, and a vacancy shall be declared.

(j) If it is not possible to secure membership as specified from among persons who reside in the County, the Board of Supervisors may substitute representatives of the public interest in mental health who are not full-time or part-time employees of the County mental health service, the State Department of Mental Health, or on the staff of, or a paid member of the governing body of, a Bronzan-McCorquodale contract agency. (§ 5, Ord. 1159, eff. May 20, 1993)

SECTION VI: VACANCIES

When a vacancy occurs, the board chair shall contact the appropriate governing board member to determine if she/he has a candidate for the vacancy and/or if the member would consider recommendations from the Mental Health Board.

SECTION VII: TERMINATION

The term of office of a rotating member who has three (3) consecutive unexcused absences from meetings of the Mental Health Board may be terminated by the Board of Supervisors after notification to the member and the Mental Health Board. The vacancy thereby created shall be filled by the appointment of another representative of the same group for the remainder of the unexpired term of the member being replaced. A person so appointed may then serve a maximum of two (2) additional terms following the completion of the unexpired term.

SECTION VIII: QUORUM

A quorum for meetings of the Mental Health Board shall consist of not less than one-half (1/2) of the currently appointed members. A majority vote of the members present shall be required for any motion, resolution, or other action. (§ 6, Ord. 1159, eff. May 20, 1993)

SECTION IX: BOARD SELF-EVALUATION

Each year the Board shall conduct a Board Self-evaluation, which shall address issues of effective Board operation and governance and accomplishment of Board statutory requirements and annual goals.

SECTION X: OFFICERS

The officers shall be a chairperson and a vice-chairperson who shall be Mental Health Board members and who shall serve on a yearly basis and be subject to election by a majority of the Board present and voting by a majority of the Board present and voting in May of each year. A secretary may be elected, unless secretarial staff is otherwise provided.

SECTION XI: MEETINGS

The Board shall be subject to the provisions of Chapter 9 (commencing with Section 54950) of Part I of Division 2 of Title 5 of the Governing Code, relating to meeting of local agencies (The Brown Act.) The Board will meet at least ten (10) times annually.

SECTION XII: REIMBURSEMENT FOR EXPENSES

Members of the Mental Health Board shall receive reimbursements for their actual and necessary expenses incurred in the performance of their duties outside the boundaries of the County. A member shall obtain written approval form the Mental Health Director prior to attending any event outside the boundaries of the County for which the member wishes to be reimbursed. Odometer reading and receipts will be required for reimbursement in accordance with the rules established by the County Auditor-Controller. Reimbursements shall be budgeted and charged against County Mental Health funds and shall be subject to the budgets limitations and restriction placed on such funds.

SECTION XIII: RESPONSIBILITIES OF OFFICERS

The Chair shall be the principal Board officer, shall Chair Board meetings and serve as the Board's chief spokesperson. He/she shall carry out the policies of the Board and shall do everything necessary to carry into effect the Board's statutory responsibilities and additional Board goals.

The Vice-Chair shall do everything necessary to assist the Chair in the performance of his/her duties. In the event of absence of the Chair, the Vice-Chair shall exercise all powers of Chair.

The Secretary shall take the minutes of the Executive Committee meetings, review the minutes of the Mental Health Board prior to public distribution and assist the Chair and Vice-Chair in the performance of their duties.

SECTION XIV: REMOVAL OF OFFICERS

An officer may be removed from office, for cause by the majority vote of all members casting secret ballots at an official Board meeting.

Adequate formal notice, in writing and person, must be given to an officer of such an impending removal action.

SECTION XV: STANDING COMMITTEES

There are three standing committees of the Board appointed by the Board Chair. The purpose of the standing committees shall be to assist and support the Board by carrying out specific tasks assigned as needed by the Board Chair and/or the Board. A subcommittee cannot take formal action on behalf of the Board without prior authorization of the Board. All LMH Board members are welcome and encouraged to attend subcommittee meetings. The standing committees are:

Advocacy and Finance: The Advocacy and Finance Committee shall provide leadership to the Board by reviewing and reporting on legislative proposals, considering budget and funding issues for mental health in Yolo County and ensuring all advising functions of the Board are carried out.

Communications and Education: The Communications and Education Committee shall provide leadership by assisting the Board inform the public on mental health issues in Yolo County,

developing education opportunities for the Board and coordinating the development of the Board's annual report required by the Health and Welfare Code and Yolo County Ordinance.

Program: The Program committee shall provide leadership to the Board on the review and evaluation Yolo County mental health needs, facilities, services and special problems required Welfare and Institutions Code and Yolo County Ordinance.

The Chairs of each of the three standing committees shall serve on the Executive Committee of the Board

SECTION XVI: SECTION XVII: EXECUTIVE COMMITTEE

The Executive Committee of the Board shall consist of the Board Chair, Vice Chair, Secretary (if appointed), Chair of the Advocacy and Finance Committee, Chair of the Communications and Education Committee, and Chair of the Program Committee. The Executive Committee shall meet as needed as determined by the Board Chair.

SECTION XVII: SUB COMMITTEES AND OTHER SPECIAL COMMITTEES

The Chair may at any time appoint task and time specific committees of the board to address strategic goals, projects or studies. These committees shall be for a time certain and will disband upon completion of the assigned task. (§ 10, Ord. 1159, eff. May 20, 1993)

SECTION XVIII: RULES OF ORDER

The authority of the Brown Act shall govern meetings of this organization and Roberts Rules of Order modified to allow open participation of the Chair, who may also set discussion time limits as appropriate.

ARTICLE II

SECTION I: AMENDMENTS

These bylaws may be amended at any meeting of this organization by a two-thirds vote of the appointed membership of the Yolo County Mental Health Board. These bylaws shall be reviewed periodically to insure compliance with State Law.

SECTION II: EFFECTIVE DATE

These bylaws shall go into effect and become effective immediately upon their adoption.

The Board shall meet and provide opportunities for client and general public input at least once per year in the cities of Davis, Woodland and West Sacramento California. The Board may at its discretion add additional locations as deemed necessary.

SECTION III: CODE OF ETHICS

A code of ethics should include, but not be limited to the following:

As a member of the Yolo County Local Mental Health Board, I:

- Will become knowledgeable about the duties and mission of the Mental Health Board, and promote those to the publics with whom I have influence;
- Will give necessary time, thought, and study to the work of the Board;
- Will attend regular meetings, and participate in committee meetings;
- Will be fully and carefully prepared for each meeting by doing the required reading and completing the necessary tasks for Board and committee work;
- Will work with fellow Board members in a spirit of harmony and cooperation;
- Will respect other speakers and listen to other viewpoints;
- Will share viewpoints, and despite differences of opinion, abide by and uphold final decisions of the board;
- Will abide by the purpose of the Brown Act;
- Will disqualify myself from discussion and vote on an issue where there is a conflict of interest or if the outcome will grant me or my employer any pecuniary or material benefits; and
- The code of ethics should be discussed with new board members and reviewed at least yearly by all members.

LMHB Budget & Finance (B&F) Committee Report,
Meeting to Plan Coming Year, June 22, 2015

Attendees: Richard Bellows, Chair, Nicki King, Robert Schelen, LMBH Chair

Start: About 8:10PM **Adjourn:** 8:35 PM

Meeting Summary:

During the LMHB meeting earlier that evening, Jim Provenza stated that the Board of Supervisors has approved a preliminary budget, which added funding for another round of Bridge-to-Housing. Jim anticipates some additional funding from the state. The final budget will be approved in Sept.

The B&F committee was pleased with the additional funding for Bridge-to-Housing. Further, the meeting decided to provide additional recommendations to the BOS when additional funding becomes available. We will meet again as a committee with Karen Larson to prioritize recommendations. These recommendations will be presented to the LMHB in an upcoming meeting. The LMHB would need to approve any recommendations prior to the Sept. BOS meeting. Dick will contact Jim Provenza in regard to the timing of that meeting.

The meeting also discussed getting involved in an extension of the Metrics Committee. However, Bob felt that this would be the responsibility of the Program Committee under the current committee system.

Richard Bellows, Chair of B&F Committee