CLAYTON CHAU, MD PhD
DIRECTOR/COUNTY HEALTH OFFICER

JEFFREY A. NAGEL, PH.D.
DIRECTOR
BEHAVIORAL HEALTH SERVICES

405 W. 5th STREET, 7th FLOOR
SANTA ANA, CA 92701

www.ochealthinfo.com

BEHAVIORAL HEALTH SERVICES

BHS UPDATE

DATE: January 20, 2021

TO: Members of the County of Orange Mental Health Board
Members of the County of Orange Alcohol and Drug Advisory Board

FROM: Jeffrey A. Nagel, Ph.D.
Behavioral Health Director

SUBJECT: Behavioral Health Services (BHS) Update for January 2021

Adult and Older Adult Behavioral Health Services (AOABH)

Crisis Services: The County's **Crisis Stabilization Unit** (CSU) census has been increased to 10 recliners due to the ability to test for Covid-19 and isolate 3 individuals at a time pending results. **In Home Crisis Stabilization** services continues to provide warm handoffs at the County CSU and the program is working to conduct all warm hand offs in person. All adult **Crisis Residential** facilities remain fully operational and have required Covid-19 testing starting in June. The Request for Proposal (RFP) for the North and South regions went out to bid and closed on 1/11/21; the RFP panel process is now underway. Additionally, on 10/6/20 the Board of Supervisors (BOS) approved two contracts with Exodus Recovery, Inc. that will provide Crisis Residential Services at HCA's **Be Well Campus** location in the form of 15 beds and a Crisis Stabilization services at the North Campus location in the form of 16 recliners for adults and 8 recliners for adolescents. The planning and contract implementation process is under way and the Medi-Cal certification and designation process has started. HCA is planning to open with voluntary clients on 2/1/21 and then involuntary clients after designation is granted shortly thereafter.

Residential Treatment Services: Residential Treatment Services is pleased to announce that Telecare is projected to open its services for Orange County's first **Sobering Station** 1/25/21.

Older Adult Services (OAS): For the months of November and December, Older Adult Services programs admitted 64 new cases. Field visits in all **OAS programs** have continued to gradually increase. OAS staff are also continuing telephone sessions with clients to address anxiety, isolation, and depression due to Covid-19 and underlying mental health conditions.

Contracted Services: College Community Services Anaheim has relocated to 511 N Brookhurst St. Suite 200, Anaheim CA 92801 as of 1/19/21. The phone number and fax number remain the same.

All **SUD Providers** continue to remain open and are providing services on site including drug testing, individual and group counseling services. Telehealth and telephonic services are offered as needed.

AOABH Collaborative Services: The Homeless Mentally Ill Outreach and Treatment (HMIOT) Grant which funded the intensive mobile services at **TAO Central FSP** ended on 12/31/20. TAO Central will be able to continue providing mobile services through the end of June 2021 using existing budget. At this time, BHS are exploring options to be able to continue providing mobile services next fiscal year. All adult FSP programs remain open and are providing services via telehealth, telephone or in person as needed. **Prop. 47** system navigators are coordinating with **Correctional Health Services** staff to do in-reach and linkage to appropriate services upon release.

Children, Youth and Prevention Behavioral Health Services (CYPBHS)

The **Children and Youth Behavioral Health (CYBH) outpatient clinic** in Santa Ana relocated to their new clinic site in the city of Orange on 1/12/21. The new address is 500 City Parkway West Suite 200, Orange, CA 92868. The CYBH outpatient clinic provides behavioral health services to children, adolescents (ages 0-20), and their families. Service offered to clients include assessment, individual and family therapy, case management, crisis intervention/intensive services, and medication support.

HCA entered into a Specialty Mental Health Services contract for **Short-Term Residential Therapeutic Programs (STRTP)** with 3 agencies as follows:

1. ChildHelp, Inc. STRTP contract is effective 11/16/20 - 6/30/21. ChildHelp will have three STRTP sites, with five beds each, for a total of 15 beds.
2. Hart Community Homes STRTP contract is effective 12/1/20 – 6/30/21. Hart will have two STRTP sites, with six beds each, for a total of 12 beds.
3. The Teen Project, Inc. STRTP contract is effective 1/1/21 – 6/30/21. Teen Project will have one STRTP site with six beds.

The STRTPs are utilized for the placement of children, youth and Non-Minor Dependents, ages 10 through 21, who are wards of the court through Social Services Agency or Juvenile Probation. The overarching goal of the STRTPs is to provide trauma-informed therapeutic interventions and integrated programming designed to address barriers to a youth's ability to safely transition and reside in a home-based family setting in support of permanency and the youth's well-being. The STRTPs are expected to provide a range of services, of varying intensity, tailored to the individual needs of the youth, which can be adjusted during his/her stay in the program and as they transition from the STRTP to a home-based family setting.

Prevention and Intervention: A new interactive app for students – **"*you and*"** has been developed using CARES Act funding. The **Phoenix House** has launched an app and website ***you and***, designed to help students manage the stressors that have resulted from the Covid-19 pandemic and resent school closures. The ***you and*** application aims to increase resiliency and provide young people with support and a welcoming virtual community during social isolation. As part of the program, students in grades K-12 receive an interactive 6-lesson evidence- based virtual curriculum series focused on improving social-emotional learning competencies, increasing positive character attributes, decreasing negative behaviors, and foster youth connectedness. The curriculum is accompanied by Workbooks and materials that align and reinforce the lesson's objective. The ***you and*** app is available to all Orange County schools. For more information, please go to the website https://youandapp.org. A promo video showcasing the app and its features https://vimeo.com/481553086/1b0b11c1db and a welcome video https://vimeo.com/481706005 The ***you and*** app is available for download through the iOS Apple store and the Google Play store. To learn how to bring ***you and*** to your school and/or community, contact Giovanna Sanguinetti at gsanguinetti@phoenixhouseca.org.

The **Adult Opioid Prevention Campaign**, "**Wrong for You**" is being refreshed and relaunched beginning in January. The goal of this campaign is to continue increasing awareness of Opioid misuse, especially now during this pandemic, where adults may be experiencing more life stressors and challenges. The relaunch of the campaign, from mid-January to mid- March, will focus on strategic use of social/digital media, local cable stations (e.g., Discovery, History, Fox Sports West, National Geographic), and print media. New to the relaunch will be radio spots on two public stations, KUSC and KPCC, which match our target audience profile.

Navigation: OC Links extended its hours Monday through Thursday from 6pm to 8pm, as the COVID-19 strategy modifications continue until OC Links is transitioned to be the 24/7 behavioral health line at the end of January 2021.

Mental Health Services Act (MHSA) Coordination

The MHSA Steering Committee met on 1/11/21. At the meeting, there was a presentation on the recent **COVID-19 Stress/Parent Survey** outcomes presented by the MHSA Coordinator, Dr. Sharon Ishikawa. Following that presentation the Chorus team from UCLA, as well as MHSA Steering Committee Member Linda Smith, presented and gave a demonstration on the **Digital Resource Navigator Innovation Project**. The MHSA Steering Committee will not be meeting during the month of February but will be invited to

the MHB/ADAB Study Meeting on 2/10/21, for a CEO Budget Quarterly MHSA Update. HCA will present the MHSA Budgets by component to the Steering Committee members on March 1.

Currently the MHSA Office is planning a series of **Community Engagement Meetings** collaborating with different targeted Community Based Organizations. The meetings will take place throughout the month of February and into the first week of March.

WELFARE AND INSTITUTIONS CODE - WIC

DIVISION 5. COMMUNITY MENTAL HEALTH SERVICES [5000 - 5952]

(Division 5 repealed and added by Stats. 1967, Ch. 1667.)

PART 2. THE BRONZAN-MCCORQUODALE ACT [5600 - 5772]

(Heading of Part 2 amended by Stats. 1992, Ch. 1374, Sec. 14.)

CHAPTER 1. General Provisions [5600 - 5623.5] [5848]

(Chapter 1 added by Stats. 1968, Ch. 989.)

5600.

(a) This part shall be known and may be cited as the Bronzan-McCorquodale Act. This part is intended to organize and finance community mental health services for persons with mental health disorders in every county through locally administered and locally controlled community mental health programs. It is furthermore intended to better utilize existing resources at both the state and local levels in order to improve the effectiveness of necessary mental health services; to integrate state-operated and community mental health programs into a unified mental health system; to ensure that all mental health professions be appropriately represented and utilized in the mental health programs; to provide a means for participation by local governments in the determination of the need for and the allocation of mental health resources under the jurisdiction of the state; and to provide a means of allocating mental health funds deposited in the Local Revenue Fund equitably among counties according to community needs.

(b) With the exception of those referring to Short-Doyle Medi-Cal services, any other provisions of law referring to the Short-Doyle Act shall be construed as referring to the Bronzan-McCorquodale Act.

(Amended by Stats. 2014, Ch. 144, Sec. 100. (AB 1847) Effective January 1, 2015.)

5600.1.

The mission of California's mental health system shall be to enable persons experiencing severe and disabling mental illnesses and children with serious emotional disturbances to access services and programs that assist them, in a manner tailored to each individual, to better control their illness, to achieve their personal goals, and to develop skills and supports leading to their living the most constructive and satisfying lives possible in the least restrictive available settings.

(Amended by Stats. 1991, Ch. 611, Sec. 35. Effective October 7, 1991.)

5600.2.

To the extent resources are available, public mental health services in this state should be provided to priority target populations in systems of care that are client-centered, culturally competent, and fully accountable, and which include the following factors:

(a) Client-Centered Approach. All services and programs designed for persons with mental disabilities should be client centered, in recognition of varying individual goals, diverse needs, concerns, strengths, motivations, and disabilities. Persons with mental disabilities:
(1) Retain all the rights, privileges, opportunities, and responsibilities of other citizens unless specifically limited by federal or state law or regulations.
(2) Are the central and deciding figure, except where specifically limited by law, in all planning for treatment and rehabilitation based on their individual needs. Planning should also include family members and friends as a source of information and support.
(3) Shall be viewed as total persons and members of families and communities. Mental health services should assist clients in returning to the most constructive and satisfying lifestyles of their own definition and choice.
(4) Should receive treatment and rehabilitation in the most appropriate and least restrictive environment, preferably in their own communities.
(5) Should have an identifiable person or team responsible for their support and treatment.
(6) Shall have available a mental health advocate to ensure their rights as mental health consumers pursuant to Section 5521.
(b) Priority Target Populations. Persons with serious mental illnesses have severe, disabling conditions that require treatment, giving them a high priority for receiving available services.
(c) Systems of Care. The mental health system should develop coordinated, integrated, and effective services organized in systems of care to meet the unique needs of children and youth with serious emotional disturbances, and adults, older adults, and special populations with serious mental illnesses. These systems of care should operate in conjunction with an interagency network of other services necessary for individual clients.
(d) Outreach. Mental health services should be accessible to all consumers on a 24-hour basis in times of crisis. Assertive outreach should make mental health services available to homeless and hard-to-reach individuals with mental disabilities.
(e) Multiple Disabilities. Mental health services should address the special needs of children and youth, adults, and older adults with dual and multiple disabilities.
(f) Quality of Service. Qualified individuals trained in the client-centered approach should provide effective services based on measurable outcomes and deliver those services in environments conducive to clients' well-being.
(g) Cultural Competence. All services and programs at all levels should have the capacity to provide services sensitive to the target populations' cultural diversity. Systems of care should:
(1) Acknowledge and incorporate the importance of culture, the assessment of cross-cultural relations, vigilance towards dynamics resulting from cultural differences, the expansion of cultural knowledge, and the adaptation of services to meet culturally unique needs.
(2) Recognize that culture implies an integrated pattern of human behavior, including language, thoughts, beliefs, communications, actions, customs, values, and other institutions of racial, ethnic, religious, or social groups.
(3) Promote congruent behaviors, attitudes, and policies enabling the system, agencies, and mental health professionals to function effectively in cross-cultural institutions and communities.

(h) Community Support. Systems of care should incorporate the concept of community support for individuals with mental disabilities and reduce the need for more intensive treatment services through measurable client outcomes.
(i) Self-Help. The mental health system should promote the development and use of self-help groups by individuals with serious mental illnesses so that these groups will be available in all areas of the state.
(j) Outcome Measures. State and local mental health systems of care should be developed based on client-centered goals and evaluated by measurable client outcomes.
(k) Administration. Both state and local departments of mental health should manage programs in an efficient, timely, and cost-effective manner.
(l) Research. The mental health system should encourage basic research into the nature and causes of mental illnesses and cooperate with research centers in efforts leading to improved treatment methods, service delivery, and quality of life for mental health clients.
(m) Education on Mental Illness. Consumer and family advocates for mental health should be encouraged and assisted in informing the public about the nature of mental illness from their viewpoint and about the needs of consumers and families. Mental health professional organizations should be encouraged to disseminate the most recent research findings in the treatment and prevention of mental illness.
(Amended by Stats. 1992, Ch. 1374, Sec. 15. Effective October 28, 1992.)

5600.3.
To the extent resources are available, the primary goal of the use of funds deposited in the mental health account of the local health and welfare trust fund should be to serve the target populations identified in the following categories, which shall not be construed as establishing an order of priority:
(a) (1) Seriously emotionally disturbed children or adolescents.
(2) For the purposes of this part, "seriously emotionally disturbed children or adolescents" means minors under the age of 18 years who have a mental disorder as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance use disorder or developmental disorder, which results in behavior inappropriate to the child's age according to expected developmental norms. Members of this target population shall meet one or more of the following criteria:
(A) As a result of the mental disorder, the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community; and either of the following occur:
(i) The child is at risk of removal from home or has already been removed from the home.
(ii) The mental disorder and impairments have been present for more than six months or are likely to continue for more than one year without treatment.
(B) The child displays one of the following: psychotic features, risk of suicide or risk of violence due to a mental disorder.
(C) The child has been assessed pursuant to Article 2 (commencing with Section 56320) of Chapter 4 of Part 30 of Division 4 of Title 2 of the Education Code and determined to have an

emotional disturbance, as defined in paragraph (4) of subdivision (c) of Section 300.8 of Title 34 of the Code of Federal Regulations.
(b) (1) Adults and older adults who have a serious mental disorder.
(2) For the purposes of this part, “serious mental disorder” means a mental disorder that is severe in degree and persistent in duration, which may cause behavioral functioning which interferes substantially with the primary activities of daily living, and which may result in an inability to maintain stable adjustment and independent functioning without treatment, support, and rehabilitation for a long or indefinite period of time. Serious mental disorders include, but are not limited to, schizophrenia, bipolar disorder, post-traumatic stress disorder, as well as major affective disorders or other severely disabling mental disorders. This section shall not be construed to exclude persons with a serious mental disorder and a diagnosis of substance abuse, developmental disability, or other physical or mental disorder.
(3) Members of this target population shall meet all of the following criteria:
(A) The person has a mental disorder as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a substance use disorder or developmental disorder or acquired traumatic brain injury pursuant to subdivision (a) of Section 4354 unless that person also has a serious mental disorder as defined in paragraph (2).
(B) (i) As a result of the mental disorder, the person has substantial functional impairments or symptoms, or a psychiatric history demonstrating that without treatment there is an imminent risk of decompensation to having substantial impairments or symptoms.
(ii) For the purposes of this part, “functional impairment” means being substantially impaired as the result of a mental disorder in independent living, social relationships, vocational skills, or physical condition.
(C) As a result of a mental functional impairment and circumstances, the person is likely to become so disabled as to require public assistance, services, or entitlements.
(4) For the purpose of organizing outreach and treatment options, to the extent resources are available, this target population includes, but is not limited to, persons who are any of the following:
(A) Homeless persons who are mentally ill.
(B) Persons evaluated by appropriately licensed persons as requiring care in acute treatment facilities including state hospitals, acute inpatient facilities, institutes for mental disease, and crisis residential programs.
(C) Persons arrested or convicted of crimes.
(D) Persons who require acute treatment as a result of a first episode of mental illness with psychotic features.
(5) California veterans in need of mental health services and who meet the existing eligibility requirements of this section, shall be provided services to the extent services are available to other adults pursuant to this section. Veterans who may be eligible for mental health services through the United States Department of Veterans Affairs should be advised of these services by the county and assisted in linking to those services, but the eligible veteran shall not be denied county mental or behavioral health services while waiting for a determination of eligibility for, and availability of, mental or behavioral health services provided by the United States Department of Veterans Affairs.

(A) An eligible veteran shall not be denied county mental health services based solely on his or her status as a veteran, including whether or not the person is eligible for services provided by the United States Department of Veterans Affairs.
(B) Counties shall refer a veteran to the county veterans service officer, if any, to determine the veteran's eligibility for, and the availability of, mental health services provided by the United States Department of Veterans Affairs or other federal health care provider.
(C) Counties should consider contracting with community-based veterans' services agencies, where possible, to provide high-quality, veteran specific mental health services.
(c) Adults or older adults who require or are at risk of requiring acute psychiatric inpatient care, residential treatment, or outpatient crisis intervention because of a mental disorder with symptoms of psychosis, suicidality, or violence.
(d) Persons who need brief treatment as a result of a natural disaster or severe local emergency.
(Amended by Stats. 2018, Ch. 128, Sec. 2. (AB 2325) Effective January 1, 2019.)

5600.35.
(a) Services should be encouraged in every geographic area to the extent resources are available for clients in the target population categories described in Section 5600.3.
(b) Services to the target populations should be planned and delivered so as to ensure statewide access by members of the target populations, including all ethnic groups in the state.
(Added by Stats. 1991, Ch. 89, Sec. 69. Effective June 30, 1991.)

5600.4.
Community mental health services should be organized to provide an array of treatment options in the following areas, to the extent resources are available:
(a) Precrisis and Crisis Services. Immediate response to individuals in precrisis and crisis and to members of the individual's support system, on a 24-hour, seven-day-a-week basis. Crisis services may be provided offsite through mobile services. The focus of precrisis services is to offer ideas and strategies to improve the person's situation, and help access what is needed to avoid crisis. The focus of crisis services is stabilization and crisis resolution, assessment of precipitating and attending factors, and recommendations for meeting identified needs.
(b) Comprehensive Evaluation and Assessment. Includes, but is not limited to, evaluation and assessment of physical and mental health, income support, housing, vocational training and employment, and social support services needs. Evaluation and assessment may be provided offsite through mobile services.
(c) Individual Service Plan. Identification of the short- and long-term service needs of the individual, advocating for, and coordinating the provision of these services. The development of the plan should include the participation of the client, family members, friends, and providers of services to the client, as appropriate.
(d) Medication Education and Management. Includes, but is not limited to, evaluation of the need for administration of, and education about, the risks and benefits associated with medication. Clients should be provided this information prior to the administration of

medications pursuant to state law. To the extent practicable, families and caregivers should also be informed about medications.
(e) Case Management. Client-specific services that assist clients in gaining access to needed medical, social, educational, and other services. Case management may be provided offsite through mobile services.
(f) Twenty-four Hour Treatment Services. Treatment provided in any of the following: an acute psychiatric hospital, an acute psychiatric unit of a general hospital, a psychiatric health facility, an institute for mental disease, a community treatment facility, or community residential treatment programs, including crisis, transitional and long-term programs.
(g) Rehabilitation and Support Services. Treatment and rehabilitation services designed to stabilize symptoms, and to develop, improve, and maintain the skills and supports necessary to live in the community. These services may be provided through various modes of services, including, but not limited to, individual and group counseling, day treatment programs, collateral contacts with friends and family, and peer counseling programs. These services may be provided offsite through mobile services.
(h) Vocational Rehabilitation. Services which provide a range of vocational services to assist individuals to prepare for, obtain, and maintain employment.
(i) Residential Services. Room and board and 24-hour care and supervision.
(j) Services for Homeless Persons. Services designed to assist mentally ill persons who are homeless, or at risk of being homeless, to secure housing and financial resources.
(k) Group Services. Services to two or more clients at the same time.
(Amended by Stats. 1993, Ch. 1245, Sec. 9. Effective October 11, 1993.)

5600.5.
The minimum array of services for children and youth meeting the target population criteria established in subdivision (a) of Section 5600.3 should include the following modes of service in every geographical area, to the extent resources are available:
(a) Precrisis and crisis services.
(b) Assessment.
(c) Medication education and management.
(d) Case management.
(e) Twenty-four-hour treatment services.
(f) Rehabilitation and support services designed to alleviate symptoms and foster development of age appropriate cognitive, emotional, and behavioral skills necessary for maturation.
(Amended by Stats. 1992, Ch. 1374, Sec. 18. Effective October 28, 1992.)

5600.6.
The minimum array of services for adults meeting the target population criteria established in subdivision (b) of Section 5600.3 should include the following modes of service in every geographical area, to the extent resources are available:
(a) Precrisis and crisis services.
(b) Assessment.

(c) Medication education and management.
(d) Case management.
(e) Twenty-four-hour treatment services.
(f) Rehabilitation and support services.
(g) Vocational services.
(h) Residential services.
(Repealed and added by Stats. 1991, Ch. 89, Sec. 75. Effective June 30, 1991.)

5600.7.
The minimum array of services for older adults meeting the target population criteria established in subdivision (b) of Section 5600.3 should include the following modes of service in every geographical area, to the extent resources are available:
(a) Precrisis and crisis services, including mobile services.
(b) Assessment, including mobile services.
(c) Medication education and management.
(d) Case management, including mobile services.
(e) Twenty-four-hour treatment services.
(f) Residential services.
(g) Rehabilitation and support services, including mobile services.
(Amended by Stats. 1991, Ch. 611, Sec. 41. Effective October 7, 1991.)

5600.9.
(a) Services to the target populations described in Section 5600.3 should be planned and delivered to the extent practicable so that persons in all ethnic groups are served with programs that meet their cultural needs.
(b) Services in rural areas should be developed in flexible ways, and may be designed to meet the needs of the indigent and uninsured who are in need of public mental health services because other private services are not available.
(c) To the extent permitted by law, counties should maximize all available funds for the provision of services to the target populations. Counties are expressly encouraged to develop interagency programs and to blend services and funds for individuals with multiple problems, such as those with mental illness and substance abuse, and children, who are served by multiple agencies. State departments are directed to assist counties in the development of mechanisms to blend funds and to seek any necessary waivers which may be appropriate.
(Amended by Stats. 1991, Ch. 611, Sec. 42. Effective October 7, 1991.)

5601.
As used in this part:
(a) “Governing body” means the county board of supervisors or boards of supervisors in the case of counties acting jointly; and in the case of a city, the city council or city councils acting jointly.

(b) “Conference” means the County Behavioral Health Directors Association of California as established under former Section 5757.
(c) Unless the context requires otherwise, “to the extent resources are available” means to the extent that funds deposited in the mental health account of the local health and welfare fund are available to an entity qualified to use those funds.
(d) “Part 1” refers to the Lanterman-Petris-Short Act (Part 1 (commencing with Section 5000)).
(e) “Director of Health Care Services” or “director” means the Director of the State Department of Health Care Services.
(f) “Institution” includes a general acute care hospital, a state hospital, a psychiatric hospital, a psychiatric health facility, a skilled nursing facility, including an institution for mental disease as described in Chapter 1 (commencing with Section 5900) of Part 5, an intermediate care facility, a community care facility or other residential treatment facility, or a juvenile or criminal justice institution.
(g) “Mental health service” means any service directed toward early intervention in, or alleviation or prevention of, mental disorder, including, but not limited to, diagnosis, evaluation, treatment, personal care, day care, respite care, special living arrangements, community skill training, sheltered employment, socialization, case management, transportation, information, referral, consultation, and community services.
(Amended by Stats. 2015, Ch. 455, Sec. 32. (SB 804) Effective January 1, 2016.)

5602.
The board of supervisors of every county, or the boards of supervisors of counties acting under the joint powers provisions of Article 1 (commencing with Section 6500) of Chapter 5 of Division 7 of Title 1 of the Government Code shall establish a community mental health service to cover the entire area of the county or counties. Services of the State Department of Health Care Services shall be provided to the county, or counties acting jointly, or, if both parties agree, the state facilities may, in whole or in part, be leased, rented or sold to the county or counties for county operation, subject to terms and conditions approved by the Director of General Services.
(Amended by Stats. 2012, Ch. 34, Sec. 117. (SB 1009) Effective June 27, 2012.)

5604.
(a) (1) Each community mental health service shall have a mental health board consisting of 10 to 15 members, depending on the preference of the county, appointed by the governing body, except that boards in counties with a population of less than 80,000 may have a minimum of five members. A county with more than five supervisors shall have at least the same number of members as the size of its board of supervisors. This section does not limit the ability of the governing body to increase the number of members above 15.
(2) (A) The board serves in an advisory role to the governing body, and one member of the board shall be a member of the local governing body. Local mental health boards may recommend appointees to the county supervisors. The board membership should reflect the diversity of the client population in the county to the extent possible.

(B) Fifty percent of the board membership shall be consumers, or the parents, spouses, siblings, or adult children of consumers, who are receiving or have received mental health services. At least 20 percent of the total membership shall be consumers, and at least 20 percent shall be families of consumers.
(C) In addition to consumers and family members referenced in subparagraph (B), counties are encouraged to appoint individuals who have experience with and knowledge of the mental health system. This would include members of the community that engage with individuals living with mental illness in the course of daily operations, such as representatives of county offices of education, large and small businesses, hospitals, hospital districts, physicians practicing in emergency departments, city police chiefs, county sheriffs, and community and nonprofit service providers.
(3) (A) In counties with a population that is less than 80,000, at least one member shall be a consumer, and at least one member shall be a parent, spouse, sibling, or adult child of a consumer, who is receiving, or has received, mental health services.
(B) Notwithstanding subparagraph (A), a board in a county with a population that is less than 80,000 that elects to have the board exceed the five-member minimum permitted under paragraph (1) shall be required to comply with paragraph (2).
(b) The mental health board shall review and evaluate the local public mental health system, pursuant to Section 5604.2, and advise the governing body on community mental health services delivered by the local mental health agency or local behavioral health agency, as applicable.
(c) The term of each member of the board shall be for three years. The governing body shall equitably stagger the appointments so that approximately one-third of the appointments expire in each year.
(d) If two or more local agencies jointly establish a community mental health service pursuant to Article 1 (commencing with Section 6500) of Chapter 5 of Division 7 of Title 1 of the Government Code, the mental health board for the community mental health service shall consist of an additional two members for each additional agency, one of whom shall be a consumer or a parent, spouse, sibling, or adult child of a consumer who has received mental health services.
(e) (1) Except as provided in paragraph (2), a member of the board or the member's spouse shall not be a full-time or part-time county employee of a county mental health service, an employee of the State Department of Health Care Services, or an employee of, or a paid member of the governing body of, a mental health contract agency.
(2) A consumer of mental health services who has obtained employment with an employer described in paragraph (1) and who holds a position in which the consumer does not have any interest, influence, or authority over any financial or contractual matter concerning the employer may be appointed to the board. The member shall abstain from voting on any financial or contractual issue concerning the member's employer that may come before the board.
(f) Members of the board shall abstain from voting on any issue in which the member has a financial interest as defined in Section 87103 of the Government Code.
(g) If it is not possible to secure membership as specified in this section from among persons who reside in the county, the governing body 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 Health Care Services, or on the staff of, or a paid member of the governing body of, a mental health contract agency.
(h) The mental health board may be established as an advisory board or a commission, depending on the preference of the county.
(Amended by Stats. 2019, Ch. 460, Sec. 3. (AB 1352) Effective January 1, 2020.)

5604.1.
Local mental health advisory boards shall be subject to the provisions of Chapter 9 (commencing with Section 54950) of Part 1 of Division 2 of Title 5 of the Government Code, relating to meetings of local agencies.
(Amended by Stats. 1992, Ch. 1374, Sec. 21. Effective October 28, 1992.)

5604.2.
(a) The local mental health board shall do all of the following:
(1) Review and evaluate the community's public mental health needs, services, facilities, and special problems in any facility within the county or jurisdiction where mental health evaluations or services are being provided, including, but not limited to, schools, emergency departments, and psychiatric facilities.
(2) Review any county agreements entered into pursuant to Section 5650. The local mental health board may make recommendations to the governing body regarding concerns identified within these agreements.
(3) Advise the governing body and the local mental health director as to any aspect of the local mental health program. Local mental health boards may request assistance from the local patients' rights advocates when reviewing and advising on mental health evaluations or services provided in public facilities with limited access.
(4) Review and approve the procedures used to ensure citizen and professional involvement at all stages of the planning process. Involvement shall include individuals with lived experience of mental illness and their families, community members, advocacy organizations, and mental health professionals. It shall also include other professionals that interact with individuals living with mental illnesses on a daily basis, such as education, emergency services, employment, health care, housing, law enforcement, local business owners, social services, seniors, transportation, and veterans.
(5) Submit an annual report to the governing body on the needs and 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 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 Behavioral Health Planning Council.
(8) This part does not limit the ability of the governing body to transfer additional duties or authority to a mental health board.

(b) It is the intent of the Legislature that, as part of its duties pursuant to subdivision (a), the board shall assess the impact of the realignment of services from the state to the county, on services delivered to clients and on the local community.
(Amended by Stats. 2019, Ch. 460, Sec. 4. (AB 1352) Effective January 1, 2020.)

5604.3.
(a) The board of supervisors may pay from any available funds the actual and necessary expenses of the members of the mental health board of a community mental health service incurred incident to the performance of their official duties and functions. The expenses may include travel, lodging, childcare, and meals for the members of an advisory board while on official business as approved by the director of the local mental health program.
(b) Governing bodies are encouraged to provide a budget for the local mental health board, using planning and administrative revenues identified in subdivision (c) of Section 5892, that is sufficient to facilitate the purpose, duties, and responsibilities of the local mental health board.
(Amended by Stats. 2019, Ch. 460, Sec. 5. (AB 1352) Effective January 1, 2020.)

5604.5.
The local mental health board shall develop bylaws to be approved by the governing body which shall do all of the following:
(a) Establish the specific number of members on the mental health board, consistent with subdivision (a) of Section 5604.
(b) Ensure that the composition of the mental health board represents and reflects the diversity and demographics of the county as a whole, to the extent feasible.
(c) Establish that a quorum be one person more than one-half of the appointed members.
(d) Establish that the chairperson of the mental health board be in consultation with the local mental health director.
(e) Establish that there may be an executive committee of the mental health board.
(Amended by Stats. 2019, Ch. 460, Sec. 6. (AB 1352) Effective January 1, 2020.)

5607.
The local mental health services shall be administered by a local director of mental health services to be appointed by the governing body. He or she shall meet such standards of training and experience as the State Department of Health Care Services, by regulation, shall require. Applicants for these positions need not be residents of the city, county, or state, and may be employed on a full or part-time basis. If a county is unable to secure the services of a person who meets the standards of the State Department of Health Care Services, the county may select an alternate administrator.
(Amended by Stats. 2012, Ch. 34, Sec. 119. (SB 1009) Effective June 27, 2012.)

5608.

The local director of mental health services shall have the following powers and duties:
(a) Serve as chief executive officer of the community mental health service responsible to the governing body through administrative channels designated by the governing body.
(b) Exercise general supervision over mental health services provided under this part.
(c) Recommend to the governing body, after consultation with the advisory board, the provision of services, establishment of facilities, contracting for services or facilities and other matters necessary or desirable in accomplishing the purposes of this division.
(d) Submit an annual report to the governing body reporting all activities of the program, including a financial accounting of expenditures and a forecast of anticipated needs for the ensuing year.
(e) Carry on studies appropriate for the discharge of his or her duties, including the control and prevention of mental disorders.
(f) Possess authority to enter into negotiations for contracts or agreements for the purpose of providing mental health services in the county.
(Amended by Stats. 1991, Ch. 89, Sec. 92. Effective June 30, 1991.)

5610.

(a) Each county mental health system shall comply with reporting requirements developed by the State Department of Health Care Services, in consultation with the California Behavioral Health Planning Council and the Mental Health Services Oversight and Accountability Commission, which shall be uniform and simplified. The department shall review existing data requirements to eliminate unnecessary requirements and consolidate requirements which are necessary. These requirements shall provide comparability between counties in reports.
(b) The department shall develop, in consultation with the Performance Outcome Committee, the California Behavioral Health Planning Council, and the Mental Health Services Oversight and Accountability Commission, pursuant to Section 5611, and with the California Health and Human Services Agency, uniform definitions and formats for a statewide, nonduplicative client-based information system that includes all information necessary to meet federal mental health grant requirements and state and federal Medicaid reporting requirements, and any other state requirements established by law. The data system, including performance outcome measures reported pursuant to Section 5613, shall be developed by July 1, 1992.
(c) Unless determined necessary by the department to comply with federal law and regulations, the data system developed pursuant to subdivision (b) shall not be more costly than that in place during the 1990–91 fiscal year.
(d) (1) The department shall develop unique client identifiers that permit development of client-specific cost and outcome measures and related research and analysis.
(2) The department's collection and use of client information, and the development and use of client identifiers, shall be consistent with clients' constitutional and statutory rights to privacy and confidentiality.
(3) Data reported to the department may include name and other personal identifiers. That information is confidential and subject to Section 5328 and any other state and federal laws regarding confidential client information.

(4) Personal client identifiers reported to the department shall be protected to ensure confidentiality during transmission and storage through encryption and other appropriate means.
(5) Information reported to the department may be shared with local public mental health agencies submitting records for the same person and that information is subject to Section 5328.
(e) All client information reported to the department pursuant to Chapter 2 (commencing with Section 4030) of Part 1 of Division 4 and Sections 5328 to 5772.5, inclusive, Chapter 8.9 (commencing with Section 14700), and any other state and federal laws regarding reporting requirements, consistent with Section 5328, shall not be used for purposes other than those purposes expressly stated in the reporting requirements referred to in this subdivision.
(f) The department may adopt emergency regulations to implement this section in accordance with the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code). The adoption of emergency regulations to implement this section that are filed with the Office of Administrative Law within one year of the date on which the act that added this subdivision took effect shall be deemed to be an emergency and necessary for the immediate preservation of the public peace, health and safety, or general welfare and shall remain in effect for no more than 180 days.
(Amended by Stats. 2017, Ch. 511, Sec. 6. (AB 1688) Effective January 1, 2018.)

5611.
(a) The Director of State Hospitals shall establish a Performance Outcome Committee, to be comprised of representatives from the Public Law 99-660 Planning Council and the County Behavioral Health Directors Association of California. Any costs associated with the performance of the duties of the committee shall be absorbed within the resources of the participants.
(b) Major mental health professional organizations representing licensed clinicians may participate as members of the committee at their own expense.
(c) The committee may seek private funding for costs associated with the performance of its duties.
(Amended by Stats. 2015, Ch. 455, Sec. 33. (SB 804) Effective January 1, 2016.)

5612.
(a) (1) The Performance Outcome Committee shall develop measures of performance for evaluating client outcomes and cost effectiveness of mental health services provided pursuant to this division. The reporting of performance measures shall utilize the data collected by the State Department of Mental Health in the client-specific, uniform, simplified, and consolidated data system. The performance measures shall take into account resources available overall, resource imbalance between counties, other services available in the community, and county experience in developing data and evaluative information.

(2) During the 1992–93 fiscal year, the committee shall include measures of performance for evaluating client outcomes and cost-effectiveness of mental health services provided by state hospitals.
(b) The committee should consider outcome measures in the following areas:
(1) Numbers of persons in identified target populations served.
(2) Estimated number of persons in identified target populations in need of services.
(3) Treatment plans development for members of the target population served.
(4) Treatment plan goals met.
(5) Stabilization of living arrangements.
(6) Reduction of law enforcement involvement and jail bookings.
(7) Increase in employment or education activities.
(8) Percentage of resources used to serve children and older adults.
(9) Number of patients' rights advocates and their duties.
(10) Quality assurance activities for services, including peer review and medication management.
(11) Identification of special projects, incentives, and prevention programs.
(c) Areas identified for consideration by the committee are for guidance only.
(Amended by Stats. 1992, Ch. 1374, Sec. 30. Effective October 28, 1992.)

5613.
(a) Counties shall annually report data on performance measures established pursuant to Section 5612 to the local mental health advisory board and to the Director of Health Care Services.
(b) The Director of Health Care Services shall annually make data on county performance available to the Legislature, and post that data on the department's Internet Web site, by no later than March 15 of each year.
(Amended by Stats. 2014, Ch. 476, Sec. 1. (AB 2679) Effective January 1, 2015.)

5614.
(a) The department, in consultation with the Compliance Advisory Committee that shall have representatives from relevant stakeholders, including, but not limited to, local mental health departments, local mental health boards and commissions, private and community-based providers, consumers and family members of consumers, and advocates, shall establish a protocol for ensuring that local mental health departments meet statutory and regulatory requirements for the provision of publicly funded community mental health services provided under this part.
(b) The protocol shall include a procedure for review and assurance of compliance for all of the following elements, and any other elements required in law or regulation:
(1) Financial maintenance of effort requirements provided for under Section 17608.05.
(2) Each local mental health board has approved procedures that ensure citizen and professional involvement in the local mental health planning process.
(3) Children's services are funded pursuant to the requirements of Sections 5704.5 and 5704.6.

(4) The local mental health department complies with reporting requirements developed by the department.
(5) To the extent resources are available, the local mental health department maintains the program principles and the array of treatment options required under Sections 5600.2 to 5600.9, inclusive.
(6) The local mental health department meets the reporting required by the performance outcome systems for adults and children.
(c) The protocol developed pursuant to subdivision (a) shall focus on law and regulations and shall include, but not be limited to, the items specified in subdivision (b). The protocol shall include data collection procedures so that state review and reporting may occur. The protocol shall also include a procedure for the provision of technical assistance, and formal decision rules and procedures for enforcement consequences when the requirements of law and regulations are not met. These standards and decision rules shall be established through the consensual stakeholder process established by the department.
(Amended by Stats. 2001, Ch. 159, Sec. 191. Effective January 1, 2002.)

5614.5.
(a) The department, in consultation with the Quality Improvement Committee which shall include representatives of the California Behavioral Health Planning Council, local mental health departments, consumers and families of consumers, and other stakeholders, shall establish and measure indicators of access and quality to provide the information needed to continuously improve the care provided in California's public mental health system.
(b) The department in consultation with the Quality Improvement Committee shall include specific indicators in all of the following areas:
(1) Structure.
(2) Process, including access to care, appropriateness of care, and the cost effectiveness of care.
(3) Outcomes.
(c) Protocols for both compliance with law and regulations and for quality indicators shall include standards and formal decision rules for establishing when technical assistance, and enforcement in the case of compliance, will occur. These standards and decision rules shall be established through the consensual stakeholder process established by the department.
(d) The department shall report to the legislative budget committees on the status of the efforts in Section 5614 and this section by March 1, 2001. The report shall include presentation of the protocols and indicators developed pursuant to this section or barriers encountered in their development.
(Amended by Stats. 2017, Ch. 511, Sec. 7. (AB 1688) Effective January 1, 2018.)

5615.
If they so elect, cities that were operating independent public mental health programs on January 1, 1990, shall continue to receive direct payments.
(Amended by Stats. 1991, Ch. 89, Sec. 102. Effective June 30, 1991.)

5616.
Nothing in this part shall prevent any city or combination of cities from owning, financing, and operating a mental health program.
(Amended by Stats. 1991, Ch. 89, Sec. 104. Effective June 30, 1991.)

5618.
Mental health plans shall be responsible for providing information to potential clients, family members, and caregivers regarding specialty Medi-Cal mental health services offered by the mental health plans upon request of the individual. This information shall be written in a manner that is easy to understand and is descriptive of the complete services offered.
(Added by Stats. 2000, Ch. 93, Sec. 53. Effective July 7, 2000.)

5622.
(a) A licensed inpatient mental health facility, as described in subdivision (c) of Section 1262 of the Health and Safety Code, operated by a county or pursuant to a county contract, shall, prior to the discharge of any patient who was placed in the facility, prepare a written aftercare plan. The aftercare plan, to the extent known, shall specify the following:
(1) The nature of the illness and followup required.
(2) Medications, including side effects and dosage schedules. If the patient was given an informed consent form with his or her medications, the form shall satisfy the requirement for information on side effects of the medications.
(3) Expected course of recovery.
(4) Recommendations regarding treatment that are relevant to the patient's care.
(5) Referrals to providers of medical and mental health services.
(6) Other relevant information.
(b) Any person undergoing treatment at a facility under the Lanterman-Petris-Short Act or a county Bronzan-McCorquodale facility and the person's conservator, guardian, or other legally authorized representative shall be given a written aftercare plan prior to being discharged from the facility. The person shall be advised by facility personnel that he or she may designate another person to receive a copy of the aftercare plan.
(c) A copy of the aftercare plan shall be given to any person designated under subdivision (b). A patient who is released from any local treatment facility described in subdivision (c) of Section 1262 of the Health and Safety Code on a voluntary basis may refuse any or all services under the written aftercare plan.
(Amended by Stats. 1997, Ch. 512, Sec. 2. Effective January 1, 1998.)

5623.5.
Commencing October 1, 1991, and to the extent resources are available, no county shall deny any person receiving services administered by the county mental health program access to any medication which has been prescribed by the treating physician and approved by the federal Food and Drug Administration and the Medi-Cal program for use in the treatment of psychiatric illness. *(Added by Stats. 1991, Ch. 89, Sec. 107. Effective June 30, 1991.)*

5848.

(a) Each three-year program and expenditure plan and update shall be developed with local stakeholders, including adults and seniors with severe mental illness, families of children, adults, and seniors with severe mental illness, providers of services, law enforcement agencies, education, social services agencies, veterans, representatives from veterans organizations, providers of alcohol and drug services, health care organizations, and other important interests. Counties shall demonstrate a partnership with constituents and stakeholders throughout the process that includes meaningful stakeholder involvement on mental health policy, program planning, and implementation, monitoring, quality improvement, evaluation, and budget allocations. A draft plan and update shall be prepared and circulated for review and comment for at least 30 days to representatives of stakeholder interests and any interested party who has requested a copy of the draft plans.

(b) The mental health board established pursuant to Section 5604 shall conduct a public hearing on the draft three-year program and expenditure plan and annual updates at the close of the 30-day comment period required by subdivision (a). Each adopted three-year program and expenditure plan and update shall include any substantive written recommendations for revisions. The adopted three-year program and expenditure plan or update shall summarize and analyze the recommended revisions. The mental health board shall review the adopted plan or update and make recommendations to the local mental health agency or local behavioral health agency, as applicable, for revisions. The local mental health agency or local behavioral health agency, as applicable, shall provide an annual report of written explanations to the local governing body and the State Department of Health Care Services for any substantive recommendations made by the local mental health board that are not included in the final plan or update.

(c) The plans shall include reports on the achievement of performance outcomes for services pursuant to Part 3 (commencing with Section 5800), Part 3.6 (commencing with Section 5840), and Part 4 (commencing with Section 5850) funded by the Mental Health Services Fund and established jointly by the State Department of Health Care Services and the Mental Health Services Oversight and Accountability Commission, in collaboration with the County Behavioral Health Directors Association of California.

(d) Mental health services provided pursuant to Part 3 (commencing with Section 5800) and Part 4 (commencing with Section 5850) shall be included in the review of program performance by the California Behavioral Health Planning Council required by paragraph (2) of subdivision (c) of Section 5772 and in the local mental health board's review and comment on the performance outcome data required by paragraph (7) of subdivision (a) of Section 5604.2.

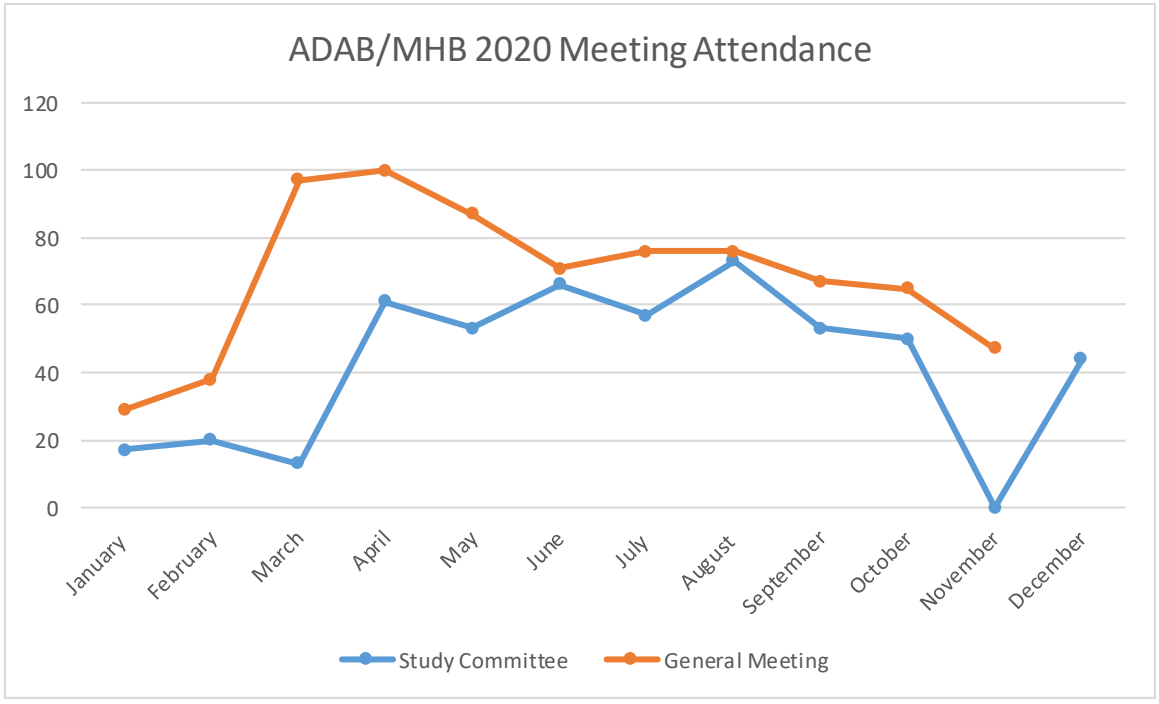
(e) The department shall annually post on its internet website a summary of the performance outcomes reports submitted by counties if clearly and separately identified by counties as the achievement of performance outcomes pursuant to subdivision (c).

(f) For purposes of this section, "substantive recommendations made by the local mental health board" means any recommendation that is brought before the board and approved by a majority vote of the membership present at a public hearing of the local mental health board that has established its quorum.

(Amended by Stats. 2019, Ch. 460, Sec. 7. (AB 1352) Effective January 1, 2020.)

Orange County Mental Health Board
2020 ACTION PLAN

	Initiative/Desired Outcome	Person/Persons leading initiative	Time Frame
1	**Increase interaction with Board of Supervisors & Policy Makers** • Each member who is a BOS representative will be responsible for regular and ongoing communication with their respective BOS • Continue working on filling vacancies for District Representatives • MHB members to participate in community meetings, city council meetings and 2 BOS meetings • Assess what other counties are doing	Vacant– 1st District Nita Tewari – 2nd District Vacant – 3rd District Duan Tran – 4th District Jim Taylor– 5th District Matt, Michaell to support All MHB	Ongoing Ongoing
2	**Increase community participation at BHAB meetings & Community Events** • Host 2 outreach community events (listening tour) • Hold two MHB meetings out in the community in the evening • Community Workshops/ Have public members tell their stories • Assess what other counties are doing to increase participation • Explore options for Advertising/Marketing of events (Social Media) • Learn more about community planning process	Matt, Joy, Sandy, and Steve	Ongoing February/April October
3	**Combine meeting and site tours** • Host 2 meetings in the community (focus Adults) • 1- SUD and 1-MH	Karla to support coordination	June & September
4	**Increase MHB knowledge in Focus Areas:** • Focus Areas: Youth Behavioral Health, Older Adults, Substance Use Disorder (SUD) • Understanding the Public Health Population Health Model- Possible Joint meeting with a Public Health committee	Karla to coordinate presentations	Ongoing
5	**Find Opportunities for Collaboration with other County Departments** • Increase our knowledge about what other county departments are doing that may overlap with mental health. Finding points of synergy and opportunities to work together	Matt, Sandy, and Clayton	Ongoing October
6	**Annual Report** • Create 2019 MHB Report • Create 2020 BHAB Report	Michaell and Karla to spearhead but all MHB involved	Feb. 2020 November 2020


ADAB/MHB 2020 Meeting Attendance
120
100
80
60
40
20
0
January
February
March
April
May
June
July
August
September
October
November
December
Study Committee
General Meeting