

January 15, 2014

1:30 to 5:00 p.m.

Kona Kai Resort & Marina

Bay Conference Room

1551 Shelter Island Drive San Diego, CA 92106

619.221.8000

ITEM #	TIME	TOPIC	TAB	PAGE
1.	1:30	Introductions and Agenda Review Barbara Mitchell, <i>Co-Chair</i>		
2.	1:35	New Business Adam Nelson, Co-Chair		
3.	1:40	Impacts of Federal Policy on State Supportive Housing Programs – <i>Simmons Ruff, Director, Corp. for Supportive Housing-San Diego</i> Barbara Mitchell, Co-Chair	A	19
3a.	2:30	<i>Discussion and Next steps</i>		
4.	2:45	Overview/Orientation to the Advocacy Committee Adam Nelson, Co-Chair	B	33
5.	3:15	Review and Approve Minutes Barbara Mitchell, Co-Chair	C	35
	3:20	Break		
6.	3:40	Overview of Budget Process Adam Nelson, Co-Chair	D	43
7.	4:10	Governor's Proposed Budget for 2014-15 Barbara Mitchell, Co-Chair	E	53
8.	4:30	Questions/ Clarifications, Public Comment		
9.	4:40	W3 (who does what by when) Barbara Mitchell, Co-Chair		
10.	4:45	Develop Report Out for General Session Adam Nelson, Co-Chair		
11.	4:50	Plus/Delta Barbara Mitchell, Co-Chair		
12.	4:55	Plan Agenda for next meeting Andi Murphy, Staff		

Committee Members: (as of Nov. 2013)

Co-Chairs:

Barbara Mitchell

Adam Nelson

John Ryan
Monica Wilson
Karen Bachand
Caron Collins

Sandra Wortham
Nadine Ford
Daphne Shaw
Chloe Walker

Staff:

Andi Murphy

California Mental Health Planning Council

Vision and Mission

CHAIRPERSON
John Ryan

EXECUTIVE OFFICER
Jane Adcock

Vision

The CMHPC envisions a mental health system that makes it possible for individuals to lead full and productive lives. The system incorporates public and private resources to offer community-based services that embrace recovery and wellness. The services are culturally competent, responsive, timely, and accessible to all of California's populations.

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

Mission

The CMHPC evaluates the mental health system for accessible and effective care. It advocates for an accountable system of seamless responsive mental health services that are strength-based, consumer and family driven, recovery-oriented, culturally competent, and cost-effective. To achieve these ends, the Council educates the general public, the mental health constituency, and legislators.

Purpose: The purpose of the Advocacy Committee is to address public issues affecting the effectiveness of mental health programs and quality of life for persons living with mental illness. This includes increasing public mental health awareness through press and media, partnering with local consumer advocacy agencies for access and improved quality of care, and responding to proposed legislation, rule-making, and budget bills based on the CMHPC platform.

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

- (a) To advocate for effective, quality mental health programs.
- (e) To advise the Legislature, the State Department of Health Care Services, and county boards on mental health issues and the policies and priorities that this state should be pursuing in developing its mental health system.
- (j) To advise the Director of Health Care Services on the development of the state mental health plan and the system of priorities contained in that plan.
- (k) To assess periodically the effect of realignment of mental health services and any other important changes in the state's mental health system, and to report its findings to the Legislature, the State Department of Health Care Services, local programs, and local boards, as appropriate.
- (l) To suggest rules, regulations, and standards for the administration of this division.

Guiding Principles: All advocacy efforts and proposed legislation shall be reviewed to ensure that the following best practices and principles are included.

Cultural Competence	Full Accessibility across the life span	Wellness & Recovery
Community Collaboration	Consumer & Family member driven or influenced	Integrated Services

OBJECTIVES:

1. Review and respond to pending legislation, proposed code language, regulatory, and judicial actions that diminishes or adversely affects MHS programs and compromises the state mental health plan.
2. Inform a mental health system that incorporates public and private resources to offer community-based services that embrace recovery and wellness, and are strength-based, culturally competent, and cost-effective.
3. Develop talking points to use for education and commentary on mental health issues in the media.
4. Respond to and partner with Consumer agencies and family member organizations to support their activities when needed.

Roles and Responsibilities:

Regular attendance of committee members is expected in order for the Committee to function effectively. If a committee has difficulty achieving a quorum due to the continued absence of a committee member, the committee chairperson will discuss with the member the reasons for his or her absence. If the problem persists, the committee chair can request that the Executive Committee remove the member from the committee.

Members are expected to serve as advocates for the committee’s charge, and as such, could include, but are not limited to:

- Attend meetings
- Speak when authorized at relevant conferences and summits when requested by the committee or the Planning Council
- Participate in the development products such as white papers, opinion papers, and other documents
- Distribute the committee’s white papers and opinion papers to their represented communities and organizations
- Assist in identifying speakers for presentations

Materials will be distributed as far in advance as possible in order to allow time for review before the meetings. Members are expected to come prepared in order to ensure effective meeting outcomes.

Membership:

NAME
<i>Barbara Mitchell, Co-Chair</i>
<i>Gail Nickerson, Co-Chair</i>
<i>Cindy Claflin</i>
<i>Caron Collins</i>
<i>Nadine Ford</i>
<i>Adam Nelson MD</i>
<i>John Ryan</i>
<i>Daphne Shaw</i>
<i>Stephanie Thal, MFT</i>
<i>Chloe Walker</i>
<i>Monica Wilson</i>
<i>Sandra Worthom</i>
<i>Staff: Andi Murphy</i> <i>(916) 440-7813</i> <i>andi.murphy@cmhpc.ca.gov</i>

General Principles of Collaboration:

The following general operating principles are proposed to guide the committee's deliberations:

- The committee's mission will be best achieved by relationships among the members characterized by mutual trust, responsiveness, flexibility, and open communication.
- It is the responsibility of all members to work toward the committee's common goals.
- To that end, members will:
 - Commit to expending the time, energy and organizational resources necessary to carry out the committee's mission
 - Be prepared to listen intently to the concerns of others and identify the interests represented
 - Ask questions and seek clarification to ensure they fully understand other's interests, concerns and comments
 - Regard disagreements as problems to be solved rather than battles to be won
 - Be prepared to "think outside the box" and develop creative solutions to address the many interests that will be raised throughout the Committee's deliberations

Decision Making:

The Committee will work to find common ground on issues and strive to seek consensus on all key issues. Every effort will be made to reach consensus, and opposing views will be explained. In situations where there are strongly divergent views, members may choose to present multiple recommendations on the same topic. If the Committee is unable to reach consensus on key issues, decisions will be made by majority vote. Minority views will be included in the meeting highlights.

Meeting Protocols:

The Committee's decisions and activities will be captured in a highlights document, briefly summarizing the discussion and outlining key outcomes during the meeting. Viewpoints will be recorded, but not be attributed to a specific member. The meeting highlights will be distributed to the Committee within one month following the meeting. Members will review and approve the previous meeting's highlights at the beginning of the following meeting.

Media Inquiries:

In the event the Committee is contacted by the press, the Chairperson will refer the request to the CMHPC's Executive Officer.

	Council Activity	Deliverable
Federal Public Law (PL) 106-310- the MHPC should perform the following functions:	Annual review of CA SAMHSA BG application	Yes
<ul style="list-style-type: none"> Review the State mental health plan required by PL 106-310 and submit to the State any recommendations for modification 	Annual review of CA Implementation Report	Yes
<ul style="list-style-type: none"> Review the annual implementation report on the State mental health plan required by PL 106-310 and submit any comments to the State 	Legislative advocacy, Participation on HCR and other issue-specific committees,	No
<ul style="list-style-type: none"> Advocate for adults with serious mental illness, children with a severe emotional disturbance, and other individuals with mental illnesses or emotional problems 	Workbook Project w/ Local MH Boards	Yes
<ul style="list-style-type: none"> Monitor, review, and evaluate annually the allocation and adequacy of mental health services within the State. 		
California Welfare and Institutions Code (WIC) 5514- There shall be a 5-person Patients' Rights Committee formed through the CMHPC. This committee, supplemented by two ad hoc members appointed by the chairperson of the committee, shall advise the Director of Health Care Services and Director of State Hospitals regarding department policies and practices that affect patients' rights.	None yet, new requirement in FY 2012-13 TBL	
WIC 5771- Pursuant to PL 102-321 the Planning Council shall be responsible to fulfill those mental health planning requirements mandated by federal law.		
WIC 5772 - The California Mental Health Planning Council shall have the powers and authority necessary to carry out the duties imposed upon it by this chapter, including, but not limited to, the following:		
1. To advocate for effective, quality mental health programs.	Legislative testimony, Participation on HCR and other issue-specific committees	No
2. To review, assess, and make recommendations regarding all components of California's mental health system, and to report as necessary to the Legislature, the State Department of Health Care Services, local boards, and local programs.	SAMHSA BG Peer Reviews, Council Meeting to showcase model programs, Legislative testimony	No
3. To review program performance in delivering mental health services by annually reviewing performance outcome data as follows:	Workbook Project w/ Local MH Boards, SAMHSA BG Peer Reviews,	Yes
<ul style="list-style-type: none"> To review and approve the performance outcome measures. 		
<ul style="list-style-type: none"> To review the performance of mental health programs based on performance outcome data and other reports from the State Department of Health Care Services and other sources. 		
<ul style="list-style-type: none"> To report findings and recommendations on programs' performance annually to the Legislature, the State Department of Health Care Services, and the local boards. 		
<ul style="list-style-type: none"> To identify successful programs for recommendation and for consideration of replication in other areas. As data and technology are available, identify programs experiencing difficulties. 		
4. When appropriate, make a finding pursuant to Section 5655 that a county's performance is failing in a substantive manner. The State Department of Health Care Services shall investigate and review the finding, and report the action taken to the Legislature.		

WIC 5772 - continued	Council Activity	Deliverable
5. To advise the Legislature, the State Department of Health Care Services, and county boards on mental health issues and the policies and priorities that this state should be pursuing in developing its mental health system.		
6. To make recommendations to the State Department of Health Care Services on the award of grants to county programs to reward and stimulate innovation in providing mental health services.		
7. To conduct public hearings on the state mental health plan, the Substance Abuse and Mental Health Services Administration block grant, and other topics, as needed.		
8. In conjunction with other statewide and local mental health organizations assist in the coordination of training and information to local mental health boards as needed to ensure that they can effectively carry out their duties.	Coordinate training needs with CiMH and CALMHBC	No
9. To advise the Director of Health Care Services on the development of the state mental health plan and the system of priorities contained in that plan.		
10. To assess periodically the effect of realignment of mental health services and any other important changes in the state's mental health system, and to report its findings to the Legislature, the State Department of Health Care Services, local programs, and local boards, as appropriate.		
11. To suggest rules, regulations, and standards for the administration of this division.		
12. When requested, to mediate disputes between counties and the state arising under this part.		
13. To employ administrative, technical, and other personnel necessary for the performance of its powers and duties, subject to the approval of the Department of Finance.		
14. To accept any federal fund granted, by act of Congress or by executive order, for purposes within the purview of the California Mental Health Planning Council, subject to the approval of the Department of Finance.		
15. To accept any gift, donation, bequest, or grants of funds from private and public agencies for all or any of the purposes within the purview of the California Mental Health Planning Council, subject to the approval of the Department of Finance.		
WIC 5820 - Each OSHPD five-year WET plan shall be reviewed and approved by the Planning Council.	Participate in OSHPD WET Advisory Committee; Coordinate Council review of 5-Yr Plan	
WIC 5821 - The Planning Council shall advise the OSHPD on education and training policy development and provide oversight for the department's education and training development.	Participate in OSHPD WET Advisory Committee	

CA Mental Health Planning Council
State Statutes - Welfare and Institution Code

4033. (a) The State Department of Health Care Services shall, to the extent resources are available, comply with the Substance Abuse and Mental Health Services Administration federal planning requirements. The department shall update and issue a state plan, which may also be any federally required state service plan, so that citizens may be informed regarding the implementation of, and long-range goals for, programs to serve mentally ill persons in the state. The department shall gather information from counties necessary to comply with this section.

(b) (1) If the State Department of Health Care Services makes a decision not to comply with any Substance Abuse and Mental Health Services Administration federal planning requirement to which this section applies, the State Department of Health Care Services shall submit the decision, for consultation, to the California Mental Health Directors Association, the California Mental Health Planning Council, and affected mental health entities.

(2) The State Department of Health Care Services shall not implement any decision not to comply with the Substance Abuse and Mental Health Services Administration federal planning requirements sooner than 30 days after notification of that decision, in writing, by the Department of Finance, to the chairperson of the committee in each house of the Legislature which considers appropriations, and the Chairperson of the Joint Legislative Budget Committee.

5400. The Director of Health Care Services shall administer this part and shall adopt rules, regulations, and standards as necessary. In developing rules, regulations, and standards, the Director of Health Care Services shall consult with the California Mental Health Directors Association, the California Mental Health Planning Council, and the office of the Attorney General. Adoption of these standards, rules, and regulations shall require approval by the California Mental Health Directors Association by majority vote of those present at an official session.

Wherever feasible and appropriate, rules, regulations, and standards adopted under this part shall correspond to comparable rules, regulations, and standards adopted under the Bronzan-McCorquodale Act. These corresponding rules, regulations, and standards shall include qualifications for professional personnel.

Regulations adopted pursuant to this part may provide standards for services for chronic alcoholics which differ from the standards for services for the mentally disordered.

5514. There shall be a five-person Patients' Rights Committee formed through the California Mental Health Planning Council. This committee, supplemented by two ad hoc members appointed by the chairperson of the committee, shall advise the Director of Health Care Services and the Director of State Hospitals regarding department policies and practices that affect patients' rights. The committee shall also review the advocacy and patients' rights components of each county mental health plan or performance contract and advise the Director of Health Care Services and the Director of State Hospitals concerning the adequacy of each plan or performance contract in protecting patients' rights. The ad hoc members of the committee shall be persons with substantial experience in establishing and providing independent advocacy services to recipients of mental health services.

5604.2. (a) The local mental health board shall do all of the following:

- (1) Review and evaluate the community's mental health needs, services, facilities, and special problems.
 - (2) Review any county agreements entered into pursuant to Section 5650.
 - (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 ensure citizen and professional involvement at all stages of the planning process.
 - (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 Mental Health Planning Council.
 - (8) Nothing in this part shall be construed to 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.

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 Mental 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 Mental 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, as well as 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) – (f) provides additional requirements regarding reporting/data.

5611. (a) The Director of Mental Health shall establish a Performance Outcome Committee, to be comprised of representatives from the PL 99-660 Planning Council and the California Conference of Local Mental Health Directors. 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.

5614.5. (a) The department, in consultation with the Quality Improvement Committee which shall include representatives of the California Mental 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.

5664. In consultation with the California Mental Health Directors Association, the State Department of Health Care Services, the Mental Health Services Oversight and Accountability Commission, the California Mental Health Planning Council, and the California Health and Human Services Agency, county mental health systems shall provide reports and data to meet the information needs of the state, as necessary.

5664.5. (a) County mental health systems shall continue to provide data required by the State Department of Health Care Services to establish uniform definitions and time increments for reporting type and cost of services received by local mental health program clients.

(b) This section shall remain in effect only until January 1, 1994, and as of that date is repealed, unless a later enacted statute, which becomes effective on or before January 1, 1994, deletes or extends the dates on which it is repealed; or until the date upon which the director informs the Legislature that the new data system is established pursuant to Section 5610, whichever is later, unless the provisions of the section are required by the federal government.

5701.1. Notwithstanding Section **5701**, the State Department of Health Care Services, in consultation with the California Mental Health Directors Association and the California Mental Health Planning Council, may utilize funding from the Substance Abuse and Mental Health Services Administration Block Grant, awarded to the State Department of Health Care Services, above the funding level provided in federal fiscal year 1998, for the

development of innovative programs for identified target populations, upon appropriation by the Legislature.

5732. (a) Given the requirements of Public Law 99-660 and the significant policy issues currently facing the mental health system in California, a master plan for mental health is required which integrates these planning and reform efforts and which establishes priorities for the service delivery system and analyzes critical policy issues.

(b) The California Planning Council's scope shall be expanded to include the development of the Mental Health Master Plan. This Mental Health Master Plan shall be distinct but compatible with the plan mandated by Public Law 99-660, the development and implementation of which is the responsibility of the State Department of Mental Health.

(c) Therefore, the California Planning Council required by Public Law 99-660 shall be expanded to include the following members:

(1) The Speaker of the Assembly shall recommend to the Governor for appointment, one council member.

(2) The Assembly Minority Floor Leader shall recommend to the Governor for appointment, one council member.

(3) The President pro Tempore of the Senate shall recommend to the Governor for appointment, one council member.

(4) The Senate Minority Floor Leader shall recommend to the Governor for appointment, one council member.

(5) The County Supervisors Association of California shall recommend to the Governor for appointment, one council member.

(d) The Mental Health Master Plan shall be completed and submitted to the Legislature and the Governor by October 1, 1991.

5750. The State Department of Health Care Services shall administer this part and shall adopt standards for the approval of mental health services, and rules and regulations necessary thereto. However, these standards, rules, and regulations shall be adopted only after consultation with the California Mental Health Directors Association and the California Mental Health Planning Council.

5771. (a) Pursuant to Public Law 102-321, there is the California Mental Health Planning Council. The purpose of the planning council shall be to fulfill those mental health planning requirements mandated by federal law.

(b) (1) The planning council shall have 40 members, to be comprised of members appointed from both the local and state levels in order to ensure a balance of state and local concerns relative to planning.

(2) As required by federal law, eight members of the planning council shall represent various state departments.

(3) Members of the planning council shall be appointed in a manner that will ensure that at least one-half are persons with mental disabilities, family members of persons with mental disabilities, and representatives of organizations advocating on behalf of persons with mental disabilities. Persons with mental disabilities and family members shall be represented in equal numbers.

(4) The Director of Health Care Services shall make appointments from among nominees from various mental health constituency organizations, which shall include representatives of consumer-related advocacy organizations, representatives of mental health professional and provider organizations, and representatives who are direct service providers from both

the public and private sectors. The director shall also appoint one representative of the California Coalition on Mental Health.

(c) Members should be balanced according to demography, geography, gender, and ethnicity. Members should include representatives with interest in all target populations, including, but not limited to, children and youth, adults, and older adults.

(d) The planning council shall annually elect a chairperson and a chair-elect.

(e) The term of each member shall be three years, to be staggered so that approximately one-third of the appointments expire in each year.

(f) In the event of changes in the federal requirements regarding the structure and function of the planning council, or the discontinuation of federal funding, the State Department of Health Care Services shall, with input from state-level advocacy groups, consumers, family members and providers, and other stakeholders, propose to the Legislature modifications in the structure of the planning council that the department deems appropriate.

5771.1. The members of the Mental Health Services Oversight and Accountability Commission established pursuant to Section 5845 are members of the California Mental Health Planning Council. They serve in an ex officio capacity when the council is performing its statutory duties pursuant to Section **5772**. Such membership shall not affect the composition requirements for the council specified in Section **5771**.

5771.3. The California Mental Health Planning Council may utilize staff of the State Department of Health Care Services, to the extent they are available, and the staff of any other public or private agencies that have an interest in the mental health of the public and that are able and willing to provide those services.

5771.5. (a) (1) The Chairperson of the California Mental Health Planning Council, with the concurrence of a majority of the members of the California Mental Health Planning Council, shall appoint an executive officer who shall have those powers delegated to him or her by the council in accordance with this chapter.

(2) The executive officer shall be exempt from civil service.

(b) Within the limit of funds allotted for these purposes, the California Mental Health Planning Council may appoint other staff it may require according to the rules and procedures of the civil service system.

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

(a) To advocate for effective, quality mental health programs.

(b) To review, assess, and make recommendations regarding all components of California's mental health system, and to report as necessary to the Legislature, the State Department of Health Care Services, local boards, and local programs.

(c) To review program performance in delivering mental health services by annually reviewing performance outcome data as follows:

(1) To review and approve the performance outcome measures.

(2) To review the performance of mental health programs based on performance outcome data and other reports from the State Department of Health Care Services and other sources.

(3) To report findings and recommendations on programs' performance annually to the Legislature, the State Department of Health Care Services, and the local boards.

(4) To identify successful programs for recommendation and for consideration of replication in other areas. As data and technology are available, identify programs experiencing difficulties.

(d) When appropriate, make a finding pursuant to Section 5655 that a county's performance is failing in a substantive manner. The State Department of Health Care Services shall investigate and review the finding, and report the action taken to the Legislature.

(e) To advise the Legislature, the State Department of Health Care Services, and county boards on mental health issues and the policies and priorities that this state should be pursuing in developing its mental health system.

(f) To periodically review the state's data systems and paperwork requirements to ensure that they are reasonable and in compliance with state and federal law.

(g) To make recommendations to the State Department of Health Care Services on the award of grants to county programs to reward and stimulate innovation in providing mental health services.

(h) To conduct public hearings on the state mental health plan, the Substance Abuse and Mental Health Services Administration block grant, and other topics, as needed.

(i) In conjunction with other statewide and local mental health organizations, assist in the coordination of training and information to local mental health boards as needed to ensure that they can effectively carry out their duties.

(j) To advise the Director of Health Care Services on the development of the state mental health plan and the system of priorities contained in that plan.

(k) To assess periodically the effect of realignment of mental health services and any other important changes in the state's mental health system, and to report its findings to the Legislature, the State Department of Health Care Services, local programs, and local boards, as appropriate.

(l) To suggest rules, regulations, and standards for the administration of this division.

(m) When requested, to mediate disputes between counties and the state arising under this part.

(n) To employ administrative, technical, and other personnel necessary for the performance of its powers and duties, subject to the approval of the Department of Finance.

(o) To accept any federal fund granted, by act of Congress or by executive order, for purposes within the purview of the California Mental Health Planning Council, subject to the approval of the Department of Finance.

(p) To accept any gift, donation, bequest, or grants of funds from private and public agencies for all or any of the purposes within the purview of the California Mental Health Planning Council, subject to the approval of the Department of Finance.

5814. (a) (1) This part shall be implemented only to the extent that funds are appropriated for purposes of this part. To the extent that funds are made available, the first priority shall go to maintain funding for the existing programs that meet adult system of care contract goals. The next priority for funding shall be given to counties with a high incidence of persons who are severely mentally ill and homeless or at risk of homelessness, and meet the criteria developed pursuant to paragraphs (3) and (4).

(2) The Director of Health Care Services shall establish a methodology for awarding grants under this part consistent with the legislative intent expressed in Section 5802, and in consultation with the advisory committee established in this subdivision.

(3) (A) The Director of Health Care Services shall establish an advisory committee for the purpose of providing advice regarding the development of criteria for the award of grants, and the identification of specific performance measures for evaluating the effectiveness of grants. The committee shall review evaluation reports and make findings on evidence-based best practices and recommendations for grant conditions. At not less than one meeting annually, the advisory committee shall provide to the director written comments on the performance of each of the county programs. Upon request by the department, each participating county that is the subject of a comment shall provide a written response to the comment. The department shall comment on each of these responses at a subsequent meeting.

(B) The committee shall include, but not be limited to, representatives from state, county, and community veterans' services and disabled veterans outreach programs, supportive housing and other housing assistance programs, law enforcement, county mental health and private providers of local mental health services and mental health outreach services, the Department of Corrections and Rehabilitation, local substance abuse services providers, the Department of Rehabilitation, providers of local employment services, the State Department of Social Services, the Department of Housing and Community Development, a service provider to transition youth, the United Advocates for Children of California, the California Mental Health Advocates for Children and Youth, the Mental Health Association of California, the California Alliance for the Mentally Ill, the California Network of Mental Health Clients, the California Mental Health Planning Council, the Mental Health Services Oversight and Accountability Commission, and other appropriate entities.

(4) The criteria for the award of grants shall include, but not be limited to, all of the following:

(A) A description of a comprehensive strategic plan for providing outreach, prevention, intervention, and evaluation in a cost appropriate manner corresponding to the criteria specified in subdivision (c).

(B) A description of the local population to be served, ability to administer an effective service program, and the degree to which local agencies and advocates will support and collaborate with program efforts.

(C) A description of efforts to maximize the use of other state, federal, and local funds or services that can support and enhance the effectiveness of these programs.

(5) In order to reduce the cost of providing supportive housing for clients, counties that receive a grant pursuant to this part after January 1, 2004, shall enter into contracts with sponsors of supportive housing projects to the greatest extent possible. Participating counties are encouraged to commit a portion of their grants to rental assistance for a specified number of housing units in exchange for the counties' clients having the right of first refusal to rent the assisted units.

(b) – (h) present additional requirements for the grants.

5820. (a) It is the intent of this part to establish a program with dedicated funding to remedy the shortage of qualified individuals to provide services to address severe mental illnesses.

(b) Each county mental health program shall submit to the Office of Statewide Health Planning and Development a needs assessment identifying its shortages in each professional and other occupational category in order to increase the supply of professional staff and other staff that county mental health programs anticipate they will require in order to provide the increase in services projected to serve additional individuals and families pursuant to Part 3 (commencing with Section 5800), Part 3.2 (commencing with Section 5830), Part 3.6 (commencing with Section 5840), and Part 4 (commencing with Section 5850) of this division. For purposes of this part, employment in California's public mental health system includes employment in private organizations providing publicly funded mental health services.

(c) The Office of Statewide Health Planning and Development, in coordination with the California Mental Health Planning Council, shall identify the total statewide needs for each professional and other occupational category utilizing county needs assessment information and develop a five-year education and training development plan.

(d) Development of the first five-year plan shall commence upon enactment of the initiative. Subsequent plans shall be adopted every five years, with the next five-year plan due as of April 1, 2014.

(e) Each five-year plan shall be reviewed and approved by the California Mental Health Planning Council.

5821. (a) The California Mental Health Planning Council shall advise the Office of Statewide Health Planning and Development on education and training policy development and provide oversight for education and training plan development.

(b) The Office of Statewide Health Planning and Development shall work with the California Mental Health Planning Council and the State Department of Health Care Services so that council staff is increased appropriately to fulfill its duties required by Sections 5820 and 5821.

5845. (a) The Mental Health Services Oversight and Accountability Commission is hereby established to oversee Part 3 (commencing with Section 5800), the Adult and Older Adult Mental Health System of Care Act; Part 3.1 (commencing with Section 5820), Human Resources, Education, and Training Programs; Part 3.2 (commencing with Section 5830), Innovative Programs; Part 3.6 (commencing with Section 5840), Prevention and Early Intervention Programs; and Part 4 (commencing with Section 5850), the Children's Mental Health Services Act. The commission shall replace the advisory committee established pursuant to Section 5814.

(d) In carrying out its duties and responsibilities, the commission may do all of the following:

(12) Work in collaboration with the State Department of Health Care Services and the California Mental Health Planning Council, and in consultation with the California Mental Health Directors Association, in designing a comprehensive joint plan for a coordinated evaluation of client outcomes in the community-based mental health system, including, but not limited to, parts listed in subdivision (a). The California Health and Human Services Agency shall lead this comprehensive joint plan effort.

5848. (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 Mental 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.

5892. (d) Prior to making the allocations pursuant to subdivisions (a), (b), and (c), funds shall be reserved for the costs for the State Department of Health Care Services, the California Mental Health Planning Council, the Office of Statewide Health Planning and Development, the Mental Health Services Oversight and Accountability Commission, the State Department of Public Health, and any other state agency to implement all duties pursuant to the programs set forth in this section. These costs shall not exceed 5 percent of the total of annual revenues received for the fund. The administrative costs shall include funds to assist consumers and family members to ensure the appropriate state and county agencies give full consideration to concerns about quality, structure of service delivery, or access to services. The amounts allocated for administration shall include amounts sufficient to ensure adequate research and evaluation regarding the effectiveness of services being provided and achievement of the outcome measures set forth in Part 3 (commencing with Section 5800), Part 3.6 (commencing with Section 5840), and Part 4 (commencing with Section 5850) of this division. The amount of funds available for the purposes of this subdivision in any fiscal year shall be subject to appropriation in the annual Budget Act.

5897. (a) Notwithstanding any other provision of state law, the State Department of Health Care Services shall implement the mental health services provided by Part 3 (commencing

with Section 5800), Part 3.6 (commencing with Section 5840), and Part 4 (commencing with Section 5850) of this division through contracts with county mental health programs or counties acting jointly. A contract may be exclusive and may be awarded on a geographic basis. As used herein a county mental health program includes a city receiving funds pursuant to Section 5701.5.

(b) Two or more counties acting jointly may agree to deliver or subcontract for the delivery of such mental health services. The agreement may encompass all or any part of the mental health services provided pursuant to these parts. Any agreement between counties shall delineate each county's responsibilities and fiscal liability.

(c) The department shall implement the provisions of Part 3 (commencing with Section 5800), Part 3.2 (commencing with Section 5830), Part 3.6 (commencing with Section 5840), and Part 4 (commencing with Section 5850) of this division through the annual county mental health services performance contract, as specified in Chapter 2 (commencing with Section 5650) of Part 2 of Division 5.

(d) When a county mental health program is not in compliance with its performance contract, the department may request a plan of correction with a specific timeline to achieve improvements.

(e) Contracts awarded by the State Department of Health Care Services, the California Mental Health Planning Council, the Office of Statewide Health Planning and Development, and the Mental Health Services Oversight and Accountability Commission pursuant to Part 3 (commencing with Section 5800), Part 3.1 (commencing with Section 5820), Part 3.2 (commencing with Section 5830), Part 3.6 (commencing with Section 5840), Part 3.7 (commencing with Section 5845), Part 4 (commencing with Section 5850), and Part 4.5 (commencing with Section 5890) of this division, may be awarded in the same manner in which contracts are awarded pursuant to Section 5814 and the provisions of subdivisions (g) and (h) of Section 5814 shall apply to such contracts.

(f) For purposes of Section 5775, the allocation of funds pursuant to Section 5892 which are used to provide services to Medi-Cal beneficiaries shall be included in calculating anticipated county matching funds and the transfer to the State Department of Health Care Services of the anticipated county matching funds needed for community mental health programs.

14682.1. (a) The State Department of Health Care Services shall be designated as the state agency responsible for development, consistent with the requirements of Section 4060, and implementation of, mental health plans for Medi-Cal beneficiaries.

(b) The department shall convene a steering committee for the purpose of providing advice and recommendations on the transition and continuing development of the Medi-Cal mental health managed care systems pursuant to subdivision (a). The committee shall include work groups to advise the department of major issues to be addressed in the managed mental health care plan, as well as system transition and transformation issues pertaining to the delivery of mental health care services to Medi-Cal beneficiaries, including services to children provided through the Early and Periodic Screening, Diagnosis and Treatment Program.

(c) The committee shall consist of diverse representatives of concerned and involved communities, including, but not limited to, beneficiaries, their families, providers, mental health professionals, substance use disorder treatment professionals, statewide

representatives of health care service plans, representatives of the California Mental Health Planning Council, public and private organizations, county mental health directors, and others as determined by the department. The department has the authority to structure this steering committee process in a manner that is conducive for addressing issues effectively, and for providing a transparent, collaborative, meaningful process to ensure a more diverse and representative approach to problem-solving and dissemination of information.

Health and Safety Code Section 128456.

In developing the program established pursuant to this article, the Health Professions Education Foundation shall solicit the advice of representatives of the Board of Behavioral Sciences, the Board of Psychology, the State Department of Health Care Services, the California Mental Health Directors Association, the California Mental Health Planning Council, professional mental health care organizations, the California Healthcare Association, the Chancellor of the California Community Colleges, and the Chancellor of the California State University. The foundation shall solicit the advice of representatives who reflect the demographic, cultural, and linguistic diversity of the state.

CALIFORNIA MENTAL HEALTH PLANNING COUNCIL

LEGISLATIVE PLATFORM

OCTOBER 2012

Mandatory Planks

- Support any proposal that embodies the principles of the *Mental Health Master Plan*.
- Support any proposal that addresses the human resources problem in the public mental health system with specific emphasis on increasing cultural diversity and promoting the employment of consumers and family members.
- Support any proposal that augments mental health funding, consistent with the principles of least restrictive care and adequate access and oppose any cuts.
- Support mental health insurance parity.
- Support legislation that ensures quality mental health services in health care reform
- Support expanding supportive affordable housing.
- Support expanding employment options for people with psychiatric disabilities.
- Support any proposal to lower costs by eliminating duplicative, unnecessary, or ineffective regulatory or licensing mechanisms of programs or facilities.
- Support any initiatives that reduce or eliminate the use of seclusion and restraint
- Oppose all bills related to “NIMBYism” and restrictions on housing and siting facilities for providing mental health services.
- Support initiatives that provide comprehensive health care and oppose any elimination of health benefits for low income beneficiaries.
- Oppose any legislation that adversely affects the principles and practices of the Mental Health Services Act.

Discretionary Planks (Require Deliberation & Discussion)

- *Support any proposal that advocates for blended funding for programs serving clients with co-occurring disorders that include mental illness.*
- *Support any proposal that advocates for providing more services in the criminal and juvenile justice systems for persons with serious mental illnesses or children, adolescents, and transition-aged youth with serious emotional disturbances, including clients with co-occurring disorders.*
- *Support any proposal that specifies or ensures that the mental health services provided to AB109 populations are paid for with AB 109 funding.*
- *Support activities that ensure that the federal government reimburses counties for the cost of mental health services to Veterans.*
- *Remain neutral or watch all legislation related to expanding the scope of professional licensure except when it affects quality of care.*

1. For items that are on the “automatic” approval planks of the platform and/or are **non-urgent** (more than seven days of response time):
 - Contact staff directly via email, with a cc to the Executive Officer, requesting action, and define the level of urgency of the request, informing staff of the deadline (and nature of the deadline i.e., which Legislative committee? How close to a final vote etc.) and suggested points that should be made in the letter.
 - *Staff performs analysis and presents the information, synopsis, and recommendation, and draft support/oppose letter to the Advocacy Committee for response and recommendation with the caveat that “approval is assumed if not contested within 7 days”.*
 - *If Advocacy Committee reviews the information and has comments, its recommendation /amendments/ approval is returned to staff with a cc to the Executive Officer and Executive Committee, including Leadership, **within 7 days**. The recommendation may be developed by a workgroup **within** the Advocacy Committee with expertise in the legislation’s subject area that is available and willing to do it within the time frame.*

2. *If the item **IS** urgent (requires response in **LESS** than seven days):*
 - *Request for action/analysis is addressed **to Executive Officer and staff, who will ensure that the information is forwarded to Leadership, Advocacy and Executive Committee***
 - *Staff performs analysis, and presents information, synopsis, and recommendation, with accompanying draft support/oppose letter, **to Leadership & Executive Committee, with a cc to Advocacy.***
 - *Leadership approves/amends recommendation and support/oppose letter, with input from Advocacy and Executive committees (if requested and time permits).*

3. Items that are NOT on the “automatic” approval planks should be vetted by **Leadership, by way of the Executive Officer or staff, who will also inform Executive Committee and Advocacy.** Request should include the same information as above – the action requested, the reason for its urgency, and the nearness of the vote. Staff may wish to perform preliminary analysis, but no document will be produced unless approved by Leadership. The final document will be distributed to the Advocacy and the Executive Committee.

Copies of Bills and/or existing Analyses may be requested from: Tracy Thompson Tracy.Thompson@cmhpc.ca.gov (916) 552-8665 or Andi.Murphy@cmhpc.ca.gov (916) 440-7813

Requests for analyses or support/oppose letters should be directed to Jane.Adcock@cmhpc.ca.gov (916) 319-9343 for “non-automatic” items with a cc to Andi Murphy.

X INFORMATION

TAB SECTION: A

 ACTION REQUIRED

DATE OF MEETING: 1/15/13

PREPARED BY: **Murphy**

DATE MATERIAL
PREPARED: 12/13/13

AGENDA ITEM: Impacts of Federal Policy on State Supportive Housing Programs

ENCLOSURES: *Changes in the HUD Definition of "Homeless",* National Alliance to End Homelessness
The Beginning of the End of Transitional Housing? ICPH, May 2011

**OTHER MATERIAL RELATED TO
ITEM:**

ISSUE:

The federal government has been aggressively addressing homelessness in recent years. Starting with changes to Federal Housing Law under the Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act in 2009, and exacerbated by recent cuts through Sequestration, the definition and degrees of homelessness and criteria for meeting the definition of homelessness are changing in order to meet the modified requirements. The emphasis is placed on moving people from shelters, and those exiting institutions that were homeless prior to institutionalization, people who will lose their nighttime residence within 14 days, families with children who are considered to have "persistent instability", and people fleeing domestic violence or other dangerous/life threatening situations (see *Changes in the HUD Definition of "Homeless",* attached). People who were in transitional housing prior to being institutionalized are not considered homeless, although oftentimes extended absences from transitional housing are cause for lease termination. Additionally, changes in California's infrastructure, such as the abolishment of Redevelopment agencies, is adding to the resource deficit and centrally located hub for housing resources.

Other changes to the new regulations include the following clarifications:

- "Youth" means less than 25 years of age
- "Long-term period" for homelessness changed to 60 days instead of 90
- "frequent moves" means two moves in the last 60 days, rather than three
- "persistent instability" is defined as a family or youth that has moved two or more times within the last 60 days.

The Institute for Children, Poverty & Homelessness (ICPH) sees this federal shift to crisis response and rapid rehousing as a disincentive for communities to fund and maintain transitional housing (see attached). ICPH notes that HEARTH "created financial incentives for communities to reduce the length of stay in shelter by (by 10% per year or to less than 20 days on average)" and "introduced a cap on the amount of funding that communities can use for traditional shelter and street outreach services in favor of prevention assistance. Such policies pressure homeless services providers to move away from transitional housing programs...."

Changes in the HUD Definition of “Homeless”

On January 4, 2012, final regulations went into effect to implement changes to the U.S. Department of Housing and Urban Development’s (HUD’s) definition of homelessness contained in the Homeless Emergency Assistance and Rapid Transition to Housing Act. The definition affects who is eligible for various HUD-funded homeless assistance programs. HUD issued draft regulations in April 2010. Based on public comments received on these initial draft regulations, HUD published the final rule in the December 5, 2011 *Federal Register*. This document summarizes the changes to the definition of homelessness under the final rule compared to both current law and the 2010 draft regulations. It also provides an analysis of the regulation’s effects and the decisions that communities and individual programs will have to make.

The new definition includes four broad categories of homelessness:

- People who are living in a place not meant for human habitation, in emergency shelter, in transitional housing, or are exiting an institution where they temporarily resided if they were in shelter or a place not meant for human habitation before entering the institution. The only significant change from existing practice is that people will be considered homeless if they are exiting an institution where they resided for up to 90 days (it was previously 30 days), and were homeless immediately prior to entering that institution.
- People who are losing their primary nighttime residence, which may include a motel or hotel or a doubled up situation, within 14 days and lack resources or support networks to remain in housing. HUD had previously allowed people who were being displaced within 7 days to be considered homeless. The regulation also describes specific documentation requirements for this category.
- Families with children or unaccompanied youth who are unstably housed and likely to continue in that state. This is a new category of homelessness, and it applies to families with children or unaccompanied youth (up to age 24) who have not had a lease or ownership interest in a housing unit in the last 60 or more days, have had two or more moves in the last 60 days, and who are likely to continue to be unstably housed because of disability or multiple barriers to employment.
- People who are fleeing or attempting to flee domestic violence, dating violence, sexual assault, stalking, or other dangerous or life-threatening situations related to violence; have no other residence; and lack the resources or support networks to obtain other permanent housing. This category is similar to the current practice regarding people who are fleeing domestic violence.

Timing and Implementation

The final regulation on the definition of homelessness went into effect on January 4, 2012. Implementation is dependent upon which year’s funds are being used. The new rule applies to all projects funded under the fiscal year (FY) 2011 Emergency *Solutions* Grant. Projects funded through the second allocation of FY 2011 ESG funding for prevention and rapid re-housing fall under the new rule, but those funded under the first FY 2011 ESG allocation, which was awarded under the Emergency *Shelter* Grant, do not.

The new definition also applies to all new and renewal Continuum of Care projects funded through the FY 2011 competition. This includes both Supportive Housing Program (SHP) and Shelter Plus Care (S+C) program grants.

The new definition will also apply to all activities using funding from FY 2012 and beyond, including both Continuum of Care projects and Emergency Solutions Grant projects (including outreach, emergency shelter, prevention, rapid re-housing, and HMIS activities). For more information, watch HUD’s [webinar](#) on the final rule.

Major Changes from the Draft Regulation

- People who are exiting an institution are considered homeless only if they resided in shelter or in a place not meant for human habitation prior to entering the institution and their stay in the institution was less than 90 days. People who were in transitional housing prior to entering an institution are not considered homeless upon exit. HUD notes that most of these individuals have historically been allowed to return to their transitional housing after exit, and HUD plans to continue this policy in the upcoming proposed Continuum of Care regulation.
- For the purposes of identifying unaccompanied youth who are unstably housed and are likely to continue in that state, youth means less than 25 years of age. The initial draft of the rule had not identified an age limit.
- HUD altered how it was defining “long-term period” and “frequent moves” as qualifying factors for being considered homeless. A “long-term period” will be 60 days instead of 90, and “frequent moves” will be two moves instead of three. As a result, to meet the third category of homelessness (persistent instability), a family or unaccompanied youth must have moved two or more times within the last 60 days.
- HUD also clarified several issues related to documentation requirements. For example, HUD specifies that third-party documentation, when available, is the preferable way to document homeless status. Lack of third-party documentation, however, cannot prevent a household from receiving emergency assistance, including shelter and victim services. In addition, HUD will allow other forms of already available documentation (including HMIS records) to count as evidence of homeless status.

Summary of Changes Compared to Current Law

The following table summarizes the new definition of homelessness, compares it to the existing definition, and summarizes the documentation requirements. Significant changes from the existing definition are underlined.

Table

1. Core Definition		
Traditional HUD Definition	New Definition	New Documentation Requirements
<p>An individual or family who lacks a fixed, regular, and adequate nighttime residence, which includes a primary nighttime residence of:</p> <ul style="list-style-type: none"> • Place not designed for or ordinarily used as a regular sleeping accommodation (including car, park, abandoned building, bus/train station, airport, or camping ground) • Publicly or privately operated shelter or transitional housing, including a hotel or motel paid for by government or charitable organizations; <p>In addition, a person is considered homeless if he or she is being discharged from an institution where he or she has been a resident for <u>30 days</u> or less and the person resided in a shelter or place not meant for human habitation immediately prior to entering that institution.</p>	<p>An individual or family who lacks a fixed, regular, and adequate nighttime residence, which includes a primary nighttime residence of:</p> <ul style="list-style-type: none"> • Place not designed for or ordinarily used as a regular sleeping accommodation (including car, park, abandoned building, bus/train station, airport, or camping ground) • Publicly or privately operated shelter or transitional housing, including a hotel or motel paid for by government or charitable organizations; <p>In addition, a person is considered homeless if he or she is being discharged from an institution where he or she has been a resident for <u>90 days</u> or less and the person resided in a shelter (<u>but not transitional housing</u>) or place not meant for human habitation immediately prior to entering that institution.</p>	<p>Acceptable evidence documenting homelessness in a place not ordinarily used as sleeping accommodation or shelter includes:</p> <ul style="list-style-type: none"> • Certification from individual or head of household seeking assistance; • Written documentation from an outreach worker as to where the individual or family was living before; or • Written referral by another housing or service provider. <p>In addition, documentation that a person was in an institution for 90 days or less includes <u>discharge paperwork</u> or a written/oral referral from a social worker, case manager, or other appropriate official that explains the entry and exit dates. If the intake worker is unable to obtain such a statement, documentation of his/her due diligence in attempting to obtain one, along with a certification from the individual, is acceptable.</p>

2. Imminently Losing Primary Nighttime Residence

Traditional HUD Definition	New Definition	New Documentation Requirements
<p>Individual or family is being evicted within 7 days from a private dwelling and:</p> <ul style="list-style-type: none"> • No subsequent residence has been identified; and • The household lacks the resources or support networks (i.e. family, friends, faith-based or other social networks) needed to obtain other permanent housing. 	<p>Individual or family is being evicted within 14 days from their primary nighttime residence and:</p> <ul style="list-style-type: none"> • No subsequent residence has been identified; and • The household lacks the resources or support networks (i.e. family, friends, faith-based or other social networks) needed to obtain other permanent housing. 	<ol style="list-style-type: none"> 1. At least one of the following stating that the household must leave within 14 days: <ul style="list-style-type: none"> • A court order resulting from an eviction notice or equivalent notice, or a formal eviction notice; • For individuals in hotels or motels that they are paying for, evidence that the individual or family lacks the necessary financial resources to stay for more than 14 days; or • An oral statement by the individual or head of household stating that the owner or renter of the residence will not allow them to stay for more than 14 days. The intake worker must verify the statement either through contact with the owner or renter, or documentation of due diligence in attempting to obtain such a statement. 2. Certification by the individual or head of household that no subsequent residence has been identified. 3. Self-certification or other written documentation that the individual or head of household lacks the financial resources and support networks to obtain other housing.

3. Persistent Housing Instability		
Traditional HUD Definition	New Definition	New Documentation Requirements
<p>People who experience persistent housing instability were not considered homeless.</p>	<p><u>People with ALL of these characteristics:</u></p> <ol style="list-style-type: none"> <u>1. Unaccompanied youth (less than 25 years of age) or family with children and youth;</u> <u>2. Defined as homeless under other federal statutes (for example the definition used by the Department of Education) who do not otherwise qualify as homeless under HUD’s definition;</u> <u>3. Has not had a lease, ownership interest, or occupancy agreement in permanent housing in the 60 days prior to applying for assistance;</u> <u>4. Has moved two or more times in the 60 days immediately prior to applying for assistance;</u> <u>5. Has one or more of the following</u> <ul style="list-style-type: none"> <u>• chronic disabilities,</u> <u>• chronic physical or mental health conditions</u> <u>• substance addiction</u> <u>• histories of domestic violence or childhood abuse</u> <u>• child with a disability</u> <u>• two or more barriers to employment, which include</u> <ul style="list-style-type: none"> <u>– lack of a high school degree or GED</u> <u>– illiteracy</u> <u>– low English proficiency</u> <u>– history of incarceration or detention for criminal activity</u> <u>– history of unstable employment</u> 	<ol style="list-style-type: none"> 1. A nonprofit, state, or local government entity that administers the other federal statute must certify that household qualifies as homeless under that statute’s definition. 2. To document that the individual has not had a lease, occupancy agreement, or ownership interest in housing in the last 60 days, certification by the individual or head of household, written observation by an outreach worker, or referral by a provider. 3. To document that the individual or family has moved two times in the past 60 days, a certification from the individual and supporting documentation, including records or statements from each owner or renter of housing, shelter or housing provider, or social worker, case worker, or appropriate official of an institution where the individual or family resided. Where these statements are unobtainable, the intake worker should include a written record of his or her due diligence in attempting to obtain them. 4. Evidence of barriers includes: <ul style="list-style-type: none"> • Written diagnosis from a licensed professional, employment records, department of corrections records, literacy, and English proficiency tests. • For disability, any of the above, written verification from the Social Security Administration (or a disability check receipt), or observation of the intake worker of disability, which must be confirmed within 45 days by an appropriate professional.

4. Fleeing Domestic Violence		
Traditional HUD Definition	New Definition	New Documentation Requirements
<p>Is fleeing a domestic violence housing situation and no subsequent residence has been identified and the person lacks the resources and support networks needed to obtain housing.</p>	<p>Any individual or family who:</p> <ul style="list-style-type: none"> • Is fleeing, or is attempting to flee, domestic violence, dating violence, sexual assault, stalking, or other dangerous or life-threatening conditions that relate to violence; • Has no other residence; and • Lacks the resources or support networks to obtain other permanent housing. 	<p>Acceptable Evidence for Individuals Fleeing Domestic Violence:</p> <ul style="list-style-type: none"> • Oral statement by the individual or head of household seeking assistance, that is certified by the individual or head of household; and • Where the safety of the household is not in jeopardy: <ul style="list-style-type: none"> ○ Written observation by intake worker; or ○ Written referral by a housing or service provider, social worker, or other organization from whom the household has sought assistance for domestic violence. <p>If the individual or family is being admitted to a domestic violence shelter or is receiving services from a victim service provider, the oral statement need only be documented by a certification of the individual or head of household, or by the intake worker.</p>

Analysis

The changes to the definition of homelessness are mandated by the HEARTH Act. HUD's final regulations provide the specific details necessary to implement those changes. For most of the changes, the HEARTH Act provided enough specificity, and HUD's proposal is simply restating the HEARTH Act's language. In other cases, the HEARTH Act provided less specific guidance, which HUD interpreted and translated into the detailed guidance necessary for implementation. Significant features of the new definition regulation include the following:

- HUD is requiring that providers maintain records for 5 years after the end of the grant term.
- The HEARTH Act states that people should be considered homeless if they were temporarily residing in a shelter or place not meant for human habitation prior to entering an institution. HUD interpreted a temporary stay in an institution to mean a stay of 90 days or less. Currently, HUD allows for stays of 30 days or less.
- The changes in the imminent homelessness category—people will be considered homeless if they are losing their housing in 14 days instead of 7 days as well as new documentation requirements—were specified in detail in the HEARTH Act, and the regulations closely follow those instructions.
- The HEARTH Act created a new category of homelessness that attempts to capture unaccompanied youth and families with children who experience persistent housing instability and have other barriers to housing. The HEARTH Act's language was more general than other language regarding the definition of homelessness. It required that the definition only apply to unaccompanied youth and families with children who are considered homeless under other federal statutes but not under the HUD portion of the McKinney-Vento Homeless Assistance Act. The HEARTH Act also required the following:
 - the individual or family has not lived independently for a long period of time, which HUD interpreted as not being on a lease or having an ownership interest in a housing unit for the past 60 days;
 - the individual or family has moved frequently, which HUD interpreted as having moved at least two times in the past 60 days; and
 - the individual or family is expected to continue to have unstable housing for one of a number of reasons—chronic disabilities, chronic physical health or mental health conditions, substance addiction, histories of domestic violence or childhood abuse, the presence of a child or youth with a disability, or multiple barriers to employment—HUD interpreted multiple barriers to employment to mean at least two of the following: lack of a high school degree or GED, illiteracy, low English proficiency, history of incarceration or detention for criminal activity, or history of unstable employment.

Overall, these changes will likely have modest impacts on homeless assistance programs. The number of people eligible for assistance through Continuum of Care programs will grow. Continuum of Care funded programs, particularly transitional housing programs, will have to evaluate how they target their assistance, whether they plan to serve people newly covered under the definition, and how they will prioritize whom to serve. Changes in data elements, intake forms, reporting forms, policies and rules may also be needed to implement the changes.

More people will also be eligible for assistance from ESG funded shelter programs. (Other changes to ESG will significantly expand ESG prevention assistance for people at risk of homelessness). Similar to the transitional housing programs, shelters funded through HUD's ESG program will have to decide whether they plan to serve people newly covered under the definition and how they will prioritize whom to serve.

The changes to the definition will have little impact on how point in time counts are conducted. The HEARTH Act prohibits HUD from requiring that communities conduct counts of people who are in imminent danger of losing their housing, experiencing persistent instability, or fleeing or attempting to flee domestic violence unless those people are being served by HUD-funded homeless assistance programs. HUD may only require CoCs to conduct

a count of people who are homeless under the core definition—residing in a shelter (including motel paid for by government or charitable organization), transitional housing, or place not meant for human habitation.

HUD will continue to issue regulations to implement the rest of the HEARTH Act. Some of those regulations may create incentives or disincentives for CoCs to serve people who are in imminent danger of losing their housing or experiencing persistent instability. For example, the HEARTH Act requires that CoCs be evaluated for their performance, and decisions about who is served may have an impact on that performance.

Although the changes to the definition will have modest effects, CoCs should use this opportunity to evaluate who their programs serve and how they serve them. Following are some questions that CoCs could consider.

- How *does* our community prioritize who to serve? How *should* we prioritize?
In many CoCs, providers each have a strategy for screening potential clients, and those strategies may not be coordinated.
- Are people we serve receiving the most appropriate intervention?
As eligibility for assistance expands, CoCs should evaluate whether newly eligible people are best served by the existing programs, which of those programs they are best served by, and whether new programs should be developed.
- How can we help providers and other stakeholders implement changes?
No matter what decisions CoCs make regarding which populations they serve and how they serve them, intake workers, providers, referring agencies, and other stakeholders will need training, technical assistance, and help with planning to ensure that the changes are implemented in a coordinated and efficient manner.

The Beginning of the End of Transitional Housing?

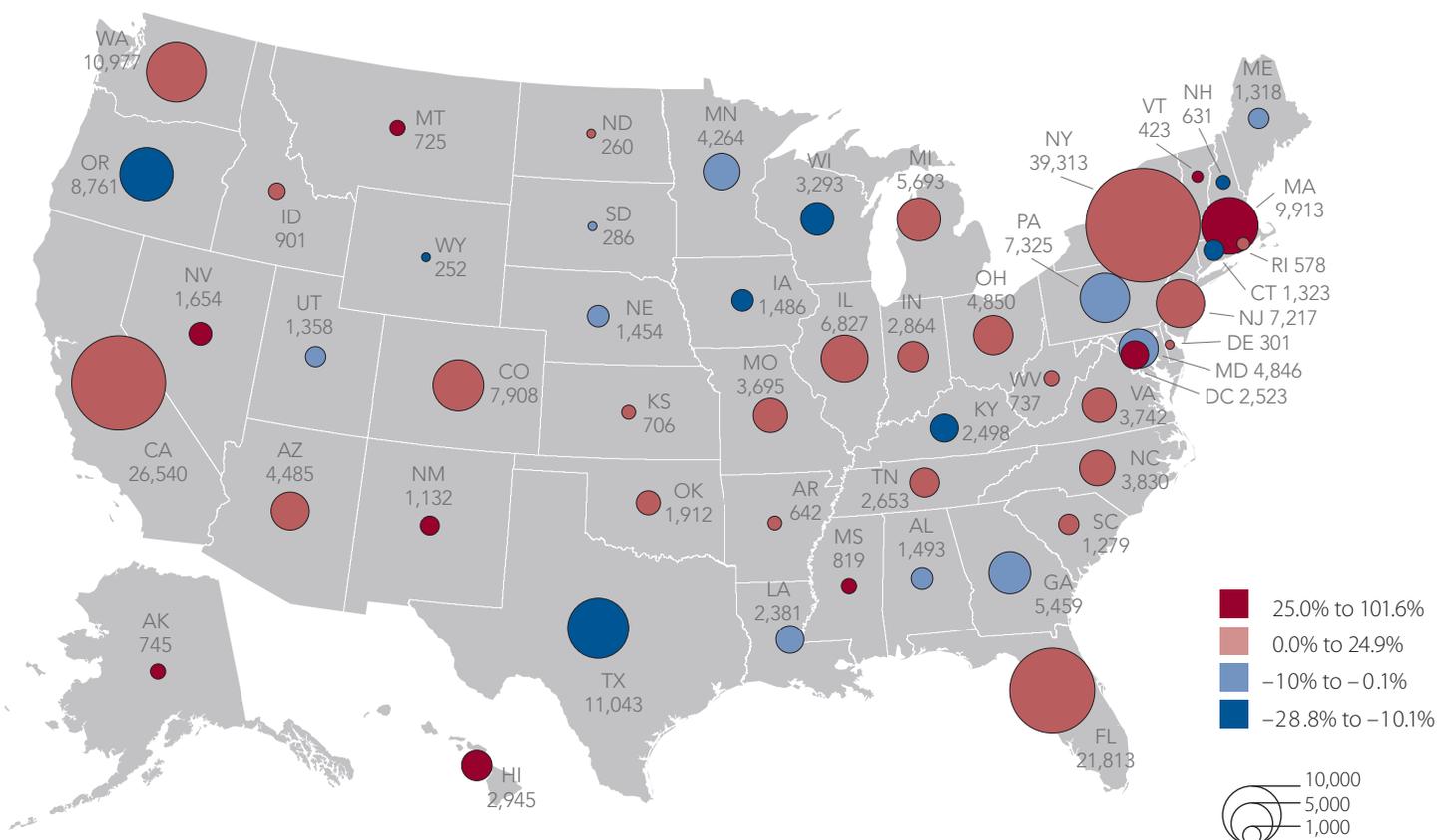
MAY 2011

a National Survey policy brief from ICPH

Over the last decade, federal homelessness policy shifted its focus to ending chronic homelessness. With newly earmarked federal funding, states were encouraged to develop ten-year plans to address the needs of this population. While long-term homeless single adults with a mental illness or substance abuse received unprecedented attention, homeless families with children were overlooked. Not surprisingly, the number of sheltered and unsheltered chronically homeless singles dropped between 2008 and 2010 (by 11.5% to 109,920), while that of sheltered persons in homeless families continued to increase (by 5.2% to 190,995).¹

The federal Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act of 2009 signaled a new shift in homelessness policy and funding away from a continuum of shelter and on-site supportive services to a crisis response system of homelessness prevention and rapid re-housing. HEARTH created financial incentives for communities to reduce the length of stay in shelter (by 10% per year or to less than 20 days on average) and implement rapid re-housing strategies for families. Additionally, HEARTH introduced a cap on the amount of funding that communities can use for traditional shelter and street outreach services in favor of pre-

Persons in Homeless Families (2010) and Percent Change in Sheltered Persons in Homeless Families (2008–10)



Source: U.S. Department of Housing and Urban Development, HUD's 2008 CoC Homeless Assistance Programs—Homeless Populations and Subpopulations; U.S. Department of Housing and Urban Development, HUD's 2010 CoC Homeless Assistance Programs—Homeless Populations and Subpopulations.
Advocacy Committee January 2014, San Diego

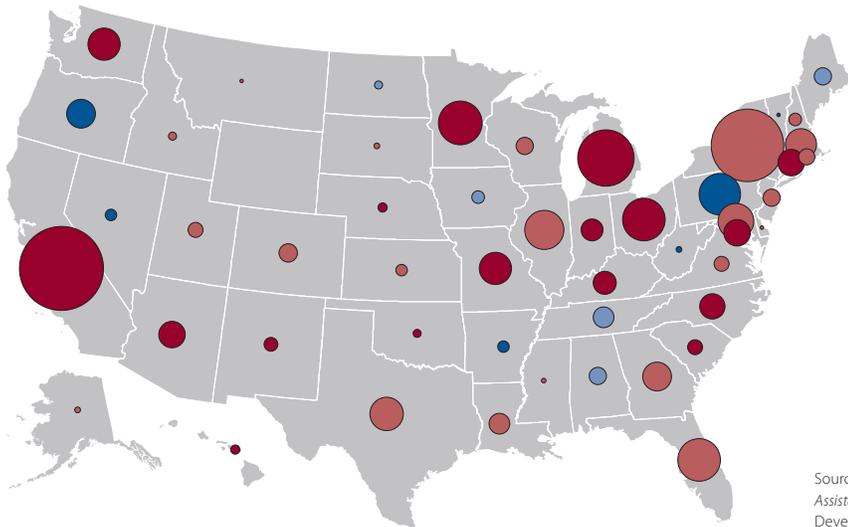
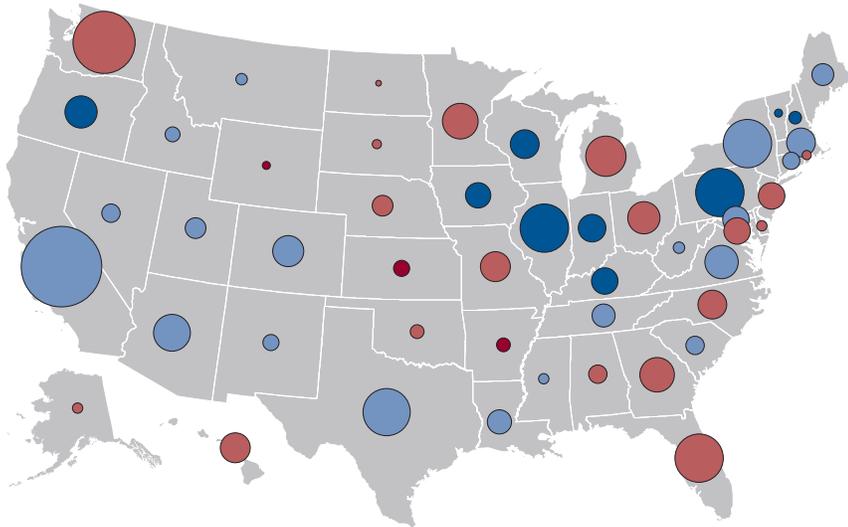
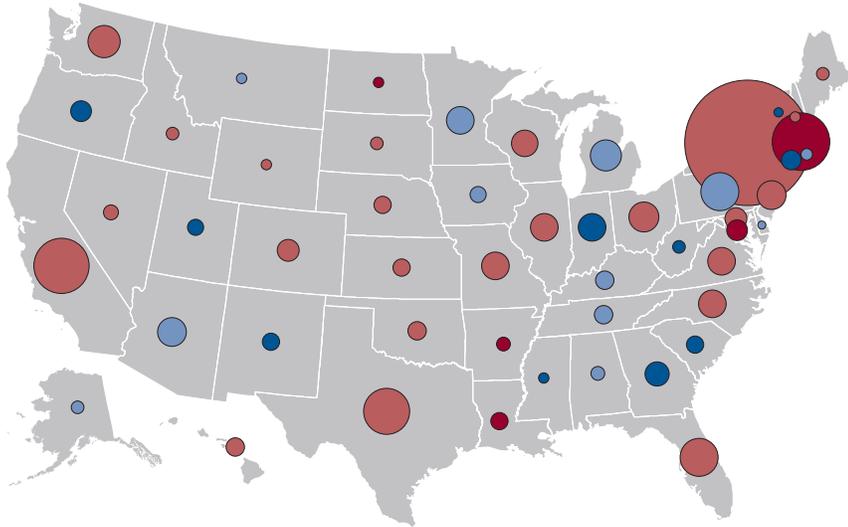
Number (2010) of and Percent Change (2008–10) in Family Shelter Beds



Emergency Shelter

Transitional Housing

Permanent Supportive Housing



Source: U.S. Department of Housing and Urban Development, HUD's 2008 CoC Homeless Assistance Programs — Housing Inventory Chart Report; U.S. Department of Housing and Urban Development, HUD's 2010 CoC Homeless Assistance Programs — Housing Inventory Chart Report.

State	Persons in homeless families (2010)	Percent change in sheltered persons in homeless families (2008–10)*	Family beds (2010)			Percent change in family beds (2008–10)		
			Emergency shelter	Transitional housing	Permanent supportive housing	Emergency shelter*	Transitional housing*	Permanent supportive housing*
USA	241,621	5.2%	107,950	109,512	95,353	9.4%	-1.3%	24.5%
AK	745	33.0%	433	273	84	-6.9%	19.7%	23.5%
AL	1,493	-0.6%	481	869	765	-2.6%	4.4%	-7.4%
AR	642	3.2%	505	450	346	52.6%	35.5%	-48.1%
AZ	4,485	7.1%	1,926	3,176	1,621	-4.0%	-2.7%	50.4%
CA	26,540	0.7%	7,196	14,820	16,379	8.0%	-6.3%	72.3%
CO	7,908	14.4%	1,191	2,331	799	8.2%	-10.0%	12.7%
CT	1,323	-28.8%	955	734	1,734	-11.3%	-1.6%	27.8%
DC	2,523	37.4%	1,001	1,660	1,632	148.4%	9.0%	54.0%
DE	301	7.1%	197	293	35	-7.5%	0.7%	16.7%
FL	21,813	2.3%	3,496	5,459	4,245	15.5%	12.0%	12.9%
GA	5,459	-0.5%	1,432	2,830	1,960	-11.3%	9.5%	23.7%
HI	2,945	60.7%	825	2,116	243	14.3%	15.3%	65.3%
IA	1,486	-11.3%	691	1,489	435	-1.6%	-14.9%	-1.6%
ID	901	23.6%	408	570	180	10.9%	-1.0%	7.8%
IL	6,827	11.4%	1,843	5,367	3,685	9.6%	-10.1%	3.0%
IN	2,864	8.3%	1,818	1,907	1,181	-15.2%	-18.8%	118.7%
KS	706	9.8%	783	692	341	6.0%	48.2%	19.2%
KY	2,498	-20.7%	839	1,704	1,318	-4.8%	-19.2%	52.4%
LA	2,381	-5.0%	784	1,365	1,000	33.6%	-0.2%	6.5%
MA	9,913	35.6%	7,859	2,049	2,298	38.4%	-7.8%	8.7%
MD	4,846	-3.9%	1,218	1,708	3,113	7.4%	-0.9%	9.6%
ME	1,318	-5.0%	448	1,136	754	12.3%	-8.5%	-5.4%
MI	5,693	1.7%	2,292	3,899	7,481	-0.3%	21.4%	92.0%
MN	4,264	-4.0%	1,854	3,046	4,589	-0.2%	9.5%	39.1%
MO	3,695	7.9%	1,832	2,210	2,438	6.8%	10.8%	27.4%
MS	819	101.6%	276	263	70	-12.7%	-1.9%	12.9%
MT	725	55.4%	279	323	47	-3.5%	-5.3%	0.0%
NC	3,830	22.1%	1,832	1,912	1,529	9.6%	0.6%	44.8%
ND	260	9.0%	273	112	198	30.0%	10.9%	-6.6%
NE	1,454	-4.7%	713	1,093	210	1.7%	15.9%	740.0%
NH	631	-20.4%	314	437	411	10.6%	-14.6%	14.8%
NJ	7,217	5.8%	1,941	1,648	785	7.7%	12.2%	0.1%
NM	1,132	46.9%	716	684	478	-14.9%	-2.8%	48.9%
NV	1,654	34.0%	564	832	356	16.0%	-8.7%	-20.9%
NY	39,313	11.3%	36,205	5,389	12,277	15.3%	-8.7%	10.9%
OH	4,850	4.1%	2,173	2,461	4,216	0.0%	15.0%	27.0%
OK	1,912	19.8%	812	512	184	1.6%	1.6%	54.6%
OR	8,761	-23.7%	1,050	2,534	1,964	-26.6%	-20.7%	-13.5%
PA	7,325	-3.3%	3,482	5,576	4,073	-0.5%	-11.8%	-21.1%
RI	578	19.1%	319	255	644	-3.3%	3.2%	13.2%
SC	1,279	3.4%	758	809	573	-10.4%	-2.5%	33.9%
SD	286	-5.6%	405	238	85	0.0%	0.0%	0.0%
TN	2,653	5.9%	841	1,233	1,002	-1.8%	-6.0%	-2.5%
TX	11,043	-20.5%	4,881	5,171	2,618	14.9%	-0.2%	2.3%
UT	1,358	-6.1%	659	1,005	559	-13.3%	-2.6%	4.9%
VA	3,742	3.5%	1,857	2,657	586	1.8%	-3.4%	1.0%
VT	423	37.6%	214	175	44	-10.1%	-24.2%	-76.8%
WA	10,977	13.4%	2,533	9,136	2,500	0.8%	11.3%	43.9%
WI	3,293	-10.3%	1,647	2,013	781	0.9%	-11.9%	1.7%
WV	737	11.0%	380	323	98	-15.0%	-3.6%	-16.2%
WY	252	-17.7%	259	171	0	23.3%	33.6%	0.0%
PR	428	90.5%	196	285	370	53.1%	30.7%	62.3%
GU	1,101	190.0%	39	108	33	0.0%	18.7%	175.0%
VI	19	-47.2%	25	4	6	-16.7%	0.0%	-71.4%

*Colors correspond to map legends.

Source: U.S. Department of Housing and Urban Development, HUD's 2008 CoC Homeless Assistance Programs — Homeless Populations and Subpopulations; U.S. Department of Housing and Urban Development, HUD's 2010 CoC Homeless Assistance Programs — Homeless Populations and Subpopulations; U.S. Department of Housing and Urban Development, HUD's 2008 CoC Homeless Assistance Programs — Housing Inventory Chart Report; U.S. Department of Housing and Urban Development, HUD's 2010 CoC Homeless Assistance Programs — Housing Inventory Chart Report.

vention assistance.² Such policies pressure homeless service providers to move away from transitional housing programming for families—a program option that provides important services such as vocational training, employment counseling, and parenting classes that address the underlying causes of homelessness—and instead focus on emergency shelter and rapid re-housing.

Recently released U.S. Department of Housing and Urban Development (HUD) data show that this transformation of the homelessness services structure is already underway. The nation's year-round bed inventory for homeless families grew by 9.3% (from 286,257 beds in 2008 to 312,815 in 2010), mainly due to a 24.5% expansion (of 18,772) in the number of permanent supportive housing beds. Meanwhile, 1,461 transitional housing beds were eliminated, representing a 1.3% decrease. In 2008, the largest share of the nation's bed capacity for families consisted of transitional housing beds (38.8%), followed by emergency shelter (34.5%) and permanent supportive housing beds (26.8%). In 2010, 30.5% (95,353) of beds fell into the permanent supportive housing category, while the share of transitional housing beds (35.0%, or 109,512 total beds) declined.³

Between 2008 and 2010, the largest number of states (20), primarily located in parts of the Midwest and across the Southwest, reduced their inventory of transitional housing beds and increased the number of permanent supportive housing beds available for families. Only five states went against the overall trend and enlarged their transitional housing bed capacity, while decreasing or not changing their permanent supportive housing bed stock. Seventeen states expanded their bed count in both categories, eight states eliminated beds of both types, and one state did not alter the number of beds for either group.

The resulting impact of federal policy is the loss of transitional housing for families.

Federal policy strongly influences which service models and homeless populations communities focus on, primarily because of targeted funding for specific types of programs

and projects. The 2009 HEARTH Act significantly redirected available funding towards prevention and rapid re-housing. As a result, the number of transitional housing beds available for families can be expected to decline even further. HUD has deemed minimal stays in shelter and a swift transition to self-sufficient living in permanent housing a “best practice.”⁴ But this approach overlooks a majority of families that require more time and supportive services to overcome barriers to financial independence, such as low educational attainment and lack of sufficient employment skills. Only time will tell if this policy shift away from transitional housing will ultimately benefit and reduce the number of homeless families.

Endnotes

¹ U.S. Department of Housing and Urban Development, *HUD's 2008 CoC Homeless Assistance Programs—Homeless Populations and Subpopulations*; U.S. Department of Housing and Urban Development, *HUD's 2010 CoC Homeless Assistance Programs—Homeless Populations and Subpopulations*.

² National Alliance to End Homelessness, *HEARTH Act Section-by-Section Analysis*, June 2009; National Alliance to End Homelessness, *The HEARTH Act: Changes to HUD's Homeless Assistance Programs*, October 2009.

³ U.S. Department of Housing and Urban Development, *HUD's 2008 CoC Homeless Assistance Programs—Housing Inventory Chart Report*; U.S. Department of Housing and Urban Development, *HUD's 2010 CoC Homeless Assistance Programs—Housing Inventory Chart Report*.

⁴ National Alliance to End Homelessness, *Summary of HEARTH Act*, June 2009.

Ralph da Costa Nunez, PhD

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Anna Simonsen-Meehan

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The Institute for Children, Poverty, and Homelessness (ICPH) is an independent nonprofit research organization based in New York City. ICPH studies the impact of poverty on family and child well-being

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Institute for
Children, Poverty
& Homelessness

www.ICPHusa.org
Advocacy Committee

and generates research that will enhance public policies and programs affecting poor or homeless children and their families. Specifically, ICPH examines the condition of extreme poverty in the United States and its effect on educational attainment, housing, employment, child welfare, domestic violence, and family wellness. Please visit our Web site for more information: www.ICPHusa.org.

The *National Survey of Programs and Services for Homeless Families* is an online resource for service providers, advocates, researchers, and public policy makers working in the field of family homelessness. The Web site provides a state-by-state snapshot of the interconnections between governmental and nonprofit work to end family homelessness. www.icprwb.org.



Red, White,
and Blue Book

**NATIONAL SURVEY
OF PROGRAMS AND SERVICES
FOR HOMELESS FAMILIES**

X INFORMATION

TAB SECTION: B

___ ACTION REQUIRED:

DATE OF MEETING: 1/15/13

PREPARED BY: Murphy

DATE MATERIAL: 12/13/13

PREPARED:

AGENDA ITEM: Overview/Orientation to the Advocacy Committee

ENCLOSURES: Vision/Mission/Charter/Mandates (pages 3 – 14 of this meeting packet)

OTHER MATERIAL RELATED TO ITEM:

ISSUE: Committees usually welcome their newest members at the January meeting. Although there is an orientation meeting for the overall Council, there is no corollary activity for the Committees. This block of time will provide an opportunity to connect a little more personally prior to jumping into the agenda items. The time will be used to introduce existing members, tell a little about ourselves, explain the role of the Advocacy committee, connect the mandates to our mission and vision, answer any questions that might arise, and identify the mentor/partners.

INFORMATION

TAB SECTION: C

 X ACTION REQUIRED:

DATE OF MEETING: 1/15/13

PREPARED BY: Murphy

DATE MATERIAL
PREPARED: 12/13/13

AGENDA ITEM: Review and Approve Draft October Meeting Highlights

ENCLOSURES: October Meeting summary/highlights

OTHER MATERIAL RELATED TO ITEM:

ISSUE:

The draft summary of the October meeting is attached. It was also emailed on November 8, 2013. No corrections were suggested.

They are attached for review and approval.

Present:

Gail Nickerson, Co-Chair

Adam Nelson, Vice-Chair

Presenter: Sharon Kuehn,
*Peers Envisioning and
Engaging in Recovery
Services (PEERS)*

Nadine Ford
Caron Collins

John Ryan
Stephanie Thal (via phone)
Daphne Shaw

Rita McCabe, DHCS

Sara Kashing, JD, CAMFT

Staff: Andi Murphy

Introductions and Agenda Review

The meeting commenced at 1:32 p.m., and introductions were made. The agenda was modified to switch the PEER Certification with the MFT presentation in order to accommodate a schedule conflict.

New Business

No new business was discussed.

Review and Approve Minutes

Minutes were approved as submitted.

The SPA and the Peer Certification Process

Sharon Kuehn, PEERS, and Rita McCabe, DHCS

A series of statewide meetings and forums have resulted in 17 draft recommendations for the implementation of a Certified Peer Specialist program in California. The recommendations include five distinct groups— Adults, TAY, Older Adult Consumers, Family member of Adult caregivers and parent/partners for children living with SED. The Peer Specialist differs from clinical providers on several fronts – they do not advise, they do not locate resources, they do not evaluate, diagnose, or prescribe. Their function and value are as empathetic guides and coaches who understand the process of recovery and healing and offer moral support and encouragement and model the process.

Pilot Program for Peer Mentoring – Alameda County pilot program for Peer Mentoring provided 40 hours training to 26 peers, “The Art of facilitating self-determination” and matched them with people recently released from psych hospital. Those accepting a peer mentor experienced a 72% reduction in readmissions to the hospital - the cost savings was over a million dollars compared to an investment of \$238K (ROI 470%).

Peer certification, and recognition/validation of its value is needed in order to make it reliably available throughout the state. It will also create a standardized education and training (and

quality control) program throughout the state, provide information on competencies for potential employers so they can make an informed hiring decision, grow it, and it will enable a mechanism to bill Medicaid. 31 states presently have a means of doing this, and 14 states include Parents/Partners. CMS has signaled its approval of recognizing Peer support as a billable service and directed States to write the option into the 1915b waiver Rehab Option plans, but a permanent amendment to the State Plan would be preferable. The federal gov't pays 50% of the billable charge in those states that are billing for services. The CMS letter requires states to train, certify and credential, address the supervision, and assure the care coordination as part of the overall individualized plan of care. Under the 1915b waiver counties may bill to "other provider rehab options" and five counties currently use those mechanisms.

The Stakeholder group recommends that the state create a distinct peer provider type called the Peer Specialist, and create a distinct service type called a peer specialist service. Some states have created a Peer Support Services Certification agency, which is what the Stakeholder Workgroup recommends for California. MHSA legislation calls for the increase of Peer and family members in the mental health services system.

Only 1/3 of California's counties have civil service Job description specifying that a job is best filled by a person with lived experience or family members. Training standards differ between counties, with one county requiring only 12 hours of training, and another calling for 480. Only five of the 31 counties REQUIRE training. The proposed Peer Specialist Certification program would require that training be required for specialists in ALL counties, and has proposed a base training module of 80 hours for basic training with a test, with additional 25 hours for a sub-specialty, and would also require continuing education units in order to keep certificate current. People would be required to disclose the nature of their experience and intern for six months prior to receiving certification.

The biggest issue is establishing a certification process and finding a means of funding it. In the current work plan, OSHPD has called for the need of establishing a process using federal funds. It has also received funds for establishing a crisis service peer providers that would establish one training program, and there is concern that the certifying body (i.e. OSHPD contractor) will try to make the same process or program apply for ALL iterations of Peer Specialists (such as, a Peer Specialist that has additional training/expertise in Crisis Intervention, or trauma informed care), regardless of population they are serving (TAY, Older Adults etc.) and not just a narrowly defined niche.

The WWT Draft Final Recommendations that were submitted to OSHPD for the establishment of a certifying body included:

- Establishing a certifying body that was peer-operated organization and/or an existing statewide organization,
- Honoring existing trainings developed by local consumer and family organizations and retaining the cultural and regional diversity they represent
- Establishing a formal Scope of Practice, Values & Ethics, standards for competencies and practices based on successful completion of curriculum, and supervision of Peer Specialists
- Adopt the definition and scope of services into a new State Plan Amendment in order to qualify for Medi-Cal Billing and Reimbursement
- Develop standards and oversight system for the training of Peer Specialists
- Develop a method/process/program for certifying Peer Specialist sites so that the site is eligible for independent billing.

The report was presented to OSHPD and has not yet been approved for release.

Discussion and next steps

What types of waivers are needed? How long would it take?

It would be better to go with a State Plan Amendment and use the means for billing that is already in place, for the time being.

What is the definition of a consumer?

Lived experience of behavioral health challenges – (indistinct – possibly some language about challenges having affected or impacted day-to-day living negatively.)

If the Peer Specialist does not evaluate or diagnose, what is the model for how a Peer Specialist would work?

The Peer Specialist might greet the person in the waiting room, establish contact, maybe broker the introduction to the therapist. If there is a concern that person is in a frame of mind that may lead to self-harm or harming others, the Peer Specialist would convey that to the clinical staff, but would not attempt a diagnosis or treatment plan.

Why hasn't the California Department of Consumer Affairs been considered for the Peer Certification Credentialing Process?

It is worth considering – in some other states that function is performed by Peer Run organizations. It may be an issue of resources – several of the other professions under their purview are experiencing long delays in certification.

Where can the Council start in supporting this effort?

OSHPD will propose strategies in the WET Plan, but has not indicated that Peer Specialists, or a Certification process, will be included. The Council could send a letter urging their inclusion, and the establishment of a certification body that is more global than just for crisis intervention services.

Suggested language from Sharon: We support the immediate implementation of certification of Peer Specialist, to be funded at a sufficient level that will allow implementation to move forward quickly. CCs to Steinberg, Beall; The Senate Select Subcommittee on Mental Health, and other likely interested, influential parties.

Council “asks” in the letter: Initiation of the Peer Certification program, adoption of the recommendations assembled by PEERs, rejection of a “one size fits all” training program that encompasses the current training for Crisis peer interventionists, identify this as a clear and higher priority, not buried in the text of the five year plan. Earmark some of the current funding to begin the process of establishing a certifying body that will vet the curriculum – this body should include affected state partners and knowledgeable, experienced stakeholders to implement the process.

Supporting language in the current proposed WET plan: “Goal 3: Facilitate a robust, statewide and local infrastructure “ Objective c: Evaluate new and expanded roles of the mental health workforce that expand the ability to draw down additional federal funds such as....”

We strongly urge OSHPD to lead the process in establishing a state-level peer specialist certification program and certification body. It will tangibly recognize the important services that Peer Specialists bring to a mental health and wellness system by prioritizing its implementation and adopting a standardized curriculum and evaluation system.

It might be better to take the idea of forming the body to sympathetic legislators to request that they carry the legislation.

Possibly two letters are needed – one to OSHPD and one to legislators.

Resolved: Advocacy committee to recommend to the Council that the Council seek an author to carry a bill that would create a Peer Certification Body and training program.

LMFTs – Recognition by Medicare

Sara Kashing, MFT, California Marriage and Family Therapists

The practitioner types that can bill Medicare/Medi-Cal have to be stated, in law, as are currently limited to five professions – physicians, psychiatrists, Doctoral psychologists, clinical

social workers, psychiatric nurses. This is not a private practice or public mental health system issue – it is across the board.

The AAMFT and CAMFT feel that there are two hurdles to achieving this eligibility:

Perceived Cost: There is a perception that allowing MFTs to bill will drive up the cost of providing mental health services due to the expansion of the workforce. In 2009, the Congressional Budget Office estimated that costs of adding LMFTs would be \$100M over 5 years, or \$400M over 10 years. CAMFT takes issue with this estimate on two fronts: there was recently a bill that reduced the cost sharing from 50% to 20%, and nobody is considering the savings that would result by adding LMFTs, whose services cost less than Psychologists, and people may opt for LMFTs instead of, rather than in addition to, psychologists.

The second misconception is that certifying LMFTs will expand the scope of services (Medicare benefits) that are billable under Medicare, such as family counseling or marriage counseling, but there would not be any services provided that are not already offered and reimbursable – only the provider would exchange. LMFTs are well represented in rural areas, and would be willing to serve underserved populations – or those who age into a Medicare coverage and lose their relationship with their LMFT.

At this point, these are the biggest barriers to including LMFTs – it has not been so much an issue of a “turf war” with other care providers. Despite the stated barrier that the lack of a nationally certified/standardized education and training prevents inclusion as a Medicare biller, the AAMFT/CAMFT do not believe that the certification issue is the problem, but the perceived economic and scope of services issue. However, the Council has received feedback from external bodies indicating that the nationally certified/standardized curriculum IS the issue, and the Council has leaned toward encouraging CAMFT and AAMFT to work towards developing these standards. There is a national certification exam, but that is not the same as the standardized curriculum, and schools have indicated to the CAMFT and AAMFT that it would be cost prohibitive to redraft and reformulate the curriculum to meet a national standard.

Discussion and next steps

The Council has encountered a feeling among some of its colleagues that the biggest roadblock is the lack of a standardized National Certification for LMFTs.

The Committee is happy to support the inclusion of LMFTs by whatever means the federal government deems appropriate for their inclusion.

Finalization of Position Statements:

Make the following changes:

Alternatives to Institutions - Short Doyle statement needs clarification. Also, amend "Allowable Rate" to Allowable Daily Rate and correct the font.

Gun Violence & Mental Illness – the citations are numbered wrong. There is a position statement that was adopted by the APA that Advocacy Committee would likewise adopt and link to – although the question was raised as to whether there were areas of concern specific to California. Most recently, many reports are observing that the biggest single factor in gun violence as a PUBLIC health concern (as opposed to a mental health issue), is access to a gun, NOT whether somebody feels violent or is depressed. Should the Council pursue the angle that ACCESS is the biggest predictor of potential violence, not mental illness. "Mental Illness is not the biggest predictor of potential gun violence, *access* is."

Resolved: Adopt the Alternatives to Institutions once corrections are made.

Modify the Gun Violence Position Statement to reflect the Public Health perspective (and correct the numbering)

Review the APA Position statement to ensure it covers areas of concern that are specific to California prior to posting on website.

Develop Report Out for General Session:

- Recommend Council pursue the establishment of Peer Certification Body by sending a letter to OSHPD and Legislators
- MFT: Federal Letter - Leave the debate on whether standardized curriculum is needed to other bodies, and support the idea of expanding the mental health workforces while urging the Associations to address all perceived barriers. Focus on the benefit of expanding the workforce and service availability for seniors and geographically isolated areas. Would Jon Perez of SAMHSA have any insight from the federal level?

X INFORMATION

TAB SECTION: D

 ACTION REQUIRED

DATE OF MEETING: 1/15/13

PREPARED BY: **Murphy**

DATE MATERIAL
PREPARED: 12/13/13

AGENDA ITEM: Overview of California's Annual Budget Process

ENCLOSURES: The California State Budget Process (adapted from CA State Assembly brochure)

**OTHER MATERIAL RELATED TO
ITEM:**

ISSUE:

The Governor announces the plan for the upcoming 2013/14 state budget on January 10th, beginning an annual process of checks and balances, negotiations and compromise for the next six months. California's state budget is approximately \$120B annually, and is comprised of State General Fund (apx. 41%) , Federal Funds (apx. 38%) , Special funds, such as Realignment (based on Vehicle license fees and sales taxes and distributed through a set formula- apx. 16%), and Bonds (Bonds or funds typically voted in through Initiatives, and dedicated to specific functions or projects - apx. 4%). Several issues come into play when the budget is developed:

Ballot box initiatives:

- Require that 40% of General Fund dollars go to Education (Prop 98)- Currently education dollars consume 41% of state budget GF dollars for K - 12 (31%) and higher education (11%).
- Allow Legislators to pass a budget (i.e. spend money) with a simple majority vote (1 more than half) but requires a 2/3 majority vote on both houses in order to raise revenue via taxes, special fees, etc.

Federal Funds - require a state "match" in order to receive them - thereby obligating nearly 25% of the General Fund dollars in order to pull down the same amount of federal dollars. Sequestration (the unilateral Federal budget reduction of 10% across ALL federal programs except Social Security) means that a federally mandated state program (like WIC) not only loses the 10% from the federal contribution, but also the General Fund "match", meaning the program potentially experiences a 20% reduction. In 2011, the State appropriated approximately \$80B of federal funds for state programs - \$41B (52%) went to Health and Human Services, and of that amount, \$29B went to Health Care Services, of which \$1.7B is allocated to Mental Health services.

In 2011-12, the annual budget for Mental Health Services was divided up between Federal (\$1.7B), Realignment (\$1.94B), and the MHSA (\$1.34B). In lean budget years, the mental health funding is often one of the first funds to be reduced because, unlike AFDC or other entitlement programs, it is not protected or prioritized. This vulnerability is what led to the original 1991 Realignment funding formula (which still prioritized social welfare and foster care programs over mental health) and later, to the Mental Health Services Act which could not be supplanted or diverted to other programs.

THE CALIFORNIA STATE BUDGET PROCESS

How the money gets from there

Figure 1 shows the portion of revenues collected from each of the three largest sources (Personal Income, Sales and Use, and Corporate Income taxes) for Fiscal Year (FY) 2011-12, which ran from July 1, 2011 through June 30, 2012. Miscellaneous taxes and fees (such as cigarette and alcohol taxes) are grouped together under the "Other" category.

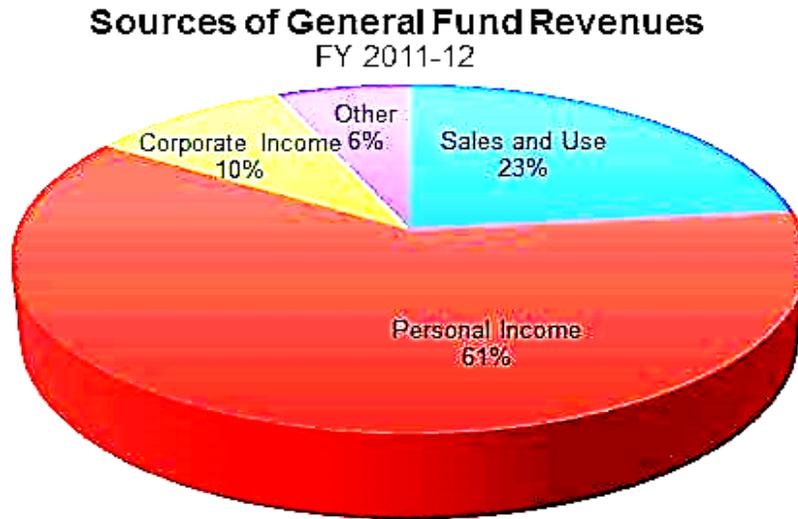
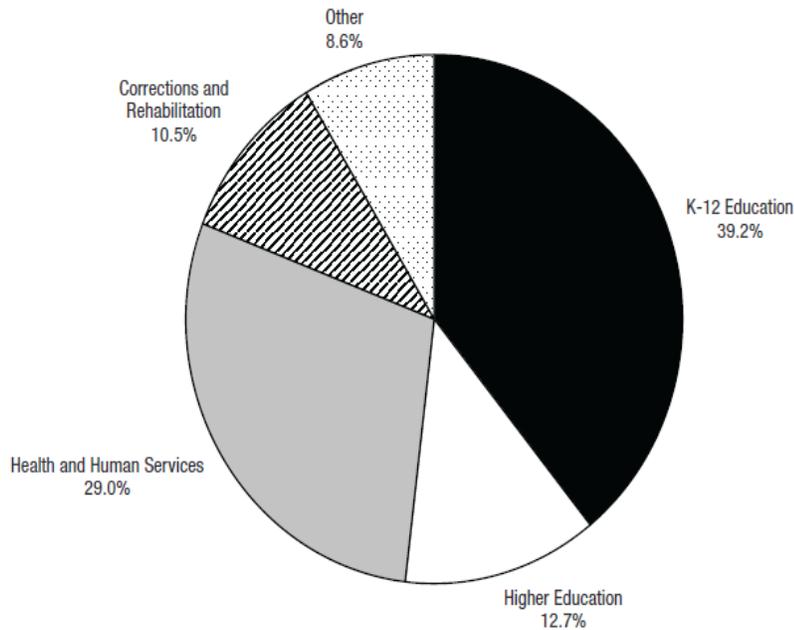


Figure 1 - Source: [State Controller's Office](#) (Monthly Statement of General Fund Cash Receipts and Disbursements)

To here

Figure 3: Slightly More Than Half of State Spending Supported K-12 and Higher Education in 2010-11



Estimated 2010-11 General Fund Expenditures = \$91.5 Billion

Source: Department of Finance

THE STATE BUDGET PROCESS

The word “budget” comes from the French word meaning leather bag or small purse.

Although California has had a Legislature since it became a state in 1850, it is only in the last 75 years that it has had a formal budget process. Regardless of California’s economic conditions, the budget “purse” is never large enough; there are always demands for more programs and services than money available. Our elected state representatives are responsible for deciding which priorities should be included. With so much at stake, it’s important to understand how the Budget process works and how you can influence it.

The Budget defines how much money will be available for education, law enforcement, fire protection and other public services. It also determines how much we pay in taxes and fees. The final decisions are a reflection of what we value and who we are as Californians.

Development of the State Budget is a year-long process.

A STATE BUDGET IS DEVELOPED

Between June and August of each year, state departments develop budget proposals to augment their existing levels of service. Departments prepare Budget Change Proposals (BCPs), which are sent to the Department of Finance (DOF) for review. The DOF analyzes these budget proposals, estimates future state revenues, and prepares a balanced expenditure plan for the Governor’s approval.

THE GOVERNOR’S BUDGET IS INTRODUCED

The Governor evaluates the DOF budget proposal and, on or before January 10 of each year, releases to the public and the California State Legislature the “Governor’s Budget” for the coming fiscal year. The Governor’s Budget is then introduced as two identical Budget Bills, one Assembly bill and one Senate bill, for consideration by each House.

The Legislative Analyst, the financial review agency of the Legislature, prepares an extensive “Analysis of the Budget Bill,” which includes program backgrounds, economic projections and recommended revisions. Soon after the Analysis is released, budget subcommittee hearings on the Budget Bill begin.

THE BUDGET IS HEARD IN COMMITTEES

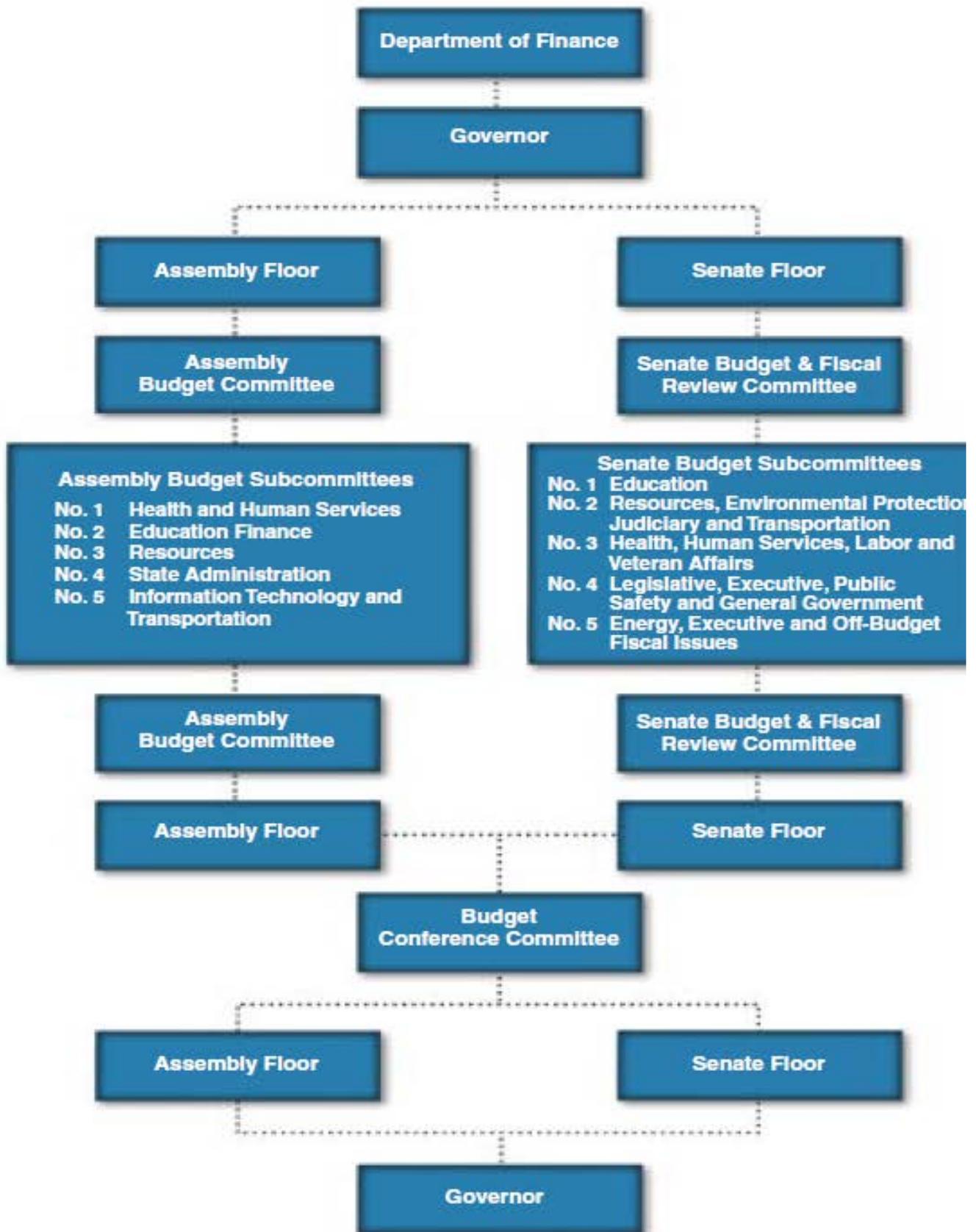
The Assembly Budget Bill is referred to the Assembly Budget Committee, and the Senate Budget Bill is referred to the Senate Budget and Fiscal Review Committee. The two committees divide their respective bills by subject matter and assign items to the appropriate budget subcommittees for public hearings.

ASSEMBLY BUDGET SUBCOMMITTEES

- No. 1 Health and Human Services
- No. 2 Education Finance
- No. 3 Natural Resources and Environmental Protection
- No. 4 State Administration
- No. 5 Information Technology and Transportation.....

SENATE BUDGET AND FISCAL REVIEW SUBCOMMITTEES

- No. 1 Education
- No. 2 Resources, Environmental Protection, Judiciary and Transportation
- No. 3 Health, Human Services, Labor and Veteran Affairs
- No. 4 Legislative, Executive, Public Safety and General Government
- No. 5 Energy, Executive, and Off-Budget Fiscal Issues.....



How to Participate

The best time for constituents to be heard on items relating to the Budget is between March and May, when Budget Subcommittees are meeting.

THE BEST OPPORTUNITY FOR PUBLIC INPUT

Most of the changes in the Budget Bill are made in the budget subcommittees of each House.

Representatives from state agencies, the Department of Finance and the Legislative Analyst's Office appear before the subcommittees and make funding recommendations. Interested citizens and groups also have an opportunity to offer input supporting the continuation, expansion or deletion of a budget item.

The most important time for constituents to be heard on items relating to the budget is between March and May, when subcommittees are meeting.

In order to influence an item in the budget, it is important to contact:

- 1) Your State Assemblymember and State Senator;
- 2) Members of the budget committees and the appropriate subcommittees; and
- 3) The Governor

Elected officials can be contacted by calling their district or capitol offices, writing a letter, scheduling an appointment or sending an e-mail

THE MAY REVISE

In mid-May, the Governor releases an update to his or her original budget based upon changes in the state's revenues, and expenditures. Known as the "May Revise," it includes the latest economic updates to ensure that the most current information is considered before the Budget is enacted. These figures are then used to draft amendments to bills being heard in the budget subcommittees. The Legislature typically waits for the May Revise update before final budget decisions are made on major programs, such as education, corrections, and health and human services.

THE AMENDED BUDGET BILLS ARE SENT TO EACH HOUSE

Upon completion of the hearings, the budget subcommittees approve, revise or disapprove specific details of the Budget. The subcommittees then submit a report to their respective budget committees.

The full budget committee of each House adopts its subcommittees' reports and sends revised Budget Bills to the Assembly and Senate floors for amendments and votes.

THE ASSEMBLY AND SENATE VOTE ON BUDGET BILLS

The Assembly and the Senate vote to pass their version of the Budget Bill and send it to the other House for concurrence. If either bill is not passed by the other House, it is sent to a Budget Conference Committee to iron out the differences between the two bills.

THE BUDGET CONFERENCE COMMITTEE

Budget Conference Committee hearings begin in early June and last until the Budget is sent to each House for final passage.

The Conference Committee, made up of three members from each House, is formed to resolve the differences between the Assembly and Senate versions of the Budget Bill.

Proposition 98, passed by California Voters in 1988, requires that at least 40% of the state budget be spent on Public Education.

These differences are often the most contentious portions of the Budget. Generally, the committee is not allowed to consider new proposals or review those issues on which the two Houses already agree.

Legislators may testify only on the first day of Conference Committee hearings. This is commonly known as “Members’ Day,” the last chance for legislators to influence what is included in the Budget. Following Members’ Day, testimony is limited to representatives from the Legislative Analyst’s Office and the Department of Finance.

The Conference Committee methodically works through the agenda, approving compromises when possible and skipping over areas where conflict remains. This process is repeated until the last few issues are settled — often during intense negotiations with the Governor.

The Budget Conference Committee passes and reports out to both Houses of the Legislature a conference committee report containing the Budget Bill.

If the Conference Committee cannot reach final agreement on the Budget, the “Big 3,” consisting of the Governor, the President pro Tem of the Senate, and the Speaker of the Assembly, often meet to resolve the stalemate.

Where the Money Comes From (General Fund)

Figure 1 shows the portion of revenues collected from each of the three largest sources (Personal Income, Sales and Use, and Corporate Income taxes) for Fiscal Year (FY) 2011-12, which ran from July 1, 2011 through June 30, 2012. Miscellaneous taxes and fees (such as cigarette and alcohol taxes) are grouped together under the “Other” category.

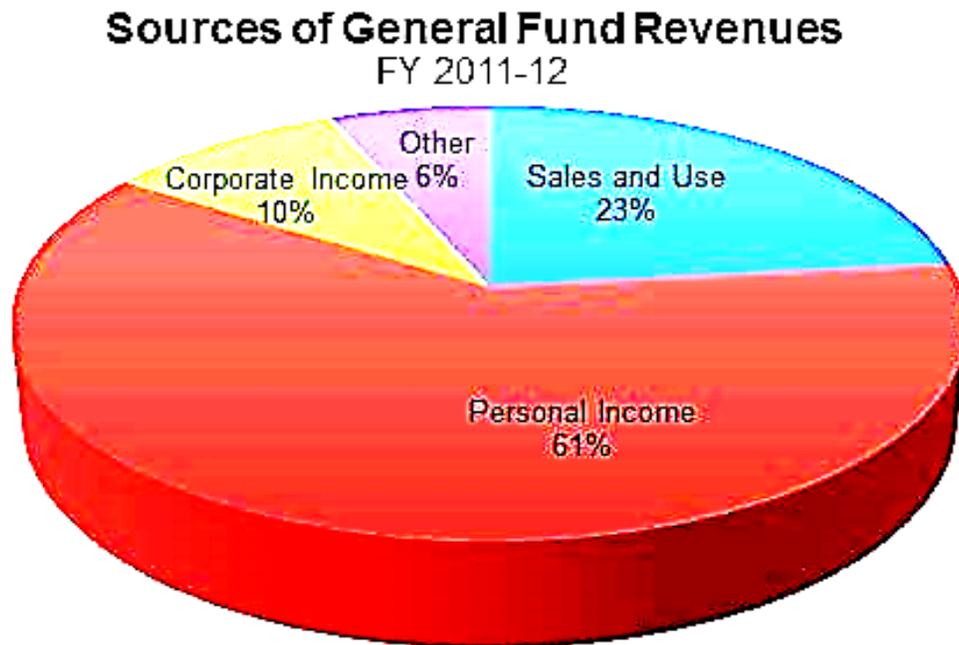


Figure 1 - Source: [State Controller's Office](#) (Monthly Statement of General Fund Cash Receipts and Disbursements)

THE FINAL PASSAGE OF THE BUDGET

In 2010, voters approved Prop 25, which changed the budget approval vote from super majority to simple majority (1 more than half in both houses). They also approved Prop 26, which raised the required votes to raise revenues/taxes from a simple majority to a super-majority vote in both houses.

Once the full Assembly and the full Senate receive the conference committee report, each caucus meets to be briefed on the contents of the final agreement, and a floor vote follows. At this time, the conference committee report containing the Budget Bill cannot be amended.

If the Budget Bill has provisions that require changes to existing law, separate bills that implement those changes — “Trailer Bills” — are introduced and voted on, generally at the same time as the Budget Bill.

Until 2010, California was one of the few states in the nation that required a “super majority” vote of both Houses to pass the State Budget before it could be sent to the Governor for approval. The California State Constitution requires that the Governor receive the Budget Bill by June 15 and Prop 25 (2010) withholds Legislators’ pay if a balanced budget is not approved and sent to the Governor.

THE BUDGET BILL GOES TO THE GOVERNOR

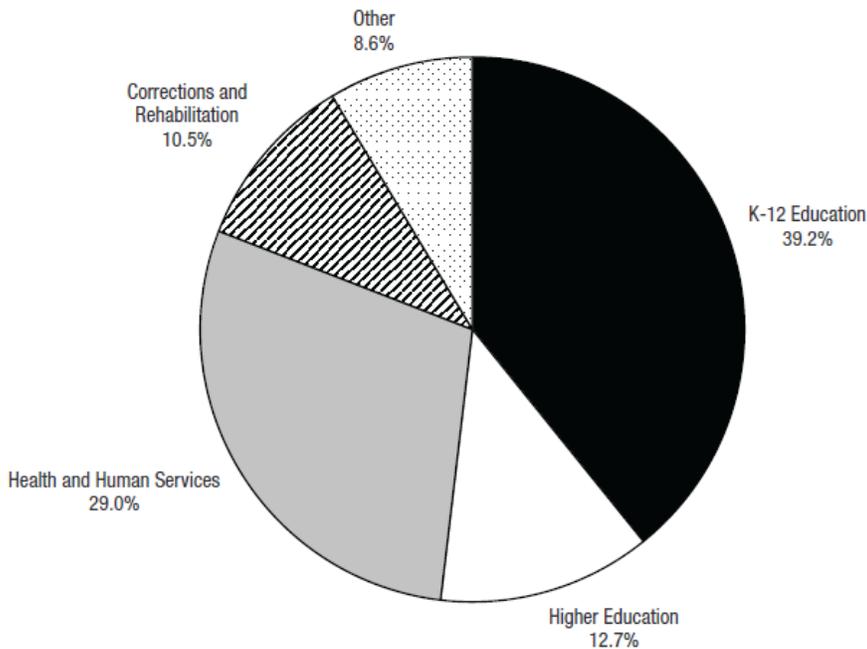
The Governor has 12 working days to sign or veto the Budget Bill after receiving it from the Legislature. By using the line-item veto, the Governor may reduce or eliminate — “blue pencil” — any appropriation before the Budget Bill is signed. The Legislature can override a line-item veto with a two-thirds vote of both Houses.

Following the Governor’s signature, the Budget Bill goes into effect on July 1.

A new budget for the state is adopted every fiscal year. The fiscal year runs from July 1 through June 30.

Where the Money Goes (2010-11 figures)

Figure 3: Slightly More Than Half of State Spending Supported K-12 and Higher Education in 2010-11



Estimated 2010-11 General Fund Expenditures = \$91.5 Billion

Source: Department of Finance

BUDGET-RELATED PROPOSITIONS 1911 - 2012 (Ballot Box Budgeting)

1911	Constitutional Amendment	Created the state initiative process.
1922	Commonwealth Club Initiative	Created the framework and timelines for consideration and enactment of the State Budget.
1933	Riley-Stewart Amendment	Established a two-thirds vote requirement for passage of the State Budget.
1978	Proposition 13	Capped property-tax rates and limited hikes in assessed values. Gave control of local property tax revenues to the state and required a two-thirds vote of the Legislature to increase taxes.
1979	Proposition 4 (Gann Spending Limit)	Limited state and local expenditures, adjusted for inflation and population.
1984	Proposition 37	Created the State Lottery, earmarking the revenues for education.
1986	Proposition 62	Required a two-step voting process for local governments to raise new general taxes; required all special taxes to be approved by two-thirds of voters.
1988	Proposition 98	Required that 40% of General Fund revenues go to public schools and community colleges.
1988	Proposition 99	Raised cigarette taxes by 25¢ a pack and by an equivalent amount on other tobacco products; allocated proceeds to health services, anti-tobacco education and research on tobacco related illnesses.
1990	Proposition 111	Increased the gasoline tax and revised the method for calculating the Gann Spending Limit. Modified Proposition 98, determining how much new revenues should go to schools.
1993	Proposition 172	Imposed a half-cent sales tax to pay for public safety services.
1996	Proposition 218	Limited the use of fees and assessments by local governments. Allowed only property owners to vote to institute new fees, and required a confirmation vote of property owners on existing fees.
1998	PROPOSITION 10	Raised taxes on cigarettes to 50 cents a pack and on other tobacco products by the equivalent of \$1 a pack; allocated proceeds to early childhood development programs administered by a new state commission.
2002	Proposition 42	Selective sales taxes collected on gasoline are permanently earmarked for transportation uses only.
2002	Proposition 49	Increases state grants to public K-12 schools for before and after school programs. No additional funding source prescribed. Currently close to \$0.5 billion of state spending devoted to it.
2004	Proposition 63	Imposes a 1% additional tax on personal income earned in the state over \$1 million. Revenue is used to fund mental health services.
2004	Proposition 1A	Freezes the current allocation in a county in place unless the Governor declares a fiscal emergency and agrees to repay imposed transfers after three years. Also requires the State to fully fund local mandates.
2010	Proposition 25	Changes legislative vote requirement to pass a budget from two-thirds to a simple majority. The two-thirds majority for passing taxes would not change.

2010	Proposition 26	Increases legislative vote requirement to two-thirds for state levies and charges. Imposes additional requirement for voters to approve local levies and charges with limited exceptions.
2012	Proposition 30	Increases income and sales taxes temporarily for education and public safety funding. Initiative constitutional amendment.

Glossary of Terms

Allotment	Part of an appropriation to be spent for a particular purpose during a specified period of time.
Appropriation	Money set apart for a specific use either by the Budget Bill or by other legislation
Appropriation Limit	Also known as the “Gann Limit.” Limits level of growth of certain appropriations from tax proceeds to prior year’s appropriation, as adjusted for changes in the cost of living and the population.
Assembly	Legislative body of 80 Members who are elected every two years and are limited to serving three terms.
Augmentation	An increase in an allotment
Bill	A proposed law or a change in the law introduced by a Member of the Legislature.
Budget	Suggested allocation of state moneys presented annually by the Governor to the Legislature for consideration.
Budget Change Proposal (BCP)	A proposal to change the level of service or funding for activities authored by the Legislature.
Budget Committees	The Senate and the Assembly committee that review the Governor’s budget proposal.
Capital Outlay	Expenditures that result in the acquisition of or addition to major fixed assets, such as buildings.
Conference Committee	Group of six members made up of three representatives from each House who are appointed to consider State Budget matters upon which the two Houses disagree.
Continuing Appropriation	Amount available each year under a permanent constitutional or statutory expenditure authorization that is automatically renewed each year.
Cost-of-Living Adjustments (COLAs)	Increases provided in state-funded programs that include periodic adjustments predetermined in state law, as well as adjustments that may be established at optional levels by the Legislature.
Expenditure	The amount of an appropriation used for goods and services ordered and received.
File	Daily printed program or agenda of business before a House and its committees.
Finance, Department of	State department under the control of the Governor that analyzes legislation and the State Budget.
Fiscal Year (FY)	A 12-month accounting period that runs from July 1 through the following June 30.
Floor	A colloquialism describing the interior of either House, sometimes distinguishing the membership from the presiding officer; matters before either House may be referred to as “on the floor.”

X INFORMATION

TAB SECTION: E

 ACTION REQUIRED

DATE OF MEETING: 01/15/14

PREPARED BY: Murphy

DATE MATERIAL
PREPARED: 12/13/13

AGENDA ITEM: Governor's Proposed Budget

ENCLOSURES: None (To be distributed at meeting)

**OTHER MATERIAL RELATED TO
ITEM:**

ISSUE:

The Governor's proposed budget is released by January 10 of each year so no information on it is available at the time this packet is prepared. The overview and synopsis will be distributed at the Advocacy Committee meeting.

