



December 30, 2013

To: California Mental Health Planning Council

From: Jane Adcock  
Executive Officer

Subject: January 2014 Planning Council Meeting

Enclosed is the packet for the January 15-17, 2014 Planning Council meeting at the Kona Kai Resort in San Diego. The hotel is located at 1551 Shelter Island Drive, San Diego, CA 95815. The hotel provides complimentary (free) same day self-parking. Overnight parking is \$5 per night.

### **Issue Request Form**

You have several copies of Issue Request Forms provided in this packet. We are enabling Planning Council members to request that committees on which they are not members address issues that are of concern to them. We have set aside the first five minutes of each committee meeting for Planning Council members to go to other committee meetings and briefly submit their issue requests. You will find Issue Request Forms in the front of this packet for your use. Please promptly return to your committee after presenting your issue request so the regular agenda items can be handled.

### **Mentorship Forum**

A Mentorship Forum will be held the evening of **Thursday, January 16**, immediately following the general session. Planning Council officers and all committee chairs and vice-chairs are specifically requested to attend. Other Planning Council members who wish to benefit from the discussion are welcome to attend.

The purpose of this forum will be to discuss the process issues involved in chairing the committees and the Planning Council. For example, experienced chairs can explain the techniques they used during the day to keep the agenda moving and manage the discussion. Vice-chairs can ask questions about techniques they observed or how to handle various problems that might occur during the course of a meeting. It is hoped that, through this process, the Planning Council will enable more members to feel qualified to serve as committee chairs or officers.

### **Committee Reports**

We have allocated 40 minutes for committee reports on Thursday morning. The focus of the committee reports is to be what tasks or objectives the committee has completed on its projects on its work plan. In addition, the committee should report any action items that it has adopted.

Please call me at (916) 319-9343 if you are unable to attend the Planning Council meeting so we can determine if we will have a quorum each day. See you soon!

Enclosures

CHAIRPERSON  
John Ryan  
EXECUTIVE OFFICER  
Jane Adcock

- Advocacy
- Evaluation
- Inclusion

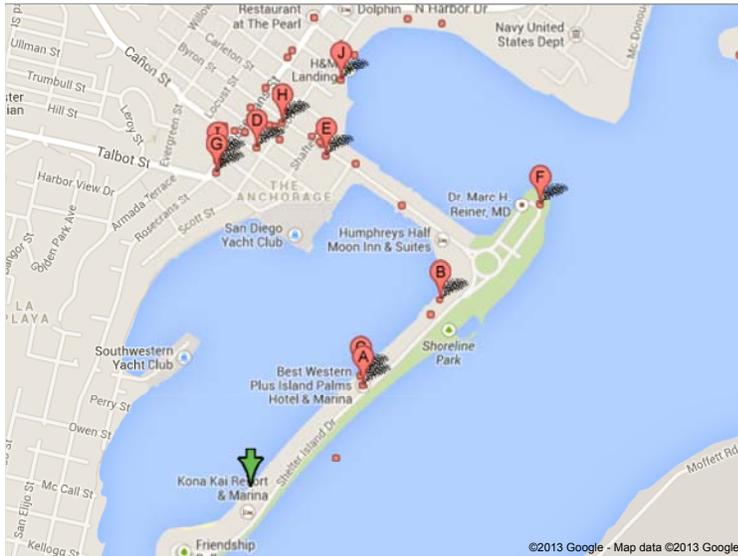
MS 2706  
PO Box 997413  
Sacramento, CA 95899-7413  
916.651.3839  
fax 916.319.8030





restaurant near 1551 Shelter Island Dr, San Diego, CA 92106

- A. **BEST WESTERN PLUS Island Palms Hotel & Marina**  
2051 Shelter Island Dr, San Diego, CA  
(619) 222-0561  
4.4 ★★★★★ 134 reviews
- B. **Humphreys Restaurant**  
2241 Shelter Island Dr, San Diego, CA  
(619) 224-3577  
4.2 ★★★★★ 169 reviews \$\$
- C. **Blue Wave Bar & Grill**  
2051 Shelter Island Dr, San Diego, CA  
(619) 223-2572  
3.5 ★★★★★ 8 reviews \$\$
- D. **Old Venice Restaurant**  
2910 Cañon St, San Diego, CA  
(619) 222-5888  
4.1 ★★★★★ 109 reviews \$\$
- E. **Brigantine Seafood**  
2725 Shelter Island Dr, San Diego, CA  
(619) 224-2871  
4.3 ★★★★★ 61 reviews \$\$
- F. **Bali Hai Restaurant**  
2230 Shelter Island Dr, San Diego, CA  
(619) 222-1181  
4.1 ★★★★★ 206 reviews \$\$
- G. **Gabardine**  
1005 Rosecrans St, San Diego, CA  
(619) 398-9810  
4.1 ★★★★★ 22 reviews
- H. **Supanee House of Thai**  
2907 Shelter Island Dr #110, San Diego, CA  
(619) 795-8424  
4.5 ★★★★★ 10 reviews
- I. **Living Room of Point Loma**  
1018 Rosecrans St, San Diego, CA  
(619) 222-6852  
4.3 ★★★★★ 20 reviews \$\$
- J. **Point Loma Seafoods**  
2805 Emerson St, San Diego, CA  
(619) 223-1109  
3.8 ★★★★★ 325 reviews \$\$

















**AGENDA**  
**CALIFORNIA MENTAL HEALTH PLANNING COUNCIL**  
**January 15, 16, 17, 2014**  
**Kona Kai Hotel**  
**1551 Shelter Island Drive**  
**San Diego, CA 92106**

Notice: All agenda items are subject to action by the Planning Council. The scheduled times on the agenda are estimates and subject to change.

**Wednesday, January 15, 2014**

**Room**      **Tab**

**COMMITTEE MEETINGS**

9:00 a.m.	Executive Committee	Bay
to		
10:50 a.m.		
11:00 a.m.	New Member Orientation	Bay
12:00 p.m.	<b>LUNCH</b>	
12:00 p.m.	Patient's Rights Committee	Coronado
1:30 p.m.	Continuous System Improvement Committee	Coronado
to		
5:00 p.m.	Advocacy Committee	Bay
	Health Care Reform Committee	La Jolla

**Thursday, January 16, 2014**

**Room**      **Tab**

**PLANNING COUNCIL MEETING – GENERAL SESSION**

8:30 a.m.	<b>Welcome and Introductions</b> <i>John Ryan, Chairperson</i>	Point Loma I&II
8:40 a.m.	<b>Opening Remarks</b> <i>San Diego County Mental Health Board Chair (Invited)</i>	
9:00 a.m.	<b>Election of Chair Elect and Changing of Officers</b> <i>Jaye Vanderhurst, Chair, Nomination Committee</i>	
9:15 a.m.	<b>Approval of the Minutes of the October 2013 Meeting</b> <i>Monica Wilson, Chairperson</i>	<b>F</b>

**Thursday, January 16, 2014 (Con't)**

**Room**

**Tab**

**PLANNING COUNCIL MEETING – GENERAL SESSION**

9:20 a.m.	<b>Executive Committee Report</b> All items on the Executive Committee agenda posted on our website are incorporated by reference herein and are subject to action.	Point Loma I&II	
9:35 a.m.	<b>Committee Reports</b> <i>Committee Chairs</i>		
10:00 a.m.	<b>BREAK</b>		
10:15 a.m.	<b>Continue Committee Reports</b> <i>Committee Chairs</i>		
10:45 a.m.	<b>Report from CMHDA</b> <i>Jaye Vanderhurst, Director, Napa County</i>		
11:00 a.m.	<b>Report from DHCS</b> <i>Rita McCabe, Assistant Deputy Director, MHSUDS</i>		
11:15 a.m.	<b>Overview of the Data Notebook</b> <i>Susan Wilson and Linda Dickerson</i>		<b>G</b>
12:00 p.m.	<b>LUNCH</b>		
1:30 p.m.	<b>Continuous System Improvement Committee: Trauma Informed Care</b> Intro Remarks: <i>Alfredo Aguirre, Director San Diego County Behavioral Health Services (Invited)</i> Adverse Childhood Experiences (ACE) <i>presented by Susan Morris Wilson</i>		<b>H</b>
2:45 p.m.	<b>BREAK</b>		

**Thursday, January 16, 2014 (Con't)**

**Room**

**Tab**

**PLANNING COUNCIL MEETING – GENERAL SESSION**

- |           |  |                    |
|-----------|--|--------------------|
| 3:00 p.m. | <b>Continuous System Improvement<br/>Committee: Trauma Informed Care Cont'd</b><br><i>Invited Panel:</i> <ul style="list-style-type: none"><li>○ <i>Dante Dauz, JD, ACE Program Manager, United Pan-Asian Communities</i></li><li>○ <i>Dawn Griffin, PhD, Program Director, Department of Undergraduate Psychology, Alliant University</i></li><li>○ <i>Betsy Knight, MFT, San Diego County Behavioral Health Services, Trauma-Informed Guide Team</i></li><li>○ <i>Charles Wilson, Project Director, Chadwick Trauma- Informed Systems Project, Chadwick Center for Children and Families</i></li></ul> | Point Loma<br>I&II |
| 4:00 p.m. | <b>Council Member Questions and Discussion</b><br><i>All</i>   |                    |
| 4:30 p.m. | <b>Public Comment</b><br><i>Monica Wilson, Chairperson</i>   |                    |
| 4:50 p.m. | <b>New Business</b><br><i>Monica Wilson, Chairperson</i>   |                    |
| 5:00 p.m. | <b>RECESS</b>  |                    |

Mentorship Forum for Council members including Committee Chairs and Vice Chairs will occur immediately following the adjournment of Thursday's General Session.

**Friday, January 17, 2014**

**Room**

**Tab**

**PLANNING COUNCIL MEETING – GENERAL SESSION**

- |           |  |                    |
|-----------|--|--------------------|
| 8:30 a.m. | <b>Welcome and Introductions</b><br><i>Monica Wilson, Chairperson</i>                  | Point Loma<br>I&II |
| 8:40 a.m. | <b>Opening Remarks</b><br><i>San Diego County Board of Supervisor Member (invited)</i> |                    |

**Friday, January 17, 2014 (Con't)**

**Room**

**Tab**

**PLANNING COUNCIL MEETING – GENERAL SESSION**

- 9:10 a.m.     **Review and Approval of Workforce Education and Training 5-Year Plan**  
*Lupe Alonzo-Diaz, Deputy Director, Healthcare Workforce Development, OSHPD and Sergio Aguilar, Project Manager, WET 5-Yr Plan, OSHPD*
- 10:15 a.m.     **BREAK**
- 10:30 a.m.     **Review and Approval of WET 5-Year Plan Continued**  
*Lupe Alonzo-Diaz and Sergio Aguilar, OSHPD*
- 11:10 a.m.     **Report from the California Association of Local Mental Health Boards/Commissions**  
*Mike Gonzales, President*
- 11:30 a.m.     **Report from Mental Health Services Oversight and Accountability Commission**  
*Richard Van Horn, Chairperson, MHSOAC*
- 11:50 a.m.     **Public Comment**  
*Monica Wilson, Chairperson*
- 12:00 p.m.     **ADJOURN**

If Reasonable Accommodation is required, please contact Jane Adcock at 916.319.9343 by January 3, 2014 in order to work with the venue to meet the request.

<b>2013 MEETING SCHEDULE</b>			
April 2014	April 17, 18, 19	Irvine	Hyatt Regency Irvine 17900 Jamboree Road, Irvine, CA 92614
June 2014	June 19, 20, 21	Oakland	Hilton Oakland Airport Hotel 1 Hegenberger Road, Oakland, CA 94621
October 2014	October 16, 17, 18	Sacramento	Lake Natoma Inn 702 Gold Lake Drive, Folsom CA 95630
<b>2015 MEETING SCHEDULE</b>			
January 2014	January 14, 15, 16	San Diego	TBD
April 2014	April 15, 16, 17	Los Angeles	TBD
June 2014	June 18, 19, 20	San Jose	TBD
October 2014	October 15, 16, 17	Sacramento	TBD



December 11, 2013

To: Executive Committee

From: Jane Adcock  
Executive Officer

Subject: **Agenda for Executive Committee Meeting**  
**Wednesday, January 15, 2014 9:00 a.m.**  
**Kona Kai Hotel**  
**1551 Shelter Island Drive, San Diego, CA 92106**  
**Room: Bay Conference Room**

CHAIRPERSON  
John Ryan

EXECUTIVE OFFICER  
Jane Adcock

The Executive Committee meeting will address the following items. All agenda items are subject to action by the Planning Council. The scheduled times on the agenda are estimates and subject to change.

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

<u>TIME</u>	<u>AGENDA</u>	<u>TAB</u>
9:00 a.m.	<b>Review and approve minutes from the October and December 2013 Executive Committee Meetings</b> <i>John Ryan, Chairperson</i>	1
9:10 a.m.	<b>Executive Officer Report on Budget, Council Membership and 2014 Meeting Agendas</b> <i>Jane Adcock, Executive Officer</i>	
9:30 a.m.	<b>Report out from Meetings with DHCS and MHSOAC re: MHSA Audit Findings</b> <i>John Ryan, Monica Wilson and Jane Adcock</i>	
9:45 a.m.	<b>Review and Discuss Operations Policies</b> <i>Jane Adcock and Tamara Jones</i>	2
10:10 a.m.	<b>Executive Committee Review of draft CMHPC Mandates Work Plan</b> <i>John Ryan and All</i>	3
10:25 a.m.	<b>Liaison Reports for CALMHBD and CCMH</b> <i>Susan Wilson and Daphne Shaw</i>	
10:35 a.m.	<b>Public Comment</b> <i>John Ryan</i>	
10:40 a.m.	<b>New Business and Designate Dinner Coordinator</b> <i>All</i>	
10:45 a.m.	<b>Evaluate the Meeting</b> <i>John Ryan and All</i>	
10:50 a.m.	<b>Adjourn</b>	

Executive Committee Members

<b>Chair</b>	Monica Wilson	<b>Health Care Reform</b>	Steven Grolnic-McClurg
<b>Past Chair</b>	John Ryan	<b>Advocacy</b>	Barbara Mitchell
<b>Chair Elect</b>		<b>Patients' Rights</b>	Daphne Shaw
<b>CSI</b>	Patricia Bennett	<b>At Large Consumer</b>	Walter Shwe
<b>CMHDA Liaison</b>	Jaye Vanderhurst	<b>At Large Fam Memb</b>	Karen Hart
<b>CALMHB/C Liaison</b>	Susan Wilson	<b>Executive Officer</b>	Jane Adcock

# AGENDA

## Patients' Rights Committee

January 15, 2014  
Kona Kai Resort  
1551 Shelter Island Drive  
San Diego, CA 92106  
(619) 221-8000

Notice: All agenda items are subject to action by the Patients' Rights Committee. The scheduled times on the agenda are estimates and subject to change.

		<b>Tab</b>
12:00 p.m.	<b>Welcome and Introductions</b> <i>Daphne Shaw, Chairperson</i>	
12:05 p.m.	Planning Council Member Issue Requests	
12:15 p.m.	<b>Review and Discuss Results of PRC Survey</b> <i>Daphne Shaw</i>	<b>A</b>
12:55 p.m.	<b>Discuss PRC Presentation to CMHPC in 2014</b> <i>Daphne Shaw</i>	<b>B</b>
1:05 p.m.	<b>New Business</b> <i>Daphne Shaw</i>	
1:15 p.m.	<b>Evaluate Meeting/Discuss Next Agenda</b> <i>Daphne Shaw</i>	
1:30 p.m.	<b>Adjourn</b>	

### ***Committee Members***

Daphne Shaw, Chairperson  
Cindy Claflin, Vice-Chairperson  
Carmen Lee  
Adam Nelson, MD  
Walter Shwe  
Richard Krzyzanowski (ad-hoc)  
Dan Brzovic (ad-hoc)

### ***Staff***

Michael Gardner

If you have any questions, concerns, or need special accommodations to participate; please call Mike Dorman at 916-552-9560 at least 3 days prior to the meeting.

Times on the agenda are estimates only and may be not be accurate.



**California Mental Health Planning Council**

**ADVOCACY COMMITTEE**

**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



**Continuous System Improvement Committee  
AGENDA  
Wednesday, January 15  
Kona Kai Resort  
1551 Shelter Island Dr.  
San Diego, CA 92106  
1:30 p.m. to 5:00 p.m.  
Coronado Conference Room**

Notice: All agenda items are subject to action by the Planning Council. The scheduled times on the agenda are estimates and subject to change.

<b>Time</b>	<b>Topic</b>	<b>Tab</b>
1:30 pm	Planning Council Members Issue Requests	
1:35 pm	Welcome and Introductions <i>Patricia Bennett, PhD, Chair</i> <i>Susan Morris Wilson, Vice-Chair</i>	
1:40 pm	Review and Approve October Minutes	
1:45 pm	Discussion: Data Notebook Review and Update <i>Susan Morris Wilson, Linda Dickerson, PhD</i>	A
2:45 pm	Break	
3:00 pm	Panel Presentation: AB 114 Implementation – San Diego <i>Invited: Tasha Arneson, PhD, Riverside County Local Planning Agency; Cheryl Rode, PhD, Clinical Director, San Diego Center for Children; Mara Madrigal-Weiss, San Diego County Office of Education</i>	B
4:30 pm	Public Comment	
4:45 p.m.	Evaluate Meeting/Develop Agenda for Next Meeting <i>Patricia Bennett, PhD, Chair</i> <i>Susan Wilson, Vice-Chair</i>	

**COMMITTEE MEMBERS**

<b>Patricia Bennett, PhD, Chair</b>	Karen Hart	Monica Nepomuceno
<b>Susan Wilson, Vice-Chair</b>	Celeste Hunter	Jeff Riel
Adrienne Cedro-Hament	Carmen Lee	Walter Shwe
Amy Eargle	Lorraine Flores	Bill Wilson



**AGENDA**  
**Healthcare Reform Committee**  
**January 15, 2014**  
**Kona Kai Resort**  
**1551 Shelter Island Drive**  
**San Diego, CA 92106**  
**Reservations: 1-800-237-6883**  
**1:30 p.m. to 5:00 p.m.**

Notice: All agenda items are subject to action by the Planning Council. The scheduled times on the agenda are estimates and subject to change.

		<b>Room</b>	<b>Tab</b>
1:30 p.m.	Planning Council Member Issue Requests	La Jolla	
1:35 p.m.	Welcome and Introductions <i>Steven Grolnic-McClurg, LCSW, Chairperson</i>		
1:40 p.m.	The Care Integration Collaborative and the CalMHSA Integrated Behavioral Health Project <i>Jennifer Clancy, MSW, Senior Associate, CiMH</i> <i>Karen Linkins, PhD, Project Director, CalMHSA</i> <i>Integrated Behavioral Health Project; Principal, Desert</i> <i>Vista Consulting</i>		<b>A</b>
2:40p.m.	Questions/Comments		
3:15 p.m.	Break		
3:30 p.m.	Update: The Affordable Care Act (ACA) and Medicaid Expansion <i>Steven Grolnic-McClurg, LCSW, Chairperson</i>		
4:00 p.m.	Call Update: Parent Partners and Covered California <i>Cindy Claflin, Vice Chairperson</i>		
4:15 p.m.	Exchanges and the Uninsured <i>Joseph Robinson, CMHPC</i>		
4:30 p.m.	Work Plan Review and Revision		
4:45 p.m.	Next Steps/Develop Agenda for Next Meeting <i>Steven Grolnic-McClurg, LCSW, Chairperson</i>		
4:55 p.m.	Wrap up: Report Out/ Evaluate Meeting <i>Steven Grolnic-McClurg, LCSW, Chairperson</i>		
5:00 p.m.	Adjourn Committee		

**COMMITTEE MEMBERS**

Steven Grolnic-McClurg, Chair  
Cindy Claflin, Vice Chair  
Josephine Black  
Suzie Gulshan

Terry Lewis  
Dale Mueller  
Joseph Robinson  
Cheryl Treadwell

Jaye Vanderhurst

\_\_\_ INFORMATION

TAB SECTION: F

X ACTION REQUIRED:

DATE OF MEETING: 01/16/14

Approve minutes from the October 2013 Meeting

DATE MATERIAL

PREPARED BY: Thompson

PREPARED: 12/13/13

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AGENDA ITEM: Approval of the Minutes of the October 2013 Meeting

ENCLOSURES: • October CMHPC 2013 Minutes

OTHER MATERIAL RELATED TO ITEM:

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ISSUE:



# CALIFORNIA MENTAL HEALTH PLANNING COUNCIL MEETING MINUTES

**October 17 and 18, 2013  
Red Lion Hotel – Woodlake  
500 Leisure Lane  
Sacramento, CA 95815**

## **CMHPC Members Present:**

John Ryan, Chair	Adam Nelson, M.D.
Beverly Abbott	Gail Nickerson
Patricia Bennett, Ph.D.	Deborah Pitts, Ph.D.
Adrienne Cedro-Hament	Joseph Robinson
Cindy Claflin	Patricia Santillanes
Caron Collins	Daphne Shaw
Amy Eargle, Ph.D.	Walter Shwe
Lorraine Flores	Stephanie Thal
Steven Grolnic-McClurg	Cheryl Treadwell
Karen Hart	Jaye Vanderhurst
Celeste Hunter	Nadine Ford
Terry Lewis	Bill Wilson
Dale Mueller	Susan Wilson
Monica Nepomuceno	

## **Staff Present:**

Jane Adcock, Executive Officer	Laura Leonelli
Linda Dickerson	Andi Murphy
Michael Gardner	Tracy Thompson
Tamara Jones	Michael Dorman

## **Thursday, October 17, 2013**

### **1. Welcome and Introductions**

Chair John Ryan brought the meeting to order. He requested the Planning Council members and staff to introduce themselves.

### **2. Opening Remarks**

Dorian Kittrell, new Deputy Director for Health and Human Services and for Behavioral Health Services for Sacramento County, welcomed the Planning Council to Sacramento County. He noted that his predecessor, Mary Ann Carrasco, had worked tirelessly during the economic crisis to get the county through it and leave the organization fiscally sound. After four years of service delivery cuts, Sacramento County is beginning to rebuild. Below are some points that Mr. Kittrell made.

- Sacramento County has about 1.45 million people and is spread over a large geographic area, which presents challenges in delivering mental health services.
- It is one of the most diverse counties in California. This has presented the opportunity to provide culturally and linguistically competent services to the community.
- The focus of Mr. Kittrell's first two years will be to rebuild the county's outpatient delivery system – to maintain and increase peer and family member support/advocacy groups, and to increase full-service partnerships.
- The large county-operated psychiatric hospital received substantial funding cuts in 2009-10. The county subsequently saw a dramatic increase in the number of hospitalizations that were occurring, because people were going to local emergency rooms rather than being served first in the 23-hour stabilization program.

Dollars are now being invested to re-open the crisis stabilization unit at the psychiatric hospital. Hospitalization numbers are now dropping.

- Grants coming from Senator Steinberg's office and the Legislature are enabling the opening of crisis services and navigation services.
- Another goal of Mr. Kittrell's is to find alternatives to hospitalization, i.e., crisis residential programming and a mobile crisis team.
- MHSA funding is providing about \$10 million for new sustainable community support. With this, Mr. Kittrell intends to rebuild the foundation of basic county outpatient services. In spite of the resiliency of contract providers and limited county clinics, the county is still falling short in terms of timeliness.

Basic outpatient services include the spectrum of medication support to full-service partnership support and case management services.

- Mr. Kittrell hopes to see a system design where consumers and family members can maintain services with their providers – where services can be wrapped and unwrapped as needed as the person goes through the recovery process.
- Even with the Affordable Care Act implementation, these are politically volatile times in regard to funding – at the federal, state, and local levels. As we move forward, we need to be prudent in how we spend the dollars. We need to ensure that there is sustainable funding in the core programming.

### **3. Approval of the Minutes of the June 2013 Meeting**

Dr. Pitts requested changes to the first paragraph on page 1: from “professional therapist” to “occupational therapist” and from “Professional Education” to “Occupational Therapy Education.”

**Motion:** The approval of the June 2013 Meeting Minutes with the changes noted above was moved by Lorraine Flores, seconded by Adrienne Cedro-Hament. Motion passed unanimously.

#### **4. Executive Committee Report**

Executive Officer Jane Adcock reported that the Executive Committee had discussed the following.

- Two new staff members are on board:
  - Laura Leonelli, who is assigned to the Continuous System Improvement Committee. She was Executive Director for the Southeast Asian Assistance Center in Sacramento County for about twelve years.
  - Tamara Jones comes to supervise the staff and handle the myriad administrative duties of the Planning Council. She worked for the state for several years.
- There are now five vacancies on the Planning Council. Ms. Adcock hopes to fill them by the January meeting, as well as to reappoint those members who would like to continue for another term.
- Mr. Ryan, Ms. Nickerson, Ms. Adcock, and Ms. Jones met with the Department of Health Care Services (DHCS) and the Mental Health Services Oversight and Accountability Commission (MHSOAC), specifically to discuss the findings of the MHSOAC audit report.
- One of Ms. Jones' first priorities will be to bring the Operations Manual up to speed.
- The new timetable for the change in Chair leadership will be in January rather than April.
- At the most recent meeting of the California Coalition for Mental Health, the Kaiser mental health workforce union gave a presentation regarding the recent sanction. Kaiser is the benchmark plan for California's healthcare reform. Their physical healthcare has come a very long way – they are the premier plan – but their mental health care is lacking. All the other health plans in the Exchange will only go as high in their standards as Kaiser, which is not satisfactory for mental health care.

Ms. Cedro-Hament commented that the Planning Council should take a stand on this issue. She suggested inviting Kaiser to come and have a dialogue with the Planning Council.

Chair Ryan suggested that it was relevant for the Planning Council to figure out how to intervene. In the push to integrate mental health and health care, mental health runs the risk of being short-changed.

Dr. Bennett noted that the Executive Committee's plan of action was not defined as yet; they were open to ideas. It is an important subject to discuss with partners in the mental

health community – how to elevate the issue through policy, education, or a combination of both.

Mr. Shwe noted that the federal government recognizes Kaiser as the model for the entire country, not just California. If the Planning Council acts on this issue, it could lead to changes in behavioral health care in the private sector in California and other states as well.

Mr. Grolnic-McClurg pointed out that Kaiser does provide mental health services to Medi-Cal beneficiaries. He recommended for the Planning Council to look at this intersection with the public mental health system.

Dr. Nelson felt that this problem is not unique to Kaiser; limiting the focus to Kaiser would result in the Planning Council missing a large part of the problem. In addition, many of the problems raised in the report about Kaiser have also been problems in a number of other localities' efforts to manage public mental health services. If the Planning Council begins to look at the issue, the scope could widen and we could get into very deep waters.

Dr. Bennett noted that Kaiser is also one of the largest holders of Medicare in the country – which involves older adults living off of Social Security.

Ms. Flores suggested bringing together all providers in the Exchange, including Kaiser, to talk about standards in order for the Planning Council to give its stamp of approval.

Ms. Cedro-Hament suggested creating a committee to begin a dialogue with the managed care industry, including Kaiser. After all, the Planning Council would like to have partnership.

Ms. Shaw mentioned that a subcommittee of the California Coalition on Mental Health has been dealing with managed care issues for some time. It would be worthwhile for this possible new Planning Council committee to contact them. Chair Ryan suggested for her and Ms. Adcock to interface with them, and bring back a report to the January meeting. Ms. Shaw agreed.

Dr. Nelson liked the idea of partnering with other agencies, and suggested inviting the California Department of Managed Health Care to the discussion.

Chair Ryan thought of inviting Kaiser Southern California to the upcoming Planning Council meeting in San Diego, to explain their system and how they deal with parity.

Dr. Bennett felt that before the Planning Council invites Kaiser to come and speak, we need a firmer foundation of understanding and knowledge.

Dr. Nelson suggested that one of the committees could take this up between now and San Diego, so we can be further along in the inquiry process.

Ms. Abbott thought of involving Peter Schroeder in an offline call, as he is a great resource.

Mr. Robinson encouraged the Planning Council to reach out to Disability Rights California, which is currently writing a white paper on parity.

Ms. Adcock closed the Executive Committee report by announcing that Dr. Pitts will be featured at the Occupational Therapy Association of California's annual conference on October 26 in Sacramento.

## **5. Council Member Open Discussion**

Chair Ryan referred the members to the California State Auditor Report in its mention of the Planning Council. He asked for comments.

Ms. Lewis asked who had represented the Planning Council during the audit, and how they were chosen. Chair Ryan responded that the auditors had talked to Ms. Adcock. Ms. Lewis felt that the Planning Council had had an opportunity then to deliver a better message. She asked how the Planning Council could help Ms. Adcock in the future.

Chair Ryan explained the audit process. The auditors had looked at the Planning Council's charge in the Mental Health Services Act (MHSA). Their concern was that the Planning Council had not reported out to the general public on its findings.

Ms. Lewis felt that the auditors' findings were not a good reflection of the Planning Council as a body, and stated that the California Association of Local Mental Health Boards (CALMHB) could be better used to show outcomes.

Dr. Nelson responded that in the field of medicine, the rule of thumb is that if you didn't document it, it never happened. He felt that everyone was saying that the Planning Council had done great work, but just hadn't properly represented it to the public and documented it. We need to a better job of reflecting the great work we're doing by means of a documentation process. Lawyers and accountants look at what's written down.

Mr. Grolnic-McClurg felt that if the Planning Council cannot fulfill its mandate because there isn't data to make that statement loud and clear, our responsibility is to make that statement consistently, repeatedly, and publicly. He also felt that because there is an External Quality Review Organization (EQRO) process looking at the public mental health system, the Planning Council should give significant input to the reports and suggest the data that should be included in them.

Chair Ryan responded that the audit report had dinged DHCS for not having good data; the MHSOAC recognized that too. The reality is that the Planning Council is dependent on those two organizations – our job is to review data and performance outcomes and studies.

Ms. Abbott referred to the MHSOAC's Dashboard – a regular report on how all their activities relate. It might be helpful to the Planning Council.

Mr. Robinson stated that going forward the Planning Council should highlight the data issue that Mr. Grolnic-McClurg spoke about – not just in reaction to something not being done.

Mr. Ryan referred to the two-pronged strategy that was planned:

1. To work with the other two organizations in order to get the reports and review them.

2. To move forward with what the CSI Committee had developed: a way to look at what data already exists and comment on it, in terms of the public mental health sector.

Dr. Bennett requested that staff take inventory of groups that are currently meeting to talk about the state's data systems – and that the Planning Council find a way to participate and report back.

Mr. Shwe felt that the auditors wanted the Planning Council to try harder, and he tended to agree. We should do what we can with the data that is currently available while advocating for much better data.

Chair Ryan reviewed the auditor's written recommendations. He reiterated that that CSI Committee is to see what data is available, and examine it to see what the Planning Council can make public comments about.

Ms. Shaw wondered if the Planning Council has ever really reviewed MHSA programs per se. Ms. Adcock responded that operationally, the Planning Council has not done any specific reviews on just on MHSA-funded programs. She intended for the Planning Council to do a better job demonstrating the input received from the counties over the years.

Along with Ms. Shaw, Ms. Nepomuceno wondered what steps the Planning Council would actually take to review MHSA programs. Chair Ryan clarified that the Planning Council's job is to review what the MHSOAC has done.

Dr. Bennett commented that the Planning Council should leave itself open to whatever it means to fulfill the mandate. One of its tasks should be to translate the technical reports coming out of the MHSOAC and make them consumer-friendly.

Chair Ryan agreed that the Planning Council has not communicated very well. However, there is much good work that it has done – for example, writing letters to legislative committees at the federal level. Legislators in California would be interested in that information.

He mentioned the White Paper on the Mental Health Illness Policy Organization. He felt that the Planning Council should look at the issues it raises and discern whether there are any to examine.

Mr. Grolnic-McClurg commented that there was a conversation to be had about the proper usage of MHSA Prevention and Early Intervention (PEI) funds. Within the counties, this issue has not been settled.

Chair Ryan commented that this issue goes back to interpretation of the language in the MHSA. Up to this point, it has been interpreted in a broad manner.

Ms. Abbott referred to the dilemma of how to reach populations that are not going to come to the mental health program for services. Some of the things cited in the report were designed for cultures, youth, and people who are not going to come through the doors. The report had felt to Ms. Abbot like a shotgun approach to identifying problems.

Dr. Pitts brought out questions about the organization that produced the paper; its website was not helpful. Yet it seems to have some intent to move the system in a particular direction.

Mr. Robinson had heard the Pro Tem speak in June. His intent was that in time, the majority of funds would go to PEI. Chair Ryan responded that the issue was what voters had been told and voted on when the MHSAs were enacted.

## **6. Committee Reports**

### **Health Care Reform (HCR) Committee**

Committee Chair Beverly Abbott stated that Planning Council members should be paying attention to possible confusion among the public when health care reform hits the ground this year. Ms. Abbott reported out on health care reform by component.

- **Medi-Cal Expansion.** Ms. Vanderhurst explained that the Mental Health/Behavioral Health Services Plan had been finalized on September 30. It provides a framework for DHCS, county mental health plans, and managed care health plans to work from to ensure that newly eligible and existing mental health consumers have access to quality services.

The HCR Committee is going to continue to review the plan against the letters submitted by the Planning Council, as well as the feedback provided by the California Mental Health Directors Association (CMHDA). The committee will also check to see that the plan reflects MHSAs principles, and that it delineates good stakeholder involvement. The committee will check that the plan serves the needs of non-specialty mental health consumers.

- **The Exchanges.** The committee will be looking at the following components:
  - Whether parity is being observed and implemented.
  - The residual population that isn't covered by Medi-Cal expansion or the Exchanges.
  - Bridge plans for "churning" – people who go on and off Medi-Cal.
  - Dual eligible pilots, also known as Cal Medi-Connect.
  - Children's services.
  - Health Homes, to be reframed into Integrated Primary Care and Mental Health.

### **Advocacy Committee**

Dr. Nelson reported that the Advocacy Committee had taken up the issue of the mental health workforce. The committee had a presentation on Certified Peer Specialists who participate side-by-side with mental health professionals and family members to increase access to services. The committee will lend its voice in getting these programs up and running in California.

The committee is considering the possibility of taking the lead in trying to generate interest among legislators in some kind of bill that would call for a Certified Peer Specialist training program and certification standards.

The committee also considered the issue of expanding the mental health workforce by allowing federally funded programs, such as MediCare and Medi-Cal, to reimburse Marriage and Family Therapists (MFTs) for their professional services. The committee raised the concern that currently, MFT training programs lack a national standard.

Dr. Bennett asked if the Planning Council had ever taken a position on the MFT issue. Dr. Nelson responded from a procedural standpoint: the Advocacy Committee planned to continue the process of gathering more information. They could possibly present a robust recommendation to the members if they still feel strongly about the efforts of MFTs to get MediCare and Medi-Cal billing capabilities.

Mr. Wilson mentioned the Working Well Together program; Dr. Nelson responded that the speaker of the presentation had represented that organization.

Ms. Thal suggested for the committee to contact Olivia Loewy at the American Association for Marriage and Family Therapy, California Division.

Ms. Hart offered her help: she is a member of the Working Well Together Advisory Board.

Ms. Shaw suggested that the idea of legislation for the Certified Peer Specialist program go to the Executive Committee.

On behalf of the Advocacy Committee, Dr. Nelson moved that the Planning Council work on drafting legislation to put in place in California a Peer Training and Certification process.

Ms. Murphy stated that the first thing to be done was to establish a certifying body. All of the other components are essentially in place – they just need to be approved.

Ms. Flores expressed a lack of knowledge about what the legislation would involve. Ms. Murphy answered that the Office of Statewide Health Planning and Development (OSHPD) had been requested to release some of the funds they had received for the establishment of Workforce Education and Training (WET) – this would be seed money to start the process.

In answer to another question from Ms. Flores, Dr. Nelson said he had the impression that agencies participating in the development of a training/certification process would be expected to comply.

Ms. Claflin pointed out that there is a National Parent Certification already in place, that has been funded for the past two years. Further, United Advocates for Children and Families (UACF) is also working on Parent Partner certification across the state.

Ms. Hart reported that four committees are established and set to move forward with the training/certification process if the funding comes through.

Ms. Shaw stated that county training would not be replaced, but standards for the training would be established.

Chair Ryan suggested for Ms. Murphy to work with the Advocacy Committee on a draft, and to bring it back to the Planning Council in January.

## **7. Report from CA Mental Health Directors Association**

Robert Oakes, the new Executive Director of CMHDA, reported on its activities.

- There have been three Mental Health Substance Use meetings. This is a place where the providers, entities, and counties sit down together and work through their responsibilities. At their last workgroup, they laid out the current coverage for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT). The CMHDA had put together a suggested list of principles for how they should move forward in delivery of services for EPSDT, and the workgroup is using it as the basis for implementation.
- Under the 2011 Realignment, Drug Medi-Cal has been transferred to the counties. In the behavioral health world, the California Association of Drug and Alcohol and the CMHDA have voted to merge. At the same time, we are trying to determine how the delivery of these services under Realignment will occur beginning in January. Part of the issue is that the delivery and methodology for certification of providers is different between mental health and substance use disorder treatments.
- The CMHDA annual retreat for the Governing Board is scheduled for the third week of November. This year there are three items on the agenda:
  - The California health care expansion and CMHDA's role in it.
  - The drug/Medi-Cal expansion.
  - The Measuring Outcomes and Quality Assessment (MOQA). Mr. Oakes felt that it is very important that providers, counties, and those individuals who are addressing the needs of clients, participate in how and what we measure; and make sure that those things we measure and are judged on, are variables about which we have some control through the delivery of our services.

Ms. Abbott commented that the "Breaking News" section of the CMHDA website is very helpful. She requested that Mr. Oakes ensure that it stays robust. He agreed.

Ms. Lewis stated that the L.A. County Office of the Mental Health Commission is honoring Pat Ryan with the annual Profiles in Hope award as Exemplary Employee.

## **(6. continued)**

### **Continuous Systems Improvement (CSI) Committee**

Dr. Bennett, Committee Chair, reported on the committee's activities.

- Dr. Renee Bradley had presented information on where the MHSOAC is in anticipating reports and evaluations from UCLA and others. She had requested the Planning Council to find ways to collaborate.
- The committee discussed systems improvement for evaluation/research/performance results.

- People from the California Association of Local Mental Health Boards (CALMHB) and Michael Ryder (who is in charge of EQRO throughout the state) have been attending CSI Committee meetings regularly, adding good information and perspective.
- The Data Notebook Subcommittee, led by Susan Wilson, has been at work.
- At the January meeting, the CSI Committee will give presentations on its work for the Planning Council.
- Over the past three months, members of the committee have been working with staff to begin to think through a response to the Planning Council's mandates. A document is taking shape: CMHPC Mandates Work Plan – Evaluation Workgroup Purpose, Goals, and Assumptions. Carol Hood has been participating on this subcommittee.

Dr. Bennett presented the draft Data Notebook to the Planning Council. She went through the assumptions with which the committee began the document, the types of data the Planning Council receives, and the performance indicator domains the committee chose.

Mr. Wilson pointed out the importance of using recent data rather than old data.

Dr. Bennett explained how the committee will use the Data Notebooks. Ms. Hart pointed out that in Domain #4, children have a different instrument from adults and older adults.

Ms. Wilson reported on the Data Notebook (formerly called the Workbook). Staffer Ms. Dickerson has been working with the committee to develop it. They have focused on making it useful for both large and small counties. It should be ready in January.

Ms. Cedro-Hament asked about the difference between the Workbook and the Notebook. Ms. Wilson answered that the Notebook has a different goal: it provides questions and data sources for mental health boards, and encourages them to pick issues particularly important to them. Thus it may be more comprehensive and educational than the Workbook.

Ms. Cedro-Hament also asked about CALMHB; Ms. Wilson answered that they will be involved when the local mental health board training piece is ready.

Ms. Lewis offered to donate her time for telephone calls; in the past her board used the initial Workbook for data. She also shared the hope that the booklet would be so basic that ordinary people would not be frightened by the data.

In answer to a question from Ms. Abbott regarding the varying population sizes of counties, Ms. Wilson replied that they will definitely be grouped somehow.

Ms. Wilson mentioned the turnover in CALMHB – training is not a one-shot deal but an ongoing issue. The committee is keeping that thought in mind.

Ms. Vanderhurst pointed out that the local mental health boards are comprised of volunteers, so the Data Notebook must be kept simple and applicable.

Dr. Bennett reviewed the statutory requirements. The Committee had considered its process and past activities, and decided to review available information – from the Web, and from MHSOAC reports and any other entities relevant to the domains. Dr. Bennett cited the kinds of data to be gathered for the domains.

She emphasized that the document is a beginning framework. She requested the Planning Council members to reflect on it, submit ideas, and give feedback.

Ms. Abbott complimented the committee’s approach. She felt that the Planning Council should act in response to the audit, and identify what we would like to do – including if there were more resources available.

Ms. Treadwell also liked the direction the committee was taking. She suggested national network sites on stress and trauma as resources to tap into and offered to steer the committee to them.

**(6. continued)**

Mr. Grolnic-McClurg reported on the process of evaluating assisted involuntary outpatient treatment (Laura’s Law) in Contra Costa County. He noted that the predominance of stakeholder input is coming from family members rather than consumers. The issue has a lot of momentum going statewide, yet there has not been much consumer involvement in this county.

Ms. Abbott felt that given the Planning Council’s history and interest in the issue, it would be good to hear from mental health directors in a future meeting.

Ms. Shaw agreed – it would be interesting to feel the current pulse. She will check with the co-chairs of the Advocacy Committee.

Dr. Nelson suggested that the CALMHB Board might be the group to contact in polling counties on what’s happening around the state.

Mr. Robinson reported that at the last meeting of the California Coalition for Mental Health (CCMH), the issue was raised of the noticeable decline in consumer participation in statewide hearings. He noted that the contracts that had been held by the network at the Department of Mental Health (DMH) are now held by the MHSOAC. Chair Ryan suggested that at the next day’s meeting, the MHSOAC could report on those contracts.

Ms. Hart stated that the client piece had gone to PEERS California Mental Health Peer-Run Organizations (CAMHPRO), a very viable, funded organization. As part of their contract, they are trying to increase client attendance.

Chair Ryan suggested for the CALMHB Board to address this question at the next day’s meeting.

**Patient Rights (PR) Committee**

Chair Daphne Shaw reported that the committee has been having monthly calls; one of them featured a presentation on patient rights. The committee is working on their own presentation to the Planning Council in March.

At the previous meeting, the committee had decided to focus on WNI Code 5220, which lays out five requirements for counties to follow regarding patient rights. They spoke with the National Alliance on Mental Health (NAMI) about getting information on whether the requirements are actually being followed, via a survey. The survey may also include questions on the Medi-Cal grievance process.

## **8. SAMHSA Update**

Chair Ryan had reported earlier that Dr. Jon Perez of the Substance Abuse and Mental Health Services Administration (SAMHSA) would not be able to speak due to the federal government shutdown.

## **9. CMHPC Mandates Work Plan**

Chair Ryan referred the members to the CMHPC Mandates Work Plan included in their packets. He emphasized the verbiage that Health Services “shall consult...” and the Planning Council “shall abide...” The Planning Council is mandated to be involved in the process of policy and procedure development.

Chair Ryan asked the members to identify wish lists. If they had the opportunity to address the Work Plan with additional resources, what would they be?

Chair Ryan reviewed the mandated requirements with the members, as summarized below with Planning Council members comments.

### For the federal mandate:

The Planning Council will notify DHCS that it needs sufficient time to review the draft state mental health plan required by PL 106-310.

Public hearings must be held on both the Mental Health Block Grant and the Substance Abuse Block Grant.

The Planning Council needs sufficient time to review the Implementation Report created by DHCS.

The mandate to advocate for adults and children is fulfilled well by both the Advocacy Committee and the whole Planning Council as a body.

The Planning Council can ask DHCS to “monitor, review, and evaluate annually the allocation and adequacy of mental health services within the state” at least every two years. In the in-between years, the Planning Council can ask DHCS to tell what has been done to improve the adequacy of mental health services in California.

Ms. Vanderhurst pointed out that we are trying to fit in to old language and the old Department of Mental Health (DMH) requirements. At some point we should renegotiate with the DHCS because the state no longer annually allocates mental health service dollars. Chair Ryan agreed that the Planning Council could ask for clarification.

Based upon the UCLA study, the Planning Council is in a position to make some statement on the term “adequacy.” We could also request an annual needs assessment on mental health services in California.

Ms. Lewis noted that the workbook being developed in conjunction with the boards and commissions to look at data is part of the monitor/review/ evaluation process that can be fed back to the Planning Council – we actually do have something we are doing in terms of that bullet item.

Ms. Adcock pointed out that the CSI system has general information about who is being served, regardless of fund source. It could be useful to look at growth in numbers of individuals being served over time, ethnic groups, age groups, and gender.

For the California Welfare and Institutions (WIC) Code:

Chair Ryan felt that the Planning Council covers #1 very well.

Ms. Adcock expressed interest in looking at the state hospitals. Ms. Shaw pointed out that the Planning Council had done a lot of work with the state hospitals in the past.

Ms. Vanderhurst noted that other sources of data are the counties' DHCS contract triennial audits and their MHSAs annual plan updates (collected by the MHSOAC).

Ms. Hart pointed out that for Medi-Cal Managed Care, in the Attestation the counties certify that they have certain reports, policies, procedures, etc. The actual review is probably what the Planning Council would want to look at for deficiencies.

Mr. Grolnic-McClurg and Ms. Abbott suggested that staff or a consultant could map out the Planning Council's functions, and options for how the functions could be met. Ms. Adcock responded that the current draft Work Plan was the staff's product; now they needed the members to contribute their knowledge and experience.

Regarding #3, Ms. Vanderhurst stated that this performance outcome data did not exist: counties follow the process of waiting for the Planning Council to do the Notebook, which the boards then review and submit back to the Planning Council.

Mr. Grolnic-McClurg said that the one consistent data that all counties are getting in evaluation is EQRO.

Ms. Flores noted that in her county, a compliance review is done to which the contract agencies are privy. That data is available. Ms. Vanderhurst commented that they were talking about the same document: the compliance review is the way DHCS ensures that counties that contract to be the mental health plan are meeting all the conditions of their contracts.

Ms. Vanderhurst pointed out that community-based organizations also function as providers in addition to the county – the counties don't hold all the data.

Ms. Flores noted that the contract agencies tend to have far more outcomes than the county mental health departments. She wondered if the contract agencies have access to the various counties' outcome measurements.

Mr. Grolnic-McClurg stated that many other providers offer mental health services in California that are funded by insurance, private pay, schools, etc. (Chair Ryan commented that he assumed the discussion involved contract agencies operated by the counties – publically funded.)

Ms. Adcock noted that staff had brainstormed about looking into special topics, e.g., suicide rates among older adults. Those could still be counted toward fulfilling the charge to look at pertinent aspects of the mental health system.

Ms. Abbott commented that the problem with looking at suicide rates is that they don't tend to vary over time. This is why she felt that the Planning Council needs the evaluation expertise. She did not want the Planning Council to go down roads that are not productive. Perhaps Dr. Joan Meisel could help the Planning Council with evaluation, should the funding come available.

Chair Ryan commented that he didn't think the Planning Council had ever fulfilled #4.

Ms. Cedro-Hament commented that there are no standards with which to evaluate.

Ms. Shaw commented on the first bullet under #3: somewhere along the line the law got changed. The mandate used to be to review and approve the performance outcome "indicators;" now it says "measures." Has this lessened the Planning Council's presence or influence?

Dr. Pitts responded that it may reflect an internal semantics change in the broader outcomes industry.

Ms. Adcock read the language of Section 5655, named in #4.

Chair Ryan commented that the Planning Council seems to have fulfilled #5 and has the clear authority to continue to do so.

Chair Ryan said that he was not aware of the Planning Council ever having fulfilled #6. He was not certain how to accomplish it. Ms. Adcock stated that this WNI code actually goes into conjunction with another on the master list: Section 5610. There are other laws that impact some of the ones that apply to the Planning Council, that need to be taken into consideration.

Chair Ryan read #7 and suggested adding it to the list of questions for DHCS.

Chair Ryan assumed that the "state mental health plan" referred to in #8 meant the block grant. They will check with DHCS. Ms. Hart thought that the "block grant" meant SAMHSA block grant.

Chair Ryan pointed out that the Notebook was part of #9.

He felt that #10 was confusing – another question for DHCS.

Ms. Adcock stated that last year's AB 109-Criminal Justice Realignment and the CSI Committee's AB 114-Children's Mental Health Services Transition fulfilled #11.

As named in #12, Ms. Hart stated that staff and members were participating in setting standards, for instance the EPSDT and Katie A. Ms. Adcock said that she had been on the California Stakeholder Process Coalition, which has recommended contract language and policy to the Department. Ms. Arneill-Py had participated in the AB 100 Workgroup, which had mapped out parts of the law and made recommendations.

Dr. Pitts asked about the "division." Ms. Adcock replied that it referred to Division 3, which meant all the mental health laws.

Regarding #12, Ms. Hart added that last year, the full Planning Council had written a letter expressing grave concern about the inclusion of stakeholders in the various processes and the demise of the Advisory Groups.

Chair Ryan and Ms. Adcock established that regarding #13, the Planning Council had never been requested to mediate disputes.

Chair Ryan confirmed that #14, 15, and 16 are options open to the Planning Council.

Chair Ryan stated that WIC 5820 and WIC 5821 are being fulfilled by the Planning Council's involvement in the Advisory Committee. Also, OSHPD will present its WET plan on October 18, and the Planning Council will produce a final review in January.

Chair Ryan commented that the bottom line is that the Planning Council has responsibilities and authority. In looking at mental health issues in California, it has the opportunity to request resources and do reports.

He continued that he and Ms. Nickerson, Ms. Adcock, and Ms. M. Wilson had met with Senator Steinberg's Chief of Staff, who does much of the draft legislation for mental health. She had made a point of walking them through the reports from the Planning Council that she has used.

Ms. Thal commented that commented that this Work Plan would be good to keep in mind every time the Planning Council develops its meeting agenda, to ensure that it is following its mandates.

Ms. Cedro-Hament recalled that the Planning Council had produced a Master Plan years ago. During the Prop 63 campaign, the Planning Council had tried to encourage counties to check out the Master Plan for guidance. Maybe it should be revisited.

Ms. Adcock responded that every new member receives a copy in the orientation binder. Staff had actually looked into developing an Addendum, but it was an overwhelming task. It is a magnificent product but some things have changed in the ten years since it was written (such as the MHSA).

Ms. Adcock encouraged everyone to skim the 10 or so pages of state statutes for the Planning Council. She was in awe of the breadth of scope that the Planning Council is to address of the mental health system.

Ms. Cedro-Hament suggested that whenever the Planning Council writes a letter, to include a reference to the Master Plan. Many of the values in the Master Plan have not changed.

Ms. Hart pointed out that the Planning Council had updated the Master Plan a few years ago, but is not utilizing it actively. We should make sure to clarify that we are referring to the updated Master Plan.

Ms. Abbott added that the Master Plan had been used to write Realignment legislation, which provided the basis for the kind of system we have today. She suggested that when the Planning Council sets meeting agenda items, to note the mandate it relates to.

## **(11.) Report from Mental Health Services Oversight and Accountability Commission**

The report was postponed for the next day.

## **(12.) Celebration and Acknowledgement of Outgoing Members**

Chair Ryan acknowledged three members who were leaving the Planning Council: Stephanie Thal, Gail Nickerson, and Beverly Abbott. (Doreen Cease was not present.)

Members shared their thoughts about these colleagues.

Ms. Collins stated that if it wasn't for Ms. Nickerson, she would not be there. Ms. Nickerson had been able to quell her uncertainty and fears about joining the Planning Council.

Mr. Shwe had succeeded Ms. Abbott as Chair, and Ms. Nickerson had succeeded him. Ms. Thal had been appointed a Committee Chair the year Mr. Shwe was Chair. He had enjoyed serving with them all.

Ms. Vanderhurst was grateful that Ms. Abbott had been her mentor when she was first assigned to the Planning Council.

Celeste Hunter acknowledged all four of those leaving. She had benefited a great deal from Ms. Abbott; Ms. Thal had always been helpful and warm; Ms. Nickerson had always been helpful and knowledgeable. Ms. Hunter acknowledged Ms. Cease for the time and effort she had put into education. They will all truly be missed.

Ms. Cedro-Hament was thankful to Ms. Abbott for the push she had given her in the cultural competency movement. Ms. Nickerson had provided a refreshing perspective about the medical side. Ms. Thal had energized the Older Adult Committee. Ms. Cease had been a friend from the same locale. Ms. Cedro-Hament will miss all four women.

Ms. Lewis read lyrics from the song, "That's What Friends Are For." She thanked Ms. Abbott for sharing her knowledge on healthcare reform.

Ms. Thal remembered joining the Older Adult Committee. She also recalled that Ms. Cedro-Hament had been her mentor. Ms. Thal thanked everyone for a wonderful nine-year experience.

## **(10.) Report from Dept. of Health Care Services**

Chair Ryan introduced Karen Baylor, the new Deputy Director at DHCS for Mental Health. She summarized her first two months on the job.

- She was learning and integrating mental health and substance use disorders into DHCS, a huge department.
- With healthcare reform, currently there is much to do to get the benefits ready to go by January 1.
- Integrating mental health into DHCS has taken a full year or more, and there still is more to do.

Chair Ryan asked to whom Ms. Baylor reports. She replied that thanks to the stakeholders a few years ago, she reports directly to Toby Douglas, DHCS Director.

Ms. Vanderhurst said that the Health Care Reform Committee is working on the behavioral health needs assessment and service plan. She asked what DHCS's next steps are for mental health now that the Affordable Care Act health care plan has been released. Ms. Baylor replied that Brenda Grealish, the Mental Health Division Chief, has been actively involved in a workgroup with the Managed Care department of Health Care Services. They have been looking at how to engage the health plans and develop the MOU that the health plans will need with their counties.

Dr. Bennett asked about the development of a meaningful, real-time data system. Ms. Baylor replied that fixes are in progress. They are trying to make sure that counties enter all the data. Dr. Bennett noted that if counties are not getting any useful data, it's not as important for them to enter it. She expressed the hope for new technology that's more simple and user-friendly. Ms. Baylor agreed; the Legislature is also asking for data.

Ms. Hart asked about the possibility of reinstating the Performance Outcome Advisory Group. She was concerned about meaningful involvement of clients and family members. Ms. Baylor responded that because of the Business Plan and the Service Plan, there is a need to develop infrastructure on communication, feedback, and stakeholder engagement in a meaningful way. They are working on a plan to do something on a regular basis, and also something for consumers and family members only – they hope to present the structure to the Planning Council, the California Institute for Mental Health (CiMH), CMHDA, the County Alcohol & Drug Program Administrators Association of California (CADPAAC), and possibly others to see if it makes sense.

Ms. Baylor stressed that meetings should be meaningful. She added that “parking lot” issues that will take time and vetting should be prioritized in an infrastructure, so something can actually be done about them. We need to have meaningful conversations about these issues and to use technology more effectively.

Ms. Abbott noted that the Health Care Reform Committee has participated in many of the DHCS stakeholder calls. She observed that this process favors people who have a lot of knowledge and are paid to participate. It is much harder for people who have not had a chance to form their ideas fully but do have a contribution to make. DHS had arranged “pre-calls” for consumers and families to ensure that they fully understood the issues. Ms. Abbott requested for Ms. Baylor to consider ways to help this category of people.

Ms. Baylor appreciated her point, and said that DHCS would be arranging “pre-calls” – town hall meetings once a month before a call, or something to ensure that those voices are heard.

Ms. Baylor stressed that as she had come from San Luis Obispo County, she valued and appreciated having the state work together with the counties as well as the stakeholders.

Chair Ryan presented Appreciation of Service Awards to Ms. Abbott, Ms. Nickerson, and Ms. Thal. Cake was served.

#### **(14.) New Business**

There was no new business.

#### **13. Public Comment**

John Sturm, Chair of San Diego's Mental Health Board, spoke in regard to Laura's Law. He addressed the need to see more representation from participants who are actually receiving the services, living with those income restraints, and dealing with those real-life situations.

Steve Leoni, consumer and advocate, voiced his respect for Ms. Abbott. He had met her when she was on the State Quality Improvement Council, then worked with her on the CSS Guidelines after the MHSA was passed. She had really listened to clients and family members, and had put their voice into the Guidelines.

Robert Pelson, Marin Mental Health Board and Chair of its Suicide Prevention Committee, requested to speak with any interested Planning Council members on the topic of suicide prevention.

Cary Martin, Chair of the San Joaquin County Mental Health Board and First Vice President for CALMHB, shared a letter containing a plea for help from parents to other parents, about a daughter's worsening severe mental illness.

Mr. Grolnic-McClurg said that he had read similar letters about residents in his county. He connected them to the Planning Council's inability to make a statement that our mental health system is not sufficient to meet the needs of the community.

Chair Ryan shared that his personal experience was similar. He had also heard many such stories. We know how to do better, but we don't have opportunities. He had hoped that the MHSA was that opportunity; it has rescued the system from some of the chaos in the state budget up to this point, but it is not sufficient. He suggested recognizing the data that is available, and putting together an advocacy report as the Planning Council's mandates require.

Ms. Hart stated that having a child with serious mental illness is every parent's nightmare. Here in the homeland of Laura's Law, and with MHSA services theoretically available, there is still a gap for certain individuals preventing them from being treated. She asked where to begin to remedy this.

Ms. Abbott said that you try over and over again to connect with the person until the door opens. This is the kind of service that's needed. You don't confront and don't argue. Intensive Full Service Partnership (FSP) programs are supposed to try to accomplish this kind of engagement.

Mr. Robinson noted that Turning Point is the adult FSP and mandated assisted outpatient treatment provider in Nevada County (where the individual resided), the daughter probably has been connected to those services. With the interpretation of 5150 and 5152 laws, and the difficulty in having someone who is presenting as a danger, to be legally held is a very complicated situation.

Dr. Nelson shared the experience of a team of people ministering to the homeless in San Francisco. He commented that he had debated with Dr. E. Fuller Torrey on Michael Krasny's Forum radio show on NPR. Dr. Nelson's position had been that with our population, there is a fairly consistent threshold where if you maintain persistence, eventually you will reach those who had been thought unreachable. However, for all of

the hundreds of success stories, there is always a percentage of people who stay beyond the threshold. That is the problem our mental health care system faces today. What responsibility do we have for people who absolutely refuse to access mental services that are desperately needed? It's an ethical question probably without a right answer.

Ed Dixon stated that many times a person does not feel safe admitting a mental illness; it comes down to the stigma. He shared his experience of working with such people. Education can be done on the spot with the individual.

Mr. Wilson stated that people with lived experience would be perfect for advocating/ helping someone going through the same situation. People with lived experience need to be engaged with providers and to function as a unit.

Ms. Cedro-Hament stated that the story in the letter was not unusual for her; she gets such letters quite often. In Los Angeles, they have a PMRT: a mobile team of clinicians sent out to do welfare checks. There must be some kind of engagement with the person with mental illness, and persistence factors in. The team is very savvy as to what they do in various situations, for example, if weapons are involved or if the person is elderly. The team communicates with the parents as well, and access is 24/7.

## **Friday, October 17, 2013**

### **1. Welcome and Introductions**

Chair Ryan greeted everyone attending the Friday morning session. Members of the Planning Council and audience introduced themselves.

### **2. Opening Remarks**

Chris Hunley, Chair of the Sacramento County Mental Health Board, gave the Opening Remarks. He stated that the main reason he joined the Mental Health Board was that he has a family member who suffers from severe mental illness. In addition, he had gone through the foster-adoption process and found the system very confusing to navigate. He could appreciate the difficulties that people who suffer from mental illness and their families go through while experiencing the different episodes that occur.

Below are highlights of Mr. Hunley's opening remarks.

- Like many of the CALMHB Board members present, the Sacramento County local board represents a diverse mix of volunteers, family members, consumers, and public interest members.
- There are a number of different polarizing issues in mental health, but coming together in a forum where people can be open helps to vet the issues properly.
- The Board believes that everyone wants the chance to be successful. Regardless of their illness or circumstance, there needs to be a support system in place to help them achieve success.

- In 2011, the Board approved and appointed a small committee to develop a feasibility study of alternatives for individuals in the county. A 100-page Feasibility Study looked at current practices and successful programs from other comparable jurisdictions. Of nine different conclusions, the majority are in place or in an advanced stage of planning.
- One of the products of the Feasibility Study was the Sacramento County Mental Health Court, a collaborative effort between law enforcement, the courts, and mental health.
- This year the Board was able to get an additional \$500,000 for post-release offenders mental health treatment and substance abuse treatment.
- None of these advocacy efforts would be possible without the Board's volunteer members. They make the time and effort to get things done. They are unpaid, and look to the CMHPC, the CALMHB Board, and other state mental health agencies for relevant training and education. The Sacramento County Department of Behavioral Health Services provides support in many ways: staff for the meetings, website maintenance, training with CiMH, etc.
- The Board looks forward to improving its networking and communications with the Planning Council and the MHSOAC. They strive to be better trained in looking at performance outcomes.

### **3. Report from the California Association of Local Mental Health Boards and Commissions (CALMHB/C)**

Mike Gonzales, newly elected President of the CALMHB/C, stated that he comes from a small northern county, Tehama. Below are highlights of his presentation.

- With the changing face of the mental health system in the state, and with changes in responsibilities of local mental health boards, the CALMHB/C itself is also changing.
- CALMHB/C is an all-volunteer organization made up of professionals, clients and consumers, and family members. They have no paid staff or IT personnel.
- At the June meeting, members elected a new executive board. Cary Martin remains on the Executive Board to share his wisdom and knowledge.
- CALMHB/C recently reviewed, revised, and implemented changes to its by-laws.
- CALMHB/C is planning upcoming meetings in the five regions of the state.
- CALMHB/C is working with CiMH to develop and implement trainings and webinars throughout the year for local mental health boards. The webinars are the only way some of the more remote counties can receive training, interact, and voice their opinions to the rest of the state members.

- CALMHB/C is forming a database of contact information for each of the county behavioral health boards and commissions.
- CALMHB/C is updating and adding to its website.
- CALMHB/C is renewing its contract with the MHSOAC.
- CALMHB/C is in the process of filing a claim to cover lost reimbursement from June 2012. It was lost in the transition between DMH and the MHSOAC.
- CALMHB/C is striving to be more involved with not only the Planning Council but also the California Stakeholders Process Coalition (CSPC) and the MHSOAC Community Program Planning Process, currently being implemented.
- CALMHB/C is striving to improve its name recognition in all the counties throughout the state.

Dr. Nelson asked, on behalf of Mr. Grolnic-McClurg, about the absence of consumer representation in discussions of Laura's Law. Other Planning Council members thought this could be happening in other areas. To gain reliable information about experiences around the state, members thought of contacting CALMHB/C for observations or actual data collection.

Mr. Gonzales responded that CALMHB/C has not had specific conversations on Laura's Law per se. He agreed to check with membership on this topic and get back to the Planning Council.

Ms. Shaw asked about discussions between CALMHB/C and the MHSOAC on securing some funding for CALMHB/C. Mr. Gonzales replied that they go through the MHSOAC contract manager. At this point, the CALMHB/C has been granted a small increase for one year.

Ms. Lewis noted that MHSOAC funding has been increased – will any of that be considered for more staffing for the CALMHB/C? Also, how about the use of interns? Mr. Martin stated that the CALMHB/C had contacted Senator Steinberg's office regarding funding, but there had not been a positive response. About the use of interns, Mr. Gonzales stated that it was a new idea and an excellent one.

#### **4. Overview of Workforce Education and Training Draft 5-Year Plan and Discussion**

Lupe Alonzo-Diaz, Deputy Director for the Healthcare Workforce Development Division at OSHPD, gave a presentation on the Workforce Education and Training (WET) Draft Five-Year Plan. Chair Ryan asked if the Planning Council's suggestions from the June meeting had been incorporated; she replied that they had.

With Ms. Alonzo-Diaz were Sergio Aguilar, Project Manager for the Five-Year Plan, and Michael Wimberly, Manager of the Health Care Reform team.

Ms. Alonzo-Diaz stated the two objectives of the presentation as (1) providing an overview of the process used to get to the current draft, and (2) giving an opportunity to obtain Planning Council feedback. Below are highlights of the presentation.

- The Five-Year Plan is intended to be the concepts, strategies, and actions that will be supported at the state and county levels.
- It is due to the Legislature on April 1, 2014. Ms. Alonzo-Diaz intends to return to the Planning Council in January for further feedback.
- With the past Five-Year Plan, seven programs were administered at the state level. The next Five-Year Plan gives an opportunity to evaluate whether the plans worked and to look at key performance indicators with more current data.
- The WIC Code requires certain core components with certain elements to be included in the next Five-Year Plan: post-secondary education, forgiveness and scholarship programs, stipend programs, regional partnerships, etc.
- To finalize Phase 1, OSHPD deployed a stakeholder process that included 14 community forums, 13 focus groups, a webinar and online survey, stakeholder interviews, advisory committees, and a career pathways committee.
- For the quantitative aspect, OSHPD has contracted with a vendor, Resource Development Associates (RDA), to gather additional information. The contractor is responsible for conducting various analyses.

Chair Ryan directed the Planning Council members to a section of the WIC Code that relates to the Five-Year Plan.

Mr. Aguilar stated that the WET Five-Year Plan provides a framework on strategies that state government, local government, community partners, education, and other stakeholders can enact to further public mental health workforce, education, and training efforts. That means that not everything in the plan is something that OSHPD can or will do. It is a comprehensive and robust plan that all stakeholders can look at to implement. It will cover the period of April 2014-April 2019.

OSHPD had taken the previous plan's vision, values, and mission, and added some unique timely elements. One of the most important elements is ensuring that we have a workforce that has the numbers, diversity, skills, and resources to deliver adequate and appropriate care as outlined in the MHSA. Mr. Aguilar elaborated further on the Vision, Values, and Mission.

Mr. Aguilar gave highlights of the three goals' objectives.

- Goal #1 concerns the future workforce. The objectives concern:
  - Expanding career awareness and outreach in order to recruit more individuals, including diverse individuals.
  - Looking at curricula to be used in training the future workforce.
  - Developing career pathway, ladders, and lattices.

- Making sure to expand the capacity of postsecondary education.
- Expanding financial incentive programs.
- Goal #2 concerns the incumbent workforce. The objectives concern:
  - Expanding continuing education training programs.
  - Ensuring retention of the incumbent workforce.
  - Evaluating methods to expand and enhance the quality of existing public mental health service delivery systems.

Goals #1 and 2 ensure a focus on diversity, cultural and linguistic competency, and regional differences.
- Goal #3 concerns the state and local infrastructure. The objectives concern:
  - Supporting collaborations and partnerships.
  - Looking at mental health shortage areas.
  - Exploring policies that stakeholders have identified as barriers.

### **CMHPC Feedback**

#### **Vision, Values, and Mission**

Ms. Collins asked Mr. Aguilar to expand on the term “inappropriately served.” He responded that because the mental health workforce does not have the full competency to provide care, sometimes care is not appropriate and does not meet the needs of the population. Those inappropriately served could consist of different cultures – racial, socioeconomic, veterans, LGBTQ.

Ms. Collins asked about the reference to “linguistic.” Mr. Aguilar explained that there are sometimes language barriers among different populations. Various training strategies could be used for those populations.

Ms. Abbott felt that the plan is good at capturing broad concepts and themes. She questioned the term “non-licensed.” In addition, she felt that “such as” statements rather than broad statements would make the plan stronger.

Dr. Pitts encouraged the use of different language on page 5, sixth bullet item: “Promote interdisciplinary care by working across disciplines.” The term “interprofessional” is currently replacing the term “interdisciplinary.”

Ms. Hart suggested adding “Inappropriately Served” to the Definitions. She asked about the term “Transitional-Age” rather than “Transition-Age” Adults and Youth.

Ms. Mueller requested additional information on the evaluation of prior WET plans – are they available somewhere? Ms. Alonzo-Diaz responded that the strategy for developing the Five-Year Plan included the qualitative and the quantitative. The qualitative aspect involved asking the community about what is and is not working. The qualitative aspect involved the contract with RDA – one of its deliverables is an evaluation of the existing statewide WET programs.

Ms. Muller asked how to stay connected in order to obtain the evaluation data. Ms. Alonzo-Diaz replied that OSHPD is providing the information to Ms. Adcock and Chair Ryan via the workgroup; they can forward the information to all the Planning Council members.

Ms. Mueller asked about Goal #3, Objective A, Action 3: when would it be possible to find out who falls within that category? It expands our thinking about course development. Mr. Aguilar responded that the “how” and “who” have not yet been developed.

Dr. Nelson suggested that part of the Five-Year Plan should include more explicit language about data collection and tools; he was particularly concerned about retention. Mr. Aguilar responded that retention is still an issue because through the stakeholder processes, different counties had told WET staff that people are leaving and retention is still not there. In the first plan, not much had been done on retention – that is why it is being expanded.

Ms. Alonzo-Diaz stated that there are a number of different data elements being collected. She stated that OSHPD already has data elements collected on two kinds of programs: contracts that DMH put together, and programs already administered by OSHPD. RDA is helping with the broader aspects rather than individual programs – on the whole in the last five years, what was the impact?

In addition, a needs assessment was submitted to the counties, as part of the balance of information being received from community stakeholders.

Dr. Nelson asked about the easiest way for the Planning Council to see the data. Ms. Alonzo-Diaz responded that WET staff has been asking the contractors to continue to share the data they collect (in the form of fact sheets or reports). She will send what they have; Chair Ryan said that it would be included in the next meeting packet.

Ms. Claflin requested definitions on “family member” and “consumer.” She noted that SAMHSA has those definitions on their website.

## **5. Continue Discussion of Workforce Education and Training Draft 5-Year Plan**

Dr. Pitts commented regarding Goal #1, Objective B: instead of the verb “develop,” she suggested “identify existing.” Developing curriculum can be quite expensive and labor-intensive, and it already does exist, having been developed by federal grants.

Ms. Hart requested that under Objective C on page 10, that there be a separate action item that would address the establishment of a state peer specialist certification for consumers, parents/caregivers, and family members. She asked that the Planning Council address this as a body.

In response, Mr. Aguilar referred to Action 1 as one of the policy areas that individuals have identified as a critical need. Ms. Hart asked that state Peer Specialist certification be identified in a separate item.

Ms. Abbott suggested moving such an item out of Objective C because so much work has already been done in this area.

Ms. Alonzo-Diaz addressed the appropriate role of OSHPD, in addition to other government partners. Stakeholders agree that a lot of good work has already been done (for example, Working Well Together and other consumer and family member organizations). The career pathways committee has been responsible for looking at the pathway for the Peer Support Specialist.

She continued that the item had been placed under Objective C because the plan needs reviewing approval by OSHPD and other government partners. OSHPD does understand the interest in and importance of the item.

Ms. Hart asked that if the item could not be moved from the “exploration” arena, that the verbiage be made more specific around the Peer Specialist certification and also more inclusive by adding “parent/caregiver.”

Ms. Abbott asked if the item could be moved under Goal 1 where it would be given more support. Ms. Alonzo-Diaz responded that they would consider adding it to a different goal. While drafting the plan their perspective had been that with certification as the outcome, it was a policy initiative.

Chair Ryan added that the Planning Council had been very much aware of including the promotion of employment of mental health consumers and family members in the mental health system. This discussion was not an administrative issue for the Administration or the Governor approving or disapproving – it was a requirement of the law for the Planning Council.

Dr. Nelson asked if stakeholders at other state agencies are expressing resistance to the Peer Support Specialist certification proposal. Ms. Alonzo-Diaz replied that the issue comes not from WIC, which is specific to inclusion of employment. Certification is a different outcome. Chair Ryan pointed out that the promotion of employment would be greatly enhanced by certification.

**Motion:** The upgrade of the State Peer Support Specialist certification for consumers, parents, caregivers, and family members, and its move to Goal #1, was moved by Karen Hart, seconded by Walter Shwe.

Dr. Nelson felt that the issue was not where the item should be in the plan. He suggested a friendly amendment: to include an item in Goal #1 suggesting that the Certified Peer Specialist needs to be added to the workforce.

Ms. Hart stated that the certification was a key issue. Mr. Shwe agreed.

Dr. Pitts pointed out that the verb “explore” was a soft action, and possibly a more declarative action was warranted.

With the friendly amendment:

**Motion:** The addition to Goal #1 of “The establishment of the State Peer Support Specialist certification for consumers, parents/caregivers, and family members.” was moved by Karen Hart, seconded by Walter Shwe. Motion passed with one abstention.

Ms. Murphy felt that since everything was being listed as a goal, that action words should be used: “facilitate,” “development,” and so on. Non-assertive language gives the impression that OSHPD and the state are not behind it. In actuality, these are requirements of the law.

Chair Ryan asked about the stipend program: when stipends are being sent to educational institutions, there should be some determination of what is being taught to the students. Mr. Aguilar responded that as in the previous Five-Year Plan, OSHPD has metrics for evaluating curriculum. The method of determining whether the proper curriculum is being taught will be a multi-pronged approach to be developed.

Chair Ryan noted that since this concerns the development of the future workforce for the public mental health sector, the student and the person who hired the student should give feedback on the student’s preparation. This information should then be given to the institutions for quality improvement.

Ms. Hart requested that the word “certification” be included in the Definitions.

## **6. Public Comment**

Robbie Townsend, CALMHB Board, asked about training in the WET plan for volunteers, suicide prevention hotline volunteers, mental health board members, and so on. Mr. Aguilar replied that there were elements of training on stigma, but not necessarily for the broader pieces. Mr. Townsend recommended including something on volunteer training.

Gwynne Foster, California Social Work Education Center (CalSWEC), commented that the plan should speak more explicitly to reducing mental health disparities and prioritizing designated shortage areas as criteria for plan activities. There is much more data available now than there was five years ago on both issues. Ms. Foster also noted that Goal #1 calls for expansion of programs – however, the budgets for many of the statewide contracts have not changed since they were executed several years ago.

Ms. Foster continued that regarding Goal #1, Objective E, Action 2, the expectation that graduating students would relocate to work may be unrealistic. She concluded that OSHPD should work to establish a clear framework for evaluation that includes measurable progress indicators for statewide and local programs. She added that the CalSWEC website contains some reports with interesting data.

Sharon Keene, Project Advisor to the CAMHPRO Peers Working Well Together Team, said that the implementation of the Peer Specialist in California is an initiative whose time has come. She suggested that rather than creating one training entity for the state, to create an agency with the authority to hold certification. It would work closely with consumer and family member leadership entities and certify training programs developed in the state’s diverse localities.

Ms. Keene continued that if we move forward with the establishment of the certification, there were some recommendations in the Career Pathways Subcommittee that would be important to its success.

Ms. Hunter referred to family members and consumers already working in the field: how would this certification process affect them? Ms. Keene answered that the draft recommendations include the establishment of a grandfathering clause that will allow minimal testing or short training offered for free.

Ms. Alonzo-Diaz said in conclusion that the team was grateful to be present and hear the Planning Council members' feedback. Next steps include:

- Release of the next draft before November 4 with a one-week open comment period.
- During that week, two statewide all-day webinar/conference calls will be held.
- The team will continue to work with the Planning Council's workgroup.
- Another Advisory Committee meeting will take place on December 12.
- OSHPD is in the process of finalizing the reconciliation of all of the dollars that were administered on a statewide basis, so they can look at the remaining balance.

Ms. Lewis requested to have changes to the plan printed in a bold font or italics; Ms. Alonzo-Diaz agreed.

## **7. New Business**

Ms. Adcock reported that Ms. Cease has been released from the hospital.

Ms. Adcock introduced Suzy Frank, Director of People Empowering People in Napa County, as the winner of the Joe Mortz Memorial Award. Ms. Frank stated that Joe's purpose, drive, and values of the consumer movements lined up exactly with her agency's. They always want people's opinions – not just to be heard, but to be put into practice. She extended heartfelt thanks from her agency to the Planning Council.

Ms. Hart stated that the Planning Council still honors and misses Joe. He always spoke on behalf of not just his own constituency but also what he felt was right for the end users of the system.

Mr. Shwe said he and Joe had joined the Planning Council at the same time. In their conversations, Joe had challenged him to do better in his role in the Planning Council.

## **(6. continued) Public Comment**

Marsha Renstrom, CALMHB Board-Superior Region and Shasta County Drug and Alcohol Advisory Board, put in a plug for the Planning Council to hold a meeting in Redding.

Herman DeBose, Los Angeles County Mental Health Commission, suggested for the Planning Council to consider Los Angeles rather than San Diego for meetings. He also felt that this Sacramento hotel should not be used again.

In answer to a question from Mr. DeBose, Ms. Adcock stated that she had begun a practice of using speakers from the local county mental health boards rather than legislators. She also explained that the Planning Council practice for meeting venues had

been to have San Diego and Sacramento as set locations, with the April meeting somewhere in Southern California near an airport.

Mr. Sturm asked about the carve-out for county services that would commence in January. Ms. Abbott explained the Cal MediConnect project. Mr. Sturm also expressed concern with a consequence of AB 109 that drugs are being smuggled into the jails at a higher rate. Mr. Sturm's last comment concerned the housing issue and limited services for people currently considered stable.

**(7. continued) New Business**

**Motion:** For the Planning Council to draft a letter of support recommending funding for the California Association of Local Mental Health Boards and Commissions was moved by Terry Lewis, seconded by Celeste Hunter.

Ms. Hart requested a friendly amendment not to be specific about exactly what the funding would be used for. Ms. Lewis agreed, and suggested to edit the old letter that had been sent in the past.

In answer to a question from Ms. Hunter, Ms. Adcock explained that there is a small contract currently held with the MHSOAC to pay for local mental health board members to travel to their CALMHB Board meetings.

With the friendly amendment:

**Motion:** For the Planning Council to write a letter of support recommending additional funding for the California Association of Local Mental Health Boards and Commissions for additional resources such as staffing, supplies, etc. to carry out their activities, was moved by Terry Lewis, seconded by Celeste Hunter. Motion passed unanimously.

**(Postponed from October 17) Report from Mental Health Services Oversight and Accountability Commission**

Aaron Carruthers, new MHSOAC Chief Deputy Director, gave an update for the Planning Council members.

- The MHSOAC recently elected Richard Van Horn as Chair and David Pating as Vice-Chair for 2014. Their leadership continues from 2013.
- Executive Director Sheri Gauger will retire in December. The MHSOAC is seeking a new Executive Director.
- The MHSOAC recently received authority to issue PEI regulations for MHSA. These regulations were drafted but never adopted. The public participation process has been extensive with three public hearings.
- The MHSOAC has changed its format by having roundtable discussions, in order to have intensive conversations about peer employment and peer respite centers.
- The MHSOAC has recently been given authority to issue grants for triage personnel –\$32 million came out of MHSA funds. The MHSOAC did a

process to create a Request for Application, which has been posted to counties eligible by statute to apply. The goal is to get 600 individuals hired. The purpose is to expand the number of mental health personnel available to provide crisis support services.

- Leadership from the Planning Council and the MHSOAC recently met with DHCS in response to the audit, to discuss ways to coordinate evaluation of both the MHSA and the community mental health system. The MHSOAC continues to extend the invitation to Planning Council staff and members to work together on this effort.

Chair Ryan mentioned that Dr. Bennett felt that Renee Bradley's attendance at the CSI Committee meeting had enhanced the committee. He requested her continued presence.

Ms. Lewis commented that last September the MHSOAC had come to Los Angeles County. Unfortunately, they came on the same day as the Mental Health Commission meeting – so it split the attendance of stakeholders. Ms. Lewis requested that when they do come to the counties, to check their calendars to make sure there are no other major meetings taking place.

Ms. Adcock said that she had been wearing a green ribbon in honor of mental health. Produced by the California Mental Health Services Authority (CalMHSA), the ribbons are intended for branding the movement for mental health. Ms. Nepomuceno announced the slogan as “Each Mind Matters” and noted that the website has several other products.

## **11. ADJOURN**

Chair Ryan adjourned the meeting at 12:09 p.m.



**X INFORMATION**

**TAB SECTION: G**

**ACTION REQUIRED:**

**DATE OF MEETING: 01/15/14**

**PREPARED BY: Tracy Thompson**

**DATE MATERIAL  
PREPARED: 12/10/13**

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**AGENDA ITEM:** Overview of the Data Notebook

**ENCLOSURES:**

- Guide and Overview: Data Notebook 2013 for California Mental Health Boards and Commissions

**OTHER MATERIAL RELATED TO ITEM:**

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**ISSUE:**

Susan Wilson, CMHPC, and Linda Dickerson, PhD, will provide an overview of the Data Notebook.



# TEHAMA COUNTY: DATA NOTEBOOK 2013

## FOR CALIFORNIA

### MENTAL HEALTH BOARDS AND COMMISSIONS



*Prepared by California Mental Health Planning Council, in collaboration with:  
California Association of Mental Health Boards/Commissions, and APS Healthcare/EQRO*

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DRAFT

## **Overview: First, Tell us about Behavioral Health in Your Community**

### 1. What are the MH programs in your county?

- a. Please provide some examples of successful MH programs in your county that seem to make a difference in people's lives. Suggestion: choose three to five examples, and list age groups targeted. (Feel free to select programs regardless of funding sources: i.e., MHSA, public—private partnerships, schools, FQHCs,<sup>1</sup> and county MH programs, etc).
- b. Do any of these programs include the use of Wellness and Recovery Perspectives<sup>2</sup> ?
- c. Do any programs focus on underserved, minorities, or special needs populations? (Suggestion: choose three to five examples most relevant to your community). Examples could include any of the following:

racial/ethnic minorities	pregnant women
children	elderly
TAY	disabled
LGBT/Q	homeless
foster youth	dual diagnosis (MH and substance use)
tribal youth	jail inmates
veterans	recently released offenders

[Leave space for text by MHB members].

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<sup>1</sup> FQHCs = Federally Qualified Health Centers

<sup>2</sup> Examples can be found in the CiMH Final Report, June 2013, for those counties participating in: "Advancing Recovery Practices: A Breakthrough Series Collaborative." Similar programs may be offered soon in other counties. Please check with your local MH/BH director for more information.

2. With respect to delivery of MH services, do you have suggestions regarding any of the following:

- a. specific unmet needs (or gaps in services),
- b. new programs,
- c. improvements to, or better coordination of, existing services,
- d. improvements in access or outreach, or
- e. access to MH services in other language(s) ?

[Leave space for text by MHB members].

DRAFT

### **Coordinating MH and Substance Use Treatment for Dual Diagnosis Clients:**

3. To what extent is substance use among MH clients an issue in your county?  
How does your county MH program measure the number of MH clients which also have a substance use problem?
  - a. If so, what percent are believed to have dual diagnoses for both MH and substance use (alcohol or drugs)?
  - b. How do your MH programs (and/or substance abuse programs) address this issue? What steps does your county take to connect MH clients with any needed substance use treatment?
  - c. What programs for substance use treatment are you aware of in your local community? Which programs have a reputation for good success in helping people to recover?
  - d. In your opinion, what factors do you think lead to successful recovery from substance use problems?

[Leave space for text by MHB members].

## **Treating the Whole Person: Integrating Behavioral and Physical Health Care**

“Individuals living with serious mental illness (SMI) die, on average, 25 years earlier than the general population.... This is a serious public health crisis for state mental health agencies.”<sup>3</sup>

Improving the physical health of clients with serious mental illness (SMI) is a national goal. The goal is better coordination of care for mental health, substance use treatment, and physical health. One helpful example for small counties can be found in the Performance Improvement Project of Tehama County,<sup>4</sup> as part of a Learning Collaborative sponsored by CiMH.<sup>5</sup>

To answer this question, you may need to seek information from your county Quality Improvement (QI) coordinator or MH director.

4. Does your county measure how many clients have seen a primary care physician or nurse practitioner in last year?
  - a. If available, please provide data (numbers, percent of total MH clients).
  - b. Describe MH program efforts to link clients to physical health care providers.

[Leave space for text from MHB members]

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<sup>3</sup> National Association of State Mental Health Directors, 2006. Cited in: “SCCI Final Report: Small Counties Care Integration”. June 2013, CiMH. This report describes the results of a Collaborative Learning Initiative in which 14 small counties participated.

<sup>4</sup> For details, see page 27, and pp. 77-80 (Appendix F), of the 2012-13 EQRO report for the Tehama County MHP, at [www.caeqro.com](http://www.caeqro.com).

<sup>5</sup> Other counties have recently participated in similar “Care Integration Collaboratives” sponsored by CiMH (for examples, see CIC Final Report, June 2013, CiMH). Please check with your local county for information about recent, or planned future, participation in care integration learning projects.

5. How does your county address wellness programs to engage and motivate MH clients to take charge of improving their physical health?

Examples of wellness programs could include classes or activities for:

- exercise
- nutrition
- healthy cooking
- stress management
- quitting smoking
- maintaining social connectedness
- managing chronic diseases (such as diabetes or high blood pressure).

[Leave space for text by MHB members]

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## System Performance Indicators

### Access: New Clients

Most counties choose to define new clients as those not seen within the prior 6 months, but some may choose to count those not seen in the prior 12 months.

This data should be available from your local QI Coordinator or MH Director. These data refer to any MH clients within the CSI/DCR<sup>6</sup> or other local MH data systems.

6. How many children and adult clients are “new” clients? That is, those who have not received MH services within the prior 6 months? What do these numbers and the way they are defined tell you about your MH program?

New Adult Clients (age 18 and older), Number: \_\_\_\_

% of All Adult Clients: \_\_\_\_

Time frame (months) for definition of New Adult Client: \_\_\_\_

New Clients, Children & Youth, (aged 0-17), Number: \_\_\_\_

% of All Child & Youth Clients: \_\_\_\_

Time frame (months) for definition of New Client: \_\_\_\_

New Clients, Transition Age Youth (TAY)<sup>7</sup>, (aged 16-25), Number: \_\_\_\_

% of All Child & Youth Clients: \_\_\_\_

Time frame (months) for definition of New Client: \_\_\_\_

[Leave space for text from MHB members]

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<sup>6</sup> CSI and DCR refer to the DHCS data systems (formerly DMH) for all MH clients reported by the counties to the state. CSI = Client Services Information. DCR = Data Collection and Reporting system for Full Service Partnership (FSP) client outcomes.

<sup>7</sup> TAY clients represent a subset of children (ages 16-17) combined with a subset of adults (aged 18-25).

**Access: Wait time for appointments**

Wait time for appointments may be one of the most critical issues for individuals or families with a member who experiences a mental health crisis.

Please examine the Timeliness data and discussion in the section of your county EQRO report labeled “Access.”<sup>8</sup> That section will provide some of the data requested below.

7. How does your county set goals and monitor wait time to appointments? What are those goals? How often are the goals met? What are the average wait times? Do they monitor and report these values separately for children’s services? Please report your numbers in the formatted table below and then discuss.

Type of Appointment	Goal (days)	% Goal Achieved	Average Time (days)
New Patient, Adult	___	___	___
New Patient, Child	___	___	___
Urgent Care/Crisis	___	___	___
Post-Hospitalization	___	___	___

Source: Your County’s MH Plan Data on Access

[Leave space for text from MHB members, to discuss above data and issues.]

8. What type of service does your county define as the “first appointment” provided after the initial request for mental health services?

[Leave space for text from MHB members]

<sup>8</sup> Note that the “Access to Appointment” data is **not** audited by the EQRO. This section of the report only conveys what the county MHP reports to the EQRO. However, for the year 2013-14 review, the EQRO will begin to ask the county MHPs to provide the data they used to determine their timeliness measures.

9. What is your opinion about the best way to define measures of “time-to-first-appointment?”

- Should timeliness be a measure of the time from first contact with the MHP (via phone or in person) to the first treatment/assessment visit?
- Should the first visit be counted if it's just filling out financial forms?
- Should “orientation” group attendance be counted as the first visit?
- Should the first visit designation only apply to face-to-face encounters with a person licensed to provide MH services (similar to the Medicare definition)?

[Leave space for text from MHB members]

10. What are examples of steps taken by your MH program to improve timely access to care? How have these steps been implemented ?

- Do these steps include efforts to reduce “no-shows” or fill empty time slots?
- For example, if tele-psychiatry hours are available, how many hours are used or actually filled each week?

[Leave space for text from MHB members]

## **Role of Access to Reduce Repeat MH Hospitalizations**

Examine the data figure below showing data for your county compared to the statewide averages. An important measure of access for patients released from the hospital is how soon they have a post-discharge follow-up appointment. Note the relationship, if any, of follow-up appointment wait time (7 days vs 30 days) on the goal to reduce re-hospitalizations within that first month after release.

[Insert EQRO Graph, Fig. 14]

[Leave space for text from MHB members]

11. In your county, consider the effect of post-discharge appointment wait time (7 days vs. 30 days) on the goal to reduce repeat hospitalizations within the first month after discharge.
  - a. What steps does your local MH program take to improve follow-up and continued care for clients after a hospitalization? (For example, what is the “hand-off” process from hospital staff to outpatient staff? Often, that could involve scheduling initial outpatient appointments).
  - b. Do they have similar strategies to help clients who received crisis stabilization or other crisis support services?
  - c. Do you have suggestions on how to improve access to care and follow-up after a MH-related hospitalization or crisis stabilization service?

[Leave space for text from MHB members]

## **Access: Barriers to Service**

12. In your county, what are the most significant barriers to service access experienced by MH clients and their families? Examples of some potential barriers might include:

- Transportation
- Child care
- Language issues or lack of translators
- Specific cultural Issues
- Too few child or adult therapists
- Lack of psychiatrist or tele-psychiatry services
- Delays getting evaluation for prescription
- Lack of means to access internet or e-mail
- Restrictive time window for scheduling appointments.

Suggestion: identify the three examples you believe to be most important to MH clients in your community.

[Leave space for text from MHB members]

## **Health Disparities and Fairness of Access**

In order to address basic questions about fairness of access to healthcare, researchers ask: Are people of all ages and race/ethnicity groups coming in for services, in numbers roughly similar to their proportion of total Medi-Cal clients?<sup>9</sup> To address that question, we examine demographic data for the state and for individual counties.

Statewide data for race/ethnicity: first, compare the percent of population for each group in the top figure (Medi-Cal beneficiaries) to the same group's percent in the next figure (recipients of MH services). Examine which groups receive a greater per cent of services (lower figure) compared to their percentage of the Medi-Cal population (top figure). [Insert 'Pie chart' Graphs from Figures 5a and 5b]

Next, compare the patterns you observed in those statewide data to the figures which follow, showing the data for your county. Examine each of the ethnic/racial demographic groups and compare to those groups who received MH services.

[Insert 'Pie Chart' Graphs from Figures 6a and 6b]

Based on your examination the data for your county, note which groups appear to receive a lower percent of services (bottom figure) compared to their percent of the Medi-Cal population (upper figure).

13. Which groups (if any) appear to be underserved? What outreach efforts are being made to minority groups in your community? What about non-English-speaking persons, homeless individuals, or other hard-to-reach populations?

[Leave space for text from MHB members]

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<sup>9</sup> Penetration Rates

## **Service Penetration Rates: Another Measure of MH Access**

This is just one measure of fairness in access to mental health services. However, penetration rates are one important standard performance indicator used by the state of California and some federal agencies.

The definition of penetration rate used in this Data Notebook is the same as the one used by the EQRO, because it is simple, easy to calculate, and much easier to understand than some other measures.<sup>10</sup> First, note the baseline value, then, look at how that measure changed over time. Such trends help give an indication of whether there is an improvement, over time, in access to services by different groups.

Next, we consider 4-year trends in penetration rate of the overall Med-Cal eligible population (adults + children) for this county.

[Insert Graph here: EQRO Figure 8].

14. How have these trends changed over time? Do you have any comments on what these trends might mean for local MH services? For example, are they increasing the total numbers of clients served over time?

[Leave space for text from MHB members]

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<sup>10</sup> Some MH board/commission members may have come across a different definition of penetration rates based on “Holzer” targets, which involved a complex statistical estimate of mental health needs in different populations. Those estimates included factors for poverty level, age, gender, race/ethnicity, and used census data from 2000, which are sadly outdated. We mention this problem because past reports from DMH, DHCS, and current reports from the MHSOAC use the Holzer estimates for reporting data from 2004 to 2012.

There is no easy or correct way to relate the EQRO penetration rates to the Holzer target numbers. One *could* try using the public health estimate that one-fifth of the population at any time may need mental health services. So, multiplying the EQRO penetration rates by five would give one a “rule of thumb” comparison to reports which use the Holzer targets. But that rule of thumb would not be strictly accurate. For one thing, the mental health needs of the Medi-Cal population are generally greater than those of the larger population

The important thing to remember is: first, choose one consistent measure (or definition). Take note of the baseline value. Then look at how that measure changed over time. Such trends give an indication of whether there is an improvement in access to healthcare services by different groups.

**Disparities in Access to Services by Race or Ethnicity:**

**Focus on Comparison of Hispanic to White Service Penetration Rates**

The following table examines service differences between Hispanic and White clients. The average claims paid per client is one indicator of relative fairness in access to services. The penetration rates shown are another measure of fairness of access to mental health services. Statewide, the approved claims per individual served are now similar for Hispanic and White clients. However, this indicator may be lagging in some counties. The penetration rate ratios are still much lower for Hispanics than for White eligible Medi-Cal recipients. Statewide, these rates for Hispanics are about one-third those for White Medi-Cal recipients. In some counties, these rates may be even lower. Please examine the most recent numbers for rates and ratios for your county (listed under MHP CY11) in the table below. Compare your county numbers to the average statewide numbers.

[Insert part of Figure D-9 here]

MH Plan Data from Tehama County, 2011.

Figure D-9. Examination of Disparities—Hispanic versus White								
Calendar Year	Number of Beneficiaries Served & Penetration Rate per Year				Approved Claims per Beneficiary Served per Year		Ratio of Hispanic versus White for	
	Hispanic		White		Hispanic	White	PR Ratio	Approved Claims Ratio
	# Served	PR %	# Served	PR %				
<b>Statewide CY11</b>	158,486	3.68%	155,835	10.06%	\$4,706	\$4,726	.37	1.00
<b>MHP CY11</b>	173	3.12%	1,396	11.50%	\$1,947	\$3,081	.27	.63

Language and culture can be critical factors to helping people engage in, and to continue, treatment. These may be key factors to help clients to gain initial access to care, especially for clients or parents of children whose primary language is not English. The numbers and cultural backgrounds of underserved populations vary considerably by county. A similar analysis may be done for other race/ethnicity groups by different counties, depending on their population and needs.

For reference, look at the data above, and also look back at the “pie chart” figures for your county shown earlier in this report, to consider other groups as well.

15. After examining the data, what do you think about the roles of language and culture for MH care in your community?

- a. Does your county measure time to access appointments for therapists who speak Spanish or other languages? How well do the medical translators do in assisting with sensitive MH services?
- b. What are specific program or service needs for some of the minority groups in your county (e.g., African-Americans, Asian/Pacific Islanders, Hispanics, or American Indian/Alaskan Natives, others)?

Suggestion: data sources might include local community organizations or churches, published reports, and your local QI coordinator or MH director.

- c. Can you provide suggestions to improve program content and outreach for minority groups in your county?

[Leave space for text from MHB members]

DRAFT

## **Retention Rates: One Measure of Client Engagement in Services**

Why are these measures important? Research shows that, without sufficient time engaged in services, often few long-lasting improvements in behavioral health are seen.

Also, if the programs do not measure these rates, they could be unaware of how many clients only get one or two services but never come back to get the help they really need. Knowing these numbers helps the county staff figure out that improvements may be needed. But other efforts are required to determine the reasons why some clients receive fewer than 5 services and whether they still have unmet MH needs.

Let us consider how these rates are measured. We examine the total number of clients in each group who received:

- just one service,
- those who received 2, 3 or 4 services,
- those who received 5-15 services (which may be the range for at least “minimally adequate care”), and
- those who received more than 15 services in a year.<sup>11</sup>

For an examination of the total number of services received, see tables/figures listed below. Take note of the numbers of services for your county, the per cent of clients who fell into each group, and then compare to the statewide numbers.

[Insert EQRO Table from Appendix D, Overall Retention Rates]

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<sup>11</sup> Some members may wish to know more detail about the types of services provided. That level of detail is provided on page 2 of [Appendix D](#) for each individual county’s EQRO report. The data tables in Appendix D are highly informative and provide a much more complete picture for evaluation.

Tehama County MHP Medi-Cal Services: Overall Retention Rates CY11<sup>12</sup>

Number of Services Approved per Beneficiary Served	TEHAMA		
	# of beneficiaries	%	Cumulative %
1 service	144	8.44	8.44
2 services	219	12.84	21.28
3 services	177	10.38	31.65
4 services	95	5.57	37.22
5 - 15 services	568	33.29	70.52
> 15 services	503	29.48	100.00

16. What are some steps taken by your MHP to improve client engagement in care? For those clients receiving fewer than five services, what is your county doing to determine if those individuals need further MH care, and to re-engage them in treatment? Do you have suggestions to improve client engagement in continued MH services?

[Leave space for text from MHB members]

<sup>12</sup> Prepared by APS Healthcare/CAEQRO. Source: Short-Doyle/Medi-Cal approved claims as of 12/10/2012. Inpatient Consolidation approved claims as of 03/04/2013. Number of services is counted by days for any 24 hours and day services, and by visits or encounters for any outpatient services.

## Vulnerable Groups and Potential Disparities in Services by Age

### Older Adults

Next, examine the percent of MH clients in your county who are older adults, aged 60 and over. Consider how these numbers compare with statewide data.

[Insert numbers here from EQRO data tables at website: [www.caeqro.com](http://www.caeqro.com)]

Tehama county: 11.5% of Medi-Cal beneficiaries were adults 60 or older, but they represented only 8% of those who received MH services. The penetration rate for this age group = 6.14%.

That value is about half of the penetration rate of 12.9% for adults aged 18-59.

17. Regarding mental health services for older adults in your county:
  - a. Social isolation and difficulty traveling to appointments are just two examples of barriers to MH care for some older adults. What are other significant barriers to access and engagement in services?
  - b. Are you aware of any programs in your region to meet the MH needs of older adults?
  - c. What do you identify as the most critical behavioral health issues for older adults?

[Leave space for text by MHB members]

## **Children and Youth:**

Examine the data for children and youth. Note the percent of MH clients in your county who are children under 18. Consider how those numbers might compare with data for other counties of similar size, or to statewide numbers.

[Insert numbers here, calculated from EQRO data tables]

Tehama county: 45.4 % of Medi-Cal eligibles were children aged 0-17.

Children (aged 6-17) represented 27.2 % of all those who received MH services (S/D Medi-Cal).

For this group (ages 6-17), the penetration rate was 9.03% for Medi-Cal eligibles accessing MH services.

18. Regarding mental health services for children and youth in your county:

- a. What effects on access to MH services do you predict from the increased numbers of children eligible for Medi-Cal benefits in 2014 and beyond?<sup>13</sup>
- b. Do you have information about programs targeted for children or youth, or to assist parents whose children have MH needs?
- c. If data are available from your county: What percent of your county budget for MH is allocated for children and youth services? What are the major funding sources for these programs?
- d. What do you think are critical areas of unmet mental health needs?

[Leave space for text from MHB members. Answer may involve discussion of information from county QI coordinator or director of MH services, if available].

## **Foster children:**

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<sup>13</sup> Some increases are due to transitioning children and families from low-income health plans, changes in certain managed care programs, and Medicaid expansion under the Affordable Care Act.

These represent an especially vulnerable group of children who have had exposure to abuse, neglect, or other trauma (e.g., loss of a parent). Many have significant mental health needs to help them cope with changes in their living arrangements, change in schools, loss of their siblings, friends, pets or other social support systems, and many other factors.

In the figure below, examine the race/ethnicity distribution for Foster Care children who are eligible for Medi-Cal in your county.

[Insert 'Pie chart' Graph, Fig. D-11]

Next, in the graph below, consider the race/ethnicity distribution for Foster Care children who received specialty MH services funded by Medi-Cal. Compare the figure below with the figure above, and examine the relative distributions of services received by race/ethnicity. Please note any apparent differences.

[Insert 'Pie chart' Graph, Fig. D-12]

Next, consider the following figure, and examine the trends for penetration rates for receipt of MH services by foster youth over recent years. Note how these rates have changed over time up to the present.

[Insert Graph: EQRO Fig. 9 Foster Care Penetration Rates]

Next, in the figure below, we consider retention rates for foster children, as one measure of the degree of engagement in MH services.<sup>14</sup> The data are grouped by numbers of services received, and the percentages of foster children who received those services.

[Insert Table from EQRO Appendix D]

Foster Children: Number of MH Services Received, CY11.

Number of Services Approved per Beneficiary Served	TEHAMA		
	# of beneficiaries	%	Cumulative %
1 service	5	4.81	4.81
2 services	14	13.46	18.27
3 services	7	6.73	25.00
4 services	3	2.88	27.88
5 - 15 services	31	29.81	57.69
> 15 services	44	42.31	100.00

19. In terms of MH services for foster children and youth, the needs are complex and go far beyond the data shown above for access by race/ethnicity, service penetration rate trends over time, or the total number of services received. For your county, consider the following:

- a. Are there any local barriers to access and engagement in MH services for foster youth or children? (One example might be if the child changes schools or is moved several times to different home placements, making it

<sup>14</sup> For more detail regarding types of services received, locate the EQRO report for your county at [www.caeqro.com](http://www.caeqro.com). At the end of that report, look at Appendix D, to find the data tables for foster children.

- difficult to maintain continuity with one therapist). Are there specific needs with respect to the child's preferred language or culture?
- b. What special MH programs or services exist for foster children or youth? Do any of these programs involve perspectives based on the effects of trauma or other serious life events on child development?
  - c. Do you have recommendations for programs or services for foster children or youth based on critical needs in your local community?
  - d. Optional.<sup>15</sup> Consider discussing some current foster child/youth programs with one of the following groups or local agencies:
    - Department/Board of Education,
    - Department of Social Services (or Child Protective Services),
    - Department of Public Health (or Health & Human Services),
    - Juvenile Justice-related agencies (e.g. family court, probation), or
    - Health care provider (e.g. pediatriacian, pediatric nurse practitioner, or a licensed child therapist or psychiatrist).

[Leave space for text from MHB members]

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<sup>15</sup> This optional question is only for those MHB members who have extra time to invest. However, talking with different agencies with responsibility for child/youth services may provide greater depth to answers for parts (a), (b), and (c). Needs –and therefore programs-- may vary greatly for rural vs. urban counties.

## **Transition Age Youth (TAY) (ages 16-25)**

The needs of youth as they transition into adulthood are multi-faceted in terms of education, work/employment, and their evolving identity and personal relationships. . Some adult programs may have a TAY-focused component. Needs for substance use treatment may be a consideration, as well as linkages to primary health care, or referral to smoking cessation programs, if desired by the individual. Some TAY clients are former foster youth. Some of these youth may lack other community and social supports. In some counties, TAY individuals may be an under-counted (and therefore under-served) component of the homeless population.

[Insert 'Pie chart' Graph, EQRO Fig.D-13] Please examine figure below which shows the race/ethnicity distribution of TAY individuals who were eligible for Medi-Cal services. You may wish to compare this distribution to the "pie charts" earlier in this report regarding the overall race/ethnicity of Med-Cal eligible persons in your county, as there may be some important differences for TAY clients.

[Insert 'Pie chart' Graph, EQRO Fig.D-14] Next, in the figure below, consider the race/ethnicity distribution of TAY clients who received MH services. Compare to the previous figure of Medi-Cal eligible TAY clients. Note any major differences in the race/ethnicity of those TAY actually served compared to Medi-Cal eligible youth.

Next, in the following graph, consider the trends in penetration rates for receipt of MH services by TAY clients over recent years. Note how these rates may have changed up to the present time (or most recent data available).

[Insert Graph, EQRO Fig.10]

Next, in the figure below, we consider retention rates for TAY, as one measure of the degree of engagement in MH services.<sup>16</sup> Because of their unique needs, this age range is one of the more challenging groups to reach and get involved in MH services. The data below are grouped by numbers of services received, and the percentages of TAY who received those services.

Insert EQRO Graph of Table from Appendix D].

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<sup>16</sup> For more detail about types of services, please find your county report at [www.caegro.com](http://www.caegro.com), and look at Appendix D, to find the data tables for MH services provided to TAY clients.

Transition Age Youth (Age 16-25): Number of MH Services Received, CY 2011.

Number of Services Approved per Beneficiary Served	TEHAMA		
	# of beneficiaries	%	Cumulative %
1 service	42	11.93	11.93
2 services	57	16.19	28.13
3 services	53	15.06	43.18
4 services	22	6.25	49.43
5 - 15 services	100	28.41	77.84
> 15 services	78	22.16	100.00

20. Regarding mental health services for transition-aged youth in your county:

a. Access: Who are the major race/ethnicity groups being served? How have the overall service penetration rates changed over time?

b. What does your MH program do to improve TAY client access to, and continued engagement in care? For example, are there peer counselors or specifically targeted youth programs?

c. Do you have suggestions to improve TAY clients' engagement in continuing MH services?

[Leave space for text from MHB members]

## **Client Outcomes: Are people getting better?**

Due to the recent re-organization of state agencies, there is not much current data for client outcomes and some aspects of mental health programs. Therefore, we are giving MHB/C members flexibility and several options in how they address this question.

Some counties collect and provide their own data regarding important areas of client outcomes, in order to evaluate the effectiveness of their programs. MHB/C members are highly encouraged to make use of such data resources or reports, if available. Other possible choices are listed below.

Please mark with an "X" the source of client outcomes data you chose to review.

- County-specific report from your local MH Director or QI coordinator
- Consumer Perception Survey (subset of questions related to client outcomes)
- Full Service Partnership data for your county (DCR dataset)
- County-level reports from MHSOAC (e.g., Consumer Services Support reports through 2010 by UCLA contract; reports for more recent years are expected in late 2014).
- Other: Please list or describe: \_\_\_\_\_.

21. Please examine and discuss data about client outcomes for improved function in these areas of daily life (as appropriate to age group: children, youth, adults, older adults):

- a. school attendance improved, or reduced school suspensions/expulsions
- b. ability to work improved (paid or unpaid, full or part-time)
- c. justice system involvement (encounters with police, numbers of arrests)
- d. housing situation (improved/unchanged, not homeless)
- e. client is better able to cope with problems of daily life

[Leave space for text from MHB members]

**Optional question (A) for discussion:**

How many CPS surveys were turned in for your county? How many were for: families of children, youth, adults, and older adults? Of those turned in, how many were filled out completely?

[Insert Data below, for the selected questionnaire items].

[Leave space for text by MHB members].

**Optional question (B) for discussion:**

Which CPS survey question items are most useful for your local MH board/commission to think about?

What conclusions, if any, do you have about the effectiveness of services received by those who answered the surveys?

What strategies do you recommend to increase participation in completing these surveys by more MH clients and families?

[Leave space for text by MHB members].

**<END>**

**X** INFORMATION

TAB SECTION: H

\_\_\_ ACTION REQUIRED:

DATE OF MEETING: 1/16/14

PREPARED BY: Leonelli

DATE MATERIAL  
PREPARED: 12/13/13

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**AGENDA ITEM:** Panel Presentation: Trauma-Informed Approach

**ENCLOSURES:**

- Brief Literature Review: Trauma and Mental Health
- Infographic: How to Manage Trauma
- San Diego Trauma Guide Team Core Competencies

**OTHER MATERIAL RELATED TO ITEM:**

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**ISSUE:**

The damaging effects of physical and emotional trauma and resulting Post-Traumatic Stress Disorder have been studied, documented and reported since the 1990's. This information is being emphasized in mental health policy and planning at the Federal level and is now being recognized and implemented in local Mental Health Plans. The trauma-informed approach is transforming service delivery and impacts the child welfare system, the juvenile justice system, and treatment of substance abuse and domestic violence. Presenters are local experts who will share their experience in designing and delivering trauma-informed mental health services.

The Continuous System Improvement Committee presents this topic as an opportunity to highlight emerging programs around the state that are employing best practices in trauma-informed care, and intends to compile our findings into a report that we can share with diverse stakeholders.



## Trauma and Adversity / Adverse Childhood Experiences

From: SAMHSA 2013-14 Block Grant Application (p. 24):

Trauma is a widespread, harmful, and costly public health problem. It occurs as a result of violence, abuse and maltreatment, neglect, loss, disaster, war, and other emotionally harmful experiences. Trauma has no boundaries with regard to age, gender, socioeconomic status, race, ethnicity, geography, or sexual orientation. Traumatic exposures may have only transient effects or result in no apparent harm; however, traumatic exposures often result in psychological harm, increased rates of mental and substance use disorders, suicide, risk-taking behaviors, and chronic physical disorders. Exposure to trauma may increase the likelihood of substance abuse and lead to disruptions in daily functioning in educational and employment settings. Trauma is an almost universal shared experience of people receiving treatment for mental and substance use disorders, including those served through public systems.

Trauma is especially prevalent among populations who have been involved with the child welfare and criminal/juvenile justice systems, or who reside in communities with high rates of violence. Given the relatively high rates of exposure to traumatic events and the potential for long-term consequences when unrecognized and untreated, it is critical that public health systems screen for and intervene early with evidence-supported trauma interventions. Trauma-specific interventions have been developed for use across the life-span; however, practitioners are often unaware of or may not use interventions based on the best evidence. With the increased recognition of the centrality of trauma in mental and substance use disorders, public systems embrace the need to create trauma-informed service delivery systems that support behavioral health consumers and survivors of trauma. A trauma-informed approach to care is based on consumer choice and decision-making, prohibition of coercive or forced treatment, and promotion of safety and strengths-based practice.

From: SAMHSA BG Application (p. 35)

*State authorities should pay particular attention to trauma.*

Individuals who have been exposed to traumatic events are at **increased risk for mental and substance use disorders**. Many symptoms of trauma are similar to and may contribute to other behavioral health problems including depression, anxiety, disruptive behavioral disorders, personality disorders, and substance use disorders. **Exposure to past trauma may also complicate treatment** for mental and substance abuse disorders.

**The current behavioral health workforce needs training on the role of trauma** in people's lives, the centrality of trauma to behavioral health disorders, trauma-specific interventions, and strategies to build trauma-informed systems that better identify and address trauma. Practitioners and policymakers also need to have a better understanding of how **their policies, practices, and behaviors can promote healing and recovery** or be secondarily traumatizing to people. There is a growing evidence base for the treatment of trauma and generic therapies have not been shown to be effective in addressing trauma. There are **a number of evidence-based approaches that states should focus on adopting**. States can better address this issue **by screening for trauma, providing trauma-focused treatments, and offering trauma-informed care**.

## Effects of Trauma into Adulthood

Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., Koss, M. P., Marks, J. S. (1998). **Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study.** *Am J Prev Med*, 14:245-258.

The relationship between traumatic childhood experiences and physical and emotional health outcomes in adult life is at the core of the landmark Adverse Childhood Experiences (ACE) Study, a collaborative effort of the Centers for Disease Control and Prevention and the Kaiser Health Plan's Department of Preventive Medicine in San Diego, CA. The ACE Study involved the cooperation of over 17,000 middle-aged (average age was 57), middle class Americans who agreed to help researchers study the following nine categories of childhood abuse and household dysfunction:

- recurrent physical abuse;
- recurrent emotional abuse;
- contact sexual abuse;
- an alcohol and/or drug abuser in the household;
- an incarcerated household member;
- a household member who is chronically depressed, mentally ill, institutionalized, or suicidal;
- mother is treated violently;
- one or no parents;
- emotional or physical neglect.

The study claims two major findings. The first of these is that **ACEs are much more common than anticipated or recognized**, even in the middle class population that participated in the study. The study's second major finding is that **ACEs have a powerful correlation to health outcomes later in life**. As the ACE score increases, so does the risk of an array of social and health problems such as: social, emotional and cognitive impairment; adoption of health-risk behaviors; disease, disability and social problems; and early death. Nearly 2/3 of ACE Study participants reported at least one ACE, and more than one in five reported three or more. The higher the ACE score, the greater the risk of heart disease, lung disease, liver disease, suicide, HIV and STDs, and other risks for the leading causes of death.

### **SAMHSA – National Center for Trauma Informed Care**

SAMHSA's National Center for Trauma-Informed Care (NCTIC) is a technical assistance center dedicated to building awareness of trauma-informed care and promoting the implementation of trauma-informed practices in programs and services. <http://www.samhsa.gov/nctic/default.asp>

Traumatic experiences can be dehumanizing, shocking or terrifying, singular or multiple compounding events over time, and often include betrayal of a trusted person or institution and a loss of safety. Trauma can result from experiences of violence. Trauma includes physical, sexual and institutional abuse, neglect, intergenerational trauma, and disasters that induce powerlessness, fear, recurrent hopelessness, and a constant state of alert. Trauma impacts one's spirituality and relationships with self, others, communities and

environment, often resulting in recurring feelings of shame, guilt, rage, isolation, and disconnection. Healing is possible.

Although exact prevalence estimates vary, there is a consensus in the field that most consumers of mental health services are trauma survivors and that their trauma experiences help shape their responses to outreach and services.

### **What is Trauma-Informed Care?**

Trauma-informed care is an approach to engaging people with histories of trauma that recognizes the presence of trauma symptoms and acknowledges the role that trauma has played in their lives. NCTIC facilitates the adoption of trauma-informed environments in the delivery of a broad range of services including mental health, substance use, housing, vocational or employment support, domestic violence and victim assistance, and peer support. In all of these environments, NCTIC seeks to change the paradigm from one that asks, "What's wrong with you?" to one that asks, "What has happened to you?"

When a human service program takes the step to become trauma-informed, every part of its organization, management, and service delivery system is assessed and potentially modified to include a basic understanding of how trauma affects the life of an individual seeking services. Trauma-informed organizations, programs, and services are based on an understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate, so that these services and programs can be more supportive and avoid re-traumatization.

### **What are Trauma-Specific Interventions?**

Trauma-specific interventions are designed specifically to address the consequences of trauma in the individual and to facilitate healing. Treatment programs generally recognize the following:

- The survivor's need to be respected, informed, connected, and hopeful regarding their own recovery
- The interrelation between trauma and symptoms of trauma (e.g., substance abuse, eating disorders, depression, and anxiety)
- The need to work in a collaborative way with survivors, family and friends of the survivor, and other human services agencies in a manner that will empower survivors and consumers

Located in Santa Cruz, California, **The California Center of Excellence for Trauma Informed Care** ([www.trauma-informed-california.org/](http://www.trauma-informed-california.org/)) is committed to helping trauma-exposed people achieve safety, connection and empowerment. It develops training and consultation to help agencies throughout California transform practice to work more effectively with clients by better understanding trauma and focusing on safety.

The California Center of Excellence for Trauma Informed Care also works locally with people exposed to trauma by providing groups that specifically address the impact of trauma on the person. Trauma-informed care is an approach or framework related to delivering services that acknowledges the impact of trauma and attempts to create a sense of safety within the program. Trauma-informed transformation is a cultural shift

towards safety-focused, strength-based, consumer-driven, empowerment-rich programming that allows consumers to take charge of their recovery, addresses unsafe behaviors and prioritizes safety as a platform for recovery. Trauma-informed programs train staff to understand the effects of trauma broadly on the population being served and over the lifespan. They assess their program design and policies to ensure that safety is the core and that potential for re-traumatization is reduced. They also approach critical incidents and problems from a trauma-informed perspective to see how to change approaches, such as rules or responses, to prevent escalation, drop-outs, removals, seclusion, restraint and other behaviors that traditionally have been understood as single problems in need of punishment or elimination. Trauma-informed programs value consumer input, participation, and inclusion in decision-making and staffing. Trauma-informed programs recognize that choice is the key to empowerment.

The Center wants to create a safe California for everyone through the **development of a trauma certification process for agencies**. Certification would promote uniform trauma-informed practices throughout California, so that agencies may better and more safely serve their clients. Agencies in Santa Cruz, San Diego, Santa Clara, and Los Angeles have been working with the California Center of Excellence for Trauma Informed Care toward a certification process that is realistic, humane, cost-effective, and efficacious.

**From: The Damaging Consequences of Violence and Trauma: Facts, Discussion Points, and Recommendations for the Behavioral Health System** (Jennings, 2004).

<http://www.nasmhpd.org/docs/publications/archiveDocs/2004/Trauma%20Services%20doc%20FINAL-04.pdf>

Highlights from this very comprehensive literature review by Ann Jennings:

- ◆ In adults, the rates for co-morbid Posttraumatic Stress Disorder (PTSD) and substance use disorders are two to three times higher for females than males, with 30% to 57% percent of all female substance abusers meeting the criteria for PTSD. Women's increased risk for co-morbid PTSD and substance dependence is related to their higher incidence of childhood physical and sexual abuse.
- ◆ Many mental health and substance abuse providers may be under the impression that abuse experiences are an additional problem for their clients, rather than the central problem. PTSD is often the only diagnosis utilized to address abuse; in fact, every major diagnostic category in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) can sometimes be related to trauma.
- ◆ Without trauma-informed interventions, there can exist a self-perpetuating cycle involving PTSD and substance abuse, where trauma (childhood or adult physical and/or sexual abuse, crime victimization, disaster, combat exposure) leads to the development of PTSD symptoms, triggering the use of alcohol and drugs, resulting in higher likelihood of subsequent traumatic events and re-traumatization, leading to development of more chronic PTSD symptoms, triggering heightened substance use, and so on.
- ◆ For persons with histories of trauma, seclusion and restraint can cause disturbing behavior to increase (rather than de-escalate), thereby re-traumatizing the client and increasing risk to staff and other

consumers. Train staff on specific alternative, trauma-informed responses to aggressive or behaviorally inappropriate actions.

- ◆ Until recently, psychologists believed that mistreatment during childhood led to arrested psychosocial development and self-defeating psychic defense mechanisms in adults. New brain imaging surveys and other techniques have shown that physical, emotional, or sexual abuse in childhood (as well as stress in the form of exposure to violence, warfare, famine, pestilence) can cause permanent damage to the neural structure and function of the developing brain itself. These changes can permanently affect the way a child's brain copes with the stress of daily life, and can result in enduring problems such as suicide, self-destructive behavior, depression, anxiety, aggression, impulsiveness... These results suggest that much more effort is needed to prevent childhood abuse and neglect. New approaches to therapy may also be indicated.
- ◆ Research, implement, and evaluate effectiveness of child abuse prevention strategies. Justify intervention based on new findings of permanent damage to the brain caused by child abuse and its impact on the individual, society, and human service fields. Justify cost of prevention strategies by a fiscal analysis that shows actual cost savings due to child abuse reduction.
- ◆ The level of exposure to catastrophic violence and loss together with the resulting posttraumatic stress have been found to be as severe in America's inner cities as in post-earthquake Armenia, war-torn Bosnia, post-invasion Kuwait and other trauma zones. Yet, the United States has no formal public health policy to address the problem.
- ◆ SAMHSA should take the lead in developing a formal public health policy to address the problem of PTSD in children. This policy should caution service providers against overlooking or misdiagnosing abuse and PTSD symptoms as symptoms of Attention Deficit Hyperactivity Disorder (ADD), Oppositional Defiance Disorder (ODD), etc.
- ◆ Mandatory trauma assessment should be available for all children referred for behavior, learning, or emotional disturbances, followed by referral to appropriate trauma treatment.
- ◆ Develop peer-professional alliances in support of a trauma-preparedness support system. One such example in Connecticut is a systematic, comprehensive, and relatively inexpensive statewide network of professionally guided, peer-conducted trauma education and support programs for people in recovery.
- ◆ Of 16 men sentenced to death in California, a history of family violence was found in all cases. Fourteen were victims of severe childhood physical and/or sexual abuse. Individual impairments were found in 16 cases, including 14 with Posttraumatic Stress Disorder, 13 with severe depression, and 12 with histories of traumatic brain injury; community isolation and violence occurred in 12 cases; and institutional failure in 15, including 13 cases of severe physical and/or sexual abuse while in foster care or under state youth authority jurisdiction. Interventions may have made a difference in reducing lethal violence and its precursor conditions.
- ◆ Elderly consumers who encounter psychological trauma earlier in life may have persisting symptoms including: marked disruptions of sleep and dreaming, intrusive memories, impairment of trust,

avoidance of stressors, and heightened vulnerability to various types of age-associated retraumatization.

- ◆ There is currently a shortage of health and mental health professionals who are educated and trained to work with trauma. Most clinical education programs lack formal courses or educational opportunities in trauma. American universities have been slow to contribute to advances in the study and treatment of trauma. Training programs, degree programs, teacher preparation courses, etc., are deficient in conveying the research data to service providers.
- ◆ Many survivors of abuse and trauma look to their spiritual leaders for guidance and healing.
- ◆ Faith communities, prayer circles, and clergy are the primary source of support for trauma survivors in communities of color.
- ◆ In addition to physical and psychological crises, traumatic experiences may generate spiritual crises, loss of faith, and questions of identity, meaning, and world-view.
- ◆ Foster collaboration between clergy/denominational leaders and mental health service providers to de-stigmatize the acknowledgement of trauma, and to bring appropriate trauma services to the churches and faith-based service providers.
- ◆ Peer support and self-help are useful and cost-effective tools in helping survivors overcome the shame that often accompanies trauma, and these tools also provide leadership, motivation and guidance.

Chapter 5. **Violence, trauma, and resilience.** Michael Ungar and Bruce D. Perry

**In:** R. Alaggia and C. Vine, Editors. CRUEL BUT NOT UNUSUAL: VIOLENCE IN CANADIAN FAMILIES, 2<sup>ND</sup> EDITION. WILFRID LAURIER UNIVERSITY PRESS, April 2012

Summary:

Humans adapt to life changes and challenges through a complex physiological and neural 'stress response system' which affects behavior and emotions. When the system is in balance, the behavioral and emotional responses are adaptive and appropriate to the situation. When the system is out of balance, eg due to prior experience of trauma, a person may be overwhelmed by stress or change resulting in negative effects on physical and mental health. Long-term exposure to stress can alter future individual responses because these stressors create alternate neural pathways that affect brain function. Genetic factors, interuterine influences, and early childhood experiences develop these neural pathways that determine stress response. Caring and attuned caregivers will help to develop a flexible and resilient stress response capacity, while negligent and erratic caregiving will contribute to abnormal development of stress and relational functions, leaving the child more vulnerable to future stresses.

The authors use case studies to build their argument that a stress response is a combination of personal genetic background, physiological factors, and the social environment that either mediates or

aggravates the stress experience. They emphasize that “trauma” is defined not as the event itself, but as **the individual’s response to the event**. They define “**resilience**” as a **process**, rather than a personal characteristic. Resilience is the successful interaction of biological, psychological and social resources that determine whether an individual is overwhelmed by trauma or stress, or whether s/he achieves well-being and even personal growth through recovering from trauma or stress. This interpretation of resilience emphasizes the capacity of a person to navigate resources and to negotiate the ways that these resources are provided that are meaningful and effective.

Recommendations for promoting resilience in mental health practice include:

- early intervention for the greatest impact;
- programs that provide and/or encourage supportive relationships and maintaining permanency in these relationships;
- allowing the child to choose the interventions that will make the most difference for their own needs;
- and integration of services across all systems of care.

From: **2008 Presidential Task Force on Posttraumatic Stress Disorder and Trauma in Children and Adolescents**, American Psychological Association (APA)

<http://www.apa.org/pi/families/resources/children-trauma-update.aspx>

It is more common than not for children and adolescents to be exposed to more than a single traumatic event. Children exposed to chronic and pervasive trauma are especially vulnerable to the impact of subsequent trauma. When children, adolescents, and families come to the attention of helping professionals, the identified trauma may not be the one that is most distressing to the child. For this reason, gathering a thorough, detailed history of trauma exposure is essential.

**After exposure to a traumatic life event, short-term distress is almost universal**

Children and adolescents vary in the nature of their responses to traumatic experiences. The reactions of individual youths may be influenced by their developmental level, ethnicity/cultural factors, previous trauma exposure, available resources, and preexisting child and family problems. However, nearly all children and adolescents express some kind of distress or behavioral change in the acute phase of recovery from a traumatic event. Not all short-term responses to trauma are problematic, and some behavior changes may reflect adaptive attempts to cope with a difficult or challenging experience. Many of the reactions displayed by children and adolescents who have been exposed to traumatic events are similar or identical to behaviors that mental health professionals see on a daily basis in their practice. Functioning in the family, peer group, or school may be impaired as a result of such symptoms. Therefore, when working with children who may display these types of reactions, the clinician must make a careful assessment of possible exposure to trauma.

Research has provided evidence about predictors of trauma recovery, although there are no perfect predictors. Recovery can be impeded by individual and family factors, the severity of ongoing life stressors, community stress, prior trauma exposure, psychiatric comorbidities, and ongoing safety concerns. Also,

poverty and racism can make this recovery much more difficult. Caretakers are affected by children's exposure to trauma, and their responses affect children's reactions to trauma. On a positive note, individual, family, cultural, and community strengths can facilitate recovery and promote resilience. Social, community, and governmental support networks are critical for recovery, particularly when an entire community is affected, as when natural disasters occur.

**Most children with distress related to trauma exposure and in need of help do not receive psychological treatment, and those who do receive a wide variety of treatments.**

The report offers many constructive suggestions and best practices for mental health professionals who diagnose and treat traumatic stress in both children and adults. A variety of issues are explored which need more investigation and research.

**From:** Rich, J., Corbin, Bloom, Rich, L., Evans and Wilson. **Healing the Hurt: Trauma-Informed Approaches to the Health of Boys and Young Men of Color**, October, 2009. Prepared for the California Endowment, Building Healthy Communities Strategic Plan by Drexel University, School of Public Health and College of Medicine.

[http://www.sanctuaryweb.com/PDFs\\_new/Rich%20Corbin%20Bloom%20Healing%20the%20Hurt%20California%20Endowment.pdf](http://www.sanctuaryweb.com/PDFs_new/Rich%20Corbin%20Bloom%20Healing%20the%20Hurt%20California%20Endowment.pdf)

Trauma has sometimes been defined solely in reference to circumstances that are outside normal human experience. This definition does not fully encompass the experiences of the young boys and men of color who are the focus of this project. For them, traumatic experiences may become an almost routine part of everyday existence. Besides violence, assault, and other traumatic events, African American and Latino males often experience more subtle and insidious forms of trauma. Their exposure to discrimination, racism, oppression, and poverty is pervasive. When experienced chronically, these events have a cumulative impact that can be fundamentally life-altering. Such traumas are directly related to chronic fear and anxiety, with serious long-term effects on health and other life outcomes for males of color.

This report extensively explores trauma as a social determinant of health, both mental and physical. The authors recognize that mental health providers can also be affected by early trauma, and by the stress within their organizations. The report makes recommendations about how programs for violence prevention and parenting (emphasizing the role of fathers) can become trauma-informed, and includes comments from key informant interviews on these issues. A chapter is devoted to foster care and the trauma associated with that experience. There is extensive coverage of existing models for trauma-informed programs, including an entire chapter on the Sanctuary Model (developed by one of the authors, Dr. Sandra Bloom). The report concludes with recommendations for next steps towards integration of trauma informed principles into the health care and mental health systems.

# How to Manage Trauma

Trauma occurs when a person is overwhelmed by events or circumstances and responds with intense fear, horror, and helplessness. Extreme stress overwhelms the person's capacity to cope. There is a direct correlation between trauma and physical health conditions such as diabetes, COPD, heart disease, cancer, and high blood pressure.

## TRAUMA CAN STEM FROM

Childhood abuse or neglect

Physical, emotional, or sexual abuse

War and other forms of violence

Accidents and natural disasters

Grief and loss

Witnessing acts of violence

Medical interventions

Cultural, intergenerational and historical trauma

TRAUMA

## HOW COMMON IS TRAUMA?

70% of adults in the U.S. have experienced some type of traumatic event at least once in their lives. That's **223.4 million people.**



+90%

In public behavioral health, **over 90%** of clients have experienced trauma.

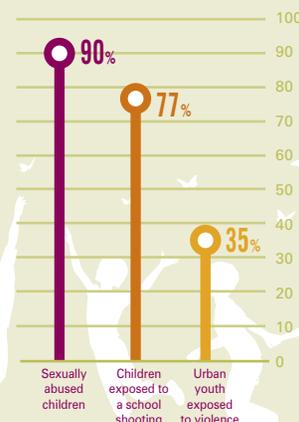
**Trauma is a risk factor** in nearly all behavioral health and substance use disorders.



In the United States, a woman is **beaten every 15 seconds**, a forcible rape occurs every 6 minutes.

More than **33% of youths** exposed to community violence will experience Post Traumatic Stress Disorder, a very severe reaction to traumatic events.

Nearly all children who witness a parental homicide or sexual assault will develop Post Traumatic Stress Disorder. Similarly, 90% of sexually abused children, 77% of children exposed to a school shooting, and 35% of urban youth exposed to community violence develop Post Traumatic Stress Disorder.



## People can and do recover from trauma



### SYMPTOMS OF TRAUMA CHECKLIST

- Headaches, backaches, stomachaches, etc.
- Sudden sweating and/or heart palpitations
- Changes in sleep patterns, appetite, interest in sex
- Constipation or diarrhea
- Easily startled by noises or unexpected touch
- More susceptible to colds and illnesses
- Increased use of alcohol or drugs and/or overeating
- Fear, depression, anxiety
- Outbursts of anger or rage
- Emotional swings
- Nightmares and flashbacks — re-experiencing the trauma
- Tendency to isolate oneself or feelings of detachment
- Difficulty trusting and/or feelings of betrayal
- Self-blame, survivor guilt, or shame
- Diminished interest in everyday activities

### HOW TO TALK TO YOUR DOCTOR

- Make your doctor aware that you have experienced trauma, past or recent
- Help them understand what is helpful to you during office visits, i.e., asking permission to do a procedure, staying as clothed as possible, explaining procedures thoroughly, or having a supporter stay in the room with you
- Ask for referrals to therapy and behavioral health support



### HELPFUL COPING STRATEGIES

- Acknowledge that you have been through traumatic events
- Connect with others, especially those who may have shared the stressful event or experienced other trauma
- Exercise — try jogging, aerobics, bicycling, or walking
- Relax — try yoga, stretching, massage, meditation, deep muscle relaxation, etc.
- Take up music, art, or other diversions
- Maintain balanced diet and sleep cycle
- Avoid over-using stimulants like caffeine, sugar, or nicotine
- Commit to something personally meaningful and important every day
- Write about your experience for yourself or to share with others

### ASK YOUR HEALTHCARE PROFESSIONAL ABOUT TREATMENTS

#### TRADITIONAL TREATMENTS

Cognitive Behavioral Therapy  
Eye Movement Desensitization and Reprocessing (EMDR) Therapy  
Talk Therapy  
Exposure Therapy  
Group Therapy

#### ALTERNATIVE TREATMENTS

Energy Processing  
Hypnotherapy  
Neuro-Linguistic Programming  
Massage Therapy  
Pet or Equine Therapy  
Trauma and Recovery Peer Support Groups  
Wellness Recovery Action Planning (WRAP)



**NATIONAL COUNCIL**  
FOR COMMUNITY BEHAVIORAL HEALTHCARE



For more information, interviews, and research on trauma check out the National Council's magazine edition on the topic

[www.TheNationalCouncil.org](http://www.TheNationalCouncil.org)

INFORMATION

TAB SECTION: I

  X   ACTION REQUIRED:

DATE OF MEETING: 01/15/14

PREPARED BY: Tracy Thompson

DATE MATERIAL  
PREPARED: 12/10/13

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AGENDA ITEM: Review and Approval of Workforce Education and Training 5-Year Plan

ENCLOSURES: •

OTHER MATERIAL RELATED TO ITEM:

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ISSUE:

Lupe Alonzo-Diaz, Deputy Director, Healthcare Workforce Development, OSHPD and Sergio Aguilar, Project Manager, WET 5-Yr Plan, OSHPD, will present the Workforce Education and Training 5-Year Plan. The council is asked to review and approve the Plan.

*The Draft Workforce Education and Training 5-Year Plan will be sent to members a week prior to the quarterly meeting.*

