

**CALIFORNIA MENTAL HEALTH PLANNING COUNCIL
MEETING HIGHLIGHTS
October 16 and 17, 2008**

**Lake Natoma Inn
702 Gold Lake Drive
Folsom, CA 95630**

CMHPC Members Present

Celeste Hunter, Chairperson	Jim Alves	Daphne Shaw
Beverly Abbott	Jorin Bukosky	Diane Koditek, MFT
Lana Fraser, CRC	Stephanie Thal, MFT	Carmen Lee
Luis Garcia, Psy D	Sean Tracy	Shama Chaiken, PhD
George Fry, Jr.	Patrick Henning	Dale Mueller, EdD, RN,
Jennie Montoya	Renee Becker	Shebuah Burke
Gail Nickerson	Walter Shwe, Past Chair	
Barbara Mitchell	Lin Benjamin, MSW, MHA	
Jim Bellotti	Karen Hart	
John Ryan	Jonathan Nibbio	

Staff Present

Ann Arneill-Py, PhD, Executive Officer	
Charles Anders	Karen Hudson
Narkesia Swanigan	Brian Keefer
Linda Brophy	Lisa Williams
Tracy Thompson	
Michael Gardner	

Thursday October 16, 2008

1. Welcome and Introductions

Celeste Hunter, Chairperson, called the meeting to order at 1:05 p.m. Planning Council Members and guests in the audience introduced themselves.

2. Crisis Residential Services

Betty Dahlquist, Executive Director, California Association of Social Rehabilitation Agencies, and Steve Fields, Executive Director, Progress Foundation provided a presentation. Highlights included:

- The Crisis Residential Treatment System Programs and the Community-Residential Treatment System Act is to provide a recovery oriented rehabilitation program that will serve as an alternative to its institutional counterpart. It provides a vehicle to transform county mental health system's reliance on those medical model hospital and institutional levels of care.
- Mr. Fields said the idea behind the first program that he opened, called La Posada, was to target individuals from psychiatric emergency room at the point of which they are at risk of being

hospitalized. This would provide clinicians in the triage setting, as well as the consumer, a different choice.

- In California there is an acute psychiatric bed crisis.
- We continue to suffer from a lack of an agreed upon understanding of where this community system of care is headed, what it should look like, and the consensus that the use of institutional treatment should be minimized whenever possible.
- In 1978 San Francisco was allowed to eliminate up to 20 of their acute inpatient beds by opening a community based crisis residential program. This was such a success that the county asked for replication of the program. Progress Foundation is in the process of opening a community-based psychiatric triage center with crises residential treatment beds. This is a model that will push the treatment system toward a community based practice using only precious high-end resources when they are actually needed.
- The crisis residential programs are Medi-Cal reimbursed under the rehabilitation option. The cost of a crisis residential treatment program in San Francisco are: a 10-bed residential treatment acute diversion program is approximately \$390/day total cost. The goal of crisis residential is to compete on an episodic cost level as well as an actual cost level.
- The principles that are used to underpin any program are:
 - To find the most normalizing environment for a particular client that allows them to work from a familiar role instead of from a patient role.
 - A full range of staffing capability.
 - If the client is not at the center of making decisions in framing the treatment plan, everyone will waste their time.
 - An environment is needed where you can actualize individualized treatment planning.
 - Program flexibility.
 - If you are not willing to take risks, you should not do this work.

Questions/Answers

Shama Chaiken: Do you have exclusionary criteria related to violent behaviors, sex offense, arson, etc.?

Answer: No we do not. When the intake interview is completed and the triage has occurred there may be people the program cannot work with. There has never been a type of behavior that brought people into the system exclusion in and of itself. The one exception is the difficulty around state laws with sex offenders.

Barbara Mitchell: Most crisis residential facilities have some exclusionary criteria.

Shama Chaiken: Can you talk about the decision related to length of stay versus people meeting specific goals? When people leave, if they don't go to transitional housing, what is the criterion for releasing them?

Answer: There really is an art to an acute psychiatric crisis. There is an initial intervention; there is a stabilization arch; and then there is the point at which the person is ready to forget any kind of

treatment. What we wanted to do was open up beds at the other end because if the emergency room kept calling us and saying we have a client for you and we were full three out of four times they were going to stop using us. County staff has to approve anyone that stays for more than two weeks. I think we would be in a more severe conversation if all we had after an acute diversion was supported housing because there are so many people not ready to go to this level after they have spent two weeks in acute diversion, particularly around their substance issues.

Daphne Shaw: I sat on the Bates Committee, way back when, which was a categorical funding at the time. At that time there was tremendous resistance on the part of the counties for doing these kinds of programs. Some counties did them because there was money available and if they wanted money then they had to do these kinds of programs. Even back then the counties did not embrace this approach.

Answer: Back then I understood the politics of a county-based system based on a county plan and a self-local control and local decision making. There was an aversion in the state to any kind of categorical funding. He would have hoped if we traveled down the road there would have been more counties who would have embraced the opportunity Prop 63 had and had an analytical model in place.

Beverly Abbott: One of the things that is difficult in California is that it is a county-run system. The state's vision is important but where the money hits the road is in the counties. Some of the counties are doing some very interesting things, but there seems to be some pieces that have not gotten off the ground.

Answer: I testified at the Little Hoover Commission that looked at mental health. Mark Raggins, from The Village, preceded me with his presentation on the Village program. I said to the Little Hoover Commission, "Mark's right. This is one of the more interesting ideas to come along; it's long overdue. Mark talked to you about Australia, South America, and Europe where he is going to talk about replicating a village. This Commission has one question to answer about change in the California Mental Health System. It is not remarkable that Australia and New Zealand want to learn about the Village, but the question you need to answer is why hasn't it even been replicated inside of Los Angeles County." Answering this question will lead us to understand what went wrong with Prop 63.

Diane Koditek: You stated with some certainty that it does not seem like there is much action from counties. Could you say a little more about where that impression comes from when looking under Capital Facilities?

Answer: I have based that upon looking at the initial CSS plans. There are virtually no crisis residential approaches embedded in that first round of county proposals for the expenditures under their allocation.

Sheree Kruckenberg: Even though CSS obviously had a capacity building piece to it, the planning and local stakeholder process was such that it did not have a systemic point of view. Instead of having a unifying set of principles and values that would inform what would happen, it was sort of a patchwork kind of thing. There is a complicated combination of factors that has played into this dilemma. The opportunity to come before the Planning Council and the public is a tremendous opportunity. She is hoping that this can carry on and as the Capital Facilities money goes out and the CSS allocations that perhaps there are now agencies that are willing to take on some of the complexities.

Answer: I think anybody who maintains a view of what enormous promise this presents is good. My narrow analysis is based on what I had hoped would be possible right out the gate, but again it goes back to that larger problem; we can't find leadership that will lay out for us a systemic, analytical, philosophical, programmatic, and clinical view of what this system should generally look like from Humboldt to San Diego.

Shama Chaiken: One of the things that the Planning Council does well is to take a problem and then figure out who the right people are to look at it in order to find out what the barriers are. I wonder if we could get a focus group together of people in the counties who have thought about this and have figured out what the barriers are and how to create pathways.

Answer: Let me make a suggestion in terms of the manual I wrote. If the Federal Government doesn't publish it then maybe the State would like to. The manual points out all these issues, including neighborhood approval strategies, how to find property, the various methods of purchasing or leasing property, etc.

Barbara Mitchell: This is an excellent idea and the other thing we might want to promote is training. When the State was rolling the housing money out of MHSA, they hired the Corporation for Supportive Housing to provide trainings. Every county had to send a group of people. Maybe the State would like to fund CASRA to do trainings for counties on how to set up crisis residential programs. It could also cover transitional residential treatment. I would like to emphasize including consumers and family members into this as well in order to provide an educational system for consumers and family members.

George Fry: I come from a small county. We received \$600,000 for housing but what can you do with \$600,000? We send clients in crises to the next county over that has a psychiatric facility in an older hospital. This hospital is going to close down at the end of this year.

Answer: This is exactly the situation Sonoma County faced. It led them to put out an RFP. They were losing their inpatient provider and they were in debt on costs. They looked at to what degree they could actually divert those resources that were going to pay for those beds out of county into a different array, including a crisis residential. The discussion becomes what are you going to do with the resources that are paying for those beds in the acute center; how many do you need for an acute option; what about a crisis residential; and what could we do to divert that. Even a shared county crisis residential program is an improvement over sending people out of county for acute care.

Beverly Abbott: There are three things we're going to do: (1) Get Steve's manual; (2) look to see how many counties come in with crisis residential in the capital facilities and CSS plans; and (3) refer to the Executive Committee for a range of options, such as where to assign training.

Delphine Brody: One question I have is how does the crisis residential center respond to those people who lose their homes and/or jobs or custody of their children because they were held in the hospital.

Answer: People usually come to our acute diversion out of emergency rooms. They have already lost their housing. It is a matter of us finding a reconnection. Within our own system of care, we have acute diversion, transitional, and a whole array of supported living apartments. If they are in our system, they never lose their housing. If we know we can retain it, which is what we do even in terms of paying what it costs to keep that in place. We do this on a case-by-case basis. We have a residential treatment program for mothers with severe mental illness where they can continue to live with their children while they go throughout the one year treatment.

3. Access to Restrictive Residential Services for Children and Youth (William Arroyo, M.D., Mary Jane Gross, R.N., M.N., and Nicette Short)

Dr. Arroyo, with the Los Angeles County Mental Health, provided the following highlights:

- The landscape of the referral network as it exists in Los Angeles.

- There is no standard for the number of state hospital beds per capita, and there is no standard for any of the other elements within this system.
- In addition to the absence of state hospital beds, which was significant for Los Angeles County four years ago, another piece missing was congregate care for children under the age of six, as well as the child welfare emergency center. In Los Angeles County we were desperate for more CTF (Community Treatment Facility) beds and at the same time we were desperate for RCL14 (Rate Classification Level) beds.
- Child welfare was taking fewer children into the system. They decreased, over an eight year span, from 40,000 to 20,000. This was fueled, in part, by lawsuits. The suits were brought about by a consortium of legal advocacy organizations in the country, claiming that the State of California and Los Angeles County were not meeting the needs of children in the child welfare system, and especially meeting their mental health needs. Los Angeles County Board of Supervisors decided they wanted to settle out of Court and a settlement agreement was established.
- In terms of Child Welfare, the decompression that took place with respect to RCL14, CTF, and IMD was to establish many more foster homes and kinship care.
- There is an increase in the number of children leaving Los Angeles for AB3632 services.
- Other challenges for Los Angeles County are resources for children with developmental disabilities and severe mental health problems; children with severe eating disorders; youth in the juvenile justice system that have severe mental illness; sexual offenders; and prevention services.

Mary Jane Gross, President and CEO Stars Behavioral Health Group, provided the following highlights on the intensive residential based children's facilities:

- There are concerns about the closing of the state hospitals, the closing of group homes in California, and in the last two years two of the five CTFs (Community Treatment Facility) have been closed.
- CTFs were designed to be a locked alternative to the state hospital and acute psychiatric hospitalization. This was for high-end children who needed special placement because of the behaviors that they were displaying.
- In the past, children grew up in orphanages, but as time has evolved we have been able to bring children into smaller treatment programs and into intensive, therapeutic, short-term treatment.
- We have evolved into home-based community-based services in a less restrictive type of environment.
- We work intensively with children to make sure they remain with their families, relatives, and extended families.
- We have increased regulatory burdens and associated costs with no commensurate increases in our reimbursement for residential services, thereby making residential services untenable.

- Many of the providers have been forced out of business because there has not been adequate funding for the types of services that these children need.
- Providers cannot afford to continue the group home services. Rates have been frozen at the fiscal year 2001-02 levels and for the last 12 out of the 16 years rates have not increased.
- There is a movement towards RBS Reform (Residentially Based Services Reform) looking at a continuum of care for the children in the group homes.
- There are over 10.5 million youths in the State of California; 100,000 are in child welfare, and 72,000 are in some kind of placement in child welfare. In probation there are 84,000 adjudicated youth per year; 26,000 of which have committed misdemeanors, 1,000 have committed felonies; and 11,000 youths who have been booked have mental illness.
- 100 percent of the children in the CTFs have persistent and severe mental disorders with very high risk behaviors; 88 percent have shown themselves to be aggressive; 69 percent suicidal; 50 percent or more have a serious mental health diagnosis; and over 50 percent also having a substance abuse issue.
- The good news is that great strides have been made and approximately 90 percent of these youths have significant gains in their behaviors within the first year of treatment.
- To be successful a good residential treatment facility must have a therapeutic potential for the child. The child must be able to benefit from treatment. It must be considered an intervention and not a destination. The children need to have a full continuum of services while they are there with the engagement of the family and agency partners.
- The key to effective services for youth are: (1) the need to have all adults coming together for the benefits of the children; (2) limit the number of external experts; (3) the CSW's and probation workers must be completely engaged when a child is in a CTF; (4) there needs to be support for the program; (5) there needs to be funding for group homes; (6) need to eliminate unnecessary regulations; (7) and limit the number of multiple audits that are conducted.
- Final Recommendations: (1) give the providers the real costs of their residentially based services and pay for that; (2) mandate wraparound as soon as the child comes into the system; (3) mandate that the CSW, the probation worker, as well as mental health participate actively in the treatment plan of children; (4) need to implement funding assistance to providers for evidence-based practices for proficient practitioners; (5) eliminate the unnecessary burdens of regulatory reviews and outside auditors; and (6) need to reduce the restrictive regulations which discourage or prevent providers from taking risks with high-end youth.

Nicette Short, with California Alliance of Child and Family Services provided the following highlights:

- California's public policy around serving children and youth out of institutional care, out of the highest end-settings and into family-based care is critical.
- In order to adhere to the public policy vision two things must occur: (1) support those community based alternatives; and (2) make sure we do not lose our continuum.
- The CTFs and the Residential Care Programs have been underfunded for years and there is an obligation to make sure that we fully fund and support all the community alternatives.
- The budget cuts, the threats to the budget, the cuts to the CTF program and the administrative burden that people have to go through to provide those community based mental health services is overly burdensome.
- The Alliance has been working on the implementation of the residentially based services reform project. The Alliance has also been working on an intensive treatment foster care program.
- She is interested in partnering in order to improve the system of care for all youth and families.

Questions/Answers

Jim Bellotti: There was a piece of legislation this year that was stalled in the Appropriations Committee. This legislation dealt with the issue of the prohibition in state law to place a child by local county welfare departments in a for-profit facility. Why was this piece of legislation stalled?

Answer: I don't know the answer to that. It had the support of both houses but then the Governor, despite many 11th hour attempts, vetoed it.

Jim Bellotti: Can the Department of Finance be asked to unlock the jam, so to speak, in order to make it more attractive for willing, capable providers here in California to provide services to students.

Answer: It would take a lot of legislative remedy.

Jim Bellotti: What is the real key why CTFs are closing? Is it rates of reimbursement?

Answer: I think there are several reasons. One is the reimbursement. In addition, there is an incredible regulatory burden placed on the CTFs. There are many parents who do not like their children socializing with the children that are often found in CTFs and group homes, and they fight to make sure that their child is placed out of the state.

Jonathan Nibbio: I don't know why more regulatory responsibility can't be shifted down at the county level and the state. We need to support families and foster families more than ever. I would ask any politician if they would want to raise their own child based on 1995 dollars.

Answer: Counties have not received EPSDT money in a timely fashion. There are small counties who have not received a single EPSDT dollar in a year. This is a very serious problem.

Gail Nickerson: Fourteen years ago I was one of those people who sent my child out-of-state to a locked facility. At that time she was totally out of my control. I didn't expect the health system, county, or the school to pay for this. I borrowed money because my child needed it and I was truly afraid something bad would happen if I didn't. There was no resource for me. I was greatly relieved to have someplace where she could be locked up and I knew she was safe.

Answer: We hear those kinds of stories a lot and you probably represent hundreds of families. This is the kind of story that we need to remember when we talk about losing some parts of our continuum. We need to make sure that options are available for all of our families in California.

Renee Becker: There are parents out there who say "we have the right for our children to be safe". When my son was placed at 12 years old he was running continuously to try to get back to our home. The decision had to be made to put him in Utah in a locked facility. When my husband was dying at UCLA, I received a call from the group home saying "we have him in an ambulance again and he was trying to get to your house and he overdosed on alcohol" I didn't have a choice at that point. I have some difficulty believing that facilities are being shut down because there is not a need. I think there is a need because there are a lot of parents like myself. My son still has problems with anger management, and there is a need for parent strategies and skills to cope with their children's anger. My son feels he was "raped" of childhood. We need to go in and look at what group homes are truly doing as far as treatment.

Answer: I think a lot of what you talked about is things we are trying to do through our Residentially Based Services Reform. We are hopeful in the pilot projects families will be engaged early and often. The legislation with RBS will allow the Department of Social Services and the counties flexibility on some of the rules and how the money is spent.

Luis Garcia: I support the criteria that we have for Full Service Partnerships. I think we need to work with the system as a whole: family members, inpatient services, outpatient services in trying to deal with the issues, such as suicide.

Answer: What we know with Medi-Cal is the minute by minute billing, let's not do that to ourselves with MHSA. Let's not put these other regulatory burdens upon ourselves. Let's look at really transforming the system.

4. Update on Cultural Competence Issues (*Rachel Guerrero, Chief, Office of Multicultural Services, Department of Mental Health*)

Ms. Guerrero provided the following presentation:

- Background:
 - Ethnic and cultural specific program intervention is part of a statewide set-aside for up to \$60 million per year to support special projects for reducing disparities based on the results of an ethnic stakeholder process.

- Proposed first step to move forward
 - The Department of Mental Health has requested authority to use \$1.5 million of the state administered mental health services funds to support this project.
 - Develop a comprehensive plan to help design the \$60 million PEI statewide project.
 - Establish a Mental Health Service Act Multi-Cultural Coalition
 - Develop the procurement process
 - Statewide stakeholder input and feedback has begun September-October, 2008
 - The \$1.5 million will provide for multiple years and will have two deliverables. The first deliverable would be to develop a statewide Reducing Disparities Strategic Plan. The contractor selected will be responsible for soliciting out and subcontracting with the five groups that MHSOAC depicted (African-American, Asian Pacific Islander, Latino, Native Americans, and LGBTQ). The first deliverable would be that the Steering Committee, with a contractor, will reach consensus on common priorities and present joint recommendation for the comprehensive strategic plan.
 - The second deliverable would be to move forward and develop a multi-cultural coalition to support the ongoing process of the Mental Health Services Act.

- What happens when the strategic plan is completed?
 - DMH will work with OAC to review the recommendations for their approval and future direction of implementation of the \$60 million.
 - The recommendation would be shared with counties and work with the counties and stakeholders.

- What is the outcome?
 - Mental Health PEI investment and evaluation of community-defined evidence for racial ethnic communities.
 - These new approaches, training strategies, partnerships, evaluation models will improve outcomes and help us move towards healthier communities
 - New service delivery approaches defined by multi-cultural communities for multi-cultural communities

Questions/Answers

Jorin Bukosky: Is there any plan to give a definition of the stakeholder process for Asian Pacific Islander, specifically regionally? Would Asian Pacific Islander include Russian and Arabic disparity?

Answer: What we envision is that there would be an RFP process asking for these communities to come together and submit that they would like to be the people that are going to bring these communities together to identify what are their issues. This would be a community-defined process in the RFP process.

John Ryan: How do you define disparity?

Answer: These communities have been defined (in the President's Freedom Commission and the Surgeon General's Report) as not having benefited from mental health care and intervention and they have a disparity in terms of outcomes, access to care, and quality of care. We are talking about disparities in terms of growing new programs to serve adults and children who have experienced disparities in the mental health system.

John Ryan: So by example, say there are 100,000 Hispanics; 25,000 meet the target population of seriously emotionally disturbed; 12,500 are treated in the system in one year. So the disparity is that we would expect the system to fully serve this population? So we are closing the line, the incidents of this target population, with the actual prevalence of who we treat? Where I get lost is having a concrete definition of what disparity is, and I would think it would be important to have some good data to indicate across all these groups what are the disparities existing based upon this definition.

Answer: Part of this effort is to serve these Latinos closer to the number that they have service needs. When I look concretely at who is getting served in the mental health system, Latinos is the biggest underserved community in this State. We are trying to develop and support new programs and interventions that will better serve these communities who have not had access to mental health care relative to their prevalence rate; relative to their population. Right now, with this funding, we are targeting those populations.

John Ryan: I think the Council needs to ask the Department, very clearly, to give clear data across the board for all these target groups as to what is the disparity that exists.

Answer: This is a very difficult request, but I think we can get it to you.

5. Report from the Mental Health Services Oversight and Accountability Commission (Patrick Henning, Commissioner)

Commissioner Henning provided the following information:

- I am very optimistic. The Mental Health Services Oversight and Accountability Commission (MHSOAC) is starting to see money come through the system, and it is beginning to have an affect over the whole system.
- We are going to start seeing from the counties what has worked and what has not work with Prop 63 dollars.
- Most of MHSOAC's time has been spent with budget. The current state of the budget has affected OAC. Because the MHSOAC is a relatively new body within government many of the positions were not protected and we lost half our staff. This has been a particularly rough time.
- Some of MHSOAC's policy recommendations regarding co-occurring disorders is on the website. "There is no wrong door in our new system of care."
- OAC has begun looking at quality of life outcomes and how to move towards a more integrated plan.

- The stakeholder process that the OAC began with has been the backbone that has allowed us to move forward.
- The economic condition has affected the rate of millionaires thus the degree of money that is coming into the Prop 63 fund.

6. Report from the California Mental Health Directors Association (Stephanie Welch, California Mental Health Directors Association)

Ms. Welch provided a handout that outlined the following information:

- There are significant cuts that face the local county mental health system.
- It is important to have a good understanding of our current financial situation with our other funding sources in order to look at how we can use the MHSA in the most strategic way.
- We are trying to move away from the language of the Integrated Plan because the Integrated Plan is just a plan. We want to have a process, a goal, and roadmap to redesigning our system in a way that meets people's needs.
- Over the course of the next year the California Mental Health Directors Association wants to have a strategic focus on how to best use resources. One way to do this is to go back to the community and focus on trying to gather some suggestions from those who are on the ground and practicing implementation and also those who are participating in a local stakeholder process. We then work on bringing their voice effectively to the table.
- One possibility to bring those voices is through the new Social Justice Advisory Committee.

Questions/Answers

Barbara Mitchell: What is CMHDA's perspective on some of the statewide MHSA initiatives, such as the housing initiative or the potential of the counties needing to give \$60 million back over a 4 year period out of PEI money? Is CMHDA still supporting the idea of statewide initiatives in these areas or are the preferring local or regional initiatives?

Answer: CMHDA is in support of the Housing Program. There is a concern about CalHFA's ability to bring good loans to developers. There is a commitment both in terms of resources that are being given for technical assistance and to bring in expertise to support the directors through CIMH and California supportive housing folks to try to help people. In terms of the PEI statewide initiatives, CMHDA took a position in May of this year to support counties in having the resources they would need to assign funds back to support these programs. It is hoped that by the end of the month there will be a set of materials that counties can use at their discretion with their Board of Supervisors to support the assignments.

7. Adjourn

Chair Hunter adjourned the group at 5:27 p.m.

Friday, October 17, 2008

1. Welcome and Introductions

Chair Hunter called the meeting to order at 8:34 a.m. Planning Council Members and guests in the audience introduced themselves.

2. Report from the Department of Mental Health (Stephen Mayberg, PhD)

Dr. Mayberg provided the following update:

- **Budget:** While the actual cuts to the mental health system were not egregious, they certainly are cumulative and programs are stretched. Both counties and providers are impacted. To complicate things further, the Governor signed an Executive Order at the end of July which meant that the Department had to stop work on all of its personal service contracts, and it was not able to pay those whom it owed money to because there was no budget. The impact of the Executive Order to the Department was that it was not able to fill its 25% vacancy rate. The Executive Order is still in place even though the budget has been signed. As a result there will be more program reductions.
- Prop 63 funds will be affected because in this economy people's income will not be as robust as in the past.
- In spite of the fact that we have this shrinking economy and shrinking availability, there are continually new demands on mental health. In the current iteration, it is felt that the Department should be running the correctional mental health system. A new division has been established. The Legislature has given the Department 11 positions, and it will grow rapidly with as many 80 people. By 2011 there is a proposal that the department will have 1,100 new mental health beds in new facilities and over 2,000 employees. MHSAs monies are prohibited from funding any of this, and the community realignment monies are protected as well.
- The Planning Council has some vacant seats. A request has been sent out to all of the people whose terms are running out to see if they are interested in serving for another term. He would like to hear from everyone as soon as possible. It is his intention to make the appointments and announce the new members at the next meeting.

Questions and Answers:

Shama Chaiken: I want to make sure to clarify a few things, and you can correct me if this is not your understanding. We have about 165,000 people incarcerated in this state, and 20% are diagnosed with a severe mental illness; 16% would remain in the Department of Corrections facility receiving treatment at a lower level of care. Of the 4% who need a higher level of outpatient care, there is still a debate about whether DMH or CDCR will be treating these people in the new facility. And there is less than 2% of the population who require acute care or intermediate care. The Department is already providing treatment for many of them. The effort in the new division would be to participate in the build-out of a new method, such as evidence-based practice for the types of buildings they are in, the type of treatments and for creating systems of continuity of care. She thanked DMH for the collaboration that is growing.

Answer: We have made the decision that it is better for CDCR to run the majority of the programs at the less than acute or long term care level. The area that is not clear is crisis beds.

George Fry: How will parolees who have mental health issues be handled? Are they going to be handled in the county mental health setting?

Answer: There are still a lot of issues that need to be addressed with how to address parolees. Counties do not have programs set up, or even slots to deal with an influx of new folks. Sometimes parolees have specific program needs, and we are trying to deal with the best collaborative way to handle this. In terms of the ongoing treatment, the definition between what parole outpatient clinics should do and what counties should do are issues of continuing debate.

George Fry: The co-occurring client will be in the re-entry facility and then after that it will impact the County Mental Health and substance abuse programs. How will we deal with that?

Answer: Dr. Chaiken answered by saying there is a lot of misunderstanding about re-entry facilities. The proposals about re-entry facilities do not change in any way the numbers of people who get out of prison. It is the same people who would be returning to communities directly from prison but they have a 12 month period of time in a facility that is in the community to which they are going to parole. Our idea was to have services that were provided both by CDCR and contracted with individuals who wish to provide services within the re-entry facility so we could do better continuity of care planning and the people.

Daphne Shaw: Keeping in mind the current budget problems that we are having and understanding it is difficult to find the money for meetings, there is a concern that several of the committees that have been in effect for some time have not met this year, specifically the State Quality Improvement Council, the Client Family Task Force, and the Performance Measurement Advisory Committee. What comments do you have in regard to this?

Answer: We are looking at all of these external groups to see whether or not they are still as relevant as they were when they were started. We will be looking at the charter and the deliverables for those committees to see if their job has been subsumed by other groups and if there is a way to combine some of the committees so that we do not have silos in the way that we approach things. With the 25% staff vacancy rate we needing to prioritize. For us it is most important to keep programs going, to get money out, and to make sure there is accountability. There may be a shake-up in the number of external meetings.

Jonathan Nibbio: One of the cuts that I am afraid will surface again is the proposed cuts on the foster care side; to cut foster care parent payments by 5% and cuts in residential care. He urged Dr. Mayberg to advocate on behalf of the foster care issue. He asked Dr. Mayberg to provide: (1) an update on TBS and *Katie A.*; and (2) small county survival.

Answer: Regarding the lawsuits with TBS and *Katie A.*, Rick Saletta has been assigned to these issues, and he is working with all of the persons who are involved to try and come up with some proposals and recommendations. He has submitted his recommendations to the Court and we will have to see what decision the Court will make. The second issue regarding small county cash flow; we are very aware of this issue, and we have made a commitment for any of the monies that we owe them, both past and future, to put them first on the future claims, so the money will go out to the small counties as the State Controller processes them. Cash flow is a big issue for the small counties and we are going to have to pay attention to it.

Beverly Abbott: I am glad to hear your comment about trying to eliminate burdens where we can. There are regulatory conflicts with what we are trying to do with our mission. Community and private providers have so many audits and so much wasted energy over regulatory requirements. I don't know what you can concretely do about this, but I hope you can give attention to it.

Answer: One of the things that we are becoming increasingly aware of are those reporting requirements, and any time we have an opportunity we are looking at what items may not be necessary. We are looking at what our minimum state and federal requirements are and how to maintain accountability.

Carmen Lee: I understand that the state has borrowed money from MHSA. When will that money be returned?

Answer: What happened was that there was a budget language that allowed the State Controller to use money that is in the MHSA pot; it is categorical money, with the proviso that it is replaced as soon as possible with the current interest that the state pays. The other proviso is that there is no ability to borrow more than is necessary.

3. Access to Acute Inpatient Psychiatric Services (Sheree Kruckenberg).

Ms. Kruckenberg introduced herself as the Vice President, Behavioral Health for the California Hospital Association. In her capacity she represents all of the hospitals in the state that provide inpatient psychiatric and chemical dependency care in the non-state hospital system. She brought along with her four operators of four different hospitals from around the state. She reviewed the agenda with those present.

- In California there is one psychiatric inpatient bed for every 5,600 in population. The other 49 states have one psychiatric inpatient bed for every 2,300 in population. Experts recommend that there should be one psychiatric inpatient bed for every 2,000 in population.
- Currently in the State of California there are 6,000 beds. Those 6,000 beds are in 140 hospitals, and of those 140 hospitals 40 are acute psychiatric hospitals. They do not have med-surge beds, do not have an emergency department, and are truly just providing acute inpatient psychiatric care.
- 46 counties do not have any child or adolescent beds; 30 counties without adult psychiatric beds; 49 counties without any geriatric psychiatric beds; 48 counties without any chemical dependency beds; and 25 counties have absolutely no inpatient psychiatric or alcohol and substance use in facility treatment at all.

Richard Bowdle, M.D., Chief, Department of Psychiatry and Director of Medical Affairs, Sutter Center for Psychiatry provided the following information:

- History and background of Sutter Center for Psychiatry. It is a not-for profit organization and promotes charity care where possible and community service and work with community organizations.
- I work for the Sutter Center for Psychiatry in Sacramento. This is a 69-bed hospital serving adults, adolescents, and children. We are the only inpatient psychiatric hospital that is serving the needs of children in our area outside of Vallejo and the Bay Area. Sutter Center draws from half of the counties of California to try and serve the needs of children. This becomes quite a challenge with the beds we have available for children, which is currently 15.
- Sutter Center is recovery-centered treatment, and all emphasis is on the recovery model. Patients are constantly involved in self determination, respect, self-directed treatment, wellness and improvement.
- NAMI has selected Sutter Center for Psychiatry as a hospital of merit to provide services for patients and their families.

- Length of stay for a child adolescent population is approximately between 5 to 5.5 days. Our mission is to get them back into the community but to keep them safe.
- The length of stay for adults is approximately 8 days; the intensive care adult can be as much as 11 days.
- We have been on a mission for the past five years to eliminate seclusion and restraint for patients.
- Barriers: We do have some difficulty for services for children and lack of available services for older adults. There are some complexities with the dual diagnosis of psychiatry, developmental disorders, and substance abuse disorders.

Jerry Gold, Ph.D., Administrative Director, Scripps Mercy Behavioral Health Center of San Diego provided the following information:

- Scripps is a not-for profit community-based health care system located in San Diego. There are five acute care hospitals and several outpatient facilities.
- While mental illness is prevalent in San Diego, the resources are limited and our health care system is fragmented and under funded.
- Inpatient care is an important part of the continuum of care for the psychiatric consumer.
- In San Diego the Community Health Improvement Partners identified mental illness as one of the top five health needs of the community.
- San Diego went from a 750 bed community to currently around 650 beds for a population of about 3 million people.
- The hospitals have become the safety net for the unfunded population.
- Scripps Mercy inpatient unit operates 40 beds and serve the chronically mentally ill. Average daily census is 38, and the average length of stay is 9 days. There are some patients on the unit that have been there for over 100 days because their families will not accept them back and there are no providers willing to accept them.
- Since 2005 the behavioral health unit of Scripps has been operating at a \$3 million loss. One of the reasons for this is that 25% of the population on the unit is unfunded.
- There are two outpatient departments; one in San Diego and one in East County San Diego. Together they see about 115 patients a day. The mission is to serve the chronically mentally ill based on a psychiatric rehabilitation model. This has been operating at a break-even point or vacillates with a loss less than \$100,000. The reasons for this is the declining reimbursement structure and the increase in costs of providing care.
- There is a psychiatric liaison team that is made up of advance practice clinicians that goes to the various hospitals within the Scripps system to provide assessment and triage of the psychiatric patients. They see about 5,500 patients per year. Scripps has collaborated with the family health centers to operate an outpatient psychiatric clinic next to one of our emergency departments at Mercy to assist with immediate psychiatric appointments once they are assessed. However the county outpatient psychiatric clinics have a two week waiting list.
- Mercy has a back-to-work program; a vocational rehabilitation program for the chronic and mentally ill. One hundred patients have entered the program, and 20 patients have actually received part time employment within the Scripps organization.
- Some of the gaps that are noted in the services in San Diego are lack of outpatient resources, the lack of crisis beds, lack of resources for the homeless, and lack of resources for the brain injured.
- Some of the regulatory requirements that are put forth are old and inhibit innovation and contribute to the gap of resources.

- Another gap is that none of the Prop 63 funds are available for Scripps to help with the psychiatric consumer in the inpatient setting.
- Another gap is stigma.
- All these factors bottleneck our health care system. Scripps looks forward to partnering with people in the community and with the Mental Health Planning Council in order to be part of the continuum of care.

Lauren Ball, MSW, LCSW, BCD, Director, Social Services and Youth Services, Loma Linda University Behavioral Medicine Center

Ms. Ball provided the following report:

- Loma Linda University Behavioral Medicine Center is an 89-bed freestanding psychiatric hospital that is associated with the larger Loma Linda University Medical Center but located at a different campus. The emergency room is at the medical center.
- Within the 89 beds, there are 29 beds dedicated for children and adolescents. Within Riverside and San Bernardino, the Loma Linda University Behavioral Medicine Center is one of two that treat adolescents 14-17, and for children under age 13 it is the only facility.
- The Behavioral Medicine Center is virtually full all the time. The average length of stay for the children's unit is six days. This is acute rapid stabilization.
- San Bernardino County has a crisis response team specifically for children. The team goes out to the community, schools, on police calls, and to the emergency rooms to try and work through these situations without having to go to the hospital. For those children who do need to come to the hospital, they coordinate wraparound services so there is a continuum of care that makes sense.
- The lack of beds for children and adolescents in this state leads to fragmented care, and the push to continue to decrease beds makes fewer services for those children who absolutely have to have that level of care.
- In many cases reimbursements do not approach what the costs are. More and more beds have closed; not because there is a lack of need but because there is a lack of structure that can support it.
- The system is inadequate, fragmented, and not properly funded. There is a need to come up with an integrated system of care that will work for these children.

Tim Medaris, RN, Director, Emergency Services, Mayers Memorial Hospital

Mr. Medaris provided the following information:

- Mayers Memorial Hospital is a not-for-profit small rural hospital in northeastern California. There are 25 acute care beds and 99 skilled nursing beds. There are no psychiatric services offered.
- Mayers Memorial Hospital is 75 miles from the closest mental health system.
- There are approximately 8 patients per month that present with psychiatric disorders at Mayers Memorial Hospital. The average holding time waiting for admission to a facility is approximately 22 hours.
- Mayers Memorial Hospital emergency room is the entry point for many patients in crisis. Some patients are suicidal, psychotic, and depressed. The patient presents in the emergency room; they receive a medical clearance from a physician; and there is a camera with video screen that links Mayers to the Behavioral Health in Redding. The patient is interviewed by either a trained

nurse or a social worker who then consults with a psychiatrist on call. They can either release the patient at that point if there is some follow-up system in place and if the patient is safe and stable to be released back to their home.

- If they are not able to be released, then Shasta County Mental Health Department begins looking for a bed.
- In addressing the gaps in the access to the inpatient psychiatric services, it is clear there are no beds. The closest beds in the north state are in Yuba City which is approximately a three and a half hour drive.
- This is a difficult situation because when the patients are held in the emergency room (sometimes for days) when the law states they can only be held for 24 hours it places us in a dilemma. Do we let them go to run out on the highway, which they often threaten to do, or do we keep them in the emergency room disregarding the law?

Ms. Kruckenberg provided the following recommendations:

- Statewide assessment of the service space that is available in each community
- A revision to the regulations
- Embrace hospitals as part of your community delivery system
- Evaluate the funding practices that are currently in place

Questions and Answers:

Barbara Mitchell: I looked at your data sheets and you indicate that there should be a minimum of one public psychiatric bed for every 2,000 people, and it said experts estimate a need for this. You quoted this from the Treatment Advocacy Center from E. Fuller Torrey in which he quotes himself from a book. Many of us find a lot of the information given out is quite controversial at best, and at worst incredibly inconsistent and based on false premises.

Answer: I do appreciate that comment and actually the TAC Report came out after we released our statistics that came from national, actual, inpatient data.

Barbara Mitchell: I would like to see what that data is because I looked at Monterey County statistics and there are 36 public beds and according to your statistics we would need 200 beds. There have been considerably more beds in our county and they were unused. I question the data presented.

Answer: That data came from the 2006 Office of Statewide Health Planning and Development and is available on the website. The national data comes from a national database that states from around the nation report in to. So it is the number of beds in California compared to the 49 other states and the nation which is publicly available data. Our intent today is to tell you we are part of your community. Embrace us and let us be part of the system of care. If we have an adequate community infrastructure, it will reduce the need for inpatient but it does not take the need away completely. Let us partner with you to help build our community structure so it works.

Mr. Gold said he can speak regarding San Diego County. Often times what happens in San Diego County is there are patients in every emergency department at the hospitals waiting placement for an inpatient bed. The consequence of this is that the emergency rooms are impacted, and they cannot take in any more patients. There is a great need for a continuum of care to increase the bed capacity. Also, the reimbursement daily rate for the Medi-Cal patient in San Diego is \$565 and does not cover the costs of the inpatient stays.

People untreated end up homeless or in jail and it costs a great deal of money to take care of a homeless and incarcerated person with the services that they need; appropriate care, at the right time, at the right place for the right person is the right thing to do. Not having enough access geographically ends up with people in jail or homeless and is not the right thing to do and is more expensive to the State of California.

There are many positive aspects to realignment, but the difficult aspect to realignment is that 58 systems of care have been developed, each of which develop their own rules, regulations, and administration. Try to work this out at a hospital when you are trying to help a distant county who has no care, and you can spend three days trying to do this. This must change.

Beverly Abbott: Dr. Bowdle, do you feel that your unit is threatened with closure?

Answer: I'm very grateful that I work in a community-based not-for-profit hospital that does support us. We cannot make our budget solo, and we are supported by the medical center that ensures that we stay viable. Because of these factors the hospital does support the operations, and it is not threatened.

Some of the threats for Scripps is that the building is very old, and it would take a significant amount of resources to rebuild the psychiatric unit. There are not resources enough with the current regulatory environment and requirements to build so when the building is no longer available for use there may be a problem. We need to figure out how we are going to treat these patients.

Jorin Bukosky: What I got from your presentation is that there needs to be development of services in all levels of the community. Some of the collateral information clearly states that we need to look at crisis residential, crisis stabilization. The first part of your potential solutions and recommendations addresses crisis stabilization and crisis residential. However, the comparative data that you provided makes it seem that there needs to be more hospitals. The last page of data gives us only a picture of the beds; it doesn't necessarily give us a picture of what other community resources are available. If that were included, i.e., the number of community beds that were available, the alternatives to hospitalization, particularly in the rural counties that don't have these resources, it would give us a better picture of what counties really lack resources altogether versus those counties that may not have hospital beds but have a broad range of community services.

Answer: I appreciate your feedback. Our recommendation number one is to do exactly what you are saying; to do an assessment of what is available.

Shama Chaiken: I have two hats on: one is from the Department of Corrections and Rehabilitation when we don't do adequate care of people who become combative and assaultive end up in the criminal justice system, especially parolees. Many are coming back in the prison system because of lack of adequate in the community. My other hat is as a foster parent. A lot of the children are in foster care, and they don't have adequate parent support. Most foster children need to be watched constantly, and it is incredibly difficult to keep these children in foster care. Supports for foster parents, both financial and respite, and one-on-one care when needed could keep a lot of kids out of the hospital.

Answer: This is the point that I continue to think of is how to keep persons out of hospitals. Having systems of care that keep people out of hospitals is a good way to prevent the need for more hospital beds.

George Fry: I live in a rural county of 40,000 people. We have a hospital in the next county that has a psychiatric section. Because it is losing money they are going to close it down the end of December. What I'd like to know is what do you suggest for a rural area?

Answer: The crisis residential homes are a wonderful service. We would like to see more of these beds in the community to provide an alternative to inpatient psychiatric hospitalization. This is our number one recommendation of what we need to develop and to have them geographically available to counties.

4. Report from the California Association of Local Mental Health Boards and Commissions (James McGhee, President, CALMHB/C)

Mr. McGee provided the following report:

- I am the newly elected President of the California Association of Local Mental Health Boards and Commissions (CALMHB/C). He provided background on himself as well as the background of the other newly elected officers of the Board.
- We will be reorganizing how we operate looking at infrastructure development, being able to provide deliverables to constituents, and looking at new committees that will provide better resources and access of information.
- The guide to California public health system is completed and in production. This guide lays out the whole system of mental health in the State of California. Copies will be distributed.
- CALMHB/C's intentions are to hold an annual conference in San Jose in June 2009. Workshops and panel discussions for this conference were reviewed.
- CALMHB/C is looking to move forward in identifying its own location, looking at raising capital for staffing, and develop a strategic plan.

5. Committee Action Items

Children and Youth Subcommittee. (no action items)

Transition Age Youth. (no action items)

Adult Subcommittee. (no action items)

Older Adult Subcommittee (Carmen Lee). The subcommittee moved that the statewide Prevention Early Intervention program (PEI) project on racial, ethnic, and cultural specific programs and intervention should require a lifespan approach including older adults. The project should also develop a definition of what constitutes a disparity. Disparity should be measured using prevalence rates and penetration rates according to five year increments by age, gender, and race/ethnicity.

Motion by Member Lee, seconded by Member Fry; the motion carried.

Cultural Competence Committee. (no action items)

Policy and System Development Committee (Beverly Abbott). The subcommittee moved to send a letter to the State Department of Mental Health urging them to prioritize getting money out to small counties.

Motion by Member Abbott, seconded by Member Nibbio; the motion carried.

Human Resources Committee (Lana Fraser, CRC). The subcommittee has no action items but it wanted to inform members that it is still closely tracking the workforce education and training activities. There may be an action item for the next meeting. A new member has been added to the HR Committee: the Executive Director of the California Foundation for Independent Living Centers representing 27 of the 29 independent living centers statewide.

Quality Improvement Committee (Gail Nickerson). The subcommittee moved to send a letter to Dr. Mayberg advocating for reactivation of those activities that create opportunities for clients and family members to give input about quality improvement (Client and Family Member Task, State Quality Improvement Council, and Performance Measurement Advisory Committee).

Motion by Member Nickerson, seconded by Jennie Montoya; the motion carried.

6. Approval of the Minutes of the June 2008 Meeting

Upon motion by Member Fry, seconded by Member Nickerson, the minutes of the June 2008 meeting was approved as presented.

7. Approval of the Executive Committee Report

Chair Hunter provided the following update:

- The Executive Committee met and reviewed and approved the Executive Committee meeting minutes for June 2008.
- Approved the budget for 2008-2009.
- Appointed a Nominating Committee. The Nominating Committee will be responsible for nominating a chair-elect for 2009.
- Discussed the expectations of Planning Council members as far as attendance is concerned. If two meetings are missed within one year then a notification is sent. A long-standing member, Ed Walker, has missed three meetings but because of his circumstances it was the Executive Committees recommendation that he remain on the Planning Council.
- The Cultural Competence Committee has been working on enhancing the cultural competence of the Planning Council. This Committee is proposing a "World View Mapping," and the Executive Committee is recommending that this exercise be done at the April Planning Council meeting.

Upon motion by Member Nickerson, seconded by Member Mueller, the Executive Committee Report was approved.

8. Public Comment

- Ms. Cary Martin, Vice Chair of the San Joaquin County Mental Health Board, quoted Dr. Mayberg as saying "Help more people get more services more quickly". This is also what he is looking for, with the help from the Planning Council, with respect to Veterans. What I come to you about specifically is the problem of military people and what is happening with them. Almost 30% of the people injured are citizens of the State of California. I ask this Council, for the purposes of cultural competence, that the State of California recognizes military service and supports inclusion of active members, its veterans, and their families as a demographic.

Chair Hunter assured Mr. Martin that military veterans is on the Planning Council's radar and thanked him for making the Council aware of this.

- Sharon Roth from San Mateo County thanked the Council for asking for the Client and Family Member Task Force to be placed as a priority.

9. New Business

Chair Hunter said, regarding Rachel Guerrero's presentation, she is suggesting that her presentation on cultural competence issues be turned over to the Cultural Competence Committee and Executive Committee for their review and input that will then provide Ms. Guerrero with their comments.

Questions and Answers:

Might there be an opportunity to provide additional comments that the Council may want to make in regards to the issues that were brought up in the presentation by the California Health and Hospital Association.

Answer: This will be referred to the Executive Committee for follow-up and referral to the appropriate committees.

Jim Bellotti: When we have presentations it seems as though people are presenting issues to us and it might be appropriate to forward these to the appropriate committees for discussion.

Answer: Yes, and I think the Children and Youth Committee is looking at some of the continuum of care issues that were brought up.

Beverly Abbott: Regarding presentations we had said we were going to do two things: try and get client and family members to be a part of every presentation and to have diversity in each presentation. It seems as though we are still struggling with this. Do people not respond to our requests?

Answer: They respond but some feel it is not possible to provide information.

10. Adjournment

Chair Hunter adjourned the meeting at 12:19 p.m.