

**CALIFORNIA MENTAL HEALTH PLANNING COUNCIL
MEETING MINUTES
January 15 and 16, 2009
Hilton Hotel
Sierra Ballroom
700 North Haven Avenue
Ontario, CA 91764**

CMHPC Members Present:

Celeste Hunter, Chair	Luis Garcia (not present Friday)
Dale Mueller, EdD, RN	Adrienne Cedro-Hament
Walter Shwe	George Fry, Jr.
Beverly Abbott	Barbara Mitchell
Richard Van Horn (not present Friday)	Lin Benjamin
Stephanie Thal	Patrick Henning (not present Friday)
Daphne Shaw	Shebuah Burke
Gail Nickerson	John Ryan
Jorin Bukosky	Caroline Casteneda
Renee Becker	Shama Chaiken
Doreen Cease (Not present Thursday)	Jim Alves
Edward Walker, LCSW	Sophie Cabrera
Karen Hart	Jonathan Nibbio
Lana Fraser	

Staff Present:

Ann Arneill-Py, PhD
Charles Anders
Linda Brophy
Michael Gardner
Karen Hudson
Brian Keefer
Narkesia Swangian
Tracy Thompson

Thursday, January 15, 2009

Welcome and Introductions

Chair Hunter called the meeting to order at 1:07 p.m. Planning Council Members and guests in the audience introduced themselves.

Orientation to Department of Mental Health (DMH) Data Systems

Marti Johnson, Acting Chief, Performance Outcomes and Quality Improvement, DMH, gave a slideshow presentation that discussed the status of data quality for California DMH, consumer perception survey data, penetration and prevalence rates, and an analysis of the initial outcomes of full-service partnerships. Highlights included:

There are four data systems:

1. Client Services Information
 2. Data Collection and Reporting System
 3. Web-Based Data and Reporting System
 4. Short-Doyle Medi-Cal Approved Claims Files
- Client Services Information (CSI) includes demographic as well as collected information about services received by people who are accessing the public mental health system. Data is submitted by the county for each person receiving public mental health services each time services are provided.
 - Counties use their own systems to collect information that is submitted to DMH monthly via batch. Any adding or changing of information fields requires changes to county-level systems. Every change impacts both the county and the statewide system.
 - The Data Collection and Reporting System collect outcome information for individuals participating in Full Service Partnerships. Forms are tailored to four age groups: child/youth; transition age youth; adults; and older adults. There are three types of forms: the Partnership Assessment Form gathers history and baseline data for eight key areas at entry into the program; the Key Event Tracking Form is completed when changes occur in key areas over time; and the Quarterly Assessment is completed every three months.
 - The Web-Based Data and Reporting System (WBDRS) is used to collect Consumer Perception Survey data. It provides information about satisfaction with mental health services and quality of life. Surveys are tailored around families and children aged 15-18, adults, and older adults.
 - Short-Doyle Medi-Cal Approved Claims provide information about mental health services and costs on services for individuals who qualify for Medi-Cal.
 - The systems are set up to be linked across each other using several key identifiers, the most important of which is the County Client Number (CCN), which is supposed to be submitted for all individuals receiving public mental health services.
 - The CSI system needs updating, which is difficult given current budget constraints. Some County systems are in a similar situation and this impedes the DMH's ability to have access to timely and accurate information.
 - The accuracy of data is an issue across all of these systems. CSI data has the lowest quality and S/D Medi-Cal Claims data the highest quality. Johnson asked the audience to keep these facts in mind as she presented them some specifics. The quality issues do not mean the data is unusable; simply that they should be put in a proper perspective.

- Prevalence is the estimated number of people in the California population with a Serious Mental Illness (SMI). Census data is 10 years old. The California Department of Finance updates census estimates annually but these estimates tend to weaken at the county level. SMI definitions at the national level do not necessarily correspond with what is reported in California. In addition, diagnoses are not consistently reported, thus making determination of SMI for a given individual difficult.
- Penetration rates are calculated by dividing the number of individuals estimated to have SMI (again based on the 10 year census data) by the number of people who actually receive services (based on inconsistently collected and reported diagnoses). Thus, further investigation at the local level should occur to improve the accuracy of information, and should include our own knowledge and expertise -- particularly as this information is viewed from a local/county perspective.
- Johnson presented a series of slides detailing data on race and ethnicity penetration and retention; race and ethnicity percent distribution; gender penetration and retention; gender percent distribution; age group penetration and retention; and age group distribution in different areas of the state.
- The Planning Council will be developing a work book that will be shared with people at the local county level that can be used to investigate the accuracy and/or meaning of any disparities and to develop plans to address them.

There was discussion among members about the data presented and whether or not it addressed the needs of the Planning Council. Johnson reiterated that the data is useful to look at but cannot be used for drawing final conclusions. However, educated guesses can be used as points of departure to go into the local community to see if the guesses make sense in a realistic way.

Johnson went to the next part of the presentation, which dealt with the effectiveness of services. DMH used the Consumer Perception Survey data and the Full Service Partnership Outcomes Indicators to begin to look at effectiveness.

The Consumer Perception Survey is administered twice yearly. It measures the perceived satisfaction with public mental health services from the perspective of the consumer. It uses the nationally recognized Mental Health Service Improvement Project (MHSIP) Consumer Surveys. Surveys are tailored to Family Member/Caregivers for youth under 15, Youth 15-17 years of age, and Adults 18 and over.

- Satisfaction with services is measured across several domains, including perceived improvement, perceived satisfaction with services, and perceived impacts on quality of life.
- Johnson showed a series of slides detailing some of the results, among them:
 - Parents tend to think that their kids aren't quite as improved as the kids themselves think they are.
 - Older adults think their improvement is a little better than younger adults, although there isn't a lot of change from year to year.

- Perceived quality of life, especially in the area of health, is not perceived to improve much. Safety is pretty good, as is general life satisfaction. Again, there isn't a lot of change from year to year.
- Consumers are mostly satisfied with the quality and appropriateness of services, although access is on the low end, particularly for youth.
- Adults and older adults seem satisfied with services.

In conclusion, people using public mental health services appear to be relatively satisfied with services outcomes, the services themselves and the impacts these services are having on their lives.

Counties get a report on the data about six months after data collection.

The Full Service Partnership (FSP) Outcomes compares data over time across eight Quality of Life Domains. There are over 200 Full Service Partnership programs across the state providing services to approximately 14,000 people last year. The FSPs use a "whatever it takes for as long as it takes" approach and are recovery-oriented.

- The approach was developed on input from multiple stakeholders. There are multi-level individual outcomes collected from multiple perspectives that use multiple sources of data.
- Available data for FSP evaluation includes:
 - Outcomes assessment via the Data Collection and Reporting System, which captures data for eight key quality of life domains over time.=
 - Consumer Perception Surveys via the Web-Based Data Reporting System.
 - Client and services information via the CSI System, which captures demographic and service information.
- Data can be linked across data systems, which provides a comprehensive picture of the impact of services on individuals.
- Data is compared across three years in the eight quality of life domains. Both Key Events (for example moving, or getting a new job) and Point-In-Time data are tracked in eight selected domains of time. The evaluation is analyzed for changes in key domain indicators over time.
- Outcomes they are looking at include increased social connectedness, increased satisfaction with services, employment, housing stability, higher independence, better school attendance, reduced psychiatric hospitalization, less criminal justice involvement, and reduced emergency room visits.
- The sample includes FSP data from 13,472 individuals. There are a total of approximately 17,000 Full Service Partners, which includes 10,365 Active Partners and 3,107 Inactive Partners.
- Indicators of Progress for FSPs include reductions in physical and mental health-related emergency interventions, a downward trend in the number of arrests per

month by age group and years in the FSP program, and an overall increase in housing stability.

- Initial outcomes analyses indicate that MHSA FSPs appear to be improving the lives of the individuals who receive them.
- Outcomes analyses methods will continue to be refined. Analyses are now underway that links FSP Outcomes data with other sources of data, such as CPS, CSI and S/D Medi-Cal approved claims data.

Questions/Comments

- Beverly Abbott noted that the MHSIP is not a perfect instrument but it is developed by national consensus and is “the best shot” so far. The data can be used by disaggregating the information to provide more specific information in some cases. Also, only 63% of mental health clients in the state feel safe, according to the data.
- Ed Walker commented that the matter of deferred diagnoses remains a chronic problem that will continue until it becomes a priority for the counties and the Department. It is embarrassing to acknowledge the persistent failure to perform a relatively simple task and there is no excuse for it.
- Lin Benjamin discussed the value of breaking down the adults 65 and over age group, as these are clients in a 40 year or more time span (i.e. 65 to 105 or more years old). Understanding who we are serving is very important. Looking by ethnicity and age, she sees disparities across the age group in terms of who is utilizing the system. Any data provides the opportunity to ask why there is this disparity and she appreciates the opportunity to raise the question about why.
- Daphne Shaw recalled trying to put together performance outcomes in the past and the clinicians having tremendous resistance to that because they didn’t want to take the time. It is valuable information and maybe the technology has improved enough to make it happen.
- Walker discussed the potential impact of real time information coming directly from consumers to family members and other interested parties. This could occur on a very frequent basis at a high order of relevance to that person’s life, depending on the kind of program they are in, and could be an important part of quality improvement.
- John Ryan: Is it possible to get good data at the statewide level? Answer: The data was pretty good at the statewide level but going down to the local county level it becomes more problematic.
- Renee Becker: The Mental Health Services Act breaks down ages into a range and one range is from 16-25 years. Is it possible to break down that 16-25 range into smaller increments? Answer: Yes, it is.
- Barbara Mitchell: The MHSIP are not service specific. Thus, a number of the questions are incredibly inappropriate to wellness and recovery based services. Unless surveys relate to the specific services, we won’t find out if people are happy with the specific service they’re getting. Answer: Part of the reason the MHSIP

Surveys are conducted is that they are included in the report to SAMHSA for outcome measures. That's the trade that the Department makes for the \$55 million Block Grant money they receive. Also, the questions are standardized nationally.

- Walter Shwe: Would it be possible to link the survey results with CSI and Medi-Cal paid claims? Answer: Yes, in fact that work is being done.
- Karen Hart: Regarding the residential status scores -- it points out one of the challenges with the Transition Age Youth group. The residential status of a 16 or 17-year old versus a 25-year old is quite different. It is difficult to assess meaning when the same number of points is assigned to a 25-year old still living at home as to a 16-year old that might be living independently with a friend. Answer: This is an excellent point, and the data can and probably should be broken out.
- Ryan: I am still struggling with the concept of unmet needs versus disparities, between age groups and gender and racial/ethnic breakouts. I want to have an intelligent understanding of that to see if, indeed, progress is being made. I appreciate all the hard work but what I am looking for is the knowledge of where we currently are in this process. If I were at a party and the Governor were to walk up to me and ask *What percent of the mental health need in the state are you addressing?* I wouldn't be able to answer that. One purpose of the Council is to know where we are and where we've been. Are we serving more people now than five years ago? In addition, there needs to be some kind of system developed so that the clinician and the consumer, in real time, know whether or not that consumer is being helped. There needs to be something more detailed behind the data being presented today. Answer: The DMH has been talking about creating a data dashboard, where people could go to pull off data, sort it, and mix and match it in different ways.
- Becker: How is the data for Transitional Age Youth pulled together, given that the data is separated differently? Answer: We collect the birth date and thus can separate data by that specific criterion, so we can rearrange the data in any way we want to.

Chair Hunter thanked Johnson for her presentation and expressed the appreciation of the Council for all the hard work that went into preparing the data.

Discussion of Implications of Issues Related to Access to and Effectiveness of Mental Health Services

Chair Hunter began the discussion by asking, based on the data just presented, what conclusions can we reach about the performance of the mental health system in reference to the retention rate and the effectiveness of services?

Ann Arneill-Py stated that more data will be coming for penetration and retention rates for every county, and the mental health boards are going to be reporting back to them on their interpretation of that data, and what will come from that is a statewide report on unmet need, as interpreted by the local mental health boards and commissions. This may be the best way to update the information on unmet need in the state. The statute requires that every mental health board and commission review and comment on its local performance indicator data and provide that report to the Planning Council, and this is to

be done annually. When the Mental Health Services Act (MHSA) was adopted the Council was able to acquire an additional staff person to work on that project. Staff has identified performance indicators on which they will develop data and provide those to the county, along with the background information they need to interpret that data.

The Council will subsequently provide data in penetration rates and retention rates by age, gender and race/ethnicity. The previous presentation did not include the penetration rates, which are some of the more interpretable data for the counties to work with. This information will be put into a workbook form, probably by the end of this fiscal year, and it will be going out to the counties along with additional training.

- Fraser commented that the MHSA calls for them to reach out to people with other disabilities who also experience serious mental health issues. The survey does not address that, even as a measurement. In addition, there is the problem that people with other disabilities have of accessing mental health services. In essence, there are people outside the door who never even get inside the door.
- Adrienne Cedro-Hament added that what her committee (the Cultural Competency Committee) really wants to see is the disparities. To do this, they need the ability to note the changes over time, to be able to establish a baseline. Also, people have different ideas as to what disparity is. Perhaps a standard definition of disparity is needed so that the same language can be consistently used.
- Ryan asked if the workbook will be able to sum up the data acquired from the various counties to present “the big picture” to the state. Will the data be aggregated? Answer: Arneill-Py responded that this would be done.
- Nibbio questioned whether the data includes people who receive their mental health services in juvenile hall, jail or state prison. He understands that it is difficult to retrieve that data. If it is not included then the report should note that the data does not reflect that population in order to more accurately represent what the numbers really are.
- Abbott noted that anyone in the county system would be included if a record (CSI) was opened on them. If the CSI was never opened they would not be covered. Also, the data would not cover those in state prisons because they are not served by county mental health.
- Walker added that it is also variable by county and in county jails; in some counties the funds for the mental health services is in the Sheriff’s budget and they may contract with a private entity. In other cases it might be in the human services budget. Also, counties are not required by statute to open a chart or establish a record. Walker stated that it would be helpful to have a brief report that, in lay terms, explained the limits of what we can do with the data -- what it tells us and what it doesn’t, saying in a very upfront way what the limitations are and how we want to use it. Note that the counties are beleaguered and it is difficult for them to provide quality data.
- Benjamin noted that most of the data doesn’t provide a breakdown of ages 65 and older. What is available is information on people aged between 65 and 75. This raises the question of whether the mental health system is prepared to serve the elderly. As people age they also have additional physical health complications. How can the

system do a better job of serving older adults? In addition, clients who are on both Medi-Care and Medi-Cal -- should the system serve them? The idea of exactly who should be served in the mental health system deserves more discussion.

- Richard Van Horn noted that the age span differentials represented suggests no disparity from one age group to another. We don't have enough data over enough time to clarify trends. Retention rates are an interesting issue; and we don't really measure them. In addition, Full Service Partnerships are effective from year one to year two, but that's the only information we have that indicates any kind of effectiveness, and there is no tracking of the individual person. Furthermore, the issues of data reliability are incredibly extreme and he is certain the state doesn't do intensive follow-through on the data (it doesn't have people that "scrub" the data to ensure its accuracy). They can't; they simply don't have the time or money. Thus, we don't really know what we're doing.
- Mitchell commented that the Council may want to focus on a community snapshot rather than individuals served. What is a healthy community?
- Walker stated that with regards to the drop-off of retention rates between 18 year old TAY's and the subsequent resurgence at age 25 -- what do we do with that information? What are the causes? Are we prepared to deal with the baby boomers? This should be revisited at some point.
- Chaiken commented on the way that data is presented, and whether it's useful to people or not is really important. A red light/green light method is meaningful to people; i.e. a red light means action should be done, a green light no action. This is a simple way to present information to people, rather than the usually cumbersome data found on charts.
- Abbott noted that there seems to be a general consensus that the services provided to people are good and helpful; however, a lot of people don't have access to those services. Sometimes we should proclaim unabashedly that we are doing good things, although some people are in the system and not getting what they need because they don't have access to newer models. Let's be sure we don't get so caught in the data where we spend tons of time describing all the things that the data does not give us. Is the data good enough to make conclusions that counties can interpret on the local level?
- Ryan noted that there are tremendous unmet needs across every group. What are the most underserved groups? Is it possible to get to a point where we can rank groups from the most to the least unmet needs? What groups are at highest risk?
- Benjamin asked if the prevalence data reflects income levels. Will we be able to determine prevalence for older adults who are Medi-Cal eligible? Executive Director Answer: Arneill-Py responded that the prevalence rate does apply to those persons who are most likely to be eligibility for services, which closely correlates to Medi-Cal eligibility.
- Hunter asked for any recommendations that the Council feels can be put forward to improve the mental health system.

- Chaiken wondered if information can be received from an additional source. Is it possible to look at data pre-MHSA and compare that with where we are now?
- Abbott suggested that the Council proceed with the workbook process delineated earlier and the additional information needed can be gleaned and added as we go.
- Ryan stated that the issue to him was having good data and how do we get to that point.
- Van Horn recommended engaging a competent outside data manager to collect, manage, and analyze data from all the counties and the various institutions that are a part of the system, so that the Council has one source and an integrated data system.
- Shebua Burke asked how the rate of homelessness versus ethnicity versus the people who aren't counted -- is there a percentage or average for that? Do we know about the true data of the homeless compared to the perceived amount we aren't able to count?
- Van Horn commented that there is no source available at this point that can provide that information, which led him to suggest hiring someone to collect the data. Also, what kind of data do we want? There has not been a rational discussion, in his memory, of how many of these data elements are essential to actually providing better service, and which ones are just a matter of a billing issue.
- Walker stated that what would be required is to be able to describe what we think the world should look like, what kind of information would tell us what we need to do to pursue that vision, and what would be the data sources that would be acceptably reliable. Given the economic reality of current state budgets, perhaps hiring an outside data manager makes sense. Such a group could also help us think through these issues. Ms. Abbott echoed these comments.
- Arneill-Py noted that the Department has done that for FSP data, which was done in lieu of trying to hire additional staff.
- Van Horn stated that the MHSOAC has an RFP to engage a consultant group to design the parameters for the overall evaluation process of the mental health system. Phase two of that process will be, having once defined the parameters, to develop a second RFP, which would be for an overall evaluation of the system itself. Thus, it is a multimillion dollar project to really understand if the Mental Health Services Act has really had an effect on the mental health system in the state, can the system be transformed and integrated, and can it truly serve those it is supposed to with reasonable services -- including of course the broadening of the Full Service Partnership definition, which is hopefully imminent.
- Walker wondered if DMH could provide some regular reports on the status of the current data -- how good is it, what are some of the issues involved. The Council would then periodically issue its own reports regarding that, including recommendations to improve the data system. This would not be a "gotcha" report; rather, it would be here's our current status and here's some things that we think could improve it. This might open up the discussion between the various agencies.

- Ryan suggested that the Council recommend to the DMH that they come back in the April meeting with the prevalence data, so we can get a clearer sense of what is needed.

Report from the Mental Health Services Oversight and Accountability Commission

Patrick Henning began his report by mentioning that Mr. Van Horn had been officially named, by the Superintendent of Education, as an appointee to the Mental Health Services Oversight and Accountability Commission (MHSOAC).

The state of the budget continues to present trouble for the MHSOAC. Talks continue about taking away the Proposition 63 funds or a variation thereof.

The MHSOAC has received plans from some of the counties, who in turn have received their Prop 63 funds, but a majority of counties don't have any plans submitted. Thus far 20 counties have submitted plans and 12 have received money. MHSOAC is streamlining their plans for distributing the funds wherever possible.

Questions/Comments

- Benjamin asked for an update on the status of the innovation guidelines. Henning responded that they are a work in progress. The budget scare puts a different spin on things; feedback from the counties and the Governor's Office suggest that the guidelines need to be as streamlined as possible.
- Walker stated that one recommendation, made at the California Mental Health Directors Association meeting, was that after counties submitted their plans, the funds could then be moved to the respective counties, but the monies couldn't be used until the plans were approved. This would move the funds from the state coffers into the county. Has that or similar ideas been discussed within the MHSOAC? Henning responded that the upcoming meeting in Santa Rosa will be mainly focused on the budget, and the sooner they are able to get the money out to the counties, the better.

Report from the California Mental Health Directors Association

Adrian Shilton, CMHDA, reported that they are very concerned regarding budget issues. The most troubling proposal from their perspective is the elimination of the funds that the state pays the counties to manage the Medi-Cal managed health care program. The administration is proposing to backfill that amount of funds with MHSOAC dollars.

CMHDA is going to vigorously oppose the proposal. However, with the state's dire budget situation, a highly coordinated strategy is needed. There is no word yet on which MHSOAC funds would be used. Please contact Pat Ryan if you have additional questions.

CMHDA is currently developing a white paper containing their thoughts on mental health system transformation. The MHSOAC is creating resource-rich services for priority populations while underserved populations are receiving inadequate services. The paper will outline CMHDA's vision for a continuum of care.

CMHDA will sponsor two bills this year. One, which was also sponsored last session and subsequently vetoed by the Governor, regards out of state placement in for-profit facilities. This will be re-introduced, to conform California law to federal law which now

allows that. Second, they will sponsor a bill related to Medi-Cal managed health care, which relates to timeframes for payments; i.e. getting those funds to counties.

A new system is being rolled out for the Medi-Cal Short Doyle Phase 2 implementation, the behavioral health care claims system. Counties are direct providers and submit claims to DMH and AOD. The concern is that this is not going to work for counties and the claims are going to be submitted and end up in a black hole, never to be seen or heard from again. They are working with DMH to resolve some of those issues.

Adjournment

Chair Hunter adjourned the meeting at 4:34 p.m.

Friday, January 16, 2009

Welcome and Introductions

Chair Hunter called the meeting to order at 8:35 a.m. Planning Council Members and guests in the audience introduced themselves.

Walter Shwe thanked Chair Hunter for her work with the Council during the past year and presented her with a letter of appreciation. Arneill-Py stated that the Council traditionally honors the Chair by making a donation to the charity of their choice. Dale Mueller assumes the role of Chair following the January meeting.

Action: The Planning Council approved the nomination of Gail Nickerson as Chair Elect for 2009. There were no abstentions on this motion.

Committee Action Items

There were no action items to report.

Approval of the October 2008 Meeting Minutes

Action: A motion made by George Fry, Jr. and seconded by Adrienne Cedro-Hament: The Minutes from the October 2008 meeting were approved as submitted, with the following addition:

- Ryan commented that, while discussing the issue of disparity with Rachel Guerrero, page 9, a portion of that discussion revolved around the struggle to form a concrete definition of the term *disparity* and what that issue has to do with the target groups. Ryan would like the minutes to reflect this discussion.

There were no abstentions on this motion.

Approval of the Executive Committee Report

The Executive Committee drafted a letter to the Governor that recommended the Council oppose three provisions of the Governor's budget for Fiscal Year 09-10: The opposed provisions are:

1. The proposal to decrease \$226 million of the General Fund by transferring those funds from Proposition 63. This requires a change to the non-supplantation requirement of the MHSA and necessitates a ballot initiation to approve the proposal.
2. The suspension of COLAs for SSI/SSP and reducing the SSP portion of the SSI/SSP grant to the federally required minimum level. Together these two changes will lead to the reduction of SSI payments from \$907 per month to \$830 per month.
3. The proposal to reduce the Medi-Cal optional benefits for adults to exclude dental, optometry and psychology benefits.

The Council discussed and clarified other issues to potentially include in the letter. Chair Hunter then called for the vote.

A motion, presented by Adrienne Cedro-Hament and seconded by Edward Walker, was made to include the following recommendations in the CMHPC's letter to the Governor:

- Specifically oppose the three provisions of the Governor's budget for Fiscal Year 09-10 referenced above
- Support the elimination of the two-thirds vote on budget matters
- Restore the VLF fee
- Increase the alcohol tax
- Address the need for discussion regarding the costs to the General Fund associated with the issues of mandatory sentencing and the imposition of the three strikes law.

Action: The above motion passed with the following abstentions:

Lana Fraser, Jim Alves, Shama Chaiken, Caroline Castaneda, Sophie Cabrera

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

James McGhee, CALMHB/C President, began his report by stating that the CALMHB/C has decided to restructure. They are looking for a centralized executive office location, most likely in Sacramento, and intend to move there in the very near future. They have organized and implemented more clearly defined agendas for their various committees to allow for easier communications with the public. Each region will have a specified plan of action. They will increase their advocacy on behalf of their members and take positions on various legislative issues.

Their annual conference will be held in June 2009.

Statewide Suicide Prevention Plan

Sandra Black, DMH Office of Suicide Prevention, provided a presentation on the Statewide Suicide Prevention Strategic Plan. Some highlights:

- Suicide is a significant problem. Suicide rates in California and the US are higher than homicide rates.

- Rates of suicide increase substantially as people age.
- Rates among whites are much higher than other racial/ethnic groups and males are at much higher risk than females.
- Suicide attempts are difficult to quantify. Data of recorded attempts shows that females are much more likely to (unsuccessfully) attempt suicide.
- Individuals with major mood disorders and schizophrenia are at much higher risk for suicide than the general public.
- There are definite trends in the data. Rural areas have much higher suicide rates than urban areas. Lesbian/gay/bisexual youth are also at elevated risk.

Part two of the Strategic Plan outlines strategies for suicide prevention, which is a very young field and thus has relatively few well-researched best practices. However, based on current research and feedback from professionals in the field, four basic strategies were identified:

1. Create a system of suicide prevention. State and local agencies working in collaboration to provide continuity of care ultimately help prevent suicides.
2. Workforce and training enhancements. There are particular groups that would benefit from suicide prevention training -- primary care providers, those in the education system.
3. Educate communities to take action to prevent suicide. People who are in a position to recognize warning signs are often not professionals -- they are friends, co-workers, family.
4. Program effectiveness and system accountability need to take a close look at current suicide prevention systems and improve the quality and value of the data that is collected.

Next steps for the Statewide Suicide Prevention Project include:

- Training and technical assistance to link California with the national expertise on suicide prevention and create a California-specific resource center;
- Formation of local suicide prevention committees that do needs assessments and develop standards and guidelines on the local level;
- Promotion of survivor support networks and coordinating with them to build a more comprehensive survivor network infrastructure;
- Partnering with other public health agencies to develop a web-based source that pulls together currently available research and resources and provides easy access for the public.

DMH Office of Suicide Prevention has been working with SAMHSA, the National Lifeline, and other repositories of expertise to better coordinate their efforts.

The American Association of Suicidology will be having its annual conference in San Francisco in April. There will be a one day workshop on the California Suicide Prevention Initiative on April 14th, the day before the conference begins.

Black concluded by reiterating the DMH's intention to build a statewide coalition for suicide prevention, which has proven to be a significant help in other states. She is hoping today to obtain some additional "next steps" on how best to work with the Council. Current next steps can be found at the DMH website at the link for the Statewide Project on Suicide Prevention, which also has copies of the Statewide Plan. It is linked on the DMH website by clicking on *Prop 63*, then *prevention and early intervention*, then *statewide projects*.

Questions/Comments

- Becker: How is your hotline different from existing suicide hotlines? How are you collaborating with other statewide consumer and family organizations? Answer: Dede Ranihan, NAMI, and Delphine Brody, the Network, are active participants on the advisory committee. They are the primary contacts from the consumer and family organizations. They are not looking at creating a new hotline for California. The national hotline, 1-800-273-TALK, funded by SAMHSA, has nine California lines currently. They can answer about 80% of the questions that come in and the other 20% go out of state. The 1-800-SUICIDE number is also part of this network.
- Burke: What is the highest priority goal on your list and how would clients participate in helping you achieve that? Is anyone working on a trace program; i.e. tracing incoming calls to respond to potential suicide attempts, or is that illegal or --? Answer: The quickest strategy right now is to get involved on the local level. There is a list of local PEI coordinators on the website. The hotlines do not trace calls. Lifeline members try to elicit information from callers but it is voluntary. The concern is that people would stop calling if they felt their call could end in them being placed in a forced hospitalization situation. There are no tracing plans at this time.
- Chaiken: CDCR is piloting a form where family members and friends of those incarcerated can provide information on potential triggers for suicide that they are aware of, although there is no requirement to give out that information. Now we have a place to send this information. Answer: Yes, thank you, please send it to us, along with any recommendations and thoughts you may have.
- George Fry, Jr.: Calaveras County has a suicide prevention committee. A young lady on the committee suggested putting together a program utilizing a wristband that said "Live on" on one side and on the other side the local hotline 1-800 number. The idea was to distribute the wristbands to junior high and high school students. Answer: I was able to meet this young lady. Calaveras is considered a rural county but the people working on it there are perfect examples of the huge sources of strength available in some of the rural counties. It is very inspirational.
- Ryan: I note that 84% of suicides are white and there is also a huge disparity among white male veterans. Does this demographic fit in? Answer: Absolutely. A very significant cultural population. Veteran white male culture is very different, very unique, and needs to be address in a specific manner.

- Hart: I would like to suggest the United Advocates for Children and Families become involved, if they aren't already. Also, are your programs at risk, given the current budget climate and it's affect on Prop 63? Answer: Well, everything is at risk. If we are not able to receive our full level of funding we will scale back where needed.
- Teresa Mills (audience member): I use social networks extensively and suggest that a Facebook and MySpace presence might be very beneficial. Answer: Looking at these types of technologies, especially those that are targeted toward youth, is a high priority. There are models out there for this that link into the existing social networks and they are determining whether to link in with them or create something new on their own. But they definitely will be heavily involved with that technology.

Update on Cultural Competence Issues

Rachel Guerrero, Chief of Multicultural Services for DMH, was not available to present her verbal report.

A motion, presented by Adrienne Cedro-Hament and seconded by George Fry Jr., was made to request a letter be sent to Guerrero asking for three things:

1. To send a report to the Council when she is unable to attend the meeting
2. To give an update on the cultural competency plan guidelines that are supposed to go to the counties, who are anxious to receive the guidelines in a timely fashion
3. To respond to the Council's request to provide information about who will be involved in discussions of potential strategies -- either one agency (CIMH) or five contractors (raised by REMHDCO).

Ryan asked if the letter could include a fourth request: an update on DMH's status regarding development of their cultural competence plan.

Action: The above motion passed with the following abstentions:

Lana Fraser, Jim Alves, Caroline Castaneda, Sophie Cabrera

Report from Department of Mental Health

Dr. Stephen W. Mayberg, Director of DMH, provided a report.

- The budget today is about \$42 billion short. To put that in context, 50% of this year's revenues would be required to pay for this huge deficit. The Governor's new budget balances this with about \$18 billion in program cuts; new revenues of about \$14 billion; and about \$10 billion borrowed.
- In February the state will run out of cash. Alternatives include the issuance of IOU's; meetings with banks this week revealed that some banks may not honor IOU's.
- The state cannot borrow money without a budget, and lenders are unwilling to take a risk until they can see the actual budget. All public works projects have been stopped.
- The majority of funds in the budget are in education, prisons, and health and human services. Proposed cuts are primarily in the health and human services arenas, as the

funding in the first two areas is more directly tied in legislatively and cannot be cut. State employees are expected to take a \$1.3 billion cut and furloughs will be mandated for the first and third Friday of each month. The face of state government is going to be dramatically different.

- The good news in the short term is that the Mental Health Services Act has some money put aside; the bad news is that the incoming cash, for the next few years at least, will be significantly reduced.
- The most critical part of Prop 63 is where we go with outcomes -- the conclusions of the data and where we go with that money. The data information is critical to meaningful discussion of what is and is not working. Preliminary data looks very good. However, there is not enough actual data from counties as yet.
- All four groups -- children, TAY, adults, and older adults -- have shown significant positive change. It shows that the “whatever it takes” approach of full service partnerships and wraparound services, etc. is the model of where we need to go.

Questions/Comments

- Walker: As the budget picture becomes clearer, a presentation on the status of the public mental health system in California would be useful. Also, the failing economy has hit counties especially hard. It is the Planning Council’s role to get some sense of the overall effect so that it can fill its advocacy and advising roles. Arneill-Py noted that this issue will be a focal point of the April 2009 meeting. Answer: Dr. Mayberg stated that one of the strengths of the mental health system is when it pulls together and visions. Some phenomenal ideas emerge. How do we “hunker down” and protect our gains so that we are ready to go when things get better?
- Hart: Is there any plan to reinstate the Performance Measurement Advisory or the state QI group? My concern is with the dwindling opportunity for clients, family members and other stakeholders to have input into these processes. If no, do we need to be looking more towards the MHSOAC for these opportunities? Answer: We are working with the counties, the MHSOAC, and the Planning Council on how we clearly define the roles and responsibilities of each of these groups and ensure that we maximize these limited resources and not duplicate effort. We need to look at transforming our administrative system. We don’t want to throw out the stakeholder process or the community process but we need to figure out how to make it move more quickly than it has so we get the input we need. How can we have clearly definable times when we want input and where everybody can have input? Some people don’t feel they have stakeholder input -- we have professional stakeholders who may or may not have people who had a place at the table before. How do we take information and have an open process where we can integrate the work that’s already done?
- Cedro-Hament: What is the status of the mental health director? How is your staff? Answer: Thank you for the question. This has been a very difficult and trying time. I really care about this stuff and talking about cuts and bringing bad news - I can’t distance that bad news from what I wish would happen. I also think it’s critical for all

of us here in leadership positions to not be overwhelmed by the magnitude of what we're dealing with, but to be resolute in our intention to deal with these issues.

- Ryan: If Prop 63 goes back on the ballot, is it your sense that there are less mentally ill homeless people on the street now than three years ago? Answer: No. And the only thing that would go back on the ballot is to address the issues of maintenance of effort and supplantation. But not to undo the initiative. It depends on how it's structured on the ballot. If you look at what a supplantation definition is, there are two parts -- dollars and programs. If you take away the dollars -- you can't ask people to do the same programs without money. It is very important for the mental health stakeholder community to raise these issues and help come up with how this can be crafted in such a way that it allows flexibility and yet protects the core programs and the core funding.
- Jerry Lubin (audience member, Chair of the Mental Health Commission in Los Angeles County): My stakeholders say they need more flexibility on how they are able to spend the money they receive under the MHSA. Also, we have to do a better job of educating the media on how much the MHSA has accomplished throughout the state. Legislators run for office every two or four years and they need to see results. Answer: Yes, education should be on the forefront about how impactful the MHSA has been. The Governor's proposal does not take money away from the mental health system. There is no flexibility in the federal requirements for Medi-Cal; those are the rules. Thus, what we can do with MHSA and what we can do with Medi-Cal is different.
- Mary Folck (audience member, CALMHB/C, Nevada County): I live in Truckee, and we are trying to institute a spirit satellite similar to the one in Grass Valley, which has made a huge positive difference for them. What a relief it is for families to have a phone number to call. Answer: Yes, and when the money is being well spent we need to make sure that people hear that. There is not one county in the state that has not made substantial changes in the way they do business. The outreach, engagement and availability are really remarkable. We need to let people see what a huge difference this has made.
- Shebua Burke: If we could collect the top ten success stories from different counties, that might be money well spent. Answer: This is a time to talk about successes. If we really do believe in a recovery model we need to talk about hope and we need to talk about building on our strength. We need to give all of us hope that we can continue to keep going forward and make the changes we need to make, and not get overwhelmed by the bad budget.

Public Comment

- Dr. Perry Turner stated that there are two pervasive failures at the state level in the overall system of supports and oversights. The first concerns the right to perform in public office. There are persistent instances in the state where that right is undermined, sometimes routinely and systematically.

The second concern is with ongoing recovery in response to the fiscal collapse of the system. When economic collapse begins to actually happen there is an incumbency to instill in consumers the sense of how to proceed if and when the system collapses and no staff is available. Consumers do recover themselves, but to instill in them -- while they still have staff -- how to proceed if staff disappears is crucially important. The failure of the overall system to address recovery models in the case of economic collapse is potentially great. DMH should provide oversight on these issues.

- Rosemary Kilby, IMD administrator and part of California Association of Health Facilities, stated that her association is struggling to see the future of locked placement facilities; i.e. how do they fit in the overall health care system both now and ten years from now?

Lin Benjamin responded that the comment is very relevant and was brought up at the System and Policy Development Committee Meeting recently, in response to the presentation by the California Hospital Association at the last full Council meeting which talked about what the acute care bed need is and where does that fit in the system. The Council should be and will be addressing this question.

New Business

- John Ryan asked that the Planning Council entertain the idea of inviting NAMI, the Network and United Advocated for Children and Families (UACF) to periodically share their experiences with them, perhaps by giving a short presentation every third or fourth Planning Council meeting.

***Action:** A motion was called to direct the Council to ask NAMI, the Network, UACF and other appropriate agencies to provide reports to the Council on a quarterly basis that describe their perceptions of the unmet needs in mental health services, and anything else they wish to share with the Council about the mental health system. The above motion, made by Shebua Burke and seconded by John Ryan, passed. There were no abstentions on this motion.*

Adjournment

Chair Hunter adjourned the meeting at 12:11 p.m.