

**CALIFORNIA MENTAL HEALTH PLANNING COUNCIL  
MEETING HIGHLIGHTS  
June 18 and June 19, 2009  
Wyndham San Jose  
1350 North First St. San Jose, California 95112**

**CMHPC Members Present**

Celeste Hunter, Past Chair	Sophie Cabrera	Renee Becker
Carmen Lee	Barbara Mitchell	Dennis Beaty, JD
Mark Refowitz	Luis Garcia, PsyD	Jennie Montoya
Susan Mandel, PhD	Jim Bellotti	Stephanie Thal, MA, MFT
Lin Benjamin, MSW, MHA	Edward Walker, LCSW	Shebuah Burke
Richard Van Horn	Jonathan Nibbio	Daphne Shaw
Karen Hart	John Black	Monica Wilson, PhD
George Fry	Adrienne Cedro-Hament	Lana Fraser
Curtis Boewer	Doreen Cease	Jim Alves
Walter Shwe	Joe Mortz (Friday only)	

**Staff Present**

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

**Thursday June 18, 2009**

**Welcome and Introductions**

Celeste Hunter, Past Chair, called the meeting to order at 1:00 p.m.

**Integrated Primary Care and Behavioral Health Programs**

Mary Rainwater, Project Director, Integrated Behavioral Health Project (IBHP) provided a presentation on Integrated Primary Care and Behavioral Health Programs. Integrated behavioral health and primary care is a service delivery system that coordinates behavioral health care with medical care—reattaching the head to the body. The Hogg Foundation for Mental Health describes it in more detail:

In this team-based model, medical and mental health providers partner to facilitate the detection, treatment, and follow-up of psychiatric disorders in the primary care setting. It is an appropriate model for treating mild to

moderate psychiatric disorders and for maintaining the treatment of severe psychiatric disorders (e.g. bipolar disorder, schizophrenia) that have been stabilized.

The important factor is not where the services are delivered, but how: There must be close coordination and collaboration between behavioral health and medical service providers resulting, ideally, in a seamless continuum of care for the clients. Alexander Blount, a national expert in this field, put it this way, "Integrated primary care is a service that combines medical and behavioral health services to more fully address the spectrum of problems that patients bring to their primary medical care providers. It allows patients to feel that, for almost any problem, they have come to the right place."

Rainwater stated that the IBHP began in 2006 as a four-year initiative and is funded by the California Endowment. The IBHP focus is primarily on the integrated behavioral health services that are provided at community health centers throughout the state. Initially, the initiative was going to sunset in 2010 but the IBHP is now merging with a sister organization within the Tides Center called the Community Clinics Initiative. A new phase of the project is now being created. The goals of the IBHP are as follows:

- Increase access to behavioral health services
- Reduce stigma associated with seeking treatment
- Improve treatment outcomes
- Strengthen linkages between mental health and primary care

Rainwater advised that the IBHP achieves these goals with the following tools:

- Awarding future grants to and identifying select programs and initiatives that will advance the integrated behavioral care movement.
- Documenting and disseminating best practice strategies and methods to both primary care and mental health providers statewide.
- Establishing a learning community of providers and stakeholders that supports collaboration, "cross-fertilization" of ideas, and implementation strategies among them.
- Providing training, mentoring, and consultation concerning integration strategies and promising practices.
- Advocating for policy and system changes needed to reduce the barriers inhibiting integration efforts.
- Improving standardization of data collection and disseminating promising practices that emerge.

Rainwater provided some background on why integrated behavioral health care is important:

- Many people in the broader community now receive their behavioral healthcare in a primary care setting, and the gap between medical and behavioral healthcare systems must be bridged.
- There is the opportunity for quality improvement of care within the primary care and specialty behavioral healthcare settings.

- Many people being served by public behavioral health services need better access to primary care.
- Community health centers serve people who need better access to behavioral healthcare.
- Behavioral health clinicians are a resource for assisting people with all types of chronic health conditions.
- There are changes underway in the financing of both healthcare and behavioral healthcare systems.

Rainwater discussed the Four-Quadrant Clinical Integration Model that serves as a guideline for assigning treatment responsibility between the specialty mental health agencies and primary care clinics. This model divides the general treatment population into four groupings based on their behavioral and physical health risks and status, and then suggests system elements to address the needs of each particular subpopulation.

The individual quadrants are as follows:

Quadrant I: Low Behavioral and Physical Complexity/Risk – served in primary care with behavioral health staff on site.

Quadrant II: High Behavioral Health, Low Physical Health Complexity/Risk – served in a specialty behavioral health system that coordinates with the primary care provider, or in more advanced integrated systems, that provides primary care services within the behavioral health setting.

Quadrant III: Low Behavioral, high physical health complexity/risk – served in the primary care/medical specialty system with behavioral staff on site in primary or medical specialty care, coordinating with all medical care providers including disease care managers.

Quadrant IV: High behavioral, high physical health complexity/risk – served in both the specialty behavioral health and primary care/medical specialty systems.

Rainwater advised that the World Health Organization (WHO) has given a global perspective to integrated care with its 2008 report "Integrating Mental Health into Primary Care", exploring worldwide initiatives. Among the report's key points is the conclusion that "integrating mental health services into primary care is the most viable way of closing the treatment gap and ensuring that people get the mental health treatment they need." The report describes best practices in Argentina, Australia, Brazil, India and several other countries and synthesizes the ten principles of integrated care researchers extracted from their findings:

- Policy and plans need to incorporate primary care for mental health.
- Advocacy is required to shift attitudes and behavior.
- Adequate mental health training of primary care workers is required.
- Primary care tasks must be limited and doable.
- Specialist mental health professionals and facilities must be available to support primary care.
- Patients must have access to essential psychotropic medication in primary care.
- Integration is a process, not an event.
- A mental health service coordinator is crucial.

- Collaboration with other government non-health sectors, non-governmental organizations, village and community health workers and volunteers is required.
- Financial and human resources are needed.

### Questions/Comments

- Barbara Mitchell: Where have you found communities with enough primary care physicians to implement a model like this? There is a managed system for Medi-Cal in our community but there are not enough health care homes. We can not find doctors who will see people and provide services. There is a deep concern for those with serious mental illness who are dying at age 50 of heart disease, cancer, and other related illnesses due to smoking. *Answer:* Workforce continues to be the number one problem. Our grantees, Open Community Health and Sierra Family, have passionate primary care physicians who are implementing this model. They are doing some very advanced work around managing metabolic syndrome in a primary care system. Part of their responsibility as a grantee is to meet with other organizations and provide them with tools for implementation. Rainwater advised that she will provide their information to Mitchell.
- Susan Mandel: Difficult times may provide opportunities. For the past three years Pacific Clinics has been working with a small primary care clinic that also deals with substance abuse. An affiliation agreement will be signed shortly which protects Pacific Clinics from financial liability, but will provide one governing board that ensures policy and consistency. This is a wonderful opportunity for assessment and follow up care. It is important to look for small clinics within your community that may be willing to do some kind of partnership.
- Richard Van Horn: Senator Debbie Stabenow from Michigan is introducing a bill in the Senate to provide a federally qualified behavioral health center. *Answer:* This is an important topic right now. Dale A. Jarvis, CPA, wrote a paper called, "Healthcare Payment Reform and the Behavioral Health Safety Net: What's on the Horizon for the Community Behavioral Healthcare System?" This can be found on the IBHP website. The IBHP has recently discussed this issue with David Maxwell-Jolly, PhD, Director of Department of Health Care Services and Stephen Mayberg, PhD, Director of Department of Mental Health.
- Edward Walker: When you spoke with did David Maxwell-Jolly, PhD, did he talk about the state's opportunity to modify the Medi-Cal contracts for the managed care provision? There would be a performance requirement for those plans to work with local behavioral health organizations to provide a primary health care home and ensure access. *Answer:* This discussion is on-going.
- Mark Refowitz: We can learn from others who have come before us. For example, the Program of All-Inclusive Care for the Elderly (PACE) programs is a very successful model. Why haven't we experienced the Medi-Cal special needs program filling this gap? There is a provision for this care to be integrated and for reimbursement. *Answer:* These models can be difficult to sustain because there must be clinical, structural, and financial

integration, and there has to be organizational leadership and commitment. There must be enough financial incentive as well as a willingness to transform personal commitment.

- Michele Curran, California Network of Mental Health Clients: The clients have worked very hard over the years to make the first integration step which was mental health and substance abuse. I am pleased to see the next step is being taken as we march toward holistic health. The next step is spirituality. Have you found a difference in those programs that had peer programs versus those that did not? *Answer:* We have not looked specifically at the utilization of peers within our programs because within the community clinic world the utilization of peers is slightly different than the way in which the mental health community utilizes peers. Many of the clinics we work with have successful peer programs. This is an effective model.

### **Rural Integrated Primary Care and Behavioral Health Program**

Connie Massie, LCSW, Corning Medical Associates, Inc. provided a presentation on the Rural Integrated Primary Care and Behavioral Health Program. Massie advised that she worked as a geriatric care manager for a multi-purpose senior services program and it was apparent that people needed access to behavioral health care via a primary care physician. Massie advised that Corning Medical Associates, Inc is located in southern Tehama County and was formed in 1986. Corning Medical Associates, Inc has two physicians, three mid-levels, and is open 6 days a week. All of Tehama County is a mental health manpower shortage area. Tehama County mental health is so impacted that many people are unable to access care for months. There are transportation issues such as a lack of taxis within the community.

Corning Medical Associates, Inc. provides the ability to coordinate care and counseling and make those services accessible for those within the community. There are better recovery rates when counseling is coupled with medication. Integrated care also helps to eliminate stigma. Many patients feel uncomfortable sitting in a mental health waiting room but feel at ease in a primary care setting. Corning Medical Associates, Inc collaborated with the county to apply for the County Medical Services Program (CMSP) grant to provide services in the clinic. The clinic was awarded the grant.

### **Questions/Comments**

- Adrienne Cedro-Hament: What makes the co-location model effective in your case? *Answer:* We are co-located but we are also billed through the clinic and are not a separate service. We have this model out of necessity in the community.
- Curtis Boewer: County Workforce, Education, and Training (WET) plans include a category for MFT training. What are we doing about getting MFT's included as a billable service within Federally Qualified Health Center's (FQHC)? *Answer:* Mary Reimersma advised that to get MFT's included in FQHC's and rural health facilities it requires MFT's to be recognized as reimbursable in Medi-Care. The American Association for Marriage and Family Therapy and the California Primary Care Association is working on this at the federal level. This is an effort that has been underway for about 10 years now.

- Susan Mandel: Are groups an option and are they billable under your funding sources? *Answer:* Groups are not billable under Medi-Cal. There is no funding mechanism at this time but it is something that should be available.
- Lin Benjamin: Do you have access to specialists such as geriatric psychiatrists or other medical specialties through your telemedicine? *Answer:* We have access to UC Davis but there can be up to a 3 month wait.
- Benjamin: Are you facing any fiscal challenges in using telemedicine? *Answer:* Line usage and reimbursement has been a hardship.
- John Black: It would be beneficial to start a peer run group inside the clinic and access some principles of the Client Network to build up peer support.

### **IMPACT: Evidence-based Depression Care**

Piedad Garcia, Ed.D, LCSW, Assistant Deputy Director, Adult and Older Adult Systems of Care, San Diego County Mental Health Services and Marty Adelman, Mental Health Program Coordinator, Council of Community Clinics, provided a presentation on IMPACT: Evidence-based Depression Care.

When did San Diego become involved in integration of primary care and mental health? In 2003 there were focus groups and roundtables addressing the issue of health care, particularly integration. The President's New Freedom Commission report emphasized the importance of a holistic approach to individuals. The President's New Freedom Commission report highlighted two goals that set the direction for San Diego. First is to recognize mental health as a part of overall health. Second is the need to establish screening, assessments, and referrals within primary health settings for clients who have mental health issues. This can be difficult to address and implement, though not impossible. With the advent of the MHSA, the discussions around integration of health care and mental health became a possibility.

As part of the MHSA process, San Diego performed a gap analysis within the community and measured the need of unserved and underserved groups as it relates to access to mental health care. San Diego County Mental Health has just completed a report that tracks for the last five years the health care disparities with Latinos. Latino's comprise 59% of the target population in San Diego.

Marty Adelman provided a report on IMPACT with older adults. The Council of Community Clinics (CCC) represents and supports 16 community clinic corporations operating over 90 sites in San Diego, Imperial and Riverside Counties. CCC is subcontracting with 9 clinic organizations to provide mental health services at 17 sites. Services first provided in February of 2007, with the majority of clinics initiating services in May of 2007. CCC serves individuals with SMI/SED who are unfunded for mental health services. These individuals do not have Medi-Cal or other health insurance and must have a social security number. This proves to be a barrier for some. CCC contracts to serve children and youth, adults, and older adults, by utilizing two different treatment models:

- Specialty Pool Services (SPS): This is a "traditional" model where "therapy" is provided by psychologist, MFT, LCSW, or interns. Medication management is provided by a

psychiatrist with a maximum of 24 visits for children and youth to include family therapy if and when possible. There is a maximum of 12 visits for adults and older adults. Short Term Medications – for up to 90 days from issuance of first prescription, then referral to pharmacy assistance programs (PAPs). Short Term Treatment Model – one year, then those needing additional treatment/services are transitioned to traditional County Mental Health providers.

The lesson learned from the SPS model is that the short term nature of this model discourages integration.

- **IMPACT:** (Improving Mood Promoting Access Collaborative Care Treatment) an evidence-based best practice which includes Behavioral Activation and Problem Solving Therapy provided by a Depression Care Manager (DCM), combined with medication management provided by a Primary Care Provider (PCP). The IMPACT model provides up to 16 visits with a DCM. These visits are not billed fee-for-service. This model also provides up to 4 visits with the PCP to prescribe and monitor medication. The treatment period of one year with medication for a period of one year. Consulting psychiatry services are provided by a CCC consultant.

The five essential elements of IMPACT are as follows:

1. Collaborative Care
2. Depression Care Manager
3. Consulting Psychiatrist
4. Outcome Measurement
5. Stepped care

The DCM's educate clients regarding the connection between mind and body (e.g. depression and diabetes) thereby assisting client's in managing their physical health issues in conjunction with mental health issues. The DCM's meet monthly as a group to receive additional training on the model and to problem solve.

The Senior Peer *Promotora* program is located in five clinics. All clinics with funding for a Senior Peer *Promotora* Program have funds for IMPACT. The purpose of Senior Peer *Promotora* Program:

- *Promotoras* focus on outreach and engagement of older adults.
- *Promotora* networks of individuals trained in outreach to older adults to link with mental health services and other resources.
- Culturally and age-sensitive outreach, engagement, education, peer counseling and support, social service referrals and other services for older adults.
- Transportation for seniors and family/caregivers through vouchers, taxi, contracted van services or other means.
- Referral source for clinics Older Adult SMI and IMPACT programs.

Adelman stated that 68.9% of clients who were approved for services by the CCC (January 1, 2007 and October 1, 2008) had not been seen previously in the County Mental Health System. This model meets the DMH expectation that counties identify under and unserved individuals and their families with MHSA funding. Adelman reported that 84% of county

clients report that English is their language preference as compared to 64% for this project and 21% of county clients report that they are Hispanic/Latino compared to 49.8% for this project.

### **Questions/Comments**

- Luis Garcia: What kind of evidence-based practices are you doing with children and youth? *Answer:* In the primary care program it is zero. Piedad Garcia advised that the initial thought was that they could recruit children and youth. It was found, however, that children would not benefit from the program because they had access to Medi-Cal. As part of the evolving program children and youth will be a focus.
- Mary Rainwater: Are you using that data regarding the percentage of people who had not been seen previously in the County Mental Health System to plan for Prevention and Early Intervention or Innovations? *Answer:* Garcia advised that San Diego is working on two projects: the Rural Initiative and the Salute Project.

### **MHSOAC Update**

Richard Van Horn provided an update on the Mental Health Oversight and Accountability Commission (MHSOAC).

- The MHSOAC approved the Memorandum of Understanding (MOU) with a sunset of six months because the MHSOAC felt there was not adequate note taken of the stakeholders desire to be a part of the MOU process.
- The contract developed between the MHSOAC and Resource Development Associates to begin phase one of the overall evaluation of the mental health services in California, is on hold due to the stop work order. Carol Hood, retired annuitant staff at the MHSOAC, is looking at alternatives to an outside contractor.
- There has been \$114 million in PEI county grants approved.

### **Kidscope/Kidconnection**

Nancy Pena, PhD, Director, Santa Clara County Mental Health Department, Sherri Terao, Ed.D., Community Program Director FIRST 5, and Maretta Juarez, LCSW, KidScope provided a presentation on Kidscope and Kidconnection. In November 2004 California voters passed the MHSA, establishing new tax revenues to expand county mental health services to children, adults and seniors. The MHSA will also fund prevention and early intervention (PEI) services, innovative programs, human resource development and capital facilities and technology improvements.

The Community Services and Supports (CSS) Plan required by the MHSA included a component for "Zero to Five System of Care Development," implemented in October 2006 through a partnership between FIRST 5 Santa Clara County, Santa Clara County Mental Health Department, Santa Clara Valley Medical Center, school districts, the courts, community-based organizations, Social Services, and other governmental agencies. This multi-agency collaborative, called KidConnections, is a project through which high risk

families are identified and the parents are offered assistance in enrolling their young children in preschool and accessing needed health and social services.

The KidConnections collaborative provides a multi-disciplinary perspective for screening, assessment and treatment for pre-school aged children in Santa Clara County. Kidconnections assessment consists of two levels.

Level I: Assessment/Screening for Intervention.

- Explores sources of child and family strengths, supports, stresses and/or traumas
- Support for behavioral/learning concerns
- Social -emotional concerns
- Behavioral concerns that may be interacting with developmental concerns at home and/or at school.
- Collaborates with Family Partner, Family and Preschool program.

Level I: Assessment/Developmental Screening.

- Observations may occur in home and/or school environment
- Collaborates with preschool program, family and family partner
- Speech and language
- Cognition/pre-academics
- Fine and Gross Motor
- Sensory Processing
- Hearing and Vision
- Self Care

Level II -Targeted Diagnostic Assessment. Assessment team includes:

- Developmental-Behavioral Pediatrician
- Mental Health Clinician
- Parent
- Psychiatrist
- Psychologist
- Social Worker
- Occupational Therapist
- Speech and Language Therapist
- Parents Helping Parents peer parent support, advocacy, linkage to community resources, including PHP's extensive network of supports

KidScope is one of the five KidConnections providers to which these young children and families may be referred for further evaluation, and is the only one of the five that is equipped to perform complex medical and developmental assessments. KidScope provides multi-disciplinary assessments for children up to the age of five by developmental-behavioral pediatricians from Santa Clara Valley Medical Center's Department of Pediatrics, psychologists and occupational therapists from Children's Health Council and follow-up support by Parents Helping Parents staff. Children are referred to KidScope by their

pediatricians for evaluation of school problems, behavior problems and developmental questions. Children who can be stabilized with short term treatment and/or medication trials may return to their primary care pediatricians for continued monitoring. Children needing longer or more comprehensive treatment may be connected to treatment centers for continued case management and services.

The KidConnections and Kidscope programs represent an innovative funding model, utilizing funding from MHSA, FIRST 5, County general funds, Medi-Cal, and State EPSDT reimbursement. The end result is that hundreds of high risk children and their families, who might otherwise go unserved, are being offered state-of-the-art culturally and linguistically competent early diagnosis and specialty treatment, linkage to entitlement health and educational services, and ongoing system navigation assistance and parental support.

### **Questions/Comments**

- Garcia: When assessments are done is there some idea about whether the diagnosis will be behavioral or cognitive? *Answer:* Maretta Juarez advised that many concerns are about speech and development. In a level one assessment there is a screening of what is going on with the child and within the family.
- George Fry: What does a school referral under level one and level two entail? *Answer:* Juarez advised that a referral under level one involves Via Services (Developmental Specialists). Via Services screens for speech and language, motor capabilities, and problem solving. This may initiate a referral to the Early Start Program. There is a higher level of assessment under level two due to the multi-disciplinary approach. Early intervention is the goal. Pena stated that referrals to schools are one of the important reasons that Parents Helping Parents is part of the assessment team. Parents Helping Parents provides peer parent support, advocacy, and linkage to community resources.
- Mary Rainwater: Are there care managers assigned when a child goes through the assessment process and how engaged are the pediatricians? *Answer:* In level two there is a developmental pediatrician that is part of the team and is very involved. Most of the children are connected to a Family Partner Program. For those children who are not initially linked, Kidconnections will make that connection after the assessment.

### **Proposed Mental Health Services Act Issue Resolution Process**

Ann Arneill-Py provided an update on the Proposed Mental Health Services Act Issue Resolution Process. Arneill-Py advised that this will be the last meeting for input. Arneill-Py asked members to review and comment on the Proposed Issue Resolution Process.

### **Background**

Last year the Mental Health Services Oversight and Accountability Commission (MHSOAC) began receiving complaints from individuals in the community about the implementation of the Mental Health Services Act (MHSA) in their counties. By statute the Planning Council is also an entity to which individuals can bring their concerns. However, the Department of Mental Health did not have a process for following up on issues that were brought to their attention. A group of staff and other representatives from the MHSOAC, Planning Council,

CA Mental Health Directors Association, mental health boards and commissions, and Department of Mental Health were charged with the responsibility of developing an Issue Resolution Process.

The basic concept that was developed is that issue filers should first exhaust their local county process to try to resolve their issues. If they are not satisfied with that resolution, then they can take their issue to the Department of Mental Health for resolution. The process also allows that an issue filer can request that their issue be handled confidentially. The Department conducts a fact finding process and determines if the county's actions were consistent with mental health agreements, statutes, or regulations. If they are consistent, then the issue filer is notified and the process ends. If the action was not consistent with mental health agreements, statutes, or regulations, then the county is asked how they intend to resolve the issue and may be required to develop a Corrective Action Plan. The issue filer is notified of the disposition of the issue.

The Planning Council has reviewed this process twice at its meetings and once during a conference call and has developed the comments on the state-level process in a letter to Dr. Stephen Mayberg.

#### Alternatives

During the last conference call, several alternatives to the proposed process were discussed without any resolution. They are described below as alternative models, including the currently proposed process. Arneill-Py asked members to discuss each model and determine which one they would like to endorse.

#### **Model 1**

Model 1 consists of the present proposal for the state-level process with the changes that the Planning Council recommended in a letter dated May 19, 2009:

1. The Department of Mental Health (DMH) should maintain a log of issues that are filed. The Planning Council will review this log on an annual basis to identify any trends in the issues that are raised.
2. The Department of Mental Health should send the issue filer a copy of all correspondence that occurs during the investigation of the issue, including communication with the county. This procedure will ensure the transparency of the investigation.
3. In addition to sending the disposition letter to the issue filer, county mental health department, MHSOAC, and the Planning Council, the letter should also be sent to the local mental health board or commission and to the county's local Quality Improvement Committee.
4. The DMH should establish a deadline for how many days the Department has to respond to the issue filer.
5. The Issue Resolution procedures should be posted in all facilities and mental health programs that receive funding from the Mental Health Services Act.
6. The DMH should establish an 800 number that issue filers can call to register their issues. Access to this number should be available in threshold languages.

7. The DMH should provide all the information on the Issue Resolution process in the threshold languages.

### **Model 2**

Model 2 consists of the currently proposed state-level process with our comments except that issue filers would not be required to exhaust the local process.

### **Model 3**

Model 3 would create a third-party entity to which issue filers would directly file their issues. There would not be a county-level process or a state-level process. There is no statutory or regulatory authority for the establishment of a third-party entity. Pursuant to Section 5655 of the Welfare and Institutions Code, the Department of Mental Health is still responsible for determining if a county is failing in a substantial manner to comply with any provision of the code or regulation. Thus, the third-party entity would have to refer its findings and recommendations to the Department for enforcement.

### CMHDA Perspective on the Local Issue Resolution Process

Nancy Pena advised that it is extremely important that there is enough engagement and dialogue about how issues will be resolved. One of the principles of CMHDA and the new Social Justice Advisory Committee is valuing and including voice and making sure that things are happening at the local level in a way that reflects the vision and values of what CMHDA is trying to do in terms of transformation. Pena stated that a mediation model works the best. When a mediation model is implemented at the local level it can be extremely successful in informing the system how it needs to change and be more responsive.

Pena commented on Model 1:

- Not having a local process would contradict the importance of having local inclusion and local involvement within communities.
- There is a concern that it could set up an adversarial process as opposed to a learning process.
- Adding another layer of efficiency and administrative structure tends to draw out the process.
- The local county mental health system is responsible for responding immediately to concerns that belong to them in terms of liability or risk. There is a concern that there would be a detachment regarding this responsibility under Model 1.

Pena commented on Model 3:

- There are instances when issues are not resolved at the local level and there needs to be another level of intervention. CMHDA would encourage and support a mediation oriented model.

Mark Refowitz commented on the Local Issue Resolution Process. Refowitz stated that he has a concern with someone trying to circumvent the local planning process and a decision that was reached by a community. Refowitz also has a concern with overstepping elected

and appointed officials at the local level. Every county has a board of elected supervisors that, in most cases, approve the plans and the content of the plans going forth to the State. Every county has a mental health board or commissions that are appointed by the Board of Supervisors who are their representatives. There is another opportunity for people to voice their concerns. Refowitz acknowledges that there are some who would feel intimidated and would want to bring their issues forward in a confidential manner.

Refowitz advised that Orange County will establish a new person on the steering committee, and Ombudsman, who will be available to anyone in the community to take complaints and concerns in a confidential manner. The Ombudsman role will be to bring those complaints and concerns into the local process.

#### Public Comment on the Local Issue Resolution Process

- Steve Leoni stated that Model 2 or Model 3 would be a better choice than Model 1. Many clients around the State feel that the local planning process has been betrayed. Leoni stated that the Issue Resolution Process should not be solely about compliance. Leoni has a concern that the community was promised something and will not receive it. There is a fear that this process will alienate clients instead of support them. Leoni stated that the mediation process can help the issue resolution in the broadest sense possible connected with quality improvement. Leoni suggested a separate grievance process for issues arising out of service that is not connected with Medi-Cal, such as housing issues. Leoni stated that he would like the DMH to host another Webinar concerning the Issue Resolution Process as there were problems with the phone lines in the previous one.
- Stacy Hiramoto, Community Partners: After the July 31, 2009 deadline, the Community Partners would like some participation from the community stakeholders to have a dialogue with the Government entities to discuss solutions. This goes a long way toward transformation.
- Michele Curran, California Network of Mental Health Clients (CNMHC): Because the CNMHC is a statewide grass roots organization it is often a timely process for staff to gather in depth input from members. The CNMHC has formed an ad hoc work group that is working to draft a document that reflects the client perspective on such an important safeguard as the Local Issue Resolution Process. This response document will be submitted to all appropriate entities by the deadline. Curran provided a list of components that the ad hoc workgroup has discussed:
  - What is the role of the local process?
  - Establishment of a regional or a state review board for resolution.
  - What is the jurisdiction of filings?
  - Can there be class filings or just individual filings?
  - Retaliation against employees
  - What are the safety systems? Should they be patterned after whistleblower laws?
  - Could remedies include financial or status reinstatement?

#### **Questions/Comments**

- Cedro-Hament: A mediation process would be good for both the local administration as well as the client. A mediation process does not seem to be an option in the three models. Many clients and family members have a fear of retaliation. There should be some type of protection for the clients and family members.
- Fry stated that he is concerned with intimidation and retaliation. Fry asked how the Orange County Ombudsman would be selected. *Answer:* Refowitz stated that this decision will be made by the 69 members of the steering committee.
- Jonathan Nibbio: The CMHPC has a diverse perspective but we can not lose sight of our responsibilities. There is a reality that there is a fear at the community level to speak up.
- Renee Becker advised that as a family member she would prefer to go to her local community with an issue. Once an attempt has been made at the local level, people should have the right to then go to the State. Who decided what happens at the local level?
- Sophie Cabrera provided some background on what the Local Issue Resolution Process will look like from the state perspective. The DMH has extended the comment period until July 31, 2009. The statute is very clear no matter what model is ultimately chosen and the state is restricted to the regulation and statute. Regarding the services issue, short of additional statutory language, would have to be worked out at the local level. In response to Becker's question regarding who decides what happens at the local level: the statute is mute on that and does not give the State the authority to impose a local process.
- Mandel: Mediation is a fine idea. The idea of keeping anything confidential in a county, whether small or large, is unreasonable and can not be done. The lack of protection is a fundamental problem within the system and retaliation is a real problem.
- Boewer stated that Colusa County has a confidential complaint e-mail as well as a confidential call in number. This was designed by the Safe Haven group and then brought to the Mental Health Board.
- Dennis Beaty: When doing an appeal of some kind to a higher authority the local body should have an opportunity to correct the error. There may be a process in place at the local level to deal with issues. The statute would not define that process because the Board of Supervisors defines the process within their county.
- Shebua Burke stated that there is a fear of retaliation. Burke stated it is important to have an impartial third party.
- Barbara Mitchell stated that the State needs to impose a uniform local process, or there should be a time frame that the complaint can be kicked to a higher level. Anonymous complaints are nearly impossible to deal with because there is no way to investigate them.

- Lin Benjamin: Can issues of transparency in the stakeholder process be addressed by State? *Answer:* Cabrera stated that the stakeholder process is included within the statute. Any step that was missed in the established process could be subject to the DMH's resolution process.
- Daphne Shaw stated that it is important to know what the local process is going to be. Is the CMHDA and the Social Justice Committee looking at this? Shaw stated she is uncomfortable with a motion until there is some knowledge about the local process.
- Karen Hart stated that most issues can be settled at the local level. This is an opportunity for the Social Justice Committee to look at the concern around retaliation.
- James Bellotti: Does the DMH have to write regulations to implement this process. *Answer:* Cabrera stated that the DMH does have to write regulations to implement this process.
- Nancy Pena stated that the Social Justice Committee is analyzing the various perspectives and elements in a methodical way. The committee is developing a matrix that incorporates the perspectives of the various stakeholder groups to see where the common ground may be. On July 8, 2009 the first draft of the "Proposed Principles and Elements for Local and State MHSA Issue Resolution" will be released. The intent is to develop a policy position that CMHDA's governing board can adopt and bring forward. It is important that the concern about fear be taken very seriously. This is an opportunity to analyze models and perform community practice reviews.
- Carmen Lee questioned what type of personal information is required when using the Colusa County call in number? *Answer:* Boewer stated that the confidential number does not record any type of caller ID and the caller makes the choice the leave any personal information.
- Arneill-Py stated that the seven items listed under Model 1 have been sent to the DMH. Arneill-Py asked that members decide if they would like to add to this list.

*A motion made by Shebuah Burke and Seconded by Carmen Lee: The CMHPC add to the language for the Issue Resolution Process that the party be an impartial third party made of clients and family members and that issue be responded to within 2 months.*

### ***Motion Failed***

- Renee: I would not second this motion- it is up to counties to take on these issues. There are many counties who do not even have family partners or peers.

**Friday June 19, 2009**

### **Committee Action Items**

**Children and Youth Subcommittee:**

- Hart stated that the Children and Youth Subcommittee voted to approve the Juvenile Mental Health Court Paper for Planning Council review.

#### Cultural Competency Committee

- Cedro-Hament advised that the CCC voted to request that the CMHPC send a letter of endorsement to the DMH supporting the Spirituality Initiative.

*Motion passes: The CMHPC shall send a letter of endorsement to the DMH supporting the Spirituality Initiative.*

*Abstentions: Dennis Beaty, Jim Alves, Sophie Cabrera*

#### Approval of the Minutes of the April 2009 Meeting

*A motion made by George Fry and seconded by James Bellotti: The April 2009 minutes were approved with the following changes*

- Cedro-Hament advised that on page 20 her first name was misspelled.
- Doreen Cease advised that she was in attendance on Thursday and not Friday.
- Burke advised that there were 2 additional comments she made that were not included.

*Abstentions: John Black, Monica Wilson*

#### Approval of the Executive Committee Report

Arneill-Py advised that the Executive Committee is recommending the following motion to the Planning Council:

- *The Executive Committee recommends that the California Mental Health Planning Council (CMHPC) adopt the Memorandum of Understanding between the CMHPC, the Department of Mental Health, the Mental Health Oversight and Accountability Commission, and the California Mental Health Directors Association with approval to sunset in January 2010 to create a mechanism and procedures to ensure access for stakeholders to provide the Council with input on the problems with the mental health system and the Mental Health Services Act in particular.*

#### ***Motion Passes***

*Seconded by: Susan Mandel*

*Opposed: Monica Wilson*

*Abstentions: Carmen Lee, Lana Fraser, Jim Alves, Sophie Cabrera*

- *A motion made by Celeste Hunter and seconded by Susan Mandel: The Planning Council approved the Executive Committee report as presented.*

Please refer to the Executive Committee minutes for further details.

#### Report from the California Association of Local Mental Health Boards and Commissions

James McGhee, CALMHB/C President, provided an update.

- McGhee provided members with the CALMHB/C 2009-10 strategic plan
- The CALMHB/C Conference will begin Friday June 19, 2009 at 1:00 p.m.

### **Report from the California Mental Health Directors Association**

Mark Refowitz provided an update on the CMHDA:

- The CMHDA is dealing with the budget issues. There is a continued deferral of AB 3632 funds.
- Seven counties have filed Joint Powers Authority (JPA). These seven counties working together will be the catalyst for other counties.
- A comprehensive statewide plan to deal with veterans and mental health issues is very important.
- There are excessive delays in getting individuals transferred to state hospitals who are found incompetent to stand trial. This creates significant issues in county jails.
- There is a concern about the elimination of Healthy Families.

### **Questions/Comments**

- Boewer: The additional issue is the flow of federal funding to counties. This is a huge issue.
- Joseph Mortz: Do counties carry that money forward on the books? *Answer:* Refowitz advised that government accounting principles are specific- you can not recognize receivables as revenue.
- Cedro-Hament: What is JPA? *Answer:* JPA stands for Joint Powers Authority. Under California Law municipalities, school districts, water districts, entities of government can join together for the purpose of conducting a very specific type business under certain rules and guidelines. Seven counties have already come together for the purpose of joining to deliver mental health programs and have filed all the necessary paperwork with the Secretary of State of California.
- Walker: The Sutter County and Yuba County mental health program operates under a JPA. So in the mental health world it is referred to as Sutter Yuba County because they are a single entity that provides mental health services for both counties. There are many around the state that counties use. The seven county JPA will be called California Mental Health Services Authorities. Other counties will be presenting this locally to join the JPA.

Walker offered special thanks to Boewer for pursuing specific information on claims payments and sharing this information with other Mental Health Directors. The controller must receive claims by June 5<sup>th</sup> every year so claims are paid within the current fiscal year. Counties were under the assumption that all claims would make that deadline after passing through the DMH, the Department of Health Care Services, and then to the Controller. None of the claims for Colusa County made the June 5<sup>th</sup> deadline. It is

the working assumption that this is true for all counties. This is an unplanned financial problem of major proportions. It is hard to overstate the significance of this problem. Many counties will lay off over 10% of their employees due to changes within the local economy. There are not enough funds to cover this financial crisis.

- Hunter: Claims that are filed after June 5<sup>th</sup> are not reimbursable? *Answer:* Walker stated that is correct. Boewer found that Colusa County claims from January 2009 forward did not make the deadline. Because of the planned delays it is uncertain when counties will be reimbursed.
- Sean Tracy reported that the DMH is working with the CMHDA on a weekly basis to discuss claims and issues related to claims. Paying claims in a timely and efficient manner is extremely important to the DMH.

### **Department of Mental Health Strategic Plan**

Sean Tracy, DMH Office of Strategic Planning and Policy, provided a presentation on the DMH Strategic Plan. Tracy described the Office of Strategic Planning and Policy roles and responsibilities:

- Philosophy: A service-oriented organization dedicated to enhancing the Department's strategic planning, organizational development, and external partnerships.
- Mission: The Office of Strategic Planning and Policy is committed to providing business valued services to advance the Department's strategic planning and policy initiatives.

The Office of Strategic Planning and Policy and the Office of External Affairs and Communication convened a group of staff, representative of a cross-section of the organization, to assist in the development of the DMH's communication strategies. This group, called the Think Tank, is comprised of hospital representatives, as well as representatives from the Office of Strategic Planning and Policy and the Office of External Affairs and Communication, and has the responsibility of developing strategies to communicate strategic planning activities and to distribute the new DMH Five-Year Strategic Plan. The Think Tank is responsible for presenting proposed communication strategies to the Strategic Planning Communication Team. The Strategic Planning Communication Team is responsible for reviewing and approving proposals prior to presentation to the DMH Executive Team. In addition, the Team was given the responsibility to develop and propose the DMH's core values. Upon completion of the core values development process the proposal was presented to the Executive Team for final approval in February 2009. Upon final approval from the DMH Executive Team, a statement is distributed by the Office of Strategic Planning and Policy in a manner that is consistent with the strategic planning pathway: DMH management, first; employees, second; and external parties, third. The final DMH Five-Year Strategic Plan is scheduled for distribution to DMH management, employees, and ultimately external partners and stakeholders by August 2009.

Main objectives of the Office of Strategic Planning and Policy through 2011:

Medi-Cal Mental Health Services Workgroup & External Partnerships: The DMH sponsors a monthly forum for key leaders within the Medi-Cal mental health system to share information, and discuss issues. The Office of Strategic Planning and Policy also works with the CMHDA, CMHPC, MHSOAC, CMHACY, and other key organizations involved with community-based mental health services.

Short-Doyle/Medi-Cal Project Planning: Short-Doyle/Medi-Cal is a computer program that adjudicates behavioral health claims. Phase 2 of the IT project will achieve timelier payments and is HIPAA compliant and standardized.

Emily Q Settlement Implementation and Katie A Workgroup: The *Emily Q* Settlement Team Nine Point Implementation Plan aims to increase the access and utilization of Therapeutic Behavioral Services (TBS) for class members in California. The *Katie A* Workgroup utilizes an Interest- Based Decision Making process in response to a court order regarding mental health services for youth in foster care.

DMH Strategic Planning & Business Plans: The DMH has a new mission, vision, values and goals. The new five year strategic plan (2009- 2014) is being developed along with departmental objectives, performance measures, and business plans.

Disaster Planning & Continuity of Operations (COOP) and Continuity of Government (COG): The Office of Strategic Planning and Policy chief serves as the Incident Manager for the DMH Disaster Operations Center. Staff provides support and back-up for disaster operations.

In summer 2008, the DMH began its strategic planning efforts by conducting multiple external one-on-one interviews. The CMHPC's Ann Arneill-Py was interviewed along with Executive Director's of the MHSOAC, CMHDA, and provider networks, as well as, DMH chiefs and Deputies and Hospital Executive Director's. As a result of the interviews there were four emerging themes:

- Identity
- Partnerships
- Internal Capacity
- Leadership/Morale

The DMH Executive Team felt that it was important to prioritize boosting the Leadership and Morale of employees and focusing on Internal Capacity. As such, the DMH held internal strategic planning sessions to empower DMH employees.

Tracy discussed the Executive strategic planning off-sites:

September 2008- Executive Strategic Planning Off-Site 1

- Internal Perspective: Leadership and moral, Internal Capacity
- External Perspective: Identity, Partnerships.
- The Executive Team collaborated during the brainstorm exercises to identify issues that face the DMH over the next five years. The four emerging themes were categorized based on external and internal perspectives and issues were identified for each perspective by members.

- Environmental Scan: DMH Internal Key Strategic Plans, including mission and vision statements were reviewed.

#### November 2008- Executive Strategic Planning Off-site II

- Summary of DMH issues: A compilation of issues facing the DMH over the next five years from the September 2008 strategic planning session were prioritized by level of importance. The level of importance was determined by majority vote.
- Mission and Vision Development: The Executive Team developed and approved the mission and vision statements through the brainstorming sessions.

#### **Mission**

The Department of Mental Health initiates, administers, supports, and enhances an integrated, comprehensive system of public mental health services.

#### **Vision**

An evolving public mental health system accessible to all Californians that inspires people to embrace quality mental health services and supports.

#### December 2008- Executive Strategic Planning Off-site III

- Environmental Scan: Review of Goals statements from various sources including the CMHPC, MHSOAC, and CMHDA. Also a review of summary of prioritized issues.

#### February 2009-Executive Strategic Planning Off-site IV

- Core Values Development: The Executive Team convened a Strategic Plan Communications Team given the responsibility of developing the DMH's core values. An explanation of the development process used by the Strategic Plan Communications Team was provided and the Executive Team reached a consensus and approved the proposed DMH core values.

#### **Final DMH Core Values**

- Leadership: Encouraging a can-do attitude and a devotion to operating principles while validating the public trust with clear communication and transparent implementation of innovative programs to fulfill the Department's mission and vision
- Excellence: Providing services in an exemplary manner with the highest integrity and continuously exceeding the expectations of those we serve.
- Resourcefulness: Implementing creative and innovative programs through efficient and effective use of resources utilizing the highest quality services based on measurable outcomes and monitoring through partnerships.
- Cultural Competence: Seamlessly embracing diversity in all aspects of policy, administration and practice.
- Hope: Belief in the intrinsic value of all people and the ability of the recovery process to restore lives, leading to the promise and resilience of individuals and the families we serve

#### March 2009 and Beyond- Next Steps

- DMH Internal Communications: Strategic Planning e-Newsletters, DMH intranet site, Think Tank, Strategic Plan Communications Team, and Strategic Plan e-mail account
- External Leadership DMH Strategic Plan Presentation: The CMHPC, CMHDA, MHSOAC, External Workgroup, and Providers.
- Launch new DMH Internet Site: Strategic Plan only.
- DMH Objectives and Business Plans Development
- Production of the DMH Five-Year Strategic Plan 2009-2014

### Questions/Comments

- Fry: Would it be possible to include feedback along with who provided the feedback on the website? *Answer:* Tracy advised that with permission this can be included.
- Mortz: Is this document set in stone or is it open for discussion? *Answer:* Tracy advised that the mission, vision, and goals are set in stone.

Mortz: With regards to the final DMH mission statement I suggest that the DMH is not for all people and does not have the legislative authority to be. It does have a mandate for public and private relationships and partnerships. Those public and private partnerships should be at the highest level of importance and this is not included within the mission statement. As a public health service we should have a concern about the public health of all residents, but we are not a service provider for all residents and this should be clarified within the mission statement. Mortz asked that the Office of Strategic Planning and Policy go back to the drawing board. With regards to the vision statement, we do not have the money to pay for all Californians. *Answer:* Tracy advised that a vision is what we would hope for and aspire to.

Mortz: The vision statement is contrary to state policy.

- Mitchell advised that she was glad to see the goal about ensuring accountability, especially in terms of outcome measurements. Mitchell hopes that the DMH is planning on publicly providing accountability and outcome measurements for programs that the voters have put into effect such as Jessica's Law and the Sexually Violent Predator Program. It would be advisable for the DMH to start educating the public about what these programs cost and what the outcomes are for these programs. *Answer:* Tracy stated that the accountability measures from many parties in the Legislature are interested in the cost and the outcomes of such programs as Jessica's Law and this is a large part of accountability.
- Cedro-Hament: Could you give us a picture of how the DMH looks in terms of Cultural Competency? I would like to see a breakdown, such as the categorization of staff in terms of gender and race. The DMH should be seen under the same lens as the counties when it comes to Cultural Competency. *Answer:* Tracy advised that this information is available through the State Personnel Board.
- Garcia advised that there is a lot of data but there needs to be an action plan. This action plan needs to be in the local county with guidance and requirements from the state.

- Mortz advised that he would like to see the addition of a core value that addresses the fact that clients would like to feel wanted as opposed to just treated.

Mortz would like a focus on disparities within the plan and would like the Cultural Competency Committee to create an action plan for benchmarks in disparities that could make its way onto the DMH's plan. Cedro-Hament advised that she feels the Cultural Competency Committee should do this as well. Mortz would like to see this as an action item for the next CMHPC meeting.

### **Report from the Department of Mental Health**

Stephen W. Mayberg, PhD, Director, Department of Mental Health, provided a report on the activities of the DMH.

- Currently, cash flow is a huge issue. The DMH is making every effort to ensure that counties are paid. It is not the case that all 58 counties have not received claims payments since January 2009. This is true for some counties and it may be related to their contractor and the timeliness of submitting bills. Through April 2009 \$908 million in claims has been paid. This is not to say that there are not issues that need to be addressed on a county by county basis.
- The latest order given by the Governor orders a 15% reduction in contracts and that contracts entered into after March 2009 be disencumbered.
- State employees have been furloughed two days and may see an additional 5% pay cut.
- The Department of Corrections is eliminating rehabilitative services in prison, outpatient services, and parole for many parolees. The Conference Committee is eliminating Proposition 36. Untreated co-occurring disorders is probably the most frequent reason people can end up back in jail, on the streets, or unemployed.
- Investing in change is something we should embrace. Opportunities to transform may be complicated by difficult times but important.
- There are 400 individuals in jails throughout the state who are awaiting admission to a state hospital. Jail is not the place for treatment. There are 1200 beds for incompetent to stand trial with 3500 people running through these beds.
- The federal courts that control mental health and dental services within the prisons have put the DMH on notice that they are going to take more beds. Failure to provide more beds will leave the DMH in contempt of court.
- The DMH is poised to get MHSA money out.
- The DMH has had the Early Implementation studies and much was learned from that study. In 2007/08 more than 377,000 unduplicated individuals received MHSA services. In the third quarter of 2008/09 there were 16,000 people in Full-Service Partnerships. About 80,000 people are getting services from system development programs and about 40,000 from outreach and engagement. There are 800 people receiving housing services.

The initial Full-Service Partnership (FSP) outcome analysis has shown that housing has improved significantly with 61% of individuals having better housing situations. This is

across all four age groups. Children in the program are showing increased school attendance. There are a number of people who show less financial dependence. Those who indicate that employment is a recovery goal of enrollment are more likely to be employed after enrollment in an FSP.

There is a study from Berkeley that shows that participation in an FSP is causal in reducing arrests and crime. Dr. Mayberg advised that he will provide staff with the website locations of these studies.

### **Questions/Comments**

- Nibbio: As we look back over the last ten years we have tried to put an emphasis on not criminalizing our children. I am a strong proponent of keeping children within the home in the least restrictive environment possible. As we close state hospitals there are still some children who need the support of some type of stabilization versus being arrested and being out in Juvenile Hall. Cuts to foster care will only make this problem worse.
- Cedro-Hament: Los Angeles has a faith-based homeless program in the Hollywood area. Despite the cuts we have become innovative. The DMH needs to support this spirituality movement.

What is AB 5xxx? *Answer:* Dr. Mayberg advised this was the trailer bill language that was implemented when the budget was proposed in January 2009. It was written without public input. There is a whole new set of trailer bill language that is being crafted that will deal with the \$28 billion. More information will be available shortly.

- Fry: In terms of the criminal justice system I am saddened by the elimination of rehabilitation. We all have a responsibility to contact our legislators and beyond to initiate change.
- Boewer: Colusa County tracks foster youth in placed out of county. Less than 20% finish high school. The WRAP team, Children's System of Care, and the Office of Education is working on changing these figures.
- Hart: The Children's System of Care Subcommittee has just completed a paper advocating the promotion of Juvenile Mental Health Courts across California. This will remain an important topic that the subcommittee will focus on.
- Mandel: What is your view of the future of the mental health system? *Answer:* Dr. Mayberg advised that the tension will increase and a number of decisions will be made that may have long term consequences that will impact the whole state. The mental health system needs to pull together and focus on what needs to be done.

### **Public Comment**

- Please see appendix for written comments from Dr. Perry Turner.
- Stacy Hiramoto, REMHDCO, Community Partners: Thank you for the leadership and support of consumers and family members.
- Kate Gillespie, Marin Mental Health Board: This is first time in many years that Marin county has presented their annual report. It is part of the bylaws to do this. It would

helpful to remind the chairs and county mental health directors that these are a requirement along with information on easy submission. Gillespie asked that the CMHPC look at the topic of a per drink tax for the use of alcohol with a nexus of supporting the dual diagnosis programs.

- Steve Leoni: The DMH issued a clarification of the requirements for FSP's on the website. This document discusses the use of non-MHSA dollars in FSP's. These funds can be used as part of the CSS funds and should be allowed to be used toward the majority requirement. At this point in time the regulations state that 51% of MHSA dollars must be used for FSP's and the rest can be divided between general system improvement and outreach and engagement. The DMH clarification waters this down. Leoni has a concern with the loss in transformation. This topic deserves attention.
- Jane Christol: Would like to see a pilot program that would conduct studies around the state within the institutions.
- Theresa Mills, CALMHB/C: People who may feel hopeless may find some peace with volunteering. This can provide direction.

#### **Revisit: Proposed Mental Health Services Act Issue Resolution Process**

*A motion made by George Fry and seconded by Edward Walker: The CMHPC provide the CMHDA Social Justice Committee the following recommendations:*

- *A timeline the same as Patient Right's timeline.*
- *A toll-free number with a reference number assigned to each "issue filer."*
- *Explore and provide an equitable mediation process acceptable to all parties*
- *Address the highly sensitive issue of retaliation fully and completely as to protect the concerns of "issue filers."*

*The CMHPC strongly urges the DMH to continue to foster good relations with all parties in advocacy for mental health in California.*

#### **Questions/Comments**

- Hart suggested an amendment under bullet 3: "Explore and provide an equitable mediation process acceptable to all parties" to include "at both the county and state levels." *Answer:* Fry and Walker accepted this amendment.
- Carmen Lee expressed concern on who will explore this mediation process and the issue of retaliation. *Answer:* Fry advised he is referring this to the Social Justice Committee to explore those issues.
- Mortz expressed concern that clients may have different procedures for complaints and in an ideal world there would be one integrated and appropriate system.

After the above discussion the motion was amended:

*A motion made by George Fry and seconded by Edward Walker: The CMHPC provide the CMHDA Social Justice Committee the following recommendations:*

- *A timeline the same as Patient Right's timeline.*

- *A toll-free number with a reference number assigned to each "issue filer."*
- *Explore and provide an equitable mediation process acceptable to all parties at both the county and state levels.*
- *Address the highly sensitive issue of retaliation fully and completely as to protect the concerns of "issue filers."*

*The CMHPC strongly urges the DMH to continue to foster good relations with all parties in advocacy for mental health in California.*

*Abstentions: James Bellotti, Monica Wilson, Sophie Cabrera, John Black*

*Oppositions: Barbara Mitchell, Dennis Beaty, Mark Refowitz*

- Daphne Shaw: Will the CMHPC wait until the Social Justice Committee has their finding in July 2009 and then discuss this topic again via conference call? *Answer:* Arneill-Py advised that CMHPC will wait until the Social Justice Committee reports to the All Directors meeting and there is a final action. The CMHPC will then have a conference call prior to July 31, 2009 to review the result and formulate final comments. The letter with the above recommendations will be sent right away.

### **New Business**

- Walker suggested that the CMHDA report and the Director's report be scheduled back to back. This will provide an opportunity for discussion. Walker would like to generate a report in order to track claim submission and payment. *Answer:* Dr. Mayberg advised that this report is published each month and available.
- Mortz asked that the CMHPC examine the integration of mental health, medical, alcohol and other drug services, and social services in HMO programs. What is being done in the private sector? Mortz would like this topic to be referred to the Policy and System Development Committee.

Mortz questioned whether the CMHPC would like to have some input on the Health Care Reform.

- Daphne Shaw: The Coalition has a subcommittee that has been dealing with the managed care issue in California for some time. At the last meeting an individual from the Governor's office, who is involved with the health care issues, presented. Because of this, there was a conference call at the federal level regarding health care issues. The Coalition was involved in this call and provided input. Shaw advised that she could ask Coalition to present to the CMHPC once there is information to share.

Meeting adjourned at 12:30 p.m.

Respectfully Submitted,

Tracy Thompson

