CALIFORNIA MENTAL HEALTH PLANNING COUNCIL
ADULT SYSTEM OF CARE SUBCOMMITTEE

MEETING HIGHLIGHTS

June 15, 2010

Hilton Oakland Airport
One Hegenberger Road
Oakland, CA 94621

Planning Council Members in Attendance:
Jorin Bukosky, Chair
John Black, Vice-Chair
Barbara J. Mitchell
Gail Nickerson
Walter Shwe
Lana Fraser
Daphne Shaw
R. Grant Jordan, MD
Kathleen O'Meara, Ph.D.
Nadine Ford

Planning Council Staff in Attendance
Andi Murphy, Staff
Ann Arneill-Py, Executive Officer

Others in Attendance
Steve Leoni
Stacie Hiramoto, REMHDCO
Kathleen Derby, NAMI

Presenters
Steve Fields, Executive Director, *Progress Foundation*
Adela Morales, Program Director, *Progress Foundation Clay House*
Susan Medlin, Hillary Westbrook, Jennifer Tuipulotu, Kate Milano- *Service Provider Individualized Recovery Intensive Training (SPIRIT) Program*
Rob Chittenden, *Michael Stolz, Disability Rights California, *Peer/Self-Advocacy Services for IMD clients*

Planning Council Member Issue Requests

Three items were submitted to the ASOC for consideration:

1) The "Recovery" System of Care has been reported implemented in the State Hospitals – What are the reported outcomes?
2) How many Department of Corrections convicts have achieved recovery and returned to prison?
3) The US Supreme Court has ruled that Sexually Violent Predators (SVP) can be kept in the Corrections or Prison System past the end of their sentence "for public safety". Can we return the SVP who have finished their sentence and been sent to the state hospitals, to the prison system? This would release some beds.

*Via conference-call

The disposition was that staff will follow up with Long Term Care services on when the final CRIPA report is expected to be released. Question two has been asked previously, and staff will respond and reply with the answer provided by the Long Term Care unit staff. The third question needs more investigating before it can be answered. Staff will research it and provide background to the ASOC members prior to deciding whether the question should be referred to Dr. Mayberg.

Welcome and Introductions

Noting that a quorum was present, the meeting was called to order at 10:05.

Updates from Other Groups

Walter Shwe provided an update on services for parolees released on non-revocable parole discussed by the CMHDA at their last Adult System of Care meeting. He described three modes of services or activities that are currently applied. One offers the parolees 90 days of voluntary services through the Parolee Outpatient Centers and then referred to county mental health, the second is dropped off at the train or bus station with $200, and the third option is referral to crisis centers or emergency rooms.

The differences in FSP service utilization and costs between programs across the State will be studied by Todd Gilmore of UCSD and CIMH. As of June, 20 counties are needed. CSI and DCR data will be studied.

IMD Step-Down Programs

Discussion:
Steve Fields began the discussion by recapping a little of California's history with community mental health services. He referenced the 1978 Bate's Bill Community Residential Treatment legislation, which contained a key element of long term care residential treatment for people otherwise referred to Skilled Nursing Facilities (SNFs). He noted that not one county proposed one long term care residential program during the legislation's five year implementation, but there was an explosion of for-profit skilled nursing care that exceeded any other state in the nation. Through the 1980s, the state was not held accountable for its lack of adherence to the spirit and intent of the federal Community Mental Health Services act, and avoided the IMD exclusion by encouraging Skilled Nursing Facilities with Special Treatment Programs. The Supreme Court eventually declared that "Intermediate Care Facilities" was a violation of the MediCaid IMD exclusion – if you are freestanding, more than 16 beds, and more than 50% mentally ill clients, and not part of a general hospital, you may not bill Medi-Cal for any services provided in that setting. Counties continued billing Medi-Cal for SNF services and for eight years, during Deukmejian's administration, there was no increase for County mental health programs. To this day, counties continue to use their limited funds for IMD/SNF services rather than opt for residential treatment services.

He observed that when the community mental health system was developed in California, county by county, the frame of reference never changed from the institutionalized model

that the state was mandated to free itself of. Thus, it relied on inpatient, outpatient, day treatment, heavy use of medications, and emergency/crisis treatment response. Other than the predominant embrace of the outdated care model there was no consistency amongst the counties regarding their philosophy or approach to client care, other than a prioritization of Medi-Cal reimbursable services. In his view, the fragmented mental health system is a direct result of being community-based without any real state oversight or direction, and innovation or change are the exception rather than the rule.

Fields argues that the IMD/Board and Care cycle is a poor proving ground for recovery. There is no real measurement for recovery and coping skills so clients are removed from a highly structured environment and placed in an unsupervised, unstructured environment located in poor, high drug trafficked areas. Ultimately, counties and the mental health system should be identifying ways to avoid IMD admissions altogether, and not just look for alternatives.

Progress Foundation established Clay Street House in 1994-95 after convincing SF County that they were wasting resources (rather than arguing recovery, appropriate treatment or other principles) by pouring it into IMDs. At the time Progress Foundation received approval for Clay house, the client base was younger, more volatile, and typically used drugs and alcohol. There was no seamless continuum of care in place so most clients cycled in and out of the IMDs. At that time, the predominant diagnoses of IMD clients was schizophrenia. When recruiting for the first Clay Street residents, program staff selected the ten clients with the poorest prognosis for "readiness" for community life. Over the years, there has been a 90% rate of success and recovery.

When establishing Clay House, there were a number of self-determined caveats or requirements:
1) It had to be long term – 4 months to a year average stay.
2) It had to be a social rehabilitation model
3) It had to have an integrated 24 hour program
4) It had to have a healthy "skeptical" eye toward medications
5) Staffing model had to be equivalent to the Crisis Residential
6) It had to be a normalized setting
7) All clients had to participate in maintaining the household

The cost per day for clients is lower than the cost of IMD beds, and because it is Medi-Cal eligible, the County's realignment funds are supplemented by Medi-Cal billing for eligible clients, current FMAP rate being 61.5%. SF's referral rate to IMDs is dramatically reduced. At Clay Street, referrals from the wait list for IMD admissions have outnumbered the number of IMD discharge referrals. Sixty percent of the clients are non-white, and 30% are African American. In San Francisco, 7% of the population is African American, almost 30% of Emergency Room visits are by African American, and, of those, 65% are African American men under the age of 35. The highest minority populations are in IMD alternatives and Crisis Residential programs because of the patterns of institutionalization and the lack of effective programs in the poor or ethnic communities. Medical problems in the client base also affected admissions into the transitional programs and the crisis residential programs. Clay

Street developed an in-house nursing program through the UC, which enabled them to broaden the base of people that could be admitted.

B. Mitchell Do you bill for both a day rate and a day rehab rate?

S. Fields Yes, the funding structure maximizes Medi-Cal if the program bills out an Adult residential Day and a day habilitation. The program has a Medi-Cal approved, certified, day program that bills out the day habilitation rate which allows the program to bill out past the day rate.

B. Mitchell One of the arguments that counties make is that, at $100 or $150 a day, IMDs are less expensive and by comparison, crisis residential programs seem less affordable.

S. Fields Yes, it is more of a comment on the values of the systems of care – that you are not willing to spend a little more to keep them in their community and it becomes a political advocacy point.

B. Mitchell Can you please describe how you address medical issues? Many of the people in our country have major medical issues along with the psychiatric disability.

S. Fields We have an arrangement with UCSF to keep nurses on staff.

J. Black Do you have any tracking tools to follow the outcomes of people who left your programs? Do they go to college, go to work, graduate?

S. Fields We don't seem to be able to track quality of life indicators. We know about the people who return, but, other than anecdotally, we don't have a system that gathers data on the recovery milestones. If we started measuring that, and knowing it effectively, then we will show what we value. The largest group goes to supportive housing, the second largest group goes to Board and Care, which bothers me, because they are not all good. The jobs and work issue is a sort of disconnect. One of the biggest services elements that has been ignored in California, especially for clients, is vocational education. You might get to it eventually, but its scarcity prevents it from being embedded into recovery from the start.

A. Morales We are lucky at Clay Street that many of the former residents call or visit us to let us know how they are doing and what they are doing. Most of them are still in the co-ops. (The Co-op is Progress Foundation's answer to supportive housing – 4 or 5 residents sharing an apartment, scattered sites throughout the city, with a case manager- with no time limit).

A typical stay at Clay begins with me visiting clients at the hospital to tell them about the program, about expectations, their participation in upkeep of the house. When they arrive, they identify their goals and develop plans to meet them. The Day treatment program has groups five days a week and the client determines what group interests them- the topics cover a wide range of subjects- from medication management to cooking or music.

When I outreach at the hospitals I start by meeting with the clients, looking over the paperwork, talking with the social workers and the doctors. I tell the client, who is slated to go to the IMD, about the program, and if he is interested I begin advocating for him to come to Clay. For those who are already in an IMD, my outreach is to participate in the monthly review meetings and to meet all of the clients there, not

only the ones who are slated for discharge. I return periodically and establish a connection with them. We run groups every couple of months to inform the clients that there are alternatives out there.

One of the things I'm finding is that some places, like Crestwood Vallejo, don't really prepare clients for housing, they just spring it on them and it scares them. By the time I get to speak to them they see me as somebody who is going to separate them from their security and things get off to a bad start. I also visit other IMDs with the same process.

B. Mitchell — What problems do you run into with conservators and how do you deal with them?

A. Morales — A lot of times the Conservators feel that the program is not supportive enough. I let them know that I will be back every month to meet with the client and I invite the conservator to come to Clay.

S. Fields — It's taking a lot of work with the county to leverage that conversation. They've had to be part of that aggressiveness. In SF, the Conservators don't operate out of the Department of Public Health, they are pretty autonomous so it is more difficult to reach them. Cracking that is a political problem, but with patience, it is improving over time. They have no perception of the type of program offered by Clay Street, so they don't have any idea of the staffing levels, or any reason to believe that they won't be woken up at 2:00 in the morning with a crisis.

B. Mitchell — Do you screen for Megan's Law list or other exclusionary populations? Parolees?

S. Fields — Everything in San Francisco is within a mile of schools. Unfortunately, it screens out people who have that record virtually every time. We do not screen out for other criminal records. As a matter of fact, the other largest trend is from forensic populations, about 28% of the referrals. 67% of the clients referred to Clay Street have a diagnosis of schizophrenia.

L. Fraser — How do you weave employment goals into development plans?

A. Morales — For people wanting to work or receive training, we refer them to two vocational agencies we use. After orientation, if the client decided to pursue the training, we incorporate it into their personal development plan. With education, if the client wants to finish their GED, we refer them to the John Adams campus and the counselors work with us.

S. Fields — The link we need to work harder on getting is the perception of characteristics society considers "appropriate" for clients to pursue vocational goals. The clients are so used to being considered unfit for work that it takes a few months to even start having that discussion.

A. Arneill-Py — How many staff do you have on any one shift?

A. Morales — During regular "business" hours we usually have four to six staff, but in the afternoons and early evenings, it is three or two, and two overnight staff.

S. Fields — We have the equivalent of about 14 full time staff. It is about $1.2 million dollar a year program, with about $600,000 of that from Med-Cal. By virtue of where they are referred from, they are all on Medi-Cal already so there is no time lost qualifying them for benefits. They are usually already on SSI too, and a portion of that money goes toward the room and board that we cannot bill Medi-Cal for, and it is usually realignment funds that are used to meet the Medi-Cal match. We almost never have anybody that is not on SSI, and if they are not, we enroll them and they are approved by the time they leave.

J. Black	Do you have any consumers or family member staff?
S. Fields	We have always hired consumers. Last year, 19% of staff across the agency self-disclosed as consumers. We are resisting county requirements that we identify slots for consumers because we do it willingly. We are disappointed that we don't have a stream of applicants or referrals but CASRA is working on that, and of course, there is staff that may not disclose. Family members apply a lot of because of their family history. For organizations that have slots, I keep looking for the career ladder, but I don't always see that, so I feel like the designated slots are a kind of dead-end.
K. Derby	I agree that slots are segregating but I also believe that they create a place for a person who can relate to consumers more and serve as a sort of tangible example of the possibilities that recovery brings.
S. Fields	My concern is that the consumer slots gets a lot of organizations off the hook to actively value, pursue and promote consumer employees.
S. Leoni	I've been associated with Progress for the last 25 years and I've seen clients with lived experience heading programs side by side with Ph.D.s holding the exact same job descriptions and responsibilities. At the same time, not to detract from the value of consumer experience, but I've seen equally effective relationship building from employees that don't have traditional mental health backgrounds through training or lived experience.
S. Hiramoto	It's really not an either/or situation. As a parallel with cultural competency, if you have a person designated, it lets you "off the hook". In my own experience, I was so busy with my regular duties that when I tried to bring in issues of cultural competence, my efforts were somewhat marginalized and people viewed my efforts as not being job-related.

Contra Costa SPIRIT Program

Susan Medlin began by describing the origins of the Service Provider Individualized Recovery Intensive Training (SPIRIT) through the Office of Consumer Empowerment. SPIRIT has been in existence since 1994 and was previously run by Jay Mahler and Sharon Keene. Although it is primarily aimed at clients interested in entering the mental health field as a component of recovery through employment generally, and, more personally, the therapeutic aspect of helping others from the position of shared life experience. It also trains county staff about the recovery process.

SPIRIT is a three-course curriculum through the community college that allows the county to collaborate with as many mental health organizations as possible and prepares consumers for entry level positions in the mental health fields. It has recently been accredited and the three courses have recently received course articulation numbers. The curriculum is divided into three parts – SPIRIT I and II are classroom training, and SPIRIT III is internships. All classes are peer-led and taught with oversight provided by accredited instructors.

Twenty-seven topics are presented to the class and cover a variety of practical and theoretical topics that range from charting /documentation, ethical boundaries, medications, and working with clinical providers to Spirituality, holistic health, and addressing cultural diversity. These are in addition to presentations on basic mental health topics such as recovery principles, group facilitation, peer support, local resources, and conflict resolution. Each of the presentations is followed up by an in-class assignment or practice session. Twenty different mental health organizations participate as

presenters as well as hosting internships. Students are matched to internships at job fairs and Department of Vocational Rehabilitation provides presentations on resumes, cover letters, and interview skills.
Students receive stipends for attending class and through their internships and they receive instruction on how to report their allowance/stipend to Social Security. Internships typically run for 10 weeks/ 15 hours a week and training is done through peers and clinical providers.

Hillary Westbrook is a program graduate and primary instructor at SPIRIT. Working through her recovery independently, she applied with SPIRIT at the suggestion of friends and became acquainted with the concept of recovery and wellness and thrived. Jennifer Tuipulotu spent her early years in foster care, was diagnosed, married, and raising four children who were also diagnosed. She worked for Children's Protective Services in the family reunification unit when she heard about the SPIRIT program. The experience has improved her work skills and personal life tremendously. Kate Milano, a current student, commented that her recovery experience was confined to twelve-step programs prior to entering the SPIRIT program. SPIRIT showed her that recovery was holistic and included mental health and not just abstinence from drugs and alcohol. It also showed her the importance of acceptance and listening and

Discussion:

B. Mitchell	What are the requirements for being an instructor? Are the instructors College employees? Are there any barriers to getting consumers hired?
H. Westbrook	We have an instructor of record who oversees everything the class instructor does. This enables us to keep the class peer-led. The instructor of record is paid through the SPIRIT program, and I am an employee of the county Office of Consumer Empowerment.
B. Mitchell	How does the stipend system work? How much are the people paid for internships – is it based on number of hours? Is it taxable income?
H. Westbrook	Mental Health Consumer Concerns is the fiscal agent. We give them the money and they write the checks. County Council has reviewed the program, and they recently refused the increase of hours because it would lead into a tax issue.
S. Medlin	Students get $25 a class, and in summer the internships are $75 a week, but it is based on the number of hours. It is not taxable because it is considered an allowance. Students fill out forms that say they are not employees and the allowance is for transportation and supplies.
B. Mitchell	How do you determine who is a consumer?
S. Medlin	We rely on their self-disclosure. The class is open to everyone, but in order to qualify for a stipend they have to be served by the county.
J. Bukosky	Are the internships located only in Contra Costa? Do the students come from all over? I noticed the course number is HHS – is this a certificate program? Is there a Health and Human Services Program at the college?
S. Medlin	We have an internship in Alameda, and students come from outside of Contra Costa. We do give a certificate of completion, but it is not a certificate program. We started a new program in psychosocial rehabilitation in partnership with CASRA, and are going through the CPRP exam.
H. Westbrook	The certificate does help the students get a job with the county. Contra Costa has an AA program for Health and Human Services. It also has a certificate program for dual diagnosis. One of the best things about the SPIRIT program is that it gives students confidence to continue and advance in their educational goals.

J. Black I agree with that. I know that my education started out slowly and I had the same experience with recovery that was mentioned earlier. I knew about 12-step but I never considered resiliency and recovery and vocations. Once I got started there was so much support out there. I encourage you to look into reintegration.com through Eli Lilly.(http://www.reintegration.com)

IMDs and Peer/Advocacy Groups in Northern California:

Rob Chittenden provided a little background to advocacy services by describing the peer self-advocacy program as a pilot project prior to the PAMI Act being passed. The PAMI Act – Protection and Advocacy for the Mentally Ill - was passed and the organization incorporated the Peer Self-Advocacy program. The program visits two state hospitals, several private institutions, care homes, and community based wellness centers and other venues to educate people about laws and opportunities affecting their recovery. He was careful to distinguish the difference between offering legal information, which DRC does provide, and legal advice, for which DRC provides referrals. The lack of encouragement he received in his youth and early adult years spurred him toward his path of advocacy.

During the course of his advocacy he has observed that institutionalization has made clients doubt their abilities and that they have seldom questioned the legitimacy of their treatment decisions. One of the first things the group does is explain what their rights are, what endangers those rights, and what institutions can and cannot do. Clients can't recognize their rights have been violated until they have their rights explained to them. The program received a legislative boost when the group invited a California Senator to visit the program when it met at Napa State Hospital, and the senator passed legislation authorizing self-help and self-advocacy.

Finding options for housing in a community setting is key to successful transitions. Having a safe place to live is critical to recovery. MHSA funding has increased these options. Lake County purchased a 10 unit hotel on Clear Lake and has a program that encourages clients to leave institutions and boards and care and back into the community by opening a Wellness Center/Drop In Center and. The ten apartments are being used as a transitional housing building and are located directly across the street from the Peer Center.

Michael Stolz joined the discussion and described the experience of one woman who was discharged from an IMD and subsequently had 30 addresses over the course of one year when her conservatorship was terminated and ultimately was without any services at all, county or otherwise. He observed that psychiatric beds have actually increased since the Olmstead Act in Skilled Nursing Facilities or other locked settings and that MHSA definition of homeless or potentially homeless expressly specifies people in IMDs.

B. Mitchell Have you looked at the issue that Conserved people being discharged from IMDs must be placed in a licensed facility vs. an unlicensed supportive housing program?

M. Stolz I would argue that there are strong arguments to challenge county laws. The WIC conservatorship section expressly says that there is a presumption that the person placed on an LPS conservatorship be placed in his or her own home, or that of a family member or friend. So, I think a county policy that limits placement to a

licensed facility does not comport with state law and I think it would be subject to a challenge under those statutory provisions and I think it is a violation of ADA law. ADA requires that people receive government services in the most integrated setting appropriate to individual need, and I think these restrictive county policies are not based on individual need.

B. Mitchell What about motor vehicles?

R. Chittenden I can speak to that. I had two vehicles, but they made me sign one over to them. I was allowed to own one, but I could not drive it. When my conservatorship was terminated, I went down to DMV and asked how to get the license back. The record keeping had not caught up to the DMV. I was told to pay the license fee and take the test, so I did, and my license was restored.

M. Stolz Under WIC section 5357 there is a provision that *"the conservatorship investigation report shall consider the imposition of each of the disabilities on the conservatee. The privilege of possessing a license to operate a motor vehicle. If the report recommends against this right, and if the court follows the recommendation, the agency providing conservatorship investigation shall so notify the Department of Motor Vehicles."* It may be considered under the context of Conservatorship, but clearly is it not automatic. If a conservatee strongly believes that he or she can operate a motor vehicle the public defender can present the case to the court.

J. Bukosky Mike, do you have a plan to update the report, "A Tale of Two Settings"?

M. Stolz Yes, we would like to update it, but we don't have a date set for it. If we do update it, I would like to focus more on the availability of MHSA housing.

Meeting Evaluation and Agenda Development:

Two items that would be interesting to pursue at the next meeting would be CMHDA's support of eliminating the IMD exclusion and Housing options, either MHSA funded or not. Are there any IMD interventions in place in order to avoid sending folks to an IMD at all? Also, following up on Joe Mortz's question on the federal SVP ruling and following up on the county IMD survey. Lake County should be invited to see if they would like to present on their transition housing program that Rob Chittenden mentioned.

Respectfully Submitted,

Andi Murphy
Staff, Adult Systems of Care