

California Mental Health Planning Council

ADVOCACY COMMITTEE

October 15, 2014

Lake Natoma Inn  
702 Gold Lake Drive  
Folsom CA 95630  
(916) 351-1500

Board Room Folsom  
1:30 to 5:00 p.m.

Time	Topic	Presenter or Facilitator	Tab
1:30	Welcome and Agenda Packet Review	Barbara Mitchell, Co-Chair	
1:35	New Business	Adam Nelson, Co-Chair	
1:45	Developing Legislative Proposals for Next Session	Barbara Mitchell Sunshine Borelli Senator Beall's Office	A (page 26)
3:00	Discussion/Next Steps	Adam Nelson	
3:20	<b>Break</b>		
3:40	Advocacy Committee Work Plan	Barbara Mitchell	B (page 42)
4:25	Legislative Platform Review	Adam Nelson	C (page 46)
4:40	Public Comment	Barbara Mitchell	
4:45	Plan Agenda For January Meeting & Develop Report Out	Adam Nelson	
4:55	Plus/Delta	Barbara Mitchell	
5:00	Adjourn		

**The scheduled times on the agenda are estimates and subject to change.**

**Committee Members:** (as of March 2014)

**Co-Chairs:** Barbara Mitchell Adam Nelson

**Members:** Karen Bachand Justin Lock  
Kathleen Derby John Ryan  
Nadine Ford Daphne Shaw  
Steve Leoni Monica Wilson, Ph.D

**Staff:** Andi Murphy

**If reasonable accommodations are required, please contact Andi Murphy at (916) 323-4501 within 5 working days of the meeting date in order to work with the venue.**

**CMHPC ADVOCACY COMMITTEE**

**Meeting Highlights**

**June 18, 2014**

**Hilton Oakland Airport**

**1 Hegenberger Road**

**Oakland, CA 94621**

**Present:**

Barbara Mitchell, Co-Chair

Adam Nelson, Co-Chair

**Presenters:** Yanna Jacobs,  
Santa Cruz County Mental  
Health; Chris Hirsch, 2<sup>nd</sup> Story

John Ryan

Steve Leoni

Daphne Shaw

**Staff:** Andi Murphy

***Introductions and Agenda Review***

The meeting commenced at 1:30. A slight change of the agenda was announced due to the absence of the presenter.

**Budget Update:**

There were no bad surprises in the budget this year. The Senate and Assembly accepted the Governor's fiscal projections despite the LAO's assertion to the contrary. There were no cuts to mental health funding. The High Speed Rail funding may lead to increased housing starts near transit lines. Reentry programs are getting a boost.

The significant implication in this year's budget is that nearly 30% of California's population is now Medi-Cal enrolled or eligible, but providers are difficult to find, particularly when the reimbursement rate for providers is not keeping a pace. Workforce will be the biggest problem during the years of Health Care Reform Implementation.

Health Care Reform committee may wish to look into this and also to try to find out how many of the new enrollees are in need of mental health services.

**New Business:**

Lack of attendance is affecting the ability to do business. Some committees employ an e-mail confirmation process prior to the meeting, but that is not foolproof and many of the absences are unanticipated.

**Review and approve minutes:** The minutes were moved to be approved (Ryan) seconded (Shaw), and tabled until the end of the meeting. If no quorum is met, the minutes will be assumed to be approved. (This is acceptable under Roberts Rules of Order unless somebody actively opposes their approval).

**CMHPC ADVOCACY COMMITTEE****Meeting Highlights****June 18, 2014****Hilton Oakland Airport****1 Hegenberger Road****Oakland, CA 94621****2ND STORY PEER RESPITE:**

Peer Respite is in a category all by itself in terms of recognition by any state entities. This program attempted to go through the Community Care Licensing but CCL did not feel they were doing anything that required licensing. It is designed to be a pre-crisis program rather than a Crisis Residential program, and guests are encouraged to maintain their “regular” lives – work, school, etc., while they work through things at the program.

It is entirely Peer-Run, and all staff are trained in “Intentional Peer Support”. The length of stay is no longer than two weeks. Ideally, a pre-registration, proactive interview (sort of a WRAP plan) is done ahead of time, but the reality is that flexibility is needed because usually people don’t show up for the interview until they feel they might be approaching a crisis mode.

**Shary** Mead, who designed Intentional Peer Support meets with 2<sup>nd</sup> Story regularly via Skype. Outreach is conducted by staff hanging out at County mental health departments telling people about it. There are also suggestions made by psychiatrists, care managers, Telecare sometimes diverts people to 2<sup>nd</sup> Story. Santa Cruz has a crisis residential and sub-acute stabilization program and 2<sup>nd</sup> Story is starting to become one of the actions.

When asked if there was such a thing as an “inappropriate” referral, the response was that typically the person who recommended the program to the person would advise the program that it was a “borderline” referral, but more often than not, referrals would come from “higher” crisis-level programs who did not feel the symptoms were severe enough to warrant sub-acute or Crisis Residential services. All guests are required to have a home to go home to or a very strong support system when they leave. There is a wait list if the program is at capacity, but staff has observed that the waiting list is not that effective – people who are able to wait are either able to find alternate support, or possibly feel sufficiently reassured that the crisis becomes less pressing.

***Staffing Hiring Process***

There are 18 staff, five who work no more than 30 hours, and 4 who are co-leaders. The rest are part-time and/or on-call. It is a 24/7 operation, four shifts a day. Encompass does the pre-screening of applicants, based on certain criteria (screen for criminal records, etc.) but the actual candidate selection is done in-house by a three or four person panel, with the only criteria being that there the person has lived experience and a desire to learn Intentional Peer Support (IPS). Other skills that are looked for are “soft” skills such as personal interaction with others etc.. It happens that former

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guests and volunteers at the house have subsequently applied to work there. HSRI performs the evaluations for approximately 50K annually.

**Financing**

Since it is currently receiving Federal Grant money, 2<sup>nd</sup> story does not bill Medi-Cal, but at some point billing may play into long term sustainability. While there is some reluctance/resistance to the philosophical contradiction of relying on “medical-model” billing, most staff would be willing to do it if it meant keeping the doors open. However, that leads to discussions on the TYPE of billing. Medi-Cal requires a knowledge of billing codes, and Rehab option would be note –taking. Regardless of billing options, it would require that the site be licensed, which might be problematic if any of the peer staff has/have arrest records. 2<sup>nd</sup> Story Respite is interested in pursuing and promoting Peer Certification if it helps address any of these issues.

Staying at the Respite has reduced the odds of returning or using Emergency Department by 78%. It was originally designed to have 8 guests, but it was difficult to find a house large enough that was near public transportation. No Community Care Licensing or certification is required because medications are not dispensed by staff – it is up to the guest to monitor and be responsible for their own medications. If the individual asks for medication reminders, the staff will provide the reminder, but staff will not suggest it. Nobody is searched or tested for drugs, but guests who are visibly impaired are asked to leave. Visible drug use is not permitted on the premises. No Special Use Permit was needed, and parking is encouraged to be confined to a busy main street and not in the neighborhood. Regular neighborhood meetings are held to hear neighbor concerns and build or solidify good will.

This model will most likely not be possible once the grant money is gone and other methods of meeting expenses will need to be identified. There is no billing, no rent collected, food is mostly provided by the program, and the staff to guest ratio is very high making this an expensive program. So far, the outcomes are very promising (see addendum) but future iterations will most likely need to be more balanced between income and expenses. The program was initially designed to hold eight beds, but finding a house with enough bedrooms along a public transportation system was not possible, so the program has started with six beds. If there were more beds the staff to guest ratio would lower and the operating costs would be less. In a year, it will be more or less entirely reliant on county funding – likely MHSA Innovation funds. This does open the door for eventual Medi-Cal billing at some point.

**CMHPC ADVOCACY COMMITTEE****Meeting Highlights****June 18, 2014****Hilton Oakland Airport****1 Hegenberger Road****Oakland, CA 94621****Program Model**

One of the reasons the program is so successful is that there is no therapeutic structure that people must adhere to as a condition of staying there. Many of the guests want to carry on with their regular life and attend school or go to work, so they appreciate not being forced to participate in the structured activities that are held in other environments like Crisis Residential or Transitional Housing. This often serves as a better example or role model than the traditional “group” activities. However, they may form their own group if they feel it is needed for as long as it needed. Rent is not charged due to the difficulty it presents to folks who are already paying rent with their sometimes limited funds.

Meals tend to be communal; the food is provided by 2<sup>nd</sup> Story, but people are welcome to donate groceries. While it is less structured than a traditional Crisis or Transitional residential, it does serve a less acute population and is actually more of a Prevention model, which diverts from the “Acute” to “Crisis” path and provides a positive diversion rather than treatment.

Neighbor relations are actively supported and maintained through an email list and phone communications. Neighbors feel comfortable calling the staff and asking about things that concern them – strange people in the neighborhood, cars parked in their area, etc., police and ambulance calls.

It was suggested that perhaps the program should start tracking crime stats and housing values to counter any arguments that are made that “these types” of programs bring down the neighborhood. 911 calls that originate from the 2<sup>nd</sup> Story house should also be tracked by the program in order to demonstrate that they were called as a preventive measure not a reaction to criminal activity.

**Discussion:**

Client satisfaction surveys are positive but not necessarily informative. The Advocacy Committee should wait to endorse it until a longer term or broader survey results are available. It is a very positive experience but it is expensive and hard to justify vis-à-vis a crisis residential program. However, this is not truly a valid argument because 2<sup>nd</sup> Story is actually more of a Preventative (pro-active) program than a therapeutic (reactive) program.

What is the status of the Peer Certification process right now? The initial meeting in early May has revealed the need and roadmap for laying out the steps that lead to eventual certification –

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identifying who the certifying body should be, what their duties should include, what type of funding might be needed to identify and then establish the body; what type of statutory language would be required and who would craft it? Will federal language be part of it? The next meeting is scheduled for July 1, 2014. The Council's ONLY role is to investigate what it would take to make it happen – not to initiate it. So far, OSHPD has provided \$10 million dollars for consumer family member education over two years, which may help pay for part of it. Earlier there was some discussion that there may need to be some type of legislative effort made, but not necessarily by the Planning Council, although it should make its commitment and support clear to the petitioner. The Advocacy committee may wish to advocate for additional funding, or offer to help with legislative or regulatory language. The request for Council volunteers to serve on the workgroup should be renewed at Friday's General Session meeting. Advocacy Committee should provide a statement supporting 2<sup>nd</sup> Story's program at the Friday morning report, and that it appears to be a very promising practicing.

Pacific Clinics is billing regular Medi-Cal for mental health services under Targeted Case management, not Peer Support. Georgia allows billing for Peer support. There is some concern that the outcome of enabling billing for peer support is that it may be "de-valued" as a billable function, and reimbursement would be at 50% of what other providers could get.

Advocacy committee might wish to focus more on data collection processes – particularly for programs that are funded by SAMHSA or other funding sources (that are not MHSA). If the CMHPC focused on federally funded programs, it would be helpful to the funding organizations.

#### *Federal Legislation:*

The Murphy Bill has not reached the Floor and Barber's Bill is considered a Democratic response to the Republican Murphy Bill. The areas of conflict in HR 3717 Murphy bill has been touted as an improvement in HR 4754 Barber and vice versa. Expansion of services under HR 3717 is viewed as an infringement against personal rights, while HR 4574 is seen as an expansion of services without the infringement. Both bills are reactive – HR 3717 against public violence and HR 4574 against HR 3717. The Murphy Bill is supported by a lot of advocacy groups – NAMI, American Psychiatric Association, American Psychological Association, most provider groups. There was also the "Excellence In Mental Health Act", which invests \$900M in community mental health program enhancements and Medicare provider reimbursements through a grant program. HR 4302 - Protecting Access to Medicare ("fix a Doc") includes language on instituting AOT programs through a grant program. Matsui has also mentioned that she is carrying a MHSA-like legislative product at

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the national level. If so, this would be worth pursuing because if it is like MHSA, it would be worth promoting or advocacy efforts on our part, because the other two appear to have devolved down to partisan camps and may not be worth putting time and effort into them. We should invite somebody from Matsui's staff to present to us on the legislation and how we might be able to support it at the state level.

*Planning for October meeting:*

Housing update? There is money flowing in now for the HCD Initiative Supportive Housing program. Also, the Transit Oriented Development (TOD) initiative should mean additional housing for urban areas.

Consider looking for legislative issues to support. Senator Beall is heading a mental health caucus; perhaps somebody from his office could talk about their vision for mental health services in California, or how we might be able to support alternatives to involuntary treatment.

Maybe we should try to articulate a happy medium between involuntary treatment and a system of care that captures people who fall between the cracks. County Public Guardian offices are maintaining LPS Conservatorships for longer than usual (after in-patient stays) in order to ensure services are offered and utilized. The services that are offered under AOT and voluntary treatment are not so different, the services themselves are not objectionable, it is the manner in which they are offered and utilized.

- Rework the Legislative Platform in October for January.
- Identify a co-chair elect.
- Identify a "theme" for next year – 2014 was Peer Certification. Maybe MIOCR for 2015?

July Meeting: Update the committee on whether we were able to obtain a presenter.

Respectfully Submitted,

Andi Murphy

**CMHPC  
ADVOCACY COMMITTEE  
CHARTER 2013**

**Purpose:** The purpose of the Advocacy Committee is to address public issues affecting the effectiveness of mental health programs and quality of life for persons living with mental illness. This includes increasing public mental health awareness through press and media, partnering with local consumer advocacy agencies for access and improved quality of care, and responding to proposed legislation, rule-making, and budget bills based on the CMHPC platform.

**Mandate: WIC 5772.** The California Mental Health Planning Council shall have the powers and authority necessary to carry out the duties imposed upon it by this chapter, including, but not limited to, the following:

- (a) To advocate for effective, quality mental health programs.
- (e) To advise the Legislature, the State Department of Health Care Services, and county boards on mental health issues and the policies and priorities that this state should be pursuing in developing its mental health system.
- (j) To advise the Director of Health Care Services on the development of the state mental health plan and the system of priorities contained in that plan.
- (k) To assess periodically the effect of realignment of mental health services and any other important changes in the state's mental health system, and to report its findings to the Legislature, the State Department of Health Care Services, local programs, and local boards, as appropriate.
- (l) To suggest rules, regulations, and standards for the administration of this division.

**Guiding Principles:** All advocacy efforts and proposed legislation shall be reviewed to ensure that the following best practices and principles are included.

<b>Cultural Competence</b>	<b>Full Accessibility across the life span</b>	<b>Wellness &amp; Recovery</b>
<b>Community Collaboration</b>	<b>Consumer &amp; Family member driven or influenced</b>	<b>Integrated Services</b> <i>End of description</i>

**OBJECTIVES:**

1. Review and respond to pending legislation, proposed code language, regulatory, and judicial actions that diminishes or adversely affects MHS programs and compromises the state mental health plan.
2. Inform a mental health system that incorporates public and private resources to offer community-based services that embrace recovery and wellness, and are strength-based, culturally competent, and cost-effective.
3. Develop talking points to use for education and commentary on mental health issues in the media.
4. Respond to and partner with Consumer agencies and family member organizations to support their activities when needed.

**Roles and Responsibilities:**

**CMHPC  
ADVOCACY COMMITTEE  
CHARTER 2013**

**9**

Regular attendance of committee members is expected in order for the Committee to function effectively. If a committee has difficulty achieving a quorum due to the continued absence of a committee member, the committee chairperson will discuss with the member the reasons for his or her absence. If the problem persists, the committee chair can request that the Executive Committee remove the member from the committee.

Members are expected to serve as advocates for the committee's charge, and as such, could include, but are not limited to:

- Attend meetings
- Speak - when authorized - at relevant conferences and summits when requested by the committee or the Planning Council
- Participate in the development products such as white papers, opinion papers, and other documents
- Distribute the committee's white papers and opinion papers to their represented communities and organizations
- Assist in identifying speakers for presentations

Materials will be distributed as far in advance as possible in order to allow time for review before the meetings. Members are expected to come prepared in order to ensure effective meeting outcomes.

**Membership:**

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**NAME**

*Barbara Mitchell, Co-chair*

*Adam Nelson MD, Co-Chair*

*Kathleen Derby*

*Nadine Ford*

*Steve Leoni*

*Justin Lock*

*John Ryan*

*Daphne Shaw*

*Monica Wilson*

*Staff: Andi Murphy*

*(916) 324-0777*

*[andi.murphy@cmhpc.ca.gov](mailto:andi.murphy@cmhpc.ca.gov)*

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**General Principles of Collaboration:**

The following general operating principles are proposed to guide the committee's deliberations:

- The committee's mission will be best achieved by relationships among the members characterized by mutual trust, responsiveness, flexibility, and open communication.
- It is the responsibility of all members to work toward the committee's common goals.
- To that end, members will:
  - Commit to expending the time, energy and organizational resources necessary to carry out the committee's mission
  - Be prepared to listen intently to the concerns of others and identify the interests represented
  - Ask questions and seek clarification to ensure they fully understand other's interests, concerns and comments
  - Regard disagreements as problems to be solved rather than battles to be won
  - Be prepared to "think outside the box" and develop creative solutions to address the many interests that will be raised throughout the Committee's deliberations

**Decision Making:**

The Committee will work to find common ground on issues and strive to seek consensus on all key issues. Every effort will be made to reach consensus, and opposing views will be explained. In situations where there are strongly divergent views, members may choose to present multiple recommendations on the same topic. If the Committee is unable to reach consensus on key issues, decisions will be made by majority vote. Minority views will be included in the meeting highlights.

**Meeting Protocols:**

The Committee's decisions and activities will be captured in a highlights document, briefly summarizing the discussion and outlining key outcomes during the meeting. Viewpoints will be recorded, but not be attributed to a specific member. The meeting highlights will be distributed to the Committee within one month following the meeting. Members will review and approve the previous meeting's highlights at the beginning of the following meeting.

**Media Inquiries:**

In the event the Committee is contacted by the press, the Chairperson will refer the request to the CMHPC's Executive Officer.

## CA Mental Health Planning Council State Statutes

**5514.** There shall be a five-person Patients' Rights Committee formed through the California Mental Health Planning Council. This committee, supplemented by two ad hoc members appointed by the chairperson of the committee, shall advise the Director of Health Care Services and the Director of State Hospitals regarding department policies and practices that affect patients' rights. The committee shall also review the advocacy and patients' rights components of each county mental health plan or performance contract and advise the Director of Health Care Services and the Director of State Hospitals concerning the adequacy of each plan or performance contract in protecting patients' rights. The ad hoc members of the committee shall be persons with substantial experience in establishing and providing independent advocacy services to recipients of mental health services.

**5771.** (a) Pursuant to Public Law 102-321, there is the California Mental Health Planning Council. The purpose of the planning council shall be to fulfill those mental health planning requirements mandated by federal law.

(b) (1) The planning council shall have 40 members, to be comprised of members appointed from both the local and state levels in order to ensure a balance of state and local concerns relative to planning.

(2) As required by federal law, eight members of the planning council shall represent various state departments.

(3) Members of the planning council shall be appointed in a manner that will ensure that at least one-half are persons with mental disabilities, family members of persons with mental disabilities, and representatives of organizations advocating on behalf of persons with mental disabilities. Persons with mental disabilities and family members shall be represented in equal numbers.

(4) The Director of Health Care Services shall make appointments from among nominees from various mental health constituency organizations, which shall include representatives of consumer-related advocacy organizations, representatives of mental health professional and provider organizations, and representatives who are direct service providers from both the public and private sectors. The director shall also appoint one representative of the California Coalition on Mental Health.

(c) Members should be balanced according to demography, geography, gender, and ethnicity. Members should include representatives with interest in all target populations, including, but not limited to, children and youth, adults, and older adults.

(d) The planning council shall annually elect a chairperson and a chair-elect.

(e) The term of each member shall be three years, to be staggered so that approximately one-third of the appointments expire in each year.

(f) In the event of changes in the federal requirements regarding the structure and function of the planning council, or the discontinuation of federal funding, the State Department of Health Care Services shall, with input from state-level advocacy groups, consumers, family members

and providers, and other stakeholders, propose to the Legislature modifications in the structure of the planning council that the department deems appropriate.

**5771.1.** The members of the Mental Health Services Oversight and Accountability Commission established pursuant to Section 5845 are members of the California Mental Health Planning Council. They serve in an ex officio capacity when the council is performing its statutory duties pursuant to Section **5772**. Such membership shall not affect the composition requirements for the council specified in Section **5771**.

**5771.3.** The California Mental Health Planning Council may utilize staff of the State Department of Health Care Services, to the extent they are available, and the staff of any other public or private agencies that have an interest in the mental health of the public and that are able and willing to provide those services.

**5771.5.** (a) (1) The Chairperson of the California Mental Health Planning Council, with the concurrence of a majority of the members of the California Mental Health Planning Council, shall appoint an executive officer who shall have those powers delegated to him or her by the council in accordance with this chapter.

(2) The executive officer shall be exempt from civil service.

(b) Within the limit of funds allotted for these purposes, the California Mental Health Planning Council may appoint other staff it may require according to the rules and procedures of the civil service system.

**5772.** The California Mental Health Planning Council shall have the powers and authority necessary to carry out the duties imposed upon it by this chapter, including, but not limited to, the following:

(a) To advocate for effective, quality mental health programs.

(b) To review, assess, and make recommendations regarding all components of California's mental health system, and to report as necessary to the Legislature, the State Department of Health Care Services, local boards, and local programs.

(c) To review program performance in delivering mental health services by annually reviewing performance outcome data as follows:

(1) To review and approve the performance outcome measures.

(2) To review the performance of mental health programs based on performance outcome data and other reports from the State Department of Health Care Services and other sources.

(3) To report findings and recommendations on programs' performance annually to the Legislature, the State Department of Health Care Services, and the local boards.

(4) To identify successful programs for recommendation and for consideration of replication in other areas. As data and technology are available, identify programs experiencing difficulties.

- (d) When appropriate, make a finding pursuant to Section 5655 that a county's performance is failing in a substantive manner. The State Department of Health Care Services shall investigate and review the finding, and report the action taken to the Legislature.
- (e) To advise the Legislature, the State Department of Health Care Services, and county boards on mental health issues and the policies and priorities that this state should be pursuing in developing its mental health system.
- (f) To periodically review the state's data systems and paperwork requirements to ensure that they are reasonable and in compliance with state and federal law.
- (g) To make recommendations to the State Department of Health Care Services on the award of grants to county programs to reward and stimulate innovation in providing mental health services.
- (h) To conduct public hearings on the state mental health plan, the Substance Abuse and Mental Health Services Administration block grant, and other topics, as needed.
- (i) In conjunction with other statewide and local mental health organizations, assist in the coordination of training and information to local mental health boards as needed to ensure that they can effectively carry out their duties.
- (j) To advise the Director of Health Care Services on the development of the state mental health plan and the system of priorities contained in that plan.
- (k) To assess periodically the effect of realignment of mental health services and any other important changes in the state's mental health system, and to report its findings to the Legislature, the State Department of Health Care Services, local programs, and local boards, as appropriate.
- (l) To suggest rules, regulations, and standards for the administration of this division.
- (m) When requested, to mediate disputes between counties and the state arising under this part.
- (n) To employ administrative, technical, and other personnel necessary for the performance of its powers and duties, subject to the approval of the Department of Finance.
- (o) To accept any federal fund granted, by act of Congress or by executive order, for purposes within the purview of the California Mental Health Planning Council, subject to the approval of the Department of Finance.
- (p) To accept any gift, donation, bequest, or grants of funds from private and public agencies for all or any of the purposes within the purview of the California Mental Health Planning Council, subject to the approval of the Department of Finance.

- 5820.** (a) It is the intent of this part to establish a program with dedicated funding to remedy the shortage of qualified individuals to provide services to address severe mental illnesses.
- (b) Each county mental health program shall submit to the Office of Statewide Health Planning and Development a needs assessment identifying its shortages in each professional and other occupational category in order to increase the supply of professional staff and other staff that county mental health programs anticipate they will require in order to provide the increase in services projected to serve additional individuals and families pursuant to Part 3 (commencing

with Section 5800), Part 3.2 (commencing with Section 5830), Part 3.6 (commencing with Section 5840), and Part 4 (commencing with Section 5850) of this division. For purposes of this part, employment in California's public mental health system includes employment in private organizations providing publicly funded mental health services.

(c) The Office of Statewide Health Planning and Development, in coordination with the California Mental Health Planning Council, shall identify the total statewide needs for each professional and other occupational category utilizing county needs assessment information and develop a five-year education and training development plan.

(d) Development of the first five-year plan shall commence upon enactment of the initiative. Subsequent plans shall be adopted every five years, with the next five-year plan due as of April 1, 2014.

(e) Each five-year plan shall be reviewed and approved by the California Mental Health Planning Council.

**5821.** (a) The California Mental Health Planning Council shall advise the Office of Statewide Health Planning and Development on education and training policy development and provide oversight for education and training plan development.

(b) The Office of Statewide Health Planning and Development shall work with the California Mental Health Planning Council and the State Department of Health Care Services so that council staff is increased appropriately to fulfill its duties required by Sections 5820 and 5821.

Federal Public Law (PL) 106-310- the MHPC should perform the following functions:	Council Activity	Deliverable
<ul style="list-style-type: none"> <li>Review the State mental health plan required by <b>PL 106-310</b> and submit to the State any recommendations for modification</li> </ul>	Annual review of CA SAMHSA BG application	Yes
<ul style="list-style-type: none"> <li>Review the annual implementation report on the State mental health plan required by <b>PL 106-310</b> and submit any comments to the State</li> </ul>	Annual review of CA Implementation Report	Yes
<ul style="list-style-type: none"> <li>Advocate for adults with serious mental illness, children with a severe emotional disturbance, and other individuals with mental illnesses or emotional problems</li> </ul>	Legislative advocacy, Participation on HCR and other issue-specific committees,	No
<ul style="list-style-type: none"> <li>Monitor, review, and evaluate annually the allocation and adequacy of mental health services within the State.</li> </ul>	Workbook Project w/ Local MH Boards	Yes
<p><b>California Welfare and Institutions Code (WIC) 5514-</b> There shall be a 5-person Patients' Rights Committee formed through the CMHPC. This committee, supplemented by two ad hoc members appointed by the chairperson of the committee, shall advise the Director of Health Care Services and Director of State Hospitals regarding department policies and practices that affect patients' rights.</p>	None yet, new requirement in FY 2012-13 TBL	
<p><b>WIC 5771-</b> Pursuant to <b>PL 102-321</b> the Planning Council shall be responsible to fulfill those mental health planning requirements mandated by federal law.</p>		
<p><b>WIC 5772 -</b> The California Mental Health Planning Council shall have the powers and authority necessary to carry out the duties imposed upon it by this chapter, including, but not limited to, the following:</p>		
<ol style="list-style-type: none"> <li>To advocate for effective, quality mental health programs.</li> </ol>	Legislative testimony, Participation on HCR and other issue-specific committees	No
<ol style="list-style-type: none"> <li>To review, assess, and make recommendations regarding all components of California's mental health system, and to report as necessary to the Legislature, the State Department of Health Care Services, local boards, and local programs.</li> </ol>	SAMHSA BG Peer Reviews, Council Meeting to showcase model programs, Legislative testimony	No
<ol style="list-style-type: none"> <li>To review program performance in delivering mental health services by annually reviewing performance outcome data as follows:</li> </ol>	Workbook Project w/ Local MH Boards, SAMHSA BG Peer Reviews,	Yes
<ul style="list-style-type: none"> <li>To review and approve the performance outcome measures.</li> </ul>		

<ul style="list-style-type: none"> <li>To review the performance of mental health programs based on performance outcome data and other reports from the State Department of Health Care Services and other sources.</li> </ul>		
<ul style="list-style-type: none"> <li>To report findings and recommendations on programs' performance annually to the Legislature, the State Department of Health Care Services, and the local boards.</li> </ul>		
<ul style="list-style-type: none"> <li>To identify successful programs for recommendation and for consideration of replication in other areas. As data and technology are available, identify programs experiencing difficulties.</li> </ul>		
4. When appropriate, make a finding pursuant to Section 5655 that a county's performance is failing in a substantive manner. The State Department of Health Care Services shall investigate and review the finding, and report the action taken to the Legislature.		
<b>WIC 5772 - continued</b>	<b>Council Activity</b>	<b>Deliverable</b>
5. To advise the Legislature, the State Department of Health Care Services, and county boards on mental health issues and the policies and priorities that this state should be pursuing in developing its mental health system.		
6. To make recommendations to the State Department of Health Care Services on the award of grants to county programs to reward and stimulate innovation in providing mental health services.		
7. To conduct public hearings on the state mental health plan, the Substance Abuse and Mental Health Services Administration block grant, and other topics, as needed.		
8. In conjunction with other statewide and local mental health organizations assist in the coordination of training and information to local mental health boards as needed to ensure that they can effectively carry out their duties.	Coordinate training needs with CiMH and CALMHBDC	No
9. To advise the Director of Health Care Services on the development of the state mental health plan and the system of priorities contained in that plan.		
10. To assess periodically the effect of realignment of mental health services and any other important changes in the state's mental health system, and to report its findings to the Legislature, the State Department of Health Care Services, local programs, and local boards, as appropriate.		
11. To suggest rules, regulations, and standards for the administration of this division.		
12. When requested, to mediate disputes between counties and the state arising under this part.		
13. To employ administrative, technical, and other personnel necessary for the performance of its powers and duties, subject to the approval of the Department of Finance.		

14. To accept any federal fund granted, by act of Congress or by executive order, for purposes within the purview of the California Mental Health Planning Council, subject to the approval of the Department of Finance.		
15. To accept any gift, donation, bequest, or grants of funds from private and public agencies for all or any of the purposes within the purview of the California Mental Health Planning Council, subject to the approval of the Department of Finance.		
<b><u>WIC 5820</u></b> - Each OSHPD five-year WET plan shall be reviewed and approved by the Planning Council.	Participate in OSHPD WET Advisory Committee; Coordinate Council review of 5-Yr Plan	
<b><u>WIC 5821</u></b> - The Planning Council shall advise the OSHPD on education and training policy development and provide oversight for the department's education and training development.	Participate in OSHPD WET Advisory Committee	

## **California Mental Health Planning Council**

# **Vision and Mission**

### **Vision**

The CMHPC envisions a mental health system that makes it possible for individuals to lead full and productive lives. The system incorporates public and private resources to offer community-based services that embrace recovery and wellness. The services are culturally competent, responsive, timely, and accessible to all of California's populations.

### **Mission**

The CMHPC evaluates the mental health system for accessible and effective care. It advocates for an accountable system of seamless, responsive mental health services that are strength-based, consumer and family driven, recovery-oriented, culturally competent, and cost-effective. To achieve these ends, the Council educates the general public, the mental health constituency, and legislators.

## CALIFORNIA MENTAL HEALTH PLANNING COUNCIL

### LEGISLATIVE PLATFORM

March 2014

#### Mandatory Planks

- Support any proposal that embodies the principles of the *Mental Health Master Plan*.
- Support policies that reduce and eliminate stigma and discrimination.
- Support any proposal that addresses the human resources problem in the public mental health system with specific emphasis on increasing cultural diversity and promoting the employment of consumers and family members.
- Support any proposal that augments mental health funding, consistent with the principles of least restrictive care and adequate access, and oppose any cuts.
- Support legislation that safeguards mental health insurance parity and ensures quality mental health services in health care reform
- Support expanding affordable housing and affordable supportive housing.
- Actively advocate for the development of housing subsidies and resources so that housing is affordable to people living on SSI.
- Support expanding employment options for people with psychiatric disabilities, particularly processes that lead to certification and more professional status and establish stable career paths.
- Support any proposal to lower costs by eliminating duplicative, unnecessary, or ineffective regulatory or licensing mechanisms of programs or facilities.
- Support any initiatives that reduce or eliminate the use of seclusion and restraint.
- Support adequate funding for evaluation of mental health services.
- Support initiatives that maintain or improve access to mental health services and maintain or improve quality of mental health services.
- Oppose all bills related to “NIMBYism” and restrictions on housing and siting facilities for providing mental health services.
- Support initiatives that provide comprehensive health care and improved quality of life for people living with mental illness, and oppose any elimination of health benefits for low income beneficiaries, and advocate for reinstatement of benefits that have been eliminated.
- Oppose any legislation that adversely affects the principles and practices of the Mental Health Services Act.

#### Discretionary Planks (Require Deliberation & Discussion)

- *Support any proposal that advocates for blended funding for programs serving clients with co-occurring disorders that include mental illness.*
- *Support any proposal that advocates for providing more services in the criminal and juvenile justice systems for persons with serious mental illnesses or children, adolescents, and transition-aged youth with serious emotional disturbances, including clients with co-occurring disorders.*

- *Support any proposal that specifies or ensures that the mental health services provided to AB109 populations are paid for with AB 109 funding.*
- *Support any policy that requires the coordination of data and evaluation processes at all levels of mental health services.*
- *Support policy that enhances the quality of the stakeholder process, improves the participation of consumers and family members, and fully represents the racial/cultural demography of the targeted population.*
- *Support the modification or expansion of curricula for non-mental health professionals to acquire competency in understanding basic mental health issues and perspectives of direct consumers and family members.*
- *Promote the definition of outreach to mean “patient, persistent, and non-threatening contact” when used in context of engaging hard to reach populations.*

## LEGISLATION REVIEW PROCEDURE

### Urgent & Non-Urgent

Approved: June 2012

24

1. For items that are on the “automatic” approval planks of the platform and/or are **non-urgent** (more than seven days of response time):
  - Contact staff directly via email, with a cc to the Executive Officer, requesting action, and define the level of urgency of the request, informing staff of the deadline (and nature of the deadline i.e., which Legislative committee? How close to a final vote etc.) and suggested points that should be made in the letter.
  - *Staff performs analysis and presents the information, synopsis, and recommendation, and draft support/oppose letter to the Advocacy Committee for response and recommendation with the caveat that “approval is assumed if not contested within 7 days”.*
  - *If Advocacy Committee reviews the information and has comments, its recommendation /amendments/ approval is returned to staff with a cc to the Executive Officer and Executive Committee, including Leadership, **within 7 days**. The recommendation may be developed by a workgroup **within** the LRFC with expertise in the legislation’s subject area that is available and willing to do it within the time frame.*
  
2. If the item IS urgent (requires response in LESS than seven days):
  - *Request for action/analysis is addressed **to Executive Officer and staff, who will ensure that the information is forwarded to Leadership, Advocacy and Executive Committee***
  - *Staff performs analysis, and presents information, synopsis, and recommendation, with accompanying draft support/oppose letter, **to Leadership & Executive Committee, with a cc to Advocacy.***
  - *Leadership approves/amends recommendation and support/oppose letter, with input from Advocacy and Executive committees (if requested and time permits).*
  
3. Items that are NOT on the “automatic” approval planks should be vetted by **Leadership, by way of the Executive Officer or staff, who will also inform Executive Committee and Advocacy.** Request should include the same information as above – the action requested, the reason for its urgency, and the nearness of the vote. Staff may wish to perform preliminary analysis, but no document will be produced unless approved by Leadership. The final document will be distributed to the Advocacy and the Executive Committee.

Copies of Bills and/or existing Analyses may be requested from: Tracy Thompson [Tracy.Thompson@cmhpc.ca.gov](mailto:Tracy.Thompson@cmhpc.ca.gov) (916) 552-8665 or [Andi.Murphy@cmhpc.ca.gov](mailto:Andi.Murphy@cmhpc.ca.gov) (916) 324-0777

Requests for analyses or support/oppose letters should be directed to [Jane.Adcock@cmhpc.ca.gov](mailto:Jane.Adcock@cmhpc.ca.gov) (916) 319-9343 for “non-automatic” items with a cc to Andi Murphy.

Updated April 2013 – new phone numbers, committee name change etc.

X        **INFORMATION****TAB SECTION      A**  X        **ACTION REQUIRED****DATE OF MEETING    10/15/14****MATERIAL  
PREPARED BY:**      Murphy**DATE MATERIAL  
PREPARED**      9/16/14

<b>AGENDA ITEM:</b>	Developing Legislative Proposals for Next Session
<b>ENCLOSURES:</b>	Proposed Legislation Worksheet, CMS Letter DHCS Peer Certification (Background Info)
<b>OTHER MATERIAL RELATED TO ITEM:</b>	Peer Specialist Progress Info Sheet Laura's Law Excerpt

**ISSUE:**

January 2015 will mark the start of a new two-year Legislative Bill cycle. It is also the year that the outgoing Senate President pro tempore has challenged his fellow lawmakers to “sponsor at least one law related to mental illness”. In past meetings the committee has discussed pursuing legislation for issues it has felt strongly about. Most recently, suggestions were based on Laura’s Law and Peer Specialist Certification. Staff received a link to an electronic legislative proposal site that prompts for various questions that will need to be answered in order to move any legislation forward, which are on the attached Proposed Legislation Worksheet.

Peer Specialist Certification has been an issue the Council voted to champion at the October 2013 meeting. While much has been accomplished in describing what it would look like, why it is needed, how it would be used, the barriers and the gateways, the process has reached an impasse created in part by hesitancy at the state level due to lack of administrative direction. The Center for Medicaid Services (CMS) has given states the leeway to include Peer support (see CMS Letter, attached). The Department of Health Care Services (DHCS) considers Peer positions to be “Other Qualified Providers” under the federal waivers (see DHCS Peer Certification Document, attached). With the new session beginning, there is an opportunity to request that funds be identified in order to pursue the next steps of establishing state recognition as a certifiable employment class. Is there a way to legislatively ensure it? What would the Planning Council “ask” be for this issue? Is legislation even needed to accomplish the goal?

Since SB 585 (Steinberg) has passed, more and more counties are enacting it in their jurisdiction – Orange, San Francisco, and Los Angeles have to date. A corollary has been drawn by a fellow Council member to the 3-strikes law – another law enacted as an emotional response to awful events –that is now facing revision or retraction because it is not sustainable. This raises the question “How will we know that Laura’s Law is working and will be sustainable in the long run?” and has been suggested as a topic for suggested legislation. Counties are still required to report on their programs to the state, but are the items they are required to report on indicative of stabilization, recovery, and social connectedness? Is the training that is required in order to enact it at the county level sufficient? (See Laura’s Law Excerpt, attached, for reporting and training items). However, the same questions apply. What is the “ask”, and what would potential legislation to accomplish this look like?

### Proposed Legislation Worksheet

Bill Title: \_\_\_\_\_

Does this bill have a sponsor?      Yes      No

1. Please explain the problem or deficiency in the existing law, and what this bill seeks to remedy.

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1. Please cite existing law: \_\_\_\_\_

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2. What does your bill do? \_\_\_\_\_

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3. Why is this bill needed? Please be specific and present significant facts, research studies, and pertinent background information.

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11. Please describe any concerns that you anticipate may be raised in opposition to your bill, and state your response to those concerns.

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12. Please provide an estimate of any costs imposed by this bill on any state or local entity or consumer. \$ \_\_\_\_\_

13. Please provide an estimate of any savings imposed by this bill on any state or local entity or consumer. \$ \_\_\_\_\_

14. Does this bill implement a new program or add a major responsibility?                      Yes                      No                      DK

15. Please summarize any studies, reports, statistics or other evidence showing that the problem exists and that the bill will properly address the problem.

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DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
7500 Security Boulevard, Mail Stop S2-26-12  
Baltimore, Maryland 21244-1850



Center for Medicaid and State Operations

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SMDL #07-011

August 15, 2007

Dear State Medicaid Director:

The purpose of this letter is to provide guidance to States interested in peer support services under the Medicaid program. The Centers for Medicare & Medicaid Services (CMS) recognizes that the mental health field has seen a big shift in the paradigm of care over the last few years. Now, more than ever, there is great emphasis on recovery from even the most serious mental illnesses when persons have access in their communities to treatment and supports that are tailored to their needs. Recovery refers to the process in which people are able to live, work, learn and participate fully in their communities. For some individuals, recovery is the ability to live a fulfilling and productive life despite a disability. For others, recovery implies the reduction or complete remission of symptoms.

**Background on Policy Issue**

States are increasingly interested in covering peer support providers as a distinct provider type for the delivery of counseling and other support services to Medicaid eligible adults with mental illnesses and/or substance use disorders. Peer support services are an evidence-based mental health model of care which consists of a qualified peer support provider who assists individuals with their recovery from mental illness and substance use disorders. CMS recognizes that the experiences of peer support providers, as consumers of mental health and substance use services, can be an important component in a State's delivery of effective treatment. CMS is reaffirming its commitment to State flexibility, increased innovation, consumer choice, self-direction, recovery, and consumer protection through approval of these services. The following policy guidance includes requirements for supervision, care-coordination, and minimum training criteria for peer support providers.

As States develop behavioral health models of care under the Medicaid program, they have the option to offer peer support services as a component of a comprehensive mental health and substance use service delivery system. When electing to provide peer support services for Medicaid beneficiaries, State Medicaid agencies may choose to collaborate with State Mental Health Departments. We encourage States to consider comprehensive programs but note that regardless of how a State models its mental health and substance use disorder service delivery system, the State Medicaid agency continues to have the authority to determine the service delivery system, medical necessity criteria, and to define the amount, duration, and scope of the service.

## Page 2 – State Medicaid Director

States may choose to deliver peer support services through several Medicaid funding authorities in the Social Security Act. The following current authorities have been used by States to date:

- Section 1905(a)(13)
- 1915(b) Waiver Authority
- 1915(c) Waiver Authority

### **Delivery of Peer Support Services**

Consistent with all services billed under the Medicaid program, States utilizing peer support services must comply with all Federal Medicaid regulations and policy. In order to be considered for Federal reimbursement, States must identify the Medicaid authority to be used for coverage and payment, describe the service, the provider of the service, and their qualifications in full detail. States must describe utilization review and reimbursement methodologies. Medicaid reimburses for peer support services delivered directly to Medicaid beneficiaries with mental health and/or substance use disorders. Additionally, reimbursement must be based on an identified unit of service and be provided by one peer support provider, based on an approved plan of care. States must provide an assurance that there are mechanisms in place to prevent over-billing for services, such as prior authorization and other utilization management methods.

Peer support providers should be self-identified consumers who are in recovery from mental illness and/or substance use disorders. Supervision and care coordination are core components of peer support services. Additionally, peer support providers must be sufficiently trained to deliver services. The following are the minimum requirements that should be addressed for supervision, care coordination and training when electing to provide peer support services.

#### **1) Supervision**

Supervision must be provided by a competent mental health professional (as defined by the State). The amount, duration and scope of supervision will vary depending on State Practice Acts, the demonstrated competency and experience of the peer support provider, as well as the service mix, and may range from direct oversight to periodic care consultation.

#### **2) Care-Coordination**

As with many Medicaid funded services, peer support services must be coordinated within the context of a comprehensive, individualized plan of care that includes specific individualized goals. States should use a person-centered planning process to help promote participant ownership of the plan of care. Such methods actively engage and empower the participant, and individuals selected by the participant, in leading and directing the design of the service plan and, thereby, ensure that the plan reflects the needs and preferences of the participant in achieving the specific, individualized goals that have measurable results and are specified in the service plan.

**3) Training and Credentialing**

Peer support providers must complete training and certification as defined by the State. Training must provide peer support providers with a basic set of competencies necessary to perform the peer support function. The peer must demonstrate the ability to support the recovery of others from mental illness and/or substance use disorders. Similar to other provider types, ongoing continuing educational requirements for peer support providers must be in place.

Please feel free to contact Gale Arden, Director, Disabled and Elderly Health Programs Group, at 410-786-6810, if you have any questions.

Sincerely,

/s/

Dennis G. Smith  
Director

cc:

CMS Regional Administrators

CMS Associate Regional Administrators  
Division of Medicaid and Children's Health

Martha Roherty  
Director, Health Policy Unit  
American Public Human Services Association

Joy Wilson  
Director, Health Committee  
National Conference of State Legislatures

Matt Salo  
Director of Health Legislation  
National Governors Association

Jacalyn Bryan Carden  
Director of Policy and Programs  
Association of State and Territorial Health Officials

Christie Raniszewski Herrera  
Director, Health and Human Services Task Force  
American Legislative Exchange Council

Debra Miller  
Director for Health Policy  
Council of State Governments

Through a SPA process, DHCS updated the language to provide the flexibility for the County MHPs to employ Peer providers. SPA 10-016 first adds recovery and resiliency language as follows:

SPA #10-016:

- Rehabilitation definition means a recovery or resiliency focused service activity identified to address a mental health need in the client plan. This service activity provides assistance in restoring, improving, and/or preserving a beneficiary's functional, social, communication, or daily living skills to enhance self-sufficiency or self-regulation in multiple life domains relevant to the developmental age and needs of the beneficiary. Rehabilitation also includes support resources, and/or medication education. Rehabilitation may be provided to a beneficiary or a group of beneficiaries.

Furthermore, SPA 10-016 includes "Other Qualified Provider" which means an individual at least 18 years of age with a high school diploma or equivalent degree determined to be qualified to provide the service. We believe that Peer provider falls under this definition. Peer (Other Qualified) providers are authorized in the SPA to provide the following services:

Rehabilitative Mental Health Services include:

1. Mental Health Services (Other Qualified Provider)
2. Medication Support Services
3. Day Treatment Intensive (Other Qualified Provider)
4. Day Rehabilitation (Other Qualified Provider)
5. Crisis Intervention (Other Qualified Provider)
6. Crisis Stabilization
7. Adult Residential (Other Qualified Provider)
8. Crisis Residential (Other Qualified Provider)
9. Psychiatric Health Facility Services (Other Qualified Provider)

We also updated the SPA to reflect Other Qualified Providers may provide TCM under the direction of a Licensed Mental Health Professional as follows:

TCM SPA #10-12B:

- Targeted Case Management services are provided by certified mental health organizations or agencies and by mental health professionals who are credentialed according to state requirements or non-licensed providers who agree to abide by the definitions, rules, and requirements for Targeted Case Management services authorized under state law.
- Targeted Case Management may be provided by or under the direction of a Licensed Mental Health Professional. Other Qualified Providers may provide services under the direction of a Licensed Mental Health Professional.

Please note that the State of California has not yet established a Peer certification process, however that is not under the purview of DHCS.

## PEER CERTIFICATION PROCESS GENERAL BACKGROUND

Over the last ten years, a group of committed individuals began to gather information and support for the peer specialist certification process. They felt that if the training and development of peer certification was consistent in the state that there would be more credibility to the practice, respect for the value of the unique service and augmented sources for reimbursement. They felt a certifying process should be codified in some way that ensured its excellence.

This group researched other state processes and other state laws, looked at the Federal waivers, the current and past state plan amendments, and collected curriculums, career ladders and operational structures. They began to line out how this should be developed in California and, in part, because of a presentation by one of their members to the Advocacy Committee of the California Mental Health Planning Council, (CMHPC), Jane Adcock, Executive Officer of the CMHPC, was directed to map out what it would take to implement the peer certification process in California.

A meeting was held on May 2, 2014. This was called for the gathering of those individuals/groups who are working in the certification process for them to share the work they have completed, what gaps exist and to begin to identify the steps still needed to be completed. This meeting resulted in the decision that the next steps identified should be taken to a larger constituency so that:

- the peer certification process should be recognized in state law to give the certification process force and effect throughout California;
- a program oversight body should be identified to administer funds, issue local level contracts for training programs and administering the certification process, including the examination and curriculum development processes; and
- a secure funding source for contracts and administration could be identified.

## Laura's Law Excerpts

### AB 1421 – Chaptered Language

#### Section 4348 (d) - Reporting

(d) Each county that operates an assisted outpatient treatment program pursuant to this article shall provide data to the State Department of Mental Health and, based on the data, the department shall report to the Legislature on or before May 1 of each year in which the county provides services pursuant to this article. The report shall include, at a minimum, an evaluation of the effectiveness of the strategies employed by each program operated pursuant to this article in reducing homelessness and hospitalization of persons in the program and in reducing involvement with local law enforcement by persons in the program. The evaluation and report shall also include any other measures identified by the department regarding persons in the program and all of the following, based on information that is available:

- (1) The number of persons served by the program and, of those, the number who are able to maintain housing and the number who maintain contact with the treatment system.
- (2) The number of persons in the program with contacts with local law enforcement, and the extent to which local and state incarceration of persons in the program has been reduced or avoided.
- (3) The number of persons in the program participating in employment services programs, including competitive employment.
- (4) The days of hospitalization of persons in the program that have been reduced or avoided.
- (5) Adherence to prescribed treatment by persons in the program.
- (6) Other indicators of successful engagement, if any, by persons in the program.
- (7) Victimization of persons in the program.
- (8) Violent behavior of persons in the program.
- (9) Substance abuse by persons in the program.
- (10) Type, intensity, and frequency of treatment of persons in the program.
- (11) Extent to which enforcement mechanisms are used by the program, when applicable.
- (12) Social functioning of persons in the program.
- (13) Skills in independent living of persons in the program.
- (14) Satisfaction with program services both by those receiving them and by their families, when relevant.

#### **5349.**

This article shall be operative in those counties in which the county board of supervisors, by resolution, authorizes its application and makes a finding that no voluntary mental health program serving adults, and no children's mental health program, may be reduced as a result of the implementation of this article. Compliance with this section shall be monitored by the State Department of Mental Health as part of its review and approval of county Short-Doyle plans.

### **5349.1. TRAINING INFO**

(a) Counties that elect to implement this article, shall, in consultation with the department, client and family advocacy organizations, and other stakeholders, develop a training and education program for purposes of improving the delivery of services to mentally ill individuals who are, or who are at risk of being, involuntarily committed under this part. This training shall be provided to mental health treatment providers contracting with participating counties and to other individuals, including, but not limited to, mental health professionals, law enforcement officials, and certification hearing officers involved in making treatment and involuntary commitment decisions.

(b) The training shall include both of the following:

(1) Information relative to legal requirements for detaining a person for involuntary inpatient and outpatient treatment, including criteria to be considered with respect to determining if a person is considered to be gravely disabled.

(2) Methods for ensuring that decisions regarding involuntary treatment as provided for in this part direct patients toward the most effective treatment. Training shall include an emphasis on each patient's right to provide informed consent to assistance.

### **AB 1569 – extends Laura's Law to 2017 -**

(b) The State Department of Health Care Services shall submit a report and evaluation of all counties implementing any component of this article to the Governor and to the Legislature by July 1, 2015. The evaluation shall include data described in subdivision (d) of Section 5348.

### **SB 585 (Steinberg) – Permits MHSA funds to be used for Laura's Law**

(10) Mental health systems of care shall have measurable goals and be fully accountable by providing measures of client outcomes and cost of services.

(d) Planning for services shall be consistent with the philosophy, principles, and practices of the Recovery Vision for mental health consumers:

(1) To promote concepts key to the recovery for individuals who have mental illness: hope, personal empowerment, respect, social connections, self-responsibility, and self-determination.

(2) To promote consumer-operated services as a way to support recovery.

(3) To reflect the cultural, ethnic, and racial diversity of mental health consumers.

(4) To plan for each consumer's individual needs.

(e) The plan for each county mental health program shall indicate, subject to the availability of funds as determined by Part 4.5 (commencing with Section 5890) of this division, and other funds available for mental health services, adults and seniors with a severe mental illness being served by this program are either receiving services from this program or have a mental illness that is not sufficiently severe to require the level of services required of this program.

(f) Each county plan and annual update pursuant to Section 5847 shall consider ways to provide services similar to those established pursuant to the Mentally Ill Offender Crime Reduction Grant Program

\_\_\_\_\_ INFORMATION

TAB SECTION B

\_\_\_X\_\_\_ ACTION REQUIRED

DATE OF MEETING 10/15/2014

**MATERIAL  
PREPARED BY:** Murphy

**DATE MATERIAL  
PREPARED** 9/16/2014

<b>AGENDA ITEM:</b>	Advocacy Committee Work Plan
<b>ENCLOSURES:</b>	Survey Monkey Questionnaire Results
<b>OTHER MATERIAL RELATED TO ITEM:</b>	See Front of Packet for Charter, Statutes, etc., if needed

**ISSUE:**

The October meeting is the time to review the purpose, accomplishments, and plans for the year ahead. There are several things pending that need to be decided:

1. A new chair/co-chair needs to be elected, and decide on a working model (i.e., co-chair model with one new co-chair cycling in each year or back to chair and vice-chair).
2. Review the current 2<sup>nd</sup> Wednesday of the month phone meeting time and see if a different time would work better for the group.
3. Discuss the results of the Survey Monkey Questionnaire in order to agree on a format for future meetings that works for the majority.
4. Identify a focus issue for the year ahead, and if a work plan product is planned, identify the outcome (product) and the steps/activities needed to complete it.

Of the 10 people who were sent the request to participate in the survey, six responded, so the responses represent a narrow majority of its intended audience. The motivation to distribute the survey was to try to gage the current level of satisfaction and improve the level of participation. The results are attached (Survey Monkey Questionnaire Results).

Overall, it appears that people feel their time is well spent and that they have a good understanding of the topic at hand. They also feel comfortable expressing their opinions. There appears to be no disagreement with formalizing a work plan with an identified product at the end of the year. There was disagreement with the statement that presentations should be limited to one per meeting, but there was also an indication that discussion time might not be sufficient for everyone to feel heard.

With those results in mind, the group will need to debate and decide on a topic or focus for the year ahead, and determine what type of product or outcome would be desirable.

### 1. I feel my time on the Advocacy Committee is well spent.

- Answered: 6
- Skipped: 0

Strongly Disagree –	Disagree –	Neither Disagree Nor Agree –	Agree –	Strongly Agree –	Total –	Average Rating –
0.00%	16.67%	16.67%	50.00%	16.67%	6	3.67
0	1	1	3	1		

### 2. The meeting topics and underlying issues are clear to me.

- Answered: 6
- Skipped: 0

Strongly Disagree –	Disagree –	Neither Disagree Nor Agree –	Agree –	Strongly Agree –	Total –	Average Rating –
0.00%	16.67%	16.67%	50.00%	16.67%	6	3.67
0	1	1	3	1		

### 3. I feel comfortable voicing my opinion on an issue.

- Answered: 6
- Skipped: 0

Strongly Disagree –	Disagree –	Neither Disagree Nor Agree –	Agree –	Strongly Agree –	Total –	Average Rating –
0.00%	16.67%	0.00%	50.00%	33.33%	6	4.0
0	1	0	3	2		

### 4. I would feel comfortable suggesting a topic or issue for a future committee meeting.

- Answered: 5
- Skipped: 1

Strongly Disagree –	Disagree –	Neither Disagree Nor Agree –	Agree –	Strongly Agree –	Total –	Average Rating –
0.00%	0.00%	20.00%	20.00%	60.00%	5	4.40
0	0	1	1	3		

### 5. I think this committee is sufficiently focused and I am clear about our purpose.

- Answered: 6
- Skipped: 0

Strongly Disagree –	Disagree –	Neither Disagree Nor Agree –	Agree –	Strongly Agree –	Total –	Average Rating –
0.00%	16.67%	33.33%	16.67%	33.33%	6	3.67
0	1	2	1	2		

**6. I think this committee would benefit from having an annual work plan as its goal.**

- Answered: 6
- Skipped: 0

Strongly Disagree –	Disagree –	Neither Disagree Nor Agree –	Agree –	Strongly Agree –	Total	Average Rating –
0.00%	0.00%	50.00%	33.33%	16.67%	6	3.67
0	0	3	2	1		

**7. I feel we have enough time to talk during the Committee meeting.**

- Answered: 5
- Skipped: 1

Strongly Disagree –	Disagree –	Neither Disagree Nor Agree –	Agree –	Strongly Agree –	Total	Average Rating –
0.00%	40.00%	20.00%	40.00%	0.00%	5	3.00
0	2	1	2	0		

**8. I think presentations should be limited to one per quarterly meeting so we could talk more,**

- Answered: 6
- Skipped: 0

Strongly Disagree –	Disagree –	Neither Disagree Nor Agree –	Agree –	Strongly Agree –	Total	Average Rating –
0.00%	66.67%	16.67%	0.00%	16.67%	6	2.67
0	4	1	0	1		

**9. My LEAST favorite topic at our Committee meeting so far has been:**

- Answered: 1 - *Housing*
- Skipped: 5

**10: (a) My favorite Committee meeting topic(s): Past Meetings**

- Answered: 2 (*Peer Support*) (*2<sup>nd</sup> Story*)
- Skipped: 4

**10: (b) For future meetings, I would like to explore:**

- Answered: 2 (*strategic reinvestment, outreach*) (*continue with legislative discussions*)
- Skipped: 4

INFORMATION

TAB SECTION C

ACTION REQUIRED

DATE OF MEETING 10/15/14

MATERIAL  
PREPARED BY: Murphy

DATE MATERIAL  
PREPARED 9/18/14

<b>AGENDA ITEM:</b>	Review Legislative Platform
<b>ENCLOSURES:</b>	See page 22 for current Legislative Platform
<b>OTHER MATERIAL RELATED TO ITEM:</b>	

**ISSUE:**

The CMHPC Legislative Platform is to be reviewed and updated annually based on recommendations from the Advocacy Committee.

Changes suggested today will be presented to the entire Council, voted on, and adopted at the January Council meeting.