

CALIFORNIA MENTAL HEALTH PLANNING COUNCIL MEETING MINUTES

January 20-21, 2010

**Bahia Resort Hotel
998 West Mission Bay Drive
San Diego, CA 92109**

CMHPC Members Present:

Dale Mueller, Chair
Beverly Abbott
Renee Becker
Lin Benjamin
John Black
Shebuah Burke
Sophie Cabrera
Adrienne Cedro-Hament
George Frye, Jr.
Luis Garcia
Karen Hart
Patrick Henning
Celeste Hunter

Carmen Lee
Marissa Lee
Barbara Mitchell
Jennie Montoya
Joe Mortz
Jonathan Nibbio
Gail Nickerson, Chair-Elect
John Ryan
Daphne Shaw
Walter Shwe
Stephanie Thal, MFT
Ed Walker, LCSW
Monica Wilson

Staff Present:

Ann Arneill-Py, PhD, Executive Officer
Linda Brophy
Michael Gardner
Karen Hudson

Brian Keefer
Andi Murphy
Narkesia Swangian
Tracy Thompson

Wednesday, January 20, 2010

1. Welcome and Introductions

Chair Mueller called the meeting to order at 1:00 p.m. Planning Council Members and guests in the audience introduced themselves.

2. Performance Indicator Proposal

Dr. Ann Arneill-Py, Planning Council Executive Officer, summarized the Proposal, which was developed as part of a process initiated about a year ago by the Department of Mental Health (DMH) to develop requirements for the annual update and integrated plan for the Mental Health Services Act (MHSA or “the Act”). The goal of this work was to streamline requirements through the use of performance indicators for accountability, as

opposed to having more complex administrative requirements. The Planning Council felt that the indicators should be used in evaluating the MHSA.

Some caveats:

- This is a minimum data set and counties, if they want to, can choose their own indicators over and above these.
- There are always concerns about data quality; however, the use of data promotes improvement in timeliness and reliability and the use and analysis of this data will improve the data quality.
- Data cannot be used independent of its local context – it needs to be analyzed by considering local conditions.
- The type of measurement required is important. Measuring the same individual over time, sometimes called pre- and post-test, is one type. Another type looks at different points in time and tracks the performance of the system overall.
- These indicators do not include any specific standards. We haven't yet generated baseline data so stating levels of achievement is premature at this point.
- Local programs could develop their own standards, if they chose to, once they have some experience with these indicators.

Criteria used:

- Data that is already being collected, and in most cases was being analyzed or reported. Thus, there is no additional administrative burden for the counties.
- Results were tied to existing indicators or statutes, as appropriate (i.e., adult systems, children's systems, the system as a whole).
- Items included in the federal government's efforts, called the National Outcome Measures (NOMs).

The data systems used to extract the data include Client Services and Information Systems (also called an "encounter-level" system). Every time a client uses a service, data is collected (on an annual basis). The Data Collection and Reporting System used for the Full Service Partnerships (FSPs) program, the main data for the MHSA, is also used.

Data forms are completed and sorted by the age of the client -- Children (1-12), Transition Age Youth (TAY) (13-17), Adults (18-59), Older Adults (60+).

Surveys are conducted and consist of several domains, including general satisfaction, perception of functioning, outcome of treatment, etc.

Suicide rates come from the Department of Public Health; out-of-home placements from the Department of Social Services and school achievement information (graduation rates, truancy, feelings of sadness/depression surveys, etc.) from the Department of Education.

The MHSA has seven outcomes that are supposed to be ameliorated; other outcomes are specifically aimed at children and adult groups, respectively.

Concern was taken to ensure that the data collected was not duplicative with sister agencies conducting evaluations.

Indicators and outcomes are generally organized by age of a population, county mental health system performance and communities.

Questions/Answers/Comments with Dr. Arneill-Py

Adrienne Cedro-Hament: What will be the next steps for this Proposal?

Answer: We're going to talk with Dr. Mayberg (DMH Director) and request that DMH produce data on these indicators, and that this be done on a regular basis. Also, we will talk with the Mental Health Services Oversight and Accountability Commission (OAC) about getting the data analyzed and working in collaboration with them.

Adrienne Cedro-Hament: So, once we get the data the committees will be looking at it?

Answer: Yes, although we haven't really talked about that as yet.

Patrick Henning: I didn't see any of the performance indicators for foster-age youth.

Answer: That's included in the TAY data.

Luis Garcia: My impression is that there is currently no data regarding social disparities. I hope we can be consistent and, working with the OAC, obtain disparities data. Also, we know that there are a lot of glitches in the overall DMH data in their existing systems. If there are large gaps in the information collection, how can we follow up?

Additional concerns were expressed about when the Council will be getting this data.

Ed Walker: I'd suggest that the Quality Improvement Committee of the Council take that issue up and work with DMH and engage CMHDA data quality. You can't begin to address the issues adequately if you don't have quality in your data. Keep in mind -- some of the data is good. But let's develop a plan for getting good data entered into the system on a consistent basis.

A motion made by Beverly Abbott and seconded by Joe Mortz: The CMHPC accepts the Performance Indicator Proposal. Further, Planning Council leadership will meet with Dr. Mayberg to develop a plan to ensure that data is obtained for the Performance

Indicators; that discussion would include a timeline for acquiring the data and consideration of contracting out pieces of the data acquisition, given that DMH has some severe staffing constraints; and include the issue of ad hoc requests versus Performance Indicator requests.

*Abstentions: Sophie Cabrera
Shebuah Burke*

Motion Passed

3. Foster Care Legislation

Rebecca Leach, California Youth Connection (CYC) Southern Region Policy Coordinator; and *Nicette Short*, California Alliance of Child and Family Services (Alliance), provided an update on foster care legislation.

Ms. Short, Senior Policy Advocate for Mental Health, noted that the California Alliance is a non-profit organization that represents about 110 organizations that serve children and families throughout the state. They are based in Sacramento. She offered a “snapshot picture” of the current foster care environment:

- About 67,000 children are currently in foster care and about 92% of them are child welfare placements, meaning that they have been removed from their family because of abuse, neglect or some other kind of trauma; the other 8% are probation placements.
- About 35% are in foster homes; 30% are with kin and supported through child welfare dollars; and 10% are in residential care programs (group homes). Several other categories comprise the remaining 25%.
- 45% of the children are Hispanic; 26% African-American; and 24% Caucasian.
- The number of children out of their family homes has dropped dramatically. Although 67,000 is a lot of kids, ten years ago the number was about 110,000. There has been a concerted effort to keep more children at home.

Studies are being conducted as to why there is such a disproportionate number of foster care children from minority families.

She noted that one of the big proposals right now is called Residentially-based Reform Projects. The goal is to get more children that are currently placed in group homes out of those programs as quickly as possible; to assess who goes into those programs better; to provide some up-front intervention so that perhaps they don't have to go into those programs; to get them home faster to their biological families; in essence, to really target the high-end population of young people who need to be home rather than in residential programs.

The Alliance put out legislation to test the possibility of changing the way group homes are funded and some of the regulations around them, and to increase the partnership between county mental health, social services, and the provider. A bill was passed, 1453, that allows for that kind of outcome. Three counties – San Bernardino, Los Angeles, and Sacramento – are moving forward with the testing.

A key component in the testing has proven to be allowing some flexibility in how the funding works, so that more of the funds can be used in pre-discharge planning with the child and the family and then to follow along with the child when they do go back home to their family or foster family to ease that transition and ensure that when the child leaves the group home they are able to stay in their permanent placement. Good outcome data should be available by the end of this year.

Other legislation includes a bill the Alliance co-sponsored with the County Welfare Director's Association and the California Mental Health Directors Association -- SB 785, by Senator Steinberg. The bill was to help foster youth who are placed out of their county of origin. There is now a mandate that the programs use standardized materials and implementation. It has proven to be a rocky road to get all the counties to use the standardized documentation materials. Thus far, we don't see a lot of benefits; we are still working on getting the counties and providers to recognize the importance of this.

SB 1318, enacted a number of years ago, increased the use of intensive treatment for foster care children with high needs. It allows for more intervention and more children can access higher-level mental health treatment. We are hopeful that more children can take advantage of this.

Ms. Leach remarked that CYC was founded 21 years ago by a group of young people who felt their voice was not being heard. It is the only nonprofit organization in California to engage foster youth in the policy making process. It promotes the participation of youth in policy development and legislative change to improve the foster care system, and strives to improve social work practice and child welfare policy. Its staff is 50% comprised of former foster youth. The focus is the belief that young people know what they want to change in the system and they need to have a say in that.

CYC has 30 chapters throughout the state that meet twice a year to discuss and recommend policy changes. This year they are working on a bill called Family Finding, which would mandate that all social workers are trained in the family program. This would allow social workers the ability to find relatives. The idea is to decrease the foster population and also allow permanent connection so that the young person, when emancipated at 18, would at least have access to one caring adult in their life.

The other current legislation sponsored by CYC is AB 12, which is from the federal HR 6893, the Fostering Connections to Success Act. This legislation is extensive and would expand options for foster care youth, including the ability to extend the foster care environment to age 21 instead of the current age 18. CYC is working with the

Alliance and other organizations to make sure that the bill is written properly. **Ms. Short** added that this is an extremely difficult environment for getting any bill that suggests increased funding through the Legislature. We are hopeful that additional federal funding is forthcoming.

CYC also supports/does not support other legislation and will analyze any bills that affect the child welfare system.

CYC youth have organized to accomplish the following Legislative changes:

- Improving foster youth education.
- Reforming non-public schools.
- Extended foster care for youth who haven't graduated.
- Higher education for foster youth.
- Housing for foster youth in higher education.
- Permanency for group home youth.
- Permanency planning involvement for foster youth.
- Foster Care Independence Act – H.R. 3443 (Chaffee).
- Extended Medi-Cal for former foster youth.
- Support for emancipated youth.
- Improving the independent living program.
- Creating housing options for foster youth.
- Post-adoption contact with siblings.
- Maintaining sibling togetherness.
- Driver's licenses applications.
- Foster youth rights.
- State foster care ombudsman.

CYC members also advocate on mental health. A large stigma exists regarding mental health services but this is something that young people believe in and advocate about.

Question: I understand that legislation has passed regarding mental health screening for all children in the child welfare service system. Is it true that only 60% of the kids actually get the screening?

Answer: I'm not sure that it was our organization (CYC) that was involved in that. I don't know the actual numbers but I do know that all youth should have a mental health screening.

Question: I'm concerned about lesbian/ gay/bi-sexual/transgender youth (LGBTQ) and the protection of all youth and their rights to spiritual beliefs and practices. Can you address that?

Answer: There are different viewpoints among foster youth about this. I know there is a large group of LGBTQ youth who would like their own group homes. Another group feels that group homes simply need to have better rules and LGBTQ should not be

segregated from the main population just because they're different. There are also some counties doing a lot of advocacy work to ensure that LGBTQ are treated fairly. It's an ongoing issue.

Ms. Leach noted that, in the children's mental health world, not a lot is changed until a lawsuit is filed. It's very sad and very true. It is the slowest, most awful process ever. It is also a great way to get people's attention and often forces resources into an area that we care about.

One lawsuit, Emily Q, was filed in 1999 by a group of public interest attorneys who banded together and filed suit against the state to bring a Medicaid-billable service, therapeutic behavioral services (TBS), to California. It's a one-on-one intensive service and is a supplemental (meaning it's only for children already receiving another mental health treatment). It specifically targets behaviors that are keeping a child at a lower level care program. It sets goals and outcomes. It is very short-term but has proven very beneficial in getting a lot of kids out of the high-end group care program.

Plaintiffs won the case several years ago but not enough movement was made in increasing TBS in California, so the plaintiffs went back to court a couple of years ago and a special Master was named, whose job was to bring the parties together (DMH, its' providers, its' parents, the Attorney General's Office, etc.). They have been working through the process and talking about how to increase TBS in California. Some administrative barriers that kept counties from moving forward with implementation have been removed, a manual was created to help clarify things, and other measures are being introduced to allow for an increase in service. Ten counties in particular are participating.

The Katie A. lawsuit, filed in 2003 against Los Angeles County specifically and the state, primarily concerns access to wraparound services and increasing the number of kids in therapeutic foster care. LA County settled the suit quickly and began implementing policies and procedures to rectify some of the problems that the lawsuit found.

A speaker from LA County referenced the need for a baseline of services – what are the best modalities for the various groups involved? The Los Angeles County settlement required evidence-based practices, but what are those? “Evidence-based” results by definition come from a particular group, but are those principles and practices replicable?

The group had an extensive discussion on the efficacy of evidence-based practices. What is the evidence behind evidence-based practices? Also, counties need to recognize the need to do a better job internally of jettisoning the things that aren't working and enacting the things that are.

Ms. Short noted that the CYC filed and won a suit against the California State Department of Social Services regarding the amount of services provided to kids living in residential care programs (group homes). Rates to residential care programs have

continually been cut; most recently last year by an additional 10%. A hearing is scheduled for February. The state will be required to give cost-of-living increases of at least 30% more than the current rate. Also, the rate classification system for group homes will be further clarified. The current economic climate is an obvious barrier in this process.

Question: Is there data on the number of foster care youth that are pregnant? What are the legal implications?

Answer: It is a huge problem. When a young person has a child in foster care that child is not a dependent of the court, so it really depends on how the county addresses those issues. Sometimes, because of the barriers the young mothers are faced with, the children do become dependents in the foster care system. There is a big push to find foster homes for those young mothers and their children. Often the young males want to have a relationship with their children and are not legally allowed to do so because they are still minors. There is a lot of work yet to be done in this area.

Question: Is birth control readily available to this group?

Answer: Yes, but part of that is education and foster youth understanding that they have a right to birth control. One problem is resources – if you can't get to the Planned Parenthood in your area, you can't obtain what you need. Another issue is the mental health of the participants.

Question: Do you think it would be a good idea to work with a county or two and some providers to design a PEI project that addresses this issue? It could have preventive properties and health education characteristics and would provide some positive skills – both in understanding one's life circumstances and also in how to form and maintain healthy connections. Also, for those youth who did become parents, it could assist them through what might become a highly traumatic event in their lives.

Answer: Although I am not aware of all the PEI projects that are out there, I haven't heard of that. I think it is a fantastic idea. Perhaps we can meet and put our heads together and come up with a game plan. We will follow up with you on that.

Question: It has been my experience that the courts hold the power regarding sex education. Only a licensed person is allowed to teach sex ed and there are tremendous restrictions by law and license on the discussion of sex.

Answer: I have volunteered to give sex ed talks and I'm not licensed; I am not aware of that restriction. One of the problems is that there are 67,000 youth in care and there aren't enough resources.

Jonathan Nibbio noted that foster care parents are required to have 24 hours of training to be a foster parent. Intensive treatment foster care (the institutional level) requires 60 hours. Some providers have much more training and some counties also require more.

The Planning Council has discussed this issue for a number of years. We are aware that there is a continuous care problem in the state. We also know that with outcomes kids do better – in their own families or in a family versus institutional setting.

We need more resources and support to recruit, train and support foster parents so they are able to better care for their foster children.

All the regulations are there and a number of agencies are available to provide pregnancy counseling, birth control, and etc. It's a matter of "connecting the dots" and ensuring that, if you are a provider, your program plans are comprehensive and include those types of services.

Question: Would it be illegal in a group home to go to family planning, say, on a monthly basis?

Answer: No, it is not illegal. If the child requests it then the provider must do so and provide transportation if needed. The age of consent for requesting family planning information is age 12.

Question: We've been talking about women with children in foster care. There is an organization in Stanislaus County that has a treatment center for drugs and alcohol that is called "Dad's Place." It's an attempt to keep the children with the father. It's important, as we talk about this issue, to include the fathers. If fathers can raise their children in wholesome atmospheres the children may not need to become foster children.

Answer: Yes, absolutely.

4. Perspectives on Foster Care from a School Counselor/Foster Parent

Joe Mortz, Planning Council Member, discussed some of his experiences living on the streets of Hollywood as a teenager, looking for a place to stay. He was institutionalized at Camarillo, where he learned how to manage his thoughts and behaviors and function with appropriate relationships. Now, as an adult, he has dual diagnoses, is a drug addict in recovery, and is gay. Until a few years ago gays were not allowed to openly be in residential services.

Mr. Mortz talked about his experiences in and opinions of the system -- as a child and now as an adoptive foster parent and school counselor. He also provided some statistical data. Highlights include:

- There is no children's DMH system of care statewide and we have no children's statewide DMH funding.
- The rate of physical and emotional deprivation of our youth is severe. Kids deserve a chance. We are the agents of responsibility.
- Although all foster children are required to have a mental health screening, a recent statewide survey found that only 60% of foster children were screened and of those who needed services, only 65% of those received service.
- Parental substance abuse is a factor in an estimated 50-60% of child welfare cases.

- Many of California's foster youth struggle in school – about 75% work below grade level. Former foster youth are less likely to have attained a high school diploma or GED; to have completed a year of college; or to have enough money to pay rent and utilities. They are also more likely to be involved in the criminal justice system.
- African American and Native American youth are 500-600% more likely to be taken into the foster care system than Caucasians. The percentage of Latino youth in the foster care system has increased from 32% in 1998 to 45% in 2008. As of July 2008, children of color comprised about 75% of children in the child welfare system.

He then discussed some perspectives from a parental point of view:

- It is not necessarily Mom's or Dad's fault!
- "System Blame" is evil!
- "System Blame" is counterproductive!
- The parent needs 24/7 competent emotional support, and sometimes a respite.
- Foster grandparents are needed. This system exists but is not well-supported.
- Foster co-parents are also needed (a care team).
- Money is needed; no one wants to ask for it but more is needed.
- Parents and agencies need training. The contract and commitment between them needs to be clear, as do the expectations. Training should be ongoing.
- Parents and agencies should work as a team.

Mr. Mortz shared some of his school counselor perspectives, for example:

- School counselors are educators, not therapists.
- Studies have repeatedly shown that, among adults with mental illness, achieving success with vocational efforts greatly promotes recovery and mental wellness.
- The research shows that day in and day out job success will greatly benefit mental wellness.
- School is the youth's vocation; school is their job.

- Research has shown that students will rise to a teacher’s and/or a parent’s high levels of expectations. Have high expectations and support achievement!
- SED (severely emotional disabled) does not mean dumb. The current system perceives SED as an excuse for low expectations and low investments.
- We can work on mental wellness, substance abuse and education simultaneously; indeed we have to, it is the only route to success.

Questions/Answers and Discussion with Mr. Mortz

Question: When did Carlos (Mr. Mortz’s foster child) discover he liked homosexuals?

Answer: A foster child does not need to have caring and nurturing for the foster parent. The foster parent should have enough love to support and care for the child. It is my responsibility to be unconditionally, totally, and appropriately nurturing and loving.

Question: With so many foster kids dropping out of school, what remedy would you suggest?

Answer: I would like to see DMH, as a matter of policy and practice, be an institutional supporter for every youth and advocates for good educational planning for every youth (my “pipe dream”). We need the institutional authorities to support the educational system. Also, schooling is for a purpose and the law says that K-12 teachers should make their curriculum relevant to the real work. The special education population needs that relevancy but they are frequently isolated from the general population. We need vocational relevance at all levels and DMH can help support that.

A speaker encouraged people to get involved in a Big Brother or similar program, which will hopefully help keep people out of foster care.

5. Presentation: Juvenile Justice System, San Diego

Alfredo Aguirre, LCSW, Deputy Director, Mental Health Services, San Diego County, introduced the presentation. He noted that their discussion will be on juvenile forensics, which generally speaking means services that support the juvenile court.

Counties differ in their support of juveniles. Some offer more institutional-based services, like juvenile hall or the ranch; others are more robust in their community-based level of care, which supports juveniles when they leave the system and prevents them from entering/re-entering. It’s difficult to find a county that does both really well and that has been our focus in San Diego County.

Dr. Philip Hanger and *Michelle Solomon* from San Diego County Behavioral Health Services continued the presentation.

Dr. Hanger noted that their focus is on a continuum of care for the children who are involved in the court system. He described the continuum available on the justice side of the court system.

We have attempted to achieve a process where we first are looking for those kids at risk, catching them as early as we can and working with them, and then caring for them and guiding them back into the community.

We have been working on providing the various elements of the system better management, direction and focus. As we combined our services under the umbrella of “juvenile forensics” the MHSA allowed us to expand.

At the core of our systematic approach of dealing with these kids is our improved, coordinated relationship with our partners. We work with probation, the courts, and child welfare services.

Early intervention and prevention are our efforts to help children avoid a higher level of placement. These children are at risk because of their mental health, their behaviors, or their school difficulties.

We have intensive case management, sometimes called “wraparound” programs, designed to garner resources and gather social networks together in order to keep these children from advancing to a higher level of care.

Probation frequently makes referrals to us, as does child welfare and foster placement.

Crisis Stabilization Services (an MHSA-funded program) provides in-home or mobile services. A mental health team comes into the home to help stabilize the child. Removing a child from the home leads to significant trauma and we work to avoid that.

Emergency Screening Units (an LPS facility) are authorized to do containments, but they are not treating facilities. A child can be detained and a crisis hopefully defused enough so the next step of hospitalization is not needed. About 50% of the time no hospitalization is needed.

A diversion from detention program sometimes occurs when a child is identified by parole/probation as appropriate. This is not a wraparound program; rather it is strengths-based and is designed for kids who are at-risk and “right on the cusp” because of the combination of criminal behaviors and mental health issues.

The siblings of gang members program is also MHSA-funded. It is not a gang prevention program, it is a mental health prevention program. We recognize that this is a high-risk population. Little kids left at home because of a police raid based on gang involvement have been exposed to violence and trauma. They are a significant asterisk

population for mental health difficulties. They have life skills and anger management issues.

Another MHSA-funded program concerns trauma-exposed children in domestic violence settings. Law enforcement identifies the child and a clinical team assesses whether the child should be provided services and where. What can we do to strengthen the 8, 9 and 10 year old? We show them alternatives that help to give them the strength to make more appropriate choices in their lives.

Some children unfortunately do end up in detention. For them we provide an array of services. Children brought to juvenile hall need to maintain their medication. We service about 850 juveniles total at juvenile hall and the ranch and about 15-20% are on medication.

If the child's emotional state escalates to a crisis they are seen by our psychiatry and clinical staff. We recognize if a child does not succeed at the probation level they are not likely to succeed outside the institution. We work on mental health services to help them succeed in their placement.

This is not comfort care; it is also not routine care. All children in the institutional setting are at high risk.

We provide services within the institution and then, when they are ready to go home, we begin the process of working with the family to help the child succeed at home. This starts before the child is released back home. Wraparound services, also MHSA-funded, take our referrals and offer intense case management.

Treatment Evaluation and Resource Management (the TERM Program) is our quality assurance process that allows us to oversee the therapy and evaluations done for the children in containment. It also provides us a screening to ensure a random selection of evaluators for those testifying in court which helps to ensure an unbiased opinion for the judge.

In the community there are the traditional services – clinics, providers, probation, etc. The favored one is the most intensive and expensive, wraparound. Because of the expenses involved, only those most complex in-need children are placed there. Quite often it is the repeat offenders who are referred to wraparound services.

Therapeutic Behavioral Services (TBS) are very effective practices that allow for in-home coaching, modeling and instruction of the caregiver. It has a significant rate of success in terms of changing behaviors.

Multi-systemic therapy is also highly focused and is primarily used for the more aggressive youth; for example, those who are oppositionally defiant. It is for the child with multiple causes for their "acting badly." It changes the system the child lives in. This is also MHSA-funded.

Lastly, a holistic approach, offered through MHSIA Innovations funding, includes physical fitness, relaxation therapy training, spirituality focus, nutrition, social skills, drama, gardening, etc. These will not be traditionally funded. Children who historically feel they do not have any control because of the trauma in their home, any way to regulate their lives, are given these holistic approaches to improve their self-regulation. Our goal is to determine the degree of improvement so these children can learn to modulate their behavior and emotions. Also, does this lead to a decrease in reliance on medication?

About 10 years ago we started to introduce services into schools. Today, we are in over 300 schools. We have significantly increased our outreach to children of color; we see that this is a significant population of former probation and child welfare services. We have found that bringing services to the consumers as opposed to making them come to us and find our clinics and find out when we're open, etc., is very successful.

Our goals in these leaner years of funding are to continue to foster our interagency relationships – our partnerships with schools, consumers, probation and the courts. We are hoping that the momentum is sufficiently developed to continue to use these tools in our county.

Questions/Answers and Discussion

Question: How do you identify the siblings of gang members, etc., and once you know of them, what is the process you use to get them into the services you are providing?

Answer: That is done in partnership with law enforcement and probation. There are also gang suppression units that we train with.

Question: If you have a gang situation and there are parents in the home, what happens if the parents don't agree with your assessment of the child's trauma?

Answer: The harsh answer is that there might be a child endangerment issue and the parents might be in danger of losing the child; the soft answer is that it's part of our education process with them.

Question: San Diego has come a long way from where it was.

Answer: Yes. We had to learn to do things that were realistic and do them incrementally. We had to recognize that we were working with a conservative county set-up and adjust accordingly.

Question: Of your 850-person population base, what is the grouping and how young is the youngest kid that you see?

Answer: We see kids as young as 0-5 years old; that is the earliest category. In the justice system the vast majority are the late adolescent age range, of course.

Question: How much parental involvement do you bring in to the picture?

Answer: For the younger population it is heavy parental involvement. For the older kids it is more of a challenge. We are not taking these kids back into idyllic environments; often the parents need substance abuse and mental health treatment as well. The emphasis is recognizing that and starting to work with the parents while the child is still in detention. It is however, a voluntary parental involvement, and part of our job is to get the parent to recognize that they need to make changes to be able to help their child.

Question: Talking about wraparound services and the continuum of care, those are very important services. One thing that troubles me is that, as we talked about providing these services, you were also talking about a majority of them being contracted out. It seems to me that these are services the counties would want to be able to provide.

Answer: The contractors are monitored by the county. We don't staff them. The funding sources, MHSA and otherwise, come through county mental health and our county Board of Supervisors has identified that working through contractors allows us to get the best "bang for our buck." But that doesn't remove our responsibility; it is still county mental health who are supervising them and are responsible for any failures, difficulties or complaints. We have established a good working relationship with our stakeholder provider community and we have a number of providers that have shown a track record of success.

Question: We are trying to figure out strategies to ensure that parents are included in the juvenile process. Is there education county-wide so parents know there is this process and do parents have the opportunity to share their perspective in the so-called 241 process?

Answer: That's a challenge, of course, getting the families involved and keeping them involved. It is difficult to educate; our courts strive to do that as do we. Sometimes it is left up to the attorney representing the family to provide the appropriate information to the families. We cannot take sides in the matter, so we can't give undue information either. But we can assist them in terms of helping them discover where they can get additional relevant information.

Question: I'm really glad this process is in place. You mentioned the TAY center – is it working, and what are its hours?

Answer: It's actually a combination of the clubhouse model and a partnership with the wraparound, which is 24/7. The center is open 7 days a week – I'll have to double-check specific hours and get back to you.

Question: Regarding stigma – what does the county have in place to cope with stigma, particularly the stigma associated with detention?

Answer: All of our efforts really are targeting stigma reduction, including early intervention, where we educate the family about things they can do before the child fails in school, gets arrested, and gets sent to detention. We're not talking about families engaging in the idea that their child has a mental illness that requires chronic treatment, but there might be behavioral issues that contribute to their school failure and there are interventions that can be done for that child who has been exposed to trauma or gang violence or who went to detention and is now coming back home.

The education in a sense is that it's necessary, not just okay, for that child to improve on that aspect of their life; i.e., the child's emotional, spiritual, logical, social aspect of their lives. Earlier is better and there is a need for them to give attention to this. The families and the kids need to know that they have options.

6. Report from the Mental Health Services Oversight and Accountability Commission (OAC)

Patrick Henning provided the report:

- The OAC has gone through a search for a new Executive Director and have decided that none is better than Beverly Whitcomb, our interim Director. Unfortunately, she has decided that she likes the position she is in. So we are going back out to recruitment. The final filing date is the 5th of next month. I cannot tell you how important it is for us to achieve stability with our Executive Director and staff. We are envious that the Planning Council has achieved this.
- In our upcoming meeting we will be looking at the Prevention and Early Intervention (PEI) Guidelines. A plan has been devised to use a statewide Joint Powers Authority. We will also be adopting our Work Plan for the Commission.

7. Adjournment

Chair Mueller adjourned the meeting at 5:30 p.m.

Thursday, January 21, 2010

1. Welcome and Introductions

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

Ed Walker stated that he is now the interim Behavioral Health Director for Butte County. He wrote a letter to his county Board of Supervisors asking that they initiate recruitment for a permanent director. He asked the Council for their assistance in promoting and highlighting the extraordinarily positive features of Butte County, which has a capable and stable management team in place. Please spread the word to prospective applicants.

Election of Chair-Elect

Stephanie Thal, chair of the Nominating Committee, announced that they had nominated Luis Garcia as the next Chair-Elect and he has accepted the nomination.

A motion made by Gail Nickerson and seconded by George Fry: The CMHPC accept the nomination of Luis Garcia as the next Chair-Elect.

Abstentions: None

Motion Passed

Mr. Garcia stated that he is truly honored to acceptance the position of Chair-Elect. He noted that he and the Council have the same goal and objective – to improve all the human beings in the mental health system.

2. Committee Action Items

Children and Youth Subcommittee. No action items.

Transition Age Youth. No action items.

Adult Subcommittee. No action items.

Older Adult Subcommittee. *Stephanie Thal* reported one action item. The Subcommittee became aware, through Rachel Guerrero, that five contracts had been awarded by DMH for reducing disparities -- for Asian and Pacific Islanders; for Latinos; for African-Americans; for Lesbian/Gay/Bi-sexual/Transgender; and for Native American. There will be work groups involved and the Subcommittee wants to write a letter to the five work groups to make sure they focus on issues of older adults as well. Their motion reads as follows:

“Write a letter to the five contractors for the Reducing Disparities Project, communicating the need for them to identify the unique needs of racial, ethnic, and culturally diverse older adults. The California Mental Health Planning Council would like to review the findings prior to plan development and also to review the Strategic Plan.”

A motion made by Stephanie Thal and seconded by George Fry: The CMHPC unanimously approved the motion to send the letter to the five working groups. A friendly amendment was suggested as an addition to the approved Motion -- that the new Transition-Age Youth (TAY) Committee be included in the letter sent to the work groups. After further discussion, the Council unanimously supported the addition of the TAY Committee.

Cultural Competence Committee. *Ms. Cedro-Hament* stated that there are no action items, but they would like to highlight two requests:

1. That the staff makes it a routine thing that the cultural competence guidelines be given to presenters whenever they are invited.

2. As of last year, the Committee has begun focusing on disparities, how we look at and address disparities. We know that data is problematic. We suggest that the different committees also look at the different disparities, which is a cross-cutting issue. In this way we can hopefully pinpoint the problem more appropriately.

Mr. Walker stated that it would be a good idea for the Council to consider modifying its cross-cutting issues matrices to focus in on disparities as the organizing principle of cultural competencies. *Mr. Garcia* added that disparities might be a good way to establish a baseline for comparison of issues.

Dr. Arneill-Py remarked that at the next meetings of the committees they should review their matrix, as one of their agenda items, to make sure they have reducing disparities as a cross-cutting issue.

Lin Benjamin commented that the Reducing Disparities Project provides the Planning Council the opportunity to collaborate with that project and to promote a dialogue. Perhaps the full Council can make that connection and consider having the Project work group contractors come before the Council and elaborate on what they are trying to achieve and we can discuss how we might work together. I think our goals are similar.

Policy and System Development Committee. No action items.

Human Resources Committee. No action items.

Quality improvement Committee. *Gail Nickerson* reported that there are no action items but they are working on a peer review for the block grant and it will involve members of their committee but they will be coming out to the larger Council also. Each team will do three reviews per year; and the team will consist of a consumer, a family member, a provider, someone from another county (a peer), and a staff member. The five members will go to the county and look at the SAMHSA-funded programs in that county. If other Council members have an interest in being a part of the peer review team, please let her know.

3. Approval of the October 2009 Meeting Minutes

Beverly Abbott remarked that on page 13, halfway down, in her comments, it currently says “the Planning Council has previously heard testimony about concerns that evidence-based practices are sometimes too right;” it should say “tight.”

Andi Murphy, speaking on behalf of *Barbara Mitchell*, noted that on page 4, where there is a mention of health insurance that is attributed to Barbara Marquez; it should be attributed to Barbara Mitchell.

Motion: The Minutes of the October 2009 Meeting were approved, as amended above.

Amendments: None

Motion passed

4. Approval of the Executive Committee Report

Dr. Arneill-Py stated that the Planning Council will be sending a letter to the Governor and the Legislative leaders on the Governor's budget that just came out. The letter will include:

- Opposition to the diversion of Prop. 63 funds and requests that the General Fund be used to make whole the managed care appropriation and the EPSDT allocation;
- A request that the state meet its' full obligation to fund the AB 3632 state mandate and that DMH fund IHSS fully and not reduce adult day health care, not only because of the effect on the clients but also because it results in increased Medicaid costs from the increased institutionalization of those clients;
- Support of the efforts of the administration to capture additional revenue and talk about the need for additional revenue to prevent the proposed draconian cuts to the safety net that will be triggered if federal money is not in place;
- Recommendation of additional revenue sources, to include a tax on alcohol that would be leveled at the median rate used by other states and to recommend an oil extraction fee;

The Executive Committee also took the following actions:

- Approval of the legislative platform for 2010;
- Approval of the 2011 Planning Council meeting dates;
- Approved the California Network of Mental Health Clients request that the Council enter into a contract with them to allow them more involvement in Planning Council activities; and that the offer of that contract would also be extended to NAMI and UACF.

A motion made by Edward Walker and seconded by Karen Hart: The Executive Committee Report, including the letter to the Governor and the legislative leaders referenced above, was unanimously approved.

Abstentions: None

Motion Passed

5. Report from the California Association of Local Mental Health Boards and Commissions (CALM Board)

James L. McGhee, CALM Board President, reported that the CALM Board is looking at holding four regional sessions that will be heavily involved in promoting the Board.

During the past year the infrastructure and systems were put in place and we look forward to moving forward in a positive way.

He stated that he was recently re-elected as Board President. Unfortunately, since June the Board has not been working effectively. Some of the members now feel that all the officers should be removed and the direction of the Board changed, and he has decided that he will no longer involve himself with the Board.

Beverly Abbott asked if the regional meetings are devoted primarily to training or to something else? Secondly, are the disputes primarily over policy or are they personality disputes? *Mr. McGhee* responded that the meetings are primarily for training. Regarding their disputes, it seems that personal agendas are in play and he has suffered through attacks on his personal reputation.

Council members expressed their appreciation for Mr. McGhee and thanked him for his efforts.

6. Report from the California Mental Health Directors Association (CMHDA)

Mr. Ed Walker provided a brief update from CMHDA:

Claims payments are now caught up. Of course, with the new Short Doyle accounting system taking over, there will be some inefficiencies as the changeover in systems occurs. We will be back in delay again, which will create extraordinary cash flow problems for some counties.

The state General Fund dollars for managed care will be paid by the end of this week or next week. The extent of cash flow problems within county behavioral health programs affects the entire county; it is the reason other departments continue to meet to try and figure out any way to resolve this immediate concern. The ongoing cash flow problems may make some counties unable to transition from one fiscal year to the next. The degree of uncertainty has never been higher regarding stable funding and sound fiscal management. These are difficult times.

On the Medi-Cal/Medicare concurrent eligibility – for those eligible for both programs there are federal rules regarding who shall be billed first. Historically, Medicare is billed first. Then, if that is denied, you then bill Medi-Cal. The federal Center for Medicare & Medicaid Services (CMS) has instructed counties that they must continue to have documented denials from Medicare in order to receive Medi-Cal claims, which for various reasons is an impossible requirement to comply with except in the simplest cases. Instead of a “denial” it is termed a “rejection.” Thus, a Catch-22 situation has been created which requires an adjustment in interpretation. It is hoped that any delay in payment will not go beyond March/April.

7. Public Comment

- *Stacie Hiramoto*, REMHDCO, noted that Dr. Arneill-Py participates in the government and community partners forum, a place where dialogue occurs between advocates and people from the government entities who are working on the MHSA. She thanked Dr. Arneill-Py and the Council for their willingness to dialogue and for their participation.

A retreat was recently held and she wanted the Council to know that many people in the community look at the Council as very supportive of stakeholders and dialogue.

Also, Judi Chamberlain, a pioneer in the consumer movement, recently passed away. NPR did a nice piece on her.

- *Theresa Bish*, Chair of the San Diego Mental Health Advisory Board for 2010, welcomed the Council to San Diego. Since her first introduction to mental health services, dating back to 1980 as a family member, she has experienced numerous budget cuts and their impacts. What is different today is that in their county they have the apt involvement of the necessary stakeholders, who come together and apply their collective thinking and intent to not only weather this crisis but to capitalize on this opportunity to be creative in replicating successful models and vetted solutions.

Already San Diego County is putting forward the best practices and principles spelled out in the MHSA to incorporate the consumer as a partner. Numerous entities are training and hiring consumers to carry out the new employment opportunities created by MHSA. We have had, as far away as New Zealand, interest in the model as created by Recovery Innovations for consumer training and recovery. Again, underscoring this county's availability to integrate the consumer into its service corps of providers and to have it be a replicable model here and abroad.

The family youth roundtable is another innovator for consumers assisting other consumers and having a model that can be deployed many times over and in any location. Twenty-four hour consumer mandate 800 numbers and surveying of consumers are precursors for a customer service model.

Additionally, San Diego has UCSD as a community partner. UCSD's reputation as one of the country's foremost research institutions allows our mental health services to draw upon and participate in the vanguard of contemporary science. Research into PTSD, as experienced by our veterans, is a national project being led here at UCSD. Other research is being done in our county by other institutions, such as Sharp Mesa Vista, led by Dr. Plopper; and there are numerous others.

Mental Health of America has initiated a program to educate our returning veterans on how to access county services when needed. Another new collaboration has just started between the county and VA on disability rights in California regarding those impacted by traumatic brain disorder. And Cisco has just announced it's collaborating with two of our community health clinics on a tele-psychiatry pilot.

All of this and more makes San Diego County an ideal pilot community for new consumer services models that mitigate the financial crisis. Although our county is large, our community of stakeholders is still highly tactical and highly engaged. Our Board of Supervisors and administrators are motivated and the mental health board is supportive of methodologies that allow consumers to obtain support, treatment and customer satisfaction and that involve other consumers in the system of care.

A roundtable is being fashioned out of a community's collective need to do more with less, and we are doing it in a multitude of languages. This makes San Diego County a premier partner to those seeking collaboration on creating the new paradigms in mental health delivery.

- *Vernon Montoya*, California Network of Mental Health Clients, thanked the Council for honoring their participation in dialogue with the Planning Council. As a former member of the Planning Council, I want you to know that we look forward to working with you in many ways and dialogues. One good example is that the California Network was asked to participate in the crisis residential program.

I am the chair of the Public Policy Committee of the Network and it's my obligation to look at all the documents that pertain to the concerns of the consumers of California. I look at thousands of documents and peruse three websites daily, listening to consumers. What I used to do first-hand in San Diego I now do on a greater level.

When the Network sat down to work with the Council we looked at it from the standpoint of client-run services. The Network feels there is still a need to take a look at the use of client-run programs in the state that already utilize what we consider to be respite care. Respite care is similar and very close to the edge of coming over and becoming a crisis residential program.

There are a lot of pitfalls involved about how to do that, and we understand that; the consumers also understand that wholeheartedly. At the same time, in the spirit of what was in the MHSA, under "client-driven," one of the portions calls for client-run programs. It also calls for volunteers and community self-help. These obligations still need to be met under the MHSA.

We have already met the peer support and the wellness recovery, and now we need to go to the next level. I call on the Council to support the use of client-run programs, to take a look at the process of respite care, which goes on throughout the United States by other organizations, like Stepping Stone, and I thank you for welcoming me to dialogue with you.

- *George Fry:* As we begin a new decade, I know that I am preaching to the choir when I note that the Council and community people here support human beings. With your third ear I ask you to listen carefully to what I have to share with you.

We are all family, each and every one of us. I have talked about family for 10 years on the Council. Today I want to talk about the importance of terminology. I want you to start using the words “human being,” not “*consumer*,” not “*client*,” not “*patient*,” but human beings. We are all human beings; we are all challenged in our intellectual capabilities to one degree or another.

I want you to start using the words “behavioral health,” not “*mental health*.” I want you to use the words “behavioral health director,” not “*mental health director*.” I want you to start using the words “behavioral health employees,” not “*mental health employees*.” And as I said, we are all challenged in our intellectual capabilities, some to a lesser and some to a more complex degree.

Unless we begin using 21st Century vocabulary we will waste our time and energy on stigma reduction. We’re going to make this change together, all of us in the room. We’re going to touch somebody else outside this room and they’re going to touch somebody and they’re going to use all this terminology. The time to be proactive as opposed to inactive is now. When we do this, Carmen Lee will see a tremendous change in stigma reduction. The commitment is now.

Last October, in Folsom, I told you about bringing the National Empowerment Center’s Alternatives Conference to Angels Camp. Here is a quick review of what transpired. We were down to one of three being selected and then one of two – Angels Camp and Anaheim, California. I went to the national conference in Omaha, Nebraska and spent \$4,150 out of my own pocket to put together this conference – to have rates for clients of \$65 nightly including taxes, as opposed to the \$157 nightly we spent in Omaha. I put together a tri-fold brochure, a DVD, made the presentation and, because I was running for City Council, I was politically sabotaged with this conference, which would have brought \$600,000-\$1.2 million to Angels Camp coffers.

I spoke to 650 participants at the conference in Omaha and they gave me a standing ovation and they were excited. The person who made the selection said “we are appreciative that your Board of Supervisors in Calaveras County supported you 100 percent, with a resolution and a letter. But we don’t understand why the mayor of Angels Camp and the city council did not step up to the plate.” And I believe that they did not step up to the plate because they have

their own hidden agenda. They treated me disrespectfully. A person on the selection committee came to me and said “if the mayor had written the letter that he had promised you he would write, and if the city council had supported you with a resolution, you would have had the conference.” The clients were furious.

If I had to do it all over again, I would spend the \$4,150 to do it again, but as my psychiatrist also said to me on the day after the election, “George, you are the captain of your ship. The problem is that the waters in Angels Camp are too shallow for you to maneuver your ship.” Thank you.

- *Ginnie Gomez*, Santa Cruz County Mental Health Board, stated that she is a Mom trying to figure out what the best choices are. In her county a lot of people are committing suicide from the medications. She was caught off-guard when one of her friends said “I want you to come to my friend’s son’s memorial,” because he had committed suicide.

When I went there I looked around, and all the people who had force-medicated my son were behind me. I was really upset to see these people at a time of transformation. I really want to see this system transformed.

I met a lot of people in alternative health care. I went to Sacramento and heard Joan Matthews Larson, who wrote the books Depression Free Naturally and Seven Weeks To Sobriety. Her son had been misdiagnosed and committed suicide. When I got there I saw a lot of people who do alternative treatment. My county wouldn’t even send me, they said “what’s that got to do with Prop. 63?”

I would like to forward you the information I learned there. I met people from Alternatives to Meds in San Francisco, started by a chiropractor who had a breakdown and saw how difficult it was. He opened Alternatives to Meds, and all the people he worked with started working with him at Alternative to Meds so they could work with people with the least amount of medication possible so they could function.

I had the opportunity to work with the CALMHB/C. When I went to the meetings the counties would say “we don’t have enough money” but then they said that when they really looked closely at what they were spending their money on, they do have the money to do the things they need to do.

And I see that we all have to start working together, we’ve got to get working together quickly. Too many people are dying and it’s time to push ahead. This is a golden opportunity and I want to move ahead as quickly as possible.

8. Transitional Housing Placement Program (THPP) and Transitional Housing Program for Emancipated Foster/Probation Youth (THP-Plus)

Nicette Short provided the introduction. She stated that the California Alliance has been very engaged with THPP since its inception several years ago. They helped craft the regulations with DSS. There is a committee within their organization where providers of transitional housing services can get together and provide technical assistance to each other. They also do advocacy at the department level on regulations and to secure better funding.

The Alliance just embarked on a project to create a best practices document. Everyone was brought together over the course of several months to create what we think is a fantastic manual that holds folks to a higher standard than what the minimum of licensing requires.

She introduced *Antoinette Harris*, who runs the EMQ Families First Housing Program; and *Jon Nibbio*, a Councilmember who is also with Family Care Network. They discussed their respective programs.

Jon Nibbio began by noting that a lot of children in the foster care system have traditionally ended up homeless and often incarcerated. People were saying “why is that?” and “what can we do about it? Certainly part of it is that many people, regardless of environment, are not ready to be out on their own at age 18. It makes sense that our foster kids would need help like all kids in this age group.

Transitional housing has been a real need for this population. In San Luis Obispo we’ve been doing transitional housing since 1999 and have served about 272 kids.

One of the biggest challenges to the program when it began was that referrals were slow. When we examined this, we discovered that referring workers were very nervous about referring kids. They were frightened about putting their foster care kids into a different, transitional housing environment. But the alternative, which is basically putting them out on the street when they turn 18, needs to be considered and factored in when deciding to refer someone.

THPP eligibility criteria is youth between 16-18 who are currently in the foster care system, or up to age 19 if they are currently working towards their high school diploma. They also need to be enrolled in the Independent Living Program (ILP) and at least working on obtaining part-time employment.

THP-Plus criteria are youth ages 18-24, but they had to be in a foster care program sometime between the age of 16-18 and their case must be dismissed from the court. Participation in the program cannot exceed a two year period.

The goal is to help them as much as we can to become self-reliant and community involved versus agency- and system-dependent.

In San Luis Obispo we have adopted all the wraparound services into all of our service delivery, including transitional housing. We don’t call it a “case plan” or a

“treatment plan;” we call it a life plan. It’s a team. The youth picks who they would like to be on their support team and a strengths-based, needs-driven, youth-involved plan is developed.

We also help develop the leadership skills of the youth and work hard to integrate their mental health services into the plan, including their medication needs. As many of you know, what the youth want is not another session with their doctor what they really want is help on how to get a job and how to obtain life skills.

Getting the community to transform enough to sustain a referral program is a must. We are also Medi-Cal provider. We have a very smart CPA that helps us with our finances. We rent apartments throughout the county. We also have a host family model, which is not a foster parent but could be a former foster parent. Host families essentially rent a room to the youth.

From time to time we’ve had kids that weren’t ready for this because of substance abuse or other issues and we’ve partnered with law enforcement to help us in some of those circumstances. However, if they’re not in our program, where will they be?

It’s really a rewarding program. Seeing a transition youth succeed, especially given all the challenges they’ve had in their life, is very satisfying.

Antoinette Harris, from EMQ Families First in Contra Costa County, stated that just about everything that Mr. Nibbio mentioned occurs in her facilities also.

Their structure is called a Scattered Site Model. They currently have four apartments in two different locations. They work closely with landlords and property managers, which is critical for them. Staff go to the apartments for scheduled and unscheduled visits. The advocacy piece is not only to have the management agree to allow them to master lease the apartment but also being able to troubleshoot, because naturally when trouble occurs at the apartments it is blamed on the teenage tenants.

Kids walk away from the program having learned more about themselves. They’ve learned conflict resolution, how to self-regulate in multiple areas, how to manage a household, how to manage a budget, etc. We give them a \$900 stipend, out of which they are to pay their share of rent and utilities. If they want cable or Internet access they have to figure out how to make that happen. They buy their own groceries, toiletries, clothing, etc. so they learn a lot about money management and prioritization.

Transitional housing is not for every youth. We are licensed for 12 and currently have six in our apartments. We are in the process of interviewing three more.

One challenging element is that some of the youths have grown comfortable in foster care. They are used to the idea that someone will provide their meals and make sure their room is clean and they are not into “you need to do that on your own.” Also,

they have to make a commitment to go to school and to work and they have to be committed to their life plan. If not, they aren't going to make it.

Of course we are willing to take a risk with some of the kids. We have adapted the wraparound principles. We have house meetings with the roommates to discuss any incidents that may occur. If law enforcement is involved we allow them to deal with the consequences of law enforcement. We let them know that there are instances that they will have to work their way through. If we keep rescuing them from dealing with the consequences they will never learn. We do have a "no fail" policy.

Over 200 youth have participated and about half of them have gone on to be successful; i.e., in employment and housing.

Mr. Nibbio mentioned that they develop a savings account when they work. There is a way to match what they save. The whole idea is that when they've finished the program they will have enough saved up to be able to make a down payment.

In our high-rent area a reality is that a lot of people, including our staff, rent rooms and share apartments and housing, so sometimes that is their exit plan. We've also worked out with local business folks that, for much of the furnishings obtained through the program, they will be able to take some of that with them when they leave.

Ms. Harris discussed the after-care program. They are not eligible for food stamps, so everything they need has to come out of their \$900 stipend plus whatever they earn. Unfortunately, a lot of the youth are not able to obtain a job. All of our youth were employed throughout the summer and we currently have five of six employed, with the six completing an apprentice.

We don't have a lot of money to set up a house. It has to be fully furnished. We partner with various faith-based community members and small businesses and generous individuals who are willing to assist our youth. For example, in December one of the Marriott's in our area was donating all the old furniture in 12 stories of rooms in one of their hotels and we were able to have access to five rooms at one point and six rooms at another, much more than we needed. So we were in contact with several youth already graduated from the program who needed furniture and we were able to give them beds, dressers, TV's, etc.

One teen mom, Lorenda, told us that she wanted to learn how to be a Mom and become an effective parent, without having people parent her child for her. When she started in the program her son was about one year old. She was accepted into the program and had to adapt to a brand new school, she had to find child care, and she settled on a Headstart program that took her son during the day.

Lorenda did well at first but unfortunately she was attacked when she went on a visit to her old neighborhood. She called us and asked for help. She said no to

counseling, to calling the police, etc. She continued to do well with her life skills but would not deal with the aftermath of her attack.

Eventually, it occurred to her that she needed to deal with the trauma that had happened in her life. She realized that she had learned many of her past behaviors from her Mom, who was in prison. She sent a long letter to her Mom, explaining the life skills she had acquired and where her life was now. She said “I’m going to be the best Mom, because I now have a model of how you do it. I’ve figured out what it means to balance a checkbook, how to make a bed, and what to do if something happens to me. I have the right to advocate for my son and for myself and I never would have learned this if I had not been in a transitional housing situation.”

Of course, some kids don’t make it through the program. But think about what it was like for you when you were between the ages of 16-19 and what was happening in your life.

Mr. Nibbio discussed issues of culture. He stated that they do provide training on various cultures, but they quickly learned that training is not enough. So they spend a lot of time talking with their staff, discussing who they are and how they deal with the world. But there is a big gap between that and how that gets modified and transitioned to assisting the foster kids. A lot of their stuff is now included in their program and they actively look for opportunities to incorporate culture into an individual life plan.

We also changed all of our employee evaluations to include an area related to culture. Are the staff integrating their unique client culture into that plan? In addition, this environment requires a lot of staff involvement around the clock. And if staff is having a hard time dealing with a client’s particular culture they are able to talk about that with their supervisor and get some ideas and some support. If necessary, we will find another worker to deal with a particularly troubling aspect.

Ms. Harris added that they have a similar cultural competency model that is incorporated into their program, including into their employee evaluations. We need to cover everything, from religious identify to sexual preferences.

Employment, housing and additional mental health services are difficult to find. We are constantly working to partner with former teachers, friends, co-workers, etc. who help us. It’s very difficult to make that transition from the children’s mental health system to try to enter the adult mental health system and we try to start that process 6-9 months before the actual transition takes place.

Questions/Answers and Discussion

Joe Mortz: Do you have any statewide data on youth in transitional housing, broken down by race and ethnicity? Or where any could be found?

Answer: *Ms. Harris* replied that the California Department of Social Services lists every single county and county contact and they submit reports – outcome measures – on what

happens in their programs, including development of independent living skills. Also, the Center for Social Service Research, which is on the UC Berkeley website, has data on transitional housing placement. (The information will be put together and sent out by *Mr. Nibbio*).

Joe Mortz: I'm wondering if you could identify some action items for the Council?

Answer: *Mr. Nibbio* responded that one thing to do is keep an eye on the dollars. A letter went out recently that talked about a substantial reduction in funds for the THPP program. We need to keep an eye on that and advocate for it. We all know that, from a cost-benefit analysis, this is going to save money. *Ms. Harris* echoed those comments. She added that one of the things that always seems to come up, from the mental health perspective, is to be understood as a youth. Sometimes that may sound like a given, but it's not always a given. Just to be understood; i.e., that the youth understands that others know that the youth have their own realities and need to be heard and understood without the adult overlay.

Renee Becker: Do you get calls from other counties who want to model your success? Also, how much responsibility does the owner of a home renting out to a transitional foster youth have, and is that extremely challenging?

Answer: *Ms. Harris* responded that she is in Contra Costa County, and they have received those calls from all of their neighboring counties. Also, they get inquiries that they often direct back to their local child welfare department, because this needs to be licensed through them. *Mr. Nibbio* stated that they also get a lot of calls and people will come and visit. The Alliance is also very active and helpful with that.

In terms of the last question, the Burton Foundation was very clever in the wording in their program. One requirement is that if someone wants to rent a room to a transitional youth, their county must have an in-place transitional housing program. We actively recruit for families and yes, there are rules and regulations, but it's not like under the microscope 24/7 because these people are no longer children that require around the clock care. So the scrutiny is not as significant as what you see in foster care but it is there.

9. Report from the Department of Mental Health

Councilmember *Sophia Cabrera* provided the update:

DMH has been working on getting the fiscal year 2010/11 guidelines out. They have been posted; it's Information Notice 10-01. These incorporate the provisions of AB X35, which gave the OAC permission and approval authority on PEI and Innovation. This one plan submission incorporates the requirement of the OAC on PEI and Innovation and the requirements of DMH on CSS housing, CAT Facilities, Technology, and WET – one submission for all the plan updates. Hopefully that will make it easier for counties.

Some of the biggest changes in these updates – AB X35 also implemented the pre-approved plan, so DMH will be able to get those plans approved and get money out to the counties more quickly. DMH is now down to about 45 days to get the approved plans out to the counties and plan payments made.

DMH is triggering the Prudent Reserve and included in the guidelines are the procedures for counties to access their Prudent Reserve.

The FY 10/11 guideline planning estimates came out in December, it's Information Notice 09-20. So counties have had their fiscal information available for about a month and many of them, since they now know how much money they have going forward, have begun their planning process.

On FY 09/10 plans, we have three counties yet to submit those plans. DMH has contacted those counties and is working with them to make sure they get their updates in so we can get their money out before the close of this Fiscal Year.

On the Medi-Cal side, the biggest project for the past couple of years has been the new Short Doyle Accounting System. It went live on 12-31-09. We are converting all the Phase One data and all counties are now in Phase Two. We will be fully implemented in Short Doyle Phase Two by March 1, 2010.

Some personnel changes – Denise Arend who was the Deputy Director of Community Services, left the Department. Mark Heilman, the Assistant Deputy Director, is now the Acting Deputy Director for Community Services. Sean Tracy, who was the Strategic Planning Officer, has taken the Assistant Deputy Director position. The Department has also picked up Gaing Nguyen, RN, MSN, who was the Mental Health Director in Fresno County. She is now working in the Director's Office as an advisor.

The Governor's budget states the intent to take the unexpended dollars currently in the MHSA fund and use those to replace the state General Fund EPSD and Managed Care allocations, which is about \$850 million.

The Traumatic Brain Injury Program is being transferred to the Department of Rehabilitation.

Questions/Answers and Discussion

Adrienne Cedro-Hament: Ms. Guerrero has told us that the cultural competency plan update guidelines are coming and my question is do you know if they've actually come?

Answer: I'm not aware of anything going out to the counties but I can check and get back to you.

Joe Mortz: What's the current status of furloughs?

Answer: The furloughs are in effect until June 2010. The Governor has said he intends to end the furloughs then but that that is contingent on cuts in the Governor's next budget.

John Ryan: The Governor's proposed budget, in terms of the \$850 million to be taken from the MHSA. Is that one time or permanent?

Answer: My understanding is that there is about \$1 billion in unrequested MHSA and the \$850 million would tap into that one time. But the only way that works is with the passage of an initiative that repeals the supplantation provisions. Once that is repealed then it would be every year that it is available.

John Ryan: Does the Governor have the ability to put on a ballot initiative in June by himself or does he need legislative support or does he need to go out and collect signatures or --?

Answer: He can do it on his own. Any Governor can place initiatives on the ballot.

10. New Business

John Ryan commented that everyone knows what is going on in Haiti. He suggested that for the next meeting we ask DMH to come and present to us an update on where mental health is at in preparation for a major earthquake in California. Are there MOU's between counties? Have liabilities been worked out? All the experts are predicting that an earthquake is going to happen here. *Ed Walker* responded that he will take that inquiry to the Governing Board.

Adrienne Cedro-Hament stated that this is the second year they have been in this Bahia Hotel-Resort and the venue is very good. In terms of cultural competency, the venue does not meet that requirement, because of the lack of public transportation to and from the hotel. However, she didn't observe a big difference in the participation in our meetings here. Also, there is a closeness here that allows us to network closely and I'd like to see the Planning Council here next year.

George Fry remarked that Calaveras County does have a disaster preparedness plan and it is reviewed annually. Also, God always gives us opportunities and today he is giving us an opportunity to meet with the CALM Board and give them input. Let's make the CALM Board vital from this day on.

Karen Hart commented that one issue we should keep in mind is eating within our per diem. That is perhaps not a big issue for the Council but certainly may be for others. From my perspective, two issues are public transportation and per diem. Also, are we within walking distance of a grocery store? Are we able to get to fast food? I simply think we need to have an awareness that those are large issues for some of our participants.

Joe Mortz stated that they received an e-mail from one of their members regarding culture and mental health from a global point of view. Orange County is integrating a

number of the cultural perspectives of the World Health Organization. He would like the Council to, at some point, look at mental health from some of the other perspectives. For example, for the United Nations there are five globally accepted medical systems and some of those other systems are very effective. A couple of those are accepted in California. I'd like to see if we can have a discussion item at some point regarding global and international perspectives of mental health.

Adrienne Cedro-Hament added that one thing that is happening now at Butte County is the use of cultural rituals in the treatment of some of their patients. It's almost like a counter to the so-called Americanization of mental illness. But the bottom line is what treatment is going to be paid for.

Ed Walker commented that the role of the community is embedded in what the staff does. Without that community connection the rituals and perspectives just referenced would not occur. Luis Garcia told him that he works with spiritual healers and others and sees them as resources for referral and collaboration.

John Ryan stated that he understood that there was a statewide effort regarding cultural competency and the counties were to provide feedback on this. The cultural competency plan is said to be on Director Mayberg's desk and we eagerly await the opportunity to look at it.

11. Adjournment

Chair Mueller adjourned the meeting at 12:31 p.m.