



May 21, 2015

To: California Mental Health Planning Council

From: Jane Adcock  
Executive Officer

Subject: June 2015 Planning Council Meeting

CHAIRPERSON  
Cindy Claffin

EXECUTIVE OFFICER  
Jane Adcock

Enclosed is the packet for the June 17-19, 2015 Planning Council meeting at the Crowne Plaza San Francisco Airport in Burlingame, CA. The hotel is located at 1177 Airport Blvd., Burlingame, CA 94010. The hotel offers complimentary guest room and meeting room internet, and discounted overnight parking of \$10 per car per day.

### Issue Request Form

You have several copies of Issue Request Forms provided in this packet. We are enabling Planning Council members to request that committees on which they are not members address issues that are of concern to them. We have set aside the first five minutes of each committee meeting for Planning Council members to attend other committee meetings and briefly submit their issue requests. You will find Issue Request Forms in the front of this packet for your use. Please promptly return them to your committee after presenting your issue request so the regular agenda items can be handled.

- **Advocacy**
- **Evaluation**
- **Inclusion**

### Mentorship Forum

A Mentorship Forum will be held the evening of **Thursday, June 18**, immediately following the general session. Planning Council officers and all committee chairs and vice-chairs are specifically requested to attend. Other Planning Council members who wish to benefit from the discussion are welcome to attend.

The purpose of this forum is to discuss the process issues involved in chairing the committees and the Planning Council. For example, experienced chairs can explain the techniques they use during the meetings to keep the agenda moving and manage the discussion. Vice-chairs can ask questions about techniques they observed or how to handle various problems that might occur during the course of a meeting. It is our hope that, through this process, the Planning Council will enable more members to feel qualified to serve as committee chairs or officers.

### Committee Reports

We have allocated 1 hour and 25 minutes for committee reports on Friday. The focus of the committee reports will be what tasks or objectives the committee has completed on its projects and on its work plan. In addition, the committee should report any action items that it has adopted.

Please call me at (916) 319-9343 if you are unable to attend the Planning Council meeting so we can determine if we will have a quorum each day. See you soon!

Enclosures

MS 2706  
PO Box 997413  
Sacramento, CA 95899-7413  
916.323.4501  
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**AGENDA**  
**CALIFORNIA MENTAL HEALTH PLANNING COUNCIL**  
**June 17, 18, and 19, 2015**  
**Crowne Plaza San Francisco Airport**  
**1177 Airport Boulevard**  
**Burlingame, CA 94010**

Notice: All agenda items are subject to action by the Planning Council. The scheduled times on the agenda are estimates and subject to change.

**Wednesday, June 17, 2015**

**COMMITTEE MEETINGS**

<b>Time</b>	<b>Event</b>	<b>Room</b>
9:00 a.m.	Executive Committee Meeting	Plaza I
10:30 a.m.	New Member Orientation Meeting	Plaza II
11:00 a.m.	Patients' Rights Committee Meeting	Plaza III

**PLANNING COUNCIL GENERAL SESSION**

**Plaza Ballroom I & II**

**Conference Call 1-877-951-3290**

**Participant Code: 8936702**

<b>Time</b>	<b>Topic</b>	<b>Presenter or Facilitator</b>	<b>Tab</b>
1:30 p.m.	Welcome and Introductions	Cindy Claflin, Chairperson	
1:40 p.m.	Opening Remarks	Stephen Kaplan, LCSW, Director, San Mateo County Behavioral Health and Recovery Services	
2:00 p.m.	Approval of Minutes from April 2015 meeting	Cindy Claflin, Chairperson	K
2:05 p.m.	Overview of Simplified Roberts Rules of Order	Susan Morris Wilson, Council Member	L
2:20 p.m.	Alternatives to Locked/Involuntary Placements	Kacy Carr, Deputy Director, Adult and Older Adult Services, San Mateo County Behavioral Health and Recovery Services	M
2:55 p.m.	Council Member Questions and Discussion	All	
3:10 p.m.	Public Comment	Cindy Claflin, Chairperson	
3:15 p.m.	<b>Break</b>		

**California Mental Health Planning Council**

3:30 p.m.	Operationalizing the Council's Behavioral Health Integration	Bruce D. Emery, M.Ed., MSW, Advocates for Human Potential	N
3:50 p.m.	Facilitated Council Discussion and Next Steps	Bruce D. Emery	
4:40 p.m.	Public Comment	Cindy Claflin, Chairperson	
5:00 p.m.	<b>Recess</b>		

**Thursday, June 18, 2015**

**COMMITTEE MEETINGS**

<b>Time</b>	<b>Event</b>	<b>Room</b>	<b>Tab</b>
7:30 a.m.	Children's Caucus	Hotel Restaurant	
8:30 a.m.	Advocacy Committee	Plaza I	
to 12:00 p.m.	Continuous System Improvement	Plaza III	
	Health Care Integration Committee	Plaza II	
12:00 p.m.	<b>LUNCH</b> (on your own)		

**PLANNING COUNCIL GENERAL SESSION**

**Plaza Ballroom I & II**

**Conference Call 1-877-951-3290**

**Participant Code: 8936702**

<b>Time</b>	<b>Topic</b>	<b>Presenter or Facilitator</b>	<b>Tab</b>
1:30 p.m.	Welcome and Introductions	Cindy Claflin, Chairperson	
1:40 p.m.	Opening Remarks	Toni Tullys, Director, Behavioral Health Services for Santa Clara County	
2:00 p.m.	Alternatives to Locked/Involuntary Placements	Santa Clara County (invited)	M
2:55 p.m.	Public Comment	Cindy Claflin, Chairperson	
3:00 p.m.	<b>Break</b>		
3:15 p.m.	Report from Dept. of Health Care Services	Brenda Grealish, Assistant Deputy, Mental Health and Substance Use Disorders	
3:45 p.m.	Council Member Open Discussion	Cindy Claflin, Chairperson	
4:30 p.m.	Report from CA Behavioral Health Directors Association	Noel O'Neill, Director, Trinity County	
4:50 p.m.	Public Comment	Cindy Claflin, Chairperson	
5:00 p.m.	<b>Recess</b>		

## California Mental Health Planning Council

Mentorship Forum for Council members, including Committee Chairs and Chair-Elects, will occur immediately following the recess of Thursday's General Session.

### Friday, June 19, 2015

#### **PLANNING COUNCIL GENERAL SESSION**

**Plaza Ballroom I & II**

**Conference Call 1-877-951-3290**

**Participant Code: 8936702**

<b>Time</b>	<b>Topic</b>	<b>Presenter or Facilitator</b>	<b>Tab</b>
8:30 am	Welcome and Introductions	Cindy Claflin, Chairperson	
8:50 am	Report from the California Association of Local Mental Health Boards/Commissions	Larry Gasco, Ph.D., LCSW, President	
9:20 a.m.	Report from Mental Health Services Oversight and Accountability Commission	Toby Ewing, Ph.D., Executive Director	
9:50 am	Public Comment	Cindy Claflin, Chairperson	
10:05 a.m.	<b>BREAK</b>		
10:20 a.m.	Committee Reports – Patients' Rights, Health Care Integration, Continuous System Improvement and Advocacy	Daphne Shaw, Chair PRC Steven Grolnic-McClurg, Chair HCI, Susan Wilson, Chair CSI and Adam Nelson, Chair Advocacy	
11:45 a.m.	New Business	Cindy Claflin, Chairperson	
12:00 p.m.	<b>ADJOURN</b>		

*All items on the Committee agendas posted on our website are incorporated by reference herein and are subject to action.*

If Reasonable Accommodation is required, please contact Chamenique Williams at 916.552.9560 by June 4, 2015 in order to work with the venue to meet the request.

**California Mental Health Planning Council**

**2015 MEETING SCHEDULE**

October 2015	October 14, 15, 16	Sacramento	Lake Natoma Inn 702 Gold Lake Drive Folsom, CA 95630
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**2016 MEETING SCHEDULE**

January 2016	January 20, 21, 22	San Diego	Crowne Plaza San Diego 2270 Hotel Circle North San Diego, CA 92108
April 2016	April 20, 21, 22	Ontario/Riverside	To Be Determined
June 2016	June 15, 16, 17	Santa Clara	To Be Determined
October 2016	October 19, 20, 21	Sacramento	To Be Determined

\_\_\_\_\_ INFORMATION

TAB SECTION K

  X   ACTION REQUIRED

DATE OF MEETING 6/17/15

MATERIAL  
PREPARED BY: Adcock

DATE MATERIAL  
PREPARED 5/14/15

<b>AGENDA ITEM:</b>	Review and Approve April 2015 CMHPC Quarterly Meeting Minutes
<b>ENCLOSURES:</b>	April 2015 CMHPC Quarterly Meeting Minutes
<b>OTHER MATERIAL RELATED TO ITEM:</b>	

ISSUE:

# **CALIFORNIA MENTAL HEALTH PLANNING COUNCIL MEETING MINUTES**

**April 15, 16, 17, 2015  
San Pedro Doubletree  
2800 Via Cabrillo-Marina  
San Pedro, CA 90731**

## **CMHPC Members Present:**

Cindy Claflin, Chair	Noel O'Neill
Monica Wilson, Past Chair	Maya Petties, Psy.D.
Jo Black	Deborah Pitts, Ph.D.
Kathleen Derby	Robbie Powelson
Amy Eargle	Darlene Prettyman
Lorraine Flores	Jeff Riel
Nadine Ford	Joseph Robinson
Steven Grolnic-McClurg	John Ryan
Karen Hart	Daphne Shaw
Celeste Hunter	Walter Shwe
Steve Leoni	Cheryl Treadwell
Terry Lewis	Arden Tucker
Barbara Mitchell	Melen Vue
Raja Mitry	Daphyne Watson
Dale Mueller, Ed.D.	Bill Wilson
Adam Nelson, M.D.	Monica Wilson
Monica Nepomuceno	Susan Wilson

## **Staff Present:**

Jane Adcock, Executive Officer	Andi Murphy
Linda Dickerson, Ph.D.	Tracy Thompson
Tamara Jones	Chamenique Williams
Laura Leonelli	

## **Wednesday, April 15, 2015**

### **1. Welcome and Introductions**

Chair Cindy Claflin welcomed everyone to the meeting. The Planning Council members, staff, and audience introduced themselves.

### **2. Opening Remarks**

Dave Pilon, Ph.D., President and CEO, Mental Health America Los Angeles, welcomed the Planning Council to San Pedro. His opening remarks concerned the topic of alternatives to locked facilities.

- Recently there has been talk about the idea that we have gone too far in our attempts to reintegrate people with mental illness into our communities.
- Dr. Pilon believes locked facilities, while they may keep people safe, will never provide people with lives of meaning and belonging.
- Dr. Pilon presented a video showing the services offered at Mental Health America's (MHA's) flagship program at MHA Village in Long Beach. It provides an alternative to keeping people in institutions and jails.
- Dr. Pilon gave a PowerPoint presentation of the programs at MHA Village. The program focuses on seven indicators of a recovery culture: Welcoming, Growth Orientation, Consumer Inclusion, Emotionally Healing Environments and Supports, Quality of Life Focus, Community Integration, and Staff Morale and Recovery.
- Dr. Pilon spends more time thinking about the care of the staff than the members. He assumes that if he provides a good environment for staff, then they will provide the best environment for the members.
- Dr. Pilon elaborated on the seven indicators.

### **Questions and Discussion**

Ms. Mitchell mentioned the trend for providers to be pressured to use all MHSA money to leverage MediCal. She asked if Dr. Pilon experiences this. He replied that he does – it's a system-wide issue. It is very difficult to hold back monies for services that aren't going to draw down federal funds. There are two solutions: keep a pocket of money used for just those services; and document to a person's psychiatric disability, explaining why the person is receiving that service. Los Angeles County has "flex" funds that are not expected to be used as a match for Medicaid.

Mr. Wilson mentioned that he received training at MHA Village. He strongly supports what is happening there, in particular bringing in homeless veterans to become reestablished in the community.

Mr. Leoni expressed enthusiasm about the MHA Village environment; he especially appreciated Dr. Pilon bringing up personal and specific issues such as going to weddings.

Ms. Nepumuceno asked if there are similar programs to MHA Village, and how the programs can be replicated. Dr. Pilon responded that the Village is a Full Service Partnership (FSP) program, and there are literally hundreds of FSPs across the state. What distinguishes the Village is its emphasis on employment. Many agencies have not made the jump to integrating employment services into their service mix – but nothing is stopping them.

Ms. Prettyman asked how the Village works with families. Dr. Pilon responded that of the seven indicators, probably family involvement is one of the weaker ones. Many

family members are on the Board of Directors; many engage in educational efforts. The Village does have many stories of people being reunited with their families after many years.

Ms. Shaw remarked that years ago, she had heard a story about the Village's psychiatrist, Dr. Mark Ragins climbing through a window in one of the living areas so that he could make contact with a client.

Mr. Mitry believed that the Recovery Transformation Progress Report honors the approach of cultural humility, so important in serving all people – it is an approach of learning. He remarked on the importance of having non-judgmental, safe, trusting relationships with other people for an outcome of wellness. Dr. Pilon firmly agreed: the two universal things that people need are belonging and meaning. Clients at the Village feel as if they have found a family there – but the agency needs to remember to help them make the bridge to the larger community outside.

Ms. Mueller asked for Dr. Pilon to comment on linkages of services to physical health. Dr. Pilon answered that the Village provides multiple approaches. It has a grant from the California Community Foundation to bring in a physician two days a week. The agency has also found that it sometimes needs to bring physical health care to people on the streets – many people the agency works with are not stably housed.

Ms. Lee stated that she has started an international speakers bureau comprised of mentally ill people trying to dispel mental illness myths. Dr. Pilon responded that such an organization helps people to grieve the losses they have suffered due to severe and persistent mental illness, heal the wound, and turn the wound into a gift for other people.

### **3. Approval of Minutes from January 2015 Meeting** *(postponed)*

#### **4. Measurements, Outcomes and Quality Assessment (MOQA)**

Debbie Innes-Gomberg, Ph.D., District Chief, L.A. County Department of Mental Health, began by describing her position as District Chief.

- She oversees MHSA implementation in the county.
- She oversees the annual updates and three-year plans the county produces.
- She reports information to the Mental Health Services Oversight and Accountability Commission (MHSAOAC), the Department of Health Care Services (DHCS), and the County Board of Supervisors.
- She oversees outcomes.

Dr. Innes-Gomberg described a project that the County Behavioral Health Directors Association (CBHDA) has embarked upon: MOQA is a statewide approach to the collection, reporting, and interpretation of mental health outcomes.

- MOQA began as a county commitment to the collection and reporting of outcomes.

- It is a process that takes time, and part of the process involves discerning data that is not right or accurate.
- The process represents a county-to-county structure to improving and increasing the use of outcomes.
- Dr. Innes-Gomberg displayed the MOQA 1 results produced by the CBHDA in a pamphlet for the Legislature.
- For MOQA 2, a CBHDA workgroup met to discuss how to move forward while reporting in a more comprehensive way. The outcomes they were collecting had to be meaningful at four levels: county, provider, consumer, and state. MOQA 2 is designed to communicate the impact of the Mental Health Services Act (MHSA) to the Legislature and the stakeholders.
- To collect goals and objectives, the CBHDA is looking at common programs it is operating in different counties, and ensuring that the goals and objectives are consistent.
- Going forward, the CBHDA hopes to report on the domains of Housing, Employment and Education, Criminal Justice, Acute Care Use, Emotional and Physical Well-Being, Stigma and Discrimination Reduction, and Service Access and Timeliness.

### **Council Questions and Discussion**

Ms. Prettyman asked about support systems. Dr. Innes-Gomberg responded that the Emotional and Physical Well-Being section includes that.

Mr. Robinson asked about the domains of Stigma and Discrimination. Dr. Innes-Gomberg responded that for counties that are doing Stigma Reduction activities, the CBHDA wanted to agree on a common methodology for measuring them. Mr. Robinson stressed that part of the charge for CMHPC members is to get out into the community and find stories of hope and recovery, and offer them to the public.

Ms. Mueller asked whether data is being collected regarding the language of the services: is it the primary or preferred language of the client? Dr. Innes-Gomberg answered that at this point, they do not have language and ethnicity in the domains. She could envision a future iteration that would take this component to the next level.

Ms. Mitchell asked if the CBHDA has designed essential elements of wellness centers and suitable outcome measurements. Dr. Innes-Gomberg responded that they are looking at employment, housing, and some other satisfaction measures; she will get the information to Ms. Mitchell.

Mr. Leoni commented that the External Quality Review Organization (EQRO) Self-Assessment includes average number of days before getting an appointment after a hospitalization. He commented that this measure is becoming outdated – many people almost walk out the hospital door into an FSP; in addition, many counties do not even have field capable services. Dr. Innes-Gomberg responded that Service Access and Timeliness will be populated by what DHCS requires counties to do. She agreed that this

measure is not the bread and butter of outcomes (although it is important for counties to collect because health care systems collect it).

- Dr. Innes-Gomberg noted that the California Institute for Behavioral Health Solutions (CIBHS), formerly CiMH, has a database they have used for some of their learning collaboratives. CBHDA is looking into using this database for counties to enter aggregate data.
- They do not want to limit MOQA to MHSA programs. The reality, however, is that MHSA is a match for almost every outpatient program with the exception of CalWorks.
- They have committed to the Steinberg Institute to produce reports every six months or so for now.
- Dr. Innes-Gomberg feels that the MHSA is working, and MOQA can supply the data to demonstrate this.

Mr. Mitry asked if wellness and resilience are implied in the level of recovery. Dr. Innes-Gomberg replied that they should be in the documentation, and that the CBHDA is still working with counties to say what measures they are collecting.

Mr. Leoni asked if consumers and family members are involved in any part of the MOQA process, and made a point for awareness about Medicaid Information Technology Architectures (MITA) – upcoming federal requirements for cost rewarding. Dr. Innes-Gomberg guessed that five years from now, counties will have worked these health information exchange issues out, and across the state counties will have come together in that regard. Regarding the stakeholder issue, CBHDA has met with the Racial and Ethnic Mental Health Disparities Coalition (REMHDCO); further, L.A. county has always included consumers and family members, as well as providers, in any decisions or work done around outcomes. She saw the issue as having different layers and would ensure inclusion of consumers and family members in the MOQA workgroup moving forward.

Mr. O'Neill sought clarification on future steps with MOQA. If the counties can use this universal website, will there be one place to enter the data into the web base, which could then be used to produce reports and information? Dr. Innes-Gomberg responded that for Phase 1, the data reported will be aggregate data rather than client-specific information. At some point in the future the universal website may be used.

Ms. Lee asked about employment – have there been any problems with SSI? Dr. Innes-Gomberg replied that it isn't easy. They try to have consumers who are presently employed, work with those who are contemplating employment.

Ms. Hart commented on outcomes for children: she hoped that we don't completely lose Transition-Age Youth (TAY) and children in this process. Dr. Innes-Gomberg agreed and remarked on the importance of education and obtaining meaningful education information, which is very subjective.

There was no Public Comment.

## **5. Behavioral Health Integration: National Perspective**

Ms. Adcock summarized that in past meetings, the Planning Council has examined the question of whether to become a Behavioral Health Council. She introduced Jon Perez, Ph.D., Regional Administrator, Region IX, Substance Abuse & Mental Health Services Administration (SAMHSA). Dr. Perez was going to bring up areas of consideration from the federal perspective as the Planning Council continues the conversation about integration.

In talking with Planning Council members, Dr. Perez had devised five areas that could impact their decision-making.

1. What are the block grants going to look like in the age of the Affordable Care Act? The SAMHSA block grant for California is about \$323 million. It is comprised of the Center for Substance Abuse Prevention, the Center for Substance Abuse Treatment, the Center for Mental Health Services, and some homeless grants and smaller grants.
2. The 1115 Waiver – Drug Medi-Cal is the carve-out, and has direct impact on aspects of mental health and the care delivery system. The larger health care system 1115 is on its way out and also has impact on mental health, mental health systems, and integration.
3. Four bills are currently making their way through the Legislature: AB 59, AB 1193, AB 1194, and AB 1300.
  - The first two are specific to Laura’s Law and how it may affect county services and treatment services.
  - AB 1194 mandates that law enforcement officials consider an individual’s history when deciding whether to place the person in a 72-hour hold.
  - AB 1300 standardizes the 72-hour psychiatric hold process.
4. The Supreme Court decision on ACA and federal subsidies is pending.
5. The Murphy bill, also known as HR 3717, would substantially change how mental health is addressed structurally and financially. It also has some direct applicability to Laura’s Law types of federal regulation.

The Presidential election could also affect the long-term environment.

The bottom line is: given this kind of environment, how do you best represent and advocate for behavioral health, that is, substance abuse and mental health? Is it better together or separate?

Dr. Perez elaborated on the five areas. He explained the Murphy bill in detail – it is bipartisan – and recommended for the Planning Council to start advocating now.

## Questions and Discussion

Council members discussed the points made by Dr. Perez.

Mr. Leoni asked about the place of substance abuse in the Murphy bill. He also inquired whether there is a federal Assistant Secretary for Substance Use. California just dismantled its Department of Mental Health – it seems that this bill goes in the opposite direction. Dr. Perez responded that he sees Substance Abuse as being subsumed under the Assistant Secretary for Mental Health position. Substance Abuse would remain in SAMHSA.

Ms. Lee asked what happened to promote the combining of substance abuse and mental health, and whether it is to the advantage of CMHPC financially to incorporate the two. She also commented on the stigmas involved: people would rather be alcoholic than mentally ill, but no one wants to be labeled either of the two. Dr. Perez responded that the general discussion is around being better able to identify and treat people who have the potential to do significant harm in the community, for example, the Sandy Hook tragedy. He continued that mental health services are not as coordinated as they should be among the federal agencies. The general trend toward a sympathetic approach to a person's issues currently has a lot of traction.

Mr. Ryan commented that last year's Murphy's bill was supported by the American Psychiatric Society, the American Psychological Society, and the National Alliance on Mental Illness (NAMI). Are there indications that those groups will continue to support it? Dr. Perez had not heard anything to the contrary.

Dr. Pitts pointed out that we need to be very careful about language when we conflate serious mental illness and dangerousness. As advocates we need to be very careful in our own discourse.

Dr. Nelson felt that the problem the CMHPC will encounter with the ultimate decision is that not everyone will be happy. The winds of change seem to be moving in the direction of bringing mental health and substance use services under the same roof, at both the state and national levels. The CMHPC needs to discern how meaningful and important it is to be part of the conversation. Dr. Nelson felt that the science suggests that we should be looking at the two along the same continuum of concerns as well as services.

He continued that Murphy does want better coordination of treatment in mental health care; he also wants the treatment of mental illness and substance use services to be more scientifically driven rather than just socially driven. Yet the CMHPC should remind the powers that be that it is important not to ignore or neglect the social aspects of care.

Ms. Shaw commented that she had participated in a roundtable discussion on 3717 with Congressman Murphy. The discussion had revolved 100% around Assisted Outpatient Treatment (AOT). That is the part the community at large is going to hear.

Ms. Adcock reminded the Planning Council members that her goal for this portion of the meeting was to have the CMHPC make a decision on whether to integrate, or to identify additional desired information.

Mr. Ryan voiced support for the integration idea, based on his years as a County Mental Health Director. The reality is that the clientele being served had history and issues with both substance abuse and mental illness.

Ms. Adcock requested a show of hands of members wanting to integrate.

Ms. Hart asked Dr. Perez to bring the Planning Council up to date on where SAMHSA, as well as the National Association of Mental Health Planning Councils (NAMHPAC), stand on the issue. Dr. Perez responded that SAMHSA supports integration. As for NAMHPAC, he believed that all of his other states were integrated.

Mr. O'Neill mentioned that over 50 of the counties already have behavioral health integrated systems. What's on the horizon now is integration of behavioral health with primary health care – something to consider regarding the relevance of the Planning Council.

Ms. Flores said that in her experience also, integration includes primary health. Even education is heading in that direction: her agency just hired a graduate of the University of San Francisco Master's program in Behavioral Health.

Regarding AOT, Mr. Leoni took exception to the idea of splitting the world into scientific and social categories. In California we are engaged in an experiment trying to propose an alternative to what the AOT people are pushing; the experiment concerns the science of recovery. Mr. Leoni believed in integration and mentioned that Social Services is another integration. A Health and Human Services Council would be a great idea – but they would still need some kind of a planning body for mental health. He expressed concern that Planning Councils that have integrated have experienced a loss of ability to advocate for mental health because their workloads have become too heavy.

Mr. Leoni continued that there are many Substance Abuse issues – dual diagnosis, laws, prison terms, drugs, police enforcement – to which the Planning Council would now have to pay attention. He wondered about the size of the bite we would be taking.

Mr. Powelson pointed out that the goals between mental health and substance use are very different. What about the prescription drug epidemic and the lock zones in schools? His county has chosen not to integrate as yet although services are much more integrated. He would want to learn more about what other planning councils are doing and the issues they are facing.

**Motion:** The California Mental Health Planning Council will begin the process of integrating into the Behavioral Health Planning Council, and form an Ad Hoc Committee to explore the particulars and a timetable for integration; the Ad Hoc Committee will report back to the Planning Council at a time to be determined. Adam Nelson moved; Lorraine Flores seconded.

Ms. S. Wilson emphasized the expertise represented in the Planning Council members. In running a substance use disorder clinic, she must interact with the mental health and primary care services on behalf of her clients. This follows the current philosophy of how the best care is provided. The CMHPC needs to walk the talk of the current philosophy.

Ms. Shaw expressed ambivalence – she was present in 1991 when this Planning Council was formed, and she referred to its unique statute which is specific regarding the CMHPC’s charge for mental health in California.

Ms. Hunter said that everyone understands the strong relationship between alcohol/drugs and mental health. However, as a Planning Council, we must not lessen our advocacy and oversight of mental health services. The field of mental health already contains huge amounts of information to learn about; alcohol/drugs will be a totally different challenge.

Ms. Lee asked why an Ad Hoc Committee is necessary when the Planning Council has already decided to integrate. Ms. Adcock responded that there are options and considerations on how to accomplish the integration.

Mr. Grolnic-McClurg was in favor of the motion, in part because he did not feel that the Planning Council is very effective in meeting its current mandate. He did not feel that there would be an enormous loss in our capacity to provide oversight of the mental health system. He believed that we could still do what we do best: advocate. He held the perspective the integrated services are better services.

Mr. Leoni felt that the Planning Council needs more information before it makes the decision to integrate. He expressed concern over the workload that would result from integration. About a year ago, a document came out from SAMHSA urging councils to consider integrating; one state had opted to establish a pilot dual council with cross-membership.

Ms. Adcock and Dr. Nelson deferred any ultimate recommendations, including the dual council structure, to the Ad Hoc Committee named in the motion.

Ms. Adcock pointed out that a decision to integrate would be predicated on the ability to change Planning Council statutes.

Ms. Hart reminded the members that we are here as an obligation directly for the block grant. She would like to see the Planning Council focus only on the aspects that SAMHSA does control and send down to us.

Mr. Mitry acknowledged that the majority of counties have behavioral health departments, and also that individuals feel strongly that the mental health focus not be jeopardized. He suggested the name “California Integrated Health Care Planning Council.”

Ms. Derby asked if there is a parallel conversation taking place on the Substance Use side. Does it have a CMHPC counterpart? Ms. Adcock responded that there is not, and the advocates that she has heard from welcome the CMHPC taking it on.

Ms. S. Wilson moved the question (thereby stopping the discussion). There were 17 ayes, achieving the 2/3 simple majority.

Chair Claflin read the motion on the table. The vote was 14 ayes, nine noes, and five abstentions. By a simple majority the ayes had it.

Ms. Derby pointed out that 17 out of 31 was not a 2/3 majority.

Ms. S. Wilson explained that calling the question means to stop the discussion immediately and vote on whether to move to the motion on the floor.

Ms. Adcock took a voice vote. With a split of 15 ayes, 15 noes, and one abstention, the motion failed and the discussion continued.

Ms. Prettyman referred to the legislation; she was very concerned about the population that is not duly diagnosed – the severely mentally ill that do not have an alcohol or drug problem. An Ad Hoc Committee would need to explore the legislation.

Ms. Nepomuceno voiced concern over how an integration would be accomplished. If we add the substance abuse topics, what will make us carry out our mandates? Would we introduce other members to our group? How would it affect our quarterly meetings?

Ms. Lee felt a little railroaded – that she had to give an answer right now. She would like to have a county or state come and speak to the Planning Council about how their own integration was accomplished.

Ms. Shaw reminded everyone that the Planning Council was formed because in 1990 the Legislature decided to sunset three advisory bodies in order to save money. The Planning Council then became federally funded.

Ms. Lewis commented that last October her committee had voted to change to the Health Care and Integration Committee; they are beginning to take on and understand that topic. She also commented that one of the Planning Council's strongest points was its potential for advocacy; she did not think that integration would take that away. Lastly she commented that the previous motion would have usurped each member's opportunity to participate in the discussion. As the Planning Council has these discussions, the process should be allowed to unfold.

Mr. Leoni stressed that the Planning Council still has more information to gather, and that a vote at this point feels premature.

Mr. Grolnic-McClurg called the question. He reminded that members that the vote would end the discussion and move on to the motion.

The motion passed to end the discussion.

Chair Claflin read the motion once again:

**Motion:** The California Mental Health Planning Council will begin the process of integrating into the Behavioral Health Planning Council, and form an Ad Hoc Committee to explore the particulars and a timetable for integration; the Ad Hoc Committee will report back to the Planning Council at a time to be determined. Adam Nelson moved; Lorraine Flores seconded.

The motion passed. Chair Claflin read the motion once more.

## **Thursday, April 16, 2015**

### **1. Welcome and Introductions**

Chair Claflin welcomed everyone to the second General Session. Members of the Planning Council and audience introduced themselves.

**(#3 from previous day) Approval of Minutes from January 2015 Meeting**

Mr. Leoni requested a change to #22 (page 43 in the overall packet): to add the word “however” to the paragraph beginning at the sentence, “Many of the recipients...”

**Motion:** Approval of the January 2015 Meeting Minutes with the amendment above was moved by Lorraine Flores, seconded by Susan Wilson. Motion carried.

**2. Office of Statewide Health Planning and Development: Status of WET 5-Year Plan Implementation**

Lupe Alonzo-Diaz, Deputy Director, Healthcare Workforce Development Division; and Brent Houser, Acting Manager, Healthcare Workforce Development Division, presented the status update on the Workforce Education and Training (WET) 5-Year Plan and budget.

- Ms. Alonzo-Diaz explained that statutorily, the Office of Statewide Health Planning and Development (OSHPD) is required to develop a 5-Year Plan that identifies the goals and objectives and some of the intended outcomes, in order to invest public workforce education and training dollars.
- Ms. Alonzo-Diaz displayed the WET budget. The WET dollars are intended to close out in Fiscal Year 2017-18.
- The budget’s categorical areas are Stipends, Mental Health Loan Assumption, Expanding Educational Capacity, Consumer and Family Member Employment, Regional Partnerships, Recruitment and Retention, and Evaluation.
- Since the adoption of the 5-Year Plan and budget, OSHPD has been releasing many Requests for Assistance (RFAs) – all grant funding is a competitive process.
- Ms. Alonzo-Diaz listed upcoming RFAs.

**Mr. Houser provided an overview of the WET programs implemented so far.**

- **Stipends:** OSHPD contracts with educational institutions to provide graduate students with stipends, in exchange for them working in the public mental health system. Professions are Psychiatric Mental Health Nurse Practitioner, Clinical Psychologist, Marriage and Family Therapist, and Social Worker.
- **The Mental Health Loan Assumption Program (MHLAP)** offers loan repayment of up to \$10,000 to mental health workers in hard-to-fill and/or hard-to-retain positions in the Public Mental Health System (PMHS), in exchange for a 12-month service obligation. MHLAP awarded 1,300 individuals in last year’s cycle.
- **OSHPD’s Education Capacity program** involves Psychiatric Residency and Psychiatric Mental Health Nurse Practitioner programs. OSHPD contracts with organizations to increase their capacity to train and provide clinical rotations in the PMHS.

- The five **Regional Partnerships** are charged with developing and implementing public mental health care workforce strategies that align with the WET 5-Year Plan, along with addressing their specific regional needs.
- **Recruitment and Retention:** two different recruitment programs associated with the second 5-Year Plan are Mini Grants and CalSEARCH; they are focused on getting students interested and involved in the PMHS to introduce them to behavioral health careers. Retention is aimed at the overall PMHS workforce.
- **Consumer and Family Member Employment:** The 5-Year Plan allocated \$10 million across FYs 2014-15 and 2015-16 for engaging in activities that increase and support consumer and family member employment in the PMHS. Mr. Houser listed the three RFAs that have already been released:
  - Local Organizational Support and Development Networks
  - Networks to Support Public Mental Health System Workforce with Lived Experience
  - Consumer and Family Member Workforce Comprehensive Needs Assessment

**OSHPD anticipates releasing an RFA before the end of the fiscal year:**

Comprehensive Assessment of Consumer, Family Member, and Parent/Caregiver Workforce.

- The Peer Personnel Support program has an appropriation from WET funding: it comes from SB 82, the MHSA administrative funds portion.
- Ms. Alonzo-Diaz stated that SB 614 would require DHCS to establish a statewide peer and family support specialist certification program by July 2016. OSHPD has not taken a formal position on the legislation and is working with DHCS and the Administration.
- Statutorily, the WET program has no funds after FY 2017-18. WET had made a commitment to the Planning Council and other constituents to evaluate the statewide programs two years into the budget. OSHPD met with the WET Advisory Committee on April 9 regarding evaluation activities. An RFA will be released via the Advisory Committee and other emails.
- OSHPD will re-evaluate the WET budget for the last two fiscal years by means of the evaluation and stakeholder engagement. Opportunities to make changes to the budget will go through the WET Advisory Committee and the CMHPC. Any changes to the dollar amounts and categorical areas require a Budget Change Proposal to go through the legislative process.
- OSHPD is also looking at areas that it can impact here and now. It is reviewing WET regulations and working closely with DHCS. OSHPD is proposing amendments to the regulations as a reflection of feedback from constituents, awardees, program administrators, and the counties.

## Questions

Mr. Powelson had spoken with a consumer who was trying to get help paying for his education as a peer counselor. Because of the rigidity of the process, it was much more difficult for consumers to get into the program than for people already on the professional track. Ms. Alonzo-Diaz responded that the MHLAP is for those who have already undergone some training and who possess a loan. For that program, counties are required to identify positions that are hard to fill and hard to retain. For the other programs there may be an opportunity to incorporate Mr. Powelson's feedback – for example the Peer Support Program.

Mr. Leoni asked what can be done about the Consumer and Family Member programs which have no funding for the last two years. He mentioned Leno's SB 614. What can happen to fix the end of the funding? Ms. Alonzo-Diaz responded that OSHPD is in the process of analyzing the bill. She explained the legislative process through which it is progressing. OSHPD has taken no position on the bill. With respect to the funding, Ms. Alonzo-Diaz said that her commitment was that before the start of FY 16-17, they would come back to the Planning Council and propose a new budget.

Mr. Leoni asked what needs to happen now to prevent the bottom from dropping out – should a Budget Change Proposal be started? Ms. Alonzo-Diaz responded that if SB 614 passes in September, it does allow OSHPD some flexibility to consider the WET funds. As long as OSHPD doesn't utilize more than \$5 million in that bucket for FY 15-16, it might still be appropriate to use some of those funds; that would be part of the process of engaging with DHCS (they are responsible for administering and implementing the program).

Mr. Mitry asked if OSHPD is gathering specific demographic data from contractors and employers about race, ethnicity, special needs, age, and so on, for the peer personnel program recruitment. The numbers will inform the reduction of disparities and target any gaps. Mr. Houser replied that with many of the RFAs, OSHPD has incorporated as a mandate that the contractors must send out a specific survey template when they conduct trainings and conferences. He did point out that OSHPD cannot require individuals to fill out the forms – it is completely voluntary and anonymous.

Ms. Mitchell asked if there is information about how many of the MHLAP loans have gone to county employees versus nonprofit employees. In her nonprofit agency, she has a huge number of employees in graduate school who have not been able to get loans. She felt that loan assumption should be given to a broader number of employees. Mr. Houser stated that since the beginning of the program in 2008, OSHPD has held several stakeholder meetings and collected information. With the increasing debt loads that many of the providers and other mental health providers are gathering, the increases proposed by OSHPD support that trend. They have been vetted through the different Advisory Committees, which are comprised of some county members as well as community-based organizations and nonprofit members.

Ms. Mitchell requested data on where the loan assumption is going – county and governmental agency employees versus nonprofit employees. Mr. Houser agreed to supply the data.

Ms. Alonzo-Diaz added that this provides additional flexibility to the administration of the program; it does not mean that individuals will be awarded the maximum amount. MHLAP has a large Advisory Committee that breaks into different teams making funding recommendations by county.

Ms. Hart mentioned that she had asked if the Consumer and Family Member money could be front-loaded into the first two years, based on the idea that OSHPD was assured that it was capable of rollover. Ms. Alonzo-Diaz responded that there is an opportunity to rollover funds within those two fiscal years that it encapsulates. However, they cannot rollover to FYs 16-17 and 17-18 without a Budget Change Proposal process.

Mr. Leoni commented that when those funds were front-loaded, they were intended to help set up the Peer Certification program. However, it turned out that the money could not be used for that purpose. Ms. Alonzo-Diaz responded that she had made clear that OSHPD did not have the statutory authority to implement Peer Certification. She had made a commitment to create a stakeholder process with an invitation to Planning Council members to participate – to advise OSHPD on how to release the RFAs. Regardless of what happened to Peer Certification, they could find ways not to derail that effort; there were other existing and best practices in which to invest.

Mr. Leoni asked why Regional Partnership was zeroed out in FY 17-18; whether as part of the Education Capacity-Psychiatry program, there was earmarked training with Consumer and Family Member viewpoints. He also asked about the grant for retention activities.

Ms. Alonzo-Diaz responded that the Regional Partnership was zeroed out because the statute was very clear regarding the dollar amounts and the fiscal years. Mr. Houser added that there is a Consumer and Family Member curriculum requirement as part of the Education Capacity program. He said that the retention RFA would fund an organization to retain their workforce by means of various strategies.

Ms. Lewis asked about the RFP in the Los Angeles Region for 18 faculty members to provide training to residents and fellows. Was that the Steinberg Institute? Mr. Houser answered that there was a partnership between the Los Angeles County Department of Mental Health and the educational institution, as well as specific sites to provide that training and supervision. He was not sure if the Steinberg Institute was involved.

### **3. Public Comment**

There was no public comment.

### **4. Report from Department of Health Care Services**

Dionne Maxwell, Ph.D., Performance Outcome System Project Lead of the DHCS, reported in place of Brenda Grealish.

- A recent reorganization at DHCS divided major sections of two departments.
  - The Department of Mental Health was divided into State Hospital and Specialty Psychiatric Programs in CDCR Facilities, and Community Mental Health Programs moved to DHCS.

- The Department of Alcohol and Drug Programs was divided into the Substance Use Disorder Compliance Division and the Substance Use Disorder Prevention, Treatment and Recovery Services Division.
- The Mental Health Division has been integrated with the Substance Use Division. A significant issue will be data sharing between the two divisions.
- Dr. Maxwell explained the Medi-Cal Specialty Mental Health Services Consolidation Waiver (1915b). It is currently in the waiver renewal process and DHCS is optimistic.
- Dr. Maxwell explained the Drug Medi-Cal Organized Delivery System Waiver. DHCS is seeking an 1115 Demonstration Waiver for the Substance Use Disorder Drug Medi-Cal Program.
- Dr. Maxwell explained the Section 1115 Bridge to Reform Waiver renewal.
- Dr. Maxwell explained the Performance Outcome System (POS) in detail. In 2012, DHCS was tasked under SB 1009 to develop and implement a POS that would establish a process for bringing together data from multiple sources, so that we could better understand the impacts of Medi-Cal Specialty Mental Health Services that are provided to children and youth under the age of 21.

The intent of the POS is to gather information relevant to particular mental health outcomes – to report on it and ascertain whether outcomes are improving for this population.

**The POS produced its first set of reports in February.**

- Different measures of access were produced: demographics (race and ethnicity, age, and gender), penetration rates, service usage, and snapshots (children arriving and exiting the system, and children who had service continuation).
- The reports are at three levels: statewide, population-based county groupings, and individual county.
- Of the children and youth who are eligible for Medi-Cal specialty mental health services, two populations are covered: the entire population and current foster care youth.

The next phase is reliant on a study from UCLA. They will identify a functional assessment tool or methodology for use state-wide. It is a huge step forward for the project because it will allow the POS to link its data with actual functional outcomes.

Expanded reporting is the next step – they have brought in UCLA. It will require cooperation between the counties and POS staff in terms of how it is enacted.

The POS uses a phased approach that should be in place in its entirety by 2018.

- Dr. Maxwell invited the Planning Council to participate in the Behavioral Health Forums. Each of four groups – Strengthening, Integration, Data, and Fiscal – will report out on a topic of interest directly tied to stakeholder concerns and interests.

The addition of a Client and Family Member Forum has helped to ground the discussion. The next Behavioral Health Forum will be in Sacramento on July 29. Webinars provide another way to participate.

## **Questions**

Ms. Tucker asked about the Client and Family Member Forum. Dr. Maxwell clarified that it is an actual part of the forum; Mrs. Adcock is responsible for it. DHCS is responsible for the other four groups.

Mr. Leoni had attended the most recent Behavioral Health Forum and had found the Fiscal Forum to be an exciting segment – it dealt with greatly simplifying all the data processes. Mr. Leoni mentioned Medicaid Information Technology Architecture (MITA), which will allow interoperability between all the states and change the whole game. Dr. Maxwell stated that DHCS is actively engaging in MITA efforts because they recognize the need to get reporting up to speed and to have their data systems communicating with each other and not be siloed. DHCS also has a Dashboard effort underway in order to make data more available and accessible.

Ms. Derby asked about the POS: in the Subject Matter Experts Workgroup, are there consumers and family members? Dr. Maxwell answered that they would be a wonderful addition.

Mr. Powelson asked why the age group chosen was 21 and under, rather than 24 and under. Dr. Maxwell answered that this was the way the legislation was written (Welfare and Institutions Code 14707.5) – it was meant to relate to the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) population.

## **5. Overview of Data Notebook 2015 and Committee Report for Continuous System Improvement Committee**

Ms. Susan Wilson, Committee Chair of the Continuous System Improvement (CSI) Committee, referred the Planning Council members to the Data Notebook 2015 in their packets.

- The objective of the Data Notebook project is twofold.
  1. To build a format that assists local Mental Health Boards in their responsibilities to report to the Planning Council.
  2. For the local Mental Health Boards to learn more about data – how to use it to advocate for their positions and to inform their stakeholders and themselves.
- One substantive change was made: the addition of a question regarding reentry into the community from incarceration of some kind.
- A new data source is the California Outcomes Measurements System (CalOMS).
- Ms. Wilson thanked the members of the California Association of Local Mental Health Boards (CALMHB) who had helped, as well as Dr. Linda Dickerson.

- **The Data Notebook has two themes:**
  1. Treatment Options and Alternatives to Locked or Involuntary Facilities, which follows the Planning Council's theme for this year.
  2. Treatment of Individuals Who Require Substance Use Disorder Treatment.
- **Next Steps are:**
  1. Data trainings by region, coordinated with CALMHB, in four or five locations around the state.
  2. Distribution in June 2015. Mental Health Directors need copies as well as the Chairs of the Mental Health Boards and the QA or MHSA people.
- Ms. Flores said that this version of the Data Notebook is very presentable: an easy read with charts included and questions that are more precise.

Mr. Ryan commended the committee for their efforts. He had heard nothing but compliments from colleagues on various Mental Health Boards.

Mr. Leoni asked how the Data Notebooks are publicized and obtained. Ms. Wilson answered that they are posted on the CMHPC website; perhaps a mailing list could be compiled.

Ms. Wilson then reported on the CSI Committee meeting. She described its Work Plan.

- Complete the Data Notebook for 2015.
- Identify best practices and make recommendations for mental health treatment in juvenile justice facilities.
- Identify best practices and make recommendations for mental health programs for homeless youth and young adults.
- Develop Performance Outcome Measures. The committee is working with the MHSOAC.

Mr. Powelson commented on the second goal: he hoped that the diversion programs for homeless youth are good ones. Currently in sheriffs' departments and some private programs, this can mean the Scared Straight programs. Ms. Wilson agreed that we need to keep an eye on that subject.

Mr. Ryan pointed out that the CMHPC, the MHSOAC, and DHCS, under the law all have responsibility for performance outcomes. Someone should examine how it dovetails together. Ms. Wilson agreed. She felt that the MHSOAC is on the same page as the CMHPC.

Ms. Flores commented that the committee had discussed working on indicators versus working on outcomes. Ms. Adcock stated that the CMHPC has statutory responsibility to approve any performance indicators that are instituted. The counties report to those indicators, then outcomes are measured from the data.

6. Committee Reports: Patients' Rights, Health Care Integration, and Advocacy  
Committee Chair Daphne Shaw reported on the Patients' Rights Committee.

- The committee has been working on helping Mental Health Boards focus attention on patient rights in their counties.
- Many advocates feel that their time is being spent on competency hearings, so they do not have adequate time to perform the other duties listed in the law. They have conveyed that in a letter to the Mental Health Directors. Two Directors have responded.
- The committee developed a survey and sent it to the Mental Health Chairs with copies to the Mental Health Directors. The committee requested that they include Patient Rights as an agenda item for discussion; they could use the survey. The committee has heard back from only three counties. The bottom line is that the Boards look at patient rights issues in their counties.
- The committee decided to send the surveys to two venues: the Patient Rights Advocacy Training (PRAT) and the individuals active in the California Association of Mental Health Patient Rights Advocates (CAMHPRA).
- Another concern was the independence of the Patient Rights Advocates – in some counties they are direct employees of the county and there may be conflict of interest.
- The committee heard a presentation by Martin Hernandez of Los Angeles County, who indicated that they have 29 Patient Advocates serving 240,000 county clients.
- The committee is discussing moving into the State Hospital arena.

Mr. Leoni inquired about the resources people have in Institutes for Mental Disease (IMDs). Ms. Shaw replied that most people are there under conservatorship so it is part of the Lanterman-Petris-Short (LPS) Act.

**Mr. Grolnic-McClurg, Chair of the Health Care Integration Committee, gave a report.**

- The committee continues to focus on the new Low to Moderate Mental Health benefit being provided by the Managed Medi-Cal Health Plans. A letter came out from DHCS that each County Mental Health Plan and each Managed Medi-Cal Mental Health Plan were required to develop an MOU clarifying who would get services where (Low to Moderate and Moderate to Severe). They needed to specify what would happen for individuals where there was some disagreement.
- The committee feels that this is a profound change for the public mental health system and the CMHPC because there is a whole new set of players providing services in the public mental health system.
- A speaker came today from the California Health Care Foundation.
- Mr. GC described the ways that the Managed Care Health Plan can provide services: they can carve them in or carve them out back to the mental health plan.

- The committee is going to look towards partnering with the California Health Care Foundation to develop a report that lists out all the plans county by county, shows the MOU, and explains how the Managed Care Medi-Cal Health Plan is choosing to provide its behavioral health services. In the same report the committee hopes to develop a listing of early successes.
- The committee has sent a letter and is looking to work with CALMHB, helping them to understand this process and the MOU in place – encouraging them to think about inviting their mental health plan and their Managed Care Medi-Cal Health Plan together to talk through the MOU.
- The second part of the Work Plan concerns the workforce for integrated health care. The specific target is to place Occupational Therapists under Licensed Mental Health Professionals.
- The committee is working on two possibilities concerning the Planning Council's theme of alternatives to locked facilities.
- The committee's approach has been facilitating conversation and helping people within the physical health plan world to learn and meet people within the mental health world.

Ms. Shaw asked where the committee is expecting to obtain the information about what the health plans are doing. Mr. Grolnic-McClurg replied that the California Health Care Foundation was very interested in partnering with the CMHPC to collate that information.

Mr. Mitry asked if there is any information about people from underserved groups being reached and engaged to participate in effective treatment and prevention modalities. Mr. Grolnic-McClurg doubted that there was such information. The committee seeks to obtain good basic information on things like penetration rates and access.

Mr. Leoni asked about health plans for hospitalized individuals – would they not be classified as Severe rather than Moderate? – and suggested having a representative from the Department of Managed Health Care on the Planning Council. Mr. Grolnic-McClurg responded that the committee had been thinking along those same lines; the reach of that stakeholder advisory group has not been wide, and they have invited the Planning Council to participate in it. Mr. Grolnic-McClurg then responded to Mr. Leoni's first point: certainly if someone is hospitalized, it could be an indicator that the person should switch from one system to the other.

Mr. O'Neill commented regarding Mild and Moderate: as a Mental Health Director in a rural county, he felt that this system is failing. Because of the lack of providers in Trinity County, beneficiaries with a Mild to Moderate diagnosis cannot receive services – so county mental health goes ahead and sees them, billing through the 1915b Waiver. Mr. O'Neill would prefer to let DHCS contract directly with the counties who want to provide Mild to Moderate services. Mr. Grolnic-McClurg responded that many in the specialty mental health care system are saying that you can't get into the Managed Medi-Cal Health Plans and you can't get seen – exactly what many people in the community are saying about the Specialty Mental Health Plans. The committee supported providing

advocates and stakeholders with information; they are very good at putting pressure in the right places.

**Committee Chair Adam Nelson reported on the Advocacy Committee.**

- Their Work Plan covers the following:
  - The committee will look at IMD utilization in various counties and at their use of community-based alternatives to treatment.
  - The committee is constructing a sample survey to send to the different county Mental or Behavioral Health Directors. Ms. Shaw was the only committee member who had success in getting information from her director.
  - Mary Marx from Los Angeles County gave a presentation to the committee; she gave some detailed information regarding IMD utilization.
  - The committee may use a consultant for help with data.
  - The committee hopes to develop an understanding of better and best practices for keeping people from being placed in IMD settings, and to produce a document for the counties to guide their future considerations.
- This year’s legislative docket includes many possible bills that will influence mental health care in California. The committee has two sets of planks: Mandatory and Discretionary.
- Dr. Nelson summarized the bills of interest: SB 29 for peace officer training; AB 1193 and SB 59 requiring all counties to opt in to Laura’s Law unless they specifically opt out; SB 1194 for clarifying the definition of dangerousness to self or others; AB 1300 for fixing LPS laws regarding 5150; and SB 614 authorizing the development of programs for peer certification.

Mr. Mitry commented that the term “Institutes of Mental Diseases or Disorders (IMD)” is shrouded in stigma. Is there a substitute name that could be used? Dr. Nelson replied that the term is actually in federal law, coined in Medicaid legislation. Possibly in the health care reform discussion, someone will come up with a less pejorative term.

Mr. Leoni reported an additional tweak to the Los Angeles statistics that Dr. Nelson had mentioned, regarding the IMD bed count fluctuation before and after the MHSA.

**7. Report from California Behavioral Health Directors Association**

Mr. O’Neill reported on the CBHDA.

- In terms of legislation, the CBHDA is completely in sync with the Advocacy Committee regarding the bills that Dr. Nelson had just mentioned. Mr. O’Neill has a stack of letters supporting SB 614. It has bipartisan support.
- SB 82, the triage grant program, has gone through three rounds of RFAs and has about \$50 million left in the pot. An effort is now underway to make adjustments to the original regulation.

- CBHDA is working on crisis stabilization and crisis residential in small counties. The facilities are expensive to run. CBHDA is asking if there is a way to use SB 82 funds for peer respite.
- The Superior Region has voted to spend about \$350,000 on Peer Certification as part of WET. They are entering into a contract with the California Association of Social Rehabilitation Agencies (CASRA) so that every county in the region can send up to four Peer Specialists for 110-hour certification training.
- CBHDA is working on the transition to Diagnostic and Statistical Manual of Mental Disorders-Fifth Edition (DSM-5). At the May meeting a panel will drill down to the specifics of what it will look like.
- CBHDA strongly supports what is happening with the 1115 Waiver. It is possible that the Centers for Medicare and Medicaid Services (CMS) will realize that for consumers, their mental health treatment is affected by where they live.
- If approved, the Drug Medi-Cal Waiver will consist of four phases of opt-in. The Bay Area will be first for implementation. The bonus regarding counties opting in is that the IMD Exclusion – the 16-bed limitation – will be waived.
- In terms of Medi-Cal cost containment, CBHDA and other agencies is going to do a pilot program for parallel testing of five counties: while they are billing for the fee for service by the minute, they will also look for another strategy for reimbursement that may be comparable yet simpler.
- CBHDA received a letter from Senator Beall; it was sent to Mike Gibson, Chair of the Joint Legislative Audit Committee. Senator Beall is asking for an audit of school-based mental health services in four counties including Santa Clara.

Mr. Wilson commented that there is a pilot program for the Real Estate Settlement Procedures Act (RESPA) in Long Beach.

Dr. Pitts mentioned that internationally, there is a long-time effort of using home-based services, especially in rural areas – in Finland in particular. The teams are professional rather than peer and have had good success, particularly for people who are housed.

Mr. Powelson commented that the border rural states have problems with inter-state services. For example, in Siskiyou County, the nearest hospital is in Medford, Oregon, but people with psychiatric conditions must travel down to Sacramento. Because of the lack of parity, people with psychiatric emergencies are receiving poor service.

Ms. Flores mentioned that in her county, they have had a peer-run crisis residential for three years. Cost effectiveness and outcomes have improved tremendously over the three years. She stressed the need for ongoing training of peers. Mr. O'Neill responded that Trinity County knows this works: in their triage program – where for crisis service, consumers come into the wellness center and meet with a peer specialist first – hospitalization rates have fallen by two-thirds in a year's time.

## **8. Public Comment**

Cary Martin of CALMHB thanked Ms. Susan Wilson and Dr. Dickerson specifically for their work on the project. The Planning Council had felt CALMHB's pain and responded in an admirable way.

## **Friday, April 17, 2015**

### **1. Welcome and Introductions**

Chair Claflin greeted everyone attending the Friday morning session. Members of the Planning Council and audience introduced themselves.

### **2. Opening Remarks**

Assembly Member Sebastian Ridley-Thomas addressed the Planning Council.

- He serves as the Chair of the Select Committee, a type of investigative/informational/study committee on mental and behavioral health in Proposition 63 implementation.
- His interest in mental and behavioral health is multifold: one perspective is public health/public protection; another is human need and moral responsibility; another is public safety and economic development.
- The state could have been a better supporter of quality programming. Veterans' programs are a significant issue. Assembly Member Ridley-Thomas gave an overview of a lawsuit recently settled regarding the use of VA property in Westwood for the care of veterans.
- The Legislature has lost a champion in Darrell Steinberg, although he has formed the Steinberg Institute which is sponsoring a bevy of bills. Assembly Member Ridley-Thomas is carrying a bill concerning foster children.
- Last Friday at the California African-American Museum, a hearing was held with respect to autism and mental health.
- The state has largely abdicated its role with respect to state hospitals; Los Angeles County is operating Twin Towers, which would have been a state hospital, as a correctional facility. Counties and deputies are not well-suited to have to deliver mental health services under the guise of law enforcement.
- The Administration has begun a conversation to build another state hospital in Norwalk. Assembly Member Ridley-Thomas supports it. We need more state hospitals in order to accommodate the skid row and homeless population.
- Assembly Member Ridley-Thomas's offices in Sacramento and Los Angeles are always at the disposal of the Planning Council. He wants his offices to be a clearinghouse for mental health; they will advertise what the Planning Council publishes, and they are set to review the Planning Council's reworked 5-Year Plan.

### **3. Report from the California Association of Local Mental Health Boards/Commissions**

Larry Gasco, Ph.D., LCSW, and CALMHB President, gave a report on the organization.

- Because of the logistical situation, CALMHB had considered cancelling their meeting with the Planning Council altogether. However, the collaboration is important.
- At tomorrow's meeting CALMHB will have to decide how to proceed; what they have done in the past fiscal year is not sustainable. The objective is to be as positive as possible and to allocate resources in the most effective way, to put the Board in a more stable financial situation.
- Although CALMHB has no staff, they will do their best to accommodate requests from the Planning Council.
- The strength of CALMHB is that the Mental Health Boards really do reflect the populations served by the mental health system.
- The current challenge is to reach the Mental Health Boards and Commissions throughout the state. This may include providing training.

Ms. Lewis commented that the Planning Council had received the Data Notebook yesterday – it is more refined now than the first version. Perhaps it could be used to gather information from the Mental Health Boards and Commissions statewide, regarding whether they have or need staff. Dr. Gasco replied that CALMHB would be supportive and would need further discussion with the Planning Council.

Ms. Lewis remarked that she and Mr. Robinson were going to suggest that the Planning Council show that it is working with CALMHB; this work could be named in the Planning Council's Work Plans. The Health Integration Subcommittee could begin to have a dialogue.

Ms. S. Wilson noted that the issue of who completes the Data Notebook on behalf of the local Mental Health Board is one that they have grappled with. She did say that the Data Notebook is actually the product of a whole group of people, and she would like to discuss this idea with others who have a major stake in it.

Mr. Ryan asked if the counties contribute to CALMHB. Dr. Gasco responded that the dues are voluntary and were raised from \$300 to \$500 annually, but this did not have an impact on participation. The number of counties participating fluctuates from year to year.

Mr. Ryan asked if the Planning Council should force the issue of funding or not funding CALMHB. Dr. Gasco said that CALMHB needed to discuss this and many more issues. He felt that the resources are available – it's the will of those holding the purse strings to allocate a reasonable amount of money to allow CALMHB to fulfill its plan, which is to assist all the Mental Health Boards throughout the state to fulfill their responsibilities.

Ms. Mitchell asked if CALMHB had considered revamping its dues structure – to look at a tiered system based on the size of the county's budget. She also asked if CALMHB gets media training for advancing positive news stories and countering negative ones. Dr. Gasco responded that CALMHB would explore the tiered system again, and that he was not aware of any media training for CALMHB although he certainly saw the importance of highlighting successes.

#### **4. Council Member Open Discussion**

Ms. Adcock presented outgoing member Monica Wilson with a Certificate of Appreciation in recognition and gratitude for her service and dedication as the Chairperson of the Planning Council in 2014. Ms. Adcock presented her with \$130 to donate to a charity of her choice. Ms. Wilson designated the United Advocates of Children and Families.

Ms. Lewis commented that adding a page to the Data Notebook to collect some information was a good idea. Regarding the tiered dues system, Ms. Lewis was in conversation with Dr. Gasco. Los Angeles County actually has a non-staff budget of only \$35,000 – a systemic problem with the Boards and Commissions. The more the Planning Council partners with the CBHDA and the MHSOAC, the more we can do to push the need.

Mr. Ryan noted that this problem has festered for a long time. It is a credit to CALMHB that they have been able to function under these constraints as long as they have. Maybe it is time to force the issue with the MHSOAC, Senator Beall, and the Department – to sit down with them and ask if there is value to having CALMHB. The Planning Council could take leadership in holding such a summit.

Ms. Lee asked who used to fund CALMHB. Mr. Ryan answered that it was the State Department of Mental Health. Ms. Shaw and Ms. S. Wilson added historical information.

Dr. Nelson asked about the added value CALMHB brings to the functioning of the individual County Mental Health Boards. He saw needs for training, education, assistance for members in performing their duties, and liaison assistance with other organizations overseeing mental health care at the state level. Can CALMHB's networking function between the various Mental Health Boards be promoted in a way that is more cost-effective?

Mr. Ryan suggested that a partnership between CALMHB and the Planning Council is a place to begin. CALMHB could articulate the value of having additional funding and staff, and the Planning Council could consider it and decide whether to go forward and support it.

Ms. Hart said that in her years of experience with CALMHB, she had seen that for many of the people in the counties, CALMHB was their only link with the state. Without CALMHB the counties would be tremendously isolated; the stakeholder piece is very important to retain.

Ms. S. Wilson, the current CALMHB liaison, mentioned training. This year CALMHB had worked hard with the California Institute for Behavioral Health Solutions (CIBHS) to learn training. It will make CALMHB more powerful to have well-trained Boards behind them. CIBHS also offers training on Advocacy which can have a media component, and on how to have an effective Board. CALMHB has made many steps forward with the finances and opportunities they have. The leadership is strong and the Planning Council has a responsibility to support them.

Ms. Prettyman asked about expenses and ascertained that CALMHB's funds pay for its members' travel to CMHPC meetings. CIBHS receives funding to train the CALMHB members. Dr. Gasco explained that CALMHB's \$55,000 contract is administered by the MHSOAC. That amount plus the dues basically pays for the 25 Directors' travel. Some of the counties pay for their own members to attend the meetings.

Dr. Gasco continued that the counties who need the training most, who are not represented among the 25 Directors, do not know the training exists. Contact information from the 58 counties is also critical to share.

Ms. Lewis mentioned that she and Mr. Robinson had talked with Dr. Gasco, Cary Martin, and other CALMHB members about putting together a Business Plan – CALMHB is a 501(c)3. She suggested obtaining the records of the old setup and the old budget, and volunteered to have the Los Angeles County Mental Health Commission be the clearinghouse for that information in order to start developing a Business Plan. It would become a goal for the Health Integration Committee.

Ms. Lewis stated that in the counties, the yearly allocation for MHSA money must be reviewed and approved by the local Mental Health Boards and Commissions before it goes on to the Board of Supervisors. One year the Los Angeles County Mental Health Commission had leveraged this power to force the Board of Supervisors to hire them a Director. The Mental Health Boards and Commissions do have this power that they can choose to use.

Mr. Powelson felt that CALMHB and CMHPC should sit down together to work out this Business Plan.

Mr. Leoni remarked that with more funding, CALMHB could be a voice at the state level for the local Mental Health Boards – tracking legislation, looking at policies, and expressing the counties' needs to the Legislature.

Mr. Ryan surmised that there were two options: to let the committee take on the task, or for the Planning Council to take some action and request that CALMHB present a value statement; then the two organizations would make a plan to go forward with obtaining increased funding.

Ms. S. Wilson felt that the CBHDA would be a very viable partner in this effort.

Ms. Shaw ascertained from the CALMHB members that they do provide an itemized budget to the MHSOAC when they negotiate their funding.

Hearing that CALMHB is a 501(c)3, Dr. Nelson expressed concern that it has certain fiduciary responsibilities: Articles of Incorporation, a charter, a Board of Directors that meets regularly; they are a fundraising organization, but what fundraising do they do? This group may have tremendous capacity to support itself.

Ms. Lewis responded that fundraising would take a coordinated effort from a staff person. Further, she did not want to get sidetracked having the Planning Council examining fiduciary responsibilities; Dr. Gasco, Ms. Wilson, or Ms. Adcock could answer those questions.

Dr. Gasco expressed thanks to the CALMHB Treasurers who had served in the past. CALMHB does indeed have Articles of Incorporation, Bylaws which are regularly reviewed, and tax records that are provided annually. The Board of Directors consists of the 25 County Mental Health Board representatives who meet on a quarterly basis. Any fundraising would have to be done by volunteers; currently there isn't even anyone to answer the phone or receive correspondence.

Dr. Gasco continued that CALMHB needs to do a better job of informing the Planning Council of where it is on many levels. He supported the idea of pulling the CBHDA into the discussion on funding.

Mr. Ryan suggested asking the committee to work with CALMHB to flesh out the subjects discussed, and to bring it back to the full Planning Council.

## **5. Public Comment**

Marcia Ramstrom, Second Vice-President for CALMHB and member of the Shasta County Mental Health, Alcohol and Drug Advisory Board, supported the idea of a tiered mandated fee structure. She said that after the quarterly meetings, the CALMHB members go back to their local Boards and Commissions and share the information. The other main value that CALMHB offers as an organization is the training.

Luvenia Jones, Alameda County Mental Health Board, said that the only training she had received during her four years on the Board was from CALMHB. She had pressed the Board to pay their dues after many years of not paying. The community the Board serves – clients and family members – is very valuable to her.

Jo Torres, a community advocate from Orange County, expressed concern about the liability of the consumers: how their rights are being met and how the rights of facilitators are being met.

Theresa Comstock of the Napa County Mental Health Board raised the issue of the lack of affordable board and cares. Can this be put on the Planning Council's agenda through the Advocacy Committee or the next Data Notebook?

Ms. Torres mentioned that they are putting many clients into Sober Livings, which have no mental health training; neither do they have oversight and accountability.

Wes Mukoyama of the Santa Clara County Mental Health Board agreed that perhaps training could be done for fund development. The best way to get money is to go to individuals who champion the cause.

Dina Ortiz of the Mendocino County Mental Health Board thanked the Planning Council for all the tools they have given her these last couple of days. She can bring them back to her Board so they can improve their advocacy for consumers who are dying in the jails, as well as ethnic groups who are not being served.

John Sturm of the San Diego County Behavioral Health Board commented on his tenure at CALMHB. The quarterly training they used to offer had been invaluable to him as a new Board member and a representative of clients and consumers. That focus is gone now. Mr. Sturm related a story of a grievance he had filed over fraudulent Medi-Cal

charges from a doctor to his patients. He then stressed that there is now a lack of psychiatrists willing to serve Medi-Cal patients.

## **6. Report from Mental Health Services Oversight and Accountability Commission**

Chair Claflin stated that there were no representatives from the MHSOAC present.

Mr. Leoni suggested for the Planning Council to write a letter expressing their disappointment – it is a valued relationship to maintain. Chair Claflin mentioned that Planning Council members had met with them a week ago.

## **7. Public Comment (continued)**

Karen Bates of Ventura County asked for an update on the certification or standardization of qualifications for Peer Support Specialists and Family Specialists. Chair Claflin answered that the bill went into Appropriations yesterday. Mr. Leoni added that it had gone through its first policy committee. There are several other steps now before it goes to the other House – this will take some time and there is still plenty of room for amendments.

Hector Ramirez commented on the importance of the CMHPC and CALMHB and on their unused potential. The Little Hoover Report documented the need for oversight and accountability at both the county and the state level. The two bodies here have such power to utilize those components of the MHSO mission.

## **8. Diversion Services for Mental Health Consumers in our Local Criminal Justice System**

Marvin Southard, DSW, Director of the Los Angeles County Department of Mental Health, spoke about some important activities connected to the Diversion.

The Health Neighborhood of Los Angeles is an effort to integrate mental health and substance abuse care for particular communities; we believe it is the biggest and most important challenge in the health care system overall.

- The consortiums coordinate the health, mental health, and substance abuse providers serving the communities to share medical records, treatment plans, and facilities for care coordination.
- The major part of the effort is outreach to the broader community – to engage them in working on the social determinants of health outcomes. Access to quality care is only 20% of what creates good health outcomes. 30% is personal health habits; 10% is the environment in which you live; 40% is the social environment – the community in which you live.
- The Health Neighborhood gets the consortium linked with the local community so they can decide the determinants of health outcomes they want to work on: childhood obesity, domestic violence, drugs, too many liquor stores, and so on.
- The very act of a community working together creates social capital that makes that community healthier.

- The Health Neighborhoods should be something a health plan wants to invest in. As health conditions improve, costs go down.
- They are starting in places that already have an existing community empowerment activity going on. They have connected with Rand and UCLA to develop federal funding for the outcomes of the Health Neighborhoods.
- Another effort in Los Angeles has been to recognize the crucial role that faith communities play in our ability to provide the support people need to achieve recovery. Spirituality is a strength in that process. They have invested for over a decade in building mental health/spirituality partnerships. They have developed clinical parameters to guide clinicians should they address issues of spirituality.
- In building faith communities of all kinds into the Health Neighborhoods, they have started a clergy academy. Training is done in English, Spanish, Korean and Mandarin.
- The link of Health Neighborhoods to Diversion is the prevention of recidivism. People released from the county jail have an After-Care Plan linking them with a primary care physician in the Health Neighborhood of their community. The After-Care Plan also links them with the faith resources of the community to which they will be returning.
- They hope to support all of this with software from the Philadelphia Prisoner Return Network, which is populated with all of the person's data. This enables those doing the discharge to link the person with a specific array of resources.

### **Questions**

Mr. Powelson raised the issue of overshadowed poverty in wealthy communities. He requested the Planning Council to remember their unmet needs. Every zip code has different communities within. Dr. Southard agreed; Los Angeles County has pockets of poverty within wealthy communities.

Mr. Leoni raised the issue of isolation – he has observed that people in San Francisco may experience it when they do not belong to an organized faith or an established ethnic group. How do we go to that community? Mr. Leoni also pointed out that those supporting others need support too. Dr. Southard responded that this hits the point exactly of a Health Neighborhood: it should be a place that re-knits the fabric of community that produces health.

Los Angeles County District Attorney Jackie Lacey, J.D. spoke next. Ms. Lacey shared her “Ted Talk” with the Planning Council.

- For 30 years Ms. Lacey has watched in frustration as the same people go in and out of the jails and prison, confronting the same issues over and over again.
- The long-term effects of incarceration are not good: 64% of people return for a new crime or a technical violation within three years of being released from prison. California has the highest recidivism rates in the nation.

- We can do better by diverting the lowest-level offenders from the criminal justice system; offering non-violent offenders the chance to change their lives and avoid incarceration has proved successful.
- Ms. Lacey described the Second Chance Re-Entry Corps, a program where women newly released from prison who violated the terms of their parole were housed in a residential facility instead of prison. The women were given conditions that leveraged their relationships with their children and families. They were also made accountable to a judge who had the power to incarcerate them. The program was astoundingly successful.
- The group that started this program began another one for veterans, the Los Angeles County Veterans Corps. Many veterans who committed relatively minor offenses have been taken to a safe, secure, voluntary residential treatment program on a VA campus. They receive medical and mental health services paid for by their VA benefits, and are mentored by other vets. They also reported regularly to a judge who held them accountable. Here also, the recidivism rate dropped to around 20%.
- Can this type of alternative sentencing also work for the problematic population of those jailed for behavior caused by mental illness? Out of roughly 18,000 people in the county jail, 17% have been diagnosed with some form of mental illness. The L.A. County Jail employs 38 full-time psychiatrists; there are actually 300 full-time employees working in the jail's psych ward. A bed there costs three times more than a regular jail bed to maintain. To complicate matters, this is one of the riskiest populations.
- Ms. Lacey shared the case of Miriam, a college graduate diagnosed at age 28 with mental illness. She was charged with felony carjacking. Ms. Lacey's office insisted that Miriam plead guilty to the felony taking of a car. She is on probation and has been ordered to cooperate with her doctors and take her medication. Ms. Lacey pointed out the difficult choices Miriam is left with when she seeks employment, with a felony conviction caused by mental illness. Today she takes her medication responsibly. But without medication she may become discouraged and end up behind bars, or she could hurt herself or others.
- Ms. Lacey stated that creating alternatives to incarceration for those with mental illness will actually require a greater risk. She leads a large working group called to explore a variety of ways to address this issue. They believe they can intercept people at various stages of the criminal justice process, and divert them in a more effective way to help them get well.
- Ms. Lacey described the Criminal Justice Mental Health Project. Its mission is to evaluate the needs of those with mental illness who have risk of entering the criminal justice system, and to evaluate the available resources and develop coordinated responses. Participants are prosecutors, public defenders, law enforcement, firefighters, paramedics, mental health professionals, judges, and probation workers.
- Ms. Lacey shared some insights gleaned from the group. Of those who are referred and become engaged in their treatment plan who are mentally ill, the recidivism rate

is 30% lower than for people without mental illness. Also, the use of the county jail as a massive mental health ward is inefficient, ineffective, and in many cases, inhumane.

- Ms. Lacey closed by posing a moral question: In the criminal justice system, are we punishing people for simply being sick? Public safety of course should have a priority, but justice must always come first in our decision-making.

### **Questions**

Mr. Wilson commented that we need to face these issues of help for the mentally ill head-on because they have been going on way too long. Ms. Lacey noted that it takes a concerted effort from all the leaders involved. Dr. Southard added that even though 20% or so of people in the L.A. County jail system suffer from mental illness, 80% have a substance abuse issue. We cannot ignore the substance abuse and addiction issues. Planning Council members can make sure that an upcoming federal benefit, which includes detox, residential treatment, outpatient treatment, sober living, etc., is publicized to their counties, which need to opt in.

Ms. Shaw asked about diversion with pleas of guilty or not guilty. Ms. Lacey replied that she and Dr. Southard have compiled a list of charges for which the offender can go to Urgent Care Centers and receive help. However, some people will not be responsive for that option; then criminal charges must be filed and the person placed on probation to be more closely monitored.

Ms. Wilson asked about restorative justice for children, to divert them out of the juvenile justice system and get them the assistance they need earlier in life. Dr. Southard gave an outline of their general strategy with diversion which employs five “intercepts.”

Mr. Powelson asked about the permanency planning that is happening for SB 82 – ensuring that triage and mobile crisis continue. Dr. Southard responded that as we create this infrastructure we must build in the sustainability. To that end, the Board of Supervisors has committed \$30 million and the project is also using the resources from the MHSA. Ms. Lacey agreed with Mr. Powelson that Miriam’s first hospitalization was the opportunity that was missed. Relatives should have been contacted; a support system should have been in place.

Ms. Derby asked about the groups of experts and decision-makers – NAMI and other community groups. Ms. Lacey answered that the group includes people with direct experience with mental illness and with the criminal justice system. Dr. Southard added that they have built around the principle of “*Nothing About Us Without Us.*”

Mr. Leoni felt that most mental illness does not inherently cause violence. Sometimes with mental illness, reality becomes distorted and people feel desperate; then they do desperate things – which are not always violent.

### **Public Comment**

Steven McCormick, Chair of the San Joaquin County Mental Health and Substance Abuse Board, expressed concern with how clients are motivated to participate when they are recalcitrant. In his county, the “Inspire” program engages clients not with threats or

jail time but by patiently opening a dialogue. Dr. Southard clarified that L.A. County's general outreach principles are not coercive.

Ms. Torres voiced concern over people in the jail system under a 5150, who have no medication and are restrained with handcuffs and shackles. They come out with physical and mental scars, afraid to get treatment.

Ms. Jones stressed the importance of housing in the equation.

Shirley Posey, a consumer and family member, applauded the work done in Los Angeles County; Alameda County has a long way to go. Even so, she had been able to give input to the judge regarding her son's treatment plan.

Ken Bonner, a clinician and ordained minister, stated that it's not just housing, but therapeutic housing plus perhaps vocational training, that is necessary.

## **10. ADJOURN**

Chair Claflin adjourned the meeting at 12:01 p.m.

X   INFORMATION

TAB SECTION        L

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

DATE OF MEETING    6/17/15

MATERIAL  
PREPARED BY:    Adcock

DATE MATERIAL  
PREPARED        5/14/15

<b>AGENDA ITEM:</b>	Simplified Roberts Rules
<b>ENCLOSURES:</b>	How to Make a Motion  Quiz: Robert's Rules of Order
<b>OTHER MATERIAL RELATED TO ITEM:</b>	

**ISSUE:**

To facilitate Council member knowledge and skill in using Robert's Rules of Order, a short overview, reminders and cheat sheets will be presented at the opening of each Quarterly Meeting.

## QUIZ: ROBERTS RULES OF ORDER (NEWLY REVISED)

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### **The President can vote only to break a tie.**

**NO:** *the presiding officer has the same rights as any other member of the body.*

*The presiding officer of an assembly of more than about a dozen members should make every effort to maintain an appearance of impartiality so that members on both sides of any issue can feel confident they will receive fair treatment. To this end the chair does not participate in debate on any issue unless (s)he gives up the chair. The chair votes only when either*

- ♦ *The vote is by ballot, in which case the chair votes along with and at the same time as all other members, or*
- ♦ *The chair's vote will change the result of the vote.*

---

### **Once a quorum has been established it continues to exist no matter how many members leave during the course of the meeting.**

**NO:** *Even when a meeting begins with a quorum present, it loses its right to conduct substantive business whenever enough members leave to bring attendance below the level of a quorum. It can resume substantive business only when enough members return, or other members arrive, to give it a quorum again.*

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### **Abstention votes count.**

**NO.** *Abstentions are instances in which members who are present refuse to vote. In the usual situation where either a majority vote or a two-thirds vote is required, abstentions are not counted and have no effect on the result. However, if the vote required is a majority or two-thirds **of the members present**, an abstention has the same effect as a "no" vote.*

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### **A member with a conflict of interest with respect to a motion cannot vote on the motion.**

**DEPENDS:** *Brown Act is YES.*

**RRONR NO:** *You should not vote on a question in which you have a direct personal or monetary interest not common to other members. However, you cannot be compelled to abstain because of such a conflict of interest.*

---

### **Debate on a motion must stop as soon as any member "calls the question".**

**SORT OF:** *The proper wording to close debate on the immediately pending motion is to say "I move the previous question". The body then needs to vote on that motion with a 2/3 vote for adoption. If the motion passes, the body will immediately consider the previous motion with no further debate. Cutting off debate infringes on the right of members to speak, thus debate should never be limited without following the proper procedure.*

---

### **Anyone can add an item to an agenda.**

**RRONR YES:** *For a proposed agenda to become the official agenda for a meeting, it must be adopted by the assembly at the outset of the meeting. At the time that an agenda is presented for adoption, it is in order for any member to move to amend the proposed agenda by adding any item that the member desires to add, or by proposing any other change.*

**BROWN ACT NO:** *The agenda provided at least 72 hours in advance of the meeting is the official agenda and cannot be modified except in emergency situations.*

---

### **Minutes of a meeting need to contain all the information from the meeting.**

**NO:** *Not only is it not necessary to summarize matters discussed at a meeting in the minutes of that meeting, it is improper to do so. Minutes are a record of what was done at a meeting, not what was said.*

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### **A board meeting cannot be held by telephone.**

**NO:** *You may hold board meetings by conference telephone call only if your bylaws specifically authorize you to do so. If they do, such meetings must be conducted in such a way that all members participating can hear each other at the same times, and special rules should be adopted to specify precisely how recognition is to be sought and the floor obtained during such meetings.*

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X   INFORMATION

TAB SECTION M

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

DATE OF MEETING 6/17/15

MATERIAL  
PREPARED BY: Adcock

DATE MATERIAL  
PREPARED 5/15/15

<b>AGENDA ITEM:</b>	Alternatives To Locked/Involuntary Placements
<b>ENCLOSURES:</b>	
<b>OTHER MATERIAL RELATED TO ITEM:</b>	

**ISSUE:**

Pursuant to the Council's focus for 2015, counties around the state will present to the members on programs they have established which provide: 1) prevention services to catch folks before a need arises; 2) diversion programs when someone finds themselves at the doorway; and/or 3) reintegration activities to assist in the transition out of a facility back into the community. The facilities include hospitals and jails.

On Wednesday, June 17, 2015, Kacy Carr, Deputy Director, Adult and Older Adult Services, San Mateo County Behavioral Health and Recovery Services will present on programs in San Mateo County.

On Thursday, June 18, 2015, we have invited Santa Clara County to present on their programs.

It is anticipated that an annual report will be prepared which will discuss the focus topic and present information on effective programs implemented throughout the state.

X   INFORMATION

TAB SECTION        N

       ACTION REQUIRED

DATE OF MEETING    6/17/15

MATERIAL  
PREPARED BY:    Adcock

DATE MATERIAL  
PREPARED        5/15/15

<b>AGENDA ITEM:</b>	Operationalizing the Council's Behavioral Health Integration
<b>ENCLOSURES:</b>	
<b>OTHER MATERIAL RELATED TO ITEM:</b>	

**ISSUE:**

Bruce D. Emery, M.Ed., MSW, from the Advocates for Human Potential, will facilitate the Council's discussion and design of a Strategic Plan to operationalize the integration of the Council. It is anticipated that there will be several steps and actions and that it will take a few years to fully achieve integration. Bruce brings both the national perspective as well as lessons learned from other states who have already integrated.