



September 29, 2014

To: California Mental Health Planning Council

From: Jane Adcock
Executive Officer

Subject: October 2014 Planning Council Meeting

CHAIRPERSON
Monica Wilson PhD

EXECUTIVE OFFICER
Jane Adcock

Enclosed is the packet for the October 15-17, 2014 Planning Council meeting at the Lake Natoma Inn in Folsom, CA. The hotel is located at 702 Gold Lake Drive, Folsom, CA 95630. The hotel provides complimentary self-parking.

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, October 16**, 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 30 minutes for committee reports on Thursday afternoon. 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
fax 916.319.8030

AGENDA
CALIFORNIA MENTAL HEALTH PLANNING COUNCIL
October 15, 16, and 17, 2014
Lake Natoma Inn
702 Gold Lake Drive
Folsom, CA 95630

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, October 15, 2014

COMMITTEE MEETINGS

Time	Topic	Room	Tab
9:00 am	Executive Committee Meeting	Folsom Boardroom	
11:00 am	New Member Orientation Meeting	Folsom Boardroom	
12:00 pm	Patients' Rights Committee Meeting	Natoma Boardroom	
12:00 pm	LUNCH (on your own)		
1:30 pm	Continuous System Improvement Committee Meeting	Natoma Boardroom	
1:30 pm	Advocacy Committee Meeting	Folsom Boardroom	
1:30 pm	Health Care Integration Committee Mtg.	Placer Boardroom	

Thursday, October 16, 2014

PLANNING COUNCIL GENERAL SESSION

Sierra Ballroom

Conference Call 1-866-723-8689

Participant Code: 8356601

Time	Topic	Presenter or Facilitator	Tab
8:30 am	Welcome and Introductions	Monica Wilson, Ph.D., Chairperson	
8:40 am	Opening Remarks	Tom Campbell, Chair, Sacramento County Mental Health Board (invited)	
9:00 am	Approval of June 2014 Meeting Minutes	Monica Wilson, Chairperson	U

California Mental Health Planning Council

Time	Topic	Presenter or Facilitator	Tab
9:10 am	Mental Health and Substance Use Overview	Jane Adcock, Executive Officer	V
9:20 am	Intro to Mental Health and Substance Use Disorders at Dept. of Health Care Services	Karen Baylor, Ph.D., Deputy Director, Mental Health and Substance Use Disorders, DHCS	
9:45 am	Overview of Substance Abuse Prevention and Treatment (SAPT) Block Grant	Don Braeger, Chief, SUD Prevention, Treatment, and Recovery Services Division	
10:15 am	BREAK		
10:30 am	Continued Overview of SAPT Block Grant and Follow-up Questions and Discussion	Don Braeger and Full Council	
11:10 am	Report from Mental Health Services Oversight and Accountability Commission	Sherri Gauger, Executive Director	
11:30 am	Executive Officer Report	Jane Adcock, Executive Officer	
11:50 am	Public Comment		
12:00 pm	LUNCH (on your own)		
1:30 pm	Committee Reports	Patricia Bennett, CSI Committee Chair; Steven Grolnic-McClurg, HCR Committee Chair; Daphne Shaw, Patients' Rights Committee Chair; Barbara Mitchel, Advocacy Committee Chair	
2:00 pm	Overview of Drug Medi-Cal and the vision for the future including the proposed waiver	Marlies Perez, Chief, SUD Compliance Division and Don Braeger, Chief, Prevention, Treatment, and Recovery Services, Dept. of Health Care Services	
2:45 pm	BREAK		
3:00 pm	Continued Overview and Follow-up Questions and Discussions	Marlies Perez, Don Braeger, and Full Council	
3:30 pm	Report from California Behavioral Health Directors Association	Noel J. O'Neill, LMFT, Director, Trinity County	

California Mental Health Planning Council

Time	Topic	Presenter or Facilitator	Tab
3:50 pm	Council Member Open Discussion	Full Council	
4:15 pm	Selection of 2015 Nominating Committee	Monica Wilson, Chairperson	
4:30 pm	Public Comment	Monica Wilson, Chairperson	
4:50 pm	New Business	Monica Wilson, Chairperson	
5:00 pm	RECESS		

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

Friday, October 17, 2014

PLANNING COUNCIL GENERAL SESSION

Sierra Ballroom

Conference Call 1-866-723-8689

Participant Code: 8356601

Time	Topic	Presenter or Facilitator	Tab
8:30 am	Welcome and Introductions	Monica Wilson, Chairperson	
8:40 am	Opening Remarks	Uma Zykofsky, Director, Sacramento County Behavioral Health Services	
9:10 am	Report from the California Association of Local Mental Health Boards/Commissions	Larry Gasco, Ph.D., LCSW, President	
9:30 am	Overview of Substance Abuse Services Compliance and Licensing	Marlies Perez, Chief, SUD Compliance Division, Dept. of Health Care Services	
10:15 am	BREAK		
10:30 am	Continued Overview of SA Compliance and Licensing and Follow-up Questions and Discussion	Marlies Perez and Full Council	
11:00 am	Status on Implementation of the Workforce Education and Training 5-Year Plan	Lupe Alonzo-Diaz, Deputy Director, Healthcare Workforce Development Division, Office of Statewide Health Planning and Development	
11:40 am	Public Comment	Monica Wilson, Chairperson	
11:50 am	New Business	Monica Wilson, Chairperson	
12:00 pm	ADJOURN		

California Mental Health Planning Council

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 October 6, 2014 in order to work with the venue to meet the request.

2015 MEETING SCHEDULE

January 2015	January 14, 15, 16	San Diego	Crowne Plaza San Diego, 2270 Hotel Circle North, San Diego, CA 92108
April 2015	April 15, 16, 17	Los Angeles	San Pedro Doubletree, 2800 Via Cabrillo-Marina, San Pedro, CA 90731
June 2015	June 17, 18, 19	Santa Clara	To Be Determined
October 2015	October 14, 15, 16	Sacramento	To Be Determined

2016 MEETING SCHEDULE

January 2016	January 20, 21, 22	San Diego	To Be Determined
April 2016	April 20, 21, 22	Ontario/Riverside	To Be Determined
June 2016	June 15, 16, 17	SF/Burlingame	To Be Determined
October 2016	October 19, 20, 21	Sacramento	To Be Determined

California Mental Health Planning Council

Executive Committee Meeting

October 15, 2014

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

Boardroom-Folsom

9:00 to 10:50 a.m.

Item #	Time	Topic	Presenter or Facilitator	Tab	Page
1.	9:00 am	Review and approve minutes from the June, July, and August 2014 Executive Committee Meetings	Monica Wilson, Chairperson	1	
2.	9:10 am	Report on Council Activities, Membership, and Future Meeting Agendas	Jane Adcock, Executive Officer		
3.	9:20 am	Review of Council Budget and Expenditures for end of FY 2013-14 and projected FY 2014-14 budget	Tamara Jones, Chief of Operations	2	
4.	9:40 am	Overview and Discussion of MH Master Plan Options and Role of Planning Council	Cynthia Burt, Consultant		
5.	10:05 am	Overview and Discussion of Council Actions to Explore Becoming a Behavioral Health Council	Jane Adcock and Tracy Thompson		
6.	10:15 am	Liaison Reports for CALMHB/C and CCMH	Susan Wilson and Daphne Shaw		
7.	10:30 am	Public Comment	Monica Wilson		
8.	10:40 am	New Business and Designate Dinner Coordinator	All		
9.	10:45 am	Evaluate the Meeting	Monica Wilson and All		
10.	10:50 am	Adjourn			

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

California Mental Health Planning Council

Committee Members:

Members:	Monica Wilson	Chairperson
	John Ryan	Past Chair
	Cindy Claflin	Chair Elect
	Patricia Bennett	Continuous System Improvement
	Noel O'Neill	CBHDA Liaison
	Susan Wilson	CALMHB/C Liaison
	Steven Grolnic- McClurg	Health Care Integration
	Barbara Mitchell	Advocacy
	Daphne Shaw	Patients' Rights
	Walter Shwe	At-Large Consumer
	VACANT	DHCS Representative
	Jane Adcock	Executive Officer

California Mental Health Planning Council

Patients' Rights Committee

October 15, 2014

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

Boardroom - Natoma
12:00 - 1:30 p.m.

Item #	Time	Topic	Presenter or Facilitator	Tab
1.	12:00 pm	Welcome and Introductions	<i>Daphne Shaw, Chairperson</i>	
2.	12:05 pm	Review/Approval: Minutes for June, July, and August meetings	All members	A
3.	12:15 pm	Review/Approval: Updated PR Survey – online and print versions	All members	B
4.	12:30 pm	Review/Approval: Revised PR letter to County Mental Health Directors	All members	C
5.	12:45 pm	Discussion: County Patients' Rights Compliance reports	All members	D
6.	1:00 pm	New Business: Patients' Rights Committee Work Plan 2014-15	All members	E
7.	1:20 pm	Public Comment	<i>Daphne Shaw, Chairperson</i>	
8.	1:25 pm	Meeting adjourned		

The scheduled times on the agenda are estimates and subject to change. Any accommodations needed, please contact Laura Leonelli at 916-324-0980

Committee Members:

Co-Chairs: Daphne Shaw, Chair Cindy Clafin, Chair-Elect

Members: Carmen Lee Richard Krzynowski, DRC
Adam Nelson, MD
Walter Shwe

Staff: Laura Leonelli

California Mental Health Planning Council

ADVOCACY COMMITTEE

October 15, 2014

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

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

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

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

Committee Members: (as of March 2014)

Co-Chairs: Barbara Mitchell Adam Nelson

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

Staff: Andi Murphy

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

**California Mental Health Planning Council
Continuous System Improvement Committee**

October 15, 2014

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

**Boardroom- Natoma
1:30 to 5:00 p.m.**

Item #	Time	Topic	Presenter or Facilitator	Tab
1.	1:30 pm	Planning Council Members Issue Requests	All Members	
2.	1:35 pm	Welcome and Introductions	<i>Patricia Bennett, PhD, Chair Susan Morris Wilson, Chair-Elect</i>	
3.	1:40 pm	Review and Approve June, July Minutes	All Members	A
4.	1:45 pm	Discussion: Update on Data Notebook progress	<i>Susan Morris Wilson, Linda Dickerson</i>	
5.	2:00 pm	Discussion: CSI Work Plan – <i>Finalizing Data Notebook and AB 114 goals; Determine Goal for Trauma Report; CMHPC Collaboration with OAC Research projects; New topics and Goals for next year</i>	All Members	B
6.	2:30 pm	Presentation: <i>MHSA Projects for Transition Age Youth</i>	<i>Lorraine Flores</i>	
7.	2:45 pm	Break		
8.	3:00 pm	Panel Presentation: AB 114 Transition, Central Valley	<i>Invited: San Juan Unified School District, White House Counseling Center; Sacramento County Office of Education SELPA; Butte County SELPA; Yolo County SELPA; Parents/family members</i>	C
9.	4:30 pm	Public Comment		
10.	4:45 pm	Evaluate Meeting/Develop Agenda for Next Meeting	<i>Patricia Bennett, PhD, Chair Susan Morris Wilson, Chair-Elect</i>	

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

Committee Members:

Co-Chairs: **Patricia Bennett, PhD – Chair** **Susan Morris Wilson, Chair-Elect**

Members: Adrienne Cedro-Hament Monica Nepomuceno
 Amy Eargle, PhD Noel O’Neill
 Lorraine Flores Maya Petties, PhD
 Karen Hart Walter Shwe
 Celeste Hunter Bill Wilson

Staff: Laura Leonelli Linda Dickerson, PhD

California Mental Health Planning Council

Healthcare Integration Committee

October 15, 2014

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

Boardroom Placer

1:30 to 5:00 p.m.

Time	Topic	Presenter or Facilitator	Tab
1:30 p.m.	Planning Council Member Issue Requests		
1:35 p.m.	Welcome and Introductions	Steven Grolnic-McClurg, LCSW, Chairperson	
1:40 p.m.	Presentation: Parity and the Healthcare Integration	Abbie Totten, Director of State Programs, California Association of Health Plans	A
2:40 p.m.	Questions/Comments		
3:15 p.m.	Break		
3:30 p.m.	Committee Discussion		
3:45 p.m.	Discussion: HCI Committee presentations for January PC full session		
4:15 p.m.	Work Plan Review and update		
4:40 p.m.	Public Comment		
4:50 p.m.	Next Steps/Develop Agenda for Next Meeting	Steven Grolnic-McClurg, LCSW, Chairperson	
4:55 p.m.	Wrap up: Report Out/ Evaluate Meeting	Steven Grolnic-McClurg, LCSW, Chairperson	
5:00 p.m.	Adjourn Committee		

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

Committee Members:

Chair: Steven-Grolnic Cindy Claflin
Vice-Chair: McClurg
Members: Josephine Black Terry Lewis
Dale Mueller Deborah Pitts Jeff Riel
Joseph Robinson Cheryl Treadwell Arden Tucker
Staff: Tracy Thompson

INFORMATION

TAB SECTION: U

X ACTION REQUIRED:

DATE OF MEETING: 10/16/14

Approve minutes from the June 2014 meeting

DATE MATERIAL

PREPARED BY: Jones

PREPARED: 09/29/14

AGENDA ITEM: Approval of the Minutes from the June 2014 CMHPC Meeting

ENCLOSURES: • June 2014 Minutes

OTHER MATERIAL RELATED TO ITEM:

ISSUE:

CALIFORNIA MENTAL HEALTH PLANNING COUNCIL MEETING MINUTES

**June 19 and 20, 2014
Hilton Oakland Airport
1 Hegenberger Road
Oakland, CA 94621**

CMHPC Members Present:

Monica Wilson, Chair	Steve Leoni
Cindy Claflin, Chair-Elect	Barbara Mitchell
Karen Bachand	Monica Nepomuceno
Patricia Bennett, Ph.D.	Adam Nelson, M.D.
Josephine Black	Maya Petties
Adrienne Cedro-Hament	Deborah Pitts, Ph.D.
Amy Eargle	Darlene Prettyman
Lana Fraser (for Jeff Riel)	John Ryan
Steven Grolnic-McClurg	Daphne Shaw
Karen Hart	Walter Shwe
Carmen Lee	Bill Wilson
Terry Lewis	Susan Wilson

Staff Present:

Jane Adcock, Executive Officer	Tracy Thompson
Tamara Jones	Chamenique Williams
Laura Leonelli	

Thursday, June 19, 2014

1. Welcome and Introductions

Chair Monica Wilson welcomed everyone to the General Session. The Planning Council members, staff, and audience introduced themselves. Chair Wilson welcomed new member Maya Petties from San Bernardino County.

2. Opening Remarks

The scheduled speaker was not present.

3. Approval of April 2014 Meeting Minutes

Ms. Adcock had a correction on page 23: "Continuous System Improvement" should read "Client Services Information".

Ms. Cedro-Hament asked about any action taken regarding the information at the bottom of page 22. Ms. Adcock reported that it is up to the CALMHB Board to move the contract from the Mental Health Services Oversight and Accountability Commission (MHSOAC) to the Planning Council, and that former Executive Director Andrea Jackson is no longer with the MHSOAC.

At the fourth paragraph on page 25, Mr. Leoni requested to add the words “for the SUD community”.

Regarding Item 4 on page 2, Ms. Prettyman requested clarification of what the amendments were.

Motion: The approval of the April 2014 Meeting Minutes was moved by Barbara Mitchell, seconded by Adrienne Cedro-Hament.

Regarding references to CALMHB, Ms. Hart requested to have the word “Board” removed. She also requested to have members who attend the meeting via telephone to be listed on the “Members Present” roster. (Ms. Adcock pointed out that it is difficult to know who is on the line.)

Motion: The above motion was voted on and approved unanimously.

(Ms. Adcock stated for the record that Ms. Hart would never be asked to leave the Planning Council because of missed meetings.)

Mr. Leoni suggested having a separate two-way telephone line for Planning Council members who have a medical issue.

4. Executive Committee Report

Executive Officer Jane Adcock reported that the Executive Committee had discussed the following.

- The first public forum was held in early May in Merced County. Over 50 people attended from three counties, with a diverse representation from the Hmong and Latino-American communities.

The next public forum will be held in the city of Rialto in San Bernardino County at the end of July. Ms. Adcock mentioned the importance of having Planning Council members present at the public forums.

- Small county program reviews have been temporarily delayed as the Planning Council staffing shifts. The program reviews will be conducted over the summer and are focused on children’s programs.
- The Planning Council has some vacancies and is soliciting applications from around the state.
- The committee set up a process for discussions around the possibility of the Planning Council integrating into a behavioral health council. An Ad Hoc Committee will develop a plan to present to the Planning Council; in addition staff will research what other states have done. In October, John Perez of the Substance Abuse & Mental Health Services Administration (SAMHSA) will present SAMHSA’s perspective on the value of behavioral health councils.
- The International Crisis Intervention Training will take place in October in Monterey County. Ms. Adcock solicited volunteers to commit ASAP. Ms. Hart provided details.

- At the October meeting, the Planning Council will focus on alcohol and drug programs. At the January meeting, the Planning Council will revisit the ripple effect of health care reform.

Ms. Prettyman commented that the public forum that Ms. Adcock had presented had been excellent. It had ended up in a town hall meeting format. Ms. Leonelli reported that about 19 of the 50 attendees had reported as being consumers or family members.

Ms. Cedro-Hament asked about the date of the San Bernardino public forum; Ms. Leonelli replied that it was scheduled for July 29 from 3:00–6:00 p.m.

Ms. Lewis asked about the small county review panels. Ms. Adcock explained that they have not been set up, but that she would discuss them with her.

Ms. Lee mentioned that the World Psychiatric Association will hold its international meeting in San Francisco this February. The emphasis will be on stigma. She also asked if the Ad Hoc Committee will be looking at substance abuse combined with mental health challenges; Ms. Adcock confirmed that they would.

Ms. Shaw noted that the Planning Council is aware that the public forum scheduled time of 3:00–6:00 can make it difficult for those employed in the private sector to attend and speak.

5. Report from Mental Health Services Oversight and Accountability Commission

Jose Osequera, MHSOAC Chief of Plan Review and Committee Operations, presented an update.

- While the MHSOAC seeks a new Executive Director, the Interim Executive Director is Sherri Gauger.
- Regarding the triage project, 22 counties have been granted awards and 17 contracts have been signed and executed. The process that counties must go through to secure approvals from their Boards of Supervisors is a lengthy one. The MHSOAC will be reporting to the Legislature on how they perceive this deployment moving in the future as well as efficiencies they can introduce.
- The Prevention and Early Intervention (PEI) regulations were submitted to the Office of Administrative Law on June 6. The regulations are undergoing the 45-day review period; additional details are on the MHSOAC website for those interested in commenting. Comments can be addressed to Lauren Quintero.
- A teleconference meeting will be held on June 26 regarding the approval of the Madera innovation.
- A full Commission meeting will be held on July 24.
- An additional community forum will be held on August 7 in Mammoth. The MHSOAC has been visiting different areas to receive feedback on mental health services.

Ms. Cedro-Hament inquired about MHSOAC's support to CALMHB. Mr. Osequera responded that the MHSOAC has assisted CALMHB administratively in terms of the services they provide. The new CALMHB contract is currently up for consideration; it will be discussed at the June 26 teleconference meeting.

Ms. Lewis encouraged the MHSOAC to discuss CALMHB's request for an increase in budget.

6. Report from California Mental Health Directors Association

Mr. Grolnic-McClurg provided the report.

- The CMHDA is changing its name to the County Behavioral Health Directors Association (CBHDA) of California. It has merged with its sister organization of directors for substance abuse programs at the county level.
- The CBHDA has selected a second representative for the Planning Council. They will be communicating with Ms. Adcock on the matter.
- The latest round of triannual audits from the Department of Health Care Services (DHCS) is underway.

Ms. Mitchell mentioned the extremely high disallowance rate around the state, especially on all-day rehab services. She asked about CBHDA's response. Mr. Grolnic-McClurg responded that all providers under the carve-out are going to have to accept the higher level of scrutiny on their notes. This is occurring because the federal government has made clear to DHCS that they are not interested in renewing the waiver unless there is an increase in oversight of the mental health plans, as well as progress in the triannual audits.

Mr. Ryan asked about the "notes" Mr. Grolnic-McClurg had spoken of. Mr. Grolnic-McClurg responded that notes can refer to charts, or to the process being followed as written: the assessment which establishes a diagnosis of functional impairment, a treatment plan that sets goals, and progress notes that are linked to the treatment plan.

In answer to questions from Mr. Leoni, Mr. Grolnic-McClurg stated that the California Institute for Mental Health (CiMH) has merged and changed its name. Regarding the increased scrutiny – whether DHCS should be taking its monitoring seriously, and the problem that time spent ensuring that notes comply takes away from more direct recovery work – he had personal thoughts but was reluctant to take a stance in his current role reporting for CBHDA.

Ms. Shaw stated that CiMH has merged with the County Alcohol & Drug Program Administrators Association of California (CADPAAC). The new name for the combined entity is the California Institute for Behavioral Health Solutions, effective July 1.

Ms. Mitchell mentioned the issue of the increasing requirements for professional and licensed staff in all services versus the move to try to bring in peer providers who generally do not have the educational background or licensure. She asked if there is a committee in CBHDA working on this. Mr. Grolnic-McClurg responded that CBHDA is working on many issues; regarding this one, they are seeking clarity with DHCS on what

the audits will look like, and making sure that they are in a position to comply with the regulations.

He continued that other groups are looking at the issue of peer providers and a change to the waiver that could encourage them. Personally, he felt that the best solution is to move away from a permanent billing cycle, and to have some kind of rate to enable a focus on using dollars effectively to increase services.

Mr. Wilson asked about the wording the federal government expects to see on billing and whatever else they need. Mr. Grolnic-McClurg answered that they have made clear that the DHCS has the responsibility to monitor their plans, and there is an expectation that the findings could necessitate an increase in compliance. The process will be county by county, where each county mental health plan is going to look at whether its specific written policies and procedures are meeting its requirements.

Dr. Bennett cautioned about the possibility of confusion around the issue of peer providers. She felt that the Planning Council should go to the Department directly and request information about the audit. Personally she welcomed more scrutiny; we know there are problems. The regulations do exist whether or not we agree with them.

Chair Wilson asked about any public meetings the CBHDA may hold regarding their organizational shift. Mr. Grolnic-McClurg was not aware of any; CBHDA may send out a press release.

Dr. Pitts asked how many counties are using day rehab. Mr. Grolnic-McClurg did not have information that any service type is under more scrutiny than others. His information was around general findings across service types.

7. Report from Department of Health Care Services

Karen Baylor, Deputy Director of Mental Health and Substance Use Disorders, reported on DHCS.

- Ms. Baylor named new team members reporting directly to her: Brenda Grealish, Division Chief for Mental Health; Marlise Perez, Division Chief for SUD Compliance; and Don Braeger, Division Chief for SUD Prevention Treatment Recovery Services (PTRS).
- Special Advisor Rollin Ives is retiring at the end of July.
- The next layer of hiring will be the Assistant Division Chiefs.
- They are working on the Mild versus Moderate definition for the managed care plans.
- They are working on the Performance Outcome system. Almost all of the data has come in from the counties.
- They are working on a dashboard for the mental health and substance use side, similar to what just rolled out to the managed care plans.
- A tremendous amount of time is spent on Katie A. – monitoring activities and providing counties with technical assistance.

- DHCS is still trying to develop a plan for the out-of-county foster kids, which includes looking at eligibility criteria.
- The Centers for Medicare and Medicaid Services (CMS) has been watching DHCS's compliance efforts with the counties. DHCS attended a quality coordinators' conference this year and talked to counties about its audit protocol. CMS is very concerned with 24-hour access lines; every call must be handled in compliance.
- There has been a push from the California Council of Community Mental Health Agencies (CCMHA) on documentation requirements for providers. Every county does documentation a little differently, so DHCS has compiled a template of the requirements and plans an overlay of the federal requirements.
- DHCS is preparing to update its contracts: with the mental health plans, Alcohol and Other Drug (AOD), and the performance contract.
- DHCS just sent out Realignment information letters and distributed growth funds. The base is still not set.
- DHCS has tried to build some bridges with the California Department of Corrections and Rehabilitation (CDCR), as much is happening with the 109 population.
- DHCS is working with the Child Welfare Council on their priority access.
- DHCS is trying to rebuild the relationship with the MHSOAC.
- On the Substance Use Disorder (SUD) side, much work is being done on the waiver. DHCS is going for an 1115 Waiver, so it is working with CMS on its total model in order to build a continuum of care and quality of care in that system.
- SAMHSA has been open to repurposing their block grant funds to help fill in the gaps where Drug Medi-Cal isn't able to. DHCS is working with them.
- There are many issues with counselor certification that DHCS is thinking through.

Ms. Lee asked if DHCS has had any problems with counties not responding with data. Ms. Baylor responded that DHCS has made dramatic changes with counties on getting Data Collection & Reporting (DCR) and Continuous Systems Improvement (CSI) data up to date.

Ms. Lee also asked if there are any new policies or growth pertaining to the older adult population. Ms. Baylor had not heard anything specific. With Realignment, when the funds are released to the counties it is a local decision.

Ms. Lee then referenced peer certification: will it allow peers to be in the mainstream as providers? Ms. Baylor replied that the drug and alcohol side has utilized peers very effectively; she would like to see the same on the mental health side. She hoped to connect with peer certification organizations on the drug and alcohol side.

Ms. Hart asked about Planning Council representation on the Compliance Advisory Committee (CAC). Ms. Baylor felt that it is hugely important. She will find out their next meeting date and inform Ms. Adcock.

Ms. Lewis expressed the concern that consumers who go through the criminal justice system cannot then work or volunteer because they cannot pass the clearances. Ms. Baylor agreed and felt that conversations with the certifying organizations would be a good idea. The same problem exists on the SUD side.

Ms. Baylor explained for Ms. Shaw that the County Mental Health Plan is all-encompassing and consists of all the money from DHCS and the federal government. The Performance Contract has no money tied to it – it consists of some of the DHCS requirements for counties. Information on patient rights relating to involuntary care should be in the Mental Health Plan contract.

Ms. Wilson asked when DHCS plans to post the External Quality Review Organization (EQRO) from 2012 and 2013. Ms. Baylor said she will follow up on the question.

Dr. Bennett asked what Ms. Baylor believes about recovery and the DHCS mandate in regard to monitoring performance of counties. Ms. Baylor responded that quality assurance activities are critical, especially in light of the program integrity issues from the Drug Medi-Cal side. Unfortunately, Medicaid is essentially still the medical model.

Ms. Baylor also mentioned that the culture within DHCS needs to embrace wellness and recovery, as well as to embrace that DHCS is here to provide technical recovery. She looks forward to bringing in clinical people with actual experience writing progress notes and doing assessments. She also felt that they need to be charged with inter-rater reliability efforts. She was pleased with the Quality Advisory Committee – she would like to see it as a partnership.

Ms. Mitchell addressed the problem that for years, the California Association of Social Rehabilitation Agencies (CASRA) has proposed to get rid of community care licensing for social rehab facilities in the state. It has always been blocked by the Department of Mental Health, specifically Steve Mayberg. DHCS can now resolve many of the problems regarding criminal records screening; the Department of Community Care Licensing blocks hiring of consumers in particular. Ms. Baylor responded that she would need more information from CASRA. Any action would have to align with the mission of DHCS. She was willing to look at the issue and would need something in writing.

Mr. Wilson felt that people with lived experience should be able to have their records help them rather than hinder them. Ms. Baylor agreed that there is much work to do on this issue.

8. Council Member Open Discussion

Mr. Ryan facilitated the process.

- Discuss integration of SUD for BH Council

Mr. Ryan stated that SAMHSA had encouraged state mental health councils to become behavioral health councils. The Planning Council's Executive Committee had decided to form a task force to examine the issue and make a recommendation.

Ms. Baylor stated that combining the mental health block grant with SAMHSA and the SUD block grant is one of her goals. She looked forward to seeing the task force's proposal. At DHCS there is duplication between the mental health team and the SUD team, and Ms. Baylor wants much more integration between the two. This includes the physical offices of personnel.

Mr. Leoni stated that for the Planning Council to combine mental health with substance abuse, membership would have to double to 80 members or the mental health membership would have to be cut by half. Further, half of the meeting agendas would concern substance abuse. He did agree that the two sides should be collaborating and learning. However, in all of the collaborations that have happened – administrative and clinical – the least integrated is the advocacy community.

Mr. Leoni suggested the idea of having two Planning Councils – a substance abuse council and a mental health council – that would share some members.

Ms. Bachand added that there are now 56 counties that are integrated into behavioral health; many have also integrated their local advisory boards. The task force would do well to look there for lessons learned.

Ms. Hart mentioned the issue of membership category criteria. She was in great favor of integration but at the same time was aware of the challenges.

Ms. Lee felt that the merge was definitely going to happen – it's just a matter of how the Planning Council will work it out.

Ms. Shaw expressed her one concern: this Planning Council is unique in its state mandate to do a number of things beyond what other state Planning Councils do. These must be combined with the federal requirements.

- Discuss federal requirement to monitor, review, and evaluate the adequacy of MH services in California

Mr. Ryan stated that Planning Councils have four federal requirements, one of which is to "...monitor, review, and evaluate annually the allocation and advocacy of mental health services within the state." Yet within its budget the Planning Council does not have the resources to do an annual Needs Assessment; everyone has been struggling with the issue of performance outcomes. UCLA did a study for the Department of Mental Health in 2011 that concluded that of the 2.2 million adults in need of mental health services, half had received no treatment at all. This was the only data the Planning Council could find.

Mr. Ryan continued that SAMHSA had since done a nationwide needs assessment with similar findings. Based upon this data, the required statement would have to say that the number of services available are inadequate to meet the identified need. An ongoing assessment of the mental health need has to be put in place.

Ms. Baylor commented that with the poor economy and corresponding funding reductions, we haven't met the need. She recommended for the Planning Council to talk to John Perez of SAMHSA to see if they could help with this. She also suggested talking with Ms. Grealish and other DHCS internal people. She added that Senator Steinberg had hounded her during the hearing about outcomes and the needs assessment. The work

must be done by DHCS, the Planning Council, MHSOAC, and the counties – a collaborative effort.

Ms. Lewis stated that another mandate for California’s 59 boards and counties is to do Program Reviews. The counties struggle with them. If the Planning Council is going to embark on this with the MHSOAC, it would make sense to add the county level boards and commissions (and probably save a lot of money because of the increased manpower).

9. Public Comment

Ms. Adcock stated that she was still in the process of seeking a consultant for the update of the Mental Health Master Plan. She also would like to have a small workgroup of committed Planning Council members to work with the consultant on this effort.

- The timeline would be from now until the end of the year.
- At this point the Master Plan concerns mental health only.
- The present task is to develop the scope of work for the subsequent contract.

A discussion followed during which the Planning Council sought to clarify the process.

Ms. Mitchell had understood that the Planning Council wanted to hire a consultant to evaluate the feasibility of the project.

Ms. Adcock stated that plenty of money is at hand, and that the actual larger contract to rewrite the document will take multiple years.

Chair Wilson stated that the minutes showed that the Planning Council had agreed as a group to go forward with the Master Plan review.

Dr. Bennett summarized the current task: a group of volunteers will work with a consultant to read through the current Master Plan, identify necessary major changes, articulate the scope of work and methodology, and put that task out to bid.

Ms. Adcock stated that at the January meeting, the Planning Council had decided to bring someone on board who is familiar with mental health, to work with the workgroup, go through the Master Plan, identify sections that are and are not still relevant, and identify new material. The workgroup and consultant would also identify the amount of time and cost required.

Mr. Grolnic-McClurg said that he had understood that the consultant would develop a workplan and then return to the Planning Council, at which point they would decide if they wanted to go forward.

Dr. Nelson suggested calling for a motion to clarify the Planning Council’s direction.

Dr. Bennett recalled that at the last meeting, the Executive Committee had agreed that they did not want to work on the Master Plan in the same way as before, but that it was very outdated and they needed to do something. They came up with the idea to discern what kind of update and what intensity of labor to undertake, then bring it before the full Council.

Ms. Prettyman had understood that an ad hoc committee would decide what to present to the consultant, but not work with the consultant. Chair Wilson confirmed.

Ms. Mitchell suggested that the Planning Council was hiring a consultant to determine feasibility, necessity, and methodology of updating the Master Plan; and to provide recommendations to the Planning Council on options for whether or not to undertake it, as well as the scope of the project.

Dr. Nelson observed that some of the present conversation was being promulgated by discussions that did not include everyone on the Planning Council (i.e., the Executive Committee). He mentioned the concerns that the Master Plan is woefully out of date and that the size of the undertaking is daunting. Toward that end, there had been discussion in the Planning Council about hiring a consultant and forming an ad hoc committee to visit the question.

Mr. Ryan recalled that former Executive Director Ann Arneill-Py had carried the workload of the original document, with the Planning Council doing the reviewing.

Motion: To create an ad hoc workgroup which is authorized to contract with a consultant for a scope of work to define feasibility, methodology, and options for the Planning Council to update the Master Plan, was moved by Steven Grolnic-McClurg, seconded by Daphne Shaw.

Ms. Lewis suggested locking in the name of Ann Arneill-Py as the consultant.

Dr. Nelson spoke in favor of the motion. He felt that specifying a name could violate rules for consultant selection.

Ms. Black said that unless Ms. Arneill-Py could be identified as Sole Source in terms of contracting, the Planning Council could be stepping into dangerous territory with the state. However, the Request for Proposal could specify experience and skill that would narrow the field.

Ms. Lewis requested to change the word from *consult* to *advise*. Ms. Wilson made the Point of Order that once a question has been called and the previous motion moved, there can be no further discussion.

Motion: The Planning Council voted unanimously to close the discussion on the Motion.

Motion: The Planning Council voted unanimously to pass the motion made by Steven Grolnic-McClurg as given above.

Mr. Leoni noted that Ms. Arneill-Py had done much of the drafting of the Master Plan, but that input had been sought from the committees and the public. As a member of the public, Mr. Leoni had drafted some amendments and ideas that had been incorporated. This time around, he would hope to see a similar process.

Ms. Prettyman commented that the ad hoc committee should include members who had worked on the original Master Plan.

Mr. Grolnic-McClurg clarified that the motion was for the ad hoc committee to be authorized to contract with a consultant. If this process was not correct, it could be amended.

10. Assembly Bill 114 Panel

Chair-Elect Claflin introduced the panel:

Dr. Bernice Stanley, Coordinator, Mental Health Programs, Oakland Unified School District

Anjanette Pelletier, Special Education Local Plan Area (SELPA) Administrator, San Mateo County Office of Education

Dr. Elizabeth Uno, Alameda County Behavioral Health Services

Leann Schultz, Program Director, United Advocates for Children and Families (UACF)

Allison Massey and Gloria Riley, Parents/UACF

Dr. Stanley described her duties at the Oakland Unified School District.

Dr. Bennett facilitated the panel discussion. She began by stating that the Planning Council is interested in the transition between AB 3632 and AB 114 – the transfer of funds and authority to deal with educationally related mental health, from the Mental Health Departments to the schools.

Dr. Bennett posed the first question:

What did you anticipate when this happened, and what were the surprises as the change was made?

Dr. Stanley: The Oakland Unified School District Special Education Department anticipated an increase in the number of referrals. The surprise was a decrease. Since school psychologists were now conducting the assessments (a lengthy process), they worked very closely with their school teams to ensure that only those students who truly could not be successful in the current programs were assessed.

Dr. Uno introduced herself and followed up with her answer to the question. She had been blindsided by the abrupt ending of the program. Her Health Director had called a stakeholders meeting to make a commitment to the special education population; they had been concerned about continuity.

Ms. Riley introduced herself as a parent and family partner helping families of children with mental health issues to obtain needed school services and Individualized Education Programs (IEPs).

Ms. Pelletier explained that SELPA tried hard to work collaboratively with other non-public agency partners. There was some real trepidation about the change – that school staff was unprepared in handling assessments, that fewer services would be offered, that assessments would decrease, that disagreements with parents would increase, and that the allocated funds would be insufficient.

She continued that the surprises were how well the planning worked out; the increase in services and assessments that were requested from the school to behavioral health and non-public agency partners; an increased awareness of what kinds of things might need to be referred sooner; more students receiving assessments and services; a broader variety of service providers available; a decrease in the number of disagreements with parents; and the realization that funds were sufficient.

Ms. Massey said that her children attended school in the Alameda Unified School District. During the transition the clinician in her son's Special Education classroom remained the same, which was a positive; but she also felt that the school administration at IEP meetings did not have the right to tell her about her son's mental health needs.

Ms. Leanne Schultz introduced herself as a parent and a supporter of families of children with mental health challenges around the Bay Area. She had seen an increase in family partners and support of families. She shared an incident in which an IEP was held which included an Educationally Related Mental Health Services (ERMHS) assessment, but no written report was ever done. At another county, Ms. Schultz attended two IEP meetings where the team made a placement decision with no ERMHS assessment – the educational experts were making determinations about the mental health needs of a child.

Ms. Riley has seen a change since AB 114. Community Support Services (CSS) used to provide a lot of help. Now, parents have to go into the schools and advocate for children. Rather than IEPs, the schools are using in-house suspensions where documentation is not done – but students are not receiving an education when they are pulled from class and sent to the principal's office. Ms. Riley had also observed an IEP where the administrator did not listen to the student and family, yet was making important decisions about the student.

What ensures that services being provided to Special Education students are culturally sensitive and address the needs of a culturally diverse population?

Dr. Stanley stated that the Oakland Unified School District makes sure to hire staff from a multi-ethnic population. Racial and economic standpoints are reflected. Training is provided for administrators and teachers in curriculum, dialectical behavior therapy, and collaborative problem solving.

Dr. Uno stated that cultural sensitivity is really a challenge in a county as diverse as San Mateo. Workforce development is key.

Ms. Pelletier said that San Mateo County and its mental health partners try to ensure that the mental health staff is culturally and linguistically reflective of the population they serve. They also try to offer cultural sensitivity and economic sensitivity training for staff, as well as mental health training. Parent mental health and behavioral health trainings are also available in a variety of languages.

Are the SELPAs and schools measuring outcomes, and if so, how are they doing that? Are the outcomes being shared with parents?

Ms. Pelletier stated that her SELPA is continuing a one-year process of measuring outcomes of a mental health capacity-building model. She described the project.

Dr. Stanley said that they are at the beginning stages of measuring outcome. However, this year they have looked at data on the referral and assessment process – through the lens of school grade level and the inclusion model. Dr. Stanley described a plan to open six self-contained classes; in three of them, students will be mainstreamed into General Education classes, and pulled out only for individual and group therapy.

What would the parents like the Planning Council to hear about what we should be advocating for at the legislative or governor's level?

Ms. Schultz mentioned the truancy program, a net that catches many children who aren't being identified; finding the reasons that hospitalization for youth in California is up; and finding the children who are not getting their needs met. If children are not getting the same services they were getting under AB 3632, what kinds of services are they getting? Legislators should know that education programs for parents to show them their rights and responsibilities should be available. Legislators should also know the value of family partners.

Ms. Riley also wondered where children are who are no longer in residential treatment facilities; they had been invaluable for her son. Legislators should know that it is a very good program, especially for African-American males.

Ms. Massey stated that having a Family Partner assigned to her for the IEP process had been crucial. She would like to see more Family Partners for parents of children in Special Education, especially children who receive mental health services.

Ms. Pelletier commented that she worried that in the coming years, the separated mental health funds would become part of the big pot of Special Education dollars. This would be a significant concern for SELPAs and parents of students with mental health needs.

What about mental health services for children who don't have IEPs? Are such services available? What happens when a child's evaluation doesn't rise to the occasion?

Dr. Stanley answered that her district understands that some students have mental health issues, however, they do not require educationally related mental health services. On every campus, there is a mental health option: either a clinic or a partnership with one of the district's mental health providers.

Dr. Uno said that behavioral health care has a large penetration into the public schools – about 140 schools across twelve districts. About 70 of them have universal access to mental health services through blended funding.

Ms. Pelletier stated that in San Mateo County, there is a broad commitment to health and mental health access. Every child is covered under the San Mateo County Health Plan.

Ms. Schultz shared a story about being charged with truancy during her daughter's major depression during her senior year. She ultimately qualified for Special Education, but the battle with the school lasted from September until March. Had Ms. Schultz not been a strong advocate with the resources to pay for an attorney and a private evaluation, her daughter would not have graduated on track. It is not easy for parents to get their children identified; the child can end up on the truancy track.

11. Follow-up Questions/Discussion

Ms. Cedro-Hament shared her concern that parents who do not have the same education, do not speak the language, and do not have the same color skin, are invisible and so are the children. What does the school system do to reach out to these children? Ms. Pelletier responded that every SELPA has a requirement to have a Child Find process.

Dr. Stanley added that large districts like Oakland are hyper-vigilant in looking for students who appear not to be doing well in school. They also have school psychologists who are attuned to non-typical student behavior and can alert special educators on each campus. They are aware of the need to provide early intervention.

Dr. Bennett noted that Dr. Uno had provided a PowerPoint handout that included data.

Mr. Wilson referred to Ms. Massey's experience and the value of having help from an advocate.

Ms. Lee shared a story about her nephew with high-functioning autism, who now successfully attends a private school in Colma.

Ms. Bachand asked what happens to foster kids who don't have parents. Ms. Pelletier responded that San Mateo County has two foster youth liaisons who ensure continuity of care for their education and health records. Dr. Stanley said that the services are very similar in Oakland. When students come into their district, the services they need are duplicated as closely as possible by working with case managers, social workers, probation and other agencies.

Ms. Lewis noted that one of the populations that is most challenging and hidden is the LGBT community. Additional issues with anxiety and anger double the problem. Do you step in and try to advise school districts regarding these students? Ms. Schultz had found that the barriers weren't so much with the school as with the individual obtaining the needed support. Ms. Pelletier said that many school districts are coming along further than you might anticipate due to some of the recent state rulings. Local policies can break down barriers that may have been in place for students in this population.

Ms. Prettyman asked if family partners and parent partners actually meet collectively with the schools. Ms. Massey answered that they meet wherever they are needed, but not as a body. Dr. Stanley stated that they have Community Advisory Committees that are a collaboration between school district leaders, community leaders, parents, and professionals. They meet monthly.

Ms. Pelletier said that San Mateo County has a Parent Resource Council which is a subset of the Community Advisory Committee. Dr. Uno stated that the Parent Partner Program in Alameda County has come through Behavioral Health Care Services. Ms. Schultz is involved in the administrative meetings and can give input from the family perspective, which has significantly impacted the program. She noted that some school districts are very receptive to working with the family partners while others are not.

Ms. Massey added that she would like to see, whenever a child is brought into the Special Education system, a meeting with the parents so a family partner can talk to them about what services to ask for and how to advocate for their child, no matter what the disability.

Ms. Nepomuceno agreed that parents who don't have the resources or know the language may give up; more parent partners and social workers are needed to help parents navigate the system. She works with the Chair of the state School Attendance Review Board (SARB) Panel; they are encouraging the assignment of a mental health representative to all their local and county SARBs.

Ms. Nepomuceno asked if the increase in referrals, assessments, and services due to the transition to AB 114 also resulted in an increase in students qualifying for Special Education. Ms. Pelletier responded that they haven't seen more students qualifying – they have seen more students receiving targeted mental health services who were already receiving Special Education services. Staff also have better skill sets.

Dr. Stanley addressed the issue of disproportionality. While they were able to see a decrease in the number of students eligible for mental health services, there is still an alarming rate of disproportionality in the district toward minorities. The district is looking for alternative ways to meet the mental health needs and keep students in the General Education population.

Ms. Nepomuceno emphasized the value of equipping school personnel to meet the mental health needs of students; counseling or therapy may not always be the answer.

12. California Reducing Disparities Project Overview

Chair Wilson introduced Marina Augusto, Chief, Community Development and Engagement Unit, Office of Health Equity, California Department of Public Health; Dr. Rocco Cheng, Corporate Director of Prevention and Early Intervention Services for Pacific Clinics; and Pashi Mikalson, Project Lead, LGBTQ Reducing Disparities Project, Mental Health America of Northern California.

Ms. Augusto gave a PowerPoint presentation on the California Reducing Disparities Project (CRDP).

- She provided definitions for *health and mental health disparities* and *health and mental health inequities*.
- She gave an overview of the CRDP organizational chart.
- CRDP was moved to the Department of Public Health in 2012. It is now housed under the Community Development and Engagement Unit of the Office of Health Equity.
- There are links to the Population Reports on the CRDP website.
- CRDP is the first of its kind to address issues of access to care and quality of care, and to increase positive mental health outcomes for racial, ethnic, and LGBTQ communities.
- CRDP is a new business model and approach. We need to be in partnership with the community – from state government to philanthropy to private – to discern the best and most effective way to address ongoing disparities.

- CRDP aims to identify successful community mental health strategies, to support local community efforts, and to move forward to provide the public mental health system with interventions.
- Ms. Augusto provided a background in terms of CRDP's origins via the state government.
- One of CRDP's mantras is, "Service delivery defined by multicultural communities for multicultural communities." It is a partnership initiative, and a challenge has been to get buy-in from the communities.
- CRDP funding is 100% Mental Health Services Act (MHSA).
- Strategic Planning Workgroup (SPW) contracts were funded by a Phase I RFP:
 - Asian/Pacific Islander: Pacific Clinics
 - LGBTQ: Equality California Institute and Mental Health America of Northern California
 - African American: African American Health Institute of San Bernardino County
 - Latino: Regents of the University of California, Davis
 - Native American: the Native American Health Center
- The California MHSA Multicultural Coalition (CMMC), a part of the CRDP support team, is comprised of 32 members representative of multi-cultural communities outside of the targeted communities under the CRDP: deaf, disabled, veterans, Eastern European, and others. It serves as an advisory body and partner.
- Also part of the support team, the Facilitator/Writer (California Pan-Ethnic Health Network) works collaboratively with the five SPW Project Managers on the final Strategic Plan.
- There is a tremendous amount of community engagement and community vetting.
- Each of the Population Reports is a standalone report, but each will feed into a draft comprehensive statewide Strategic Plan.
- Ms. Augusto explained activity outcomes from Phase I.
 - Phase I was about the development of the Population Reports and gathering recommendations for the Strategic Plan.
 - The Strategic Plan is currently at the California Health and Human Services Agency for review, because it calls out different organizations, such as the Department of Education and the Legislature, for action.
- Phase II is the implementation. It will take the Population Reports and the Strategic Plan as a blueprint for the state to move forward.

- The community turned out to want many levels of change including policy, systems, and provider. The project grew from the original intention – the target communities are all in different places in terms of data collection, policy in place, and issues of racial and ethnic disparity.
- Once the Strategic Plan is in the 30-day public review process, there will be community forums in Fresno, the Bay Area, and L.A. CRDP is simultaneously developing a conceptual framework for Phase II. Also, a webinar will be held in mid or late July.

Ms. Mikalson spoke next.

- She referred to the Population Report *First, Do No Harm: Reducing Disparities for Lesbian, Gay, Bisexual, Transgender, Queer and Questioning Populations in California*.
- She examined the terms *tolerant* and *accepting*.
- She sought to have providers, advocates, and policy makers to be *affirming* of LGBTQ people.
- She encouraged the Planning Council to read Parts 1 and 3 of the report.

Dr. Cheng was the last speaker.

- The Asian Pacific Islander (API) Population Report Executive Summary, *In Our Own Words*, has been brought to Washington by former Assemblyman Mike Eng.
- This spring Dr. Cheng spoke at the White House on community outreach and engagement.
- The API community is trying to form alliances and invite different perspectives.
- Dr. Cheng described the five geographic regions of the API SPW.
- They use a strength-based approach, looking at strengths in the cultural and spiritual heritage that people can incorporate in their journey of recovery and maintaining wellness. It is a grass-roots, bottom-up approach.
- The SPW sampled traditionally marginalized communities such as Hmong, Lao, Cambodian, and Pacific Islander. They also collaborated with other SPWs.
- The SPW collected information by means of eight community forums, 23 focus groups, individual interviews, surveys, observation site visits, and all kinds of meetings.
- Dr. Cheng referred the Planning Council to pages 12 and 13 of the Executive Summary for its definition of cultural competence.
- Two-thirds of the API communities in California are immigrants. They read ethnic newspapers and listen to ethnic radio.

- Even though we think we are providing good service to the community, we need to continue to build capacity – to bring the best quality to the community, whether it is evidence-based practice or community-defined evidence.
- With disparity, a fundamental issue is access.

13. Questions/Discussion

Ms. Cedro-Hament referenced page 8 of the Planning Council Master Plan – the three recommendations talk about barriers, access, and research. She asked what impact the CRDP is having on local planning for innovation. Ms. Augusto replied that the Office of Health Equity has an inter-agency agreement with the Department of Health Care Services; they have just begun to talk about how they will work together on the Cultural Competence Plan Requirements.

Dr. Cheng added that CRDP comprises less than 1% of MHSA funding. They are hoping to use what they have documented in the project to work with county mental health systems. Ms. Mikalson commented that in working with counties, she has encountered a great deal of discomfort regarding sexual orientation and gender identity – supplying that data and collecting demographics.

Mr. Leoni mentioned that in the future, it would be great to break out the API groups by heritage more directly because of the often vast differences among them. He also commented on the confusion between the terms *ethnic* and *racial* in the communities.

Mr. Leoni pointed out the issue of “clinical directedness” in which clinicians are not really listening but are imposing their world view on the client. The issue could be acknowledged by CRDP.

Ms. Black noted that disability is a cross-cutting issue that will affect every group, socioeconomic level, and mental health issue. She urged a more systemic approach where appropriate in order to accommodate people with other disabilities. She agreed with Mr. Leoni that often a therapist or counselor won’t understand disability and the culture around it, and will think it’s all about disability, where in actuality there may be some other huge issue. She would like to see this explored further.

14. Public Comment

Robbie Powelson of Marin County CALMHB spoke regarding cultural competency: something left out of the equation is latitudinal cultural differences that come with age. It is important to address the prejudice toward young people.

Ms. Adcock pointed out that the packets contain the Executive Summaries from all five reports. She stated that Ruben Cantu will be writing the next phase: the Strategic Plan. It will be very important for the Planning Council to look over the plan and provide input during the 30-day review.

Mr. Leoni expressed dismay that the Planning Council did not receive presentations from the African American, Latino, and Native American groups; the latter group in particular has been chronically neglected.

In answer to a question from Ms. Mitchell, Ms. Adcock stated that the entire reports are posted online.

15. New Business

Ms. Adcock stated that volunteers for the ad hoc workgroup to seek a contractor to develop a plan that addresses feasibility and options for revising the Mental Health Master Plan were: Darlene Prettyman, Adrienne Cedro-Hament, Barbara Mitchell, and Karen Hart.

Dr. Pitts commented on the increasing number of psychiatric nursing homes; they are not a part of the public mental health system. It is a troubling issue that she would like the Planning Council to explore. Ms. Adcock said she would contact Dr. Pitts about the issue.

Mr. Ryan suggested for Ms. Adcock to meet with Ms. Baylor regarding the federal requirement to monitor, review, and evaluate the adequacy. He requested for her to draft a one-page summary for the Planning Council to look over; they could see if they could address it once and for all this year. Ms. Adcock agreed: the Planning Council should meet with them to talk about different pieces of the picture for which they may have data. The Planning Council could do a partial report, and as data becomes more robust, branch out.

Ms. Lee noted that Pat Corrigan of the University of Chicago is putting together a bound book called *Coming Out Proud*. It will consist of writings from providers, family members, and consumers in mental health.

Ms. Shaw asked Dr. Pitts about the funding source for the facilities she had mentioned. Dr. Pitts thought it was probably MediCare.

Ms. Prettyman commented that as a psych nurse she had done many psych assessments in skilled facilities that housed people with psychiatric disabilities. They are abysmal, especially the Alzheimer's Units. The issue is growing as the population ages.

Ms. Mitchell expressed interest in having the Advocacy Committee look at the issue. In her experience as a supportive housing provider, many people have lived in this housing for over 20 years and are aging; they develop serious physical problems and must move to skilled nursing.

Dr. Pitts said that she was concerned with people whose admissions were based not on physical health needs but on psychiatric needs.

16. RECESS

Chair Wilson adjourned the meeting at 4:49 p.m.

Friday, June 20, 2014

1. Welcome and Introductions

Chair Wilson greeted everyone attending the Friday morning General Session. Members of the Planning Council and audience introduced themselves.

Chair Wilson shared a reflection from Maya Angelou:

“I have learned that you shouldn’t go through life with a catcher’s mitt on both hands. You need to be able to throw some things back.”

2. Opening Remarks

The scheduled speaker was not present.

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

Cary Martin, CALMHB President, thanked the Planning Council for its most recent offer of assistance. CALMHB’s mission is to support mental health boards and commissions to carry out the legislative mandate of mental health service to all the people of California.

- CALMHB understands the needs of Mental Health Board members because its membership comes from the boards.
- CALMHB members are the troops on the ground, legislatively entwined with the Planning Council’s mission. This should re-invigorate the Planning Council’s assistance.
- Forty counties pay dues to CALMHB, which has assisted numerous counties in training. CALMHB does represent all 58 counties.
- The smallest county does not pay dues, but CALMHB assists in its training anyway.
- Recently CALMHB’s benefactors were in the Department of Mental Health. By edict of the Legislature, they were transferred to the Department of Health Care Services. However, CALMHB was not transferred in the process – it should have been because of the mandate.
- Mr. Martin requested the Planning Council to think about what CALMHB is called upon to do, beginning with 5650 of the Welfare and Institutions Code (which is a formidable charge).
- Embodied in the law is the requisite that the Mental Health Board or Commission has to involve the public in all stages of the process. The responsibility of the Director is to assure to the Department of Health Care Services that this has been done. It becomes quite an undertaking to carry out the edict of the Legislature.
- Because they are voluntary servants to the state, they come without adequate training – a real problem for managing mental health services in the state. This is

why Mr. Martin places such emphasis on understanding data and translating that picture to the Board of Supervisors.

- Mr. Martin asked everyone to revisit the corresponding section of the Welfare and Institutions Code, and think again about the responsibilities and necessary support for those people who populate boards and commissions across the state. It is a serious business.

Mr. Ryan asked if CALMHB has been involved with the MHSOAC in negotiating a three-year contract. Mr. Martin had no knowledge of any negotiations. He did understand that the payment in arrears for a meeting held a couple of years ago was under consideration.

Dr. Larry Gasco, CALMHB Los Angeles Regional Coordinator, answered that he had been asked to confer with the MHSOAC contract staff. For technical reasons, there was only enough money for one year. It was agreed to reduce the contract to a two-year term and provide funding for last year and this year at approximately the same level. They were to begin working on a three-year contract immediately. However, CALMHB had not seen the two-year contract or any evidence of a three-year contract.

Mr. Ryan suggested that they check with the MHSOAC. He also suggested for CALMHB to articulate in writing what they want and need to operate the organization – before the contract is finalized.

Ms. Shaw asked if dollar amounts and needs had been discussed with the MHSOAC. Dr. Gasco responded that he had asked for a budget increase five or six times higher. The contract staff had agreed, but said that there was no money. A staffer suggested going the legislative route. As Mr. Martin had said: although CALMHB has received promises from the MHSOAC, it has not received any ongoing support. The immediate issue is the lack of a contract – as of June 30, CALMHB is out of business.

4. California Reducing Disparities Project Strategic Plan Update

Ruben Cantu, Program Director, California Pan-Ethnic Health Network (CPEHN), provided an update on the CRDP Strategic Plan, a snapshot of what it looks like, and the process for its development. (The Strategic Plan is not yet approved for public comment so copies are not available.)

- CPEHN is a statewide health advocacy organization that works to improve the health of communities of color in California. It focuses on four major areas under this framework:
 1. Cultural competence and linguistic access.
 2. Increasing and maintaining access to health care. (The Affordable Care Act has been a huge boon for many communities of color.)
 3. Addressing the social and environmental determinants of health.
 4. Data collection and analysis.

- The 2010 census showed that 60% of Californians were people of color. The LGBTQ population isn't even counted.
- Mental health disparities exist in terms of both access and diagnoses.
- Mr. Cantu provided a background of CRDP. Begun in 2010, it is the first of its kind in the nation.
- Close to 7,000 people from the five targeted populations have been involved in the CRDP from the beginning.
- The Strategic Plan is a synthesis of the five Population Reports – their findings and recommendations. It is a vision and a roadmap, as well as strategies and recommendations.
- The process was as follows.
 1. CPEHN thoroughly read through the Population Reports.
 2. They developed a spreadsheet and prioritized the recommendations, coming up with four themes and five goals.
 3. The CRDP staff was involved in every step of the way.
 4. Drafts of the Strategic Plan were shared with the Office of Health Equity of the California Department of Public Health, as well as the public agencies who had been called out for action.
 5. Revisions and corrections were made. That version went through the California Department of Public Health leadership, and is now under review at the California Health and Human Services Agency.
- The Strategic Plan provides:
 - A background on California's public mental health services.
 - A snapshot of mental health disparities.
 - An overview of current efforts to reduce disparities.
 - An overview of disparities reduction work.
 - Appendices on the impact of Health Care Reform, social and environmental determinants of health, and details of the Strategic Plan process.
- The heart of the Strategic Plan is the Community Plan for Reducing Disparities in Mental Health. It includes the four themes and five goals.

Themes:

- Address and incorporate cultural and linguistic competence at all levels – service delivery, County Department of Mental Health, and state agency.

- Implement capacity building in two ways: community-based organizations and service agencies, and state agencies and County Departments of Mental Health.
- Improve data collection standards – a broad theme that breaks down into specificity among the population groups.
- Address the social and environmental determinants of health. CPEHN addressed this issue in its biennial statewide conference this week.

Goals:

1. Increase access to mental health services for unserved, underserved, and inappropriately served populations. This involves using schools, co-location of mental health services with primary care services, ensuring that people know where to go, etc.
 2. Improve the quality of mental health services for unserved, underserved, and inappropriately served populations. This involves having a culturally and linguistically competent workforce and services.
 3. Build on community strengths to increase the capacity of and empower unserved, underserved, and inappropriately served populations. An underlying message in the Population Reports is the importance of culture in reducing disparities.
 4. Develop, fund, and demonstrate the effectiveness of population-specific and tailored programs. This is the focus of the next phase of CRDP.
 5. Develop and institutionalize local and statewide infrastructure to support the reduction of mental health disparities. Involves ensuring that the community is engaged in the implementation of the Strategic Plan, replicating many of the models that the project undertook to develop the Strategic Plan and Population Reports, and developing partnerships between the communities, counties, and state.
- Phase II involves a four-year pilot program to take \$60 million and pump it into the communities to replicate some of the promising practices identified in the Population Reports. CPEHN is recommending that the funding be available to local community-based organizations.
 - CPEHN is awaiting approval from the state to begin the 30-day comment period. It will disseminate the Strategic Plan widely among stakeholders. Also, three community forums will be held.

CPEHN will review the comments, prioritize them, strategize them, and incorporate them. The Strategic Plan will then go back through the approval process, and finally will be released to the public. Happening concurrently (hopefully) will be the release of the RFP from the state for the Phase II funds. The four-year program will then begin.

5. CRDP Strategic Plan Continued

Mr. Ryan asked about the difference between an unmet need and a disparity. Mr. Cantu explained that disparities have to do with the disproportionate impact something is having on a community. An example is looking at access to health care: going into the Affordable Care Act, the rate of uninsurance in the Latino community was much higher than the rate in some of the other populations. The Latino and the African-American Population Reports include some numbers on unmet need and disparity.

Ms. Cedro-Hament felt that the reports from yesterday's and today's presenters were impressive.

Motion: For the Planning Council to send a letter to every Mental Health Director endorsing the five CDRP reports for inclusion in their Innovative Proposals, and to let the Planning Council know when they have done so, was moved by Adrienne Cedro-Hament, seconded by Walter Shwe.

Ms. Mitchell suggested waiting until the next phase which will include the Strategic Plan's specific recommendations.

Mr. Grolnic-McClurg said that because you can't include a report in MHSA projects, it might make sense to amend the motion. Perhaps the letter could include a recommendation that the reports in their entirety be shared with the stakeholder groups and that the information in them be utilized in considering innovation projects.

Ms. Cedro-Hament replied that plans are currently being done at the local level. She felt that there is information in the reports that Mental Health Directors can use now.

Friendly Amendment: For the Planning Council to write each Mental Health and Behavioral Health Director for each county, recommending that they review each of the Strategic Plan Population Reports, share them with their MHSA stakeholder groups, and consider the information and strategies presented in the reports in formulation of their county Mental Health Service Act Innovation programs, was moved by Steven Grolnic-McClurg, accepted by Adrienne Cedro-Hament.

Ms. Fraser asked if the strategies will be also be released once they are vetted; Mr. Cantu replied that they would. The five goals and 25 strategies are part of the Strategic Plan. Ms. Fraser noted that the challenge in implementation is always keeping the Strategic Plan in front of people so their activities relate to it.

Ms. Lee asked about the average amount for grants being given locally for capacity building. Mr. Cantu answered that the amount would depend on the scope of the proposal.

Mr. Leoni cautioned that some would stigmatize recovery as something that the white Anglo community dreamed up – but recovery does apply to cultural communities. As we close other disparities, a new disparity affecting people in recovery should not emerge.

Motion: The Friendly Amendment above was seconded by Susan Wilson. It was voted on and approved unanimously.

(8.) New Business

Mr. Grolnic-McClurg offered an idea to restructure the timing of the three-day Planning Council meetings: to move the committee meetings to Thursday morning, and move the four-hour block of full Planning Council meeting to Wednesday afternoon. This would eliminate the eight-hour day (Thursday) of sitting in one room attending one meeting.

Dr. Pitts noted that speakers and the public would be obligated to come for three days rather than two.

Ms. Cedro-Hament commented that on Thursday afternoons the members become lethargic; they need to have some energy.

Ms. Mitchell noted that feedback from CALMHB, many of whose members attend on Thursdays, is warranted.

Ms. Adcock said that such a meeting change would entail amending meeting contracts with the hotels for October, January, and April.

A CALMHB member stated that their members would have to miss an important part of the meeting were it to move to Wednesdays.

Ms. Hart suggested not having panel discussions back to back – rearranging not the time, but the content of the meetings.

Mr. Grolnic-McClurg stated that it is difficult to have one meeting in one room, sitting around a large table for eight hours, and still to stay involved. In addition, we have some but not entire control over the presentation style of the guest speakers. We need to structure meetings such that we can be as attentive as possible, regardless of the presentation style of the speakers.

Ms. Shaw recalled when the Planning Council would meet on Thursdays and Fridays only – the full session would meet for a total of eight hours.

Ms. Adcock stated that when the Planning Council streamlined down to four committees, the group determined that they wanted to spend more time together – so they went to the all-day Thursday format.

Ms. Mitchell suggested that some of the human resources meeting content could be moved back into a committee. For example, yesterday Dr. Pitts had introduced the issue of adults with mental illness in skilled nursing; previously that would have been sent to the Adult Committee. More committees had meant that the Planning Council had more capability to look at specific issues (including those brought by the public).

Mr. Grolnic-McClurg suggested making the initially suggested change first, then separating out the conversations about whether we need twelve hours of General Session and whether we need different or more committees.

Ms. Cedro-Hament felt that having more committees would give some of the issues more focus. She also felt the need for the Planning Council members to re-energize themselves.

Chair Wilson asked for an informal consensus from the Planning Council on restructuring meetings to Wednesday morning, Executive Committee meeting; Wednesday afternoon,

General Session; Thursday morning, committee meetings; Thursday afternoon, General Session; and Friday morning, General Session.

Ms. Lewis felt that the inclusion of CALMHB should be considered in whatever structure the Planning Council develops, and the Planning Council should continue the present structure until we can sort these questions out.

Ms. Wilson suggested that if no one has profound objections to the new structure, the issue should be turned over to the Executive Committee to work with Ms. Adcock for a trial run.

Ms. Hart felt that people's attention spans are being stretched with the lengthy presentations such as this meeting had scheduled.

Chair Wilson obtained general consensus from the Planning Council to try out the new meeting schedule for October.

6. Committee Reports

CSI Committee

Susan Wilson gave the report in place of Committee Chair Pat Bennett.

- The committee welcomed new member Maya Petties.
- The first Data Notebook has come back, from Glenn County.
- Renee Bradley gave an update on MHSOAC research projects. She addressed the question of how to improve the data we have. There are problems with disaggregating the data in order to get more detailed information. She also addressed the question of how to get deliberate feedback from boards on the usefulness of the Data Notebook. The committee will coordinate with CiMH on ensuring that this discussion continues.
- Ms. Leonelli and Ms. Wilson will write a paper on AB 114. They gave a presentation to the committee on the subject.
- A panel held a discussion on Trauma-Informed Care. It included a program in place at the San Francisco Unified School District called Support Not Suspensions.
- The committee heard a presentation from Steven Blum of Contra Costa County Mental Health Services on evidence-based practices for treating trauma in adults.

HCR Committee

Committee chair Steven Grolnic-McClurg reported.

- The major focus was continuing to look at the new set-up in the public mental health system. There is a requirement that by July, the mental health plans and their local health plan partners have an MOU in place that explains how individuals who present will get correctly referred to either the health plan or the mental health plan, and also that they have a dispute resolution process.

- A representative from Alameda County gave a presentation on how that county has set this up, primarily looking at their communications in process with Beacon Health Strategies – a group that is contracted with many California counties to provide mental health services for low to moderate consumers.
- Andrew George with the Department of Managed Health Care gave a presentation on the process for providing oversight for managed health plans, as well as the tools we can use to help support consumers who are not getting care. There are two of these tools: a help center and a complaint unit. Mr. Grolnic-McClurg described the grievance and appeals process.
- The committee is tracking the new waiver for substance abuse services.
- The committee agreed to change its name to the Health Care Integration Committee.

Ms. Lee commented that if she sought mental health help, she would need a case manager to navigate the complicated process he had described. Mr. Grolnic-McClurg agreed on this point; that is why it is important that we partner with the Department of Managed Care to help them understand the community they are working with.

Dr. Nelson felt that the health care reform process is not even halfway through, although the process does include integration. He agreed with Ms. Lee about the bureaucratic quagmire of the system. It is in serious need of repair.

Ms. Shaw commented that the Coalition has had a committee for a long time that examines issues around managed care and parity. To facilitate enforcement, the Department of Managed Care has received ten new positions.

PR Committee

Committee Chair Daphne Shaw reported.

- The committee reviewed their presentation at the previous Planning Council meeting.
- The committee discussed the letter they intend to write to county Mental Health/Behavioral Health Directors regarding the concern that much of Patient Advocates' time is being spent at hearings – they have insufficient time to carry out their other duties.
- The committee discussed the survey they sent out regarding the five items that by law are supposed to occur as part of Patient Rights. They are considering restructuring the survey in some ways. Because of CALMHB's lack of staff the PR Committee will try to communicate directly with all of the Mental Health Board Chairs, asking them to place the survey on their meeting agendas.
- The committee will look for disability rights reports that may exist containing data that the committee can “mine”. They are interested in the actual Patient Rights Advocate/Client ratio.

Advocacy Committee

Dr. Adam Nelson reported for Chair Barbara Mitchell.

- The committee is watching federal legislation wending its way through Congress:
 - The Helping Families in Mental Health Crisis Act, promulgated by Representative Tim Murphy.
 - The Strengthening Mental Health In Our Communities Act, promulgated by Representative Ron Barber.

The two pieces of legislation have become polarized, however. Republicans are backing Representative Murphy's bill and Democrats are backing Representative Barber's bill, which weakens the chances of either bill becoming law.

- Because of the recent tragedy in Santa Barbara, there has been interest in introducing state legislation on gun violence restraining orders.
- A Planning Council task force has been created to look into the issue of peer certification.

Mr. Leoni reported that the committee heard a presentation on peer-supported respite housing given by a service in Santa Cruz County called Second Story. It is 100% peer-run with just six beds. Data is preliminary as yet.

7. Public Comment

John Sturm, San Diego Mental Health Board, spoke about mental health parity. He is finding that with trauma care, when patients are trying to get a specific kind of treatment, it is very difficult to get it approved and to find the funding.

Andrew Phelps, past Chair of the Berkeley Mental Health Commission, spoke about the nature of mental illness and engaging the problem scientifically. The Global Summit on Diagnostic Alternatives is studying the improper, non-humanistic way diagnoses are done. He also worked with the International Critical Psychiatry Workshop in May 2013 which addressed the problem of diagnostic alternatives. There is a social co-problem with this culture change advocacy: we must learn to relate to each other differently.

Ken Bonner, a clinician in the medical field and a Commissioner in Santa Barbara County, stated that it is time for action in our communities. He is part of a group called the Rebuild Organization which deals with the problem that communities are out of control.

Robbie Powelson affirmed Steve Leoni's support of Second Story Respite House. It is an incredible cutting edge program. Regarding reducing disparities, he expressed concern about age discrimination toward the young. There are barriers within our system that make it difficult for young people to be involved.

Dr. Larry Gasco thanked the Planning Council for speaking in support of CALMHB's efforts to secure additional resources. He also thanked Gail Nickerson and Daphne Shaw for helping to show him the legislative and historical realities that impact CALMHB directly. He recognized the assistance of Susan Wilson, Jane Adcock, and Tamara Jones in negotiating contracts with the hotels.

Maria Correia, Santa Cruz Mental Health Board, raised the issue of peer support in Santa Cruz – at Second Story in particular. It is a very small project, and although good things seem to be happening, a very small number of clients have been served in the last four years or so. With a SAMHSA grant of \$5 million, only about 100-150 guests have been served. The same guests tend to return over and over. The project needs to be scrutinized; questions should be asked regarding use of the funds.

Dr. Mohammed M. Asiad, Family Practitioner in Imperial County, stated that in this county there is no rehab center and no psychiatric hospital. We need to lobby for youth. Families are breaking apart because of drug abuse; methamphetamine use is on the rise. So many youth are lost in a vicious cycle of drugs, yet there is no rehab center. We should learn from European and Israeli governments who support rehab centers for youth.

Cary Martin, CALMHB President, hoped that the Planning Council had heard his written remarks at the April meeting. It referenced the strengths of the Planning Council. Because of CALMHB's relationship with the Planning Council, Mr. Martin was able to get the EQRO to agree to have more consumers and family members involved. Mr. Martin also recommended the Military 101 programs.

9. ADJOURN

Chair-Elect Clafin adjourned the meeting at 12:05 p.m.

X INFORMATION

TAB SECTION: V

___ ACTION REQUIRED:

DATE OF MEETING: 10/16/14

DATE MATERIAL

PREPARED BY: Jones

PREPARED: 09/29/14

AGENDA ITEM: Mental Health and Substance Use Overview

ENCLOSURES: Excel spreadsheet--Community Mental Health Funding Amounts: Role of Major Funding Sources

OTHER MATERIAL RELATED TO ITEM:

ISSUE:

**Community Mental Health Funding Amounts
Role of Major Funding Sources**

Actual/Estimated/Projected Totals for the Major Community Mental Health Funding Sources (In Millions)												
	FY 03/04 (actual)	FY 04/05 (actual)	FY 05/06 (actual)	FY 06/07 (actual)	FY 07/08 (actual)	FY 08/09 (actual)	FY 09/10 (actual)	FY 10/11 (actual)	SFY 11/12 (actual)	SFY 12/13 (estimated)	SFY 13/14 (projected)	SFY 14/15 (projected)
State General Fund (SGF)	\$611.3	\$621.6	\$653.5	\$721.8	\$738.5	\$701.0	\$518.0	\$619.4	\$0.1	\$0.0	\$142.5	\$0.0
Realignment I*	\$1,159.3	\$1,189.9	\$1,217.1	\$1,230.9	\$1,211.5	\$1,072.4	\$1,023.0	\$1,023.0	\$1,097.6	\$1,324.0	\$1,438.0	\$1,526.0
Realignment II**	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$1,131.0	\$1,128.0	\$1,140.0
Federal Financial Participation (FFP)	\$987.5	\$955.5	\$1,019.9	\$1,076.8	\$1,266.4	\$1,404.6	\$1,619.2	\$1,799.9	\$1,562.5	\$1,465.0	\$1,737.0	\$2,073.0
Mental Health Block Grant (SAMHSA)	\$55.6	\$53.5	\$54.4	\$54.7	\$55.1	\$53.7	\$54.0	\$53.7	\$53.1	\$57.4	\$57.4	\$57.4
Proposition 63 Funds (MHSA) Allocations/Distributions	\$0.0	\$12.7	\$316.9	\$426.3	\$1,488.2	\$1,117.0	\$1,347.0	\$1,165.1	\$1,029.9	\$1,589.0	\$1,091.0	\$1,633.0
Redirected funding for EPSDT and Mental Health Managed Care	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$861.2	\$0.0	\$0.0	\$0.0
Other	\$255.2	\$276.2	\$295.4	\$306.8	\$313.3	\$233.9	\$187.6	\$139.4	\$139.4	\$150.0	\$150.0	\$150.0
TOTAL	\$3,068.9	\$3,109.4	\$3,557.2	\$3,817.3	\$5,073.0	\$4,582.6	\$4,748.8	\$4,800.5	\$4,743.8	\$ 5,716.4	\$ 5,743.9	\$6,579.4

*Includes \$14 million in Vehicle License Fee Collections. FY 11/12 and FY 12/13 and amounts from Governor's proposed FY 13/14.

**Managed Care and EPSDT share of 2011 Behavioral Health Subaccount only. FY 12/13 and 13/14 growth estimated on percentage of growth in Behavioral Health Subaccount from Governor's proposed FY 13/14 budget.

State General Fund (SGF): The SGF is funded through personal income tax, sales and use tax, corporation tax, and other revenue and transfers. Prior to the Governor's FY 2011/12 Budget Proposal, the primary obligations of the SGF provided to counties for mental health are to fund specialty mental health benefits of entitlement programs including Medi-Cal Managed Care, Early and Periodic Screening Diagnosis Treatment (EPSDT) and Mental Health Services to Special Education Pupils (AB 3632).

Realignment: Realignment is the shift of funding and responsibility from the State to the counties to provide mental health services, social services and public health. There are two sources of revenue that fund realignment: 1/2 cent of State sales taxes and a portion of State vehicle license fees. The primary mental health obligation of realignment is to provide services to individuals who are a danger to self/others or unable to provide for immediate needs. It is also a primary funding source for community-based mental health services, State hospital services for civil commitments and Institutions for Mental Disease (IMDs) which provide long-term care services. 2011 Realignment gives counties the funding responsibility for EPSDT and

Federal Financial Participation (FFP): FFP is the federal reimbursement counties receive for providing specialty mental health treatment to Medi-Cal and Healthy Families Program beneficiaries. The amount of federal reimbursement received by counties is based on a percentage established for California called the Federal Medical Assistance Percentage (FMAP).

Proposition 63 Funds (MHSA): The MHSA is funded by a 1% tax on personal income in excess of \$1 million. The primary obligations of the MHSA is for counties to expand recovery based mental health services, to provide prevention and early intervention services, innovative programs, to educate, train and retain mental health professionals, etc.

Other: Other revenue comes from a variety of sources--county funds are from local property taxes, patient fees and insurance, grants, etc. The primary obligation of the county funds is the maintenance of effort (the amount of services required to be provided by counties in order to receive realignment funds).

Source: MHSOAC Financial Services Committee

May 2014

Updated Annually